OBSERVATOIRE FRANÇAIS DES DROGUES ET DES TOXICOMANIES

www.drogues.gouv.fr

DRUGS AND DEPENDENCE

INDICATORS AND TRENDS 2002

FRANCE

Foreword

Developing knowledge on drugs and the behaviour of addition, and, in addition, making it available to the public, is one of the key aims of the three-year plan for the fight against drugs and the prevention of dependence, adopted by the Government in June 1999.

In this regard, the concern of the public authorities is not only to base policies on validated scientific data, but also to ensure that this data is shared by everybody. There is no other way if we wish, on the one hand, to foster a genuine public debate on the drugs question, free from any a priori ideology, and, on the other hand, make public opinion support the policy in operation, which aims, in a pragmatic may, to reduce the human, health and social risks from the use of drugs.

In this perspective, the MILDT (Mission interministérielle de lutte contre la drogue et la toxicomanie—Interministerial Mission for the fight against Drugs and Drug Addiction) has tried to promote an active policy of collection and distribution of data and available knowledge to specialist and non-specialist professionals, and to the general public: requests to INSERM (Institut national de la santé et de la recherche médicale—National Institute for Health and Medical Research) for collective reports (knowledge assessments) on controversial questions (effects on health concerning the consumption of drugs, such as cannabis or alcohol); distribution of information brochures to the general public (such as the book, Drugs: know more, risk less*, with more than 5 million copies distributed); national information campaigns in the newspapers, radio and television.*

The distribution of the work done by the OFDT (Observatoire français des drogues et des toxicomanies—French Observatory of Drugs and Drug Addiction) on the different aspects of psychoactive drug consumption and their consequences, is in line with these objectives: knowing who consumes what, monitoring development over time, having relevant indicators on the measurable consequences of the consumption of various drugs, and being aware of the activities of the services responsible for prevention or care. This is the descriptive knowledge that is important to both public authorities and everybody who is concerned, or simply interested.

I am particularly pleased to welcome this fourth edition of Indicators and Trends from the OFDT. In passing, it appears important to me to make the point that the scientific autonomy of the Observatory, in its activities of statistical and epidemiological monitoring, is the best gauge of the impartiality and quality of its work. This autonomy can only provide comfort to the OFDT in its status, as a place of reference and indisputable expertise, for the monitoring and analysis of the consumption of all psychoactive substances—illicit drugs, but including alcohol, tobacco and the misuse of psychotropic medications.

Nicole MAESTRACCI,
Présidente de la MILDT—President of the MILDT

Preface

The growth in the data available for the field of drugs and drug addiction has not reduced the interest of a summary document. To the contrary, the placement of numerous surveys and analysis texts in their entirety online, on the Internet site www.drogues.gouv.fr, has made a concise presentation of the state of our knowledge essential.

The 1996 edition had 125 pages, that of 1999 reached 270, and this edition has 368. Yet despite this, a number of areas are not adequately covered, particularly certain aspects of tobacco and alcohol consumption, which were introduced into the field analysed by the OFDT, more recently than illicit drugs. The detailed presentation of knowledge on the illnesses and mortality related to the consumption of tobacco and alcohol, must be completed, as must the presentation of data regarding the accident rate related to inappropriate consumption of alcohol or illicit drugs. The development of knowledge at the departmental and regional level is also part of the objectives to be achieved.

The continuous update of our knowledge regarding the consumption of drugs and its consequences is an essential platform for conducting an appropriate public policy, taking into account, at the same time, of epidemiological realities, developments in society and the state of the legislation. The OFDT has become the coordinator, the silent partner and the clearinghouse for making knowledge available to all. Its independence from the structures that coordinate and conduct government action—guaranteed by its scientific college [status]—associated with its capacity to produce data that are useful or essential to their actions, allows us to know where we stand, to specify what we should be concerned about, and to have reason to hope that our actions will reduce the human tragedy related to the excessive or inappropriate use of drugs, whether licit or illicit.

Robert FINIELZ,
Président du conseil d'administration de l'OFDT
President of the Management Board of the OFDT

Claude GOT,
Président du collège scientifique de l'OFDT
President of the OFDT Scientific College

Reading guide

Drugs and Drug Dependence. Indicators and trends is designed so that each chapter can be read independently. This choice sometimes means repetition and referral from one chapter to another.

Due to this structure, each chapter includes a detailed Table of Contents, a 'Markers' sheet showing the main points, and a specific bibliography (heading: 'For more information').

The general Table of Contents, and those at the beginning of the four main sections, are printed on a blue background, thus allowing easy navigation through the report.

In order to allow for a more or less technical reading of this report, four specific types of reference have been used:

(OFDT, 1999)	Reference to the Bibliography situated at the end of each chapter or section, in which the references are classified in alphabetical order.
①	Reference to a methodological description of the statistical source used; this information is grouped together in the appendices, under the heading 'methodological references'.
primary drug	The terms indicated by a blue colour, and a different character font to the rest of the text, indicate an entry in the Glossary, or in the Appendix, which explains certain terms that are proper to the vocabulary of the fields involved.
(1)	This reference is specific to the chapter 'Legal framework and structures' and relates to the principal legislative and regulatory texts, the complete references to which are set out at the end of the chapter.

The meaning of acronyms is, in principle, explained when they appear for the first time in a chapter. It is, however, always possible to refer to the complete list at the end of this work.

The Index, in the Appendix, completes the reading tools for this work. It is preceded by the Table of Illustrations (tables and graphs) presented in the report.

Mobilised network

Agence française de sécurité sanitaire des produits de santé (AFSSAPS) French Agency for the Sanitary Safety of Healthcare products
Association nationale de prévention de l'alcoolisme (ANPA) National Association for the Prevention of Alcoholism
Caisse nationale d'assurance maladie (CANAM) National Illness Insurance Fund
Caisse nationale de l'assurance maladie des travailleurs salariés (CNAMTS) Salaried Employees National Illness Insurance Fund
Centre d'analyse et d'intervention sociologique (CADIS) Centre for sociological analysis and intervention
Centre de documentation et d'information sur le tabac (CDIT) Tobacco Documentation and Information Centre
Centre de recherche psychotropes, santé mentale et société (CESAMES, ex GDR psychotropes, politiques et société) Centre for the Research of Psychotropic Drugs, Mental Health and Society (CESAMES, formerly GDR, psychotropic drugs, policies and society)
Centre de recherche, d'étude et de documentation en économie de la santé (CREDES) Centre for the Research, Study and Documentation of the Health Economy
Centre européen pour la surveillance épidémiologique du Sida (CESES) European Centre for the Epidemiological Monitoring of AIDS
Centre français d'éducation pour la santé (CFES) French Centre for Health Education
Centres d'évaluation et d'information sur la pharmacodépendance (CEIP) Pharmacodependency Evaluation and Information Centres
Commission nationale des stupéfiants et psychotropes National Commission for Narcotics and Psychotropic Drugs
Conseil de prévention et de lutte contre le dopage (CPLD) Council for the Prevention and Fight Against Doping
Drogues alcohol tabac info service (DATIS, ex DIS) Drugs, Alcohol and Tobacco Information Service
Fédération française des spiritueux French Spirits Federation
Fédération nationale des observatoires régionaux de la santé (FNORS) National Federation of Regional Health Observatories
Information médicale et statistique sur la santé (IMS Health) Medical Information and Statistics on Health
Institut de recherche en épidémiologie de la pharmacodépendance (IREP) Research Institute for the Epidemiology of Drug Addiction
Institut de recherches scientifiques sur les boissons (IREB) Institute for Scientific Research on Beverages
Institut de veille sanitaire (InVS, ex RNSP) Health Watch Institute
Institut national de la santé et de la recherche médicale (INSERM) National Institute for Health and Medical Research: Units SC8 and 472
Institut national de la statistique et des études économiques (INSEE) National Institute for Statistics and Economic Studies
Institut national de recherche agronomique (INRA) National Institute for Agronomic Research
Institut national de recherche pédagogique (INRP) National Institute for Pedagogic Research
Mission interministérielle de lutte contre la drogue et la toxicomanie (MILDT) Interministerial Mission for the Fight Against Drugs and Drug Addiction
Observatoire européen des drogues et des toxicomanies (OEDT) European Observatory for Drugs and Drug Addiction
Office français de prévention du tabagisme (OFT) French Office for the Prevention of Nicotine Addiction
Réseau national d'information et de documentation (TOXIBASE) National Network for Drug Dependency Documentation
TREND and SINTES networks

Ministry of Economy, Finance and Industry

General Customs and Indirect Duties Department (DGDDI): Legal Affairs, Litigation and Anti-Fraud Division, Office D3

Customs laboratory, Ile-de-France

Ministry of Education

Department of school education (DESCO)

Ministry of Employment and Social Affairs

General Health Department (DGS): 'Addictive Practices' Office (SD6B) and 'Fight Against HIV' Office (SD6A, formerly AIDS Division)

Department of Research, Studies, Evaluation and Statistics (DREES)

Department of Hospital Management and Healthcare Organisation (DHOS): Office for the Organisation of Regional Healthcare Services and Specific Populations (O2)

Ministry of the Interior

Anti-Drug Mission (MILAD)

Central Office for the Repression of the Illicit Trafficking of Narcotics (OCRTIS)

Police Scientific Laboratory of Lyon

Ministry of Defence

Central Administration of the Military Health Department (DCSSA)

Central Administration of the National Service (DCSN)

Central Administration of the National Gendarmerie (DGGN): Technical service for judicial research and documentation

Ministry of Youth and Sports

Sports Department: Office for the Protection of Athletes and the Public

Department of Youth and Popular Education

Ministry of Justice

General Administration and Equipment Department (DAGE): Statistics, Studies and Documentation Division (SDSED)

Penitentiary Administration Department (DAP): Division for Persons in the Hands of Justice, Studies Office and Budget Forecasting (PMJ1)

Contributions to this project

Director of Publication

Jean-Michel COSTES

Project co-ordinator

Hélène MARTINEAU

Members of the report project group, authors

François BECK
Jean-Michel COSTES
Thierry DELPRAT
Cristina DIAZ-GOMEZ
Nicolas GILIO
Alain LABROUSSE
Stéphane LEGLEYE
Hélène MARTINEAU
Carine MUTATAYI
Christophe PALLE
Abdalla TOUFIK

Special contributions

Pierre-Yves BELLO
Claude FAUGERON
Claude GOT
Olivier GUÉRIN
Patrick PERETTI-WATEL
Patrick SANSOY

Members of the OFDT Scientific College

President: Claude GOT¤

Gérard BADEYAN
Joseph CANDALOT
Sylvain DALLY
Alain EHRENBERG
Alain EPELBOIN
Claude FAUGERON
Jean-Dominique FAVRE
Olivier GUERIN
Claude JACOB
Monique KAMINSKI
Serge KARSENTY
Pierre KOPP
Antoine LAZARUS
Dominique PÉCHEUX
Alain SAGLIO
Annie SASCO
Michel SETBON
François CLANCHE
Marc VALLEUR

Special thanks for their participation

Marc-Eric ALEPÉE
Christel ALIAGA
Sylvie ALLOUCHE
Marie ANGUIS
Jacques ARÈNES
Philippe ARVERS
Christine BARBIER
Hassan BERBER

Dominique BILLET
Michel BOUCHET
Norbert BOUTARD
Gérard BROWNE
Gérard CAGNI
Laurence CALLARD
Chloé CARPENTIER
Martine CAUVILLE
Matthieu CHALUMEAU
François CLANCHÉ
Baptiste COHEN
Karine COM
Laure COM-RUELLE
François COURAUD
Éric DANON
Christine DEMESSE-BACHELERIE
Simona DRAGOS
Nathalie DUPARC
Julien EMMANUELLI
Anne de l'EPREVIER
Robert FINIELZ
Jean FRANKA
Michel GANDILHON
Arnaud GAUTIER
Nathalie GAUTRAUD
Isabelle GREMY
Marie-Claire GUIDOTTI
Philippe GUILBERT
Alice GUITON
Martine GIACOMETTI
Maud GUILLONNEAU
Jean-Marie HARDRE
Roger HENRION
Maguy JEANFRANÇOIS
Évelyne JIMENEZ
Éric JOUGLA
Annie KENSEY
Jean-Pierre KILQUE
Nicole LABROSSE-SOLIER
Hugues LAGRANGE
Nadine LANDREAU
Sylvie LEDOUX
Bernard LEGOUEIX
Nicole LEYMARIE
Dominique LUCIANI
Nicole MAESTRACCI
Hervé MÉCHERI
Éliane MICHEL
Danielle MILLION
Hélène MORFINI
Françoise MOYEN
Karina ODDOUX
René PADIEU
Dominique PÉCHEUX
Elda PHILIPPE
Pierre POLOMENI
Guillaume PRUNIER
Jean PUIG
Alain RAUSS
Hubert REDON
Monique REUZÉ
Catherine RICHARD
Michel RIEU
Olivier ROCHE
Annie SASCO
Catherine SERMET
Élisabeth SEVENIER
Marie-Françoise SOMBART
Sergine TELLIER
Xavier THIERION
Frédéric THOMAS
Odile TIMBART
Charlotte TRABUT
Alain TRUGEON
Jean-Paul TRUCHOT
Dominique VUILLAUME

Graphic design – Production monitoring

Frédérique MILLION

Introduction

'To conduct public policies, it is essential to understand and measure the phenomenon to be dealt with' (extract from the government plan for the fight against drugs and drug dependence 1999-2001).

The public authorities desired that a report on the status of the drugs and drug dependence phenomenon be established periodically by an independent organisation. The French Observatory of Drugs and Drug Addiction, an autonomous public establishment, has been entrusted with this task since 1995. It is now publishing this fourth edition of its report, three years after the adoption of the government plan, to which the previous edition was attached. The inventory drawn up here allows a better grasp of the extent and complexity of the phenomenon, which the pubic authorities had to tackle, its development over the last two years, and the structures implemented for this purpose.

Public policy has been oriented, since 1999, toward a new approach of preventing and treating all uses of psychoactive drugs, irrespective of their judicial status. This approach, while fully acknowledging the medical and social specifics of each product, gives priority to the concept of the behaviour of use rather than to the product. To better fulfil its task, oriented toward a perspective of assisting decisions, the Observatory has consequently extended its field of monitoring. This report therefore covers alcohol, tobacco and psychotropic medications on the basis as illicit drugs.

Approach adopted

Work method

The intention of this summary of the available data and analyses on drugs and drug dependence is to show the phenomenon, its development and trends in as global a manner as possible. It requires work designed to explore and clarify the significance of series of numbers and compare one with the others, although the data comes from completely different sources, and are often produced using different methodological protocols.

The approach adopted followed both pedagogic and technical objectives. It means not simply showing the indicators and presenting trends, but also specifying the origins and the limits on interpretation due to the comparison of various points of view.

The Observatory oversaw the supervision and drafting of the report with the assistance of a project group, formed internally, who defined its orientations and discussed the different stages of its production. The Scientific College was involved to validate the initial orientations and the overall report. External validation was sought, chapter-by-chapter, from competent experts. This report, therefore, is the fruit of intense teamwork, backed up by the mobilisation of the network of experts, which the Observatory has formed during its work.

Form of the report

The report comprises three sections. The first section deals in a transversal approach to the different drugs concerned, with the measurement of the 'drugs' phenomenon in France and the description if its characteristics: the perception and opinions of the French on the subject, the consumption of drugs, the health, social and penal consequences, the supply of drugs, and finally, geographic consumption. This part also covers certain aspects specific to illicit drugs, across the range of drugs.

The second part is a product-by-product breakdown of the analysis plan of the preceding transversal approach. The chapters therein might appear partially redundant due to the editorial line used, to encourage autonomous reading of each chapter.

The third part is devoted to the presentation of the legal and institutional framework covering the consumption of drugs in France. Going beyond a simple reminder of the principal legal provisions in relation to the different drugs, this part retraces the recent developments in public policies since the publication of the previous edition of the 'Indicators and Trends' report. It then outlines the structures and means implemented

by the public authorities to tackle the phenomenon. Certain areas, such as prevention, which were only touched on, in the previous edition, have been particularly developed.

Monitoring methods: sources of information

All of the sources of information used in the report are briefly described in an appendix. They can be broken down into large categories, about which it is appropriate to describe the main characteristics and the limits as to their capacity to describe the phenomenon. Two comments of a general nature must, firstly, be made.

The mobilisation of the available sources of information provides a photo of the drugs and drug dependence phenomenon. The representation of a reality obtained in this way is largely dependent on the sources of information, of that which they seek and can observe. The compartmentalisation of information systems (licit and illicit drugs), the ambivalence of sources (indicators of the development of the phenomenon and/or the development of the actions of an institution) and the lack of data in certain areas are the main limits, which must be underlined. Sometimes, only delivering partial elements of monitoring, they restrict the value of the desired perspective. For example, it is difficult to treat the healthcare consequences of the use of large drug categories in the same way.

In focussing on the drug user populations, which is inherent in this type of exercise, it should not be forgotten that these are sub-groups of the general populations and that certain trends emerging might only be a simple reflection of more general trends found in the entire population.

Surveys of the general population

These surveys are based on statements made by respondents. This type of investigation is designed to measure the behaviour, attitudes or opinions of the general population, or a part thereof, in relation to the use of drugs. The method used is the questioning of a representative sample of these groups. These surveys have the advantage of giving a direct measurement of the phenomenon, and particularly of its size, in the entire population, and a reasonably reliable measurement of its development. It is, however, sometimes difficult to detect relatively rare behaviour though such means. The results give a picture of declared consumption.

Sales data

The sales data, only available for licit products, give, when recorded, another picture of consumption behaviours and their development.

Records

The national statistics produced from obligatory declarations (deaths, AIDS, etc.) allow estimation of one part of harmful use, from the damage-induced point of view.

Administrative statistics

The administrative statistics and certain studies targeting a particular population, defined by the institution involved in the field (for example: health/persons having had care, justice/persons imprisoned), provide a partial view of the drugs' use phenomenon, taken from a particular angle. In addition, the hidden population not seen by the institution escapes these statistics by definition.

These sources of information are particularly valuable for the analysis of major trends due to their permanence, regularity, and availability. However, their use is delicate, and it is important that their limitations be carefully taken into account. The indicators produced are 'indirect indicators', as the inertia inherent in the way in which they are produced does not generally allow the highlighting of recent trends in the phenomenon. In addition, these sources of information present specific problems: limited theoretical field, reliability, double counting, etc.

Qualitative studies

These special studies concern population sub-groups directly touched by the use of drugs, but are not selected in an institutional manner. Work of an ethnographic nature is one example. In addition to the quality of the description of use and behaviours, this type of approach reaches the "hidden" part of the phenomenon:

individuals not seen by an institution. These special studies describe behaviours in a qualitative manner, but do not measure their extent.

Structure for monitoring emerging phenomena

Since 1999, the OFDT has implemented a specific structure for monitoring emerging phenomena (TREND). On the one hand, this consists of a network of 'sentinel' observers centred on the 'urban area' (marginalized, problematic drug users) and the 'party area' (drug users attending night establishments or 'techno' gatherings) and, on the other hand, a system for the collection and analysis of synthetic drugs.

This structure, which intersects with the different methods previously described, sets itself apart from the others by the subject that it observes: emerging phenomena. Without excluding recourse to statistical methods, the information it provides is mainly of a qualitative nature: observations on the grounds of cross-validation and analysis allow the detection of trends that complete the findings provided by regular surveys and statistics.

Definitions and concepts

A glossary in the appendices specifies the meaning of certain words used in the report. Nevertheless, it is appropriate to define, in the introduction, some general concepts that structure the presenting of the indicators and trends.

Drugs—psychoactive products

What term should be used to encompass all of the drugs covered by the field of observation: drugs, psychoactive products (or substances)?

The meaning of the term 'drugs' differs depending on the point of view from which it is envisaged (judicial, clinical or toxicological approach). Its general acceptance is more oriented toward the field of illicit products. It does, however, offer the advantage of being able to take into account the intentions of the subject in the search for the product's psychoactive effect.

The concept of psychoactive products gives the appearance of much greater precision, but in reality, it covers products of exceptional problematic usage (coffee, chocolate, air, water, etc.), and therefore, a much wider field than the field of observation previously determined.

The following definition is proposed for the term 'drugs': a natural or synthetic psychoactive product, used with a view of modifying a person's state of conscience or improving performance, with a potential of harmful use, abuse, or dependence, and use might be legal or illegal. This definition includes: narcotics, (ONU agreements), psychotropic substances (ONU 71 agreement), alcohol, tobacco, glues and solvents, hallucinogenic mushrooms and synthetic substances not yet classified.

Based on this definition, and by agreement, the term '**drugs**' (or sometimes, 'psychoactive drugs') covers all of the products taken into account, including the following sub-groups: **alcohol, tobacco**, 'psychotropic medications', and 'illicit drugs'. **Psychotropic medications** include the following four classifications: hypnotics, neuroleptics, anxiolytic agents, and antidepressants. **Illicit drugs** covers narcotic products (outside the medical prescription framework) and certain products not classified as narcotics, that are diverted from their normal use (glue, solvents, synthetic substances, misused medications, etc.).

Observed use behaviours: use, harmful use, dependence

In regard to behaviours, there are three distinct categories: use, harmful use and dependence. These distinctions are common within the international scientific environment. They are based on the definitions of the World Health Organisation (CIM 10) and the American Psychiatric Association (DSM IV).

Use is understood as consumption that does not result in harm. This consumption can vary in intensity and can de qualified as experimental, occasional or regular.

Harmful use (or abuse) is understood as consumption, which implies, or can imply, health (somatic or psychic), social (incapacity to meet obligations at work, in school, in the family, etc.) or judicial harm. This harm can be dependent on specific contexts of use (driving a car, pregnancy) and, finally, be caused by the user, personally, or to a third party. In relation to the definition, the concepts of harmful use or abuse imply a repetition or consistency of behaviour.

Dependence is understood as a psychopathological behaviour that has biological, psychological and social characteristics. The main criteria contributing to its definition are: compulsive desire for the drug, difficulty in controlling consumption, taking the drug to avoid withdrawal symptoms, the need to increase doses to achieve the same effects as before, and the central place of the drug in the user's life.

These international definitions, developed from a clinical perspective, present the problems or certain levels. This means that some dangerous, but ad hoc, uses are not taken into account in the terms harmful use or abuse. It is also true that much discussion could be given to the definition of dependence. In addition, these concepts are not currently covered by the statistics. From an operational point of view, it is, therefore, very difficult to evaluate the proportion of consumers with a behaviour of harmful use or one of dependence. In this perspective, it is, however, possible to use indirect methods of estimation and to study the methods used in the surveys to mark the 'threshold' of passing from simple use, to use likely to imply abuse or dependence.

Doping

The doping problem is not confined to sport, even if it primarily concerns athletes. Taking medications to surpass one's own intellectual or physical attributes is a fact of society that touches all the social categories. It is not drug addiction in the strictest sense, even if the substances used are often psychoactive products. The definition given according to the law is the following: 'use of substances or procedures (the use of which is subject to restrictive conditions) which artificially change capacities or mask the use of substances or procedures which have this property, when the conditions of use of these substances or procedures are not fulfilled'.

The doping examined in this report concerns all the practices used by French people, aimed at improving physical or intellectual performance and, more especially, those of amateur athletes. Within the sporting environment, two phenomena must be distinguished:

- the practice of doping to improve performance (which is covered in the chapter devoted to doping),
- the consumption of drugs, some of which are classified as doping substances, by athletes for social or other reasons. The link between the consumption of drugs and practising sport is described in the chapters relating to the products consumed.

Reference points

Comprehensive approach to all drugs

Perceptions, opinions

- The French have developed a distinct hierarchy regarding the potential danger of different drugs: heroin, cocaine and to a lesser extent, ecstasy are placed clearly on top, cannabis being associated, like alcohol and tobacco, with a less serious danger.
- These perceptions are related to certain characteristics of individuals, primarily their age and consumption behaviour. This is particularly the case for cannabis: the perception of its dangers, the belief that its use leads to the use of more harmful drugs, and the opinions regarding its legal status that are strongly split between those who have consumed it, and those who have not.
- The support of the French for public policy actions in this area is strong: there is keen global support for risk reduction measures, linked to existing prohibition. In the case of cannabis, two out of three French people are in favour of this prohibition; the others mostly recommend a regulatory regime.

Consumption

- In the general adult population, a large majority of the French population have experimented with licit drugs. As they are consumed in a repeated or regular manner by large sections of the population, they represent a substantial portion of problematic drugs consumption.
- Experimentation, and especially current use of illicit drugs is more marginal. With the exception of cannabis, already experimented with by one French person in five, the other drugs concern only a small part of the population.
- The use of drugs affects mostly men and young adults, except in the case of alcohol, (consumption increasing with age) and psychotropic medicaments (consumption increasing with age and mostly women).
- During the 1990s, the consumption trends were as follows: reduction for tobacco, stable for alcohol and psychotropic medicaments (with the exception of antidepressants whose consumption increased), and an increase for cannabis.
- Amongst young people, the findings were relatively similar, but with some marked differences. Contrary to adults, the consumption of tobacco amongst young people is growing and has reached virtually the same level for girls as boys.
- The use of psychotropic medicaments, with the exception of medical prescriptions, is clearly growing, in particular amongst boys.
- The phenomenon of trivialising the consumption of cannabis is much more marked amongst young people. Experimentation with it at the end of adolescence has exceeded the symbolic threshold of 50%.
- Without achieving the extent detected for cannabis, the consumption of other substances is increasing, leading to the finding of a diversification of drugs experimented with and consumed, in particular in the party context, by certain young people: hallucinogenic mushrooms, synthetic drugs and to a lesser extent, cocaine.
- Initiation to the three main drugs consumed by young people occurs, on average, in the following order: alcohol (13 years), tobacco (14 years) and then cannabis (15 years). Consumption of these drugs is heavily interlinked.

Healthcare and social consequences

- It is the consumption of licit drugs that has the most serious health consequences. The number of annual deaths in France attributable to alcohol reaches 45,000, with 60,000 for tobacco. Currently, the number of annual deaths attributable to illicit drugs cannot be estimated; the main data available originates from overdose deaths detected by police services, and deaths from AIDS amongst drug users, which were of the order of 300 in 2000.
- The impact on mortality of the different drugs cannot be accurately compared due to the partial nature of data on illicit drugs, and because the estimated deaths do not relate to the same population. While the case of alcohol and tobacco relates to a population over 60 years, that of illicit drugs relates to a population with an average age of 30 years.
- The health damage resulting from alcohol and tobacco are much more serious for men than women, due, primarily, to a much higher consumption by men of these drugs in previous years. However, this difference is tending to narrow in the case of tobacco, due to the increase in the proportion of women smokers.

Comprehensive approach to illicit drugs

Healthcare and social consequences

- The problematic consequences of illicit drug use are largely dominated by the consumption of heroin, which continues to be the prime drug associated with the health and social care of illicit drug users. The consumption of cocaine is also frequently encountered, mostly in connection with opiates. It is estimated that there are between 150,000 and 180,000 'problem' opiate or cocaine users.
- A large part of the population involved in this problematic consumption of opiates or cocaine are receiving health and social care, in particular substitution treatment.
- Amongst this population, intravenous injection was frequently practiced during the 1990s. This practice is currently in regression.
- Receptions into care related to cannabis are becoming more numerous (15% in 1999).
- The number of deaths that result from the use of illicit drugs continues to diminish (a trend that began in 1994). The prevalence of VIH (Virus de l'Immuno déficience Humaine: human immunodeficiency virus, HIV) continues the decline observed at the beginning of the 1990s—16% of intravenous users in 1999. The prevalence of VHC (Virus de l'Hépatite C: Hepatitis C Virus, HCV) is increasing and has reached a very high level: 63% of intravenous users in 1999.

Criminal consequences

- Infringements of drug law led to more than 100,000 arrests in 2000. These have been growing constantly since 1970, and primarily involve users (95,000 arrests for use or use with resale, that is 93.5% of all cases) and, more particularly, cannabis users.
- During the 1990s, the development in numbers of arrests followed four main trends: the explosion in cases related to cannabis, the strong drop-off in those for the use of heroin since 1995, the growth in those related to cocaine, and the appearance and development in those for ecstasy use.
- Some arrests for use had a judicial follow-up and subsequent conviction (15,000 in 1999). In this case, possession as an infraction is frequently linked with another infringement of drug law (trafficking). The number of convictions for use has been stable for a number of years. Cases of imprisonment are less frequent (approximately 400 in 2000) and reduced during the 1990s.

The supply of illicit drugs

- The supply of illicit drugs, as detected by the activity of law enforcement services, is dominated by cannabis—the quantities seized tripled over the last ten years. Its moderate price and large availability make cannabis a very accessible drug.
- The number of seizures of cocaine and the quantities seized are increasing, but vary considerably from year to year as they depend on the realisation of major special operations.
- The clandestine market in synthetic drugs is expanding.
- The heroin market appears to be stagnating.
- The number of arrests, and convictions for narcotics trafficking, which had been increasing since the beginning of the 1990s, started to reduce at the end of that decade. The data on arrests for 2000 shows a reverse in this trend with an increase across all types of drugs. Cannabis is the most important in arrests for narcotics trafficking, but less so than in the case of use.

Comprehensive approach to all drugs

Perceptions and opinions

The perceptions and opinions of the French population on drugs and drug addiction were examined on the basis of a telephone survey of the general population, carried out in April 1999, which covered 2,000 persons aged between 15 and 75 years (EROPP [9]. Other surveys carried out during the 1990s were also used when they assisted in monitoring the trends.

Perceptions regarding drugs

In 1999, the drug that was most often spontaneously referred to as a drug by 15-75-year-olds was cannabis (78%), followed by cocaine (54%), heroin (45%), ecstasy (39%), LSD (27%), tobacco (21%), alcohol (20%) and crack (12%). A increasing minority spontaneously named alcohol as a drug (20% in 1999 against 14% in 1997).

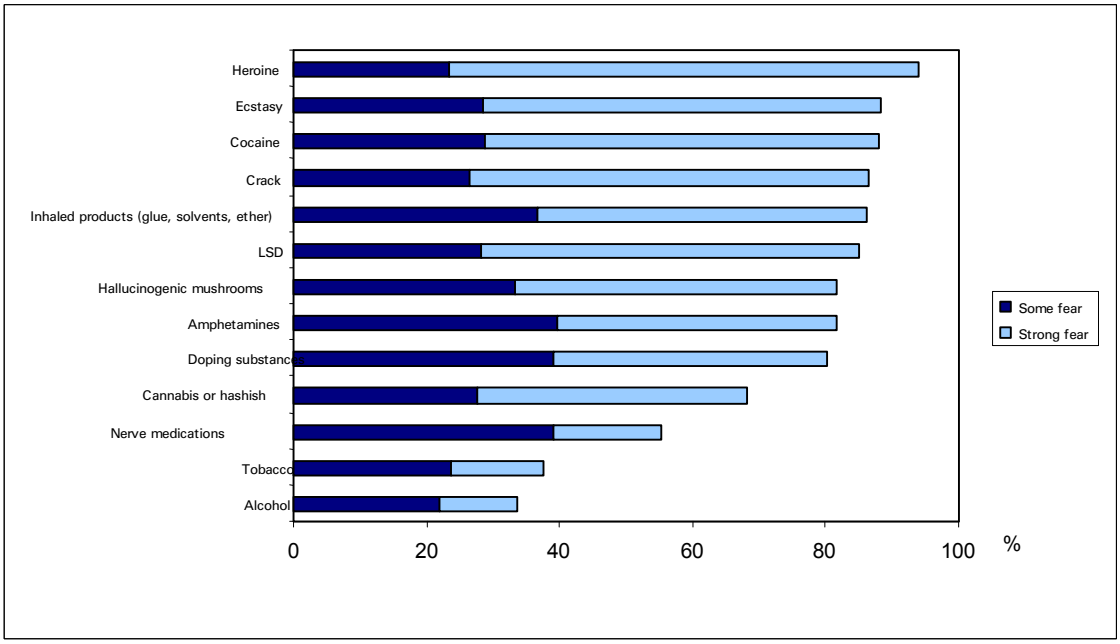
Regarding health risks, heroin and cocaine are considered immediatlely dangerous by a very large majority (85%). Experimentation with ecstasy is least often perceived as dangerous (76%). For more than half of the 15-75-year-olds, cannabis is harmful as soon as it is tried, but one third considers that regular use is not dangerous. The risk of dependence is considered much higher for heroin and cocaine (56% and 58% respectively consider that it exists from the first experimentation) than it is for cannabis (38%).

In terms of the hierarchical order of danger for seven drugs, a relatively large majority chose heroin (41%) ahead of cocaine (20%) and ecstasy (17%), followed by alcohol (6%), cannabis (3%), tobacco (2%), and medecines for nervous conditions (2%). It must be underlined that the survey did not distinguish between the danger of dependence, and the social, or physical, risks, which limits the interpretation of the answers. Amongst the 15-75-year-olds, 70% consider that the use of cannabis leads to the use of more dangerous drugs. Only 13% disagree with this idea, and 14% totally disagree. However, this theory of escalation appears less strongly anchored in public opinion than in 1992.

The level of fear regarding experimentation with these drugs is greater than 80% for all illicit drugs except cannabis (for which it is 68%). It reaches 55% for psychotropic medicaments and approximately 33% for tobacco and alcohol. For all drugs, women indicated a stronger fear than men, in particular for cannabis and alcohol. There were large disparities in the level of apprehension depending on the age of those surveyed. For alcohol and tobacco, and for substances usually associated with younger persons (ecstasy, inhaled drugs and hallucinogenic mushrooms), the proportion that indicated a fear increased with age, from 18 upwards. For cannabis, this development is much clearer. Other products, such as heroin, LSD, psychotropic

medicaments, amphetamines or doping substances, generated less differentiated fears depending on age [9].

Percentage of individuals who had a fear of taking different products, even once, in 1999 *{210a}*



Source: EROPP 1999, OFDT

Opinions in relation to public policies

The majority of 15-75-year-olds consider the prohibition on the use of narcotics to be legitimate, although relatively ineffective. Almost half categorically rejected the idea of legalised use (under conditions), of cannabis, with this proportion approaching three-quarters for heroin. Even though one-third favoured such a legalisation of cannabis (versus 12% for heroin), the legalisation (free sale) of cannabis encountered very strong opposition: only 17% approved. Of those who favour a revision of the law, regulation is the main demand. It is mostly men and young adults who favour free sale. Finally, while the questions in relation to the prohibition of cannabis use show relatively variable answers, those for heroin are much more consistent.

Obligatory care in connection with an arrest is also widely accepted (nine out of ten individuals favour it). If the resort to substitution drugs is looked on favourably by 81% of the French population, the sale of syringes without medical prescription does not meet with the same level of acceptance (63% favourable opinion). The controlled heroin distribution is a less well accepted measure than these last but, nevertheless, a majority of the French people are not completely against it (53%). The level of agreement with the last three propositions is markedly higher for those who have already used cannabis and diminishes with age. Finally, the medical use of cannabis is accepted by more than two thirds of 15-75-year olds (more frequently by men than by women). Only a quarter of the French people, mainly older and little qualified, think that it is possible to have a world without drugs. On the whole, the measures taken in France in connection with the reduction of risks have met with increasing acceptance since the beginning of the 90s. Nevertheless, a majority remains in favour of prohibitive measures except where legalisation is envisaged

within a therapeutic framework: it is thus not only the substances, but also their use referred to, that influence the opinions expressed on public policies.

The existence of an activity by the public authorities in assisting dependent users is acknowledged by some two thirds of 15-75-year-olds (66%). However, 63% consider that it should be intensified and 21% that another appraoch is required. A very large majority (86%) consider it important to inform young people—the proportion of individuals who think that it should be spoken about less reduced during the 1990s. Information for young people is considered adequate by 71% of individuals and dangerous by 15%. On the other hand, 58% of the French people consider themselves well informed about drugs. The level of information found increases regularly with the school level, and appears to be highest amongst respondents who have already used cannabis during their lives [9].

Factors associated with perceptions and opinions

The perceptions and opinions in relation to heroin users, and public policy in the matter of drugs and drug addiction were articulated in a coherent way, and echo the value systems of each: those most attached to traditional values were the most hostile to these users and most inclined to vote for a coercive and repressive policy. Conversely, those who questioned the policies, objected to the further stigmatising of heroin users, were more critical in relation to the prohibitions on use, and more favourable to a policy of risk reduction.

Regarding the socio-demographic profile, the youngest, and particularly the oldest, showed the strongest fears and the most substantial need for information. Gender appeared to be a small factor as far as its effect on an opinion, and its effect disappeared most often when the question of experimentation with an illicit drug was taken into account. The fear regarding drugs and the attitudes of rejection in relation to drug addicts were clearly less frequent amongst persons who had a certain familiarity with illicit substances, whether they had consumed them, been offered them, or had users amongst their friends. For other factors, generally, persons with a high level of education and those who felt well-informed about drugs had less stigmatising perceptions of drugs and their users, and were more favourable to risk reduction measures, and the idea of the regulation of cannabis consumption [9].

Consumption of drugs in the French population

Estimates of the number of consumers

Before attempting to answer questions about the number of users and their characteristics, it is necessary to define what is meant by consumption. It frequently occurs that figures are set up against one another that relate to different definitions of consumption and so cannot be reasonably compared. Consumption is characterised by two fundamental parameters: the quantity consumed and the frequency of consumption.

In order to put the consumptions of various drugs into perspective, it is therefore necessary to define 'consumption levels' . Four levels are used for the present report:

- Experimentation—that fact of having taken, at least once during life, the drug
- Occasional use
- Repeated use
- Daily use.

Based on indicators currently used in the international level, these four categories establish a gradation of the consumption intensity. These different groups fit into each other: repeated users are a sub-set of occasional users who are, in turn, a sub-set of experimenters.

The resulting figures are indicative; there is a large margin of error. The data must be interpreted as a simple guide to the scale of the different modes of consumption of the various psychoactive substances and of their relative weights in the total consumption.

Estimation of the number of drug users in mainland France in 1999

	Alcohol	Tobacco	Psychotropic medicaments	Illicit drugs	
				Cannabis	Other drugs
Experimenters [1]	43 million	36 million	///	9.5 million	1.5 million
Occasional users[2]	41 million	15 million	8.4 million	3.3 million	220,000
Repeated users [3]	14 million	13 million	3.8 million	1.7 million	///
Daily users [4]	8.9 million	13 million	2.4 million	280,000	///

(extrapolated to cover the entire 15-75 age group in mainland France, about 44 million persons in 1999, from the results of a survey of the general population)

[1] *Experimenters*	*Alcohol*	*At least once in life*
	Tobacco	*At least once in life*
	Cannabis	*At least once in life*
	Other illicit drugs [5]	*At least once in life*
[2]*Occasional users*	*Alcohol*	*At least once in year*
	Tobacco	*Admit to being active smokers*
	Medicaments	*At least once per year*
	Illicit drugs [6]	*At least once per year*
[3]*Repeated users*	*Alcohol*	*At least 3 times per week*
	Tobacco	*At least 1 cigarette per day currently*
	Medicaments	*At least 1 sleeping pill or 1 tranquilliser once per week*
	Cannabis	*At least 10 times per year*
[4]*Daily users*	*Alcohol*	*At least 1 glass per day during the last twelve months*
	Tobacco	*At least 1 cigarette per day currently*
	Medicaments	*At least 1 sleeping pill or 1 tranquilliser per day, more or less during the last thirty days*
	Cannabis	*At least 30 times during the last thirty days*

[5] *When inhaled drugs (glues, solvents) are taken into account, this number reaches 2.4 million.*
[6] *When inhaled drugs (glues, solvents) are taken into account, this number reaches 300,000.*

Sources: Health Barometer 2000, CFES, OFDT production (except problem use of illicit drugs)

Alcohol is the psychoactive product most deeply embedded in the culture and in consumption practices. It is most frequenty the object of experimentation and occasional use. When it comes to regular uses, it is outstripped by tobacco where for every two experimenters there is one "active" smoker. This smoker is almost always a regular smoker (at least 1 cigarette per day) and in two cases out of three a heavy smoker (10 cigarettes per day and more).

The use of psychotropic medicaments is in part for medical use and in part resembles that of other drugs. The border between these two types of consumption is difficult to draw. In the absence of adequate criteria for a clear delimitation, it is only possible to quote the available figures on total consumption.

Even if experimentation with illicit drugs is spreading, the number of declared or detectable users of these products is considerably less than for the drugs previously referred to.

On the basis of these guide data, which should not be regarded as giving more than a rough idea, the later chapters of the report will seek to define the consumption levels more precisely and to find prevalence trends, product by product. In the perspective of assisting decisions, it is more impotant to provide satisfactory appreciation of the trends rather than seeking great precision, often illusory, in the numbers.

Once the level and frequency of consumption is established, it is essential to be able to evaluate the share of drug users affected by abusive or dependent behaviour. To do this, we cannot rely on international definitions, produced from a clinical perspective, and which are difficult to interpret in statistical terms (see introduction). The surveys on the consumption of psychoactive substances nevertheless provide 'thresholds' of the movement from simple use, to use likely to imply abuse or dependence, by using the responses to the frequency of consumption, the quantities consumed, the age of initiation, or perception by the subject of his/her own dependence (DETA test for alcohol—DETA: Diminuer entourage trop alcool—Reduce alcohol-based surroundings).

These thresholds will be defined for alcohol, tobacco and cannabis in the chapters on each of these drugs. The estimation of the number of opiate and cocaine users with problems is given in this chapter, in the section 'comprehensive approach to illicit drugs'.

Consumption in the general adult population

The consumption of psychoactive substances is described here using the age groups most affected and for all 18-75-year-olds, based on the results of a survey using a representative sample of the French adult population [3].

Frequency of experimentation with psychoactive drugs amongst 18-75-year-olds, 18-25-year-olds and 26-44-year-olds in 2000, by age

(in %)

	18-75-year-olds	18-25-year-olds	26-44-year-olds
Alcohol	95.9	93.9	95.9
Tobacco	82.0	80.0	84.7
Psychotropic medicamedicaments [1]	19.7	13.1	16.3
Cannabis	21.6	46.8	31.7
Volatile glues and solvents	2.7	5.7	4.0
Cocaine	1.5	2.2	2.5
LSD	1.5	2.9	2.3
Amphetamines	1.4	1.6	1.8
Ecstasy	0.8	2.8	0.9
Heroin	0.7	0.9	1.2
Medicaments 'to drug oneself' [2]	0.7	0.9	1.1
Hallucinogenic mushrooms	0.4	0.6	0.5
Opium, morphine	0.3	0.1	0.3
Poppers	0.1	0.1	0.2

[1] For psychotropic medicaments, the questions covered the previous twelve months
[2] Term used during the survey.

Source: Health Barometer 2000, CFES, OFDT production

Amongst 18-75-year-olds, the psychoactive substances most frequently experimented with are alcohol and tobacco. The most consumed illicit drug, by far, is cannabis with 21.6% of experimenters, with this prevalence being at a much lower level than that related to licit drugs. One person in five of the 18-75-year-olds used psychotropic medicaments during the year. Experimentation with the other products—inhaled products (volatile glues and solvents), LSD, cocaine, amphetamines and to an even lesser degree, ecstasy, heroin and medicaments 'to drug oneself' involved only a small minority of individuals.

The consumption of psychoactive substances involved, above all, young people, with the exception of psychotropic medicaments and daily consumption of alcohol. More than one-third of 16-44-year-olds consumed cannabis during their lives. Amongst adults, the proportion of experimenters decreases with age; it amounts to no more than 2.5% of 55-75-year-olds. The age breakdown of experimenters is very similar for medicaments 'to drug oneself' and heroin, as is the case for LSD and cocaine, the latter clearly involving the 18-44-year-olds generation (more than 2% of users during their lives in this section). Amongst the 18-34-year-olds, approximately one individual in twenty used an inhaled drug. Experimentation with ecstasy is almost zero above 35 years, while, conversely, experimentation with amphetamines has virtually no relation to age.

Experimentation with psychoactive substances other than psychotropic medicaments is a clearly masculine behaviour. With the exception of amphetamines, for which the difference between gender is not significant, men are, for all illicit drugs, two to three times more numerous than women in having consumed them during their lives. There are almost twice as many cannabis experimenters amongst men (29%) than amongst women (15%). Finally, tobacco engenders a particular place with men, even if in the older generations the gender ratio remains strong.

For its part, repeated use primarily involves tobacco and alcohol, and cannabis at a much lower level. Amongst 18-75-year-olds, three out of ten are daily tobacco smokers and approximately one-third took alcohol at least three times a week. The repeated use of cannabis (at least ten times in the last twelve months) involved 3.4% of 18-75-year-olds (15% of 18-25-year-olds and 3% of 26-44-year-olds). Repeated consumption (at least once during the year) of soporifics or tranquillisers reached 9.1% of 18-75-year-olds. For the other products, use during the year was very rare.

Repeated consumption of at least two of the drugs, alcohol, tobacco or cannabis, involved 15% of the population from 18 to 44 years. Repeated multiple consumption, including cannabis, was very rare above 45 years. In the 18 to 44 year-olds, the alcohol-tobacco association is the most frequent (9.6%), followed by tobacco-cannabis (3.4%), alcohol-tobacco-cannabis (1.7%), and alcohol-cannabis (0.4%). The majority of multidrug users are masculine, especially when the two substances most consumed by men, alcohol and cannabis, are taken together. There are, however, experimenters of the three products, with the exception of half of the alcohol and tobacco multidrug users (48%), who indicated they never smoked cannabis.

Regarding developments during the 1990s, cannabis became widely spread, the consumption of alcohol appeared relatively stable, and that of tobacco reduced amongst men and increased amongst women. The low prevalence obtained for the other products makes any extrapolation extremely difficult. It appears, however, that the general trend is an increase (in particular for cocaine and the amphetamine-ecstasy couple), with the exception of heroin and the medicaments taken 'to drug oneself' [3].

Consumption by adolescents

The consumption of psychoactive substances by adolescents is described on the basis of the results of two surveys: the first covered young people at the end of adolescence, questioned during the Call to Preparation for Defense Day [*Journée d'Appel de Préparation à la Défense*] (JAPD) [8], and the second covered school-going young people from 14 to 18 years of age [7].

Frequency of experimentation with psychoactive drugs amongst young people at the end of adolescence in 2000, by sex and age

(in %)

	Girls, 17 years	Boys, 17 years	Boys, 18 years	Boys, 19 years
Alcohol [1]	77.3	80.8	79.3	82.7
Tobacco	79.4	76.0	78.4	84.0
Cannabis	40.9	50.1	54.9	60.3
Psychotropic medicaments [2]	29.0	10.6	12.7	13.6
Hallucinogenic mushrooms	1.6	4.5	6.9	8.7
Poppers	1.3	3.4	4.8	8.3
Ecstasy	1.4	2.8	4.7	6.7
Inhaled drugs	3.3	4.9	6.6	6.3
LSD	0.8	1.6	2.8	4.8
Amphetamines	0.6	1.4	2.4	3.7
Cocaine	0.6	1.3	2.7	3.3
Heroin	0.4	0.9	1.4	1.3

[1] Consumption during the last thirty days.
[2] Entitled in the questionnaire: "medicaments for the nerves, to sleep".

Source: ESCAPAD 2000, OFDT

At the end of adolescence, after tobacco, alcohol, cannabis and psychotropic medicaments, the products most likely to be experimented with are hallucinogenic mushrooms, *poppers*, ecstasy and inhaled products with, to a lesser extent, LSD, amphetamines and cocaine. At the age of 17, these experiments are always more frequent amongst boys than amongst girls, except for tobacco and psychotropic medicaments. For boys of 19, experimentation exceeds 5% for four other substances: hallucinogenic mushrooms, *poppers*, ecstasy and inhaled products.

At 17, 76% of girls and 75% of boys have tried at least two of the tobacco, alcohol and cannabis drug trio. At this age, experimentation with all three of these substances is most frequent amongst the boys (47% as against 39%), whereas a greater number of girls have only experimented with alcohol and tobacco. Multiple experimentation becomes more frequent with age, reaching 83% at 19 years (and 57% for the combination of tobacco, alcohol and cannabis). It is very rare to have tried cannabis without having already experimented with tobacco and alcohol. Irrespective of age and sex, experimentation with all three of these products is more frequent than having tried only two of them, suggesting a close association between them [8].

Frequency of repeated use of alcohol, tobacco and cannabis amongst young people at the end of adolescence in 2000, by sex and age

(in %)

	Girls, 17 years	Boys, 17 years	Boys, 18 years	Boys, 19 years
Alcohol	5.5	16.0	17.5	22.3
Tobacco	40.2	41.9	45.6	50.9
Cannabis	12.6	23.8	28.5	32.7

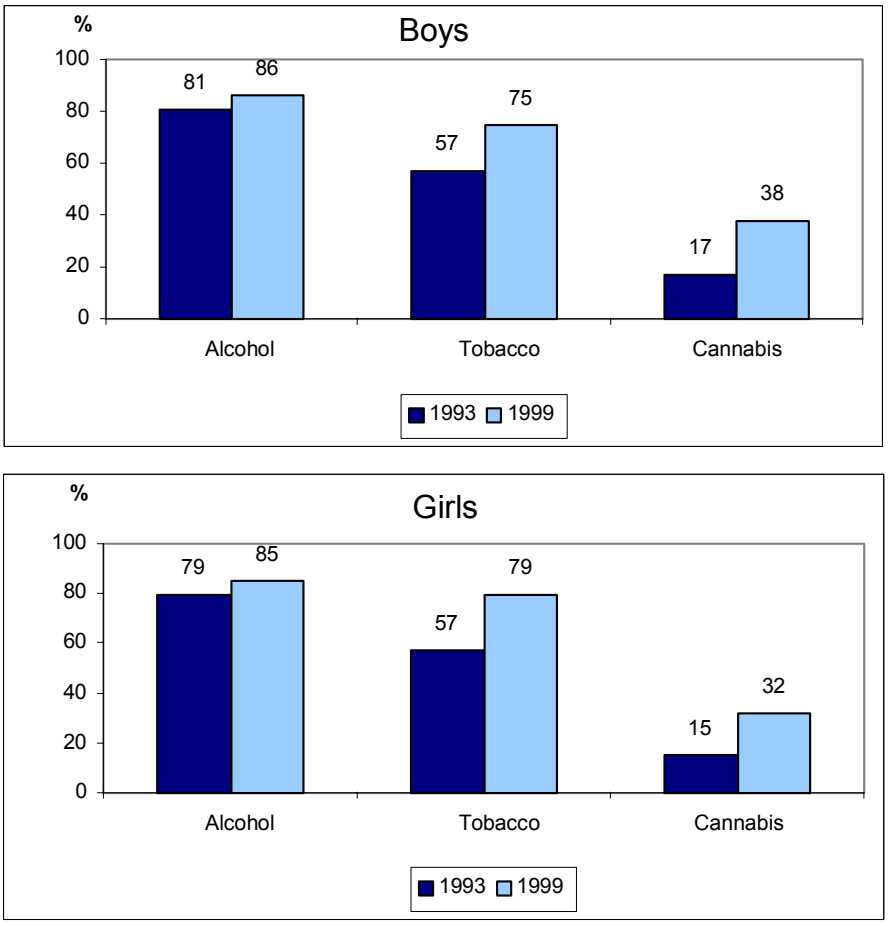
Source: ESCAPAD 2000, OFDT

The repeated use of alcohol (at least ten times per month) and cannabis (at least ten times per year) are behaviours with a clear masculine bias whereas repeated use of tobacco shows little

sexual differentiation. These behaviours all increase with age. For the other substances, cases of repeated use are much rarer.

At 17 years of age, repeated multiple consumption is twice as frequent amongst boys (23% of boys as against 12% of girls); for both sexes, it is mainly tobacco and cannabis that are concerned. Tobacco is the psychoactive substance most frequently involved in repeated multiple use ; indeed, irrespective of age and sex, the rarest multiple use is that excluding tobacco (alcohol and cannabis). From 17 to 19 years of age, repeated multiple use grows to reach 34% [8].

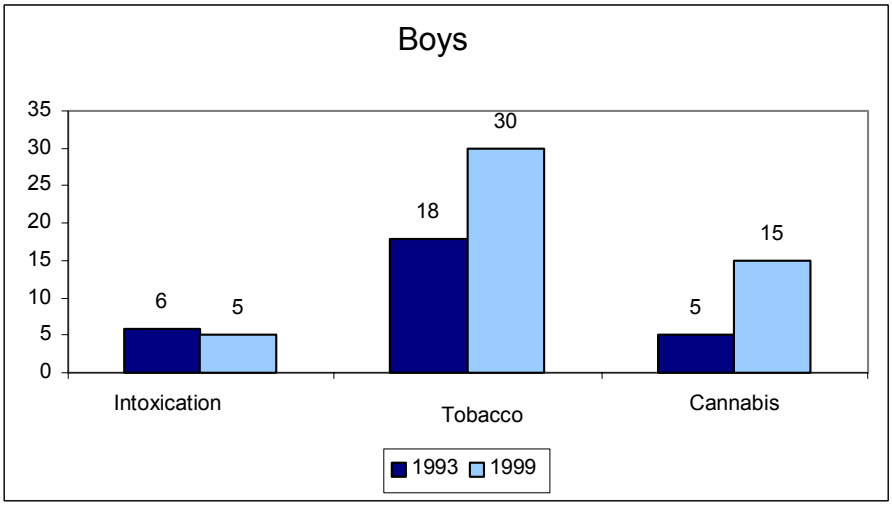
Frequency of experimentation with alcohol, tobacco and cannabis at 16 years in 1993 and 1999, by sex {220a1&2}

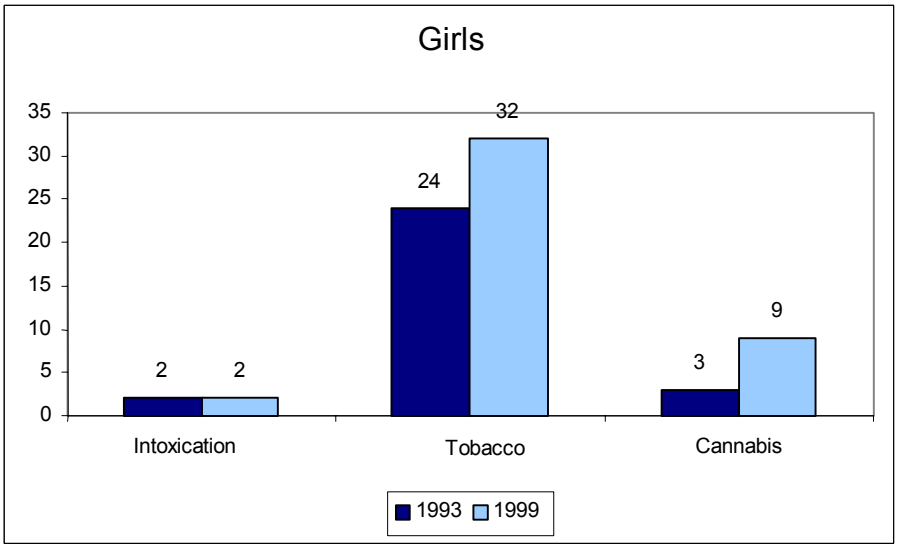


Sources: INSERM 1993 ; ESPAD 1999, INSERM/OFDT/MENRT

Between 1993 and 1999, developments depended on the product. The percentage of young people having consumed tobacco at least once increased substantially: for both sexes and all ages, it is situated approximately 20 points higher in 1999. In this period, the use of tobacco during their lives had increased even more for girls: in 1999, they had experimented more often, at all ages, than boys, whereas in 1993 this experimentation was more often feminine at 14 years and more often masculine at 18 years. The increase is less marked for alcohol than for tobacco. However, it must be said that experimentation with alcohol was already widespread in 1993, even if experimentation with alcohol appears earlier in 1999. For cannabis, this increase is very clear, particularly for 15 year-olds. For the other psychoactive products, the level of experimentation appears to have increased globally between the two surveys, particularly amongst the youngest boys [5] [7].

Frequency of repeated use of tobacco and cannabis and repeated intoxication at 16 years in 1993 and 1999, by sex {220b}





Sources: INSERM 1993; ESPAD 1999, INSERM/OFDT/MENRT

In the period 1993-1999, repeated consumption increased substantially, with a more or less marked trend depending on the drug. For tobacco, there was an upward trend in daily use. As in the case of experimentation, daily use is more frequent in girls of all ages in 1999, whereas in 1993 they smoked more often on a daily basis than boys at 14 years, but less at 18 years. The repeated consumption of alcohol appears to be stabilising, and repeated intoxication has reduced between the two surveys. For cannabis, there is a clear increase at all ages and for both sexes [5] [7].

Health and social consequences of drug use

The first measurable consequence of drug use is the generation of requests for assistance from dependent users or 'abusers' to the professionals in the healthcare and social sector. These are called 'requests for treatment directly related to the use of drugs'. The second approach consists of attempting to measure the global consequences of the use of drugs on the morbidity and mortality of the French population. These two aspects are dealt with successively.

The requests for assistance from users in difficulty may be addressed to numerous institutions and professionals in the healthcare or social sector. The measurement of the care cases or requests depends on the capacity to collect information from these professionals, which is much easier when the structures specialise in the area of addictions than when they are generalist structures. The data are collected in a systematic manner from structures specialising in alcoholism (CCAA: Outpatient Alcohol Treatment Centres) and drug addiction (CSST: Drug Addiction Treatment Centres). Regarding tobacco, as the computerisation of specialised consultation is in process (at the time of publication of the report), the active file data has been estimated from surveys that have not yet been published.

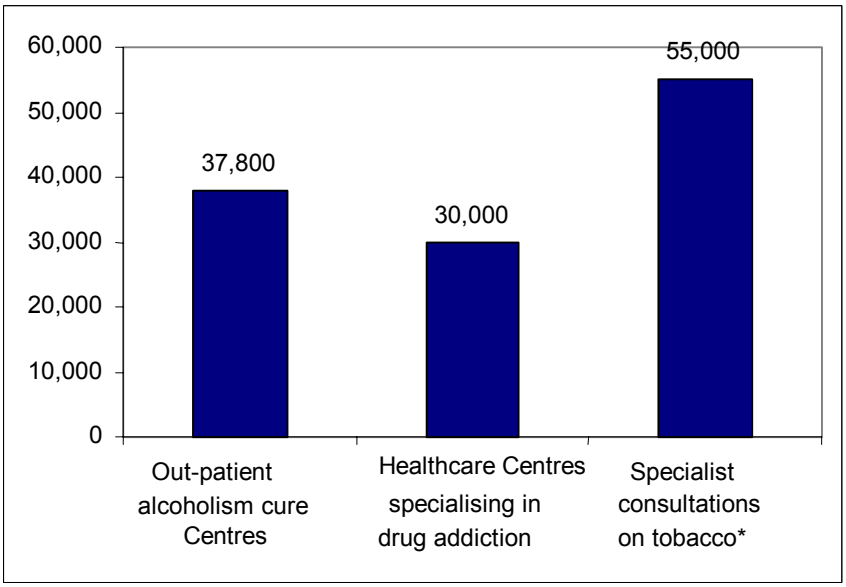
In order to provide a rough estimate of the importance of the different drugs in request of treatment, the number of persons received into the various types of specialised structure was initially put into perspective. Taking account of the multiplicity and heterogeneity of illicit drugs, the cases of care in the CSST are then examined.

Requests for treatment in all the specialised structures

In 1999, according to the available information, the number of new consultants is 55,000 in the structures specialising in tobacco versus 38,000 in the CCAA, and approximately 30,000 in the CSST. For all requests, approximately 80,000 persons were seen in 1998 in the CCAA and 64,000 in the CSST in 1999, with the corresponding data for tobacco consultations not being available. The number of requests is not only related to the request for care, but also, in large measure, to the supply.

The differences in active files must also be considered by taking into account the care cases by the city medical services that are not on the same scale, depending on the drugs. In the last Health Barometer survey involving general practitioners in 1998, they evaluated persons who sought a consultation for alcoholic withdrawal at 1.7 patients per week, tobacco withdrawal at 1.9 patients per week, and heroin addicts at 1.7 patients per month. [21].

Annual number of new consultants in the structures specialising in alcohology, drug addiction and tobacco science, at the end of the 1990s *{230b}*



** Estimated number in the case of specialist consultations on tobacco*

Sources:

Alcohol: CCAA activity reports, 1998 (drinkers only), DGS;

Illicit drugs: Survey on the care of drug addicts in November 1999, DREES/DGS;

Tobacco: Survey on hospital and non-hospital tobacco consultations 2000, DH/OFT.

While the figures of care cases related to the consumption of illicit drugs and alcohol are collected at regular intervals, and are, in principle, exhaustive, the data on tobacco was collected for the first time recently, and is based on the extrapolation of partial results.

The comparison of data obtained from the CCAA and the CSST shows some resemblance and some differences between the respective clienteles.

Persons attending the CSST are, on average, a little more than ten years younger than those attending CCAA (31 years and 41 years respectively). The breakdown between men and women is, on the other hand, identical in both types of structure (three men to one woman). Socio-economic background, measured by the number of persons with a paid job, appears less good in the CSST clientele, but structures should be compared by identical age.

Morbidity and mortality related to tobacco, alcohol or illicit drugs

Putting consequences of the consumption of substances into perspective in terms of morbidity and mortality is difficult, due to the differences in the size of the populations involved, the diversity of the measurement methods, and the variety of the effects of these drugs, particularly over time. The consequences of consumption can be immediate (accidents, violence, suicides, overdoses for alcohol and illicit drugs). They may occur in the short or medium term (HIV, problems related to intravenous use, psychiatric problems), or in the long term (cancers, cirrhoses related to alcohol or hepatitis C, cardiopathies, and more generally, all those pathologies for which alcohol and tobacco are risk factors). Comparison is made even more complex due to the fact that consumers of one substance are also frequently consumers of one or more other drugs.

Use of tobacco results in several types of damage due to both its dangers and the very high number of consumers. This damage occurs most often at the end of life, which explains why young people are not very concerned.

The same factors apply to alcohol, with the difference that the health consequences appear earlier: amongst young adults (accidents, violence), then toward the fifties, most often, for cirrhosis, and at a slightly older age for the other pathologies (cancers, cardio-vascular illnesses).

For illicit drugs (essentially opiates and cocaine), since the consuming population is substantially less than that for other substances, the damage affects a much lower number of persons. However, consumers of illicit drugs suffer damage, on average, at a much earlier age (the average age of persons who died from overdoses in 2000 was 31). It should be noted that the damage to health resulting from the consumption of these substances is very often linked to the practice of intravenous use. Moreover, in the case of illicit drugs, certain damage, whether immediate (accidents), or long-term, is not measured due to the relatively recent nature of such consumption development, and there being a minority and partly hidden nature (more, at least, than in the case of alcohol and tobacco).

In summary, the data on the health consequences of the consumption of different substances must be put into perspective by relating them to the number of persons who are involved in the risk consumption of these drugs. Currently, a consensus has not been reached on this latter concept and the measurement of the corresponding populations, which makes the practical implementation of such a calculation difficult. It is nevertheless certain that a reasoning in terms of the mortality rate would give a less contrasting picture of the health consequences related to each of the substances than if number of deaths only are taken into account (60,000 for tobacco, 45,000 for alcohol and some hundreds for illicit drugs).

Studies on the social cost that were done in France (Kopp et al, 2000) and in different countries, make a comparison of the health cost possible, on a monetary basis. Without entering into the details of the cost, it can be said that the costs of damage are proportional to the number of years of life lost. They are, therefore, much more substantial when this occurs earlier. This difference does not, however, compensate for the difference between the numbers of persons suffering damage from alcohol and tobacco on the one hand and illicit drugs, on the other.

Cost of morbidity and mortality related to alcohol, tobacco and illicit drugs during the second half of the 1990s.

(in billions of francs)

	Tobacco	Alcohol	Illicit drugs
Healthcare expenditure	14.5	18.6	2.3
Hospital	7.6	10.2	0.9 (1)
City medical services	6.9	8.2	0.6 (2)
Specialised care	nd	0.2	0.7 (3)
Loss of revenue and production	35.7	42.5	0.8
Deaths	32.9	41.9	0.8
Hospitalisation	2.8	0.6	nd
Total	50.2	61.1	3.3

(1) Estimation of the cost of care related to HIV and AIDS in hospitals in 1995.
(2) Cost of care by the city medical services for users receiving buprenorphine substitution treatment in 1997.
(3) Drug addiction provisions in the budget of the Ministry of Employment and Social Affairs in 1998

Source: according to (Kopp et al., 2000)

Taking into account the statistical gaps referred to above on the subject of the evaluation of the consequences of illicit drugs consumption, it is possible that they are partly under-estimated (mortality from overdoses; the cost of care in hospitals and the city medical services, which does not measure perfectly the consequences, in terms of accidents and the long-term consequences not taken into account, particularly regarding hepatitis C). Nevertheless, due to the relatively low number of consumers (referring to the number of alcohol and tobacco consumers), this under-estimation would not be of the kind to change the order of the substances regarding the cost of damage.

It must also be stressed that the consequences of drug consumption are examined only in terms of morbidity and mortality. In the absence of data, the social consequences of the consumption of alcohol and illicit drugs (loss of employment, incomes, marginalisation, marital violence) have not been measured.

The morbidity and mortality related to tobacco and alcohol are examined in detail in the chapters covering these two drugs. Taking into account the multiplicity of illicit substances, a specific section deals, on a comprehensive basis, with the morbidity and mortality related to each of these drugs.

Geography of the consumption of drugs

Amongst 12-75-year-olds, Languedoc-Roussillon, Midi-Pyrénées, Aquitaine and Limousin are distinguished by a prevalence of a higher than average daily use of alcohol, while in PACA, Haute and Basse-Normandie, it is lower than the average. Being intoxicated within the last twelve months is a more frequent behaviour in Bretagne, Pays de la Loire and Franche-Comté, and a rarer one in the Centre and Champagne-Ardenne regions [3].

Amongst 15-44-year-olds, the daily use of tobacco appears to be fairly uniform throughout French territory. Aquitaine is below the average while the Nord and Alsace are above it. Recent use of cannabis is more frequent in Bretagne, Aquitaine and in the Paris region, and less so in the Centre, Auvergne, Nord and Picardie regions. Regarding experimentation with cannabis, the Southeast of France is below the average. At 17 years, the level of experimentation and repeated use of psychoactive substances are not uniform throughout the territory. For the most common products (alcohol, tobacco and cannabis), there is an East-West contrast, with the west of France showing more frequent experimentation. For alcohol (experimentation with intoxication and repeated use of alcohol), this pre-eminence is confirmed for the entire West, with the Southwest topping the list. For cannabis (experimentation and repeated use), the Northwest (particularly boys) and the Southwest (particularly girls) stand out. Finally, for tobacco (experimentation and daily use) only the Northwest shows more frequent experimentation. Although, for these three substances, the Eastern regions fall within the average, it must be stressed that in the North and Paris region, the consumption patterns observed are lower than elsewhere (with the exception of the repeated use of cannabis in the Paris region). For these two regions, the consumption patterns are also lower for experimentation with stimulating agents (cocaine, ecstasy, amphetamines, LSD), or with hallucinogenic mushrooms. These products do not conform to the East-West contrast: stimulating agents are more often experimented with in the South (East and West) and the Northeast, and hallucinogenic mushrooms in the Northwest and Northeast [8].

Comprehensive approach to illicit drugs

Problem uses of illicit drugs

As this section deals primarily with the consequences, on a health, social or criminal level, which may result from the use of illicit drugs, it is appropriate to attempt to estimate the number of users involved. To do this, it is necessary to clearly differentiate 'illicit drug users', primarily involved in 'recreation' type consumption, and 'illicit drugs users with problems', likely to suffer substantial consequences from a health, social or criminal point of view.

This estimation may be approached via the number of opiate or cocaine users with problems, albeit on a restricted basis. In actuality, opiates and cocaine are the main drugs consumed by these users. The frequent association of the consumption of opiates and cocaine by these users prevents the establishment of estimates for each of these drugs. Opiate and cocaine users with problems are, therefore, dealt with globally in this section on the basis of a comprehensive approach to the different illicit drugs.

Estimation of the number of opiate and cocaine users with problems.

For heroin and cocaine, substances that are much more rarely consumed, but likely, nevertheless, to result in substantial consequences to a non-negligible number of users, the OFDT has been concerned, for a number of years, with improving the estimation of their number. The calculation methods use indirect indicators (requests for treatment, police interrogation, AIDS cases, etc.) and are based on European standards defined for this purpose. As the consumption of heroin and cocaine is very largely interlinked, it is not possible to estimate the number of consumers of each drug separately.

The consumption of drugs, such as heroin and cocaine, is difficult to detect through surveys on the general population, particularly if it is of the abusive type, or involves dependence. The *Observatoire européen des drogues et des toxicomanies* (OEDT: European Observatory for Drugs and Drug Addiction) has, therefore, chosen to show the number of 'opiate and cocaine users with problems' amongst the five key indicators common to all countries of the European Union. A methodological protocol aimed at estimating the population involved has been developed. The pragmatic definition is that of: intravenous drug users, or regular consumers of opiates or cocaine. The term 'with problems' refers to consumption that may induce recourse to the healthcare and social system and/or visibility by the law enforcement system. Different methods of estimation are proposed, but none of them can be considered as the best. For this reason, the concomitant application of different methods and their comparison is advised.

Estimates of the number of opiates and cocaine users with problems in France, in 1999

Method	Prevalence
Demographic multiplicative	146,000
Extrapolation of treatment data	180,000
Extrapolation of police data	150,000
Multivariant statistical analysis	178,000

Source: OFDT

The application of the European protocol to France gives, for 1999, a range of estimates for users of opiates or cocaine with problem from 150,000 to 180,000 . The four methods are described in detail in the technical report quoted as a reference (Costes, 2001).They are subject to variation depending on the working hypotheses and the sources of data used. The main interest of this exercise is in the application of the different methods and their cross-validation. Thus, the convergence in their results confirms the reliability of such an estimate.

The estimate made for the previous report was from 142,000 to 176,000 users of opiates with problems in 1995. The comparison of the estimates for 1999 and 1995 tends to indicate a stabilisation in the number of users, however this conclusion should be treated with great caution, in particular with two facts in mind:

- The coverage of the estimate has grown, as it has been extended from opiate users with problems to those of opiates and cocaine. However, the significanceof this extension of cover is reduced by the fact that the consumptions of these two types of product are very much interlinked.
- The methods used have changed.

The current estimate is based, in part, on the results of a method known as 'capture-recapture' that was applied to several French towns (Toulouse, Marseilles, Nice, Lille, Lens). These results make local estimates of the prevalence of the use of opiates and cocaine in the five largest French towns.

This method makes it possible to calculate a confidence interval for each estimate, the size of which shows very well how important it is to keep in mind that these estimates should only be considered as giving a rough idea.

Estimation of the number of opiate and cocaine users in five cities in France, in 1999

Location	Number	Number (confidence interval)	Prevalence (15-59 years) %	Confidence interval
Toulouse	2,802	2,577 - 3,027	6.50	6.0 - 7.0
Lille	5,296	4,444 - 6,148	10.00	8.4 - 11.7
Lens	1,557	1,387 - 1,727	7.00	6.2 - 7.7
Marseille	5,758	4,663 - 6,853	10.60	8.4 - 12.6
Nice	4,541	3,255 - 5,826	15.30	11.2 - 19.6

Source: Prevalence survey 1999, ORSMIP – OFDT (Chevalier, 2001)

Health and social consequences of the use of illicit drugs

Use of illicit drugs leads part of the consumers into having recourse to the medico-social care system. The number and characteristics of the persons taken into care in the medico-social institutions due to their dependence on (or abuse of) illicit drugs are described first. The consequences of the use of these drugs in terms of mortality and morbidity are dealt with in the second section.

Request for treatment in the CSST and healthcare establishments

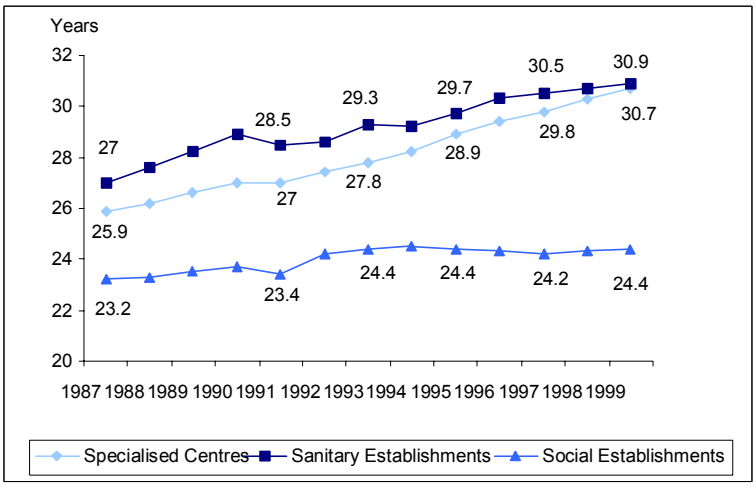
In November 1999, there were a little less than 27,000 cases of care in the healthcare and social structures that responded to the survey [17]. By comparison with 1997, the increase in the number of cases was 6%.

The cases of care in specialised drug addiction treatment centres, numbering 17,400 in November 1999, represent the majority and an increasingly substantial share of all of the healthcare and social institution cases. By comparison with November 1997, the number of cases has remained stable in the social centres and reduced in the healthcare establishments. These developments are, however, partly related to changes in the number of structures who responded to the survey, in which there was a clear reduction in the healthcare establishments.

Age of users

The trend of users taken into care by the CSST and healthcare establishments being older is continuing, with the age difference initially observed in the two types of structure practically disappearing by 1999.

Average age of persons taken into care for drugs use by the healthcare and social system, from 1987 to 1999 {2301}



Source: Survey on the care of drug addicts in November, DREES/DGS;

The less rapid process of increased age seen in healthcare establishments is associated with the reduction in the proportion of cases related to opiates. The age of users in the social establishments is staying at around 24 years. Essentially, the centres and associations in this category (prevention clubs and teams for the most part) traditionally reach a fairly young public.

Drugs at the origin of care

In November 1999, the cases of care in the CSST and the healthcare establishments were, for the greatest majority, related to opiates. When account is taken of the presence of substitution

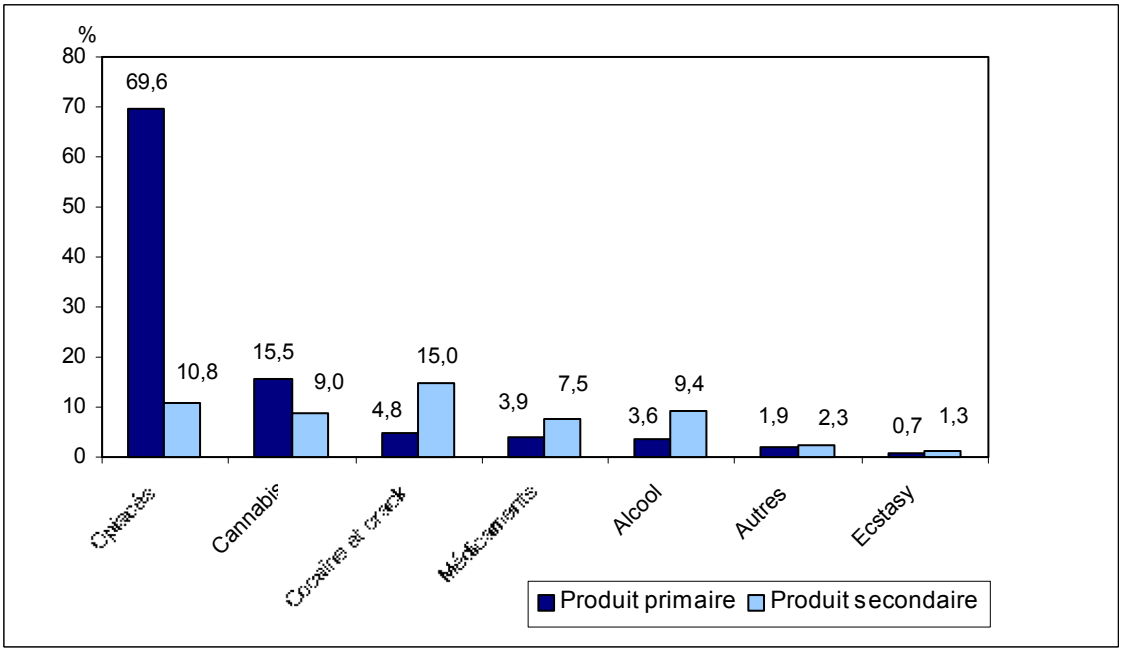
treatments, the share of cases related to opiates exceeds 80%. The figures taken from a survey for a one-month period tend, however, to overestimate the number of these users. These patients, often receiving substitution treatments, attend these healthcare structures more regularly than others, and, therefore, there is a great probability of their presence in a given month. If it were possible to count the number of different users attending during the year, the share of opiates would, without doubt, be lower. On the other hand, with the development of multidrug consumption, numerous users are having difficulty with a number of substances in addition to opiates, the most frequently encountered of which are cocaine, benzodiazepines, and alcohol. Opiate dependence is still very often, however, the common denominator.

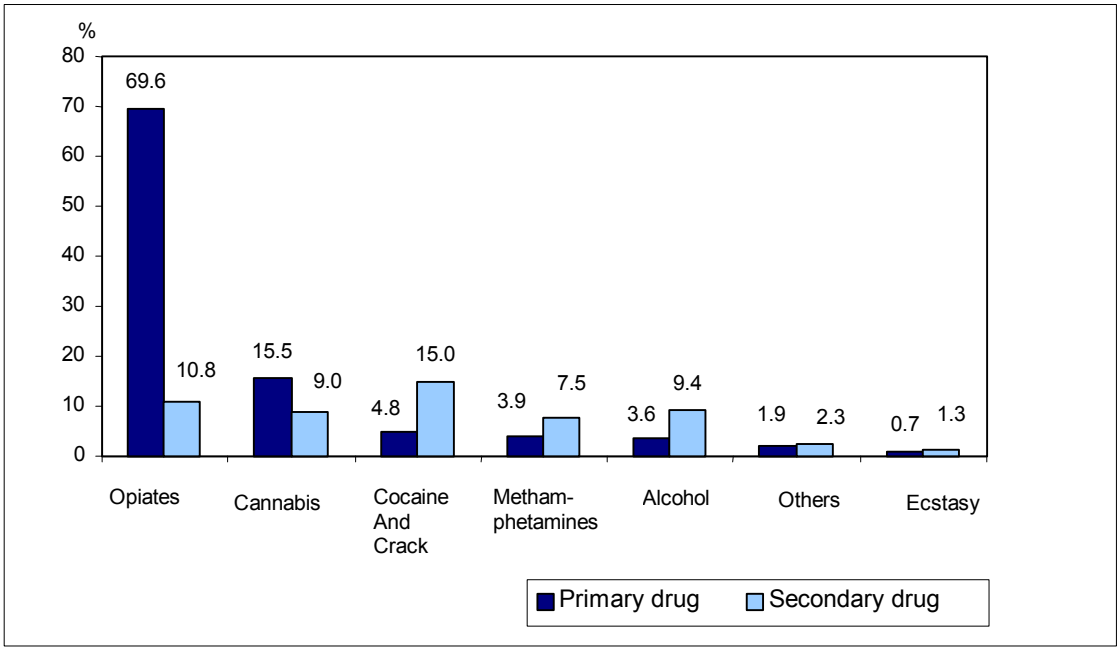
Far behind the opiates, cannabis is the second drug represented in care cases for primary drugs. Its users are considerably different from opiate users, the first being on average five years younger than the second. But cannabis is also mentioned as a secondary drug, most often at the same time in cases of care for opiate use: when cannabis is given as a secondary drug, the associated primary drug is an opiate in three cases out of four. Ecstasy users, with little representation in care cases, are also distinguished from opiate users by their youth (24 years on average). Users of medicaments (as a primary drug) are different again, due to the high proportion of women (40%).

Cocaine, alcohol and medicaments have in common the fact that they are represented much more often as secondary drugs than as primary drugs. Taking into account the proportion of opiates in care cases, all secondary drugs are generally associated, to a different degree, with opiates: more than 90% of cases for cocaine, 70% for medication, and 50% for alcohol.

Amphetamines or LSD are only marginally represented in cares cases as a primary or secondary drug.

Recourse of drug users to CSST and healthcare establishments, per the drugs at the origin of care, 1999 {2302}





The percentages refer to all of the cases for which at lest one drug is mentioned as the origin of care, excluding double counting; N = 19.564 in 1999

Source: Survey on the care of drug addicts in November 1999, DREES/DGS

The data in relation to the drugs at the origin of the care must be compared with the importance of substitution treatment in all cases. This treatment was mentioned in a little more than half of the care cases in CSST and healthcare establishments in November 1999. Methadone is cited in approximately one case in five (21%) and buprenorphine in almost one case in three (32%).

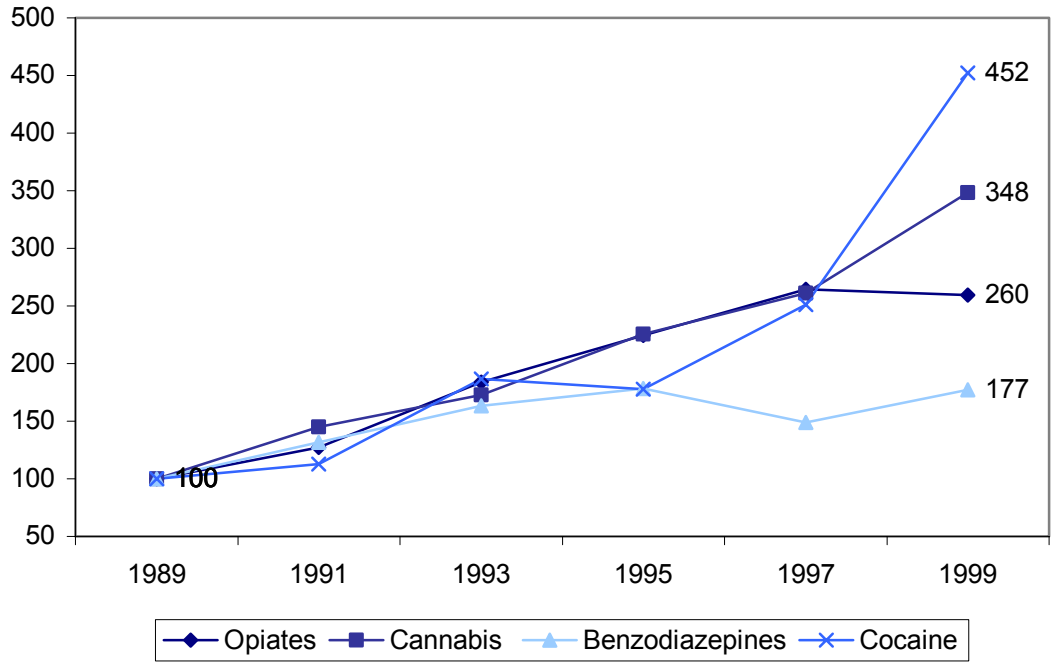
These average percentages vary depending on the drugs at the origin of the care. Substitution treatment was present in three cases out of four for cases related to opiates, one case in two for those related to cocaine

(45%), one case in three for benzodiazepines, and one case in four for the majority of the other drugs. The lowest proportion appears in cases related to cannabis and ecstasy (12% and 14% respectively). The mention of substitution treatments amongst persons taken into care for non-opiate primary drugs (but in these cases opiates are often declared as secondary drugs) reflects the situation of opiate-dependent users receiving substitution treatment, and who have a problem with another substance.

Development in cases between 1989 and 1999

The total number of cases increased considerably between 1989 and 1999, a development related to both the increase in the number of structures, and in the development of substitution treatments for opiates. By stabilising the users in the healthcare structures, these treatments tend to increase the number of persons attending the institution each month, and, therefore, increase the number of cases counted in a survey during a given month. For the same reason, the share of cases related to opiates tends to appear more substantial during a given month, than over the year. It is probable that part of the increase in cases related to opiates between 1994 and 1997 can be explained by the more regular attendance at CSST by opiate users, whose number may not have varied in the second half of the 1990s.

Recourse of drug users to CSST and healthcare establishments per the primary drug at the origin of care, from 1989 to 1999 {base of 100 in 1989) *{2303}*



Source: Survey on the care of drug addicts in November, DREES/DGS;

The cases of care for opiate and cannabis use grew at the same rate until 1997, with a subsequent quasi-stabilisation for opiates and a sustained growth for cannabis. The cases of cocaine use developed more slowly than those for opiate or cannabis use at the beginning of the 1990s. The growth thereafter was very rapid, especially between 1997 and 1999. The development partly concerns persons receiving substitution treatment and who are also opiate dependent. At the care level, cocaine and opiates appear to be closely associated.

Care cases related to the benzodiazepines as a primary product have had a tendency to stagnate since 1995, which contrasts strongly with the growth found for other substances. It is difficult to know whether the explanation is due to lower demand, or if the polarisation regarding opiate users has made the structures, and particularly the CSST, less receptive to these uses or if, finally, the survey device used did not reflect this aspect. As for cocaine, this approach in terms of primary product only reveals part of the size of the problem related to the consumption of benzodiazepines, which are frequently cited as secondary drugs.

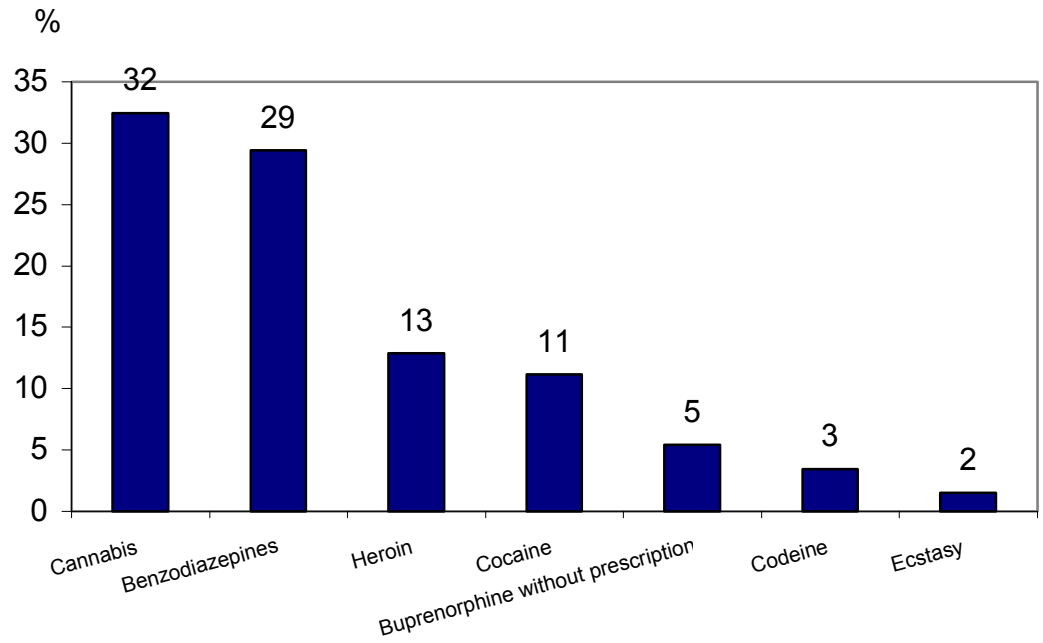
These substances also appear much more frequently amongst the recently consumed drugs (see the section hereunder on drugs consumed).

Taking into account the developments for the different drugs, the cases related to opiates represent an identical proportion in 1989 and 1999, while those related to cannabis have increased, essentially between 1997 and 1999, as for those related to cocaine and crack. The share of benzodiazepines and medicaments has, on the other hand, substantially reduced (from 9% to 4%).

Drugs consumed recently

The surveys on persons seen by the care structures also covered drugs consumed in a recent period (month or week). These drugs do not always coincide with those at the origin of the care. In the case of a user receiving substitution treatment, heroin may be at the origin of the care, although it has not been consumed for a certain period of time. For this reason, heroin, very much in the majority of the drugs at the origin of care, is currently consumed by only a minority of users who have recourse to the healthcare structures [18]. The proportion of current heroin consumers has substantially reduced since 1995, a development which coincides with the development of substitution treatments. Consumption of cocaine, benzodiazepines and cannabis is, on the other hand, encountered much more often than previously.

Frequency of consumption of drugs during the last week amongst drugs users receiving healthcare, by drug *{2304}*



Readin g the graph: 32% of the 2,030 subjects included in the survey had consumed cannabis during the previous week; as a subject may have consumed a number of products, the percentages should not be added. Only the principal drugs are represented in this graph.

Source: OPPIDUM 1999, CEIP

Multidrug dependence and multidrug use

In this report, multidrug dependence represents the situation of a user where two drugs are at the origin of the care. In November 1999, multidrug dependence appeared in a little more than one in two cases (56%) of primary drug care, a proportion which has slightly increased since 1997 (54%) [17]. Cocaine is particularly involved in multidrug dependence. When it is cited as the product at the origin of care (primary or secondary), nine times out of ten it is associated with another drug. In 80% of cases, the other drug at the origin of care is heroin.

Multidrug dependence is defined by reference to the drugs consumed recently (week or month), when at least two drugs are mentioned. In the November 1999 survey, two drugs were mentioned for 50% of users having consumed at least one drug and three drugs were mentioned for approximately 20% of these. These percentages have remained stable between 1997 and 1999.

Multidrug users appear to be in a more difficult situation than single drug users, without the differences appearing to be very substantial. By comparison with opiate users who consumed a single drug, those who consume three drugs are more numerous in intravenous use (43% versus 36%), and are less numerous in having stable paid employment (12% versus 17%).

The frequency and type of association are variable depending on the drug examined. Amongst the strongest associations, heroin can be cited amongst cocaine users (44% of cases), and cannabis amongst alcohol consumers (40% of cases). The consumption of ecstasy, less frequent even amongst users having recently consumed a drug, is associated with the consumption of cannabis in one in two cases.

Intravenous injection

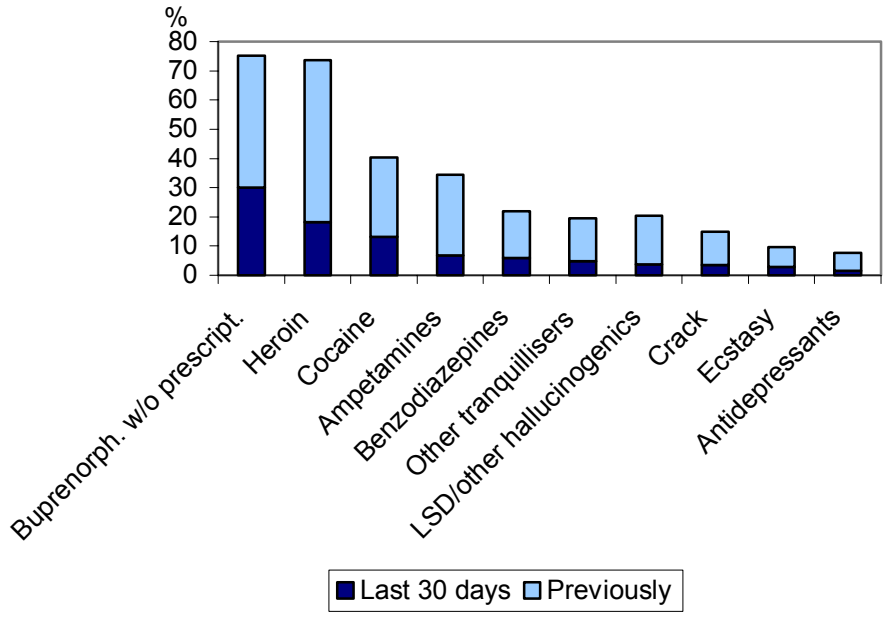
The practice of injection, irrespective of the drug involved, is at the origin of the primary health consequences suffered by drug users (infectious diseases of a viral or bacterial origin, increased risk of overdose, anaphylactic shock, abscesses, etc.) (Emmanuelli, 2000). This is why the observation of this practice is of great importance.

In the CSST and healthcare establishments, in November 1999, a little more than 14% of persons in care had used intravenous injection during the previous thirty days, and almost 50% before that [17]. The situation is very different in the social establishments in which more than 80% of users have never practiced injection—this is explained by the characteristics of the users attending these structures (the majority being young cannabis users).

Amongst the CSST and healthcare establishment care cases, the share of users currently practicing intravenous injection has reduced as against 1997 and 1996 (14% in 1999 versus 17% in 1997 and 21% in 1996). A reduction of the same order occurred amongst intravenous users taken into care for the first time (13% in 1999 versus 16% in 1997).

The practice of intravenous use varies depending on the product at the origin of care, and is particularly related to the abuse and dependence of opiates. Persons in care for cocaine use are also concerned with this practice, even when the persons also dependent on opiates are excluded (mention of substitution treatment and/or opiates as a secondary drug at the origin of care).

Frequency of the practice of intravenous use according to the primary drugs at the origin of care, in 1999 *{2305}*



Note: in order to monitor the prevalence of intravenous use excluding opiates as precisely as possible, the calculation is done on the basis of the number of primary drug care cases, excluding, for non-opiate drugs, the cases with substitution treatment or opiates as a secondary drug.

Source: Survey on the care of drug addicts in November 1999, DREES/DGS

Amongst persons having recently consumed opiates or cocaine, the proportion of intravenous users is much greater. According to the OPPIDUM survey [18], it reached 18% amongst consumers of cocaine or buprenorphine without a prescription, and 36% amongst consumers of heroin. In the November survey [17], the prevalence of intravenous use is equally high amongst persons having consumed these drugs within one month, and particularly high in the cases of association between opiates and cocaine (cocaine + heroin: 50%; cocaine + Subutex®: 63 %). Amongst heroin users, the share of users using intravenous injection has been reducing rapidly for a number of years (75% in 1995 against 36% in 1999).

In the surveys referred to above, risks related to the practice of injection (sharing and re-use of syringes) are not described, and it is, therefore, difficult to ascertain their development in the recent period. The repeated surveys by the *Institut de recherche et d'études sur les pharmacodépendances* (IREP: Institute for the Research and Study of Drug Addiction) of drug users recruited into the healthcare centres, or the street (active or prior intravenous users and non-intravenous users) showed a marked reduction in the sharing of syringes from the end of the 1980s to 1996 (from 50% to less than 20% of users questioned), and a stability at a higher level of syringe re-use. In another survey carried out in 1998 amongst users attending syringe exchange programmes, the percentage of intravenous users having shared their syringe was approximately 20%, with re-use mentioned by approximately one user in two (Emmanuelli et al., 1999). However, the population under study only involved active intravenous users who most often showed difficulties with regard to help, and who are representative only of the clientele attending syringe exchange programmes—this would tend to overestimate the level of this risk practice.

Morbidity related to illicit drugs

On this question, the only data available is the prevalence of HIV, HCV and the number of new AIDS cases. In the absence of information on new infections, the dynamic of the epidemic can only be imperfectly shown by the reported figures, as persons indicating seropositivity could have been infected either recently, or ten to fifteen years previously.

In the context of this report, the data used have come from permanent national surveys that allow the monitoring of developments in prevalence. In the two existing surveys of this type (that of DREES/DGS [17] and CESES (*Centre européen pour la surveillance épidémiologique du Sida*: European Centre for the Epidemiological Monitoring of AIDS)), the information on the serological status is of a testimonial nature, which restricts the value, even if in the case of HIV, the agreement between the testimony and test results appears to be reasonably good. To put the results of the different surveys, whether national or local, into perspective, we can refer back to the previous Indicators and Trends report (OFDT, 1999) and the report on the SIAMOIS indicators from the *Institut de veille sanitaire*: Health Monitoring Institute (Emmanuelli, 2000).

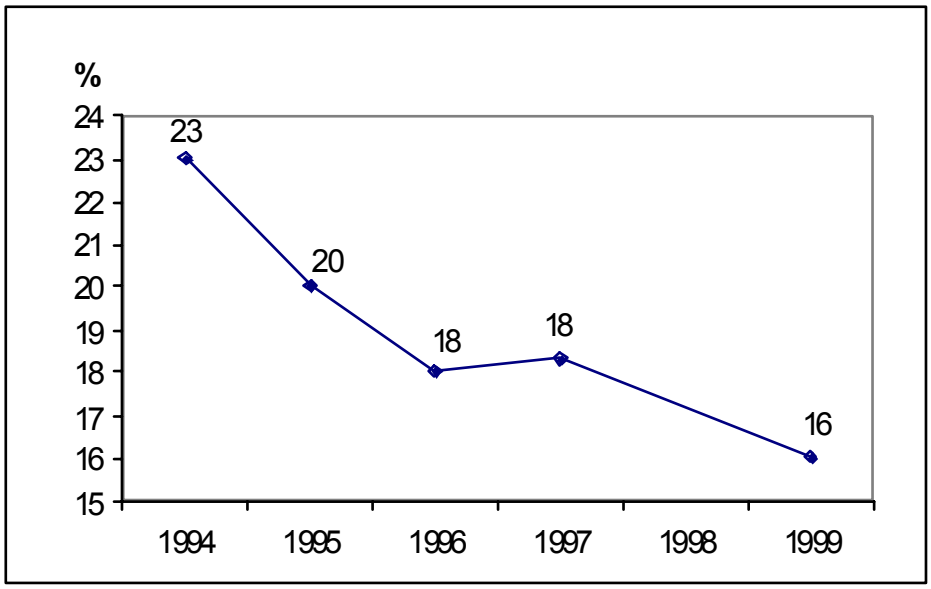
Prevalence of HIV

The prevalence of HIV is at different levels depending on whether users practiced intravenous injection, or not. Amongst the persons seen in the special drug addiction treatment centres (CSST), the indicated prevalence of HIV established in 1999 was a little less than 6% of non-intravenous users and 16% amongst intravenous users [17]. It should be noted that amongst the former, the serological status is unknown in 37% of cases as opposed to 14% of the latter. The prevalence of HIV amongst intravenous users taken into care for the first time is 13%.

According to the data from the surveys carried out by the CSST in the month of November [17], the prevalence of HIV amongst intravenous users has tended to decrease since 1994. A

survey repeated with a longer periodicity (the last time in 1996: IREP, 1996) showed that the decline increased toward the end of the 1980s. In the graph below, the fairly sharp decrease between 1994 and 1996 could have been the result of the reduction in the number of new infections from the end of the 1980s (Emmanuelli, 2000), and the substantial number of deaths of users from overdose and AIDS at the beginning of the 1990s. Despite the plateau observed in 1997, which may be related to the decrease in the deaths of HIV-seropositive drug users, the downward trend seems to have continued until 1999. The impact of the policy on the prevention of infectious risks, and on the reduction of the prevalence of HIV also appears to be indisputable, even if it is difficult to measure it precisely. It should, however, be noted that the prevalence of HIV amongst intravenous users taken into care for the first time in the specialised centres remained stable between 1997 and 1999.

Declared prevalence of HIV amongst injecting users attending specialised establishments from 1994 to 1999 *{2306}*

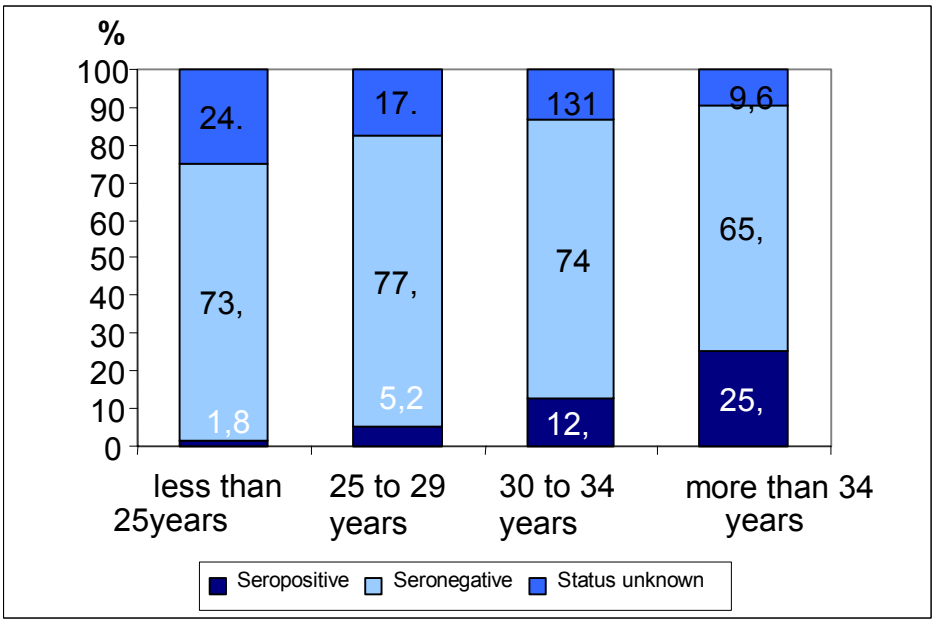


Source: Survey on the care of drug addicts in November, DREES/DGS

Another permanent survey was done by the Centre européen pour la surveillance épidémiologique du Sida (CESES: European Centre for the Epidemiological Monitoring of AIDS) every six months, between 1993 and 1998, amongst users in care in the CSST with accommodation. This population was also included in the previously referenced surveys. The results also show a marked downward trend at the beginning of the period (from the second half of 1993 to the second half of 1995), followed by a plateau (until the second half of 1996), and then the continuation of the prevailing downward trend, at a very low rate, until the first half of 1999 (Six et al., 1999). Although the developments are very similar in both surveys, the prevalence in the survey conducted by the CESES is lower by three to four points, than are the results from the DREES/DGS survey, throughout the period. This difference may be explained by the age and geographic location breakdown of the two surveys' populations and, possibly, by a selection effect related to the type of structure. On the same date (first half of 1998), the declared prevalence of HIV amongst users attending syringe exchange programmes was 19% (Emmanuelli et al., 1999), much higher figures than those of the DREES/DGS survey. Here also, the recruitment related to the type of structure (specially provided for intravenous users) is, without doubt, the origin of the difference.

The prevalence of HIV is strongly related to age, doubling more or less from one five-year age bracket to another, with, however, an uncertainty in relation to the high percentage of unknown serology amongst young people. The prevalence grows with the duration of exposure to the virus—much longer amongst the eldest. The lower prevalence amongst young people may also be explained by the effect of the risk reduction policies (prevention messages, wider access to sterile syringes, and substitution products).

Declared prevalence of HIV amongst injecting users seen by specialised centres, by age bracket, in 1999 *{2307}*



Source: Survey on the care of drug addicts in November 1999, DREES/DGS

It should also be noted that amongst the indicators seen in the specialised centres, more women are seropositive than men (18.5% against 15.1% in November 1999).

Regional disparity is analysed in the geographic section at the end of this chapter.

New AIDS cases

The number of new AIDS cases amongst drug users is declining [14]. The decline was particularly pronounced in 1996 and 1997. Between 1997 and 2000, the downward movement has continued, but at a lower rate. A similar development has been recorded in respect to new AIDS cases amongst homosexuals. The new cases diagnosed amongst heterosexuals also declined until 1999, but at a slower rate than amongst drug users and homosexuals, by which the spread of the infection peaked in the middle of the 1980s. The reduction of new AIDS cases amongst heterosexuals did not continue in 2000.

The efficacy of treatments associated with numerous antiretrovirals explains the larger part of the reduction in new AIDS cases in all transmission groups, particularly amongst drug users.

Compared to the cases declared by homosexuals, the proportion of cases in which AIDS appears in subjects who are unaware of their seropositivity is much lower amongst drug users, which appears to be explained by the fact that a greater proportion of them are examined than are the others. A reasonably good knowledge of their serological status has allowed drug users to benefit, like homosexuals, from the new association of antiretrovirals, which appeared in France in 1996.

New AIDS cases declared amongst drug users, from 1987 to 2000

1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999*	2000*
343	640	905	1,079	1,218	1,342	1,493	1,376	1,317	962	423	346	285	244

** Revised data*

Source: AIDS monitoring system, InVS

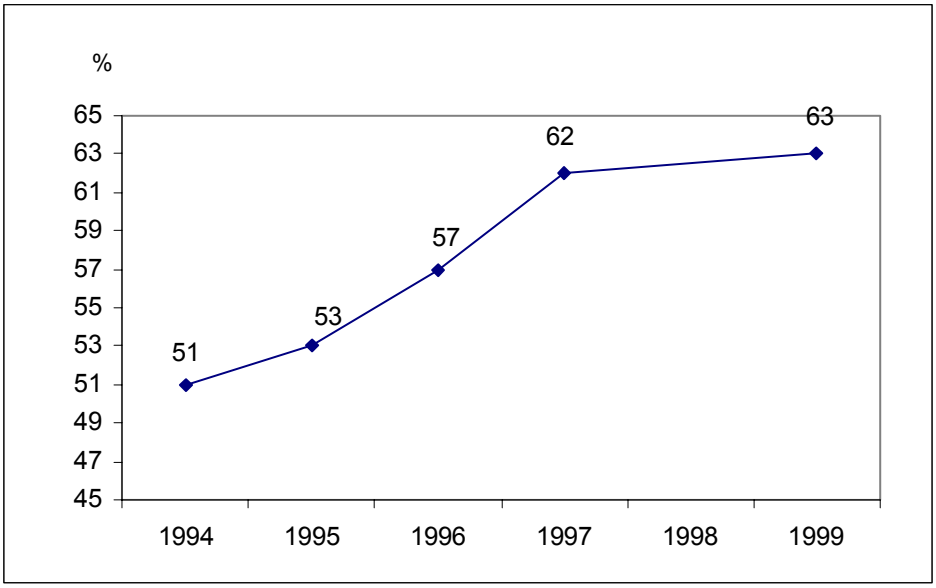
Hepatitis C

As in the case of HIV, the declared prevalence of HCV is strongly related to the practice of injection. Amongst the persons seen by the specialised establishments in November 1999 [17], the seropositive proportion for HCV was 20% for non-injectors as opposed to 63% for intravenous users. Maintaining the principle that only a little more than half of the non-intravenous users knew their serological status, the high level of prevalence in the latter poses a question. Some of the non-intravenous users might have used the intravenous route, even if exceptionally. The risk of contacting the virus from a single injection is much greater in the case of hepatitis C than it is for HIV (see below).

Tattooing is also a method of contamination that must be taken into account. Unprotected sexual relations and the sharing of straws by consumers using the nasal passage are also evoked, but are the subject of discussion. Amongst intravenous users, the knowledge of their serological status is better, with 81% of statuses known, which is higher than in 1997 (approximately 75%). Amongst first cases, the proportion of seropositive cases is 54%, a figure that has remained stable between 1997 and 1999.

Conversely to HIV, the prevalence of HCV has been increasing since 1994. The small change between 1997 and 1999 might be the sign of a tendency to level out, a development that must, however, be confirmed. The explanatory factors for this upward trend have often been explained and are only briefly recalled here: higher prevalence of HCV, with high infectivity and the greater resistance of this virus to the external environment. The result is a high probability that every intravenous drug user will come into contact with the hepatitis C virus and become infected when this occurs. The substantial persistence with certain risk practices (re-use of syringes and the sharing of injection equipment other than the syringe) also contributes to the high level of prevalence.

Declared prevalence of HCV amongst intravenous users attending specialised establishments, from 1994 to 1999 *{2308}*



Source: Survey on the care of drug addicts in November, DREES/DGS

In the survey done by the Centre européen pour la surveillance du Sida (CESES: European Centre for the Epidemiological Monitoring of AIDS), the questions about HCV were introduced in 1996. The statistical data amongst intravenous users is almost identical to those in the graph (63% in the first half of 1998), with an increase until the first half of 1997, then a tendency to stabilise.

For the same reasons as for HIV, the prevalence of HCV is age-related: amongst the under-25s, injectors attending the specialised centres in November 1999 (N = 1,121), approximately 38% declared themselves seropositive with 28% having an unknown status, whereas amongst the 35 years and older bracket (N = 3,132), 77% were seropositive with 16% having an unknown status.

Contrary to the findings for HIV, women practicing injection do not appear to be significantly more affected by HCV than men.

For an analysis of regional disparities, please refer to the geographic sector at the end of this chapter.

Double infection

Of all of the intravenous users who knew their serological status, 13.3% were infected by HIV and HCV. In 1997, the proportion was 14.4%. Amongst persons who are HIV seropositive, almost 88% also declared being HCV seropositive in 1999, as opposed to 83% in 1997.

Mortality amongst illicit drug users

According to the sources, a distinction must be made between deaths directly related to the use of illicit drugs and those indirectly related, such as drug users dying from AIDS.

As in the case of deaths attributable to smoking and alcoholism, part of those related to the use of illicit drugs can be measured through the national register of the causes of death [13] kept by the Institut national de la santé et de la recherche médicale (INSERM: National Institute for Health and Medical Research), which collects this information from death certificates. But the fastest available data comes from the Office central pour la répression du trafic illicite de stupéfiants (OCRTIS: Central Office for the Repression of Drug-related Offences) and corresponds to overdoses brought to the knowledge of the police services [29], as they are subjected to police investigation. This data might then be completed by the data provided by the DRAMES

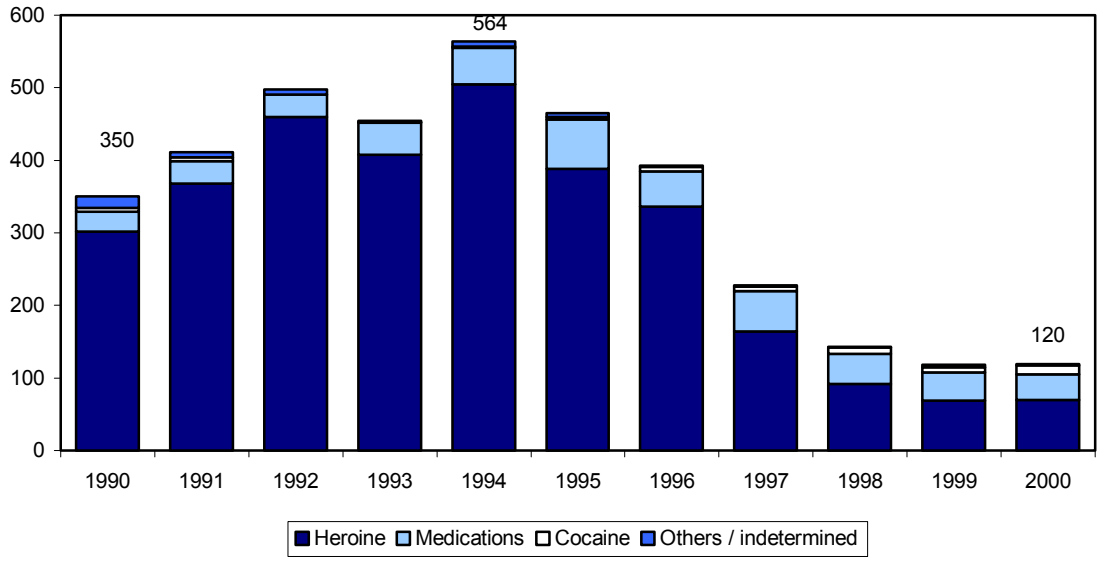
[19] (Décès en relation avec l'abus de médicaments et de substances: Deaths Related to the Abuse of Medicaments and Substances) monitoring structure, as supplied by the CEIP, the Centres d'évaluation et d'information sur la pharmacodépendance: Drug Addiction Evaluation and Information Centres.

None of these sources capture cases of mortality from which the use of drugs is not the immediate cause, such as suicides, road accidents, etc.

Overdoses detected by the police

The deaths from overdose recorded by the police services have fallen substantially since 1995. The number has been divided by almost five, from the maximum recorded in 1994 (564 deaths) and the lowest level achieved in 2000 (120 deaths).

Deaths from overdose detected by the police, from 1990 to 2000 *{230a}*



Source: FNAILS, OCRTIS

Even though it is not out of the question that deaths from overdose are less visible than before, the reduction in the number of deaths also seen in the INSERM data (see below) confirms the reduction in this phenomenon.

In major part, the trend is explained by the reduction in the cases of overdoses related to heroin, which, while still corresponding to almost 6 deaths out of 10, have reduced in both absolute and relative terms since 1995. The explanatory factors for this are the development of substitution treatments and the reduction in heroin consumption. However, it is possible that the number of deaths has reached a level below which it cannot be reduced. The reduction has slowed since 1999, possibly coinciding with the new craze for heroin reported from observations on the ground.

In parallel with the reduction in deaths from overdoses related to heroin, those related to cocaine (although limited to ten) have more and more weight in all overdoses, especially those attributable to medicaments that currently correspond to almost one death in three (most often medication habitually consumed by heroin addicts, as substitution or not: Subutex®, methadone, Skenan®, Tranxene®, etc.).

The results of toxicological analyses often reveal the presence of a number of substances. This is the case for one-third of the overdoses recorded in 2000.

From the declarations of toxicological experts, a study conducted on 123 deaths that occurred in 1998 [19] showed that narcotics were the cause of death in 3 cases out of 4, and half the cases were in association with psychotropic drugs. The other thirty deaths were attributable to buprenorphine (Subutex®) or methadone, always in association with other substances.

However, the comparison of characteristics of these deaths with those of the 143 overdoses counted by the OCRTIS for the same year, concluded that there was a maximum of 15 doubles. This leads to the conclusion that the number of overdoses is probably underestimated, irrespective of the source examined.

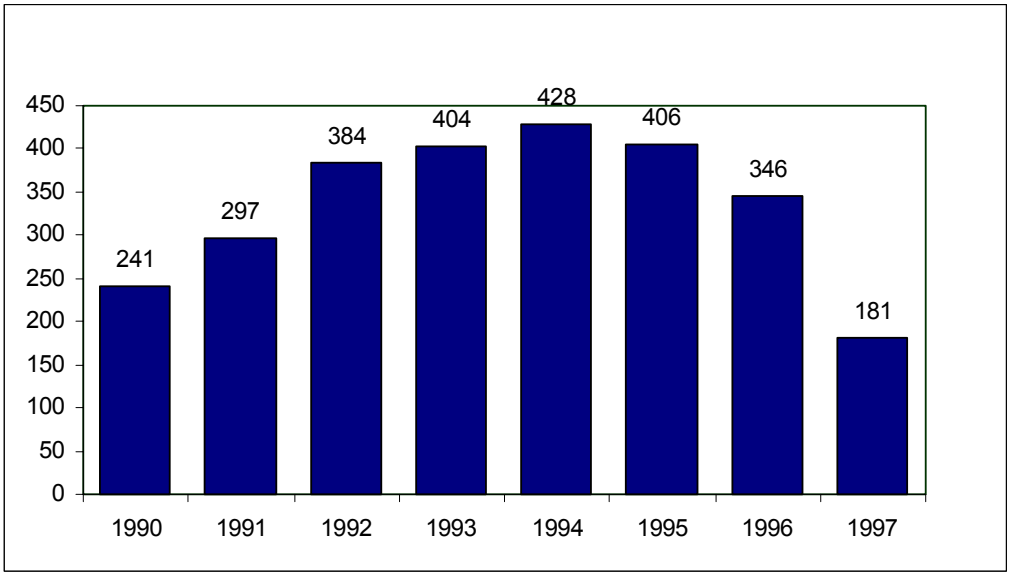
Other measurements of drug-related deaths

The deaths noted in the INSERM register of the causes of death do not only relate to overdoses, for all deaths in which the drug use is indicated as an associated cause are likely to be recorded. This source does not provide a reliable indicator of overdoses in the strictest sense, as certain deaths whose cause is not immediately identified are classified as 'cause unknown', even if, subsequently, the medico-legal examination reveals that it was a death from overdose [13].

Therefore, it is not possible to directly compare, or cumulate the number of deaths obtained from the OCRTIS and INSERM sources.

According to the International Classification of illnesses (9th edition), deaths related to drugs are grouped within three distinct causes: psychoses due to drugs, dependence, and the drug abuse without dependence. By agreement, INSERM codes the deaths related to illicit drugs (overdoses) essentially as pharmacodependency, whereas deaths resulting from the abuse of drugs without dependence refer almost exclusively to deaths related to tobacco and alcohol. There was no case of a death caused by psychosis.

Deaths with pharmacodependency registered in the death certificates, from 1990 to 1997 {230b}



1997 is the latest recorded year at this time.

Source: National file on the causes of death, INSERM-SC8

The cases of deaths from pharmacodependency have been declining since 1994. This initially steady reduction accelerated in 1997. At least half the deaths are related to opiate use. This trend corroborates the findings for police-detected overdoses, even though it isn't possible to verify whether or not these are the same deaths.

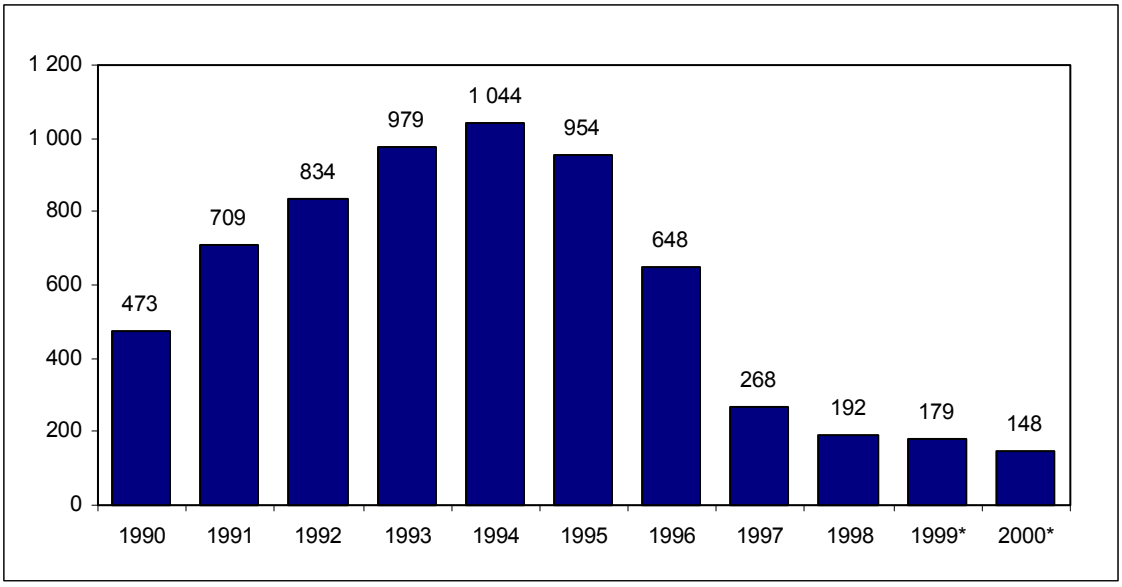
Deaths from AIDS by intravenous drug users.

The number of deaths from AIDS amongst drug users has continued to decline in 2000. After the peak of 1994, these deaths have reduced by 25% on average each year. Until 1999, a similar development was seen for all deaths due to AIDS, irrespective of the method of contamination, but the deaths of drug users were the only ones to decline further in 2000 [14].

The proportion of deaths from AIDS amongst intravenous drug users reduced in 2000, although it increased throughout the last ten years, from 20% in 1990 to 30% in 1999.

The new antiviral treatments and their wider availability explain, in greater part, the reduction in the number of deaths from AIDS amongst drug users.

Deaths from AIDS amongst intravenous drug users, from 1990 to 2000 *{230c}*



*

Revised data

Source: AIDS monitoring system, InVS

Criminal consequences of illicit drug use

According to the laws in effect in relation to the use of narcotics, every person consuming these substances is open to criminal sanctions up to imprisonment, and, therefore, might be subject to police interrogation, followed (or not) by a conviction and/or imprisonment. This section targets the determination of the numbers and characteristics of the persons concerned by each of these stages.

The available data show the funnel effect of the criminal system: for 90,000 cases of police interrogation in 1999, 6,700 convictions for use as a principal offence were pronounced, of which 1,500 were subject to a penalty of fixed-term imprisonment. Less than 400 cases of imprisonment for use occurred.

The differences between the categories and accounting units used by the police and the justice system make the statistical monitoring of persons questioned throughout the 'penal channel' (from interrogation to imprisonment) impossible. Particularly, this prevents a numerical breakdown for determining the number questioned or convicted according to the drug used.

Cases of police interrogation for use

During 2000, approximately 94,300 cases of police interrogation for use or use/dealing in narcotics took place in France [28]. They represent 95% of all cases of police interrogation for offences against the narcotics legislation (ILS infraction à la législation sur les stupéfiants—offences against the narcotics legislation). The remaining 5% related to cases of trafficking.

Cases of police interrogation for use and use/dealing of narcotics in 2000, by drug, sex, nationality and age.

	All cases of police interrogation		Women	Foreigners	Average age
	Number	%	%	%	In years
Cannabis	82,349	87.3	6.8	6.6	21.8
Heroin	5,833	6.2	13.3	11.4	28.3
Cocaine	2,323	2.5	18.1	12.0	29.6
Crack	869	0.9	14.0	23.2	31.3
Ecstasy	1,921	2.0	13.4	4.9	23.3
Others*	1,044	1.1	10.6	13.5	-
Total	94,339	100.0	7.7	7.2	22.3

** Medicaments, LSD, hallucinogenic mushrooms, opium, morphine, etc.*

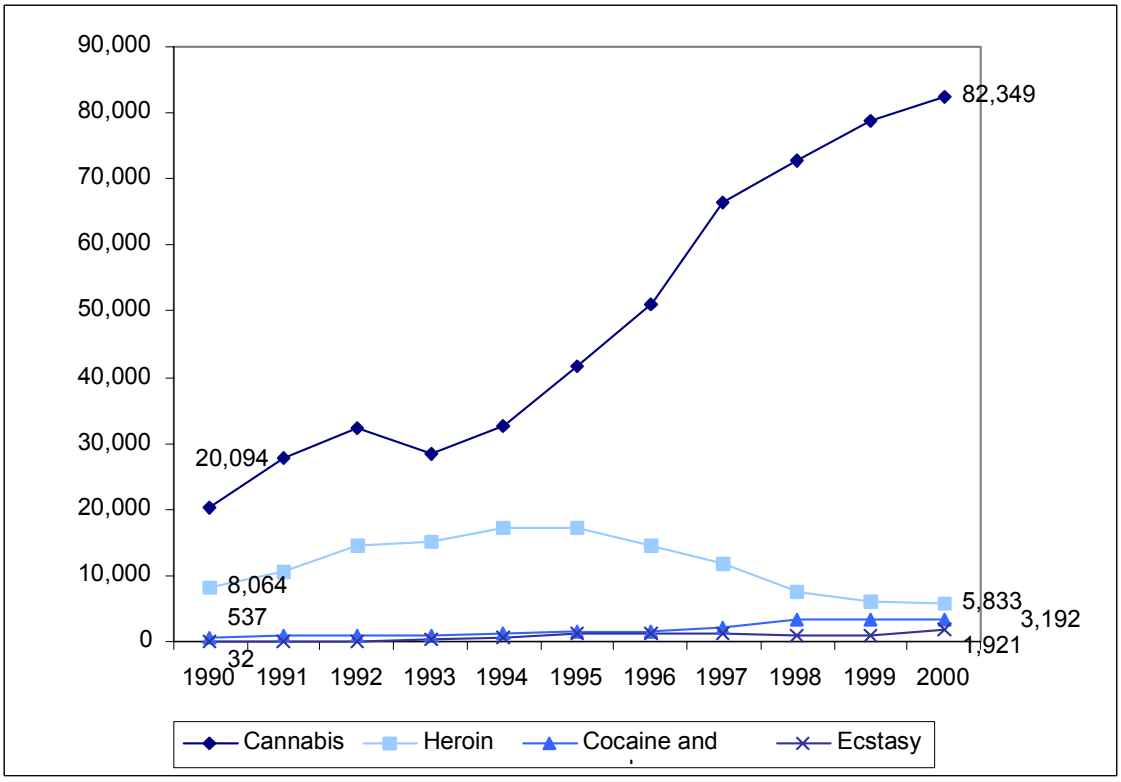
Source: FNAILS 2000, OCRTIS

In the cases of police interrogation for use, cannabis was the substance in question in nearly nine out of ten cases. Far behind, with 6% of cases, heroin was the second substance mentioned, followed by cocaine and ecstasy. The share of the latter drug in cases of police interrogation had increased substantially as opposed to 1999.

Development between 1999 and 2000

During the past ten years, the development in cases of police interrogation was marked by four main trends: an explosion in the cases of interrogation related to cannabis, the sharp decline for the use of heroin in the second half of the 1990s, the development in the cases of interrogation for cocaine and crack use, and the appearance and development in those for ecstasy use [28].

Cases of police interrogation for narcotics use from 1990 to 2000, by drug *{240a}*



Source: ***FNAILS, OCRTIS***

The cases of police interrogation for cannabis use have quadrupled since 1990. At that time, this substance was the cause of one case of interrogation in two, as opposed to nine out of ten in 2000. These cases of interrogation now constitute one of the largest mass offences, almost at the same level as those for voluntary blows and injuries. The substantial number is, without doubt, the consequence of the massive use of cannabis, as shown by surveys of the general population on the consumption of psychoactive substances. The absence of the indication of the product in question in the statistics on convictions and imprisonment does not, however, allow the determination of the penal follow-up given to these cases of police interrogation. Faced with a fairly substantial number of cases of interrogation, using not negligible public resources, it appears essential that minimum statistical elements should be available to measure the consequences thereof, at least from the judicial point of view.

The sharp decrease in the cases of interrogation for heroin use since 1990, constitutes the second notable development that occurred in the last ten years. These have fallen from more than 17,000 in 1995, reaching less than 6,000 in 2000. It must be noted that this reduction slowed down in 1999 and 2000 and that a plateau might have been reached. The years of strongest reduction correspond to the introductory phase and operational start-up of the buprenorphine substitution treatments. The estimated number of persons receiving these treatments has continued to increase in 1999 and 2000, but at a slower rate. Both developments (cases of interrogation for heroin and the substitution treatments) are apparently interlinked.

The third fact marking the ten-year period was the increase in the cases of interrogation related to the use of crack and cocaine. At the beginning of the 1990s, this growth was primarily imputed to the increase in the cases of interrogation related to crack, probably associated with a spreading phase of this product at the end of the 1980s and the beginning of the 1990s. In the second part of the ten-year period, it was largely cocaine that was the cause of the case increases of police interrogation. The graph above shows the existing symmetry, since 1995, between the curves for the cases of interrogation for cocaine use and those for heroin. The sharp decrease in the cases of interrogation related to heroin was accompanied by a rapid progression in those related to cocaine. Subsequently, almost simultaneously, both the downward evolution for heroin and

the upward evolution for cocaine slowed down. One of the hypotheses that might explain the apparent link between the two curves is that it was partly the same population. A heroin user, who was also a consumer of cocaine, would only have previously appeared in the cases of police interrogation as a heroin user. If the same person being questioned were receiving a substitution treatment and, from time-to-time consumes cocaine, the person will only appear as a cocaine user. A similar phenomenon of a change in etiquette appears to be manifesting itself at the level of requests for treatment.

*The growth in the cases of police interrogation for use or use/dealing of ecstasy is also one of the strong trends found over the course of the ten-year period, as shown in the graph on page 51. This growth occurred in two stages, with the first phase of growth between 1990 and 1995, following the introduction of this new drug into France and then, after four years of stagnation, a doubling in the number of cases of interrogation between 1999 and 2000. According to the analyses produced by the structure for observing recent trends TREND [33], the availability pf ecstasy increased considerably in the traditional dealing places between 1999 and 2000 while it remained stable in the 'party environment' (*techno *parties). This development could partly explain the growth in cases of police interrogation—the police and the gendarmerie serving in territory better known for street sales than dealing during* rave *parties.*

In 2000, these different developments were reflected by a lesser concentration of interrogation on heroin and by a more equal breakdown between drugs. This could be explained by the development of substitution treatments and the diversification of substances consumed. The supply of drugs has adapted to these changes; the dealers are now more 'multi-menu'.

Characteristics of users questioned

As for requests for treatment, the characteristics of users questioned are different depending on the drug. In regard to age, cannabis and ecstasy users (average ages of 22 and 23 years respectively) are different from users of cocaine, crack and heroin, who are much older (average ages of 30, 31 and 28 years respectively in 2000).

The majority of users questioned were men. Their share of cases of interrogation is particularly high for cannabis (approximately 93%).

Finally, the comment can be made that foreigners were in a minority in the cases of the police interrogation of users, except in the case of crack (one in five users questioned).

Mandatory treatment and other alternatives

Following the interrogation of a user, the police services or the gendarmerie contact the deputy public prosecutor of the serious crime court within their area. This magistrate can either file the matter, according to different systems (no follow-up, under conditions, with direction), order mandatory treatment, or move for prosecution. Filing occurs in a large majority of cases. Mandatory treatment is one of the alternatives to prosecution, at the discretion of the deputy public prosecutor. It is different to the others (filing with conditions or with direction) through the imposition of a stronger coercive framework, with the deputy public prosecutor always having the possibility of again moving for prosecution if the user does not meet his obligations. Only the number and characteristics of the persons subject to mandatory treatment are described in this section. The data available at the time of publication of this report do not allow the developmental measurement of the other alternatives to prosecution encouraged by the circular of June 1999, in regard to the judicial response to drug addiction.

The number of mandatory treatments ordered and undertaken.

When mandatory treatment is decided upon, the user is, without exception, summoned to the serious crime court to be notified of the measure. Then the offender has the obligation to make contact with the services of the Direction départementale des affaires sanitaires et sociales (DDASS: Departmental Management for Health and Social Action), who will direct him/her, if this appears justified, to an

appropriate healthcare structure. Each of these stages is a source of loss, which explains the difference between the number of mandatory treatments ordered by the magistrates and the number of mandatory treatments that actually result in contact with the healthcare structures (mandatory treatment undertaken).

Mandatory treatments ordered and undertaken, from 1993 to 1999

	1993	1994	1995	1996	1997	1998	1999
Number of mandatory treatments ordered [(1)]	6,149	7,678	8,630	8,812	8,052	8,022	7,737
Number of persons directed to the DDASS [(2)]	4,591	6,500	7,220	7,294	6,628	-	6,652*
Number of mandatory treatments undertaken [(2)]	4,064	5,760	6,072	6,331	5,723	-	3,437*

** Data estimated from information provided by 83 departments from 104*

Sources: [(1)] Public prosecutors framework, Ministry of Justice,[(2)] DGS (information provided by the DDASS)

In 1999, the magistrates ordered approximately 7,700 mandatory treatments. Having seen a period of growth during the first half of the 1990s, their numbers have decreased since 1997.

This reduction, fairly limited in 1998 and 1999, could be related to the decline in the cases of police interrogation of heroin users, and, for 1999, to the impact of the circular of 17th June 1999 referred to above. The latter, in effect, recalled that mandatory treatment should be reserved for dependent persons and asked that this measure be re-centred on its original task. The possible consequences of this circular should, however, have more effect on the data for 2000. Moreover, the other healthcare obligations, which arise following a conviction—particularly, a stay of execution with testing—appear to be on the increase. It is possible that this growth is occurring to the detriment of mandatory treatment.

The ordering of mandatory treatment remains concentrated within certain departments; in 1999, half of them were concentrated in ten departments. They are often departments situated in geographic zones where all the indicators related to drug addiction are at high levels (the north and northeast borders, the Paris region, and the Southeast).

All the mandatory treatments ordered were not completed. In 1997, a little more than 6,600 persons were directed to the DDASS and almost 5,700 persons made contact with the healthcare system. The 1999 data are partial, certain DDASS not having submitted their figures to the General Health Department. They do, however, give a good idea of the size of the loss between the different stages in the procedure; of the number of mandatory treatments ordered, 86% resulted in contact with the DDASS and 52% with the healthcare structures. In 1997, the last figure reached 86%. Subject to the reserve that the figures are incorrect, due to the absence of certain important departments (Nord, Alpes-Maritimes), this ratio has fallen considerably. The figures for 2000 must be awaited before judging the permanence of this development.

Users receiving mandatory treatment

In 1997, the population receiving mandatory treatment was mainly composed of cannabis users (60% of mandatory treatments undertaken) and a little more than one-third of heroin users (36%) The same year, mandatory treatment of 'hard' drug users, such as heroin or cocaine, was only indicated in one-quarter of the departments that had recourse to it. The role attributed to mandatory treatment appears to be very different depending on the magistrates. Against the standard concept of the mandatory treatment being aimed at taking dependent users into care, there is an opposite use for preventive purposes. In the case of more restricted or recreational consumption, some magistrates use the mandatory treatment as a frame for socio-educational follow-up, psychological care, or the delivery of a preventive message (Sagant, 1997).

Convictions for use

The statistics for convictions taken from the Casier judisiare national (National Criminal Record register) show the judgement decisions against users prosecuted before the court. A conviction can sanction a number of offences, which is often the case for convictions for offences against the narcotics legislation. The conviction might be envisaged by considering only the principal offence—the counting mode used in the justice statistical Yearbook—or by taking all the associated offences into account. The second approach enriches the first.

Number of convictions for the principal offence

During 1999, slightly more than 6,700 convictions were ordered for the illicit use of narcotics as the principal offence. This figure has been relatively stable for a number of years (except the fall recorded in 1995 following the Presidential amnesty). After the cases of possession and/or acquisition, use is the most frequently sanctioned offence against the narcotics legislation (ILS) by convictions.

The number of convictions for use has developed in a parallel manner to all of the convictions for ILS and represents, at maximum, one-third thereof.

Convictions for illicit use of narcotics (as the principal offence), from 1992 to 1999

	1992	1993	1994	1995	1996	1997	1998	1999*
Number of convictions for use	7,374	8,157	6,201	4,670	6,751	6,640	6,622	6,742
% of the total convictions for ILS	33.7	25.8	28.3	22.6	28.3	27.6	27.8	28.8

** Provisional data*

Source: CJN, SDSED - Ministry of Justice (data published in: Ministry of Justice, 2001)

The quasi-stability in the number of convictions for use contrasts with the large growth in the cases of police interrogation for this offence. It appears to work as though the 'funnel' constituting the penal system was calibrated for a given number of convictions, irrespective of the number of cases of police interrogation. As the growth in the latter is especially related to cannabis users, it could be thought that these users are rarely convicted. In this case, it would surprisingly appear that the large decline in the cases of police interrogation for heroin use in the years from 1996 to 1998 (compensated very little by the growth in those for cocaine and ecstasy use) was not reflected in a reduction of convictions.

Number of convictions as associated offences

The offence of the use of narcotics appears, in fact, more often than is shown by the accounting of principal offences. In effect, in 1999, an offence of use appears in almost 15,000 convictions, most of the time in association with other offences (78% of convictions mention use).

Convictions for offences of use and associated offences, from 1991 to 1999

	1991	1996	1997	1998	1999*
Number of convictions for use (at least one offence of use)	11,505	15,493	15,685	15,026	14,864
Thus:	100.0	100.0	100.0	100.0	100.0
use only (in %)	36.9	19.5	21.5	23.1	22.1
use and non-ILS offence (in %)	19.1	15.4	14.3	14.1	15.1
use and other ILS offence (in %)	44.0	65.1	64.2	62.8	62.8

** Provisional data; ILS: offence against the narcotics legislation.*

Source: CJN, SDSED—Ministry of Justice

The use of illicit substances is mostly associated with another offence against the narcotics legislation. When another offence is linked to narcotics use, theft is determined in almost half of the cases.

The most frequent combinations of offences are those associated with the use and transport of narcotics (probably corresponding to 'ant' activity), use and possession or use and transfer (user-dealers in both cases).

Little change occurred in the situation between 1998 and 1999. On the other hand, changes have taken place since the 1991 data, in particular:

- The increase in convictions involving at least one offence of use
- An increase particularly in respect to convictions associating use with another offence (their proportion increased from 44% to 63%)
- The reduction in the 'use and other offences' association.

These developments probably reflect the changes in the practices of magistrates who, for the legal definition of the same crime, have a tendency to use a greater number of offences than before, and, in particular, that of use when the crime is related to narcotics.

In effect, since 1994, the revision of the nomenclature of the conviction statistics has resulted in the fragmentation of certain categories in order to ensure more appropriateness between the facts and their legal description. In legally describing the same matter, the magistrates can now use not one, but a number of offences. 'This overly legal description is, without doubt, the origin of the reduction by half of the convictions for single offences between 1991 and 1995' (Burricand et al., 1999).

Type of penalties pronounced

Convictions for narcotics use and the type of penalty pronounced in 1999

	Total (numbers)	% penalty of imprisonment	% penalty of fine	% other penalties[1]	Total	% fixed-term imprisonment[2]
Use as principal offence	6,742	58.4 %	26.9 %	14.6 %	100 %	(37.6 %)
Use as a single offence	3,282	46.0 %	37.3 %	16.8 %	100 %	(38.2 %)
Use associated with other offences	11,582	78.7 %	11.6 %	9.7 %	100 %	(45.3 %)
Of which:						
use and trafficking	1,119	94.8 %	3.4 %	1.8 %	100 %	(54.9 %)
use and transport	3,518	85.0 %	7.6 %	7.4 %	100 %	(45.3 %)
use and transfer	2,017	84.1 %	6.0 %	9.9 %	100 %	(40.3 %)
use and possession – acquisition	2,660	56.5 %	27.6 %	15.9 %	100 %	(31.9 %)
use and other offences	2,247	82.4 %	8.2 %	9.4 %	100 %	(55.3 %)

[1] Penalty of substitution, educational measure, exemption from penalty
[2] Reading note: 38.2% of penalties of imprisonment for use as a single offence are fixed-term.

Source: CJN, SDSED - Ministry of Justice

Convictions for use alone, or for use as the principal offence, are sanctioned by fairly similar penalties; more than half are subject to a penalty of imprisonment (of which two in five are fixed-term) and approximately one-third are ordered to pay a fine (see table on page 56).

Similar penalties are used for cases in which use is sanctioned together with possession—acquisition, which indicates that the judges use this double legal definition to finally sanction simple use.

In all other cases, the type of penalty shows that it is not the use, but the associated offence that was the reason for prosecution. The majority of these cases are subject to a penalty of imprisonment (almost half of

which are fixed-term). The other penalties are rarely required. In the case of fixed-term imprisonment, the period involved varies from 18.6 months in the case of use and trafficking to 6.4 months in the case of use and another offence (as opposed to 2.1 months in the case of use alone).

Comparison with the penalties used in the case of trafficking (see below) shows that use does not appear to be seen as a mitigating circumstance for trafficking. It is possible that in certain cases, the association of use with trafficking arises more from a systematic multiple legal definition rather than the certainty or suspicion that the person being questioned is a user.

Imprisonment for use and inmates imprisoned for use

Persons convicted for the use of narcotics can be subject to a penalty of imprisonment, fixed-term or with deferment (partial or total). Enumeration of the cases of imprisonment following conviction for use alone is difficult. In effect, the data from the penitentiary establishments only shows one offence—the offence shown as first in the conviction. This is generally the most serious offence, but it can be otherwise. All the cases in which use is associated with a more serious offence do not, therefore, appear in the statistics on imprisonment for use, unless this appears first in the conviction for some reason.

Number of cases of imprisonment in 2000 and development

During 2000, almost 400 persons were imprisoned in metropolitan France for the use of narcotics (34 in the overseas departments). These represent less than 1% of the entrants in that year and a little more than 4% of cases of imprisonment for offences against the narcotics legislation (ILS). The latter essentially correspond to cases of trafficking (see below).

The cases of imprisonment for the use of narcotics have been reducing since 1993, both in absolute and relative terms.

Cases of imprisonment for the use of narcotics (as the principal offence), from 1993 to 2000

	1993	1994	1995	1996	1997	1998	1999	2000
Number of cases of imprisonment for use	1,213	1,034	892	870	700	468	471	395
% of the total number of cases of imprisonment for ILS	10.2	8.6	7.1	7.3	6.6	5.1	5.2	4.4
% of total cases of imprisonment	1.5	1.2	1.1	1.1	0.9	0.7	0.7	0.6

Field: metropolitan France

Source: DAP/SDSED - Ministry of Justice

During the 1990s, the number of entrants convicted for the use of narcotics was divided by three, the reduction was constant.

Prison population on a given date

At the start of 2000, the penitentiary administration listed less than 300 persons imprisoned for the use of narcotics (as the principal offence); that is 34% of persons imprisoned for ILS and 0.6% of the total prison population.

An *ad hoc* survey, conducted on a given day in the French penitentiary establishments, allowed the refinement of the principal offence analysis and revealed that on 1st November 2000, 197 persons were imprisoned for the use of (only) narcotics, slightly more than in 1994. These inmates represented a very small part of the prison population.

Inmates imprisoned for the use of narcotics on a given day in 1994 and 2000

	1st April 1994	1st November 2000
For use only	168	197
As a % of the prison population	0.3	0.4
For use and possession	-	2,692
As a % of the prison population	-	5.5

Field: metropolitan France and overseas

Source: Manual reports from establishments, PMJ1 – DAP – Ministry of Justice

The number of persons in the penitentiary establishments for the reasons of use and possession is much greater; 2,700 persons on 1st November 2000, of which half are awaiting judgement.

Repression of the supply and trafficking of illicit drugs

The seizures made by the law enforcement services in France are only a very indirect indicator of the supply of illicit drugs. They are, in effect, also related to the activities of the services involved. Luck may also play a role in the annual variations. It is therefore essential to monitor seizures over longer periods.

As for use, the repression of trafficking is described with the assistance of indicators in relation to the number and characteristics of traffickers appearing in the statistics on police interrogation, convictions and imprisonment.

Drug seizures

It is very difficult to make a comparison between the quantities of different drugs seized. At the outset, the values of the same weights of different drugs are quite different: Cannabis, with a low per gramm price, is often trafficked in substantial quantities, often some tonnes, while heroin circulates in much smaller batches. Therefore, a number of tonnes of cannabis might be seized in one operation, which never happens with heroin. Moreover, as France is a transit country, part of the quantities seized is not destined for the internal market. It is, therefore, the development in seizures that it is interesting to monitor.

Recent developments in seizures

Quantity of drugs seized in 1998, 1999 and 2000, by drug

	1998	1999	2000
Cannabis (herb, resin, oil) (kg)	55,698	67,480	53,579
Heroin (kg)	343	203	444
Cocaine (kg)	1,050	3,687	1,311
Crack (kg)	25	10	22
Amphetamines (kg)	165	232	230
Hallucinogenic mushrooms (kg)	4.8	5.6	11
Ecstasy (doses)	1,142,226	1,860,402	2,283,620
LSD (doses)	18,680	9,991	20,691

Sources: FNAILS, OCRTIS

After a record year in 1999, the quantities of cannabis seized have returned to their 1997 and 1998 levels [28]. The situation was quite similar for cocaine.

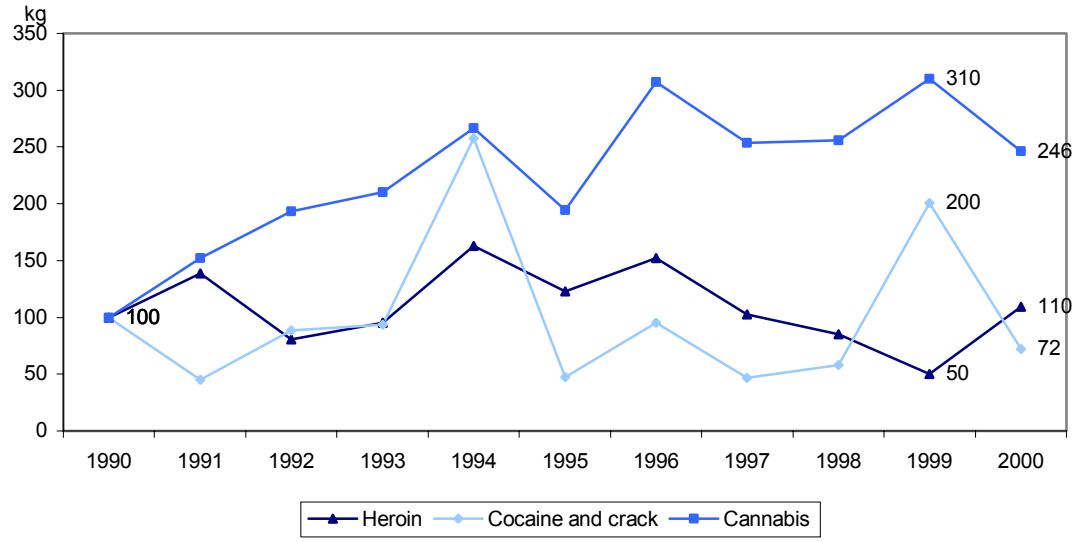
For the first time since 1996, the quantities of heroin seized have grown steadily in 2000. It should be noted, however, that the reduction in 1999 and the increase in 2000 are related to minor variations in the number of major operations involving more than 5 kg. The number of such seizures fell from 11 in 1998 (totalling 194 kg) to 5 in 1999 (53 kg), and increased to 15 in 2000 (273 kg). The influence of these few major amounts, which represent more than 60% of the quantities of heroin seized in 2000, mean that the figures must be carefully interpreted. In addition, the variation found is, for a good part, the result of an increase in the quantities seized, which were destined for Great Britain and Spain (approximately 270 kg for these two countries). France was the destination for a third of the quantities of heroin seized in 2000.

After a period of limited seizures, the quantities of ecstasy seized have substantially increased since 1998. This development is also related to the growth in those destined for Great Britain. France is a very marginal destination of the ecstasy seized (less than 105 in 2000), although its share is increasing.

Development in seizures between 1990 and 2000

The last ten-year period was marked by the large increase in seizures of cannabis, with a rapid and continuous upward growth to 1994 (multiplication by 2.5 in the quantities seized), followed by a fluctuation around this level until 2000.

Quantities of cannabis, heroin, cocaine and crack seized, from 1990 to 2000 (base of 100 in 1990) *{250a}*



Source: FNAILS, OCRTIS

The trend during the ten-year period was not the same for heroin and cocaine; the level reached in 2000 being close to that of 1990.

The quantities of heroin seized, which had been growing between the end of the 1980s and the mid-1990s, despite fluctuations, decreased substantially between 1997 and 1999, but recovered again in 2000.

The quantities of cocaine seized fluctuated, slightly below the level of 1990, with the exception of 1994 and 1999, during which exceptional seizures were made.

Outside the annual variations, approximately one-third of the quantities of cannabis seized were to be re-sold on the national territory, against half for heroin and one-fifth for cocaine.

Police interrogation, convictions and imprisonment for trafficking

As for users, the penal statistics regarding traffickers do not allow the judicial monitoring of a case or a person throughout the penal channel. The details per drug are only available for police interrogation data.

Police interrogation

During 2000, the police, gendarmerie, and customs services questioned 6,500 traffickers, which represented 6.5% of the cases of interrogation for offences against the narcotics legislation (ILS) [28].

More than 8 out of 10 traffickers questioned were involved in local trafficking or dealing activities and 2 out of 10 in large scale trafficking, importation or exportation.

Cases of police interrogation for trafficking in narcotics in 2000, by drug, sex, nationality, and age.

	All cases of police interrogation for trafficking		International trafficking (=1,245)	Local trafficking and dealing (= 5,286)
	Number	%	%	%
Cannabis	3,625	55.5	37.1	59.8
Heroin	1,228	18.8	17.6	19.1
Cocaine	1,088	16.7	34.0	12.6
Crack	200	3.1	0.7	3.6
Ecstasy	312	4.8	8.9	3.8
Others*	78	1.2	1.7	1.1
Total	6 ,531	100.0	100.0	100.0

** Medicaments, amphetamines, LSD, khat, etc.*

Source: FNAILS 2000, OCRTIS

The cases of police interrogation of traffickers by drug are more diversified than for users. Cannabis, with slightly more than half the cases, is less dominant (As a reminder, it represented 87% of cases of police interrogation of users.). With almost one case of interrogation in five, heroin and cocaine are the drugs most frequently in question, after cannabis, in these types of interrogation.

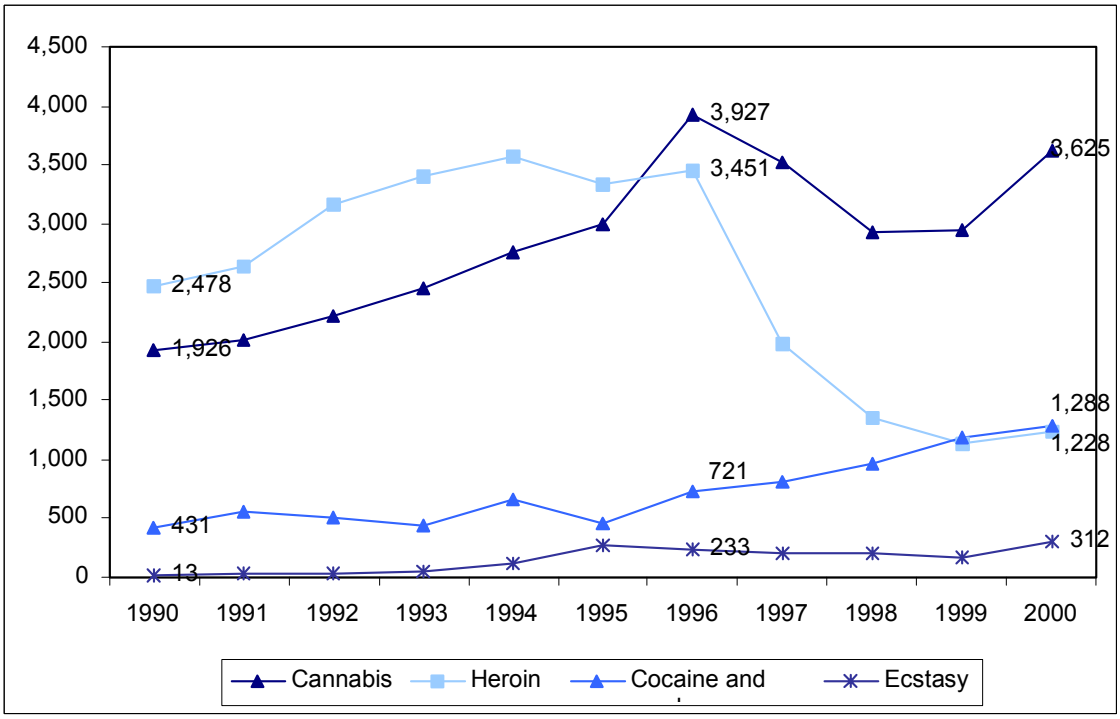
In the cases of police interrogation of small traffickers (local trafficking or dealing activities), cannabis occurs slightly more often (it appears in 60% of cases). But, the main difference is the fact that the cases of international trafficking appear to be strongly related to cocaine.

During the first half of the ten-year period, the cases of police interrogation for trafficking were rising or stable for all drugs (see the graph on page 65).

While the police interrogation of cocaine traffickers continued to increase, those for trafficking in cannabis and heroin fell after 1996 and until 1999. The decrease in cases of heroin trafficking should be compared with the decrease in the police interrogation of users of this drug.

In 2000, the number of cases of police interrogation for trafficking increased, irrespective of the drug, breaking the previous downward trend for cannabis and heroin.

Cases of police interrogation for narcotics trafficking from 1990 to 2000, by drug *{250a(b)}*



Source: FNAILS, OCRTIS

Convictions for trafficking

While the police statistics refer only to three categories of trafficking (international or local trafficking and dealing), the nomenclature of the judicial statistics is more detailed, using the offences against the narcotics legislation, which are sanctioned under the penal code.

Contrary to the cases of police interrogation, the convictions for trafficking are more numerous than those for narcotics use; 16,700 and 6,700 convictions, respectively, as the principal offence.

The convictions for narcotics trafficking involve, more particularly, four types of offence: possession—acquisition; trade, employment or transport, exportation or importation; the supply or transfer of narcotics. In 1999, there were also 68 convictions for assisting in the use of narcotics, 10 cases of the non-justification of income (an offence currently called 'drug procuring') and 55 other ILS.

Convictions for narcotics trafficking (as the principal offence) and type of penalty in 1999; by type of offence

	Total (numbers)	% penalty of imprisonment	% penalty of fine	% other penalties[1]	Total	% fixed-term imprisonment[2]
Possession, acquisition	8,945	78.9 %	12.0 %	9.1 %	100.0 %	(49.2 %)
Supply and transfer	2,363	86.6 %	5.3 %	8.0 %	100.0 %	(55.5 %)
Trade, employment, transport	3,403	87.5 %	7.1 %	5.4 %	100.0 %	(54.7 %)
Trafficking (exportation – importation)	1,839	96.3 %	2.6 %	1.1 %	100.0 %	(73.0 %)

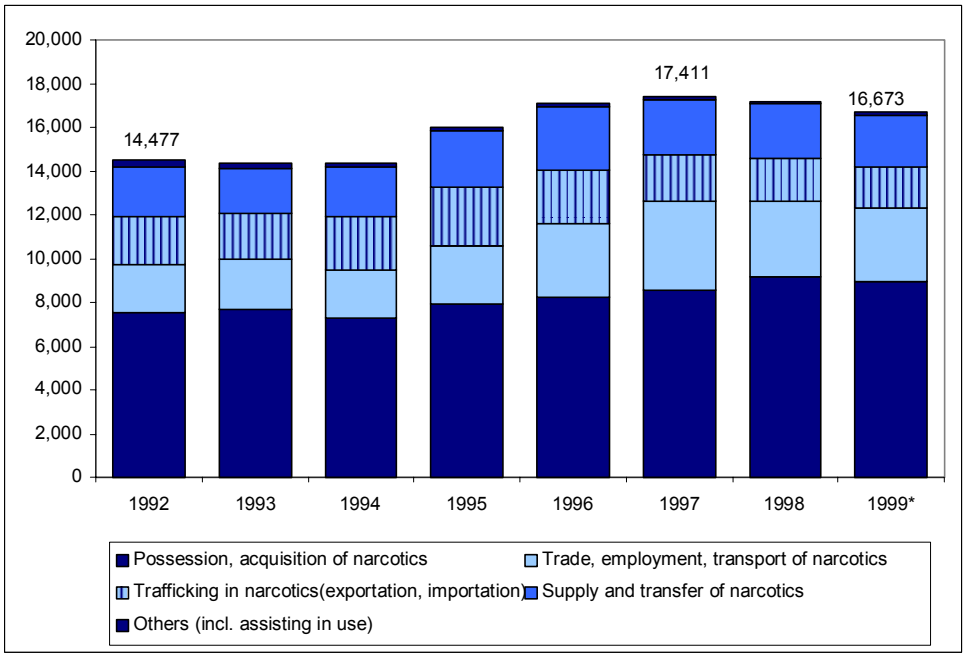
[1] 'Other penalties': Penalty of substitution, educational measure and exemption from penalty
[2] Reading note: 49.2 % of penalties of imprisonment for possession/acquisition as the principal offence are fixed-term.

Source: CJN, SDSED - Ministry of Justice

The higher up in the trafficking scale, the more penalties of imprisonment are favoured. The share and duration of the fixed-term imprisonment also increases in consequence.

Offences of trafficking are more likely to be indicated as the principal offence than are those of use. Nevertheless, the multiple legal descriptions of cases are frequent. On average, in 1999, for the offences in the previous table, the magistrates used 3.6 offences to legally describe the case. Almost 23,6000 convictions sanctioning at least one offence of trafficking (in the broad sense, excluding use) were counted in this way. The most frequent associations were those sanctioning use and transport together (15% of convictions), use and possession/acquisition (11%) and, cases of possession, trade and transfer without import/export or use (15%).

Convictions for trafficking in narcotics (as the principal offence), from 1992 to 1999 *{250b}*



*

Provisional data

Source: CJN, SDSED - Ministry of Justice

After a period of relative stagnation, the increase in the convictions for trafficking in narcotics noted in 1995 essentially covered the cases of trade, employment, or transport of narcotics (+22% in 1995), supply and transfer (+12%) and importation/exportation (+10%). It continued for two years, but since 1997-1998 all convictions have reduced.

On the other hand, there has been an increase in absolute and relative terms in the convictions for ILS of minors: 451 cases in 1995 (that is 2.2% of convictions for ILS) as opposed to 1,594 in 1999—6.8% (Ministry of Justice, 2001, p.231).

Imprisonment for trafficking and inmates imprisoned for trafficking

The penitentiary statistics in their turn use a different nomenclature than the previous ones. The level of detail is less as a distinction is only made between cases of trafficking, transfer, use and other ILS. Moreover, the figures only show the principal offences.

At this stage in the criminal channel, it is logical that the offences most severely punished under the penal code are more represented in the cases of imprisonment. Therefore, during 2000, the persons imprisoned for narcotics trafficking represented 62% of all of the cases of imprisonment for ILS and 8% of all entrants (as opposed to 45 and 0.6% for use) [31].

Cases of imprisonment for trafficking in narcotics (as the principal offence), from 1993 to 2000, by type of offence

	1993	1994	1995	1996	1997	1998	1999	2000
Trafficking	7,845	7,726	7,991	7,842	6,869	5,720	5,867	5,538
Transfer	686	1,140	1,053	987	910	863	491	616
Other ILS	2,091	2,158	2,653	2,244	2,115	2,074	2,296	2,345
Total ILS	11,835	12,058	12,589	11,943	10,594	9,125	9,125	8,894
Total offences	82,201	84,684	81,398	78,778	75,098	71,768	72,172	66,862

Field: metropolitan France

Source: FND, DAP/SDSED - Ministry of Justice

As for all cases of imprisonment for ILS, those for trafficking and, to a lesser degree, for the transfer of narcotics, have been declining since 1993. In parallel, the other ILS category represents more and more cases of imprisonment (from 18% of those for ILS in 1993 to 26% in 2000).

We note that the recorded reduction in the number of cases of imprisonment for ILS is of the same order as that for all cases of imprisonment, all offences included (respectively 4% and 3 % on average each year). Within the ILS, those for use have reduced the most.

The number of persons convicted (excluding accused persons) of ILS in the prisons on a given date is also declining, in both absolute and relative terms. On the 1st January 2001, the penitentiary administration listed 4,085 persons convicted for ILS, which is 14% of the convicted prison population. On 1st January 1995, the 6,118 inmates detained for ILS represented 21% of the convicted [31].

Laundering of drug money

The fight against the laundering of money related to illicit drugs is a priority reaffirmed in the law of 31st December 1987, which criminalized this act for the first time.

Set up at the start of the 1990s within the Ministry of the Economy and the Budget, the co-ordination section responsible for the traitement du renseignement et de l'action contre les circuits financiers clandestins (TRACFIN: Processing of Information and Action Against Clandestine Financial Circuits) has the task of receiving and processing the declarations of suspicion by financial organisation and transmitting files, which

show acts likely to relate to narcotics trafficking or the activities of criminal organisations, to the judicial authority.

Since implementation, TRACFIN receives an increasing number of declarations of suspicion; from 179 in 1991, the section recorded 1,244 in 1998. The activity essentially began in 1995. This progression is linked, particularly, to more effective co-operation with the banking and financial services involved (DGDDI, 1999).

These declarations relate to the laundering of the products of all crime and not simply to drugs money.

In 2000, TRACFIN recorded 2,537 declarations of suspicion and 156 files were brought to justice. If the number of files transmitted to justice seems low by reference to the declarations of suspicion, it must be clarified that some inquiry files are on-going for more than a year before being transmitted to the public prosecutor; in addition, a substantial proportion of the files transmitted include, in fact, a number of declarations of suspicion. In 1998 and 1999, 223 and 268 of these declarations resulted in judicial proceedings; that is almost 17% of all the notifications of suspect operations received during these years. According to TRACFIN report on activities for 2000, it appears that the French jurisdiction showed a certain severity in the repression of the criminality category; of the 21 convictions for the crime of money-laundering pronounced in 1999, 19 involved the penalty of imprisonment, the average duration of which was 32 months.

Geography of the consequences of the use of illicit drugs

The socio-health consequences of the use of illicit drugs in the regions can be approached through the DREES/DGS data on the number of cases. This data also allows the obtaining of the regional breakdown of HIV and HCV cases amongst injectors.

These regional data, relating to the penal response to the use of illicit drugs, correspond to the number of cases of police interrogation and the number of convictions for use, whether or not associated with other offences.

Healthcare and social consequences

Treatment requests

Only the number of cases for cannabis and the opiates are sufficiently high to be the subject of analysis at the regional level.

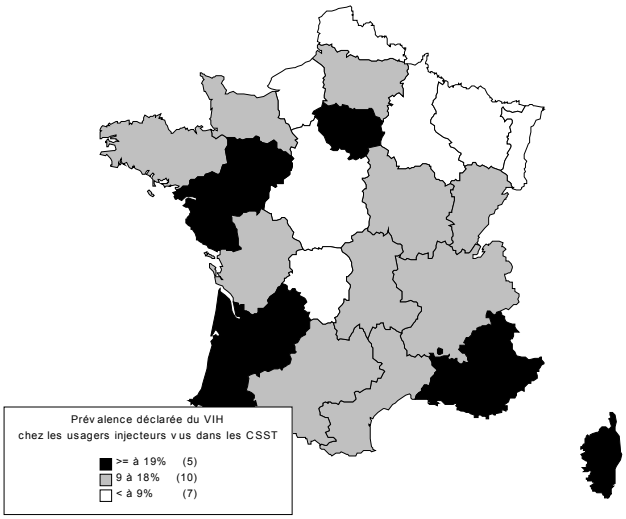
In all regions, the cases of care for a primary drug, related to the number of inhabitants, are more numerous for the opiates than for the other drugs The number of cases per inhabitant related to opiates is, however, particularly high in the regions in the Mediterranean perimeter, Ile-de-France, Alsace and in the Nord-Pas-de-Calais region, traditionally affected by drug addiction. Care cases related to cannabis are, on the other hand, most numerous in Limousin, Poitou-Charentes, and Bretagne.

Some regions are more polarised on one drug (clearly above or below the national average for a specific drug): Alsace, Languedoc-Roussillon and Ile-de-France for opiates, Limousin, Bretagne and the Midi-Pyrénées region for cannabis [17].

Morbidity

The national prevalence of HIV amongst injectors (16% according to the data from the survey done in November 1999 [17]) masks substantial regional disparities. In the regions in the north of France, the prevalence is below 10%. It is particularly low in Lorraine (4 %), Nord-Pas-de-Calais (5 %), Alsace (7 %) and particularly high in Corse (34 %) and in the PACA, Ile-de-France and Aquitaine regions (22 to 23 %) [17].

Prevalence of HIV amongst injecting users in 1999, by regions *{3601}*



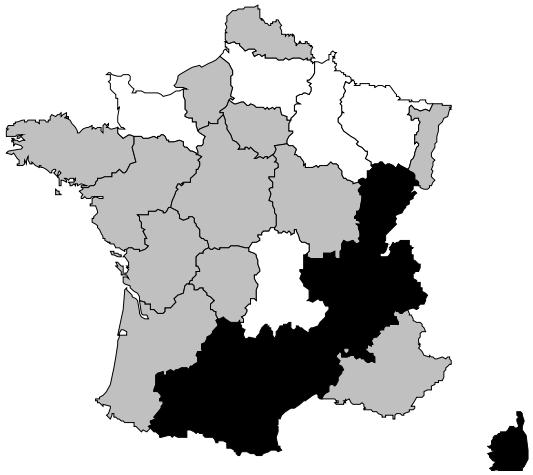
Source: Survey on the care of drug addicts in November 1999, DREES/DGS

The data obtained in the context of a multi-centre study done in 1999 confirms all these results (Chevallier, 2001). The declared prevalence reached 30 % in Marseilles and 22 % in Nice (as opposed to 23 % on average in the PACA region). In Toulouse, the prevalence is 16 % (15 % in the Midi-Pyrénées region). The prevalence is, on the other hand, very low in the north of France (2.5 % in Lille and 6 % in Lens against 5 % on average in the Nord-Pas-de-Calais region).

The disparities are partly explained by the ages of users. In the three regions with the lowest prevalence, the average age of injecting users was between 28 and 29 years; in the regions with the highest prevalence, the average age was more than 23 years.

The regional disparities in prevalence are less strong for HCV than for HIV. If the two extreme values are excluded (Corse et Champagne-Ardenne), the prevalence was between 50% and 69% in November 1999 [17], while for HIV, also excluding the extreme values, the range is from 4% to 22%. Due to the massive nature of the HCV epidemic, the prevalence appears to break down in a more even manner across the territory. However, as was previously indicated, the serologies are less well known and the declared prevalence has a lesser degree of reliability than for HIV.

Prevalence of HCV amongst injecting users in 1999, by regions *{3602}*

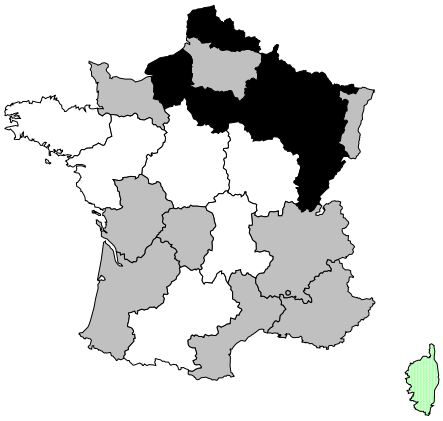


Source: Survey on the care of drug addicts in November 1999, DREES/DGS

Criminal consequences

The regions that recorded more cases of police interrogation than the national average (35 cases of police interrogation per 10,000 inhabitants, from 15 to 44 years of age) are all concentrated in the north or east of France, the maximum being recorded in the Nord-Pas-de-Calais, with 61 cases of police interrogation for 10,000 inhabitants. With the majority of cases of police interrogation being cases of the use or use/dealing of cannabis, this situation is very close to that described in the chapter dealing with this drug [28].

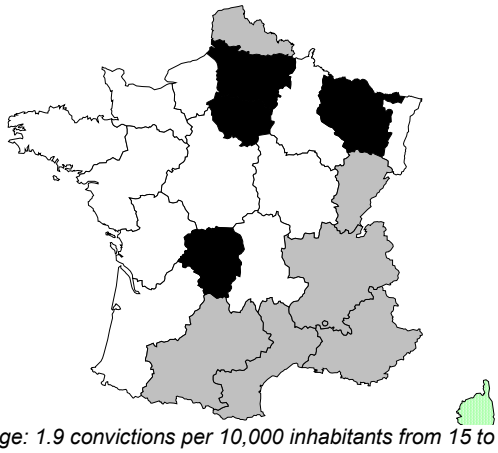
Cases of police interrogation for use alone and use/dealing in 1999 by region *{360a}*



National average: 36.0 cases of police interrogation per 10,000 inhabitants from 15 to 44 years of age.
Source: FNAILS 1999, OCRTIS

The geographic dispersion of convictions for use alone or for use and possession alone are not the same as for the cases of police interrogation in 1999.

Convictions for use alone and use/possession alone in 1999 by region *{360b}*



National average: 1.9 convictions per 10,000 inhabitants from 15 to 44 years of age.
Source: CJN 1999, SDSED - Ministry of Justice

Four regions are distinguished by a number of convictions related to the population, which are clearly greater than the national average. These are Ile-de-France, Lorraine, Picardie and Limousin [28]. Only the first two are part of the regions that recorded a large number of cases of police interrogation.

For further information

- BECK (F.), LEGLEYE (S.), PERETTI-WATEL (P.), A LOOK AT THE END OF ADOLESCENCE: CONSUMPTION OF PSYCHOACTIVE DRUGS IN THE ESCAPAD 2000 SURVEY, PARIS, OFDT, 2000, P. 220.
- BECK (F.), PERETTI-WATEL (P.), EROPP 99: SURVEY ON THE REPRESENTATIONS, OPINIONS AND PERCEPTIONS IN RELATION TO PSYCHOTROPIC DRUGS, PARIS, OFDT, 2000, P. 203.
- BECK (F.), LEGLEYE (S.), PERETTI-WATEL (P.), ALCOHOL, TOBACCO, CANNABIS AND OTHER ILLICIT DRUGS AMONGST COLLEGE AND SECONDARY SCHOOL STUDENTS: ESPAD 1999 FRANCE, VOLUME II, PARIS, OFDT, 2001, (TO BE PUBLISHED).
- BELLO (P.Y.), TOUFIK (A.), GANDILHON (M.), RECENT TRENDS, TREND REPORT, PARIS, OFDT, 2001, P. 167.
- BURRICAND (C.), HARAL (C.), CONVICTIONS FOR OFFENCES AGAINST THE NARCOTICS LEGISLATION. EVOLUTION 1991-1995—STUDY REPORT, PARIS, MINISTRY OF JUSTICE, 1999, P. 42.
- CAZEIN (F.), PINGET (R.), LOT (F.), DAVID (D.), PILLONEL (J.), LAPORTE (A.), 'RECENT AIDS TRENDS IN FRANCE (JANUARY 1998-JUNE 2000)', BEH, N° 52, 2000, P. 233-235.
- CHEVALLIER (E.), LOCAL ESTIMATES OF THE PREVALENCE OF THE USE OF OPIATES AND COCAINE IN FRANCE. A MULTI-CENTRE STUDY IN LENS, LILLE, MARSEILLES, NICE AND TOULOUSE, PARIS, OFDT/ORSMIP, 2001, P. 112.
- CHOQUET (M.), LEDOUX (S.), HASSLER (C.), ALCOHOL, TOBACCO, CANNABIS AND OTHER ILLICIT DRUGS AMONGST COLLEGE AND SECONDARY SCHOOL STUDENTS: ESPAD 1999 FRANCE, VOLUME I, PARIS, OFDT, 2001, (TO BE PUBLISHED).
- CORKERY (J.M.), DRUG-RELATED MORTALITY IN FRANCE: A VIEW FROM ACROSS THE WATER, 30 P., (TO BE PUBLISHED).
- COSTES (J.M.), 'COUNTRY REPORT: FRANCE', IN EMCDDA, PREVALENCE AND PATTERNS OF PROBLEM DRUG USE FOR ALL EUROPEAN UNION MEMBER STATES. FINAL REPORT, LUXEMBOURG, OFFICE FOR OFFICIAL PUBLICATIONS OF THE EUROPEAN COMMUNITIES, 2001, (TO BE PUBLISHED).
- DELABRUYÈRE (D.), CONVICTIONS IN 1998, PARIS, MINISTRY OF JUSTICE, 2000, P. 250 (COLL. JUSTICE STUDIES AND STATISTICS, NO. 16).
- DGDDI (DIRECTION GÉNÉRALE DES DOUANES ET DROITS INDIRECTS), CUSTOMS REPORT FOR 2000, MINISTRY OF THE ECONOMY, FINANCE AND INDUSTRY, 2001, (TO BE PUBLISHED).
- EMMANUELLI (J.), LERT (F.), VALENCIANO (M.), SOCIAL CHARACTERISTICS, CONSUMPTIONS AND RISKS AMONGST DRUG USERS ATTENDING SYRINGE EXCHANGE PROGRAMMES IN FRANCE, PARIS, OFDT/INVS/
- INSERM, 1999, P. 62 (STUDY NO. 18).
- EMMANUELLI (J.), CONTRIBUTION TO THE EVALUATION OF THE SIAMOIS RISK REDUCTION POLICY: DESCRIPTION, ANALYSIS AND PUTTING INTO PERSPECTIVE OF THE OFFICIAL SALES DATA FOR SYRINGES AND SUBSTITUTION DRUGS IN FRANCE FROM 1996 TO 1999, (2 TOMES), SAINT-MAURICE, INVS, 2000, P. 55 + 93
- GRÉMY (I.), TRENDS IN THE MORTALITY OF DRUG ADDICTS. BIBLIOGRAPHICAL STUDY ON THE COHORT SURVEYS, PARIS, ORS D'ILE-DE-FRANCE, 1997, P. 65.
- GUILBERT (P.), BAUDIER (F.), GAUTIER (A.) (DIR.), HEALTH BAROMETER 2000, VANVES, CFES, 2001, (TO BE PUBLISHED).
- INVS (INSTITUT DE VEILLE SANITAIRE), 'SURVEILLANCE OF AIDS IN FRANCE: SITUATION AFTER TWO YEARS OF INTERRUPTION', BEH, N° 38, 2000, P. 163-169.
- IREP (INSTITUT DE RECHERCHE ET D'ÉTUDES SUR LES PHARMACODÉPENDANCES), MULTI-CENTRE STUDY ON THE ATTITUDES AND BEHAVIOURS OF DRUG ADDICTS FACED WITH THE RISK OF CONTAMINATION BY HIV AND THE HEPATITIS VIRUSES. SUMMARY REPORT, PARIS, IREP, 1996, P. 455.
- KOPP (P.), FENOGLIO (P.), THE SOCIAL COST OF LICIT (ALCOHOL AND TOBACCO) AND ILLICIT DRUGS IN FRANCE, PARIS, OFDT/ARMI, 2000, P. 277.

■ MINISTRY OF JUSTICE, DAGE, SDSED, JUSTICE STATISTICAL YEARBOOK. 2001 EDITION, PARIS, DOCUMENTATION FRANÇAISE, 2001, P. 339.

■ OCRTIS (OFFICE CENTRAL POUR LA RÉPRESSION DU TRAFIC ILLICITE DES STUPÉFIANTS— CENTRAL OFFICE FOR THE REPRESSION OF DRUG-RELATED OFFENCES), USE AND TRAFFICKING OF NARCOTIC DRUGS IN FRANCE IN 2000, PARIS, MINISTRY OF THE INTERIOR, 2001, P. 114.

■ OFDT (FRENCH OBSERVATORY OF DRUGS AND DRUG ADDICTION), DRUGS AND DRUG ADDICTION: INDICATORS AND TRENDS, PARIS, OFDT, 1999, P. 270.

■ RABORD (M.), 'MANDATORY TREATMENT', SOCIAL HEALTH EXCHANGES, N° 81, 1996, P. 49-52.

■ SAGANT (V.), REPORT ON THE APPLICATION OF THE CIRCULAR OF 28TH APRIL 1995 REGARDING THE HARMONISATION OF PRACTICES IN RELATION TO MANDATORY TREATMENT: SUMMARY AND ANALYSIS OF THE REPORTS OF THE PUBLIC PROSECUTORS, PARIS, MINISTRY OF JUSTICE, 1997, P. 95.

■ SETBON (M.), DE CALAN (J.), MANDATORY TREATMENT: EVALUATION OF THE LEGAL STRUCTURE FOR THE CARE OF QUESTIONED DRUG USERS, CNRS-GAPP/OFDT, 2000, P. 159.

■ SIMMAT-DURAND (L.), CESONI (M.-L.), GOYAUX (N.), KLETZLEN (A.), MARTINEAU (H.), THE NARCOTICS USER BETWEEN REPRESSION AND CARE: IMPLEMENTATION OF THE LAW OF 1970, GUYANCOURT, CESDIP, 1998, P. 503 (STUDIES AND PENAL DATA, N° 77).

■ SIX (C.), HAMERS (F.), BRUNET (J-B.), SIX-MONTHLY SURVEY OF THE HIV, HCV AND HVB INFECTIONS AMONGST THE RESIDENTS OF THE SPECIALISED CENTRES FOR THE CARE OF DRUG ADDICTS, WITH ACCOMMODATION. GLOBAL REPORT ON THE 10 SIX-MONTH SURVEY PERIODS, FROM JULY 1993 TO JUNE 1998, SAINT MAURICE, CESES, 1999, P. 93.

■ TELLIER (S.), THE CARE OF DRUG ADDICTS IN THE HEALTHCARE AND SOCIAL STRUCTURES IN NOVEMBER 1999, PARIS, DREES, 2001, P. 47.

.

Alcohol

Reference points

Sales

- During the first half of the 1990s, sales of alcohol continued the downward trend that had started at the end of the 1950s. This decline was, however, of a lower size than that recorded for the preceding ten-year periods. The trend changed during the second half of the 1990s: alcohol consumption appears to have stabilised. The reduction in the quantity of pure alcohol consumed can be entirely attributed to the reduction in the consumption of wine.

- In 1998, households spent approximately 80 billion francs on alcoholic drinks, of which 60% was for wine. The State received a little more than 25% of this amount in the form of taxes.

Consumption

- In the **general adult population**, over the past ten years, the alcohol consumption indicators are relatively stable, whether for consumption, intoxication or problematic consumption

- In the general adult population, alcohol is, by far, the most consumed psychoactive substance: only 2.5% of French people declare never having taken a drink, 29% consume only occasionally, 42% at least once a week and 21% every day. Nine per cent show signs of current or past dependence and may be considered as having, or having had, problematic alcohol use.

- The alcohol most frequently consumed is wine, ahead of beer and spirits.

- Daily consumption is essentially masculine and is strongly associated with age.

- Fourteen per cent of adult declare having had at least one episode of intoxication during the last twelve months. Such episodes are more frequent among men (22%) than women (7%) and occur most often between the ages of 18 and 25 (51% of men and 22% of women).

- Intoxication is not more frequent among regular drinkers: in effect, more weekly drinkers reported having been intoxicated (24%) than daily drinkers (11%).

- Among young persons, the development in consumption during the 1990s was, as for adults, relatively stable.

- At 16 years of age, 86% of boys and 85% of girls said they had already drank an alcoholic drink during their lives, with repetitive use (at least ten times in the month) being the case for 14% of boys and 5% of girls. At the same age, 51% of boys and 42% of girls admitted to at least one episode of intoxication and 5% of boys and 3% of girls to repetitive intoxication (10 and more per annum).

- For both genders, alcohol is the psychoactive substance which is experimented with earliest: on average at approximately 14 years of age. The first episode of intoxication occurs approximately two years after the first consumption of alcohol.

Healthcare and social consequences

- Alcohol is the direct origin of a certain number of pathologies: cirrhosis of the liver, foetal alcoholism syndrome. It is also more or less directly implicated in the occurrence of a large number of other injuries: cancers in the aero-digestive tracts, illnesses of the circulatory system (joint responsibility of tobacco for these two groups of pathologies), cancer of the liver, optical neuritis, alcoholic neuritis, psychic problems, accidents, (road, domestic, work), brawls and suicides. The number of deaths in France attributable to alcohol was evaluated at 45,000 in 1995; we do not have a more recent estimation.

- Due to a much greater consumption of alcohol, the problematic healthcare consequences related to alcohol are much greater for men than for women.

- With regard to the harmful consequences of alcohol consumption, some studies show evidence of possible health benefits from alcohol consumption (cardio-vascular illnesses): a very moderate consumption of wine, even daily, will reduce global mortality. The conclusions of a summary of knowledge on this subject, undertaken in the context of a collective report requested from INSERM, (*Institut national de la santé et de la recherche médicale*: National Institute for Health and Medical Research) have just been published.

- In 1998, 80,000 alcohol consumers were taken into care by the *centres de cure ambulatoire en alcoologie* (CCAA: Alcoholism out-patient cure Centres). This number is an increase over preceding years. Three out of four patients are men. The average age of patients is 41 years. They are principally persons who are alcohol dependent or "excessive" consumers.

Consumption of alcohol by the French population

The consumption of alcohol in the French population is described on the basis of survey results from representative samples of the young or adult populations.

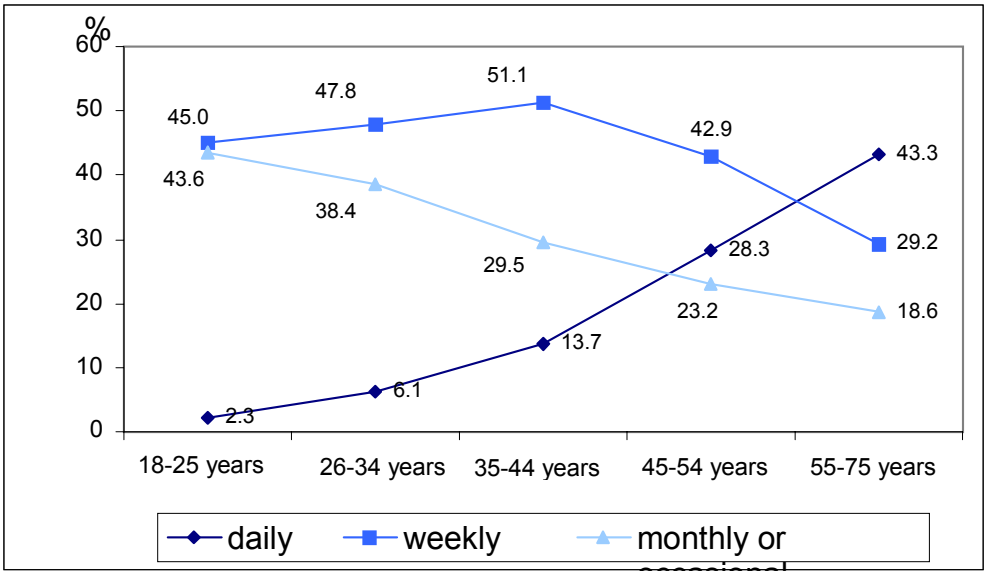
Consumption by the general adult population

In the general adult population, alcohol is the most consumed psychoactive substance: only 2.5% of the French population declare never having taken a drink, almost three times as many women as men [3]. In 1995, 4.5% of 18-75 year-olds declared never having drank alcohol during their lives. In 1999, this was 4.1% (2.5% declaring never having drank even a slightly alcoholic drink such as cider or shandy). But this relative increase in the declarations of consumption during their lives does not imply that it had increased at the same time. All the indicators show, to the contrary, a great stability in behaviour, linked to a reduction in the volume of consumption.

The consumption of alcohol is examined primarily on the basis of its frequency over the last twelve months.

A distinction is therefore made between daily (21.5%), weekly (drink at least once per week, but not every day: 42.1%), monthly or occasional drinkers (who drink at least once a year, but less than once a week: 29.0 %).

Frequency of alcohol consumption in the general adult population in 2000, by age and type of use *{3111}*



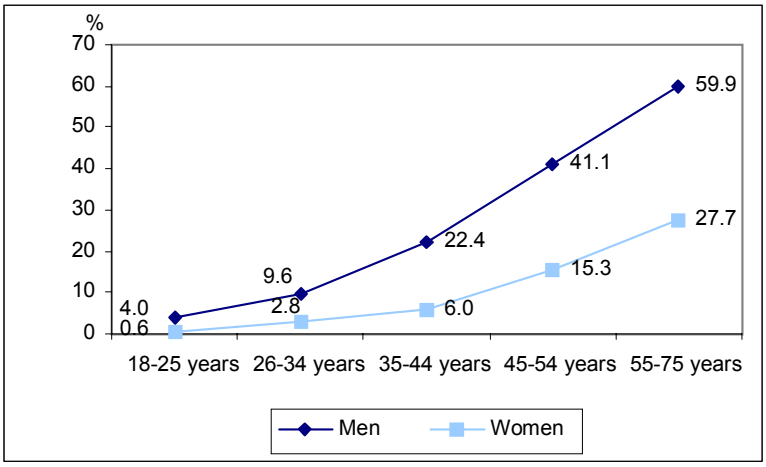
Source: Health Barometer 2000, CFES, OFDT production

From 18 to 54 years of age, it is weekly consumption which involves the greatest number of persons, reaching its highest point in the 35-44 age bracket; monthly or occasional consumption, which involves almost half of the 18-25 year age bracket, sees its share continually reduce with age to a point where only one-fifth of over 55s are involved. Conversely, daily consumption, to the detriment, firstly of monthly or occasional consumption and then weekly consumption, sees its share increase and then become predominant among over 55s.

The most frequently consumed alcohol is wine (83.6% of the French admit having drank it during the year), ahead of other alcohols (including champagne, cider, etc.: 64.7 %), spirits (60.3%) and beer (56.5 %).

Daily consumption

Frequency of daily consumption of alcohol (during the last 12 months) in the general adult population in 2000, by gender and age *{3112}*

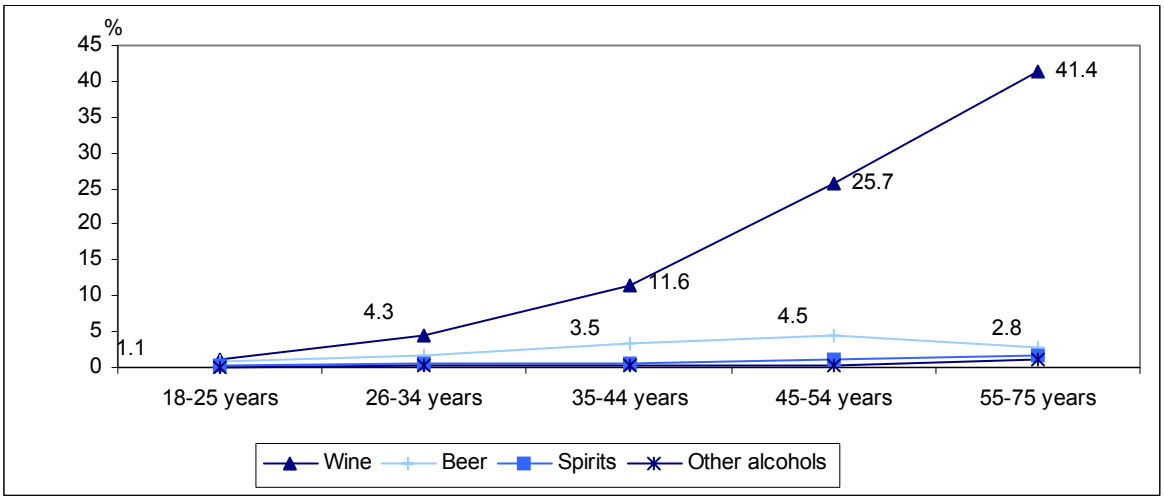


Source: Health Barometer 2000, CFES, OFDT production

Daily consumption is predominantly masculine (31.2% of men against 12.3% of women) and grows strongly with age to involve almost 60% of men over 55 years of age. Less frequent rates of consumption (weekly, monthly or occasional) are less differentiated on a gender basis.

The proportion of daily drinkers has been reducing for some years: if the last week is examined, it has reduced from 22.6% of adults in 1995 [2] to 20.3% in 1999 [3], with a constant population structure.

Frequency of daily consumption of alcohol (during the last 12 months) in the general adult population in 2000, by age and type of drink *{3113}*



Source: Health Barometer 2000, CFES, OFDT production

Wine is the single alcoholic drink whose daily consumption is so substantial: it represents the virtual totality of daily consumption with all alcohols included. Thereafter, the daily consumption of beer never exceeds 4.5% in an age bracket, and that of the other types of drink is anecdotal.

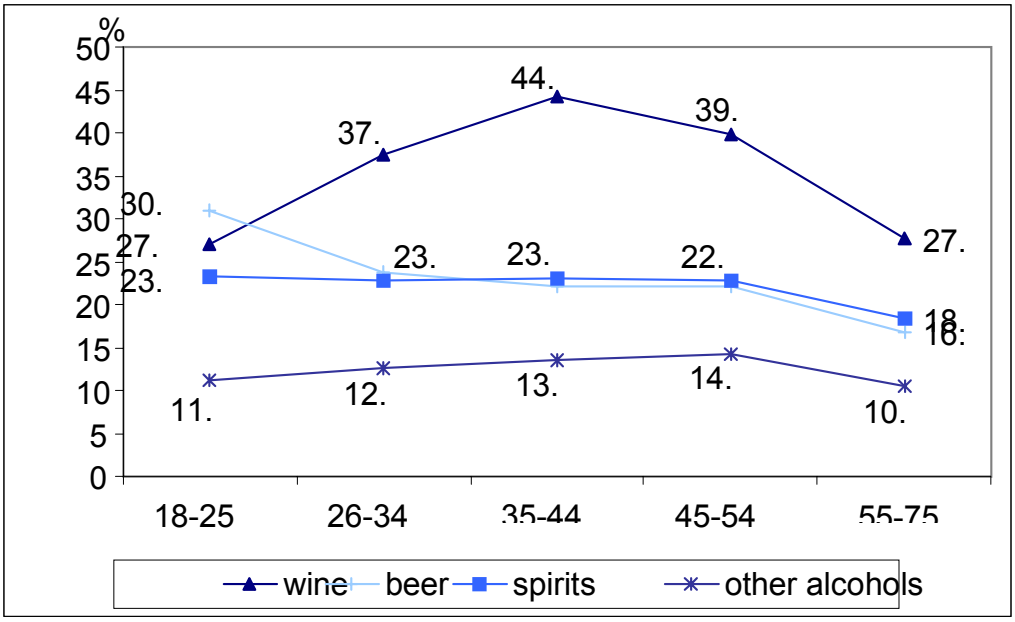
A series of five-yearly surveys done by ONIVINS (*Office national interprofessionnel des vins*: National Interprofessional Wine Office) and INRA (*Institut national de recherche agronomique*: National Institute for Agronomic Research) between 1980 and 2000 showed that the consumption of wine in the French population has reduced during the last twenty years, but that the share of non-drinkers has now stabilised at 37% of the population above 14 years of age (Aigrain *et al.*, 2000).

Daily consumption is essentially masculine and is strongly associated with age. It is, moreover, closely linked to the professional situation. There are three opposite groups from this point of view: the liberal professions, retired and other inactive persons, for whom this mode of consumption is very frequent; employees in the private or public sectors and unemployed persons who occupy an intermediary position; and finally students, for whom it is relatively less common.

Weekly consumption

The weekly consumption of alcoholic drinks (drinking at least once a week) involves more than 40% of the population up to 45-54 years of age. Wine is still the most consumed drink after 25 years of age, but its use is a little more rare after 45-54 years of age [3]. The other drinks, and in particular beer and spirits, whose daily consumption is anecdotal, are consumed on a weekly basis (in this case essentially at the weekend) by almost 20% of the population.

Frequency of weekly consumption of alcohol (during the last 12 months) in the general adult population in 2000, by age and type of drink *{3114}*



Source: Health Barometer 2000, CFES, OFDT production

Quantities consumed

The quantities consumed on the previous night depend on the gender but relatively little on age. On average, among person who drank on the previous night, men drank 3.0 glasses and women 1.7 [3]. This difference between men and women increases slightly with age: 1.1 glasses among 18-25 year-olds, against 1.3 after 55 years of age. The quantity drank the previous night is highest between 18 and 25 years of age (3.2 glasses for men and 2.0 for women), and fluctuates with age among men, while it progressively reduces among women (1.6 glasses among over 55s). Among those who had drank the previous night, daily consumers drank on average 2.8 glasses, weekly drinkers 2.3 and monthly or occasional drinkers 1.7: the frequency of consumption appears, therefore, to be globally related to the quantity consumed.

The details for the days of the week underline a well-known fact: consumption at the weekend is much greater than that during the week (number of glasses on average for drinkers: 2.4 from Monday to Thursday, against 2.6 for Friday and 2.9 for Saturday and Sunday). As is the case for the quantity drank the previous night, the quantity drank on Saturday increased with the frequency of consumption reported over the year; nevertheless, weekly consumers are a notable exception as they admit drinking as much as daily consumers (3.0 glasses). In addition, contrary to the average drank the previous night, the quantity drank on Saturday clearly reduces with age (5.6 glasses between 18 and 25 years of age, against 1.9 at over 55 years of age). Thus, on Saturday night, the 18-25 year-old weekly consumers drink, on average, more than daily consumers of the same age.

Finally, the type of drink consumed varies according to the day examined. During the week, wine is present (with minor fluctuations depending on the day) in 80% of declared consumption, beer in almost 20%, spirits in less than 15% and other alcohols in a little more than 5%. At the weekend (Friday, Saturday, Sunday), beer is present to a greater degree (57%), but it is primarily spirits (79%) and other alcohols (73%) which become more frequent; wine remains present in the majority of cases (80%).

The number of types of drink and the total quantity consumed therefore increases significantly at the weekend. This certainly contributes to explaining why intoxication is more frequent among weekly consumers (who drink more at the weekend) than among daily consumers, who nevertheless drink more on average over the week.

Intoxication

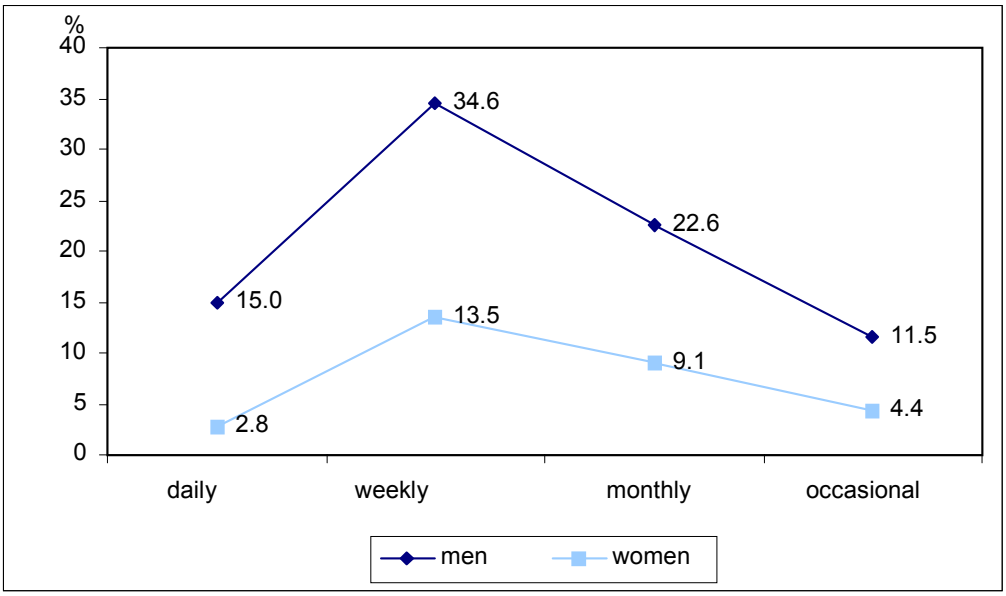
Fourteen per cent of adults admit having had at least one episode of intoxication during the last twelve months [3]. In 1995, this proportion amounted to 15% [2]. The prevalence of repetitive intoxication (at least four episodes admitted during the year) has also remained fairly stable between the two surveys: it involved 4.2% of the population in 1995 as against 4.6% in 1999.

The prevalence of intoxication depends initially on gender and age. Such episodes are three times more frequent among men (21.6%) than among women (6.7%) and vary significantly depending on age. The peak is situated between 18 and 25 years of age (50.6% of men and 22.2% of women)

Of those who admit having been intoxicated during the year, the average number of episodes of intoxication is 4.6% (5.1% for men and 2.9% for women). This number decreases with age: 5.9 between 18 and 25 years of age to less than 3 above 45 years of age. At all ages, it is substantially higher among men, but the most important differences involve primarily those under 35 years of age, and particularly those under 25 years of age. Above 55 years of age, the difference between the genders is not significant.

The proportion of repetitive intoxication (at least four episodes) among persons having admitted at least one episode of intoxication during the year provides an indicator of their recurrence. This decreases with age: it reduces from 35.0% among 18-25 year-olds to 15.2% among those over 45 years of age. The difference between genders is substantial (29.2% of episodes of intoxication are repetitive among men as against 20.1% among women) with the maximum at 18-25 years of age (38.5% against 26.7%). It is therefore among young men that intoxication appears to be most often sought after [3].

Prevalence of intoxication during the last twelve months, in 2000, by frequency of consumption and gender *{3116}*



Source: Health Barometer 2000, CFES, OFDT production

Age and gender are not the only factors associated with intoxication: the frequency of alcohol consumption during the year also pays an important role. However, an increase in the frequency of

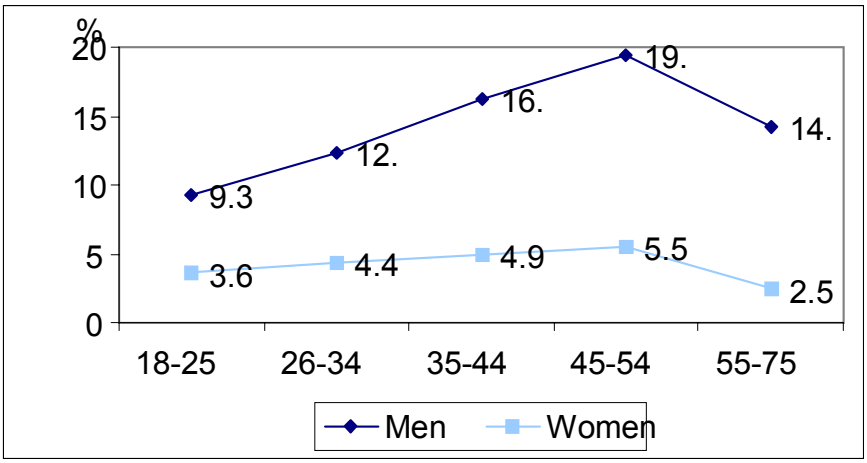
consumption is not always related to an increase in the frequency of intoxication. In effect, in order, the most numerous in having been intoxicated during the year were the weekly consumers, followed by the monthly consumers (once a month), daily consumers and finally occasional consumers (less than once a month). As young people drink less frequently but are intoxicated more often than older persons, and as there is a substantial difference between the genders, these concurrent factors must be checked in order to correctly understand this relationship. Weekly and daily consumers therefore have more or less the same chance of having been intoxicated at least once or in a repetitive manner.

Intoxication and repetitive intoxication are therefore linked to at least weekly consumption, particularly at the weekend: 18.8% of persons who admitted having drank during the weekend preceding the survey had been intoxicated during the year (5.6% at least four times), against 8.5% for the others (2.2% respectively).

With gender and age checked, repetitive intoxication (at least four episodes of intoxication during the year) is little dependent on the professional activity, but is more frequent among more the most well-off households [3].

Signs of dependence and problematic use

Proportion of persons showing signs of potential dependence on alcohol during their lives, in the general adult population, in 2000, by sex and age *{3117}*



Source: Health Barometer 2000, CFES, OFDT production

The Health Barometer questionnaire asked people about their previous or current risk of alcohol dependence using the DETA test for alcohol (DETA: *Diminuer entourage trop alcool:* Reduce alcohol-based surroundings). The prevalence throughout life has remained stable between 1995 (8.3%) and 1999 (8.9%).

While less than one adult in ten is concerned, men are three times more at risk than women (14.6% against 4.1%) and the difference between the genders increases with age. As the DETA test relates to use throughout life, it is not possible, with due diligence, to conclude that there is an increase in prevalence of the signs of dependence with age. It is however, reasonable to consider that the answers are relatively cyclical, which allows the fall in the curves after 55 years of age to be interpreted as a change in the mode of consumption and the relationship with alcohol: smaller quantities, intoxication being rarer, etc.

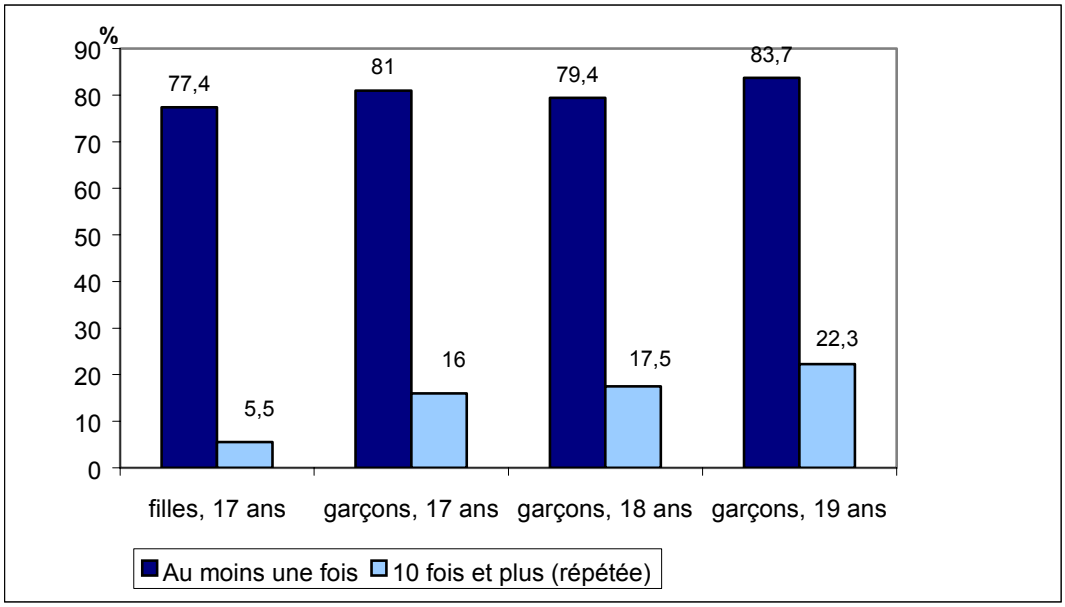
The consumers for whom the DETA test is positive have a special consumer profile. They overestimate, more often than others, the maximum daily quantities of alcohol deemed "at risk" (four glasses for men and three for women) and are four times more numerous than the others in admitting repetitive intoxication (13.8% against 3.25). They are also twice as numerous in drinking daily (39.8% against 19.7%) and their consumption on the previous Saturday exceeds five glasses (22.3% against 6.4%) much more often.

Consumption by adolescents

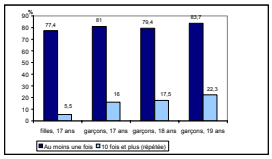
In the school environment, between 1993 [5] and 1997 [7], experimentation with alcohol increased slightly, increasing, at 16 years of age, from 81% to 86% among boys and from 79% to 85% among girls. Repetitive use (at least ten times during the month) does not appear to have shown notable growth between

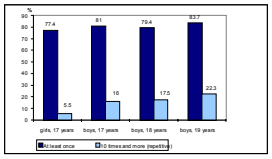
the two surveys, but comparison is difficult because the questions were not the same. As regards intoxication, between 1993 and 1999, the proportion of young people who admitted having had at least ten episodes of intoxication during the year remained stable among 14-16 year-olds, but reduced slightly among 17 and 18 year-olds (145 to 10% among boys of 18 years of age and from 3% to 2% among girls of the same age).

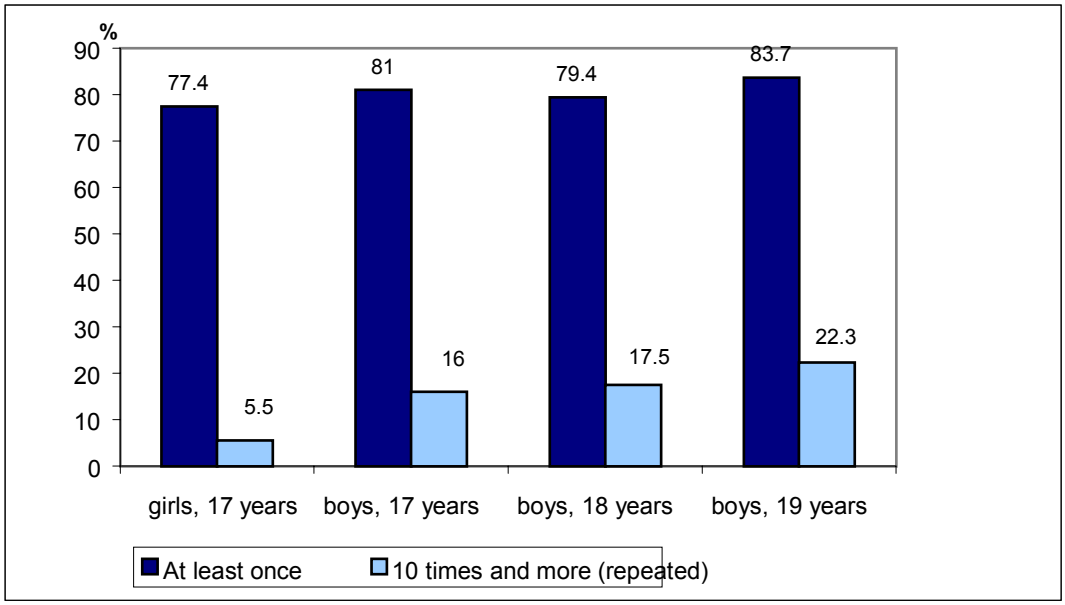
A very large majority of young people admit to having consumed alcohol during the last thirty days. At 17 years of age, this consumption is a little more frequent among boys, and increases little with age until 19 years of age [8]. The differences are much greater for repetitive consumption. At 17 years of age, 49.5% of girls admit having already being intoxicated during their lives, against 63.3% of boys. Among the latter, the prevalence of intoxication increases with age, reaching 74.8% among 19 year-olds.



Frequency of alcohol consumption during the last thirty days among young persons at the end of adolescence, in 2000, by sex and age *{3118}*







Source: ESCAPAD 2000, OFDT

Alcohol is the drug that is experimented with soonest (13.6 years of age among girls, 13.1 among boys). The first episode of intoxication is later than the first consumption of alcohol by approximately two years, irrespective of age and gender: it appears to be a relatively late stage in learning about alcohol. Girls admit to being intoxicated for the first time on average five months after boys of their age. It must therefore be noted that the very much earlier masculine consumption of alcohol is associated with a very much earlier first episode of intoxication.

Repetitive consumption of alcohol depends on schooling: young people who have left the school system are more numerous than the others in having drank at least ten times during the month preceding the survey. Among students, those registered in the professional channels have a greater chance, when gender, age and school year repetition are checked, of having done so; but, contrary to widespread opinion, the fact of having repeated a school year is not associated with the repetitive use of alcohol.

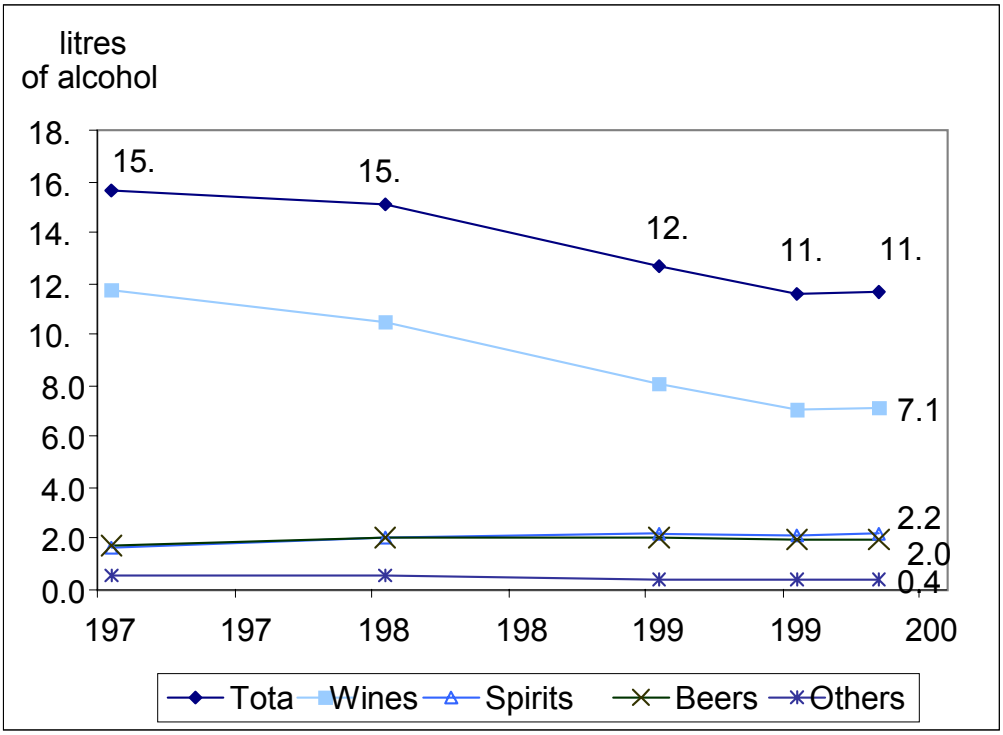
Young people who have already attended a techno party are twice as numerous as the others in having consumed in a repetitive manner (22.5% against 11.5%). With age, gender and school year repetition checked, students in such cases are twice as likely as the others to have drank in a repetitive manner. This ratio intensifies among young people who have left the school system.

Sales of alcoholic drinks

Alcoholic drinks available to French consumers

In 1998, the annual consumption of alcoholic drinks measured in pure alcohol was 11.7 litres per inhabitant, as against 15.7 in 1970. The downward movement in the consumption of alcohol began at the end of the 1950s. After the phase of marked reduction in the 1980-1995 period, consumption appears to have stabilised in the second half of the 1990s.

Sales of alcoholic drinks to consumers residing on the French territory from 1970 to 1998 *(3131)*



Source: Update of data given in (Got et al., 1997, p. 35)

In France, alcohol is mainly consumed in the form of wine, a product which represented approximately 61% of the volume of pure alcohol consumed in 1998 and, in a much lower proportion, in the form of spirits (19%) and beer (17%). Between 1970 and 1995, the share of wine reduced steadily and the reduction in the quantity of pure alcohol consumed may be attributed in the greater part to this reduction; the consumption of spirits (in equivalent pure alcohol) increased by one-third between 1970 and 1990 and has changed little since then. The consumption of beer increased by 20% between 1970 and 1980 and then reduced until 1995. Since that time, consumption measured in pure alcohol has stabilised and may even have increased for all products, including wine. Taking account of the uncertainties inherent in this type of calculation, variations of a minor size must, however, be carefully considered. It must be pointed out that the data on the quantities of pure alcohol consumed take account, since the opening up of the Single Market in 1993, of the development in the purchases of alcohol by non-residents, mainly of British nationality, in the border areas close to England.

The development in the consumption of wine is itself the result of two opposite trends between 1970 and 1995, on the one hand, the doubling of the quantities of "superior" wines (AOC (*Appellation d'origine contrôlée*: Appellation of origin) and VDQS *(Vin délimité de qualité supérieure:* Superior quality wine) consumed, and, on the other hand, the division, by more than two, over the same period, of the quantities of other wines (*vins de table (table wines) and vins de pays(higher class table wines*) consumed.

Household expenditure

In 2000, households spent almost 84.5 bullion francs on alcoholic drinks, of which 50.6 billion was on the category of wines, ciders and champagnes, 9.8 billion on beer and 24 billion on other alcoholic drinks. The share of alcohol in household budgets between 1990 and 2000 reduced from 1,45% to 1.33% (INSEE (*Institut national de la statistique et des études économiques*: National Institute for Statistics and Economic Studies), 2001). It must be clarified that this figure does not include expenditure related to the consumption of alcoholic drinks in cafes, restaurants and hotels.

The volume[1] of alcoholic drinks consumed increased by 7% between 1992 and 1998, an average per annum increase of approximately 0.8%. The relative prices of these drinks remained almost stable between 1993 and 1998, which indicates that their average price varied in the same way as all prices over this period.

Of the 84.5 billion spent by households in 2000, the State received a little more than 19 billion francs in the form of taxes on alcohol (excluding VAT). These receipts have remained practically stable compared with 1999 (+0.5%[2]).

[1] The volume of consumption is calculated by deducting the increase in the price index for alcoholic drinks from the increase in the value of consumption

[2] Data provided by the General Department of Customs and Indirect Duties

Health and social consequences of alcohol consumption

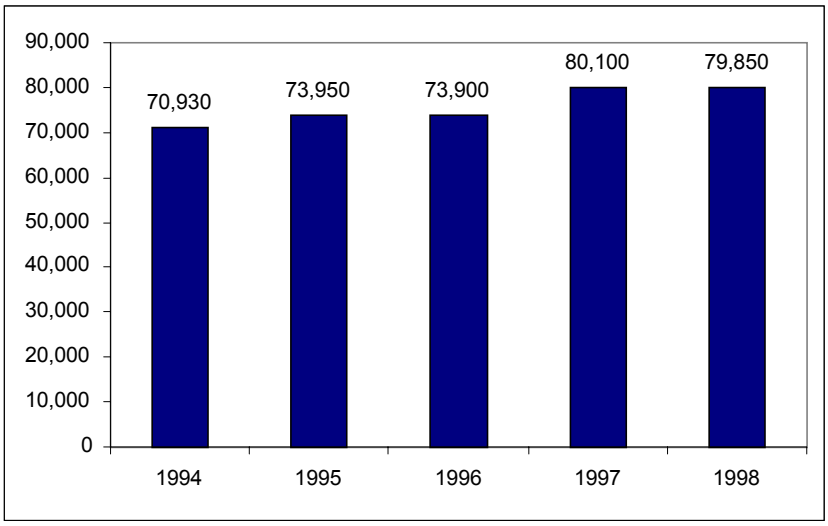
*In 2000, households spent almost 84.5 bullion francs on alcoholic drinks, of which 50.6 billion was on the category of wines, ciders and champagnes, 9.8 billion on beer and 24 billion on other alcoholic drinks. The share of alcohol in household budgets between 1990 and 2000 reduced from 1,45% to 1.33% (INSEE (*Institut national de la statistique et des études économiques*: National Institute for Statistics and Economic Studies), 2001). It must be clarified that this figure does not include expenditure related to the consumption of alcoholic drinks in cafes, restaurants and hotels.*

Demands for treatment

Specialist structures

In 1998, the number of consultations (consumers of alcohol[3]) seen in the *centres de cure ambulatoire en alcoologie* (CCAA: Alcohol Out-patient Treatment Centres) amounted to approximately 80,000 persons, a figure which is almost identical to that for 1997 [16]. If, however, account is taken of the variation in the number of centres who replied to the survey, the increase amounted to approximately 10%. Between 1994 and 1998, the number of cases of care increased at a moderate rate.

Consultations by consumers of alcohol in centres de cure ambulatoire en alcoologie (CCAA: Alcohol Out-patient Treatment Centres) from 1994 to 1998 *{3121}*



Source: Activity reports of the structures specialising in alcoholism, 1998, DGS

The *centres de soins spécialisés pour toxicomanes* (CSST: Specialised Centres for the Care of Drug Addicts) also admit persons who have difficulty with alcohol. The numbers are, however, very limited in relation to the figures given above. In the month of December 1999, approximately 700 persons had recourse to the CSST (*centres de soins spécialisés pour toxicomanes*: Specialised Centres for the Care of Drug Addicts) due to their consumption of alcohol as a primary drug and approximately 1,800 as a secondary drug.

Cases of care by the city medical services

On the basis of a survey conducted in 1999 [21], general practitioners saw, on average, a little less than two patients (1.7) who wished to stop drinking, during the week preceding the survey. If this figure is extrapolated to all general practitioners, it is equivalent to approximately 92,000 persons seen per week.

[3] The CCAA also receive the close friends of drinkers

As for illicit drugs, it was doctors who are part of a network, and more so when its purpose was alcohol, who saw the greatest number of persons who had a problem with this drug. As a positive factor associated with the care of a large number of these patients, reference can also be made to the proportion of patients who benefit from free medical assistance, the number of admissions, and the fact that the doctor is of masculine gender.

By comparison with 1993, the average number of patients wishing to stop drinking who were seen during the previous week has reduced (1.7 in 1999 against 2.3 in 1993). This development may be explained in different ways. Firstly, patients may have had more recourse to the specialist structures. Secondly, it is possible that doctors are less and less inclined to take difficult patients, for whom they feel it will not be effective, into care. The third possible explanation is that the number of persons with a problem with alcohol has reduced. It should be noted, however, that the number of persons with a risk of alcohol dependence, such as are measured by the Health Barometers in 1995 [2] and 2000 [3] (DETA test)(DETA: *Diminuer entourage trop alcool* - Reduce alcohol-based surroundings) has remained constant in percentage terms. It appears, in fact, to be difficult to determine whether the number of persons currently dependent on alcohol is lower than it was ten years ago.

Characteristics and orientation of persons in care.

The only available data relates to the number of new consultations received in the CCAA (*centres de cure ambulatoire en alcoologie*: Alcohol Out-patient Treatment Centres), which covers a little less than half (47% in 1998) of all consultations. The figures come from two sources, the activity reports of the CCAA [16] and an annual more detailed survey conducted on the initiative of the *Association nationale de prévention de l'alcoolisme* (ANPA: National Association for the Prevention of Alcoholism) in the CCAA which are part of its network [15], and which represents almost 50% of alcohol users who had a consultation in the CCAA.

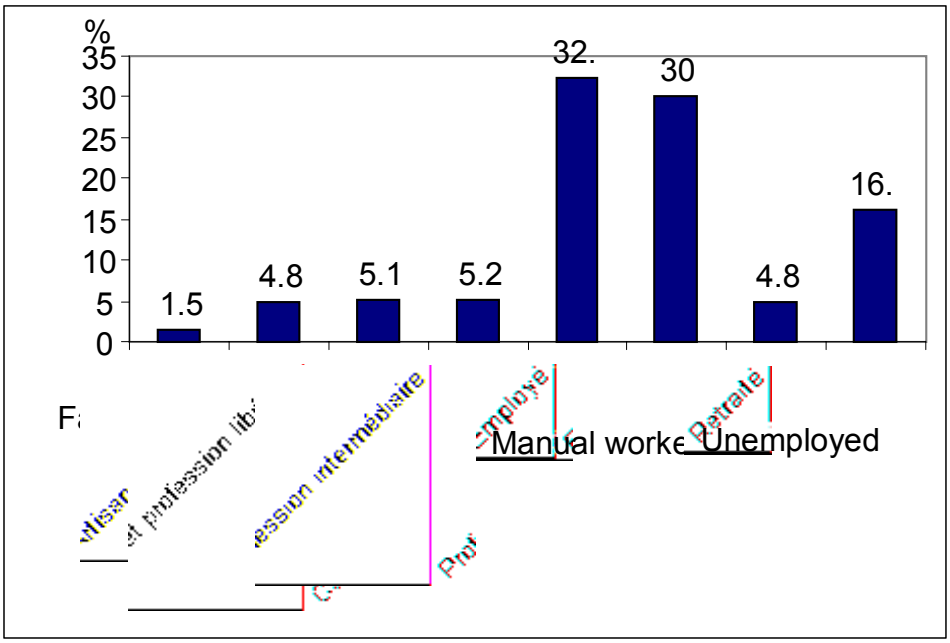
Age, gender and socio-professional category

Three consultations out of four are with men, this proportion tending to reduce slightly since 1994 [16]. According to the ANPA (*Association nationale de prévention de l'alcoolisme:* National Association for the Prevention of Alcoholism) data, the average age of patients was 41 years in 1999, with the average age for all the CCAA (*centres de cure ambulatoire en alcoologie*: Alcohol Out-patient Treatment Centres) being, without doubt, slightly higher. A little less than two-thirds of new patients were between 30 and 49 years of age, and the share of the under 30s is quite low (between 15% and 23% depending on the source). Between 1994 and 1998, the share of persons aged from 20 to 29 years reduced steadily to the benefit of those over 40 years of age [16]. The persons taken into care in the CSST (*centres de soins spécialisés pour toxicomanes:* Specialised Centres for the Care of Drug Addicts) for alcohol use, are, on average, younger (33 years of age), but they nevertheless form the oldest category among users attending theses structures [17].

Approximately four patients out of five have and educational level lower than the baccalaureate. One out of ten had higher-level education [15]. This breakdown appears to be relatively close to that found for the whole French population.

The socio-professional categories most represented in the ANPA sample are employees and manual workers. If the socio-professional category structure of those who have declared a profession is compared to the structure of the active population, an under-representation is noted in the CCAA of executives, liberal professions and particularly intermediary professions (6% against 20%) while manual workers and employees are over-represented. The taking into account of the different gender structures in the CCAA and in the active population would have the effect of reducing the over-representation of manual workers and accentuating that of employees.

New consultations in centres de cure ambulatoire en alcoologie (CCAA: Alcohol Out-patient Treatment Centres) in 1999, by socio-professional category *{3122}*



Source: Consultations in the CCAA in 1999, ANPA

Insertion

A little more than one patient out of eight has no stable residence (precarious situation or homeless) and this proportion has remained practically unchanged since 1994 [15]. As regards work, a little more than one-third of those who are of an age or are in a position to work have no regular professional work, which proportion has been reducing since 1994. In the ANPA (*Association nationale de prévention de l'alcoolisme:* National Association for the Prevention of Alcoholism) sample, approximately one person in two is working professionally, and one in four is either unemployed or receiving RMI (*Revenu minimum d'insertion*: Minimum Insertion Income). The persons in care in the CSST (*centres de soins spécialisés pour toxicomanes:* Specialised Centres for the Care of Drug Addicts) for alcohol use appear to be less well inserted socially as two-thirds have no paid professional work.

Drugs used

Among the new consultations, 30% admit having consumed a number of types of alcoholic drink [15]. 22% indicated that they only drank wine, 19% beer and 13% spirits. As in the case of surveys on the consumption of alcohol in the general population, the type of drink consumed is strongly associated with age. Beer is the cause in the large majority of cases among young patients. Toward 40 years of age, the proportions of wine and beer consumers tend to balance out and wine becomes predominant in the higher ages. As regards other drugs, more than two-thirds of new patients say they smoke; approximately one in ten admit associating alcohol and medications and one in twenty admit to smoking cannabis. The other illicit drugs are rarely referred to (lees than 1% of cases).

The profile of the beer-drinking patient in the CCAA (*centres de cure ambulatoire en alcoologie*: Alcohol Out-patient Treatment Centres) corresponds to that of a younger person and is more often masculine than is the case for other drinks. Among beer consumers, alcoholism occurs earlier and takes place more in cafes than among other alcohol users. This patient associates tobacco and cannabis more frequently and is sent to the CCAA by the justice and/or as a result of a positive alcohol check in a much greater proportion than for other drinkers.

Some of the persons seen in the CSST (*centres de soins spécialisés pour toxicomanes:* Specialised Centres for the Care of Drug Addicts) for their alcohol problem also have, or have had, problems with illicit drugs. Substitution treatment is reported for 23% of them and 30% have already practised injection.

Orientation

The medical environment was at the origin of 40% of contacts with the CCAA (*centres de cure ambulatoire en alcoologie*: Alcohol Out-patient Treatment Centres) in 1998 (30% of the ANPA (*Association nationale de prévention de l'alcoolisme:* National Association for the Prevention of Alcoholism) sample in 1999). One quarter of new consultations in the CCAA were sent by the administrative and judicial services (driving under the influence of alcohol, justice, DDASS (*Direction départementale des affaires sanitaires et sociales*: Departmental Management for Health and Social Action), etc.), 11% by the social services and 3.5% by the associations (particularly associations of previous drinkers). In the CCAA, a spontaneous request occurred in only 20% of cases, against 40% in the CSST.

Before making contact with a CCAA, some of the patients had already taken healthcare steps. This was withdrawal in 22% of cases, psychiatric treatment in 16% and, care by the treating doctor in 15% [15].

Among the new consultations with drinkers in the CCAA, approximately two out of three were considered, at the start of care, as "alcohol-dependent", one in five as "excessive drinkers" and one in six as "occasional drinkers". The latter category makes contact with the CCAA primarily following a positive alcohol check on the road.

Morbidity

Negative consequences of alcohol consumption

Alcohol consumption is at the direct origin of a certain number of pathologies (cirrhosis of the liver, optical neuritis, alcoholic neuritis, foetal alcoholism syndrome) for which alcohol can therefore be considered as being the origin of virtually all the cases diagnosed. But alcohol is also involved in a more or less direct manner in the appearance of a large number of pathologies. It is certainly associated with the increase in cancers of the upper aero-digestive tract (ascribed to both alcohol and tobacco) and to liver cancer in patients who have developed an alcoholic cirrhosis. There is also a probable link between alcohol and breast cancer and colorectal cancer (Alcohol. Effects on health, 2001). Alcohol is also involved in illness of the circulatory system (myocardiopathy, hypertension and cerebrovascular accidents) and psychic problems. This substance is also very often implicated in accidents (road, domestic, work), violence and attempted suicide. To try to determine the impact of alcohol on morbidity, either the illnesses for which alcohol is considered as responsible for virtually all cases (essentially cirrhoses and cancers of the upper aerodigestive tract) can be used, or on a larger scale, the relative risks and the attributable fractions for all the pathologies involved can be calculated.

Due to the absence of systematic data on the number of cases diagnosed for all of the pathologies, the impact in terms of morbidity from the consumption of alcohol is difficult to evaluate. Studies conducted on the cost of alcohol have attempted to measure, with the aid of attributable fractions, the impact on the healthcare system. According to the two most recent studies, the cost was situated within a range of from 14 to 18 billion francs in the middle of the 1990s (Kopp *et al*., 2000; Reynaud *et al*., 1999), which represents approximately 30% of the cost of all the pathologies examined. Due to the absence of data, a number of pathologies could not be taken into account in both studies. Moreover, the pathologies included were not the same for one study to the next.

As regards traumas, alcohol was the cause of 30% to 40% of mortal road accidents, of 10% to 20% of work accidents and of at least 20% of domestic accidents. For suicides, the range, which is quite large, is between 5% and 25% (Reynaud *et al.*, 1999).

Due to the absence of systematic data on the number of cases diagnosed for all of the pathologies, the impact in terms of morbidity from the consumption of alcohol is difficult to evaluate. Studies conducted on the cost of alcohol have attempted to measure, with the aid of attributable fractions, the impact on the healthcare system. According to the two most recent studies, the cost was situated within a range of from 14 to 18 billion francs in the middle of the 1990s (Kopp *et al*., 2000; Reynaud *et al*., 1999), which represents approximately 30% of the cost of all the pathologies examined. Due to the absence of data, a number of pathologies could not be taken into account in both studies. Moreover, the pathologies included were not the same for one study to the next.

The morbidity related to alcohol can also be approached by means of surveys aimed at determining the proportion of persons with excessive alcohol consumption or who are alcohol dependent amongst those in contact with the healthcare system. Different studies were conducted during the 1990s, mainly in the hospital environment.

The percentage of persons, among hospitalised patients, who can be considered as having a problem with alcohol is between 13% and approximately 20% (Com-Ruelle *et al.*, 1997; Reynaud *et al.*, 1998; Malet *et al.*, 1999; Arvers *et al.*, 2000). In the short-stay services, the range is from 18% to 24%. The prevalence of alcohol problems among hospitalised persons is three to four times higher among men than among women. As regards age, it is persons aged from 45 to 55 years who appear to be most affected. In all the surveys, these patients were seen most often in the psychiatric services (30% to 40% of hospitalised persons). In the survey conducted in the hospitals in the Auvergne region, patients in difficulty with alcohol were found equally frequently in the gastroenterology (36%), intensive care (27%), neurology, ENT, ophthalmology, and pneumology (from 22% to 23%) services.

Mortality[4]

The mortality data are initially approached on the basis of the three causes of death related totally or principally to the consumption of alcohol: psychosis and alcohol addiction, cirrhosis of the liver, and cancer of the upper aerodigestive tract (VADS: *Voies aérodigestives supérieures*). The second part relates to the calculation of all of the deaths attributable to alcohol.

"Restricted" estimation of the number of deaths related to alcohol

En 1998[5], a total of a little over 23,000 deaths related totally or predominantly to the repetitive and excessive consumption were recorded, of which approximately 10% were due to alcohol addiction, 40% to cirrhosis of the liver and 50% to VADS (*Voies aérodigestives supérieures*: upper aerodigestive tract) cancer.

80% of the cases were men, an excessively high death rate which reflects the over-representation of men among users.

In more than one case in two these deaths were of persons under 65 years of age and hold an important place in premature mortality: between 45 and 54 years of age, these three causes represent one death in five among men and one death in ten among women. Their number also varies on the basis of the socio-professional categories: while for all causes of death the excessively high death rate index of manual workers/employees by comparison to the higher executive/liberal professions is 3, it reaches a maximum value of approximately 10 for the three causes of death related to alcohol.

Deaths related to chronic alcohol poisoning in 1998, by cause and gender

Causes of death	Men		Women		Total	
	Number	%	Number	%	Number	%
Alcohol addiction	1,992	10.8	549	11.6	2,541	11.0
Alcoholic or unspecified cirrhosis	6,282	34.2	2,581	54.7	8,863	38.4
Cancers of the lips, oral cavity or pharynx	4,289	23.3	714	15.1	5,003	21.6
Cancer of the oesophagus	3,709	20.2	723	15.3	4,432	19.2
Cancer of the larynx	2,116	11.5	155	3.3	2,271	9.8
Total chronic alcohol poisoning	18,388	100.0	4,722	100.0	23,110	100.0

Source: National register of the causes of death 1998, INSERM-SC8

[4] This part incorporates, with the exception of the part on the enlarged estimation, the principal elements developed by E. Michel and E. Jougla, in the INSERM collective report (Michel *et al.*, 2001). See also, by the same authors, the October 2001 issue of the *Studies and Results* review by the Division for research, studies, evaluation and statistics.

[5] Last known figures

"Enlarged" estimation of the number of deaths related to alcohol

According to the most recent estimates, the number of deaths attributable to alcohol in France was calculated at 45,000 in 1995 (Hill, 2000). This calculation is based, as for morbidity, on the determination of the fraction of deaths attributable to alcohol of a certain number of causes of death.

As can be seen in the following table, alcohol was responsible for the totality of deaths form psychosis and alcohol addiction syndrome and the majority of deaths from cirrhosis of the liver, cancer of the upper aerodigestive tract and cancer of the liver. Alcohol was also the cause of one death in two of death by suicide in men and one death in three in traffic accidents. Half of the deaths related to alcohol occurred before 65 years of age, 12% between 25 and 44 years of age and 38% between 45 and 64 years of age. On the basis of the data shown, alcohol was responsible for approximately one death in four before 65 years of age in men and one death in ten thereafter.

Total number of deaths and fraction of deaths attributable to alcohol in 1995, by cause and gender

	Total number of deaths among men	Fraction ttributable to alcohol (in %)	Total number of deaths among women	Fraction ttributable to alcohol (in %)
Cancer				
Oral cavity	1,577	84 %	373	24 %
Pharynx	2,880	89 %	330	30 %
Oesophagus	3,947	86 %	666	55 %
Rectum	3,460	12 %	6,303	5 %
Liver	4,868	71 %	1,468	54 %
Larynx	2,210	79 %	151	15 %
Mental problems				
Psychosis and alcohol addiction syndrome	1,924	100 %	489	100 %
Cardiovascular				
Ischemic cardiopathy *	4,916	39 %	3,770	7 %
Alcoholic cardiomyopathy*	93	100 %	8	100 %
Cerebrovascular illness*	6,221	26 %	3,775	8 %
Respiratory				
Pneumonia, flu*	1,964	36 %	822	7 %
Digestive				
Cirrhosis of the liver	6,391	91 %	2,981	69 %
Acute pancreatitis*	433	40 %	332	40 %
Chronic pancreatitis	69	70 %	17	55 %
Traumas and poisoning				
Traffic accidents	4,077	34 %	1,677	33 %
Accidental fall	1,256	49 %	596	11 %
Suicide	7,961	53 %	3,027	13 %
Homicide	308	50 %	202	50 %

** Before 75 years of age*

Reading note: among men, 84% of the 1,577 deaths from cancer of the oral cavity are attributable to the consumption of alcohol.

Source: National register of the causes of death 1995, INSERM-SC8 and (Hill, 2000)

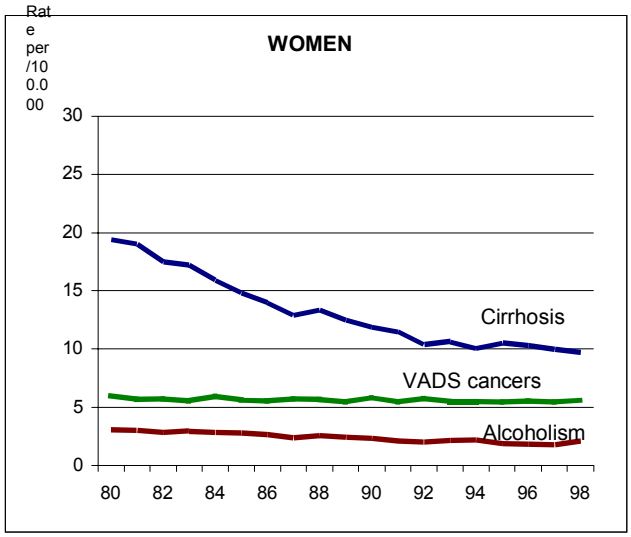
Developments

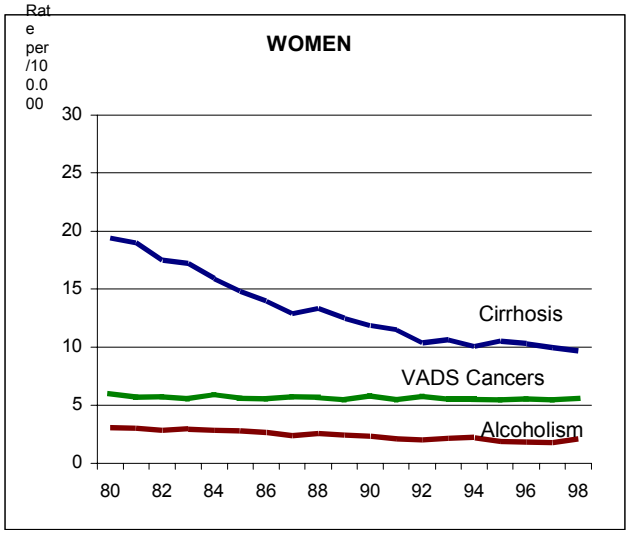
The number of deaths attributable to alcohol reduced by 13% between 195 and 1995 (at least 7,000 deaths). The reduction in relative terms was substantial among 45-64 year-olds and smaller among those under 45 years of age. As the same attributable fractions were used on both date, this drop results from the reduction in the total number of deaths from the three causes normally referred to (psychosis and alcohol addiction, cirrhosis, cancer of the upper aerodigestive tract), but also for the majority of causes of death taken into account.

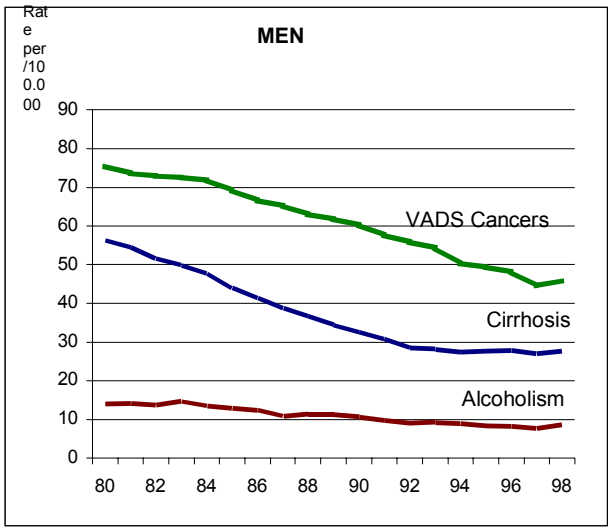
For the three causes most directly related to alcohol, mortality has reduced overall by 40% in 20 years, principally due to the reduction in deaths from cirrhosis for both genders and deaths from cancer of the VADS (*Voies aérodigestives supérieures*: upper aerodigestive tract) among men. It should be noted, however, that

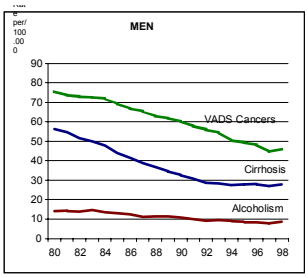
the number of deaths from cirrhosis has only reduced very slowly since the start of the 1990s. It is necessary to examine cirrhosis of a viral origin in this development.

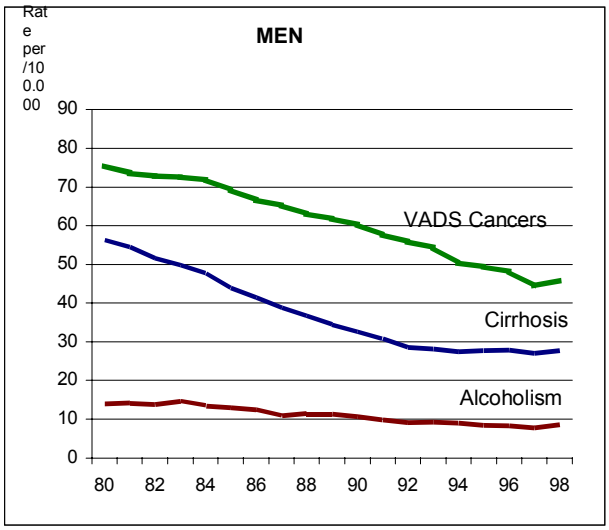
Between 1997 and 1998, deaths from alcohol addiction and cancer of the VADS increased among men and women and have remained virtually stable for cirrhoses. Such an increase had not be recorded for a large number of years. The results of one or two subsequent years must be awaited before concluding on a reversal of the trend.











Rate of mortality related to chronic alcohol poisoning from 1980 to 1998 among subjects aged 15 years or more (comparative rate* per 100,000)*{3123}*

** Reference population = 1990 census for both genders*

Source: National register of the causes of death, INSERM-SC8

The reduction in deaths related to alcohol since the end of the 1970s can be compared with the downward movement in the quantities of pure alcohol consumed per inhabitant, a movement which began at the end of

the 1950s. The existence of a relation between these two terms (known as the "Lederman law") is the subject of discussion. Fairly close developments in the average quantity consumed per inhabitant and, for example, the deaths from cirrhosis have been shown for a number of countries. However, in a global context of a reduction in mortality, it is difficult to ascertain which is the respective share of the reduction in average consumption, therapeutic progress and a better detection of some illnesses in the reduction of mortality related to alcohol.

Benefits of alcohol consumption

At the same time as the harmful consequences of the consumption of alcohol, the possible health benefits of this drug must be considered. Different studies show a J curve linking death and alcohol consumption. By comparison with abstainers, a small consumption of alcohol (at maximum 10g to 20g of pure alcohol per day for men and less for women) appears to reduce the risk of deaths related to coronary and cardiovascular illness in general (*Alcohol. Effects on health*, 2001). Above this threshold, the risk of death increases with the quantity of alcohol consumed.

Criminal consequences of alcohol consumption

The role of alcohol in numerous offences committed appears to be important even if few studies or data allow it to be clearly shown. Only the data in respect of alcohol checks and convictions related to driving under the influence of alcohol are subject to annual monitoring.

Alcohol checks

In 1999, approximately 9.7 million alcohol checks took place in France, of which a little more than 80% were preventive checks and the remaining 20% took place following an accident. The number of detections more than doubled between the end of the 1980s and 1995 and subsequently stabilised at that level until 1998, but increased substantially again in 1999 (+12%). The proportion of positive detections was, on average, 2.0% in 1999. This percentage was 1.4% for preventive checks against 15.9% for drivers involved in a fatal accident (ONISR (*Observatoire national interministériel de sécurité routière*: National Interministerial Observatory for Road Safety), 2001). If reference is made to the number of fatal accidents in which at least one driver involved showed an illegal alcohol level, a higher proportion of positive checks is obtained (32% in 1994) (*Biechler et al.*, 1999).

The rapid growth in the number of detections is accompanied by a reduction in the share of positive detections, which reduced from 2.6% in 1989 to 1.5% in 1995. The constant growth of this rate since that date can be explained in part by the reduction in the illegal alcohol rate to 0,5 grams per litre of blood in 1995, which resulted in an immediate increase in the positive detection rate. It is difficult to ascertain what proportion of the remainder of the increase is due to lesser vigilance on the part of the French population in relation to drink-driving and/or to a much greater efficiency of the checks.

Convictions

Following a pronounced reduction in 1996 and 1997, the number of convictions for driving under the influence of alcohol exceeded the 1994 in 1999, without however reaching the exceptional level reached in 1996 (approximately 106,000 convictions). These convictions are one of the largest offences handled by the courts (23% of convicted offences in 1998). It should be noted that of the entirety of convictions, 10% related to subsequent offences, the number of which is steadily increasing (ONISR (*Observatoire national interministériel de sécurité routière*: National Interministerial Observatory for Road Safety), 2001).

The persons convicted are, in 94% of cases, men, whose average age is 38 years. In ten years, the share of young people from 18 to 24 years of age has clearly reduced, going from more than 20% to 13%, while the share of those above 40 years of age has increased by more than one-third, reaching 43% in 1999.

The number of convictions for involuntary homicide by drivers under the influence of alcohol has remained stable between 1998 and 1999. The trend has been downward since the end of the 1980s.

These offences are punished by penalties of imprisonment in virtually all cases (98%) and half of them are fixed-term (in part or in whole).

The convictions for involuntary injuries by drivers under the influence of alcohol have been moving downward since the end of the 1980s. A penalty of imprisonment is pronounced in 80% of convictions with a fixed-term part in less than 10% of cases.

Alcohol checks and convictions related to driving under the influence of alcohol, from 1990 to 1999

	1990	1992	1994	1996	1998	1999
Number of positive detections	116,613	119,601	129,910	132,283	167,465	193,192
Convictions for driving under the influence of alcohol	93,043	99,725	101,274	95,251	101,636	103,088
Involuntary injuries by drivers under the influence of alcohol	5,766	5,858	4,889	4,294	4,029	3,919
Involuntary homicides by drivers under the influence of alcohol	607	608	505	485	453	451

Source: ONISR

Geography showing the consumption of alcohol

Regional approach

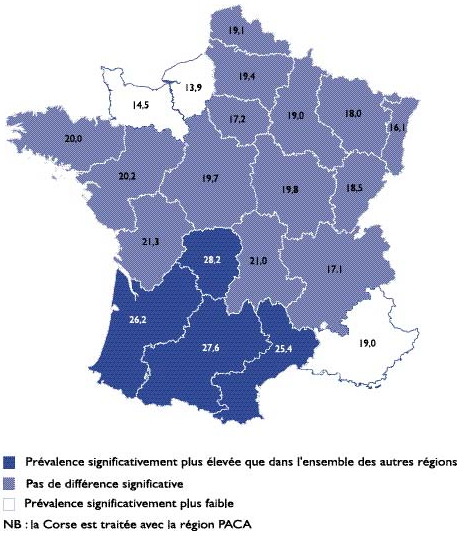
The geographic data on the consumption of alcohol come from two surveys: the first relates to the consumption by adults in the general population [3] and the second relates to young people at the end of adolescence, questioned during the Defence Preparation Day [8].

The socio-healthcare consequences of alcohol consumption in the regions are drawn from the requests for treatment [16] and the data on mortality [13].

Consumption in the general population

The regional geography is shown on using two indicators: the daily consumption of alcohol during the last twelve months and the prevalence of intoxication during that period. The results are based on the population aged from 12 to 75 years.

Prevalence of the daily consumption of alcohol during the last twelve months among 12-75 year-olds in 2000, by region *{314a}*

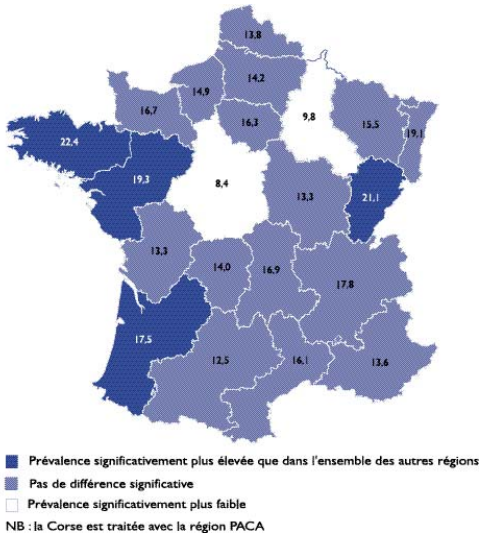


Inter-regional comparisons with age and gender checked

Source: Health Barometer 2000, CFES, OFDT production

Seven regions distinguish themselves from the rest of France from the point of view of the prevalence of the daily consumption of alcohol during the last twelve months: Limousin, Aquitaine, Midi-Pyrénées and Languedoc-Roussillon are clearly above the average while Basse-Normandie, Haute-Normandie and the PACA region are clearly below it. The South-West of France appears therefore to be the region where daily consumption is particularly anchored. On the other hand, the remainder of the West coast, particularly Bretagne and the Pays de la Loire are situated within the average. The disparities between the genders are particularly high in the South and the North-East and particularly low in Ile-de-France and Haute-Normandie.

Prevalence of intoxication during the last twelve months among drinkers from 12-75 years of age in 2000, by region *{314b}*



Inter-regional comparisons with age and gender checked

Source: Health Barometer 2000, CFES, OFDT production

Five regions distinguish themselves from the rest of France from the point of view of the prevalence of intoxication during the last twelve months: Bretagne, the Pays de la Loire and Franche-Comté are significantly above the average, while the Centre and Champagne-Ardenne are clearly below it. The South-West, above the average for daily consumption, does not stand out from the point of view of intoxication. The two Normandies and the PACA region are within the average, although below it for daily consumption. The difference between genders is mainly quite low in the south and higher in the west and east of France.

Consumption at the end of adolescence

The geographic data on the alcohol consumption are drawn from the survey conducted on young people at the end of adolescence, during the Defence Preparation Day [8].

For both genders, the prevalence of intoxication is minimal in the Parisian region (41% and 47%) and in the North (43% and 54%), and is at the maximum in the South-West (61% and 71%), with the North-West arriving in second position: 53 % and 68 %). At 17 years of age, experimentation with intoxication is therefore more frequent in the west of France. The difference between the two genders is minimal in the Parisian regions (7 points) and at the maximum in the Centre-East (22 points).

At 17 years of age, 5.5% of girls and 16.0% of boys reported having consumed alcohol at least ten times during the last thirty days. This repetitive use reproduces the geographic disparities observed for experimentation with intoxication: the Parisian region and the North are again distinctive, with the lowest prevalence (3% for girls and 10% for boys in the Parisian region and 4% and 12% respectively in the North), while the highest prevalence is found in the three regions in the West, particularly the South-West (10% for girls and 20% for boys).

At a more detailed level of analysis, it appears that the regional variations are more marked for boys than for girls. In other respects, the difference between the two genders is minimal in the Parisian regions (6 points) and at the maximum in the North-West (13 points).

Prevalence of the repetitive use of alcohol* at 17 years of age in 2000, by region *{314c}*

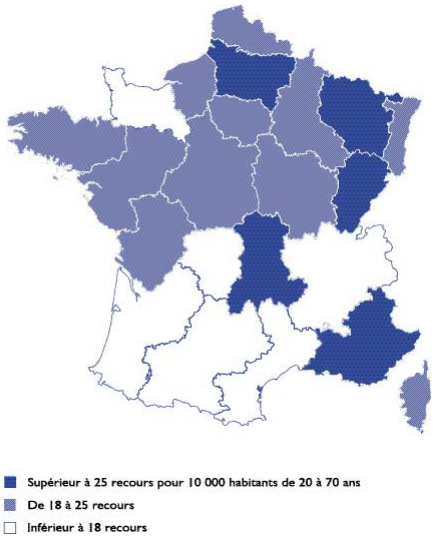
Inter-regional comparisons with age and gender checked
** At least ten times during the last thirty days*

Source: ESCAPAD 2000, OFDT

Demands for treatment

The regional breakdown of the number of care cases in the CCAA (*centres de cure ambulatoire en alcoologie*: Alcohol Out-patient Treatment Centres) per inhabitant shows a split between the north and south of France, which partly confirms the breakdown of deaths related to alcohol. The PACA region and Basse-Normandie are, however, exceptions. The situation in these two regions can be explained by an effect of supply, with the number of care cases being very largely related to the presence of (healthcare) structures.

Care cases in out-patient alcohol treatment centres in 1998, by region *{3141}*



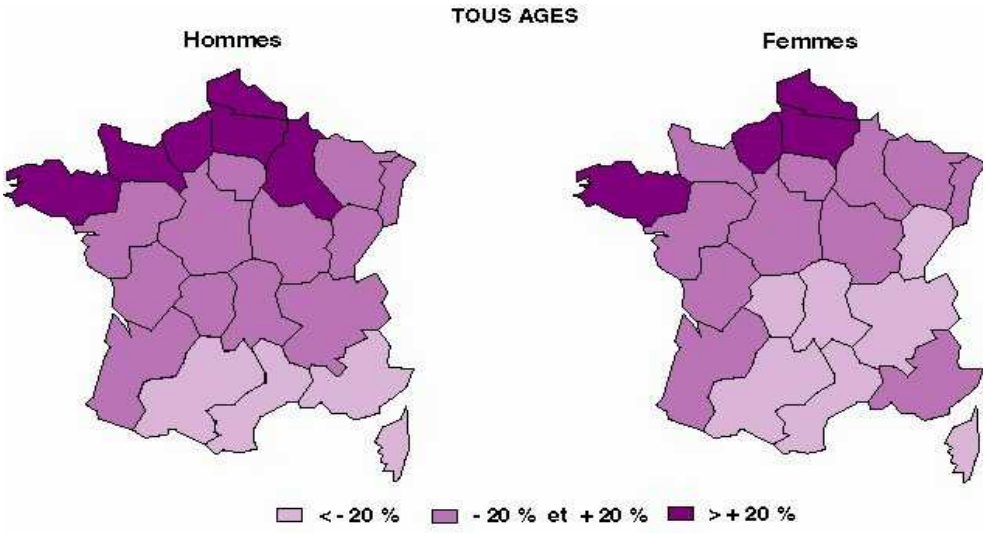
Source: Activity reports of the structures specialising in alcoholism, 1998, DGS

Mortality

For the three causes of death most related to alcohol (psychosis and alcohol addiction, cirrhosis of the liver and cancers of the upper aerodigestive tract), there is a strong split between the North and South among men, with an excessively high death rate in the first group of regions and a lower death rate in the South (see map on page 91). This difference between the North and the South appears in all of the causes of death and is not specific to deaths related to alcohol. The role of alcohol in a large number of pathologies explains, without doubt, one part of the global differences in mortality between the North and the South. Other factors of a

social, cultural or environmental order also play a part, without doubt, in explaining the regional disparities in mortality (Michel et al., 2001).

Rate of mortality related to chronic alcohol poisoning from 1992 to 1996, by gender and region *{3142}*



Variations in rates against the average for France

Source: National register of the causes of death, INSERM-SC8

European approach

In order to compare the situation in France with those of its European neighbours, from the point of view of alcohol consumption and its consequences, the data was essentially taken from the ESPAD (European School survey Project on Alcohol and other Drugs) survey on school-going young people in thirty European countries (Hibell *et al.*, 2001) and a study on mortality related to the consumption of alcohol in France and Europe (Michel *et al.*, 2001).

Consumption

In 1999, a comparison of 17 European countries showed France with the highest consumption of alcohol expressed in litres of pure alcohol consumed per inhabitant and per year (EUROSTAT, 1999).

Within the school-going population and among the thirty countries covered by the ESPAD survey, the use of alcohol by French students of 16 years of age is above the average, for consumption during the year and the month, as is the frequency of intoxication during the year. This survey also showed that:

- for at least ten uses during the year (occasional consumption), France is in the second half of the classification;
- for more than ten uses per month (repetitive consumption), France is at the end of the first third (8% overall, 12% for boys and 5% for girls). Malta (20 %), Denmark (18 %), Ireland and the United Kingdom (16 %) are at the top. The differences between genders is low in these countries, contrary to that which is observed in France;
- for the consumption of beer and wine (more than three glasses during the month), France is in a median position, although it is in the first third for spirits. It is in the same classification for the quantities drank last time (beer, wine and spirits);
- for ten or more episodes of intoxication during the year, France is among the last (3% overall, 6% for boys, 1% for girls), against 39% for Denmark. Here also, the difference between genders is high in France, but low for the countries most concerned (Hibell *et al*., 2001).

Mortality

Within the countries of the European union, France holds the record for mortality related to alcohol among men in 1994, with an excessively high death rate of 27%, closely followed by Germany. Remaining with men, a distinction can be made between Southern Europe (with the exception of Greece), which is situated within the average, and Northern Europe, where mortality is lower than the average (Michel *et al*., 2001).

Among women, mortality related to alcohol is highest in Germany, while in France it is a little below the European Union average. The north-south split is less marked than among men, while the Scandinavian countries are also a zone of lower than average mortality for women.

For further information

■ *Alcohol. Effects on health,* Paris, INSERM (Institut national de la santé et de la recherche médicale: National Institute for Health and Medical Research) 2001, p. 360 (Coll. Collective report).

■ *The specialist structures for the fight against alcoholism in 1998: information from the standard reports*, Paris, Office of mental health, drug addiction and dependence, General Health Department, Ministry of Employment and Social Affairs, May 2000, p. 17

■ Aigrain (P.), Laporte (J.-P.), Melani (C.), Noblet (C.), "Survey on the consumption of wine in France in 2000: initial results in relation to the frequency of consumption. Memorandum presented to the 25th General meeting of the OIV" *Onivins Infos*, no. 74, June 2000, p. 99-107

■ ANPA (Association nationale de prévention de l'alcoolisme; National Association for the Prevention of Alcoholism), *Consultation in the CCAA* (*centres de cure ambulatoire en alcoologie*: Alcohol Out-patient Treatment Centres) *in 1999*, Paris, ANPA, 2000, p. 52.

■ Arènes (J.), Guilbert (P.), Baudier (F.) (dir.), *General practitioner Health Barometer 98/99*, Vanves, CFES publications, 1999, p. 218.

■ Arvers (P.), Moulia-Pelat (J.-P.), Favre (J.-D.), Auzanneau (G.), Brunot (J.), Delolme (H.), "The prevalence of addictive behaviour among hospitalised patients. Multi-centre survey conducted on a given day in the army training hospitals in 1999", *BEH (Bulletin épidémiologique hebdomadaire: Weekly epidemiological bulletin), no. 15, 2000, p. 1-6.*

■ Biechler (M.-B.), Filou (C.), Fontaine (H.), *Car driving and accidents related to alcohol*, INRETS, 1999, p. 127 (Summary no. 35).

■ BECK (F.), LEGLEYE (S.), PERETTI-WATEL (P.), *A look at the end of adolescence: consumption of psychoactive drugs in the ESCAPAD 2000 survey*, Paris, OFDT, 2000, p. 220

■ Beck (F.), Legleye (S.), Peretti-Watel (P.), *Alcohol, tobacco, cannabis and other illicit drugs among college and secondary school students*: *ESPAD 1999 France,* volume II, Paris, OFDT, 2001, (to be published).

■ CFES (Comité français d'éducation pour la santé: French Centre for health Education), *Health in figures: alcohol*, Paris, CFES, 2001, p. 38.

■ Choquet (M.), Ledoux (S.), *Adolescents, national survey*, Paris, INSERM, 1994, p. 346

■ Choquet (M.), Ledoux (S.), Hassler (C.), *Alcohol, tobacco, cannabis and other illicit drugs among college and secondary school students*: *ESPAD 1999 France*, volume I, Paris, OFDT, 2001, (to be published).

■ Com-Ruelle (L.), Dumesnil (S.), *Alcoholism and tobacco addition among hospitalised persons*, Paris, CREDES, 1997, p. 173 (Collective report no. 1164).

■ National Council for Evaluation, Plan general Commissariat, *The law in relation to the fight against smoking and alcoholism Evaluation report*, Paris, Documentation française, 2000, p. 555

■ EUROSTAT, *Statistical yearbook 1999*, European Community Publications Office, 1999, p. 530.

■ FNORS (Fédération nationale des observatoires régionaux de la santé: National Federation of Regional Health Observatories), "Alcohol and its consequences for health", in FNORS, *Health observed in the regions of France*, Paris, FNORS, 1999, chap. 8.1, p. 1-12

■ Got (C.), Weill (J.) (dir.), *Alcohol in figures, consumption and consequences: indicators in France*, Paris, Seli Arslan, 1997, p. 350

■ Hibell (B.), Andersson (B.), Ahlstrom (S.), Balakireva (O.), Bjarnasson (T.), Kokkevi (A.), Morgan (M.), *The 1999 ESPAD report: Alcohol and Other Drug Use among Students in 30 European Countries*, Stockholm, CAN, 2000, 362 p.

■ Hill (C.), "Alcohol and the risk of cancer", *Public health news and file*, no. 30, 2000, p. 14-17.

■ INSEE, *Statistical Yearbook for France. 2001 Edition,* results from 1999, Institut national de la statistique et des études économiques: (INSEE: National Institute for Statistics and Economic Studies), Paris, 2001, p. 981.

■ KOPP (P.), FENOGLIO (P.), *The social cost of licit (alcohol and tobacco) and illicit drugs in France*, Paris, OFDT/ARMI, 2000, p. 277

■ Legleye (S.), Ménard (C.), Baudier (F.),

■ Le Nézet (O.), "Alcohol", in the Health Barometer 2000, Vanves, CFES, 2001, (to be published).

■ Malet (L.), Reynaud (M.), *Excessive alcoholism in Auvergne: results of a survey on a given day of 28th may 1999*, Clermont-Ferrand, National Public Health Network, DRASS, Auvergne, CHU, Clermont-Ferrand, 1999, p. 68.

■ Michel (E.), Jougla (E.), "Mortality related to chronic alcohol poisoning in France", in: *Alcohol. Effects on health*, Paris, INSERM, 2001, p. 339-357 (Coll. Collective report).

■ ONISR (Observatoire national interministériel de sécurité routière: National Interministerial Observatory for Road Safety), *Road safety in France. Annual Report 2000,* Paris, Documentation française, 2001, p. 147.

■ Perez-Diaz (C.), *Alcohol and delinquency: an inventory*, 2000, p. 104 (Documents from

■ CESAMES (*Centre de recherche psychotropes, santé mentale et société*: Centre for the Research of Psychotropic Drugs, Mental Health and Society), no. 7).

■ Reynaud (M.), Bernoux (A.), Leleu (X.), Meyer (L.), Lery (J.-F.), Ruch (M.), "The prevalence of excessive alcoholism among hospitalised patients", *Alcohology*, Vol. 20, no. 3, 1998, p. 231-238.

■ Reynaud (M.), Parquet (P.J.), *Persons in difficulty with alcohol: use, harmful use, dependence: proposals.* Mission report 1998, Vanves, CFES, 1999, 293 p.

Cannabis

Reference points

Consumption

- The consumption of cannabis has spread considerably in the last few years, particularly amongst the young.
- In 2000, one French person in five had already tried cannabis. Amongst young people at the end of adolescence, this proportion becomes a majority.
- Amongst the young, consumption is mostly occasional but becomes more regular and involves larger volumes with age. Thus, of boys of 19 who have tried cannabis (60%), more than one in three are regular or heavy users.
- Cannabis is used by people in all social groups. It remains strongly linked to age and, to a lesser extent, sex: heavy consumption amongst adolescents and young adults, then falling to become a marginal activity after the age of 50, with higher consumption amongst men than amongst women. However, the difference between the sexes is less marked for younger generations of consumers.
- Cannabis use is very often associated with that of tobacco and alcohol. Cannabis is very common on the party scene, accompanying the taking of stimulants and hallucinogens when such consumption takes place.

Health and social consequences

- Registrations for health or social care in connection with the use of cannabis increased markedly from 1997 to 1999.
- Cannabis use is the reason for registration 15% of registrations for care for drug use.
- The profile of those cared for by health and social services for use of cannabis is very different from that of opiate users as revealed by the same system: they are younger (25 on average), more frequently registering for the first time (60%) and more often referred by the courts (25%).
- In the absence of data on the involvement of cannabis in the incidence of road accidents or of cancer, no serious consequences (morbidity and mortality) of cannabis use are currently recorded.

Legal consequences

- Arrests for the cannabis use and for use with dealing increased considerably during the 1990s. It is the substance that is most frequently involved, by far, in arrests of users (79,000 out of 90,000).
- Amongst arrested users of drugs, cannabis users are the youngest group (22 on average). Minors arrested for use, although very much in the minority, are becoming more numerous and getting younger, the inverse of the tendency observed in other groups of arrested users for age to increase.

Supply and trafficking

- The number of seizures of cannabis and the quantities seized are on the increase. A high proportion of seizures made in France involve hashish from Morocco.
- Cannabis is very accessible with moderate prices and high availability. There are a wide variety of forms of the substance consumed, particularly in terms of the quantity of active component (THC) contained. Analysis of samples from seizures shows a significant presence of high concentration cannabis (THC > 8%), in 4 cases out of ten for resin.

Consumption of cannnabis by the French population

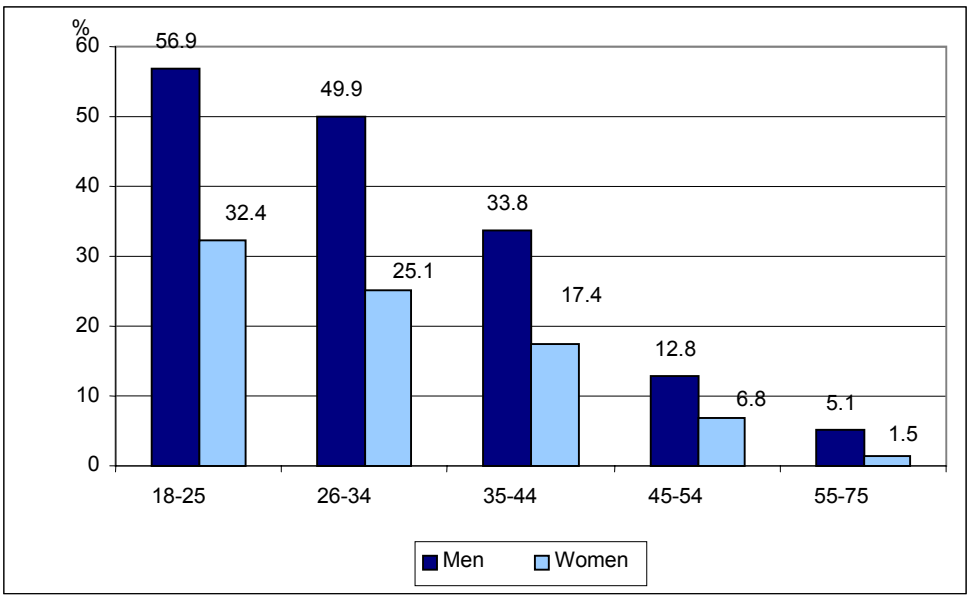
The consumption of cannabis in the French population is determined using the results of declarative surveys from representative samples of the teenage or adult populations.

Consumption by the general adult population

In the general adult population, cannabis is the illegal drug whose consumption is highest by far: among the 18—75 year age group, one individual in five (21.6%) has experimented with the drug. Occasional use of this substance (at least once a year) involves 6.5% of individuals, while 3.6% are involved in repeated use (at least ten times a year) and 1.4% in regular use (ten times a month or more).

There are about twice as many men who have experimented with cannabis (28.9%) as there are women (14.7%). In the 18—34 age group, more than two in five (40.5%) have experimented with the drug. The proportion of people who have experimented with the drug decreases with age so that by 55-75, the figure is only 3.3%. This is an indicator of a 'generation effect': the oldest generations have experimented with cannabis much more rarely (generally in adolescence) than the youngest ones.

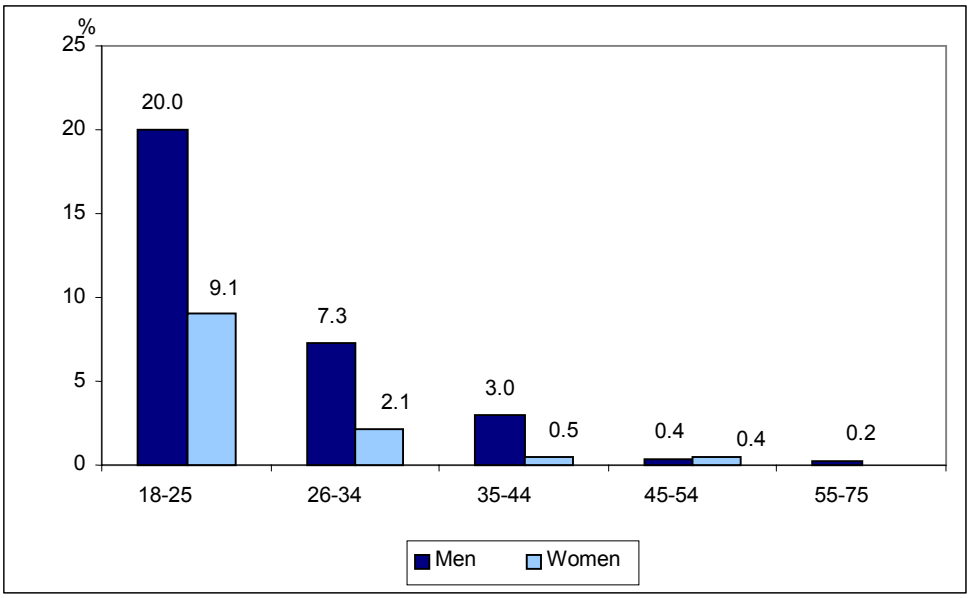
Frequency of experimentation with cannabis in general adult population in 2000, by sex and age *{321a}*



Source: Baromètre Santé 2000, CFES, Annual Report OFDT

Repeated consumption of cannabis is much rarer than experimentation: although it involves 14.6% of young adults aged 18-25, it represents 1.6% of the over-26s. As with experimentation, it is greater among men.

Frequency of repeated consumption of cannabis in general adult population in 2000, by sex and age *{321b}*



Source: Baromètre Santé 2000, CFES, Annual Report OFDT

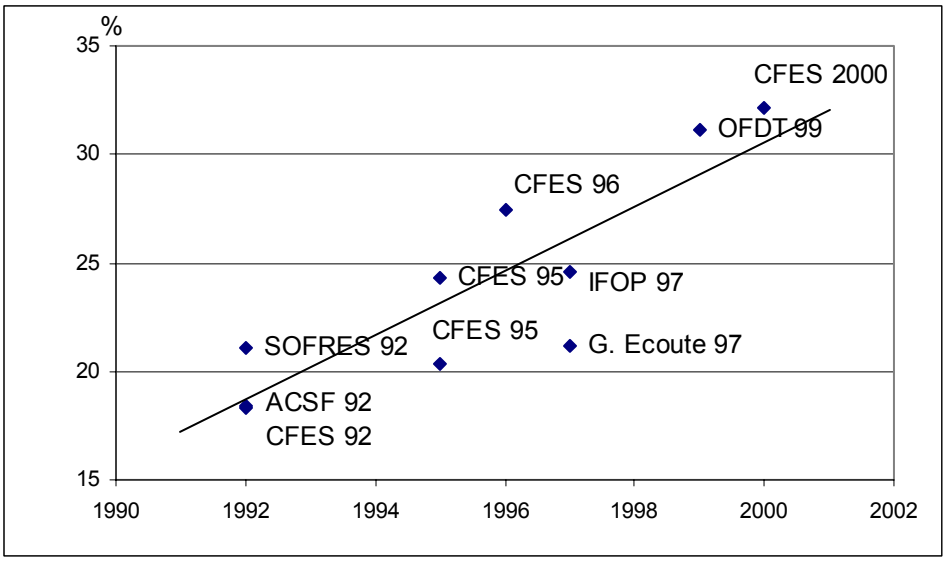
Among those who have experimented with cannabis but who have not consumed it over the last twelve months, a large majority (eight out of ten) cite a lack of attraction to, or their disinterest in this substance as the main reason for this. The other reasons put forward, such as absence of opportunity and concerns for health, are much less common (less than one in ten). For those who currently consume the drug, the reasons given for their most recent consumption are more varied: a desire for relaxation and well-being (30%) and curiosity (30%) come top, above the desire for amusement (12%), conviviality (10%), pleasure, joining in with one's partner, wanting to be like one's peers ('to do what everyone else is doing') and intoxication.

Among the under-44s, repeated consumers of cannabis are greater in number among school pupils and students (16.2%) than among workers or unemployed people. In the working population, repeated consumption is rare (less than 6%), and the differences between socio-professional categories are small. Also, repeated consumption of cannabis is more common among single people than among couples, or among people with symptoms of alcohol or tobacco dependence. All these relations hold true independently of age and sex.

Among the repeated users, about 180,000 people have already tried to stop taking cannabis without success or have had to cut down on an activity because of their cannabis consumption – these are indicators of potentially problematic use.

Over the last decade, the percentage of the adult population (the 18-44 age group) who have experimented with cannabis has grown larger and larger. This increase is a sign of cannabis use becoming less restricted and more widespread as an activity.

Frequency of cannabis consumption over lifetime amongst those aged 18-44 from 1992 to 2000 *{321c}*



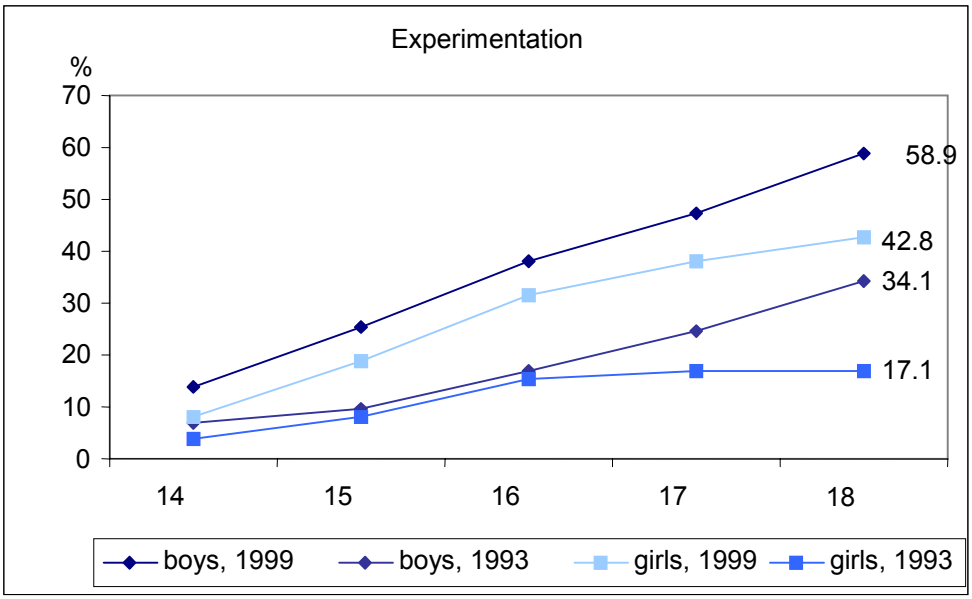
Sources: ACSF, 1992; CFES, 1992, 1995, 1996, 2000; IFOP, 1997; Publimétrie, 1997; OFDT, 1999

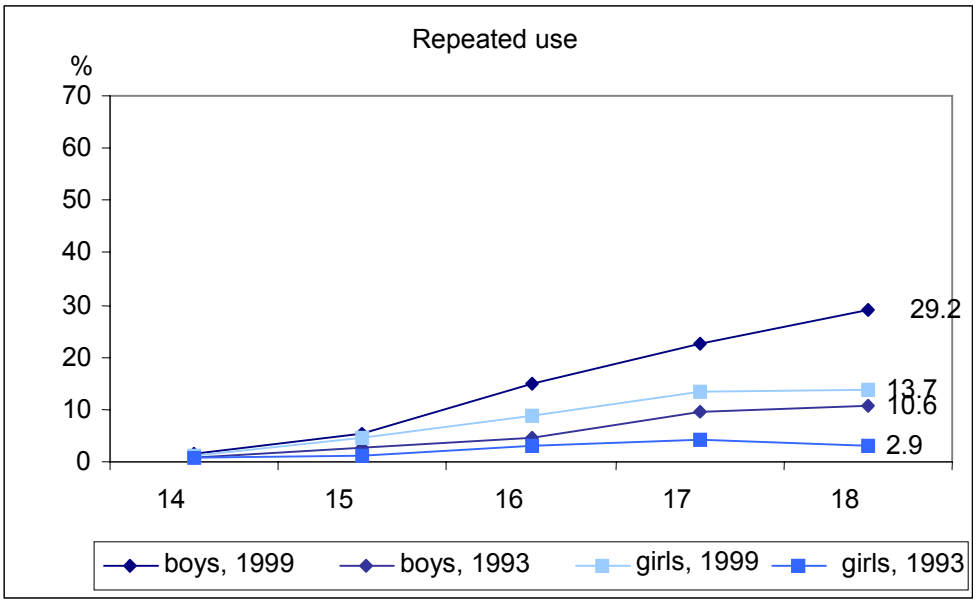
This expansion in use is still more marked when examining the corresponding data relating to young people (see below). This data is actually more relevant for this type of report, given the extent to which experimentation with cannabis is strongly connected to age (centred on adolescence and the start of adulthood).

Consumption by adolescents

Between 1993 [5] and 1999 [7], among those still in education, a trend for cannabis consumption to rise can be observed.

Frequency of experimentation and of repeated use of cannabis amongst young people still in education in 1993 and 1999, by sex and age *{321d-1&321d-2}*





Source: INSERM 1993; ESPAD 1999 , INSERM/OFDT/MENRT

As regards experimentation, there is a marked rise from the age of 15. At the age of 18, in 1999, 59% of boys and 43% of girls report having already taken cannabis, as against 34% and 17% in 1993. For repeated use of cannabis (at least ten times over the last twelve months), the increase shows up at all ages and for both sexes. The surveys undertaken in France in 1997 (Ballion, 1999), as well as those conducted between 1983 and 1998 among secondary school pupils in Paris, confirm this trend towards more widespread use of cannabis (De Peretti *et al,* 1999).

Experimentation

Experimentation with cannabis has become a majority activity among young people as they reach adulthood. More than half of the boys questioned report having already used cannabis, and this proportion goes up to 54.9% at the age of 18 and 60.3% at 19. At the age of 17, experimentation is more common among males (50.1% as against 40.9% of girls), but the difference between the sexes is much lower than that found for other illegal substances.

Experimentation with cannabis occurs before, or at the same time as, the eventual succession of other less common substances. At any given age or sex, after alcohol and cigarettes, substances taken by inhalation are those for which experimentation occurs at the earliest age (almost always before 15); psychotropic medicines[1] come next (between 15 and 16 years of age, except for boys of 17 who have tried them at 14.6 years on average), followed a few months later, on average, by cannabis.

Repeated use

Consumption profiles are largely determined by age and sex, particularly with regard to repeated consumption (more than ten incidents of consumption reported over a year). At the age of 17, there are as many girls as boys among the 'low' consumers (less than ten times a year); however, there are far fewer girls among the 'repeated' consumers. There are more boys of 17 who report having smoked cannabis more than forty times over the year than boys who report having smoked it only once or twice (13.5% as against 11.7%), whilst there are three times fewer girls in the corresponding case (4.5% as against 13.4%). The cannabis consumption patterns over the year are highly differentiated according to sex.

In addition, less than a quarter of boys of 17 report smoking in the repeated consumption category, whilst this group includes a third of boys at the age of 19.

[1] The survey does not distinguish those taken without prescription

Using the reported frequency of consumption, it is possible to put together a typology of cannabis consumers ranging from the abstainer to the heavy consumer.

Frequency of cannabis consumption among young people at the end of adolescence in 2000, by sex, age and type of consumption

(in %)

Type of consumption	Definition	Girls, 17 yrs	Boys, 17 yrs	Boys, 18 yrs	Boys, 19 yrs
Abstainer	Never	59.2	49.9	45.1	39.8
Experimenter	Has consumed, but not during the year	5.0	5.4	6.5	8.2
Occasional	Between 1 and 9 times a year	23.3	20.9	19.9	19.4
Repeated	More than 9 times a year and less than 10 times a month	7.4	9.3	9.9	10.1
Regular	Between 10 and 19 times a month	2.6	6.4	6.2	6.8
Heavy	20 times a month or more	2.6	8.0	12.4	15.8

Source: ESCAPAD 2000, OFDT

Regarding this classification system, the most marked variations with age relate mainly to the categories at both extremes. So, for boys aged between 17 and 19, the proportion of abstainers falls by 10 points and that of heavy users rises correspondingly by 8 points.

Among the defining elements for situations in which cannabis is consumed, it appears that smoking alone is a rare pattern of behaviour for girls but not for boys. Smoking cannabis in the morning or at lunchtime is more common. An individual who has smoked cannabis alone will almost always also have smoked at the start of the day, whilst having already smoked in the morning does not necessarily imply having already smoked alone. These two practices correspond very strongly to at least a repeated use of cannabis. In this sense, they may be considered as subsets of the most frequent usage patterns, even if the overlap is not absolute. However, this profile does not appear to be connected automatically to 'problematic' situations in terms of well-being.

Frequency of cannabis use in the morning or when alone among young people at the end of adolescence in 2000, by type of consumption

(% in line)

Type of consumption	Morning or afternoon			Alone		
	never	sometimes	often	never	sometimes	often
Occasional	57.2	40.4	2.4	81.9	16.2	1.9
Repeated	17.9	69.8	12.3	46.4	46.6	7.0
Regular	4.7	58.9	36.4	19.9	60.2	19.8
Heavy	1.1	22.7	76.1	4.5	38.2	57.3

Source: ESCAPAD 2000, OFDT

The proportion of friends who take cannabis is strongly connected to the frequency of use of the respondent. Also, those who have at least repeated use always have at least some friends who also take cannabis, whilst the others only very rarely have friends who all take the drug. At 19, about half of the boys report that the majority of their friends smoke cannabis.

Experimentation with cannabis and repeated consumption are not connected to whether consumers are still at school or not: at the age of 17, young people no longer in education are no more numerous than are school pupils and students among those who have consumed cannabis once or repeatedly over the course of the year [8]. It is the same, among school pupils as those who have already repeated a grade or who have entered into a professional occupation. Although cannabis consumption over the year involves a large proportion of 17-year olds, young people of this age who have already been to a rave are slightly greater in

number than the others in this category (51% as against 37% of 17-year olds). It is the same for repeated consumption (14% as against 9% at 17).

In terms of experimentation, cannabis only rarely appears in isolation from tobacco and alcohol.

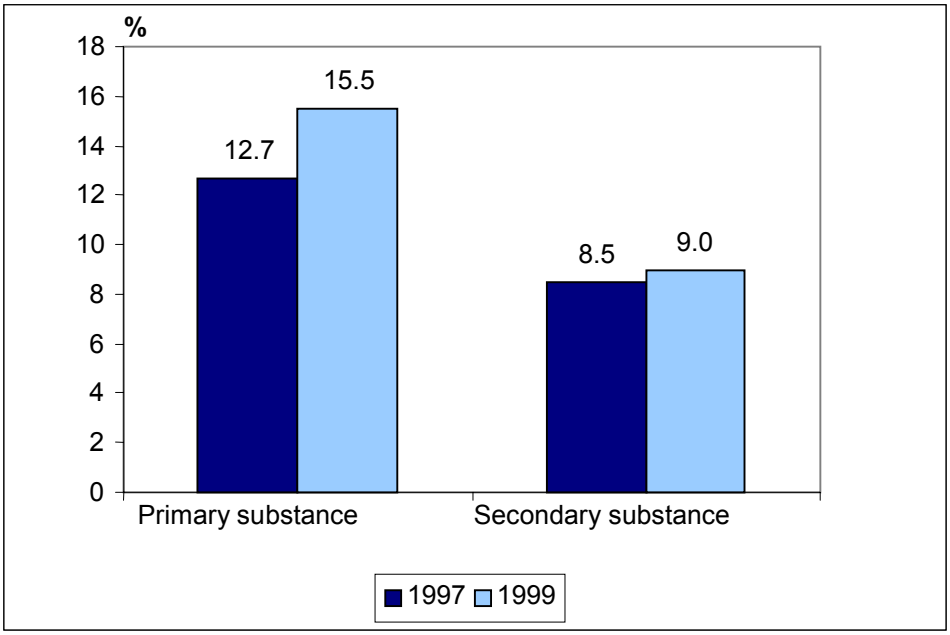
Health and social consequences of cannabis consumption

The use of cannabis causes a proportion of consumers to require medical and/or social assistance. Here we will first describe the number and the characteristics of the people who are registered with medical or social institutions as a result of their dependence on (or abuse of) cannabis. The consequences of cannabis use in terms of morbidity will be covered in a later section. The data presented, in the majority of cases, is collected from users by the institutions with which they are registered.

Demands for treatment

This increase relates specifically to cannabis when cited as primary substance: in 1999, this substance appeared in more than 15% of registrations for assistance (or just over 3,000 cases), a level never before reached since the regular survey was initiated at the end of the 1980s. Registrations have increased by 40% between 1997 and 1999, if the variation in the number of organizations responding to the survey between these two dates is taken into consideration. This rise in registrations with cannabis as primary substance cited is largely (2/3 cases) attributable to the increase in the number of first-time registrations.

Proportion of cannabis in total registrations of drug-users in 1997 and 1999 *{323a}*



Total registrations in November in specialist centres and health centres, with no cases counted twice, with at least one substance cited as the reason for registration (see methodology annexe); N = 18,075 in 1997; N = 19,564 in 1999.

Source: Survey on registration for care of drug addicts in November 1997 and 1999, DREES/DGS

Characteristics of persons in care

The characteristics of users are described on the basis of registrations for use of cannabis as the primary substance only. The secondary substances cited are mainly cases associated with opiates, which is due to the predominance of this family of drugs among the registrations for treatment. The characteristics of users citing cannabis as a secondary substance are therefore very similar to those of users of opiates, whose characteristics are described elsewhere.

In November 1999

The persons described in the registrations for care for use of cannabis as primary substance have characteristics that are opposite to those of users of opiates. The former are on average much younger (25.5); nearly 60% of them were registering for the first time and one in four was referred to a treatment organization by the judiciary system (as against one in twenty for opiates). Multiple dependence is much less common than in the case of opiates or that of cocaine: a secondary substance is only mentioned as a contributory reason for registration in 40% of cases as against 60% for opiates and more than 70% for cocaine. Alcohol is cited as secondary substance in a relatively large number of cases - 16% - and, apart from the opiates (see below), the other substances are only rarely mentioned (4% for psychotropic drugs, 2.5% for ecstasy, less than 2% for cocaine). Consumption over the most recent thirty-day period focuses almost exclusively on cannabis (92% of cases) and alcohol (24%[2]). The other substances feature only minimally.

A substitution treatment, mention of opiates as secondary substance and practice of injecting appear, together or singly, as characteristics in a limited number of these registrations. These registrations therefore seem to concern a small minority of users or former users of opiates (just over 10% of registrations connected with cannabis), older on average (29.3), who are injecting or have injected drugs (65% of cases) and who apparently have a problem with cannabis.

Among those registering for the first time, the specific characteristics of cannabis users are more marked. People registering for the first time are even younger on average (23). Two out of three of them are under 25 and one in three is a student or still at school. In one case out of three, also, these people are referred for treatment by the legal system.

Profile of registrations relating to cannabis and to opiates (as primary substance) in 1999

	Cannabis	Opiates
Number of registrations (substance no.1)	3,030	13,613
% first registrations	57	29
Average age	25.5	31.5
% under 25	52	13
% male	82	76
% referred by legal system	24	6
% employed	29	39
% students and pupils	20	2
% receiving RMI (French minimum income allowance)	15	31
% with opiates as secondary substance	8	10
% following substitution treatment	12	75
% who have injected (currently or previously)	16	73
% who have injected in the last 30 days	3	19

Source: Survey on registration for care of drug addicts in November 1999, DREES/DGS

Development from 1997 to 1999

The increase in registrations for care between 1997 and 1999 was not accompanied by significant changes in the characteristics of the people concerned. The average age remained almost constant, probably due to the speed of rotation of people registered for care, as these users only received treatment for short periods. On the other hand, an increase in the number of those in permanent employment (from 11 to 18%) may be noted. However, this particular development applies to all the registrations for care, regardless of substance cited. The percentages of people involved in opiate use, substitution treatments and injecting are decreasing. Among

[2] One person may be using several substances, so that the total is not equal to 100%.

first registrations, and despite the large increase in their number, the average characteristics of users have remained constant.

Mortality and morbidity

According to recent work on synthesis carried out on cannabis (Roques, 1999), this substance apparently shows no neurotoxicity (reversible or irreversible effect on the structure or functions of the central or peripheral nervous system). The existence of a specific psychiatric syndrome related to cannabis use has not been able to be proved. The theory has also been put forward that this substance might act as an indicator of the presence of a schizophrenic condition: here too the theory does not seem to have been confirmed, although this question is still being debated. When smoked, on the other hand, cannabis does seem to have toxic effects on the respiratory and cardiovascular system. Its role in incidence of cancers of the upper aerodigestive tract and the lungs is the subject of some discussion (Carriot *et al.*, 2000). Moreover, like any substance that alters perception, its use is dangerous in circumstances requiring all of an individual's attentive faculties to be active (driving, for example).

Whatever the case, there is not much reliable data to shed light on these issues. Current statistical systems (French national register of causes of death [13] and overdoses recorded by the police [29]) have not recorded any deaths directly attributable to cannabis over the last thirty years. Even today, there is still no incontrovertible epidemiological data, making measurement of toxicity in relation to the respiratory system impossible. The little information that does exist, however, calls for implementation of a sufficiently large-scale study to produce solid conclusions on this aspect. On the issue of driving and cannabis use, several studies, both in France and abroad, have made it possible to estimate the incidence of drug use amongst drivers involved in traffic accidents. The figures obtained range from 6 % to 16 % (Mura *et al*., 1999, p. 200 ff.). The second figure comes from a French study dating from 1998. For this study, the presence of narcotics was investigated systematically in blood samples taken from 164 persons for alcohol testing, as is required for drivers involved in accidents causing serious injury or death (Mura *et al*., 1999).

In the majority of studies carried out up to now, the absence of a control group made it impossible to determine any increase in the risk of a road accident that might be caused by the use of cannabis. A recent study, results of which have not yet been published, used this methodology and should provide some interesting information. Also, according to the legislation in force since 1st October 2001[3], drivers involved in a fatal road accident are to be systematically tested for cannabis (as well as opiates, cocaine and amphetamines). The data is to be collected in order to study the role played by cannabis and other illicit substances in road accidents. The results of this study are expected to be available at the end of 2004.

[3] Law No. 99-505 of 18 June 1999 regarding road safety requires the systematic testing for narcotics of drivers involved in a fatal road accident. The decree regarding testing for narcotics to be carried out on drivers involved in a fatal road accident came into force on 1 October 2001 (decree no. 2001-751 of 27th August 2001).

Criminal consequences of the use of cannabis

The use of cannabis, as with any illegal drug, can result in arrests and legal consequences. The only data available relates to records of arrests, convictions and imprisonment, without mentioning the substance concerned. It is therefore not possible to describe the legal consequences following arrests for use of cannabis.

Police interrogation for use in 2000

Cannabis is by far the substance most frequently involved in cases of arrests of users: nearly 9 out of 10 arrests for use alone with about 74,000 cases and nearly 8 out of 10 for use accompanied by dealing activity, with 8,700 cases recorded in 2000. The substance that gives rise to the second highest number of arrests for use or use with dealing is heroin, a substance which, with 5,833 arrests in 2000, comes far behind cannabis.

Arrests for cannabis use and use with dealing in 2000

	Cannabis	All substances	Cannabis as percentage
Use only	73,661	83,385	88.3 %
Use with dealing	8,688	10,954	79.3 %
Total	82,349	94,339	87.3 %

Source: FNAILS 2000, OCRTIS

As with the other substances, the majority of persons arrested for cannabis use or use with dealing were only arrested once in the course of the year. In 1999, only 8% were arrested several times (as against 15% for arrested users of cocaine and heroin).

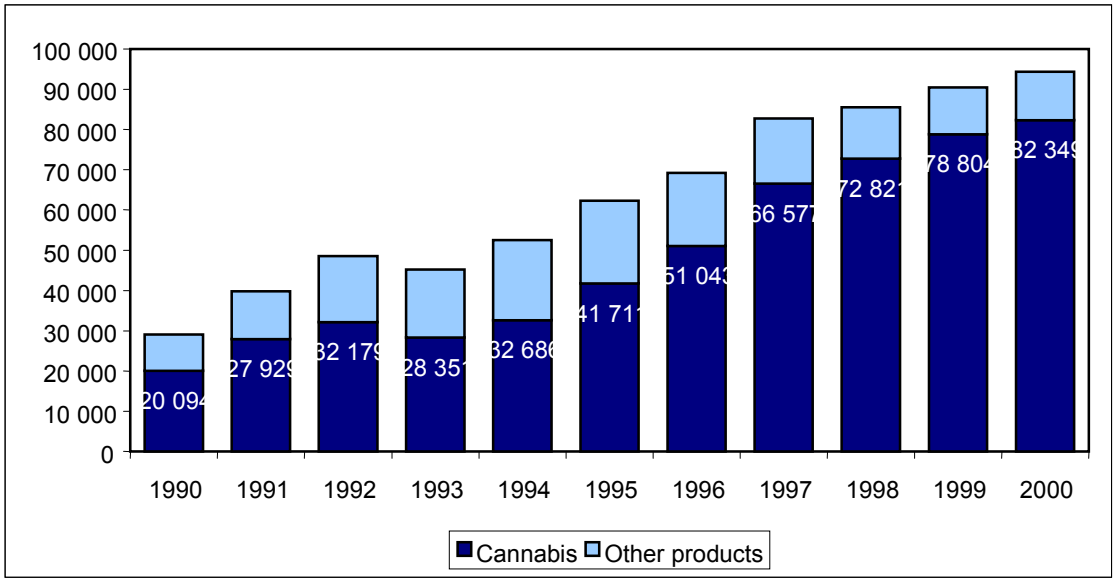
Development in cases of police interrogation for use since 1990

The increase in arrests of cannabis users continued in 2000. The cases of use alone rose by 4% in relation to 1999, a smaller increase than that of the preceding year (+10% between 1998 and 1999). The increase is particularly marked for cases of use with dealing (+9%), whereas these had been falling since 1998.

The increase in arrests of cannabis users over the last eleven years represented an average rise of 16% per year, a significant increase, but lower than those recorded for cocaine, crack or even ecstasy.

On the other hand, their proportion of the total number of arrests is becoming larger and larger: from 70% at the start of the 1990s, they represented 80% in 1997, and 88% in 2000.

Arrests for cannabis use or use with dealing from 1990 to 2000 *{324a}*



Source: FNAILS, OCRTIS

Characteristics of users questioned

Cannabis users are the youngest of all arrested users (average age of 21.8 in 2000), followed by ecstasy users (23.3), and are much younger than heroin users (28.3).

The trend towards arrested drug users being older, as observed for more than ten years for most of the substances in question, does not apply to cannabis users. Their average age, which has been stable for a long time, has even fallen slightly since 1995. More and more minors are being arrested for cannabis use, and they are getting younger and younger, and are frequently still in education: 1 in 3 for arrested cannabis users, as against 1 in 5 for arrested ecstasy users and 1 in 20 for arrested heroin, crack or cocaine users. In parallel with this development, people without a reported occupation are less well represented: less than a third of cannabis users as against half of heroin or cocaine users and three-quarters of arrested crack users. This distribution is a recent development, and is the result of a trend observed over about the last five years, which is represented by the fall in arrested cannabis users without a declared occupation, a fall that is compensated by the rise in students/high school pupils and manual workers.

The proportion of foreigners among arrested cannabis users is small and, apart from ecstasy, is lower than that recorded for other substances: 7% as against 11% for heroin users, 12% for cocaine users but 5% for ecstasy users. Regardless of substance involved, this proportion has decreased over the 1990s.

Overall, based on the few characteristics recorded, the profile of cannabis users is similar to that of arrested ecstasy users and is markedly different from that of heroin, cocaine and crack users.

Supply and trafficking of cannabis

Information about the international and national supply of cannabis comes mainly from examination of seizures carried out by the international and national services. Local supply is determined by observations made in the field.

International trafficking and supply routes to France

Although there are no global statistics on the development of cannabis production throughout the world, it seems likely, looking at the seizures carried out, that the supply of products derived from this plant (cannabis herb, resin, oil) is increasing in scale and responding to a demand known to be in constant expansion over all continents (UNODCCP, 2001b). Seizures of cannabis (herb or resin) showed a marked rise in 1999, exceeding the level at the start of the 1990s. The increase was particularly large for seizures of cannabis herb (+35%).

Quantities of cannabis seizures worldwide from 1993 to 1999
(in tonnes)

	1993	1994	1995	1996	1997	1998	1999
Cannabis herb	3 368	2 329	3 200	3 039	3 048	2 942	3 959
Resin	843	901	1 053	851	787	898	900
Total	4 211	3 230	4 253	3 890	3 835	3 840	4 859

Source: UNODCCP

It has also been observed that home-grown cannabis is produced all over the world. Home-grown cannabis generally gives four harvests per year and has a higher level of THC (from 9% to 22%). In Europe, the Netherlands with *nederwiet* is the largest producer of this form of the drug. This type of production is increasingly often controlled by criminal organizations (INTERPOL, 2000)

Despite the diversity of supply, Moroccan resin represents more than three-quarters of seizures in Europe and more than 90% in France. According to the Moroccan authorities, the area of cannabis planting should have stabilized at about 50,000 hectares from 1992 (UNODCCP, 2001b). However, the increases in seizures and observations in the field imply that in reality they might have doubled (OGD, 2000). In 1999, 693 tonnes of cannabis resin were seized in Europe (including 600 from Morocco) and 157 tonnes of cannabis herb, as against 580 and 156 tonnes, respectively, in 1998. The other supplier countries are, for hashish, Pakistan and Afghanistan and, for marijuana, South Africa, Columbia and Jamaica (INTERPOL, 2000).

Quantities of cannabis seized in Western Europe from 1993 to 1999
(in tonnes)

	1993	1994	1995	1996	1997	1998	1999
Cannabis herb	138	273	362	244	199	169	132
Resin	416	507	456	445	549	681	687

Source: UNODCCP

In France, after a record year in 1999, the quantities of cannabis resin seized in 2000 rose to nearly 54 tonnes, or an equivalent level to that of 1997 and 1998. The number of seizures, on the other hand, is rising steadily and has reached more than 50,000.

Quantities of cannabis seized in France from 1990 to 2000

(in kg)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Resin	21 289	31 836	40 658	44 840	55 890	39 203	35 576	51 664	52 176	64 097	48 711
Cannabis herb	454	1 278	1 394	933	2 096	3 056	31 280	3 452	3 522	3 382	4 866
Plants/stems	-	-	-	-	-	-	-	38 115	34 266	23 287	24 295
Oil	11	7	18	11	29	11	5	5	1	2	3

Source: FNAILS, OCRTIS

The 44% rise in seizures of cannabis herb results mainly from an exceptional discovery of more than a tonne from Albania, on its way to Belgium.

Morocco, whether directly, or via Spain, is, as in preceding years, the identified source of more than 80% of cannabis resin seized. About a third of the quantity of resin seized was intended for the French market. The rest would have been distributed on the British, Dutch or Italian markets.

France, on the other hand, is the main intended recipient for cannabis herb seized on its national territory. 24,292 stems of cannabis were destroyed, including nearly 15% in the Pacific French territories [28].

Traffickers questioned by the police in France

In 2000, 3,625 traffickers in cannabis derivatives were caught in France by the police, customs and gendarmerie, or 56% of the total of traffickers arrested in that year. The annual increase is particularly high: +23% since 1999 for an annual average of 6% since 1990. As a reference point, the number of seizures increased by 13% in 2000.

Arrests for trafficking in cannabis from 1990 to 2000

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Cannabis	2 129	2 016	2 214	2 456	2 750	2 986	3 927	3 514	2 920	2 948	3 625
All substances	5 198	5 303	5 982	6 451	7 179	7 107	8 412	6 560	5 541	5 506	6 531
As % of total	41,0	38,0	37,0	38,1	38,3	42,0	46,7	53,6	52,7	53,5	55,5

Source: FNAILS, OCRTIS

Nearly nine out of ten traffickers arrested in 2000 are considered as local traffickers or dealers, the majority of whom were involved in trafficking in resin (87% of all traffickers arrested and 90% of local traffickers or dealers).

The so-called 'international' traffickers, i.e. those involved in import and export activity, therefore numbered 462 in 2000 and three-quarters of these were involved in dealing in resin. Their involvement in dealing in cannabis herb seems significantly greater than that of the smaller traffickers.

In 2000, 80% of traffickers arrested in France were of French nationality. The proportion of foreigners is greater among international traffickers than among other traffickers arrested: the figures are 59 and 14% respectively.

Local supply: availability, price and quality

The availability data has come from surveys of the general population, the price data from the TREND [33] monitoring system and the quality data, relating to concentration of active principle in seizure samples, from police and customs laboratories.

Availability

Among the 18-75 age group, 34.0 % have been offered cannabis, with the figure higher for men than for women (41.9% and 26.3% respectively). More than two-thirds of 18-25 year olds have already been offered the drug and, in this age group, this applies to four men in five (as against six out of ten women). If women are less frequently consumers of cannabis, they are also less commonly offered the drug.

Young people aged 14 to 19 who are still in education report that two-thirds of them know where to buy cannabis (65.8%) [7]. When put in order (the responses are not exclusive), educational institutions come top (39.3%), followed by the home of the dealer (38.7%), bars and night-clubs (26.2%), then public places (parks, streets) (25.5%). The responses given depend on the level of experimentation: more than half of those who have experimented with cannabis report that they can easily obtain it in their educational institution or from a dealer, as against less than a third for non-experimenters.

Price

The national average price for cannabis resin in 2000 over the ten metropolitan sites of the TREND system is about 33F per gram (between 20 and 50F) and, for cannabis herb, about 35F (between 18 and 50F).

On the techno party scene, the price per gram of resin is about 25F but varies with the event in question.

In the French overseas departments, cannabis resin is very rare. It is reported only in French Guyana. On the other hand, cannabis herb, whether locally produced or imported, is widely available. Its average price is about 17F per gram (10F in Martinique, 15F in Guyana and 25F in Reunion).

Quality

Laboratory analysis of police and customs seizures shows that one sample in five (21%) of cannabis herb contains a level of THC higher than 8%. This proportion doubles for cannabis resin so that two samples in five (41%) are shown to have high concentrations of THC.

THC concentration in cannabis samples seized by the National Police and by Customs in 1999

	Cannabis herb		Resin	
	Numbers	%	Numbers	%
0-4%	122	46%	60	16%
4-8%	88	33%	162	43%
8-12%	39	15%	69	18%
12-20%	15	5,5%	63	17%
+ 20%	1	0,5%	19	6%
total	265	100%	373	100%

Source: TREND 1999, OFDT (data provided by the Lyon forensic science laboratory and the Paris interregional customs laboratory)

Geography showing the consumption of cannabis

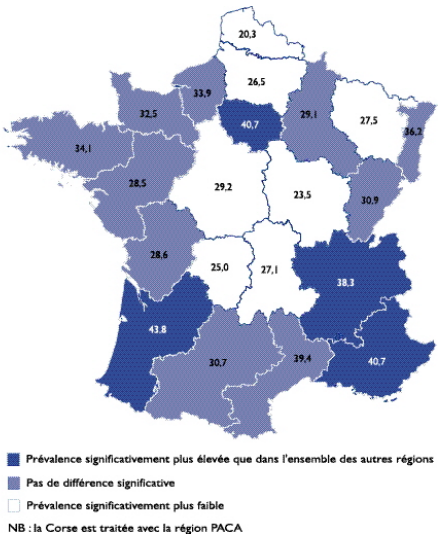
Regional approach

Geographical data on consumption is available from Baromètre Santé for the whole population and from the declarative survey conducted among young people at the end of adolescence, during Call-Up and Preparation for Defence Day.

The social, health and legal consequences of cannabis use in the different regions are studied using data from registrations for care in the month of November and from arrests.

Consumption in the general population

Prevalence of experimentation with cannabis among 15-44 year olds in 2000, by region *{328a}*



Prevalence significantly higher than in other regions as a whole

No significant difference

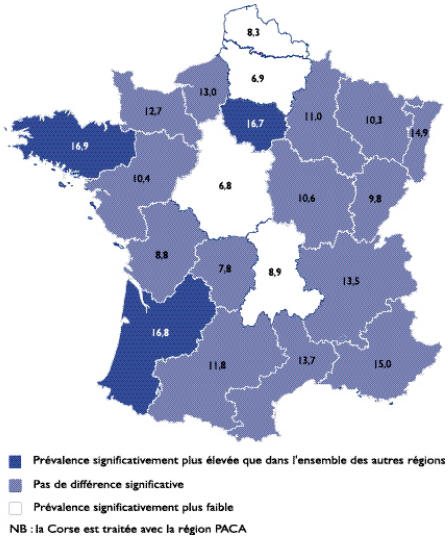
Prevalence significantly lower

Corsica is included in the region PACA

Interregional comparisons independent of age and sex

Source: Baromètre Santé 2000, CFES, Annual Report OFDT

Prevalence of cannabis consumption over preceding twelve months among 15-44 year olds in 2000, by region *{328b}*



Prevalence significantly higher than in other regions as a whole

No significant difference

Prevalence significantly lower

Corsica is included in the region PACA

Interregional comparisons with age and sex constant

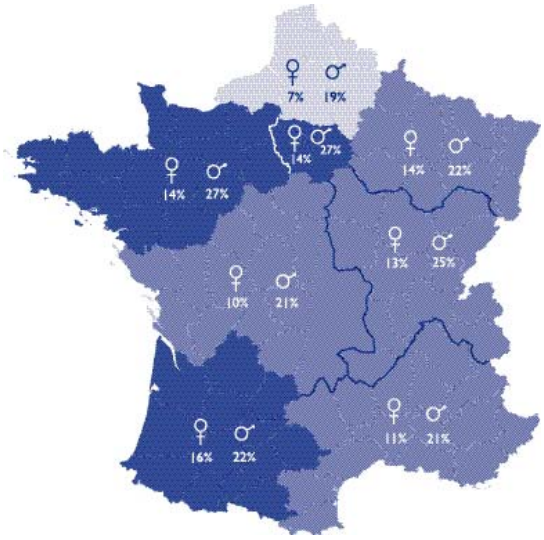
Source: Baromètre Santé 2000, CFES, Annual Report OFDT

In visual terms, experimentation and consumption of cannabis among 15-44 year olds divides France into three large areas with more or less well-defined borders: both are rarer in the North and in central France, average or higher in the South, West and East, and are particularly high in Ile-de-France, Aquitaine and, to a lesser extent, Brittany.

Consumption at the end of adolescence

At 17, experimentation with cannabis is more common in the South West (51% of girls and 51% of boys) and in the North West (43% and 55%). Prevalence is at its highest for girls in the South West, and for boys in the North West. For both sexes, it is at its lowest in the North (30% and 44%). The gap between boys and girls is zero in the South West, reaches 14 points in the North, and is greater than 10 points in the North West, Central West and Central East regions.

Prevalence of repeated use* of cannabis among 17 year olds in 2000, by region *{328c}*



Interregional comparisons independent of age and sex

**at least ten times during the last twelve months*

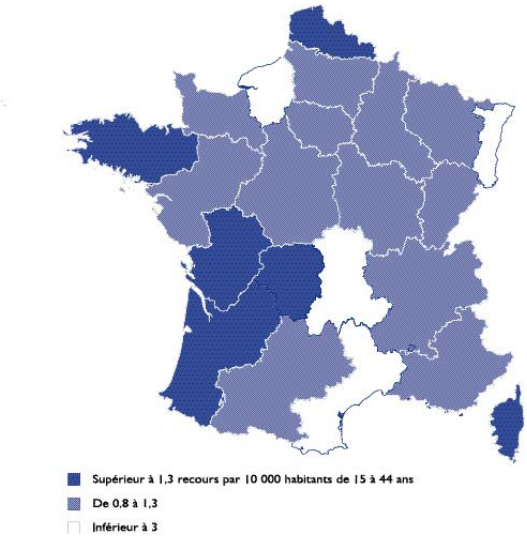
Source: ESCAPAD 2000, OFDT

At 17, 12.6% of girls and 23.8% of boys report repeated use of cannabis. The geographical differences are similar to those observed for experimentation: higher prevalence in the South West (16% for girls, 22% for boys) and the North West (14% and 27%), especially for girls in the South West and especially for boys in the North West. Similarly, the prevalence for girls and boys is at its lowest in the North (7% and 19%). On the other hand, although the Paris region counts as average for experimentation, it has higher prevalence of repeated use, identical to that of the North West. The regional differences seem to persist, or even to become more marked, when higher levels of consumption are considered. However, as for experimentation, the gap between the two sexes is smallest in the South West (6 points) and largest in the North (13 points), with a difference of 12 points for the North West, the Paris region and the Central East region.

Demands for treatment

Two regions stand out for having a number of cannabis-related registrations per inhabitant that is twice as high as the national average (2.4 and 1.9 as against 1.1 for all the regions together) – Limousin and Poitou-Charentes. This characteristic is all the more striking since, when all substances are concerned, both these regions are characterised by a low number of registrations per inhabitant. At the other extreme is Alsace, where the number of cannabis-related registrations per inhabitant is particularly low. Here also, there is a specific characteristic of the region, since the number of opiate-related registrations per inhabitant is significantly higher than the national average, in this region. Languedoc-Roussillon is in the same situation, whereas in Auvergne the number of registrations per inhabitant is quite low regardless of substance concerned.

Cannabis-related registrations in 1999, by region *{328d}*



Higher than 1.3 registrations per 10,000 inhabitants aged 15-44

Between 0.8 and 1.3

Lower than 3

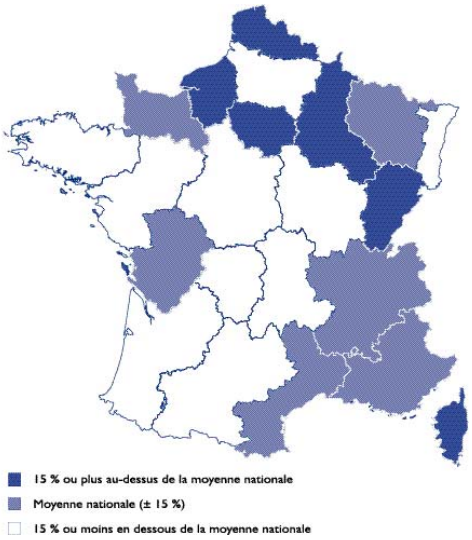
Source: Survey on registration for care of drug addicts in November 1999, DREES/DGS

Arrests

In 2000, half of all arrests of cannabis users took place in four regions (Ile-de-France, Nord-Pas-de-Calais, Rhone-Alpes and Provence-Alpes-Cote d'Azur), i.e. the most populated regions, which also record the greatest number of arrests of users for all substances.

When arrests for use of cannabis are considered in relation to the population of the region most affected by consumption, the order is somewhat altered. After the North and the Paris region, where cannabis is widely available, regions such as Corsica, Franche-Comte, Champagne-Ardenne and Haute-Normandie appear, regions that, in proportion to their population, have a high number of arrests for cannabis use. It is fairly logical to see the regions on the Mediterranean coast appearing among the areas where arrests for cannabis use are high, since they are so close to Morocco. For the rest, the map is definitely an illustration of a widespread distribution of cannabis combined with police activity.

Arrests of cannabis-users in 2000, by region *{328e}*



15% or more above national average

National average (+/-15%)

15% or more below the national average

National average: 328 arrests per 100,000 inhabitants aged 15 to 44

Source: FNAILS 2000, OCRTIS

European approach

To understand the situation of France in relation to its European neighbours, with regard to cannabis consumption and its consequences, the data studied come from the 2000 Annual Report of the OEDT (European observatory of drugs and drug addiction) as well as from other information collected by this body. This data is complemented by that from the ESPAD survey conducted among young people still in education in thirty European countries (Hibell, *et al.,* 2001).

Consumption

Cannabis is the illegal substance with the highest consumption by far within the countries of the European Union. Within the adult population, experimentation involves between 10 and 30% of individuals. Among 16-34 year olds, this level approaches 40% in the countries with the highest number of consumers (Denmark, United Kingdom and France).

The figures for the different countries of the European Union indicate a rise in the level of experimentation over the 1990s, followed by a recent stabilisation in most countries. Overall, consumption of cannabis is more experimental than lasting.

Within the population of those still in education and among the thirty countries covered by the ESPAD survey, cannabis use by French school pupils of 16 (both experimentation and repeated use) was the highest, for boys and for girls (Hibell *et al.*, 2000). Only the United Kingdom and the Czech Republic were at the same level.

Demands for treatment

The proportion of cannabis-related registrations seems on average to be close to 10% in the countries of the European Union. France therefore has figures a little higher than average, in this respect. Cannabis accounts for a particularly low proportion of registrations in Spain, Greece, Sweden and Italy (between 6 and 8% of registrations) and a particularly high proportion in the Flemish part of Belgium (30%), in Germany (22%) and in Finland (19%).

Arrests

Apart from the differences in recording systems, the police data in Europe depends largely on national policies and legislation concerning drugs. Comparison of figures for arrests does however, bring out some similarities, such as the rise in drug-related arrests over the course of the 1990s[4] and the dominant position of cannabis within these arrests.

Eight countries hold detailed data relating to the grounds for arrest and the substance in question. In 1999, the proportion of arrests for use or possession, in connection with cannabis, varies between 45% in Luxembourg and 88% in France[5]. Among the countries for which figures are available, France counts the largest number of cannabis-related cases among arrests for use/possession of narcotics. Next come Italy, United Kingdom, Austria and Ireland.

In almost all the countries, cannabis was less strongly represented among arrests for use or possession of narcotics in 1995 than in 1999. However, cannabis-related arrests, on whatever grounds, formed the majority in all countries, except for Italy, Luxembourg and Portugal, where heroin was the substance with which the largest number of arrests were associated.

[4] The term 'drug-related arrests' has very different definitions in different countries. The grounds for the arrest and the substance concerned are not always recorded.

[5] Portugal counts 33% of arrests for use/possession of cannabis as sole substance, but 22% of arrests reveal the presence of several substances, details of which are not recorded.

For further information

■ Cannabis: Quels effets sur le comportement et la santé?, [Cannabis: How does it affect behaviour and health?] Paris, INSERM (Institut national de la santé et de la recherche médicale – National institute for health and medical research), 2001, (Col. Expertise collective), (to be published).

■ Ballion (R.), Les conduites déviantes des lycéens, [Deviant behaviour in high-school students] Paris, OFDT/CADIS, 1999, Baudier (F.), Arènes (J.) (dir.), Baromètre Santé adultes 95/96, Vanves, CFES, 1997, 288 p.

■ Baudier (F.), Janvrin (M.-P.), Arenes (J.), Baromètre Santé jeunes 97/98, Vanves, CFES, 1998, 328 p.

■ Beck (F.), Peretti-Watel (P.), EROPP 99: survey on representations, opinions and perceptions relating to psychoactive substances, Paris, OFDT, 2000, 203 p.

■ Beck (F.), Legleye (S.), Peretti-Watel (P.), Regards sur la fin de l'adolescence : consommations de produits psychoactifs dans l'enquête ESCAPAD 2000, [Views of the end of adolescence: consumption of psychoactive substances in the ESCAPAD 2000 survey] Paris, OFDT, 2000, 220 p.

■ Beck (F.), Legleye (S.), Peretti-Watel (P.), 'Drogues illicites: pratiques et attitudes', 'Illegal drugs: practices and attitudes] in Guilbert (P.), Baudier (F.), Gautier (A.) (dir.), Baromètre Santé 2000, Vanves, CFES, 2001, (to be published).

■ Beck (F.), Legleye (S.), Peretti-Watel (P.), Alcool, tabac, cannabis et autres drogues illicites parmi les élèves de collège et de lycée : ESPAD 1999 [Alcohol, tobacco, cannabis and other illegal drugs among college and high-school students: ESPAD 1999] France, volume II, Paris, OFDT, 2001, (to be published).

■ Bello (P.-Y.), Toufik (A.), Gandilhon (M.), Tendances récentes, rapport TREND, [Recent trends, TREND report] Paris, OFDT, 2001, 167 p.

■ Carriot (F.), Sasco (A.-J.), « Cannabis et cancer », Revue d'épidémiologie et de santé publique, ['Cannabis and cancer', Review of epidemiology and public health] vol. 48, no. 5, 2000, p. 473-483.

■ Choquet (M.), Ledoux (S.), Adolescents, enquête nationale, [Adolescents, national survey] Paris, INSERM, 1994, 346 p.

■ Choquet (M.), Ledoux (S.), Hassler (C.), Alcool, tabac, cannabis et autres drogues illicites parmi les élèves de collège et de lycée : ESPAD 1999 [Alcohol, tobacco, cannabis and other illegal drugs among college and high-school students: ESPAD 1999] France, volume I, Paris, OFDT, 2001, (to be published).

■ De Peretti (C.), Leselbaum (N.), Les lycéens parisiens et les substances psychoactives : évolutions, [Paris high-school students and psychoactive substances: developments] Paris, OFDT/INRP-Paris X, 1999, 170 p.

■ Hibell (B.), Andersson (B.), Ahlstrom (S.), Balakireva (O.), Bjarnasson (T.), Kokkevi (A.), Morgan (M.), The 1999 ESPAD report: Alcohol and Other Drug Use among Students in 30 European Countries, Stockholm, CAN, 2000, 362 p.

■ INTERPOL (International Police organization), Situation du trafic de cannabis dans le monde – 1999, [The cannabis trafficking situation worldwide] Lyon, INTERPOL, 2000, 19 p.

■ Mura (P.) (dir.), Alcool, médicaments, stupéfiants et conduite automobile, [Alcohol, medicines, narcotics and driving] Paris, Elsevier, 1999, 239 p. (Col. Option Bio).

■ OCRTIS (Office central pour la répression du trafic illicite des stupéfiants – Central office for law enforcement relating to traffic in illegal narcotics), Usage et trafic de produits stupéfiants en France en 2000, [Use and trafficking of narcotic substances in France in 2000] Paris, ministère de l'Intérieur, 2001, 114 p.

■ OEDT (Observatoire européen des drogues et des toxicomanies – European observatory of drugs and drug addicts), Rapport annuel 2000 sur l'état du phénomène de la drogue dans l'Union

européenne, [Annual Report 2000 on the drugs situation in the European Union] Luxembourg, European Community Official Publications Office, 2000, 50 p.

■ OGD (Observatoire géopolitique des drogues - Geopolitical observatory of drugs), La géopolitique mondiale des drogues 1998-1999, [World geopolitics of drugs] Paris, OGD, 2000, 262 p. (www.ogd.org).

■ Richard (D.), Senon (J.-L.), 'Le cannabis', [Cannabis] Toxibase documentation review, no.2, 1995, p. 1-25.

■ Roques (B.), La dangerosité des drogues : rapport au secrétariat d'État à la santé, [Danger ratings of drugs: report to the Secretary of State for Health] Paris, Odile Jacob/Documentation française, 1999, 318 p.

■ Tellier (S.), La prise en charge des toxicomanes dans les structures sanitaires et sociales en novembre 1999, [Registration of drug addicts with health and social organizations in November 1999] Paris, DREES, 2001, 47 p. (Working document no. 19).

■ UNODCCP (United Nations Office for Drug Control and Crime Prevention), Tendances mondiales des drogues illicites 2001, [World trends in illegal drugs] New York, United Nations, 2001a, 282 p.

■ UNODCCP (United Nations Office for Drug Control and Crime Prevention), World Drug Report 2000, Oxford, Oxford University Press, 2001b, 172 p.

■ Zimmer (L.), Morgan (J.-P.), Marijuana: mythes et réalités. Une revue des données scientifiques, [Marijuana: myths and facts. A review of the scientific data] Geneva, Georg, 2000, 315 p. (Médecine et Hygiène).

Cocaine and crack

Reference points

Consumption

- The consumption of stimulants in general, and cocaine in particular, appears to have been growing over the past few years, a finding that is more distinctly discernible among specific populations (persons attending festive events, opiate-dependent users).
- Experimentation, and more importantly, actual use of cocaine remains relatively limited. However in the year 2000, 1.4% of French people from age 18 to 75 years had experimented with cocaine.
- Within the adult population, the highest level of experimentation is found generally within the 18-44 age group, and more particularly among 35-44 year olds (1.6% for women and 4% for men). Among younger people, experimentation varies between 1% and 3% depending on gender and age.
- Women are always less numerous in admitting to experimentation with cocaine. Irrespective of gender, experimentation is found especially among young adults.
- Consumption of cocaine is frequently noted in a context associated with other licit and illicit drugs, primarily alcohol, tobacco and cannabis. This is particularly the case in festive environments in which cocaine is associated with other stimulants and hallucinogenic drugs.

Healthcare and social consequences

- Healthcare and social care cases arising from cocaine or crack use increased appreciably between 1997 and 1999. The majority of this increase relates to previously monitored users and opiate dependants, especially those receiving substitution treatment.
- Use of these two drugs is the cause of care in less than 5% of primary drug cases and 15% for secondary drugs.
- Cocaine is particularly involved in multidrug use as the cause of health or social care; its consumption is often linked to the use of opiates.
- This finding explains the profile of cocaine users seen in the healthcare and social structure, which is close to that of opiate users within the same structure.
- Cases of deaths attributable to cocaine appear to be rare.

Criminal consequences

- Cases of police interrogation for use and drug dealing of cocaine or crack have greatly increased over the last ten years, in particular since 1997. They are very much in the minority compared to cases of police interrogation for the use drug dealing of cannabis (3,200 versus 82,300), but currently represent half of those in relation to heroin (5,800).
- More and more cocaine and crack users interrogated by the police are older. In 1991, the respective average ages for the drugs were 29 and 31 years.

Supply and trafficking

- The number of cocaine seizures and the quantities seized are rising, but there are large variations from one year to the next, arising from the influence of *ad hoc* operations that may not have been completed at years end.

- Cocaine is becoming more and more accessible. Although its price fell considerably in the 1990s, it appears to have stabilised.
- The supply of crack appears to be a relatively localised phenomenon, primarily affecting the Parisian region, the Antilles and Guyana.

Consumption of cocaine and crack by the French population

The consumption of cocaine and crack in the French population is described on the basis of survey results from representative samples of the young or adult populations. The trends that emerge from these surveys are corroborated by information from the field, both in the profile of consumers and their modes of use.

As cocaine consumption is rare, both in the adult and adolescent populations, only experimentation is considered here. Experimentation with crack in the adult population is too low a phenomenon for reliable study, because the question was not explicitly asked. In the same way, among young people, its investigation posed two difficulties: the low number of experimenters, and the level of comprehension of the question, confirmed by a relative ignorance of the drug [9].

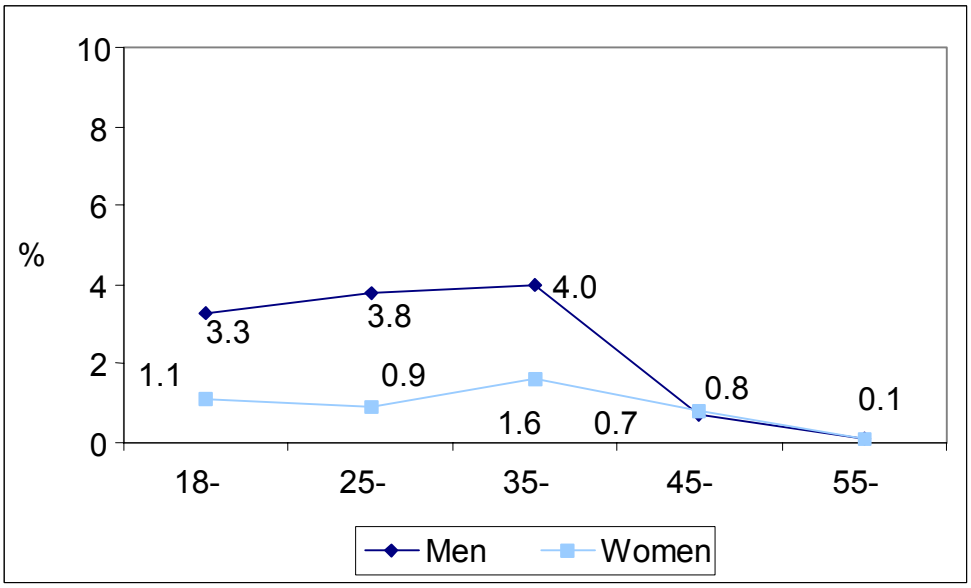
Experimentation by the general adult population

Within the general adult population, experimentation remains rare and is primarily found in young adults [3]. Consumption is predominantly masculine. While there is a marked division among men in their forties, with experimentation being much more frequent below 44 years, the contrast is less marked among women.

Over the past few years, an upward trend appears to be emerging. The use of cocaine among 18-44 year olds has, between 1995 [2] and 1999 [3], increased from 0.5% to 1.2% among women, and from 2.8% to 3.7% among men. This data is corroborated by field observations that show a marked spread in the distribution of cocaine, particularly in the context of festive events.

Above 44 years, the experimentation rate for this drug is extremely low.

Frequency of experimentation with cocaine in the general adult population in 2000, by gender and age *{331a}*



Source: Health Barometer 2000, CFES (Comité français d'éducation pour la santé: French Centre for Health Education), OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction) production

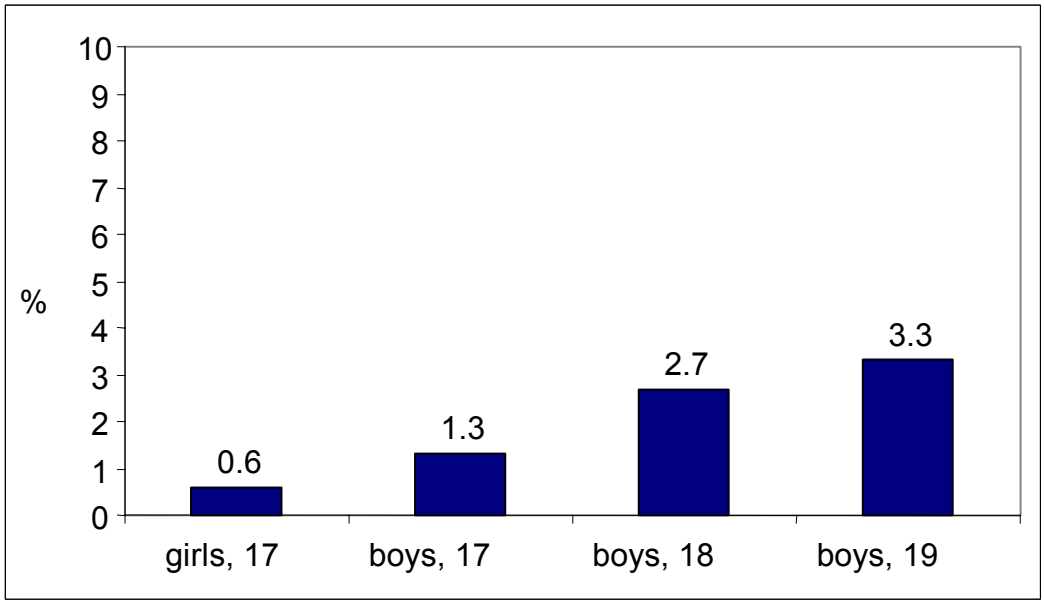
Among adults, experimentation with cocaine is observed in all social environments. Experimenters with cocaine are not, however, of sufficient number to allow the formulation of a precise socio-demographic profile of them. Some features emerge, however: experimentation is significantly more common among unemployed persons registered with the ANPE (5%). However, the socio-professional category, education degree, or level of household income did not allow a differentiation of this experimentation.

Experimentation by adolescents

Among educated young people, 1.2% of girls and 2.1% of boys from 14 to 18 years of age admitted having already taken cocaine during their lives [7]. Experimentation with cocaine has been on the increase since 1993, reaching 0.8% among girls and 1.4% among boys, with the difference being significant for boys [5].

At the end of adolescence, prevalence among boys and girls is equally higher, and increases with age among the latter between 17 and 19 years [8].

Frequency of experimentation with cocaine among young people at the end of adolescence in 2000, by gender and age *{331b}*



Source: ESCAPAD 2000, OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction)

More young people who have left the school system have experimented with cocaine than others, as is the case for students registered in professional channels, and who have already repeated a school year. Thus, when gender, age and school year repetition are checked, experimentation is found more frequently among young people who have left the school system, and, among students, those registered in professional channels, and who have repeated a school year. Moreover, young people who have already used cocaine are markedly more regular consumers of alcohol, cannabis and tobacco, than the others.

While experimentation with cocaine involves only a small proportion of young people who have already attended *techno* parties (4.2%), these are seven times more likely to be experimenters than others (0.6%). When gender, age, professional channels, and repetition are checked, experimentation with cocaine is found more frequently among those who attended such an event.

Observations in the field

These data are from the TREND [33] device that operates in thirty sites in France and during *techno* party events.

Profile of consumers

In metropolitan France, the emergence of a number of cocaine-user categories has been observed over the last number of years:

- Young consumers of cannabis, ecstasy or other synthetic drugs, who come into contact with cocaine either in their locality, or when participating in a party event (techno or discotheque)
- Persons receiving substitution (methadone or high dosage buprenorphine)
- Persons in precarious social situations, on the very fringes of society, and multidrug addicts.

In the overseas departments, cocaine is still essentially reserved for socially well-integrated persons.

Crack users in cities are, for the most part, marginalised persons, some of whom alternate the use of crack and opiates. Nevertheless there are also occasional crack consumers among well-integrated groups, or even cocaine consumers who, from time to time, experiment with the smokeable form of this drug.

In the Antilles and in Guyana, profiles of crack consumers vary. As in the city, however, the majority of use is by persons in serious social difficulty. In these departments, the broad availability and low prices have contributed to a 'democratisation' of consumption, the scale of which is difficult to estimate.

Modes of use

Cocaine is still sniffed, particularly among well-integrated consumers, or those frequenting the *techno* environment. Use of the intravenous route is infrequent and mainly involves users, or previous users, of injected heroin or substitution drugs. Although in a minority, this practice is developing in the *techno* party area. As regards the practice of injecting crack, it is almost exclusively seen in Paris. Finally, the smokeable mode of cocaine (in hydrochloride form) is even more rare, because it involves a substantial of loss of the drug in the process. Regarding cocaine that is smoked, this in generally in the form of cocaine base (crack).

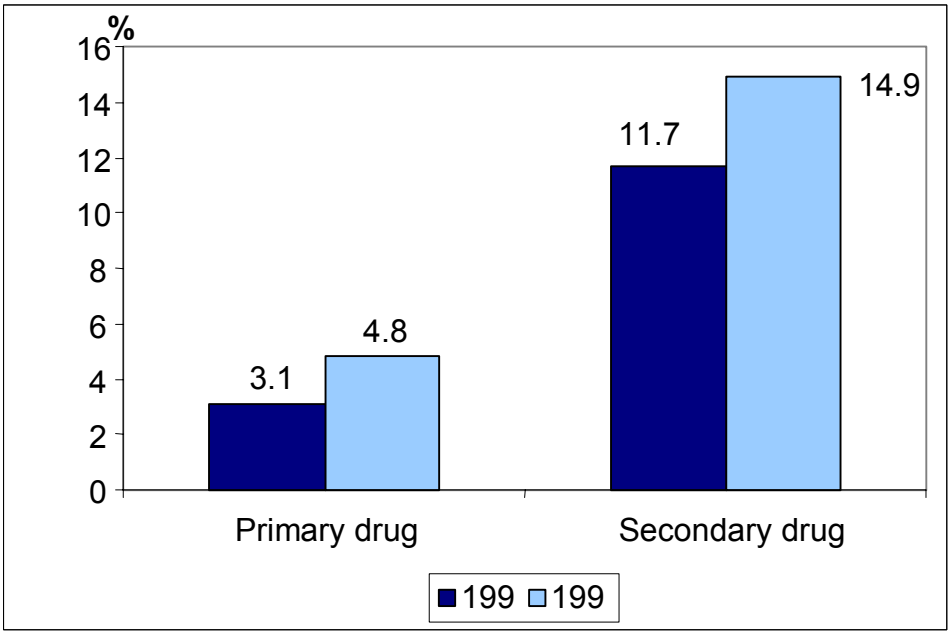
Healthcare and social consequences of the use of cocaine and crack

Use of cocaine and crack drives a fraction of its consumers into the medico-social care structure. The number and characteristics of the persons taken into care in the medico-social institutions due to their dependence on (or abuse of) cocaine, are described first. The consequences of cocaine use, in terms of mortality and morbidity, are dealt with in the second section. The data shown is, in the majority of cases, collected from users by the care institutions, or the police services (mortality).

Demands for treatment

Between 1997 and 1999 the number and percentage of cases related to cocaine and crack have increased markedly, whether for primary drugs (+80%) or secondary drugs (+33%). Despite this growth, cocaine and crack are a very small proportion of all care cases for primary drugs (a little less than 5%). They appear, however, much more often as secondary drugs (almost 15%), which shows that cocaine is particularly implicated in multidrug use and dependency, more specifically in association with opiates.

Share of cocaine and crack in the entirety of drug-user care cases in 1997 and 1999 *{333a}*



Entirety of cases in the month of November in specialised and healthcare establishments, excluding double counting, with at least one drug product being the cause of care (see methodological appendix); N = 18, 075 in 1997; N = 19,564 in 1999.

Source: Survey on the care of drug addicts in November 1997 and 1999, DREES/DGS

The data from the OPPIDUM [18] survey showed an increasing trend in the proportion of recent consumers (in the previous week) of cocaine since 1996 (11% in 1999 as opposed to 7% in 1996). In the DREES/DGS survey, the proportion who had consumed cocaine and crack in the last thirty days had increased from 9% to 12% between 1997 and 1999.

Characteristics of persons in care.

The characteristics of users are drawn from the cases of care for cocaine and crack use as a primary drug only. The secondary drugs referred to, are, in the majority of cases, associated with opiates, due to the preponderance of this family of drugs in care cases. The characteristics of users mentioning cocaine and crack as a secondary drug are very similar to those of opiate users, which aspect is described elsewhere.

In November 1999

Generally, the characteristics of persons described in care cases of cocaine use as a primary drug, are similar to those of opiate users. This average profile results from the aggregation of three sub-populations:

- The first group of persons (a little more than 50% of cases related to cocaine in November 1999) had a simultaneous problem of abuse or dependence in relation to cocaine (or crack) and opiates.

These users are receiving substitution treatment[1] and/or consume opiates as a second drug. Their profile is identical to those opiate users as a primary drug (average age over 30 years, small proportion of first-care cases, frequent practice of injection, high prevalence of HIV and VHC[2]).

- A group of persons without an associated case of care related to opiates (a little less than 40% of care cases in November 1999[3]).

These users are a little younger than the opiate users (29.7 years on average). The proportion of first-care cases among them is very high (50%), which is probably explained by a more ad hoc *case of care than those of opiate users, who have settled into the healthcare structures by their substitution treatments. The practice of injection reported is much lower than in the case of opiate users (23% of cases for current or previous injection, and 10% for injection in the last thirty days).*

- A final group consisting of crack users in the Antilles-Guyana region (10% of care cases in November 1999).

These users are, on average, older than those in the cities (33.7 years), half of them being 35 years or more. They are almost exclusively men (94% of cases) and are first-care cases in almost one in two cases (46% of cases). Opiates and substitution treatment are almost completely absent, as is the practice of injection. The only associated drugs in these care cases are cannabis and alcohol. Finally, by comparison with the preceding

[1] Such treatment is prescribed, without exception, in cases of dependence on opiates

[2] See the chapter on opiates

[3] The "given month" survey method tends to overestimate the persons regularly attending healthcare structures (the case of opiate user receiving substitution treatment)

groups, a higher proportion of users are sent to the healthcare structures by a legal decision (22%).

Profile of care cases related to cocaine, crack and opiates (as a primary drug)

	Cocaine with associated opiates[1]	Cocaine without associated opiates[2]	Crack in the Antilles-Guyana region	Opiates
Number of cares cases (primary drug)	474	333	95	13 613
% of first-care cases	27	50	46	29
Average age	30,9	29,8	33,7	31,5
% under 25 years	12	28,9	11,6	13
% of men	81	78	94	76
% of persons sent by the justice	7	11	23	6
% of persons employed	33	34	37	39
% of pupils and students	5	4	4	2
% of persons receiving RMI	32	22	30	31
% of persons having used the intravenous route (currently or previously)	72	23	3	73
% of persons having used the intravenous route within the last 30 days	21	10	0	19

[1] Cases of care in cities with a mention of substitution treatment and/or opiates as a second drug.
[2] Cases of care in cities without mention of substitution treatment and/or opiates as a second drug.

Source: Survey on the care of drug addicts in November 1999, DREES/DGS

Development 1997-1999

For all of the care cases related to cocaine, the principal changes that have occurred between these two years are the increase in the proportion of substitution treatments (from 35% to 45%) and the reduction in the percentage of first-care cases (from 48% to 38%). These developments are mainly the result of differentiated growth in the numbers of each of the groups referred to above. The number of users receiving substitution treatment, or with opiates as secondary drugs has doubled, the number of users without association with opiates has increased by 50%, and crack user numbers in the Antilles and Guyana have reduced slightly. It should be noted that, as in the case of all care cases (all drugs included), the practice of injection, within the last thirty days, has reduced quite considerably, in proportion, in the last two groups (from 27% to 21% in the first group and from 16% to 10% in the second). Also, a general phenomenon, the consumption of heroin during the last thirty days has dropped (from 27% to 18%[4]), while that of Subutex® is increasing (from 6% to 12%).

In total, approximately two-thirds of the overall growth in care cases related to cocaine and crack results from the increase in the number of multidrug-dependent users, most of whom are receiving substitution treatment for opiates. The increase in the average age of all the groups, and the trend of a reduction in the percentage of first-care cases and the under 25 year-olds, shows that the increase in care cases related to cocaine can only be marginally attributed to the youngest users.

[4] The percentage relates to persons taken into care for cocaine use and having consumed at least one drug within the last thirty days.

Morbidity and mortality

Consumption of cocaine can be the cause of death through overdose, and manifests itself through different pathologies (endocarditis, cerebrovascular accidents, and psychiatric conditions). As for other substances, there is little data on these questions. The available figures relate to deaths by overdose, as provided by the police services, and the prevalence of HIV and VHC infections, originating from surveys of users and the medico-social care structures.

Morbidity

The practice of intravenous injection is the main risk factor in the transmission of HIV and VHC among drugs users. As previously indicated in care cases related to cocaine, the majority of persons with which injection is mentioned are opiate users, usually receiving substitution treatment. The same prevalence is noted to the same degree for users of opiates as a primary drug. As for all opiates users, the prevalence of HIV is reducing, and that of VHC increasing.

Reported prevalence of HIV and VHC among persons in care in 1997 and 1999 for cocaine use as a primary drug, in specialised establishments

	1997	1999
Prevalence of HIV in persons having practiced injection (currently or previously) as a % of the number of known pathologies	20 (N = 165)	14.9 (N = 329)
% of unknown pathologies	23 (N = 213)	16.1 (N = 392)
Prevalence of VHC in persons having practised injection (currently or previously) as a % of the number of known pathologies	53.3 (N = 149)	59.7 (N = 315)
% of known pathologies	30 (N = 213)	19.7 (N = 392)

Source: Survey on the care of drug addicts in November 1999, DREES/DGS

Mortality

In the year 2000, according to police services, cocaine was the direct cause of 11 deaths out of the total 120 recorded deaths from overdose. Analysis of five of these deaths revealed the presence of other substances (cannabis, hallucinogenic mushrooms, crack, ecstasy or heroin). Crack appears to be the main cause of overdose.

The number of cocaine-related deaths has fluctuated over the last fifteen years and for the first time is greater than ten cases. In the context of a substantial reduction in deaths related to heroin during the 1990s, the part in relation to cocaine tended to increase. The presence of cocaine was also detected, in 2000, in five cases of deaths directly related to heroin or methadone.

Criminal consequences of the use of cocaine and crack

The use of cocaine and crack, as for all illicit drugs, may result in police interrogation and criminal proceedings. Only the cases of police interrogation can be described. Sentences and imprisonment that do not refer to the drug in question cannot be dealt with here.

Police interrogation for use in 2000

During the year 2000, law enforcement services recorded almost 2,000 cases of police interrogation for simple cocaine use, which represents 2.3% of the total number of cases of police interrogation for simple use [28]. When user-dealers are taken into account, this proportion amounts to 2.5%. Cocaine is the third leading drug causing police interrogation of users in France, but is well behind cannabis (87.3% of users questioned) and heroin (6.2%).

The number of cases of police interrogation for crack use is much lower (869 in 2000) and amounts to less than 1% of cases of police interrogation for drug use. It should be noted that almost one-third of cases of police interrogation occur in the little crown, and another third in the Antilles and Guyana.

Cases of police interrogation for use and drug dealing of cocaine and crack in 2000

	Cocaine	Crack	Cocaine and crack	All drugs included
Simple use	1 944	707	2 651	83 385
Drug dealing	379	162	541	10 954
Total	2 323	869	3 192	94 339

Source: FNAILS 2000, OCRTIS (Office central pour la repression du trafic illicite de stupéfiants: Central Office for the Repression of Drug-Related Offences)

As for other drugs, the majority of persons questioned for use or drug dealing of cocaine were only questioned once during 1999 (85% of them). The majority of those arrested more than once were arrested for the use or possession of a drug other than cocaine, principally cannabis (145 persons) and heroin (99 persons).

Development in cases of police interrogation for use since 1990

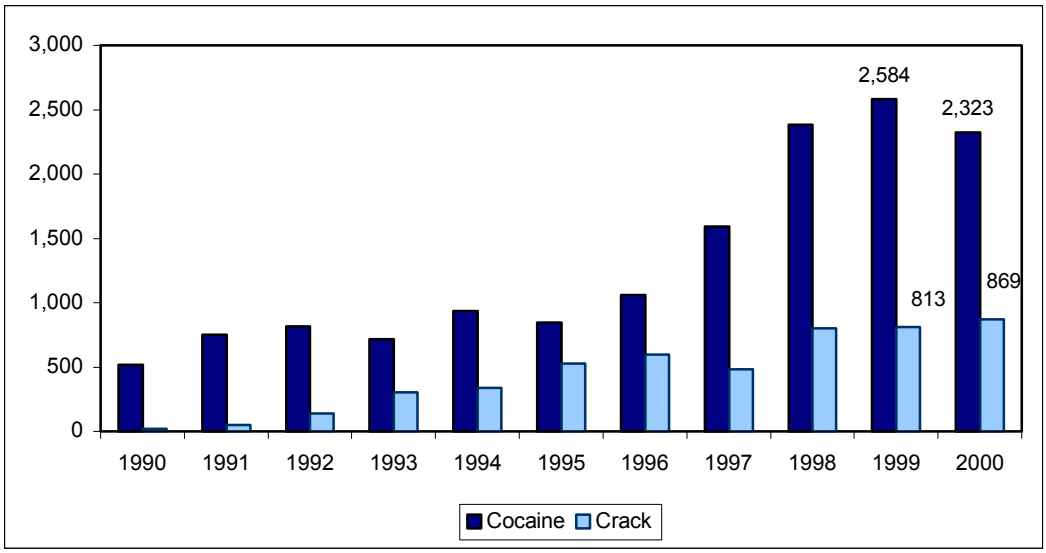
The reduction in the cases of police interrogation for cocaine use in 2000 (-10%) appears to be a break in the upward trend observed over the ten-year period. In 1999, the rise had already been more modest than in previous years. The police interrogation of crack users increased by 7% between 1999 and 2000.

From 1990 to 1999, cases of police interrogation for cocaine use multiplied by five, a more rapid progression than for all cases of police interrogation of users (which tripled). Growth was also exceptional for crack (+56% on average each year). This is, however, partly due to the introductory phase of a new substance into the nomenclature, and the low numbers at the beginning of the period. The population

is very different compared to other users and is certainly more visible to the police. However, the transfer of police interrogation cases from cocaine toward crack can be assumed to be due to a better knowledge of the drug.

It is too early to say whether the reduction observed in 2000 represents a new trend, and whether the cases of police interrogation for cocaine use reached a peak in 1999.

Cases of police interrogation for use or drug dealing of cocaine or crack from 1990 to 2000 *{334a}*



Source: FNAILS, OCRTIS (Office central pour la repression du trafic illicite de stupéfiants: Central Office for the Repression of Drug-Related Offences)

Characteristics of users questioned

In the year 2000, cocaine and crack users were the oldest of the users questioned: respectively 29.6 and 31.3 years as opposed to 28.3 years for heroin users and 21.8 years for cannabis users. Among the cocaine and crack users questioned, there were only 63 minors who were essentially cocaine users.

As for heroin users, the ageing trend of this population has been confirmed for a number of years now: cocaine users questioned in 1990 were, on average, 27.9 years old. For crack users, this trend is only visible from 1995.

The differences observed in the breakdown by professional category among users questioned are age-related: as in the case of heroin users, more cocaine and crack users than the average admitted not having a job (49% of cocaine users and 73% of crack users) and there are fewer students and secondary school pupils (6% and 2% respectively). The data are reversed for cannabis users, one-third of whom are unemployed, and another third are students or secondary school pupils.

Almost 82% of cocaine users questioned were men, a slightly smaller proportion than that observed among crack users (86%) or other users questioned. There has been little change over the years.

Finally, as regards nationality, the majority of cocaine and crack users were French, as was the case for all users questioned. But the number of foreigners is greater among crack users than among any other users questioned. They represented 13% in 2000.

Supply and trafficking of cocaine and crack

The international and national supply of cocaine and crack is examined mainly via the seizures made by the international and national services. Local supply is described from field observations.

International trafficking and supply routes to France

In the year 2000, 43 [metric] tonnes of cocaine were seized in Western Europe (INTERPOL, 2000). During the 1990s, the European market (in the geographic sense) became an increasingly valuable destination for cocaine, which seems to be suggested from the regular growth in seizures.

Quantities of cocaine seized in Western Europe, from 1993 to 1999
(in metric tonnes)

1993	1994	1995	1996	1997	1998	1999
17.3	29.4	21.0	31.2	38.8	36.1	44.1

Sources: UNODCCP

This increasing trend cannot be attributed to an increase in production, because the annual global supply of cocaine hydrochloride coming from South America has remained relatively constant over the last five years: approximately 800 tonnes per annum, of which 200 to 300 tonnes were seized according to INTERPOL (INTERPOL, 2000). The influx of cocaine into Europe is rather the consequence of the United States market saturation—the traditional destination of the drug—that forced the traffickers to seek new markets.

Cocaine arrives in Europe primarily through Spain and the Netherlands, most often after transit through the Caribbean. 63% of seizures from 1997-1998 had transited through this region.

The quantities of cocaine hydrochloride seized in France amounted to 1,311 kg in the year 2000, showing a reduction of 64% over the previous year, although the number of seizures remained constant (approximately 1,800) [28]. This apparent reduction in trafficking is probably artificial and reflects the fact that 1999 was marked by three exceptional seizures which, in total, amounted to more than 2,400 kg. If the last seizures are compared to those of 1998, an increase of more than 25% is noted, which appears to better fit the trends observed elsewhere (increase in consumption and much greater availability in certain environments). The quantities of cocaine seized annually are always subject to considerable variation due to frequent large busts.

Quantities of cocaine seized in France, from 1990 to 2000
(in kg)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Cocaine	1 845	831	1 625	1 715	4 743	865	1 742	844	1 051	3 687	1 311
Crack	0	0.4	1.9	5.2	10.2	8.6	10.5	16.3	25.1	10.6	22.2

Source: FNAILS, OCRTIS

In 2000, a large part of the cocaine seized in France came from Brazil and Venezuela via the Netherlands, which appears to be an important new point of entry (22% of the quantities seized, whose source was identified in 2000, as opposed to 4% in 1999).

Except in unusual years, the main countries of destination are: France, the Netherlands, the United Kingdom, Italy, (and less so in 2000, Spain) with 25%, 18%, 16% 15% and 3% respectively of the seized quantities whose destination was identified. One new fact is the emergence of a black African drug connection with more than 100 kg destined for Togo and the Ivory Coast.

It is difficult to discuss the international supply of crack, as it is most often manufactured on the spot from cocaine hydrochloride. With 22 kg, the quantities of crack seized have doubled versus 1999. However, it must be noted that 12 kg came from a single seizure in Martinique [28]. Increasing quantities of crack are seized each year coming from the Antilles. The number of seizures is also increasing steadily (325 in 1995 and 472 in 2000).

In France, as throughout Europe, the importation of cocaine is not done by large criminal organisations, but by casual groups of criminals or commercial companies with licit businesses (OGD, 2000). Likewise, a substantial fraction of the retail trade is still in the hands of a relatively large number of individuals or small groups who supply cocaine to 'groups of friends', and which are not considered to be 'criminal operators'.

Nevertheless, some traditional Turkish, Kurdish, Yugoslav, Kosovo-Albanian and Moroccan drug networks, in liaison with Colombian gangs, have started to diversify their activities, originally centred on hashish and heroin, and now including cocaine (INTERPOL, 2000).

Traffickers questioned by the police in France

In the year 2000, 1,088 cocaine traffickers were apprehended by law enforcement services, representing 17% of all traffickers questioned that year [28]. With 200 cases of interrogation, crack traffickers correspond to 3% of all cases reported in 2000. The number of cases of police interrogation for trafficking in these two drugs has increased over the last ten years (14% on average each year for cocaine and 38% for crack).

Cases of police interrogation for cocaine and crack trafficking, from 1990 to 2000

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Cocaine	397	537	448	383	541	376	623	711	789	1 003	1 088
Crack	16	25	59	60	116	73	98	100	183	185	200
All drugs	5 198	5 303	5 982	6 451	7 179	7 107	8 412	6 560	5 541	5 506	6 531

Source: FNAILS, OCRTIS (Office central pour la repression du trafic illicite de stupéfiants: Central Office for the Repression of Drug-Related Offences)

Almost 40% of police interrogation cases regarding cocaine in 2000 related to so-called international traffickers, that is, involved in importation or exportation activities. This proportion is substantial compared to the all-drug average—19% of international traffickers. Mirroring the seizure data, trafficking in crack seems to be on a smaller scale, as 96% of traffickers questioned in 2000 were considered as local traffickers or

dealers [28]. As for the police interrogation of users, law enforcement action in relation to local trafficking took place primarily in Paris, in the Antilles and in Guyana (64% and 32% respectively in 2000).

In 2000, one in five of the international cocaine traffickers questioned by police was of French nationality. Among the foreigners, the countries most represented were the Netherlands, Brazil, Italy, Great Britain, Spain, Surinam and Colombia. Regarding local traffickers involved in the running of a dealer network, the majority (77%) were of French nationality.

Although the number is lower, the composition of crack-trafficking groups questioned is somewhat unusual when compared to other drugs. The proportion of foreigners is quite substantial: three-quarters of those questioned in 2000 were, for the most part, from African countries (Gabon, but also Somalia and Senegal) and, to a lesser degree, from Guyana and Surinam. Crack trafficking appears to have been developed by West Indians (impossible to count), and taken over by the African community for some years now.

Local supply: availability, price and quality

The data given here are taken from the TREND [33] observation device for availability and price, and the police and customs laboratories for composition of samples seized.

Availability

Since the implementation of the TREND device in 1999, the data converge to show a net increase in the availability of cocaine in all metropolitan areas.

In the *techno* party environment, despite some differences between regions and events, the availability of cocaine is on the increase.

Formerly available in private areas known only to the initiated, this small trafficking is spreading increasingly into public areas. In some places, it is no longer necessary to call on intermediaries to obtain cocaine.

This phenomenon is partly related to changes noted in the small cannabis and heroin-trafficking networks. Some dealers have started, in effect, to also sell cocaine, while others are progressively moving toward its exclusive sale. Small cocaine trafficking, like its consumption, remains, nevertheless, faintly visible. No cocaine hydrochloride open scene was found in the TREND areas. On the other hand, there have been, since the beginning of the 1990s, open cocaine base (crack) scenes in Paris, the Antilles and in Guyana. Within the *techno* party environment, in parallel with the spread of cocaine hydrochloride, the small-scale manufacture of cocaine base has developed.

Due to the methods of manufacture[5], the availability of crack goes hand-in-hand with that of cocaine. Thus, the consumption of crack was indicated by all the TREND sites, with the exception of the island of Réunion, where cocaine itself is very rare. The virtual absence of street dealing of crack on the sites (with the exception of Paris, the Antilles and Guyana) contributes to reducing the visibility of the phenomenon. It is only in these four departments that small trafficking has achieved a high degree of organisation and structure. This is evidence of the regularity of supply and the relative price stability.

[5] Crack is made from the chlorohydrate form of cocaine (powder).

Price

Compared to the level reached some years ago (between Fr 800 and Fr 1,200 per gram), the price of cocaine has fallen. During 1999 and 2000, the average prices found by the metropolitan TREND sites remained stable around Fr 500 to Fr 600. In the *techno* party environment, the price per gram is also stable and is traded, depending on quality, between Fr 350 and Fr 600.

Regarding crack, prices vary: between Fr 4 and Fr 10 per dose in Guyana, Fr 10 and Fr 20 in Martinique and from Fr 40 to Fr 50 in Paris.

Quality

The purity rate of cocaine (hydrochloride and base) seized by the national police and customs services showed a drop between 1998 and 2000. Between 1999 and 2000, the share of samples with high purity (between 50% and 100%) reduced by 16%. These results should be cautiously interpreted insofar as they are the result of the purity rates of cocaine samples circulating in France, and also the strategies and practices of law enforcement services.

On the basis of samples seized, the most common diluting products are found to be mannitol, lactose, caffeine, procaine and lidocaine.

Purity rate of cocaine and crack samples seized by the national police and customs, from 1998 to 2000

	1998		1999		2000	
	Number	%	number	%	number	%
0-20 %	15	2 %	15	2 %	42	5 %
20-50 %	106	13 %	99	15 %	201	25 %
50-100 %	670	85 %	522	83 %	543	70 %
Total	791	100 %	636	100 %	786	100 %

Source: TREND, OFDT (data provided by the scientific laboratory of the Lyon police and the inter-regional laboratory of the Paris customs).

Geography showing the consumption of cocaine and crack

Regional approach

The number of general population surveys is too few to show the geographic aspect of the consumption phenomenon. Only in the Southwest region is there prevalence for cocaine that is slightly higher than for all the other regions (1.9% versus 0.8%) at 17 years of age.

The socio-medical or criminal consequences of cocaine and crack use in the regions are considered on the basis of the care-case data in the month of November [17] and those of police interrogation [28].

Demands for treatment

In the majority of regions, cocaine (excluding crack) represents a proportion of care cases that is close to the national average (3.6%).

We must, however, refer to the case of Languedoc-Roussillon in which cocaine represents 7% of care cases in the region, Lorraine (6.0%) and the PACA region (5.7%), in which the proportions are significantly higher than the national average. Cocaine is a little under-represented, on the other hand, in the Rhône-Alpes (2.4 %), Alsace (2.5 %), Bretagne (2.5 %), and Poitou-Charentes (2.6 %) regions. It is totally absent in care cases in Réunion.

When compared with 1997, care cases related to cocaine have increased in all regions. This growth was, however, particularly strong in the Languedoc-Roussillon and PACA regions, where cases have almost multiplied by three.

Contrary to cocaine, the cases of crack-user care[6], as such, are very localised, and appear almost only in the Antilles-Guyana regions (42% of all care cases for cocaine) and Ile-de-France (45 %). This very strong localisation is confirmed by field observations of the TREND [33] monitoring device, which reveals that crack trafficking only appears in Paris, the Antilles and Guyana, and by police sources (see *infra*).

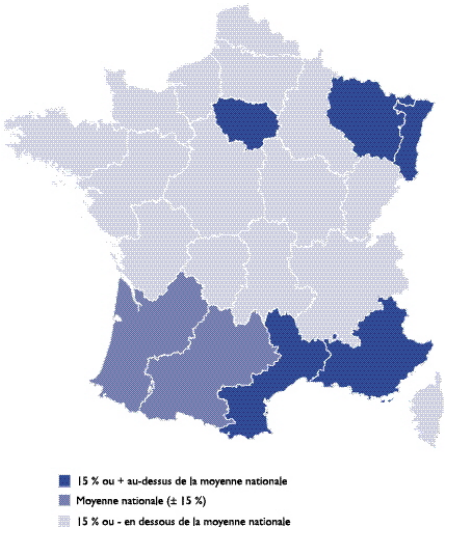
Police interrogation

The cases of police interrogation for use and drug dealing of cocaine are quite concentrated, as almost half of them occurred in two regions: Ile-de-France (29 %) and Provence-Alpes-Côte d'Azur (21 %). These regions are also part of those in which most of the cases of police interrogation for all drugs were recorded.

These two regions are also distinctive by the importance of interrogation for cocaine, when cases of interrogation of the population most concerned with consumption are taken into account. More generally, all the regions of the South (Southeast or Southwest) stand out, probably due to their proximity with Spain, where there is a large availability of cocaine.

[6] It is likely that the consumption of smoked cocaine is not systematically categorised as crack use, as observations on the ground seem to suggest a wider territorial spread [TREND].

Cases of police interrogation of cocaine users in 2000, by region *{338a}*



National average: 13.2 cases of police interrogation per 100,000 inhabitants from 20 to 39 years of age.

Source: FNAILS 2000, OCRTIS (Office central pour la repression du trafic illicite de stupéfiants: Central Office for the Repression of Drug-Related Offences)

The cases of police interrogation of crack users are very localised—in 2000, more than half occurred in Ile-de-France (41 % in Paris and 10 % in Seine-Saint-Denis) and more than 40 % in the Antilles and Guyana (25 % in Martinique, 13 % in Guyana and 5 % in Guadeloupe).

European approach

In order to compare the situation in France with those of its European neighbours, from the point of view of cocaine consumption and its consequences, the data was taken from the annual report for 2000 of the European Observatory for Drugs and Drug Addiction (OEDT, 2000) and other information collected by that organisation. The data is augmented by the ESPAD survey on school-going young people in thirty European countries (Hibell, *et al*., 2001).

Consumption by the general population

Among young adults, cocaine is consumed much less often than cannabis: 1% to 6% of individuals aged from 16 to 34 have tried cocaine. This use appears to be lower than for ecstasy for all of the 1990s.

Figures from the different countries of the European Union show a global increase in such use during the 1990s, which no longer appears to be the prerogative of a single social group. In effect, we as seeing a 'democratisation' of cocaine consumption, and its spread to a larger population of consumers.

Among the school-going population, experimentation with cocaine by French pupils of 16 years of age is slightly lower than the average (2% versus 1%), for both boys and girls (Hibell, *et al*., 2001).

Demands for treatment

As in France, cocaine was very little represented at the end of the 1990s, in the demands for treatment in the majority of EU countries. According to the latest data available, this drug has, however, a particularly important position in the Netherlands (a little more than 20% of care cases) and Spain (11%). It is singularly weak in Greece, Denmark, and

Ireland (between 0% and 2%) (OEDT, 2000). France is situated, together with England, Germany and Italy, in the intermediary group of countries in which the share of cocaine is between 3% and 7%. It is not, however, certain that the profile of persons taken into care for cocaine use in the different countries is always identical. In Germany, as in France, a strong association with opiates is found, which is much less frequent in Italy, Spain and the Netherlands. In the majority of European countries, the share of cocaine in care cases increased towards the end of the 1990s.

Police interrogation

Conversely to cannabis or heroin, cocaine does not appear to be the primary drug in question in cases of police interrogation related to drugs[7] in Europe. In 1999, cocaine represented less than 10% of cases of police interrogation for use or possession.

With a proportion of 3% of cases of police interrogation for use/possession of cocaine, France is close to Ireland (2%), the United Kingdom (4%) and Portugal (5%). The highest proportions were recorded in Germany (9%), Austria (8%), Italy (7%) and Luxembourg (6%).

The United Kingdom reported 829 cases of police interrogation for the use or possession of crack, compared to 813 cases in France. In both cases, crack represents less than 1% of users questioned.

[7] The term "cases of police questioning related to drugs" may have a very different definition depending on the country. The reason for questioning and the drug are not always reported.

For further information

- Baudier (F.), Arènes (J.) (dir.), Adult Health Barometer 95/96, Vanves, CFES, 1997, 288 p.
- Beck (F.), Legleye (S.), Peretti-Watel (P.), A look at the end of adolescence: consumption of psychoactive drugs in the ESCAPAD 2000 survey, Paris, OFDT, 2000, 220 p.
- Beck (F.), Legleye (S.), Peretti-Watel (P.), 'Illicit drugs: practices and attitudes', in Guilbert (P.), Baudier (F.), Gautier (A.) (dir.), Health Barometer 2000, Vanves, CFES, 2001, (to be published).
- Beck (F.), Legleye (S.), Peretti-Watel (P.), Alcohol, tobacco, cannabis and other illicit drugs among college and secondary school students: ESPAD 1999 France, volume II, Paris, OFDT, 2001, (to be published).
- Bello (P.Y.), Toufik (A.), Gandilhon (M.), Recent trends, TREND report, Paris, OFDT, 2001, 167 p.
- Choquet (M.), Ledoux (S.), Adolescents, national survey, Paris, INSERM, 1994, 346 p.
- Choquet (M.), Ledoux (S.), Hassler (C.), Alcohol, tobacco, cannabis and other illicit drugs among college and secondary school students: ESPAD 1999 France, volume I, Paris, OFDT, 2001, (to be published).
- Domic (Z.), Richard (D.), Senon (J.L.), Ingold (R.), Toussirt (M.), 'Cocaine', Toxibase documentary review, no. 2, 1996, p. 1-34.
- Hibell (B.), Andersson (B.), Ahlstrom (S.), Balakireva (O.), Bjarnasson (T.), Kokkevi (A.), Morgan (M.), The 1999 ESPAD Report: Alcohol and Other Drug Use among Students in 30 European Countries, Stockholm, CAN, 2000, 362 p.
- INTERPOL (International police organisation), Report on cocaine trafficking in the world - 2000 (1999 data), Lyon, INTERPOL, 2000, 33 p.
- OCRTIS (Office central pour la répression du trafic illicite des stupéfiants: Central Office for the Repression of Drug-related Offences), Use and trafficking of narcotic drugs in France in 2000, Paris, Ministry of the Interior, 2001, 114 p.
- OEDT (Observatoire européen des drogues et des toxicomanies: European Observatory of Drugs and Drug Addiction), Annual Report 2000 on the state of the drug phenomenon in the European Union, Luxembourg, European Community Publications Office, 2000, 50 p.
- OGD (Observatoire géopolitique des drogues: Drugs Geopolitical Observatory), The world drugs geopolicy 1998-1999, Paris, OGD, 2000, 262 p. (www.ogd.org).
- Senon (J.L.), 'Substitution treatments for opiate addition in healthcare centres: the OPPIDUM programme of the pharmacodependency evaluation and information Centres' Internal medicine annual, vol. 151, supp. A, 2000, p. A10-A17.
- Tellier (S.), The care of drug addicts in the healthcare and social structures in November 1999, Paris, DREES, 2001, 47 p. (Working document no. 19).
- Thirion (X.), Barrau (K.), Micallef (J.), Haramburu (F.), Lowenstein (W.), Sanmarco
- UNODCCP (Office des Nations unies pour le contrôle des drogues et la prévention du crime: United Nations Office for the Control of Drugs and the Prevention of Crime), World trends in illicit drugs 2001, New York, United Nations, 2001, 282 p.

Ecstasy and amphetamines

Reference Points

Consumption

- Ecstasy consumption first started in France at the beginning of the 1990s and has risen steadily since then. Nevertheless, experimentation, and moreover, its current use remain relatively limited. It seems to be confined to young adults and dance environments.

- Within the adult population, the levels of experimentation with ecstasy are low (0.7% of women and 2.2% of men aged 18-44). For young people, experimentation varies between 1 and 7% depending on gender and age. The consumption of amphetamines is more long-standing but, like ecstasy, experimentation and current use remain limited.

- Within the adult population, the levels of experimentation with amphetamines are low among 18-44 year olds (1.2% of women and 2.3% of men). For young people, experimentation varies between 1 and 4% depending on gender and age.

- Less women admit to having experimented with ecstasy and amphetamines. For both genders, prevalence increases with age.

- Consumption of ecstasy and amphetamines is often observed in an environment where there is also consumption of other legal and illegal drugs, mainly alcohol, tobacco and cannabis. This is the case particularly at dance events in which these products are combined with other stimulants and hallucinogenic products.

Health and social consequences

- The use of ecstasy and amphetamines causes a very low number of cases requiring health or social care, and seems to have stabilised over recent years.

- People who require care following the use of ecstasy have a profile similar to that of cannabis users. They are young as well. On the other hand, they are more likely to use multiple drugs, unlike the latter.

- People who require care following the use of amphetamines have average characteristics that are different to those of ecstasy users. In particular, they are older and more frequently use injections.

- At this time, the serious health consequences of using ecstasy and amphetamine have not been identified, apart from their implication in certain exceptional cases of death that have occurred since 1999, and in the absence of information on their possible implication in road accidents. Scientific expertise available on the subject indicates that psychiatric disorders and potential for long-term neurotoxicity are linked to the consumption of ecstasy.

Criminal consequences

- Police interrogation on the use and dealing of ecstasy has increased considerably over the last decade, with the exception of 1998 and 1999. However, it remains in a minority when compared to all the police interrogation incidents for narcotics use and dealing (1,900 as against 94,300). Police interrogation incidents linked to amphetamines remain relatively stable and marginal (about a hundred).

- Users of ecstasy taken in for interrogation seem closer to those of cannabis than those of heroin or cocaine. They are young, mainly aged between 18 and 25.

Supply and trafficking

- After a significant increase in the first half of the 1990s, seizures of ecstasy seem to have levelled off.
- Ecstasy and amphetamines are very accessible in dance environments. The price of these products has tended to decrease during recent years.
- The generic term ecstasy, in fact, covers a very wide range of products. The pills sold under this name do not always contain the researched active substance (MDMA), but rather several active substances for which the interaction is not known—in particular assorted medications used differently than in their normal use. When MDMA is present, the dosages vary greatly.

Consumption of ecstasy and amphetamines by the French population

The consumption of ecstasy and amphetamines within the French population is described through the results of declaratory surveys in representative samples of the populations of young people or adults. The trends that emerge from these surveys are corroborated by information from the field, on the profile of consumers and their methods of use.

As the consumption of ecstasy and amphetamines is rare in the adult population, only experimentation will be considered here. On the other hand, amongst adolescents, recent use of ecstasy is also included.

Reports of ecstasy and amphetamines within the French population appear less clear than those of other products, such as cocaine or heroin. Those relating to ecstasy reveal either a total lack of knowledge of the product, or uncertainties as to its effects—somewhere between the 'love pill', strong stimulating agents and products that are dangerous to health [9]. Amphetamines are not systematically used like drugs, due to their more recent usage as an appetite suppressant or stimulating agent. Today, however, those products have been withdrawn from the market.

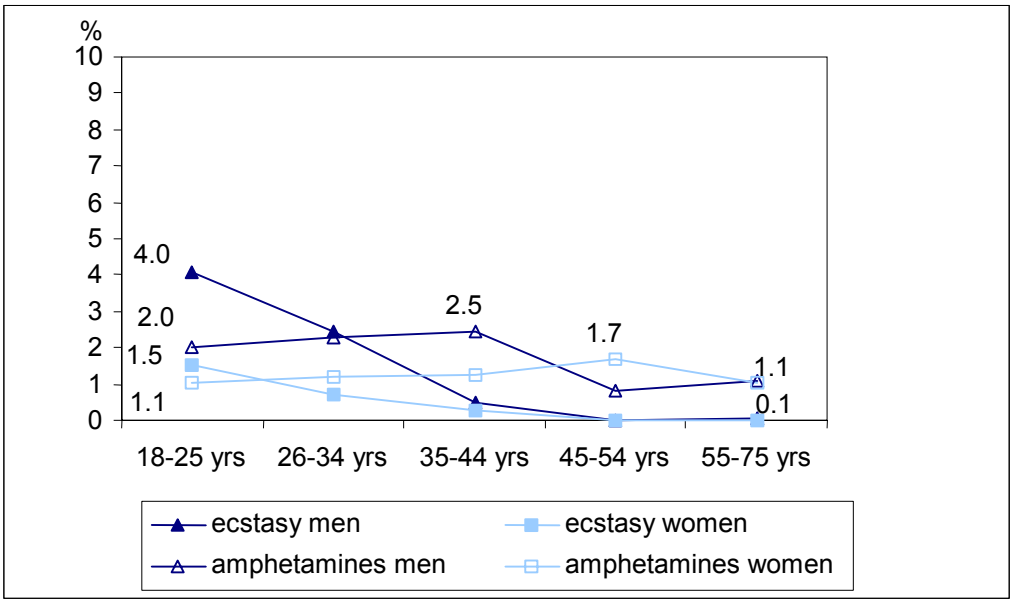
Experimentation by the general adult population

Within the general adult population, experimentation with ecstasy remains rare and focuses primarily on young adults [3]. Consumption is mainly by the male gender.

During recent years, a distinct trend is emerging toward an increase. For 18-44-year-olds, between 1995 and 1999, experimentation with amphetamines and/or ecstasy has gone from 0.7% to 1.6% for women and from 1.8% to 3.5% for men [3]. This data is corroborated by observations from the field, which reveal an expanding dissemination of these products, particularly for use within the context of dance events.

Amongst those over 44 years old, the rate of experimentation is extremely low for ecstasy, but is slightly higher for amphetamines. Women are the exception on this point; experimentation amongst them appears relatively constant for all age ranges. This could be due to the use of amphetamines as appetite suppressants within the context of diets.

Frequency of experimentation with ecstasy and amphetamines within the general adult population in 2000, by gender and age *{341a}*



Source: Health Barometer 2000, CFES (Comité français d'éducation pour la Santé: French Centre for Health Education); exploitation, OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction)

Amongst adults, experimentation with ecstasy or amphetamines has little to do with socio-economic status. The households most affected seem to be comfortably off, but the question of income has given rise to numerous non-responses. Finally, it should be noted that experimentation is often associated with a higher level of education [3].

The appearance of ecstasy may have been brought to the fore in the middle of the 1990s. In 1995, at the time of the survey on the behaviour of drug users in the centres of selection carried out by the army health service on young people called up, 0.5% of them declared that they had experimented with ecstasy. In a similar survey carried out in 1996, 5.1% declared that they had taken it during their lifetime (Louboutin-Croc *et al.*, 1997).

Experimentation by adolescents

Amongst educated young people, 1.8% of girls and 3.4% of boys aged 14 to 18 admitted to having taken ecstasy during their lifetime [7]. Experimentation with amphetamines is at a similar level and has been constant since 1993 [5].

Frequency of experimentation with ecstasy and amphetamines amongst educated 14-18 year olds in 1993 and 1999, by gender

(in %)

	Amphetamines		Ecstasy*	
	Girls	Boys	Girls	Boys
1993	1.6	3.0	-	-
1999	1.6	3.0	1.8	3.4

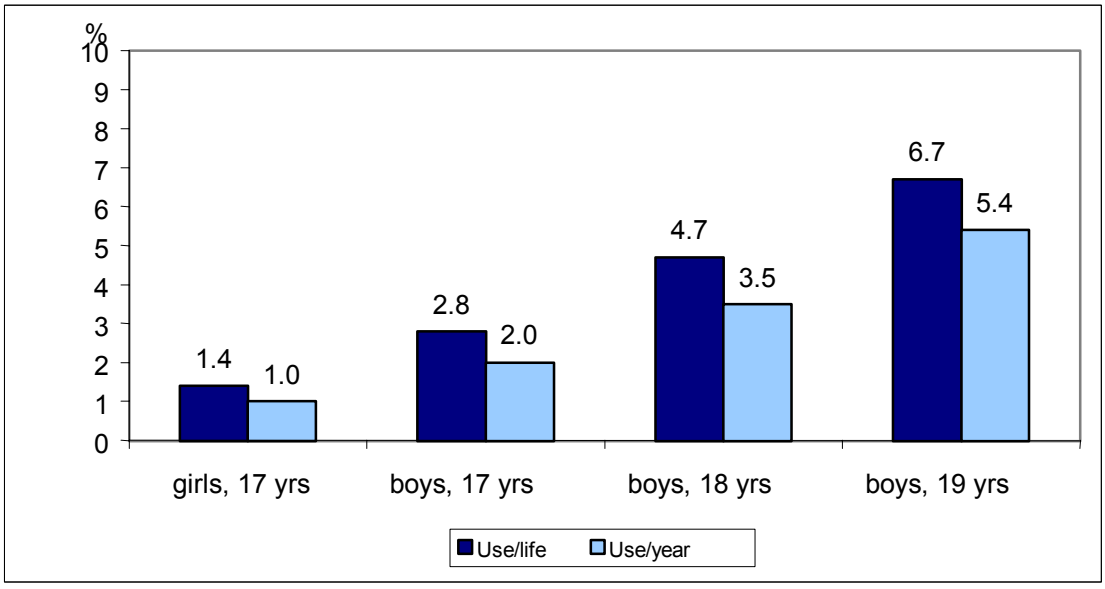
** Question not asked in 1993.*

Sources: INSERM (Institut national de la santé et de la recherche médicale: National Institute for Health and Medical Research) 1993; ESPAD (European School Survey Project on Alcohol and Other Drugs) 1999; INSERM (Institut national de la santé et de la recherche médicale: National Institute for Health and Medical Research)/OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addition)/MENRT (Ministère de l'éducation nationale, de la recherche et de la technologie: Ministry of National Education, Research and Technology)

The increase in ecstasy use has become clear from a survey carried out in 1983, 1991 and 1998 in Parisian secondary schools. They show that 3% of secondary-school pupils had already tried ecstasy in 1998, as opposed to 0.1% in 1991 (De Peretti *et al*., 1999).

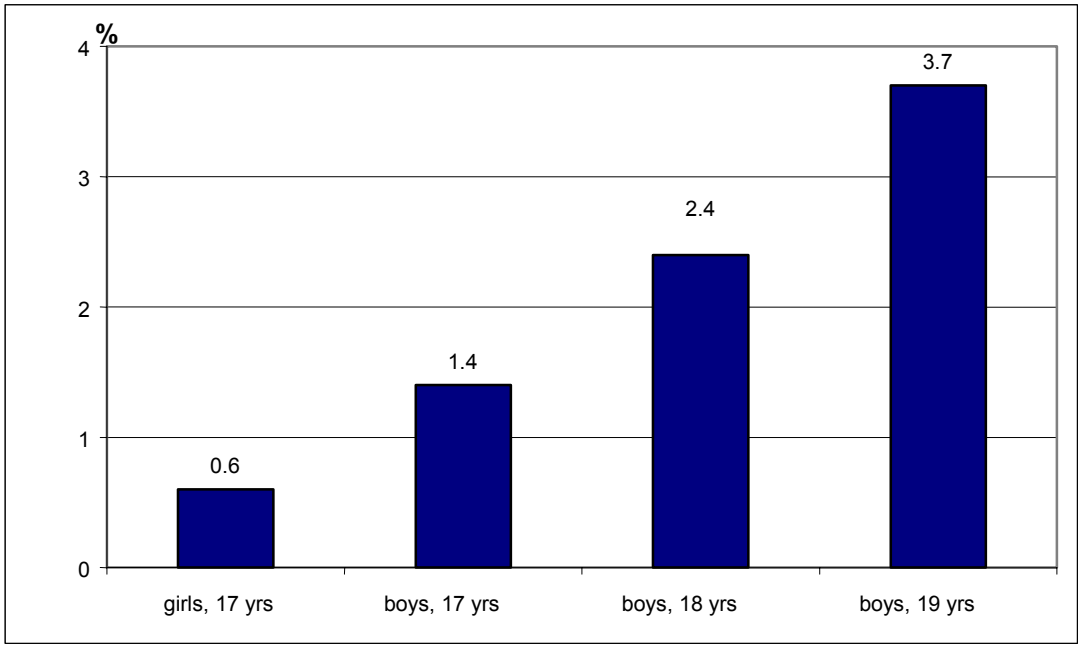
At the end of adolescence, prevalence for the two products is also higher for boys than for girls. It also increases with age for both genders between the ages of 17 and 19 [8]. More than half of adolescents who have taken drugs during the year have only done it once or twice. Those who admit to having consumed ecstasy on more than ten occasions during the year represent less than 15% of those who have experimented with this substance (6% for girls aged 17). This proportion is low in relation to that observed for cannabis, but significantly higher than for the majority of other products.

Frequency of consumption of ecstasy amongst young people at the end of adolescence in 2000, by gender and age *{341b}*



Source: ***ESCAPAD (Enquête santé et consommation au cours de l'appel de préparation à la défense: Health and Consumption Survey During the Call Up for Preparation for Defence) 2000; OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction)***

Frequency of experimentation with amphetamines amongst young people at the end of adolescence in 2000, by gender and age *{341c}*



Source: ESCAPAD (Enquête santé et consommation au cours de l'appel de préparation à la défense: Health and consumption Survey During the Call Up for Preparation for Defence) 2000; OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction)

Young people leaving the school system are more numerous in having experimented with amphetamines or ecstasy compared to others [8]. Amongst school pupils, factors such as age, gender (being a boy), and repeating a school year, are linked to experimentation with both ecstasy and amphetamines. On the other hand, the path followed leads to different outcomes, depending on the product under consideration. Following a professional career is associated with experimentation and consumption of ecstasy in the year—not the case for amphetamines. Furthermore, young people who have taken one of these products are clearly more often frequent consumers of alcohol, cannabis and tobacco than others.

Although experimentation with ecstasy and amphetamines only account for a low proportion of adolescents who have already been to a technological career fair (9.5% have already taken ecstasy and 4.3% have taken amphetamines), among adolescents who have never been, the proportion is much less (less than 1% for the two products). Among educated adolescents, these links clearly relate to gender, age, educational path and controlled repetition of a school year, and become even more pronounced amongst adolescents who have left the Educational System 8.

Observations in the field

This data is the outcome of the TREND (Tendances récentes et nouvelle drogues: Recent Trends and New Drugs) [33] device, which operates on thirteen sites in France as well as at festive *techno* events.

Consumer profiles

Four profiles for ecstasy consumers have been identified, particularly in the technical environment:

- A population essentially composed of young people more or less socially accepted: students, employees, and trainees. This is the dominant profile at authorised dance events that have an admission charge.
- People well accepted socially, although not necessarily young, and who regularly go to discos.

- People who come from disadvantaged socio-economic environments. This section of consumers more often attends events that are not authorised (*free-party* and teknivals).
- People who are social misfits, wanderers, living in groups, and who mainly attend large music festivals, including in recent years, the *teknivals*.

As far as amphetamines are concerned, consumers in the social music environment have the same profile as those for ecstasy.

Methods of use

Ecstasy tablets are generally ingested—'swallowed'. Some people dissolve them in liquid before taking them. Usage via nasal inhalation (powder, crushed tablet) seems to be on the increase. Rare cases of injection have been recorded.

In the environment of socially excluded street users, amphetamines are more often injected or swallowed. On the other hand, within the social music environment, these are mainly snuffed (sniffed) or swallowed. A small minority inject amphetamines, or smoke them.

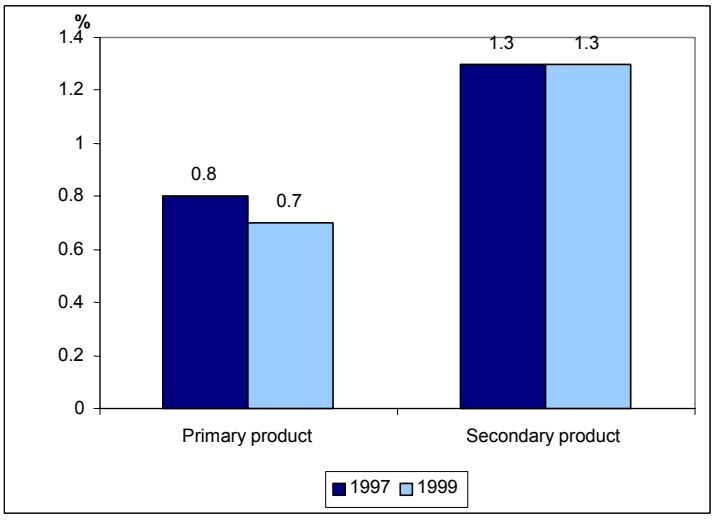
Health and social consequences of ecstasy and amphetamine consumption

Use of ecstasy leads some consumers to resort to the medical social care system. We will first describe the number and characteristics of the persons requiring care in medical social institutions because of their dependence on (or their abuse of) ecstasy and amphetamines. The consequences of ecstasy use, in terms of morbidity, will be broached in the second section. The data presented has been, for most cases, collected from users by the care institutions.

Demands for treatment

As the primary product and secondary product, ecstasy causes a very low number of people to be taken into care. This proportion hardly changed between 1997 and 1999. Nevertheless, the end of the 1990s has been perceived as a dissemination period of this product, even outside the sphere of social music events. Several hypotheses can be put forward to explain the low number incidents linked to this product. Firstly, it is possible that consumption of ecstasy only causes health problems in the short term that require care—in a low number of cases. However, we can also make the case that those users who have problems due to this product, turn to a general practitioner in larger numbers, even if the data currently available does not allow us to confirm this. It has also been considered that those people specifically made calls to the hospital emergency services[1]. In a study carried out on almost a 1,000 patients seen by the three emergency services in Paris, a little over 3% were listed as ecstasy users (Pezous *et al.*, 2001), a proportion similar to that observed for those taken into care.

Percentage of ecstasy users within the total cases of drug users taken into care in 1997 and 1999 *{343a}*



This relates to the total number of calls in the specialist establishments and health care establishments, without double counting, with at least one product cited as the cause for being taken into care (see methodological appendix).
N = 18,075 in 1997 and N = 19,564 in 1999

Source: Survey on cases of drug addicts being taken into care in November 1997 and 1999, DREES (Direction de la recherche, des études, de l'évaluation et des statistiques: Department of research, Evaluation and Statistics)/DGS (Direction générale de la santé: General Health Department)

Amphetamines are cited even less often than ecstasy. In November 1999, the number of cases of people being taken into care when this type of substance was the primary product was 0.4%, and 0.6% when it was the secondary product. The number of people being taken into care because of these products decreased between November 1997 and November 1999. However, as the numbers are very low, this decrease is difficult to interpret.

Characteristics of persons in care

The characteristics of users are only described from the point of being taken into care for using ecstasy as the primary product. The secondary products cited are, in most cases, associated with opiates, because of the appeal and domination of this family of products. The characteristics of users mentioning ecstasy as the secondary product, are, therefore, almost identical to those of opiate users—appearance described in other respects.

In November 1999

People taken into care for ecstasy use demonstrate significant similarities to cannabis users by the much lower average age in the total number of calls (24.3 years old) and a much higher proportion of first calls (64%). The proportion of these users taken to court by care institutions is also worth noting (17%), linked like cannabis, to the age and the significance of the first calls. In effect, prosecutors employ a higher number of mandatory treatment measures among young users who have not been, or could not be questioned.

These cases of custodial care are characterised by an increased proportion with association of other products: a secondary product is mentioned in nearly 80% of cases, with a fairly significant representation of cannabis (27% of cases) and LSD (16%), a product that is, however, rarely cited. Recent consumption patterns suggest that these users are much less centred on their primary product than cannabis users: 52% have consumed ecstasy during the last thirty days, 59% cannabis, 25% opiates, 16% cocaine, or crack. Within this group, therefore, there is much more of a multiple drug culture, than with cannabis users.

As for all products, within these custodial care cases, there is a small minority of opiate users under substitution treatment, and who have already used injections.

People taken into care for use of amphetamines have average characteristics that are different to those of ecstasy users. Their average age is over 30 years old, and among them there is a small proportion of first calls (one person in four). On the other hand, the practice of injection reflects a significant proportion of those being taken into care, and linked to amphetamine usage (44% of cases). As for the custodial care cases linked to cocaine, it is quite common to find opiates as a second product (21% of cases) and substitution treatments (23%).

Profile of those taken into care linked to ecstasy, amphetamines and opiates (as primary product) in 1999

	Ecstasy*	Amphetamines	Opiates
Number of people taken into care (primary product)	140	71	13,613
% of first calls	64	25	29
Average age	24	32	31.5
% less than 25 years old	65	20	13
% of men	86	69	76
% of people taken to court	17	6	6
% of people in employment	42	31	39
% of pupils and students	10	4	2
% of people receiving RMI (revenue minimum d'insertion: minimum benefits paid to those with no other source of income)	10	32	31
% of people with cocaine as secondary product	7	21	18
% of people under substitution treatment	14	23	75
% of people using intravenous routes (currently or previously)	18	44	73
% of people using intravenous routes during the last 30 days	5	11	19

Source: Survey of those drug addicts being taken into care of in November 1999, DREES (Direction de la recherche, des études, de l'évaluation et des statistiques: Department of Research, Evaluation and Statistics)/DGS (Direction générale de la santé: General Health Department)

Evolution 1997-1999

The only perceptible variation during this period relates to the proportion of pupils and students taken into care for use of ecstasy, which drops from 29 to 10%, and correlated to a significant increase in the proportion of users who have a job, steady or intermittent. This change can be ascribed to a general trend encompassing all products, which conveys perhaps the global repercussions of the employment situation, including drug users taken into care. It may also reflect the positive impact of substitution.

As far as the custodial care cases linked to amphetamines, it should be noted that the average age has increased (from 30.4 to 32.4) and the proportion of people using injections during the last thirty days has dropped (from 25.6% to 10.6%)—this last change being common to all products.

Morbidity and mortality

According to reports produced in France at the end of the 1990s on the state of knowledge relating to ecstasy (Roques, 1999, INSERM (Institut national de la santé et de la recherche médicale: National Institute for Health and Medical Research), 1998), consumption of this substance presents a certain risk to human body, even though only a limited number of accidents attributed to this substance have been reported. Two deaths associated with the consumption of ecstasy were registered for the first time in 1999 by the police services. In 2000, only a single case was reported, but the presence of ecstasy has also been detected in three other deaths linked to heroin, cocaine or methadone [29].

Psychiatric disorders (sleep, depressive, and psychotic disorders) resulting from the consumption of ecstasy—generally associated with other products—have also been described in the literature in France and abroad (Roques, 1999). The data necessary to measure the extent of this is not, however, available at this point in time. Several pieces of research also show that ecstasy can cause neuronal degeneration; we do not know whether this can be reversed or not. It may, therefore, be possible that we will see, in the long term, neurodegenerative diseases appear in regular consumers of ecstasy (Roques, 1999).

Criminal consequences of the use of ecstasy and amphetamines

As for any illicit drug, using ecstasy and amphetamines can lead to police interrogation and have legal consequences. Only the instances of police interrogation can be described. Convictions and imprisonment that do not mention the product as a cause cannot be discussed here.

Police interrogation for use in 2000

In 2000, ecstasy was the cause in approximately 1,500 instances of police interrogation for simple use to which can be added close to 500 instances of drug dealing [28]. This data is much higher than that of 1999 during which 915 users of ecstasy were questioned. We also counted 9 instances of police interrogation for simple use of khat in 2000.

Police interrogation for use and drug dealing of ecstasy and amphetamines in 2000

	Ecstasy*		Amphetamines		All products
	number	direct %	number	direct %	mixed
Simple use	1,432	1.8	103	0.1	83,385
Drug dealing	489	4.7	18	0.2	10,954
Total	1,921	2.1	121	0.1	94,339

Source: FNAILS (Fichier national des auteurs d'infractions à la législation sur les stupéfiants: National File of Inciters of Offences Against Legislation on Narcotics) 2000, OCRTIS (Office central pour la répression du trafic illicite de stupéfiants: (Central Office for the Repression of Drug-related Offences)

Instances of police interrogation regarding ecstasy represent 2% of the total. This share, although rising, remains lower than that for cannabis (87%), heroin (6%) or cocaine and crack (3%).

Instances of police interrogation for use of amphetamines are even less numerous (121 in 2000). Essentially these concern cases of simple use (without drug-dealing activity).

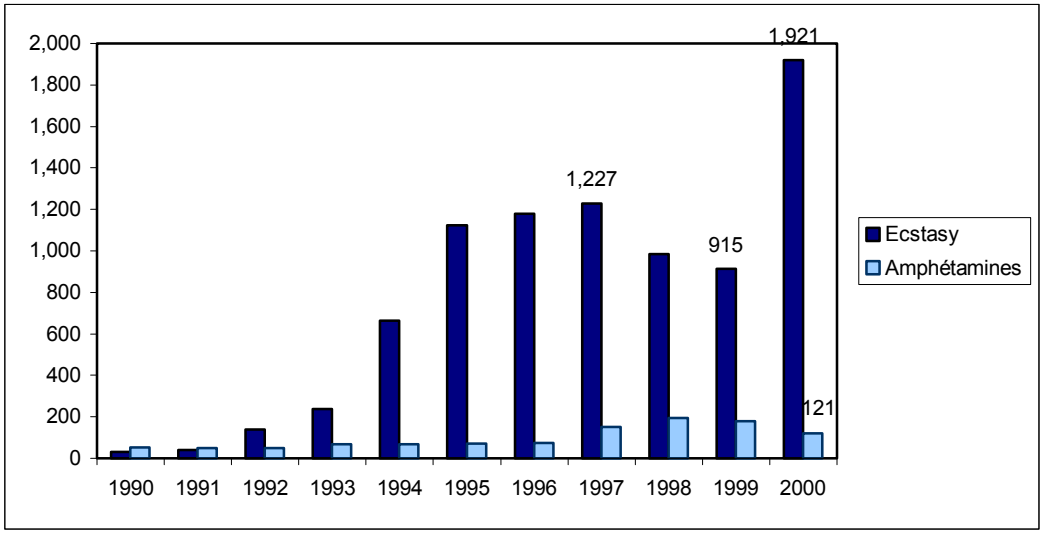
Developments in cases of police interrogation for use since 1990

The increase in cases of police interrogation of ecstasy users in the year 2000 completely disrupts the trend observed over recent years.

The first cases of police interrogation linked to ecstasy use were reported in 1990. The growth has been significant, multiplying by nearly 40 between 1990 and 1997. As for crack, this growth is linked in part to the introduction phase of a new substance into the nomenclature, and to the low numbers at the beginning of the period.

In 1998, the first drop was observed (-20%), which seemed to be confirmed in 1999 (-7%). However, the trend reversed between 1999 and 2000 when it doubled again. This increase can be explained by more intense police activity against *rave parties*, and by a greater awareness of police officers to this phenomenon, as all the police indicators are on the increase (seizures and other instances of police interrogation). The consumption trends do not allow us to explain the annual differences observed between 1997 and 2000. In effect, the use of ecstasy has exploded since 1999.

Police interrogation for use or drug-dealing of ecstasy and amphetamines from 1990 to 2000 *{344a}*



Source: FNAILS (Fichier national des auteurs d'infractions à la législation sur les stupéfiants: National File of Inciters of Offences Against Legislation on Narcotics), OCRTIS (Office central pour la répression du trafic illicite de stupéfiants (Central Office for the Repression of Drug-related Offences)

Data from the national police force concerning the number of checks carried out at rave parties during the year 2000 definitely indicate a rise in the number of evenings brought to the attention of police units between 1999 and 2000. However, this rise (+9% more evenings detected) has nothing to do with instances of police interrogation and, above all, detections were more significant in 1997 and 1998.

Number of rave-party evenings brought to the knowledge of police units, from 1997 to 2000

1997	1998	1999	2000
608	578	487	529

Source: Action by the police force, STRDJ-DRJ (Service technique de recherches judiciares et de documentation – Division recherche judiciare: Technical Department for Judicial Research and Documentation – Judicial Research Division) (March 2001)

This data, therefore, does not allow us to explain the size of the increase in instances of police interrogation in 2000. All the same, we can see a certain number of indicators that show a greater involvement of the police force in this area in the year 2000—the number of offences relating to narcotics (up fourfold) and those linked to usage (up fivefold) being the most significant multiplying factors than for the other types of offences.

However, according to analyses reported by TREND—the observation device for recent trends [33], ecstasy availability clearly increased in traditional drug-dealing places between 1999 and 2000, while it remained unchanged in the "dance area" (*techno* parties) (Bello *et al*, 2001). This finding could explain, in part, the increase in instances of police interrogation—the police and police force are responding to an area more associated with street sales than with trade during a rave or *techno* party.

The instances of police interrogation concerning simple use or drug-dealing of amphetamines does not follow the same trend as that of ecstasy: It was relatively constant until 1997 (between 50 and 70 instances of police interrogation per year), but increased considerably over the last three years, although falling again in the year 2000. It must be said that such fluctuations are, in part, due to the relatively low numbers.

Characteristics of users questioned

Users of ecstasy called in for interrogation are relatively young (23.3 years old on average in 2000), compared to heroin users (28.3 years old) or those of cocaine and crack (29.6 and 31.3 years old). However, they are on average one-and-a-half-years older than users of cannabis.

Their slightly higher average age can be explained by the high concentration of 18-25-year-olds, rather than by the presence of minors (as is the case for cannabis users called in for interrogation). Thus, the 54 minors called in for interrogation in 2000 for using ecstasy represent only 3% of the total of these instances of interrogation, as opposed to a proportion of 15% of minors for cannabis.

The growth in instances of calling in for interrogation in the year 2000 affects all age groups, but the average age has risen slightly, nevertheless (from 22.7 to 23.3 years old), and is again equivalent to that observed each year since 1995.

Ecstasy users called in for interrogation are also more akin to cannabis users in the fact that they belong to the socio-professional class: a little over a third have no declared profession, and about one in five is either a worker or employee, or still a student or secondary-school pupil. The latter class are, nevertheless, less numerous among ecstasy users called in for interrogation, as those of cannabis.

Approximately 87% of ecstasy users called in for interrogation are men, and 95% are French. These proportions are close to those of other users called in for interrogation, and vary little from one year to the next.

With an average age of 24.5 years old in 2000, users called in for interrogation for using amphetamines are older than those for ecstasy. This can be explained mainly by the relative significance of those older than 30. Their socio-professional distribution is, on the other hand, very similar (there are just a few more users who do not have a profession). Foreign users constitute 10%, but this represents a low number of 12 instances of interrogation in the year 2000.

Supply and trafficking of ecstasy and amphetamines

International and national supply of ecstasy and amphetamines is investigated mainly through the seizures reported by international and national services; local supply is described through field observations.

International trafficking and supply routes to France

Although rising on all continents, seizures of ecstasy remain relatively concentrated in Western Europe. Those involving other amphetamine-type stimulants practically tripled in 1999, essentially because of more intense trafficking in Asia.

Quantities of ecstasy and other amphetamines seized on a world scale and in Western Europe, from 1993 to 1999

	1993	1994	1995	1996	1997	1998	1999
Ecstasy (in thousands of tablets)*							
Western Europe	2,572	2,728	2,415	6,990	4,282	5,201	14,891
World	2,608	4,284	2,472	7,414	6,198	7,349	19,959
Amphetamine type stimulants (in kg)							
Western Europe	1,668	2,131	1,619	3,238	4,453	4,793	3,523
World	5,134	4,707	6,541	8,894	11,120	12,436	32,436

** The data is to be treated with caution, as the current status of the questionnaire does not include any specific entry for ecstasy. Certain countries may be aware of these seizures in other columns (amphetamine-type stimulants, for example).*

Sources: UNODCCP (United Nations Office for Drug Control and Crime Prevention)

In Western Europe, seizures of ecstasy have steadily risen and 1999 appeared to be a record year with more than 14 million tablets seized, almost three times more than the previous year. The seizures are particular significant in the United Kingdom, but also in the Netherlands, Germany and Belgium.

INTERPOL considers that the explosion of seizures in Europe is not only linked to the growth in demand found in European countries, but also linked to that of world demand, as Europe is a production site. Thus, in 1999, of the total ecstasy tablets seized in Europe, 1.6 million at least were destined for North America, and 1 million to other areas of the world.

As far as the seizures of amphetamines in Europe are concerned, after several years of growth and a peak in 1998, a global drop was seen in 1999, which assumed variable proportions depending on the country (INTERPOL, 2000). As for ecstasy, the Netherlands appears to be the main source of this type of drug.

In France, since 1990, the quantities of ecstasy seized have often doubled from one year to the next. The explosion of seizures in France dates from 1998, the year during which the police services seized six times more ecstasy than in the previous year, but in approximately the same number of raids. The statistics are the same in 1999, when 74% of seizures where made in two significant raids (from 20,000 to 580,000 tablets).

In 2000, not only have the quantities increased (by approximately 23%), but the number of seizures has also grown, from 649 to 1,409 [28]. All the police indicators for ecstasy are, therefore, on the rise in 2000.

Quantities of ecstasy and amphetamines seized in France, from 1990 to 2000

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Ecstasy (in thousands of tablets)	13	62	14	133	255	274	349	199	1,142	1,860	2,284
Amphetamines (in kg)*	16	20	13	43	80	104	128	194	165	233	230*

**Including 218 kg of methamphetamines.*

Source: FNAILS (Fichier national des auteurs d'infractions à la législation sur les stupéfiants: National File of Inciters of Offences against Legislation on Narcotics), OCRTIS (Office central pour la répression du trafic illicite de stupéfiants (Central Office for the Repression of Drug-related Offences)

As for previous years, ecstasy shipments intercepted in 2000 came essentially from the Netherlands and Belgium. For the first time, significant seizures from Germany have also been identified.

Seizures of amphetamines are also on the increase if they are added to those of methamphetamines, a product reported for the first time in the year 2000. While the origin of these seizures is often unspecified, Great Britain is the source in the majority of cases.

Whatever the supply routes of ecstasy or amphetamine, one of their main characteristics is that they are part of multiproduct shipments. Thus, at the time of the most significant seizure of 1999—584,290 ecstasy tablets—39 kg of cocaine was also found, along with 171 kg of marijuana, and 239 kg of hashish (OCRTIS Office central pour la répression du trafic illicite de stupéfiants: Central Office for the Repression of Drug-related Offences, 2000).

Traffickers questioned by the police in France

To reinforce the picture of the seizures, instances of police interrogation for trafficking of ecstasy practically doubled in the year 2000. Furthermore, 17 amphetamine traffickers were apprehended by the enforcement services in France. Taken together, they represent 5% of the total instances of police interrogation for trafficking.

Instances of police interrogation for trafficking of ecstasy and amphetamines, from 1990 to 2000

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Ecstasy	13	31	27	47	126	276	233	208	199	169	312
Amphetamines	11	7	12	30	18	9	24	15	34	23	17
All products	5,198	5,303	5,982	6,451	7,179	7,107	8,412	6,560	5,541	5,506	6,531

Source: FNAILS (Fichier national des auteurs d'infractions à la législation sur les stupéfiants: National File of Inciters of Offences Against Legislation on Narcotics), OCRTIS (Office central pour la répression du trafic illicite de stupéfiants: Central Office for the Repression of Drug-related Offences)

The proportion of traffickers questioned linked to import and export activities (known as international) has particularly increased in the case of ecstasy and amphetamine (36% and 37%, respectively, as opposed to an average of 19% for all products). This means, perhaps, that the networks of these products, due to the proximity of production and consumption sites, are a lot less hierarchical, and that their roots, therefore, are more easily accessible by enforcement services. But, this could also be a reflection of more mobile trafficking, with products circulating more frequently across borders.

Ecstasy and amphetamine traffickers questioned are mostly French (65% in 2000). Among the foreign traffickers questioned, many countries are represented, but mainly the Netherlands and Great Britain.

Local supply: availability, price and quality

The data presented here is the result of the observation device TREND [33] for availability and price, and of the SINTES (Système d'identification national des toxiques et substances: National Identification System for Toxic and Other Substances) [32] for the constitution of samples collected or seized.

Availability

The availability of ecstasy, and amphetamines in powder form (*speed*), at *techno* dance events has expanded during recent years.

In urban areas, most of the TREND observers indicate that ecstasy and amphetamine distribution in powder form is increasing in traditional sale places, outside of the dance event framework..

In the overseas departments (counties), ecstasy is difficult to get hold of, or rare. Amphetamine powder is reported as being totally absent, or extremely rare.

The small amount of ecstasy trafficking, within the *techno* dance scene takes place between people participating in the event, and small professional traffickers, notably of cannabis and cocaine, who operate both at *techno* parties and in urban centres.

Price

The average price of an ecstasy tablet at *techno* parties varies between F50-150. The current price, more stable over recent years, is close to 100 F.

One gram of amphetamine can be currently bought for around F100, sometimes less. This price has practically halved in recent years.

Quality

During the year 2000, MDMA was the substance most often detected in samples from SINTES (Système d'identification national des toxiques et substances: National Identification System for Toxic and Other Substances). It was found in 67% of run-of-the-mill samples and in 82% of samples in the form of tablets.

Among those samples containing MDMA and having a quantitative dosage (683), the average quantity of MDMA per tablet was 75 mg. Doses ranged from 0.08 mg per tablet to 212 mg. Three-fifths of the tablets had less than 100 mg of MDMA. Eight tablets (1.2%) had a dosage that was higher, or equal to, the lowest lethal dose known (150 mg of MDMA).

Amphetamine was the third most common psychoactive chemical found in the SINTES (Système d'identification national des toxiques et substances: National Identification System for Toxic and Other Substances) during the year 2000, following MDMA and caffeine. The 88 samples were mainly divided between tablet form (n = 44) and powder form (n = 42).

The substances most frequently associated with amphetamine are caffeine (69% of the samples), MDMA (13%), MDA (4%) and MDEA (2%). A quantitative dosage of amphetamine was available for 12 tablets. The dose of amphetamine was 14 mg on average and ranged from a 1 mg minimum, to a 50 mg maximum, that being below the smallest lethal dose known (1.5 mg/kg, or 75 mg for an adult of 50 kg).

Geography showing the consumption of ecstasy and amphetamines

Regional approach

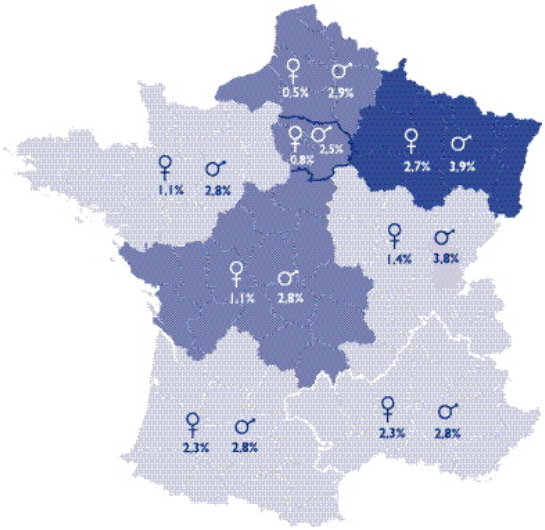
Geographical data for consumption is available from a declarative survey carried out among post-adolescent young people, on the day of call-up for defence preparation [8].

The social health or criminal consequences of using ecstasy and amphetamines in the regions are summarized from custodial-care case data during the month of November [17] and from instances of police interrogation [28].

Consumption during adolescence

The region where experimentation with amphetamines or ecstasy is the strongest is the North East (3.3% as opposed to 2.2% for all the other regions) at 17 years old. The disparity between the remaining regions is very modest—in decreasing order: Central East, Southeast and Southwest (all at 2.6%), the Northwest (2.4%), Central West (1.9%), and finally, North and the Parisian regions (1.7%).

Prevalence of experimentation with amphetamines or ecstasy at the age of 17 in 2000, by region *{348a}*



Controlled interregional comparisons by age and gender

Source: ESCAPAD (European School Survey Project on Alcohol and Other Drugs) 2000, OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction)

Demands for treatment

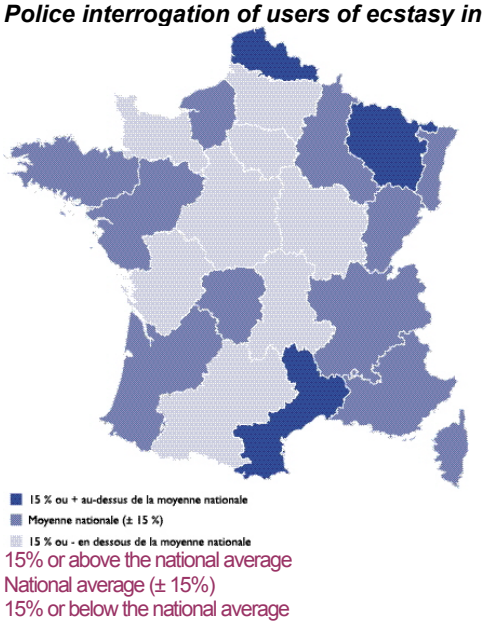
Due to the low numbers, analysis by region is tricky. Nevertheless you can say that in the regions where the numbers of cases of taking into care with all products together are significant (Ile-de-France, North, PACA (Provence-Alpes-Côte d'Azur), Rhône-Alpes, Languedoc-Roussillon, Midi-Pyrenees, Alsace, Lorraine), the share of ecstasy is close to the national average. There are no regions where ecstasy plays a particularly significant role in the instances of taking into care.

Police interrogation

The 1,900 instances of police interrogation for use and drug dealing of ecstasy established in 2000 are concentrated in a small number of regions, which have each registered between 100 and 400 instances of police interrogation. The numbers by department are therefore low.

In relation to the population of the regions and that concerned with usage of ecstasy (between 20 and 39 years old), police interrogations appear to be higher in three regions: North and Loraine, probably because of their location, close to the border with zones with high availability (Belgium, and notably the Netherlands), and Languedoc-Roussillon.

Police interrogation of users of ecstasy in 2000 by region *{348b}*



National average: 1.1 instances of police interrogation per 10,000 inhabitants aged 20 to 39.

Source: FNAILS (Fichier national des auteurs d'infractions à la législation sur les stupéfiants: National File of Inciters of Offences Against Legislation on Narcotics) 2000, OCRTIS (Office central pour la répression du trafic illicite de stupéfiants: Central Office for the Repression of Drug-related Offences)

No clear link can be established between the number of instances of police interrogation of users reported by all the enforcement services, and the number by department of *rave* evenings brought to the knowledge of the police force in the year 2000.

The regional map of police interrogations in 1999 shows a larger number of regions close to the national average. The spread of police interrogations is therefore more significant in 2000 and could be a sign of uniformity in police practices, as well as of spread of consumption in the field.

The police interrogations of amphetamine use and drug dealing are not numerous enough to be represented on a map. The 121 interrogations reported in 2000 are distributed mainly over five regions, which reported between 10 and 30 interrogations each.

European approach

To see the situation in France in relation to its European neighbours, from the point of view of ecstasy or amphetamine consumption and its consequences, the data from the 2000 annual report from the European Observatory for drugs and drug addicts (OEDT, 2000) as well as other information gathered by this organisation was studied.. This data was compiled from the ESPAD survey (European School Survey Project on Alcohol and Other Drugs), carried out among young educated people in thirty European countries (Hibel, *et al*, 2001).

Consumption

Within the general adult population, the most important trends in France are close to those found on a European level by the OEDT (Observatoire européen des drogues et des toxicomanies: European Observatory for Drugs and Drug Addicts):

- Amphetamines and ecstasy rank second place in the illicit products most often consumed in Europe, behind cannabis.
- Within the adult population, France lies in the average of the European countries, where 1 to 4% of individuals have already consumed amphetamines. Figures for ecstasy are very close. However, the United Kingdom clearly presents a higher prevalence, notably for amphetamines (10%).
- For young adults, approximately 1 to 5% of individuals aged between 16 and 34 have tried amphetamines, and the proportion is similar for ecstasy. Again, the United Kingdom seems atypical with 16% for amphetamines, and 8% for ecstasy.
- The figures for the different countries of the European Union indicate that the increase in the consumption of ecstasy observed during the 1990s seems to have stabilised, and, indeed, is showing signs of a decrease. The figure for amphetamines remains stable globally, and is rising in certain countries.
- The consumption of amphetamines or ecstasy is very rarely regular; it is either experimental or sporadic.

Among the school population and the thirty countries included in the survey, the level of experimentation with amphetamines by 16-year-old French pupils is within the average (2%), and that with ecstasy slightly above the average (3% as opposed to 2%) (Hibell, *et al*, 2001).

Demands for treatment

In the EU countries for which data is available on ecstasy, the share of this product in the total of the instances requiring care is, as in France, a little higher. This percentage only exceeds 1 to 1.5% the case of Ireland (3.5%) and Luxembourg. For this product, France is also within the European average.

Police interrogation

Unlike cannabis or heroin, ecstasy does not appear the primary product causing police interrogations linked to drugs[1] in Europe. In most of the countries for which information is available, ecstasy represents less than 5% of instances of police interrogation for use or possession of narcotics in 1999. With 1%, France is, therefore, at the same level as Italy or Luxembourg. The United Kingdom and Germany account for 3% of

[1] The term "police interrogation linked to drugs" refers to very different definitions, depending on the country. Information on the grounds for interrogation and the product is not always given.

cases for use/possession of ecstasy, and Austria 5%. Thus, with 13% of instances of interrogations for use/possession of ecstasy, Ireland clearly stands out from the other European countries.

With regard to amphetamines, the situation is even more accentuated: France, in the same way as Italy or Luxembourg, hardly registers any interrogations for use/possession of amphetamines, whilst the share is 10% in the United Kingdom, and 6% in Ireland and Germany. Belgium also registers numerous interrogations linked to amphetamines, with a share of 16%, all offences together.

For further information

■ Ecstasy: biological and clinical data in the context of usage, Paris, INSERM (Institut national de la santé et de la recherche médicale: National Institute for Health and Medical Research), 1998, p. 345 (Coll. Collective expertise).

■ Baudier (F.), Arènes (J.) (dir.), Health Barometer for adults 95/96, Vanves, CFES (Comité français d'éducation pour la santé: French Centre for Health Education), 1997, p. 288.

■ Beck (F.), Peretti-Watel (P.), EROPP (Enquête sur les représentatives, opinions et perceptions relatives aux psychotropes: Survey on Representatives, Opinions and Perceptions Relating to Psychotropic Drugs) 99: survey on the representations, opinions and perceptions relating to psychotropic drugs, Paris, OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction), 2000, p. 203.

■ Beck (F.), Legleye (S.), Peretti-Watel (P.), Views on the end of adolescence: consumption of psychoactive products in the survey ESCAPAD (Enquête santé et consommation au cours de l'appel de préparation à la défense: Health and Consumption Survey During the Call-up for Preparation for Defence) 2000, Paris, OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction), 2000, p. 220.

■ Beck (F.), Legleye (S.), Peretti-Watel (P.), 'Illicit drugs: practices and attitudes', in Guilbert (P.), Baudier (F.), Gautier (A.) (Dir.), Health Barometer 2000, Vanves, CFES (Comité français d'éducation pour la santé: French Centre for Health Education), 2001, (to be published).

■ Beck (F.), Legleye (S.), Peretti-Watel (P.), Alcohol, tobacco, cannabis and other illicit drugs amongst secondary school pupils: ESPAD (European School Survey Project on Alcohol and other Drugs) 1999 France, volume II, Paris, OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction), 2001, (to be published).

■ Bello (P.Y.), Toufik (A.), Gandilhon (M.), Recent trends, TREND report, Paris, OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction), 2001, p. 167.

■ Choquet (M.), Ledoux (S.), Adolescents, national survey, Paris, INSERM (Institut national de la santé et de la recherche médicale: National Institute for Health and Medical Research), 1994, p. 346.

■ Choquet (M.), Ledoux (S.), Hassler (C.), Alcohol, tobacco, cannabis and other illicit drugs amongst secondary school pupils: ESPAD (European School Survey Project on Alcohol and other Drugs) 1999 France, volume I, Paris, OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction), 2001, (to be published).

■ De Peretti (C.), Leselbaum (N.), Parisian pupils and psychoactive substances: evolutions, Paris, OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction) / INRP (Institut national de recherche pédagogique: National educational research institution)-Paris X, 1999, p. 170.

■ Hibell (B.), Andersson (B.), Ahlstrom (S.), Balakireva (O.), Bjarnasson (T.), Kokkevi (A.), Morgan (M.), The 1999 ESPAD (European School Survey Project on Alcohol and other Drugs) report: Alcohol and Other Drug Use Among Students in 30 European Countries, Stockholm, CAN, 2000, p. 362.

■ INTERPOL (Organisation internationale de police criminelle: International police and crime organisation), Report on the situation of narcotics in Europe in 1999, Lyon, INTERPOL (Organisation internationale de police criminelle: International police and crime organisation), 2000, p. 65.

■ Laure (P.), Richard (D.), Senon (J.L.), Pirot (S.), 'Psychostimulants and amphetamines', Documentary review Toxibase, no. 2, 1999, p. 1-28.

■ Louboutin-Croc (J.P.), Arvers (P.), Eono (P.), Portron (J.M.), Samson (E.), Dubin (F.), Brodin (C.), De Cacqueray (L.), Rey (J.L.), Abgrall (J.), 'Epidemiological follow-up surveys on "drug-related behaviour" in the centres of selection in 1995 and 1996', Documentary review Toxibase, no. 4, 1997, p. 61-70.

■ OCRTIS (Office central pour la répression du trafic illicite des stupéfiants: Central Office for the Repression of Drug-related Offences), Use and trafficking of narcotics. Statistics 1999, Paris Ministry of the Interior, 2000, p. 109.

■ OCRTIS (Office central pour la répression du trafic illicite de stupéfiants (Central Office for the Repression of Drug-related Offences), Use and trafficking of narcotic products in France in 2000, Paris, Ministry of the Interior, 2001, p. 114.

■ OEDT (Observatoire européen des drogues et des toxicomanies: European Observatory of Drugs and Drug Addiction), Annual report 2000 on the status of the phenomenon of drugs in the European Union, Luxembourg, Office of official publications of the European Communities, 2000, p. 50.

■ Pezous (A.M.), Ferrand (I.), Nuss (P.), Emergencies as observatory of the acute complications of the new methods of usage and new drugs, Paris, OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction), 2001, (to be published).

■ Roques (B.), The dangerousness of drugs: report to the secretary of state for health, Paris, Odile Jacob/French documentation, 1999, p. 318.

■ STRJD-DRJ (Service technique de recherches judiciaires et de documentation-Division recherche judiciaire: Technical Department for Judicial Research and Documentation – Judicial Research Division), 'Rave' evenings. 2001 figures, Rosny-sous-Bois, Head office of the national police force, 2001, p. 17 (internal report).

■ Sueur (C.), Rave Mission, World Medicine, Research report – action: use of synthetic drugs (ecstasy, LSD, dance pills, amphetamines....). Reduction of risks in the techno environment, Paris, MDM (Médecins du Monde: Doctors of the world), 1999, p. 475.

■ Tellier (S.), Taking drug addicts into care in the health and social structures in November 1999, Paris, DREES (Direction de la recherche, des études, de l'évaluation et des statistiques: Department of Research, Evaluation and Statistics), 2001, p. 47. (Working document no. 19).

■ UNODCCP (Office des Nations unies pour le contrôle des drogues et la prévention du crime: United Nations Office for Drug Control and Crime Prevention), World trends for illicit drugs 2001, New York, United Nations, 2001, p. 282.

Heroin and other opiates

Reference points

Consumption

- Experimentation and current use of heroin and other opiates remains rare in both the adult and adolescent populations. This is still truer of current use.

- Among adults aged 18-44, 0.4% of women and 1.7% of men have experimented with heroin. Among young people still in education, 0.8% of girls and 1.4% of boys in the 14-18 age group report having already taken heroin at some point in their lives.

- For all ages, heroin use is more common among males than among females.

- Occasional consumption of heroin fits into a context of consumption of other legal and illegal drugs, chiefly alcohol, tobacco and cannabis. This is especially the case on the dance scene where heroin has recently been associated with stimulants and hallucinogenic substances.

- Problematic consumption of heroin is even more limited despite being more visible in social terms (it is estimated that there are 150,000 to 180,000 'problem' users of opiates or cocaine, mostly opiate users).

Health and social consequences

- The large majority (70%) of registrations for care for the use of illegal drugs are connected with abuse of or dependence on opiates. Between 1997 and 1999, the number of registrations for care in connection with opiates remained more or less stable while their share in the total of registrations fell, principally because of the rise in registrations in connection with cannabis and cocaine.
- The population of opiate users registered for care continues to grow older. Its average age increases by roughly one year every two years: in November 1999, the average age was 31 with only a small minority (13%) under 25. These users were mainly men (3 out of 4), most of whom were not in paid employment (more than 60%) although the proportion in paid employment has increased in recent years. The majority of these people (more than 70%) had already been in contact with care facilities in connection with their use of opiates.
- A secondary substance was recorded in 57% of registrations for opiate use, with cocaine the most commonly cited substance (18% of cases), followed by cannabis, alcohol and medicines (7 to 10% of cases each).

- The great majority of opiate users registered for care have already used intravenous injection (73%). The use of this method of administration is, nevertheless, in decline.

- The establishment of substitution treatments and the rapid rise in their use in the mid-90s have profoundly altered the care afforded to opiate users. Many of them now follow substitution treatments. At the beginning of 2001, it was estimated that 84,000 opiate users were undergoing substitution treatment, buprenorphine (74,000) being more frequently prescribed than methadone (11,000).

- In connection with the development of substitution treatment and risk reduction policies, the number of overdoses attributable to heroin has been declining sharply since 1994. Heroin remains, nonetheless, the product most frequently implicated in deaths by overdose (70 out of 119 in 2000).

- The reported prevalence of HIV infection is falling sharply amongst opiate users who have recently or previously practised injection (15% in 1999). The number of deaths due to AIDS amongst drug users is continuing the downward shift started in 1994, thanks to the prolongation of life-expectancy afforded by the new antiviral treatments (1,037 in 1994, 180 in 2000).
- The reported prevalence of HCV, on the other hand, is rising (65% in 1999).

Criminal consequences

- Heroin is the second most frequently involved substance in arrests for use or use with dealing of narcotics (5,800 cases in 2000), far behind cannabis (82,300 arrests) and ahead of cocaine (some 3,200 arrests).

- Since 1996, arrests of heroin users have fallen continuously in number. As a proportion of all arrests, they have also fallen (6.2% of arrests in 2000). The most recent data seems to suggest that the trend is now levelling out to a stable number of arrests.

Supply and trafficking

- In the course of the 1990s, the quantities of heroin seized fluctuated considerably. Having fallen noticeably for three successive years since 1996, a sharp rise occurred in 2000 (440kg). The number of arrests for heroin trafficking has followed the same pattern, but the rise in 2000 was less marked (1,200 arrests).

- Heroin is currently less accessible in urban areas than it has been in recent years. An inverse trend is observed on the dance scene. Both the purity and the price levels of heroin seem currently to be falling slightly.

Consumption of heroin by the French population

The consumption of opiates in the French population is determined using the results of declarative surveys from representative samples of the teenage or adult populations. The trends that emerge from these surveys are corroborated by data from the field, on the profile of users and their methods of use.

As use of heroin is very rare, both in the adult and the adolescent population, only experimentation with it will be considered in this report. Use of other opiates, since it is even more rare, will not be covered here.

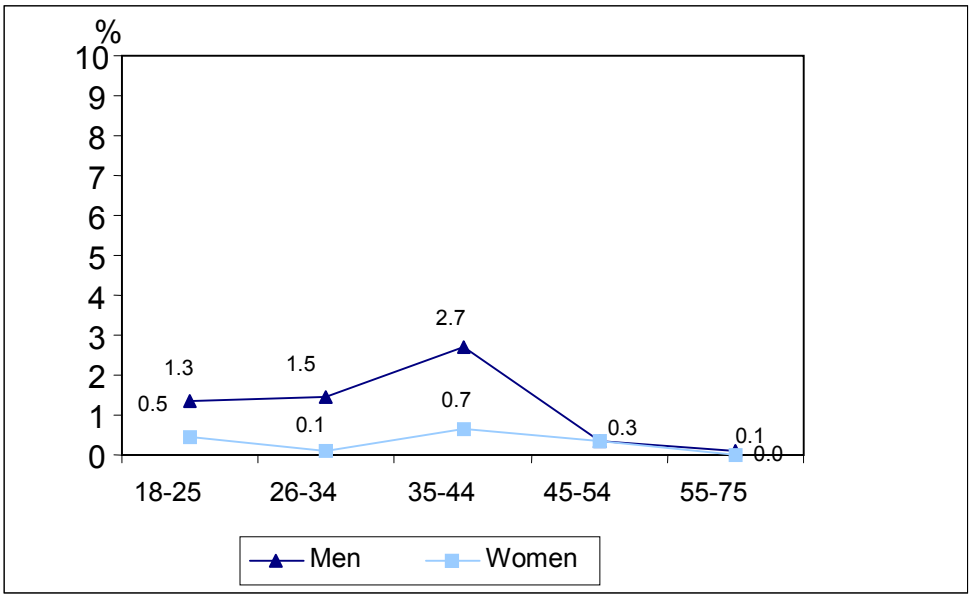
Experimentation by the general adult population

In the general adult population, experimentation is extremely rare and mainly involves men whose age is somewhere around thirty. At all ages, consumers are predominantly male.

In recent years, the number of users has tended to level off, or even to fall. Amongst the 18-44 age group, between 1995 and 1999, use of heroin at some point went from 0.3 to 0.4% for women and from 0.9% to 1.7% for men. However, the apparent rise in use among the men is only due to the larger proportion of previous users. This data is corroborated by observations in the field, which show a certain loss of interest in heroin over the 1990s, even though new forms of use are sometimes noted among young people (in particular, smoking heroin).

After the age of 44, the level of experimentation with this substance is extremely low.

Frequency of experimentation with heroin in the general adult population in 2000, by sex and age *{371a}*



Source: Health Barometer 2000, CFES, Annual Report OFDT

Among adults, experimentation with heroin is observed in all social groups [3]. The number of those who experiment is not large enough to allow construction of an accurate socio-demographic profile. Nevertheless, certain characteristics can be observed: there is a significantly higher proportion of experimenters among the unemployed (2.3% as against 0.6%). Educational qualifications, socio-professional category and household income do not throw up any differences relating to experimentation. On the other hand, there are more experimenters among people who present symptoms of possible alcohol or tobacco dependence. These connections remain present when age and sex are taken into account.

Experimentation by adolescents

Amongst young people still in education, 0.8% of girls and 1.4% of boys aged 14-18 reported having already taken heroin at some point in their lives [7]. Experimentation with this substance has been stable since 1993, having reached 0.5% among girls and 1.1% among boys [5] at that time, with only minor changes since for either sex.

This levelling off at a very low level of consumption is also visible in the results of a survey conducted in 1983, 1991 and 1998 among Paris high-school students. The survey shows that 0.2% of the students had already tried heroin in 1998, as against 0.4% in 1991 and 1.0% in 1983 (De Peretti et al., 1999).

At 17, incidences of experimentation are also a little higher among boys (0.9%) than among girls (0.4%), and rise with age between 17 and 19, whilst still remaining very low [8].

It is difficult to construct a reliable profile of experimenters with heroin at the end of adolescence, as a result of their low number. Only a few points may be observed: young people who are no longer in education represent a larger number of those who have experimented with heroin than others. Among school pupils, only the factors of repeating a grade and of sex (being a boy) are connected with experimentation; the subject combinations taken (standard or vocational) has no influence. Moreover, young people who have already taken heroin are much more commonly also repeated users of alcohol, cannabis and tobacco.

Experimentation with heroin only involves a small proportion of young people who have attended a rave (2.0%), but it is still about four times more common than among young people who have never attended this type of event (0.5%). Thus, among young people still in education, when sex, age, subject combinations taken (vocational or not) and repeating a grade are taken into account, those who have attended such an event are three times more likely to have experimented with heroin.

Observations in the field

This data comes from the TREND system [33] operating on thirteen sites in France as well as at techno rave-type events.

Consumer profiles

In metropolitan France, the large-scale growth in prescription of substitution treatments has led to a profound transformation of the landscape of opiate use. Currently, four opiate-user profiles may be distinguished:

- those for whom the primary substance is still heroin and who receive substitution treatment when heroin is unavailable or in short supply;
- those who receive substitution treatments consistently and whose use of heroin itself is occasional, recreational and more or less under control;
- highly marginalized multiple users of opiate medications (Subutex®, Moscontin®, Skenan®, Néo-Codion®) and benzodiazepines;
- and lastly those who have changed to using cocaine/crack and for whom opiates are no longer the primary substance but the substance used to regulate these stimulants.

It should be noted, also, that small-scale use of heroin and Subutex® is observed among young people on the techno dance scene.

In French overseas departments, heroin is not widely used by the local population, but is instead used by those who are native to the cities or who have lived there for several years.

Methods of use

Although intravenous injection of heroin remains the dominant method in the TREND system sites, it is becoming increasingly common for heroin to be administered via the nasal passage and lungs. On the other

hand, on the techno dance scene, snorting or smoking heroin are the dominant practices and injecting, although a minority method, is slowly increasing.

Buprenorphine (Subutex®) and morphine sulphate (Skenan®, Moscontin®) are taken intravenously by a significant proportion of users. The users in question are essentially injectors or former injectors of heroin and they seem to be older than the non-injectors. The youngest users prefer to take heroin via the nasal passage, considering this to be less risky and less stigmatised.

On the techno scene, the opium derivative, rachacha, is most often smoked or ingested, or even taken as a drink in the form of an infusion. There are anecdotal reports of cases of this substance being injected.

Health and social consequences of the use of heroin and other opiates

The use of opiates leads a proportion of users to register with the socio-medical care system. Here we will first describe the number and the characteristics of those registered with social and medical institutions and with local clinics as a result of their dependence on (or their abuse of) opiates. Consequences of use of these substances in terms of morbidity and mortality will be covered in a later section.

Demands for treatment

The data presented, in the majority, was collected from users by the registering institutions. The data relating to registrations with local doctors come from surveys of a sample group of GPs.

Registrations with drug care organizations (CSST and health institutions)

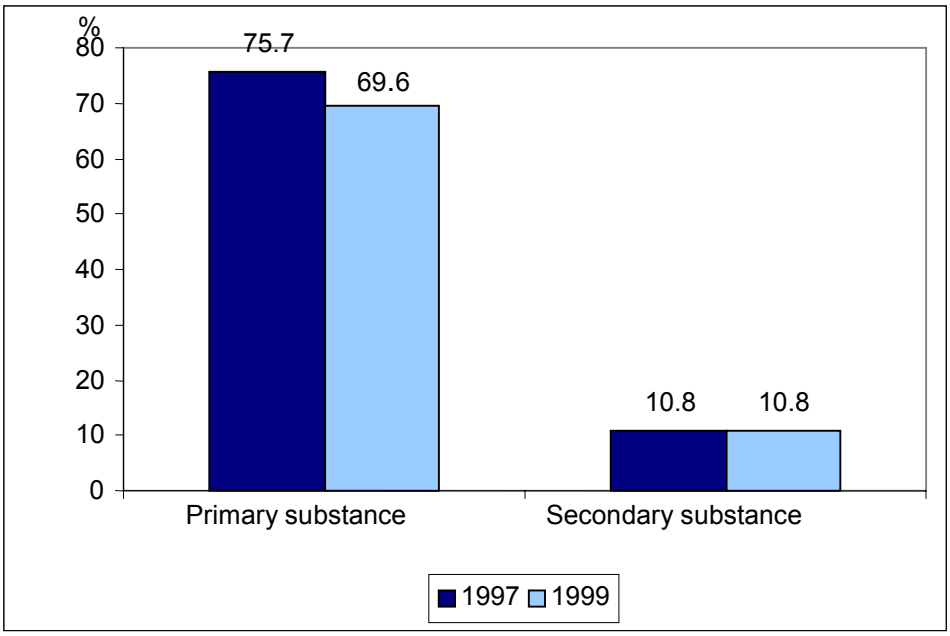
In France, the great majority of registrations with drug care organizations for the use of illegal drugs are connected with abuse of or dependence on opiates. Between 1997 and 1999, the number of registrations for care in connection with opiates remained more or less stable (-3%) while their share in the total of registrations fell, principally because of the rise in registrations in connection with cannabis and cocaine. In November 1999, there were about 13,600 registrations connected with opiates as primary substance [17].

Within the opiates category, development is differentiated according to the substances concerned. Three subcategories have been distinguished: heroin, which remains largely in the majority as the substance for which registrations are made, with 85% of the total opiate-related registrations in November 1999; non-prescription buprenorphine, which represents 6% of these registrations; and other opiates (codeine, non-prescription methadone, morphine, opium), recorded in 9% of these registrations. Registrations connected with heroin are falling (-8%) while those connected with buprenorphine (non-prescription) are rising markedly. It should be emphasized that in relation to the estimated number of people undergoing substitution treatment using buprenorphine (see below), registrations connected with the transferred use of this drug remain very small in number. about 800 cases in November 1999, or a little more than 1% of the estimated number of people undergoing treatment with buprenorphine at this time. Registrations connected with other opiates (codeine, non-prescription methadone, morphine, opium) are gradually rising in number.

Developments are also differentiated according to the registration organizations concerned. Registrations connected with opiates are continuing to rise in specialist institutions, while they are tending to decrease in health centres, but not very dramatically, if account is taken of variations in the number of organizations that responded to the survey.

In a survey carried out among the three emergency services in Paris (Pezous et al., 2001), just over three out of four users of illegal drugs presented a problem connected with the use of opiates, a proportion that is comparable to the figure from the survey cited above. It is possible, however, that these users are over-represented, because the acute complications that they sometimes present cause them to come into contact with these services more often than other users.

Proportion of opiates in total registrations of drug users in 1997 and 1999 *{373a}*

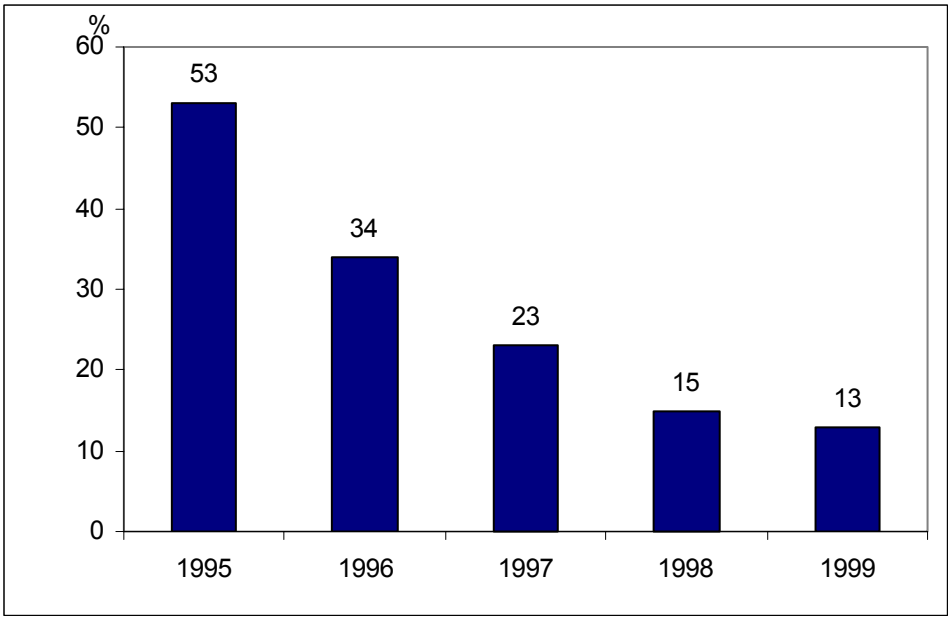


Total registrations of drug users in specialised centres and health centres, with no cases counted twice, with at least one substance leading to registration for care (see methodology annexe)
N = 18,075 in 1997 and N = 19,564 in 1999.

Source: Survey on registration for care of drug addicts in November 1997 and 1999, DREES/DGS

Although the opiates remain greatly in the majority of those substances giving rise to registration, current and recent heroin use does not involve more than a minority of users in contact with the health system. Within a sample group of users registered with different care organizations in October 1999, only 13% had used heroin within the last seven days [18], a proportion that has fallen markedly in relation to 1995 (53% of cases). The figures from the survey conducted in November on substances used within the last thirty days are comparable (about 16% of registrations with at least one substance giving rise to the registration cited) and are following a similar trend. This fall in the use of heroin is very largely related to the growth in substitution treatments. Many users undergoing substitution treatment have been registered as a result of their use of heroin, but have not used it within the recent period.

Percentage of heroin users among drug users registered with organisations from 1995 to 1999 *{373a}*



Source: OPPIDUM, CEIP

Registrations with local doctors

- Number of patients using heroin

According to a survey carried out at the beginning of 2001 amongst a representative sample of general practitioners [20], almost 60% had agreed to treat at least one opiate dependent person during the previous year and 38% had done so during the previous month (Coulomb *et al.*). 2001). The average number of opiate users seen each month in a local surgery was 1.9. Extrapolating this figure to all active general practitioners, we obtain 100,000 as the approximate number of opiate users seen each month by GPs in urban surgeries at the beginning of 2001. We are only concerned with an order of magnitude, subject to significant margins of error connected with estimates of the number of patients seen by doctors who refused to contribute to the survey, with the size of the sample and with retrospective collection of data by telephone (memory distortion). Furthermore, if, for each GP, the patient population is different, a single patient could have visited several doctors in the course of the month and thus have been counted several times.

Doctors who have seen at least one heroin user during the previous twelve months very often prescribed substitution treatments, 79% of them with buprenorphine (Subutex®), 18 % with methadone[1] [20].

- Characteristics of doctors registering heroin users for care

The doctors who never see an opiate user are more likely than others to be practising in towns of less than 20,000 inhabitants (true for 70 % of them). 90% of them consider themselves badly trained or untrained in caring for drug users and quote lack of demand as the main reason for treating none. Conversely, the majority of doctors who see more than ten users per year are working in towns with more than 20,000 inhabitants and mostly consider that they have been trained. Doctors who are part of a network, 10% of the sample, see a much greater number of heroin users than the others [20]. The data from the Baromètre Santé General Practice give similar indications.

- Trends in the numbers of heroin using patients registered for care with general practitioners.

The survey whose results are quoted above was also carried out in 1995 and 1998 enabling comparisons to be made. Since 1995, the percentage of doctors who had seen at least one dependent heroin user during the

[1] These last two figures are not additive: a single practitioner may prescribe buprenorphine to some of his patients and methadone to others.

previous year had not changed. On the other hand, the percentage who had seen ten users or more during the previous year increased markedly between 1995 and 1998 but remained stable between 1998 and 1999. The average number of heroin users seen over the year by the doctors who agreed to respond to the survey went from four in 1995 to seven in 1998, then to nine in 2001, with this last change (from 7 to 9) not being statistically significant. The changes between 1995 and 2001 reflect the rise in registrations for care of heroin users in general practice, undoubtedly followed by stabilization in recent years.

Between 1998 and 2001, the proportion of GPs who had seen at least one heroin user and prescribed buprenorphine only increased slightly (from 76% to 79%). On the other hand, the percentage of doctors who had prescribed methadone tripled from 6% to 18 % [20]. The following section takes a closer look at the estimate of the number of patients undergoing substitution treatment.

Number of opiate users undergoing substitution treatment

Registration of opiate users has been profoundly altered by the increased availability of substitution treatments in drug care centres and general practices. The legal and regulatory framework for prescriptions for these treatments is covered in greater detail in the last part of this report, concerning mechanisms.

- Estimates from surveys of care organizations and general practitioners.

Within the institutional care system (specialist centres and health centres), substitution treatment is reported in three-quarters of registrations for opiate use. In absolute terms, these treatments involved 12,000 people in November 1999, including 4,500 for methadone and nearly 7,000 for buprenorphine.

There is currently no national survey of patients registered for care with general practitioners. The survey conducted at the start of 2001 of a representative sample group of doctors does provide us with some information, however. Doctors who have seen at least 1 opiate dependent patient during the previous twelve months reported monitoring 10 patients on average undergoing treatment with buprenorphine during the year, and 4 during the month. For methadone, the average number of patients was 1.2 over the year and 0.7 over the month.

Extrapolating for all doctors gives an order of magnitude of 70,000 to 75,000 patients per month at the end of 2000, data that fits the sales figures for Subutex® (see below). The same calculation applied to methadone, on the other hand, gives a much higher estimate of the number of patients than that calculated using the sales figures. Given the size of the sample and the relatively small number of doctors prescribing methadone, extrapolating for all doctors is undoubtedly more questionable.

- Estimate using sales of substitution treatment substances

The estimates based on declarative data may be compared with those produced, with certain assumptions, from dispensing pharmacy sales and from quantities of methadone supplied to the CSSTs.

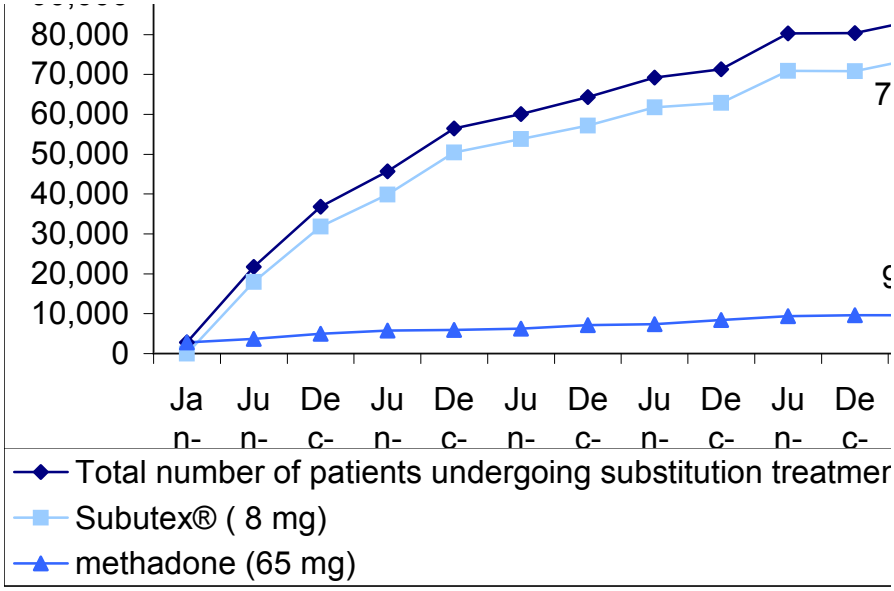
Based on the assumption of a prescribed average dose of buprenorphine (Subutex®) of 8mg per day, monthly sales at the end of the first quarter of 2001 correspond to about 74,000 patients who have taken their treatment every day for a month. For methadone, based on the assumption of a prescribed average dose of 65mg per day, this estimate is about 5,300 patient-months treated by general practitioners in the same period. The estimated number of patients calculated using the quantities of methadone supplied to specialist centres for drug user care, which is about 5,000, must be added to this figure. The total obtained is about 10,000 patients per month undergoing substitution treatment with methadone. Depending on the assumptions used, the total number of patients undergoing substitution treatment could therefore be estimated at about 84,000 in March 2001.

The assumptions of average prescribed doses were generally corroborated by surveys on substitution treatments, generally undertaken locally in 1997 and 1998. In some more recent surveys focusing on prescriptions presented for reimbursement, the average prescribed stated doses are closer to 10mg (Ronflé *et al.*, 2001). Conversely, however, a survey such as that undertaken in the context of a general practice network

in Charente-Maritime (Sorbe, 2000) showed a fall in average stated doses to 7mg in 1999. It is difficult to obtain an accurate idea from this compartmentalized data, but the possibility of an increase or decrease in the average stated dose cannot be ruled out completely. The estimate of the number of patients would then be changed.

The assumption of strict observation of prescriptions by all patients also requires comment. Studies carried out by social security bodies at local level all show up the existence of a small minority of users (not more than 5 to 6%) who obtain prescriptions for buprenorphine from more than two doctors, which may be explained by patients considering their dosage insufficient, but also by dealing for transferred use. Given that this phenomenon is a minority practice, taking it into account does not significantly affect overall estimates. The number of patients who use buprenorphine according to the prescriptions of their doctors is probably slightly lower than the figures cited. The corresponding quantities of buprenorphine might be used partly by people undergoing treatment but on low doses and partly by a limited number of occasional users.

Estimate of number of patients undergoing substitution treatment (with constant average stated dose), from 1996 to 2001 *{373c}*



Source: SIAMOIS, InVS; DGS/SD6B

- Change in sales of substitution treatment substances

Since the entry onto the market of high-dose buprenorphine (Subutex®) at the start of 1996, sales of this drug have increased very rapidly while sales of methadone, in comparison, have developed very slowly, both in CSSTs and at general practices. This frequently clearly stated difference (OFDT, 1999; Emmanuelli, 2000) is connected with the regulatory framework that only allows methadone treatment to be initiated in CSSTs, with follow-up, after stabilization, at general practices. The development of methadone treatment is therefore limited by supply (existence of local CSST, medical personnel available for registration) and by more restrictive prescriptions that may discourage certain users. It will also be noted that follow-up in general practice is gradually expanded even though it always represents only a very small proportion of buprenorphine treatments: at the start of 2001, quantities of methadone prescribed in general practice (corresponding to about 4,500 patients over the month) were similar to those prescribed in CSSTs (about 5,500 patients over the month).

After the phase of increasing use in 1996 and 1997, the increase in methadone and buprenorphine sales continued to be sustained in 1998 and 1999. In the first half of 2000, the increase in buprenorphine sales reached 15%; after dipping in the second half of 2000, it seemed to rise again in the first half of 2001. However, as has been mentioned above, it may be that the increase in the number of patients undergoing

substitution treatment with buprenorphine illustrated by the graph on page 163, is overestimated partly due to use of the assumption of an average dose of 8mg. Monitoring of dosages at national level would be necessary to improve knowledge of the changes in the number of patients undergoing treatment.

Characteristics of persons in care for opiate use

In drug care organizations (CSST and health institutions)

As for all substances covered in this report, the characteristics of the users are determined from the registrations for primary substance. The users citing opiates as secondary substance do not differ from users of opiates as primary substance.

Taking account of the preponderance of opiates among registrations, the characteristics described here are those of the great majority of persons attending those health and social institutions that receive drug users.

- Age, sex, activity

Users of opiates registered in November 1999 had an average age of 31 with only a small minority (13%) under 25. The majority of these people (more than 70%) had already been in contact with care facilities in connection with their use of drugs. The proportion of three men to one women in these registrations remains constant from year to year, which makes opiates (as with medicines) one of the two families of substances for which men are greatest in number. The majority of users of opiates, like other drug users, have no paid occupation (more than 60%) and only 20% have a stable paid job.

- Associated substances, method of use

A secondary substance was recorded in about 57% of these registrations, with cocaine the most commonly cited substance (18% of cases in which opiates were primary substance), followed by other opiates (other than those cited as primary substance), cannabis, alcohol and medicines (7 to 10% of cases each). Among persons registered for opiate use, who had used a substance over the preceding thirty days (58% of cases), 36% took heroin, 16% Subutex® and 9% other opiates. Cocaine use is cited in nearly 17% of cases.

The great majority of opiate users registered for care have already used intravenous injection. According to the data from the survey conducted in November 1999, three in four have used or are using this method and just under one in five has injected the drug during the preceding thirty days. Recent injecting is more common in cases where opiate use during the preceding month is sited: the proportion reaches 44% for those who have taken heroin or non-prescription buprenorphine and exceeds 50% when cocaine is also associated. It should be noted, however, that among those who have recently used heroin, the most widespread method of use in 1999 is via nasal passage (about 60% of cases in the OPPIDUM survey).

Profile of registrations connected with opiates (as primary substance) in 1999.

	Opiates
Number of registrations (primary substance)	13 613
% first registrations	29
Average age	31,5
% under 25	13
‰	
% men	76
% referred by legal system	6
% employed	39
% pupils and students	2
% receiving RMI (minimum income allowance)	31
% persons with cocaine as secondary substance	18
% persons undergoing substitution treatment	75
% persons taking by intravenous injection (currently or previously)	73
% persons taking by intravenous injection over preceding 30 days	19

Source: Survey on registration for care of drug addicts in November 1999, DREES/DGS

- Users undergoing substitution treatments

In three out of four cases, persons registered for use of opiates in 1999 are undergoing substitution treatment, with buprenorphine being more frequently prescribed than methadone (57% as against 40% respectively). Users undergoing treatment are distinguished from other registered opiate users by being one year older on average (31.8 as against 30.7), by a higher percentage of persons in paid occupations (40% as against 30%) and by a smaller proportion of recent injections (17% as against 21%). Amongst patients undergoing substitution treatment who had not used opiates during the last thirty days, the proportion of injecting users was much lower (8%).

Certain features differentiate patients on methadone from those on buprenorphine. According to the survey carried out in November 1999, the first category of patients are on average older than the second (about 33 as against 31) and are more often female (29% as against 21%). Patients undergoing treatment with buprenorphine more commonly have a job, which is connected to the greater proportion of non-permanent employment (fixed-term contracts, temporary work, work experience), while the proportion of stable paid employees is identical in both groups (about 20%). Current use of intravenous injection is most frequent among patients on buprenorphine (20% as against 15%), but there are also more of this group who have never used intravenous injection (31% as against 18%). It should also be noted that the incidence of HIV is higher among patients undergoing treatment with methadone (18% as against 13.5%). These results on the whole corroborate those of the OPPIDUM survey of 1998 [18], which also show the greater proportion of people in non-permanent employment among those using non-prescription buprenorphine, in comparison with those taking the same drug on prescription.

The data presented above give a snapshot (taken in November 1999) of the characteristics of users undergoing substitution treatment seen in the drug care institutions. These patients are just as likely to have been undergoing treatment for several years as for several days. These figures therefore cannot by themselves show up an improvement in the situation of patients undergoing substitution treatment, which would require monitoring of the same patients over time. Only one national study following patients treated with buprenorphine, which is already rather old, has been produced so far (Fhima *et al.,* 2001). The results of the analysis of about 500 patients followed over two years by the same general practitioners show a marked decrease in use of heroin (from 40% to 11%), in use of cocaine (from 44% to 17%) and in injecting (41% as against 22%). When measured by the scales described in the publications, the social situation and the seriousness of the condition of the patient were significantly improved. This study has been subject to criticisms, however. The majority of doctors and patients who took part in this study had previous experience

of substitution treatment. It may therefore be envisaged that the inclusion of well-motivated patients and those already registered for a long time gives results that are particularly favourable to substitution treatment (Morel, 2000). Another study, following patients undergoing buprenorphine treatment is currently in progress.

- Developments in characteristics of opiate users

Between 1997 and 1999, the average age of opiate users continued to rise roughly at the rate of one year in age every two years, as it had done since the start of the 1990s. The proportion and number of under-25s fell (1,700 persons in 1999 as against 2,200 in 1997). As an effect of the market situation and/or the substitution treatments, the proportion of those in paid employment has increased significantly (from about 34% to 39%).

Regarding the use of substances, it should be emphasized that the marked increase in the proportion of registrations with another opiate as secondary substance (18.4% in 1999 as against 13.8% in 1997). Heroin is in decline among substances used during the preceding thirty days (from 48% to 35%[2]), a decrease that is also recorded for the category of other opiates (from 21% to 9%), while there is an increase in use of non-prescription buprenorphine (from 10% to 15%), cocaine (from 12% to 17%) and cannabis (from 33% to 37%).

The practice of injecting is taking place slightly less often, a change that appears more marked when one looks at those who have recently used heroin. Undoubtedly, this may be seen as a possible effect of anti-heroin publicity put out in the context of the risk control policy.

Methods of use for heroin users registered with drug care organizations from 1995 to 1999
(in %)

Method of use	1995	1996	1997	1998	1999
Heroin users practicing intravenous injection/total heroin users	75	66	60	52	36
Heroin users via nasal passage/total heroin users	29	39	40	47	62

Source: OPPIDUM, CEIP

At general practices

The surveys available, whether local or in some cases expanded to two or three sites, focus on patients seen by general practitioners in the context of substitution treatment. The results seem to show that the profiles of these patients are quite similar to those registered in the CSSTs: male in 70 to 80% of cases, aged about 30 on average. The differences between forms of questioning on professional activity make comparisons difficult. The proportion of persons with permanent or regular work rarely comes to more than a third of the sample.

These surveys are always conducted with doctors involved in networks, and therefore often in contact with specialist organizations. This may partly explain this similarity.

As an example, the OPPIDUM survey allows comparison of patients undergoing treatment with buprenorphine, all of whom were registered with CSSTs, whether the person responsible for the substitution procedure in progress practises as a GP or in a CSST (Thirion *et al.,* 2001). The subjects registered with local general practices in 1998 were younger on average (28.8 as against 31.4), less likely to be living as part of a couple and less likely to have children to look after, with these last two variables certainly connected to a large extent with age. They were also more likely to practise intravenous injection of the buprenorphine (24% as against 10%) or of an associated substance (31% as against 16%). On the other hand, the differences are not significant in terms of sex, occupational activity or economic instability.

[2] The percentage refers to persons who have used at least one substance over the preceding thirty days.

Morbidity and mortality

Use of opiates may be the cause of overdoses and various pathologies that are connected with intravenous injection of these substances (viral infectious diseases, bacterial or fungal diseases, abscesses, vein problems, etc.) As with other substances, there is not much data on this subject. The figures available relate to the prevalence of the HIV and HCV infections as shown by surveys of users and registering health and social organizations [17]. The great majority of new cases of AIDS recorded relate to users of opiates by intravenous injection. The data on other pathologies comes from a survey of a sample group of general practitioners.

Morbidity: prevalence of HIV and HCV and other pathologies

The data presented here relate to the incidences of HIV and HCV among injecting users registered in November 1999 for use of opiates as primary substance. For a presentation of the data on HIV and HCV for all registered users, refer to the chapter on the transverse approach.

In November 1999, the proportion of injecting users who were aware of their serological status was just over 86%, a figure that has increased slightly by comparison to November (84%).

The reported incidence of HIV is falling sharply amongst opiate users who have recently or previously practised injection. The reported incidence of HCV, on the other hand, rose again between 1997 and 1999.

Reported incidence of HIV and HCV among users registered* for use of opiates as primary substance in 1997 and 1999.

(in % of known serologies)

	1997	1999
Incidence of HIV among those who have practiced intravenous injection (currently or previously)	18,7	15,4
Incidence of HIV among those who have practiced intravenous injection during the preceding 30 days	20,5	17,5
Incidence of HCV among those who have practiced intravenous injection (currently or previously)	62,8	64
Incidence of HCV among those who have practiced intravenous injection during the preceding 30 days	63,9	65,4

**In specialist centres only.*

Source: Survey on registration for care of drug addicts in November 1997 and 1999, DREES/DGS

Among doctors questioned at the start of 2001 in the survey of registration of drug users at general practices, the number of opiate-using patients who have had a sexually-transmitted disease in 2000 was, on average, 0.6 patients per doctor. Also reported by the doctor were 0.1 cases of overdose, 0.8 emergency admissions to hospital, and 0.2 attempted suicides. The data has not significantly changed by comparison with 1998, except for the overdoses, which are decreasing sharply.

Mortality

For 120 deaths by overdose recorded by the police in 2000, 71 are directly attributable to the use of heroin. This substance remains the most frequently involved substance in this type of death [29].

Most often, heroin is found alone, but 18 cases in 2000 showed use of heroin with another substance (mainly alcohol, cannabis, cocaine or medicines).

The number of overdoses attributable to heroin and recorded by the police has been falling sharply since 1990 and provides the core explanation for the general decrease observed for this type of death.

Deaths by overdose connected with heroin, recorded by the police, from 1990 to 2000

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Heroin	302	368	460	408	505	388	336	164	92	69	71
Total	350	411	499	454	564	465	393	228	143	118	120
As % of total:	86,3	89,5	92,2	89,9	89,5	83,4	85,5	71,9	64,3	58,5	58,8

Source: FNAILS, OCRTIS

The general statistics for mortality also allow cases of death connected with use of opiates to be counted – these are not necessarily overdoses, strictly speaking. Thus, in 1997, INSERM (the national institute for medical research) recorded 72 deaths due to dependence on a morphine type substance[3] for a total of 86 deaths due to dependence on drugs, where the substance is identified[4]. The 1997 level is equivalent to that of 1990 with regard to deaths due to dependence on opiates, while it reached 199 in1995 [13].

During the year 2000, OCRTIS also recorded 11 overdoses, whose analysis showed the presence of Subutex®, 11 overdoses with methadone and some deaths connected with other opiate-based medicines (Skenan® or Temgésic®). Often, the analyses show the presence of several of these substances at the same time.

Since 1996, 122 cases of deaths of drug addicts treated with buprenorphine were recorded by the national drug safety system or the legal medical institutes (National commission of narcotics and psychotropic substances, 2001). Toxicological analysis was practised on 96 of them. It revealed the presence of other substances combined with buprenorphine in 90 deaths, in particular benzodiazepines. This combination seems to make respiratory depression more likely to develop – this may prove fatal. Intravenous injection would contribute to making these accidents more serious.

[3] Heroin, methadone, opium and derivatives.

[4] The total number of deaths recorded that year was 181.

Criminal consequences of the use of opiates

The use of opiates, as with any illegal drug, may lead to arrests and legal consequences. Only the arrests may be described here. Court rulings and imprisonments which do not mention the product involved cannot be covered here.

Arrests for use in 2000

With nearly 6000 arrests of users in 2000, heroin is the second most frequently involved substance in this type of arrest, far behind cannabis (over 80,000 arrests) and ahead of cocaine (some 2,300 arrests). Arrests of opium or morphine users are rare (21 and 14 cases, respectively in 2000).

Heroin is therefore the opiate most often involved in arrests for use or use with dealing. As for other substances, cases of use only are the most numerous (about 5,000 in 2000).

Arrests for heroin use and use with dealing in 2000

	Heroin	All products	Heroin proportion
Use only	4 831	83 385	5,8 %
Use with dealing	1 002	10 954	9,1 %
Total	5 833	94 339	6,2 %

Source: FNAILS 2000, OCRTIS

A certain number of arrests may also be noted here for use or use with dealing in opiate-based medicines or those currently used by heroin addicts as substitutes. This refers to cases where users have not been able to prove that they have prescriptions for substances (no prescription sheet, no confirmation from their doctor or where they admit to use without prescription).

Therefore, the law enforcement services in 2000 counted 151 arrests for use or use with dealing of Subutex®, 54 of Rohypnol®, 28 of methadone, 9 of Tranxène® and 8 of Skenan® [28].

Development in cases of police interrogation for use since 1990

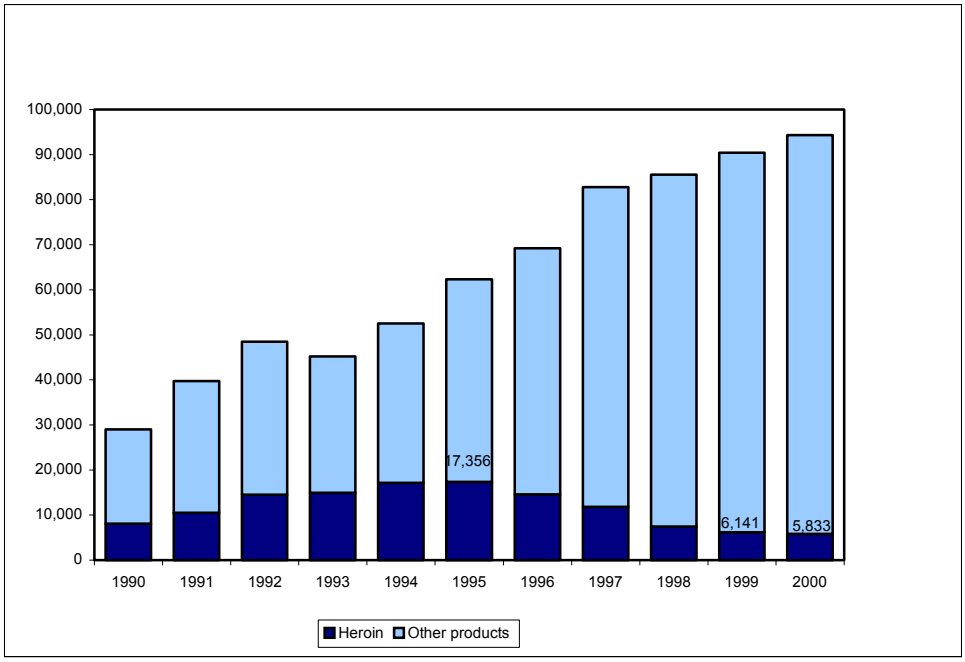
For the first time in five years, arrests of heroin users did not record a sharp fall in 2000 in comparison with that of preceding years: -5% in 2000 as against –18% in 1999 and even –37% in 1998.

The development over the last ten years shows two phases: a rise in arrests up to 1995 followed by a fall, the two changes compensating each other exactly (the average annual growth rate over this period is almost zero).

The main consequence of this fall is that arrests for heroin represent a smaller and smaller proportion within arrests of users as a total. corresponding to one in three arrests up till 1995, they represent less than one in ten from 1998.

Thus, although heroin is still, throughout this period, the second most frequently involved substance in arrests for use or use with dealing, the gap between heroin and cocaine or crack is narrowing: fifteen times more in 1990, the ratio is no more than two in 2000. With the rise in cases involving ecstasy in 2000, the ratio changes to three for arrests involving both substances.

Arrests for heroin use and use with dealing from 1990 to 2000 *{374a}*



Source: FNAILS, OCRTIS

The extension of the use of substitution treatments, the loss of interest in this substance among the youngest age group (both because of the portrayed image of the heroin addict and for the mainly intravenous method of use), or even the influence of AIDS prevention publicity (from the Seringue AIDS organization) are possible factors explaining the fall in the number of heroin users generally. On the other hand, the development of multiple drug addiction may also have an influence on the decrease in arrests for heroin use, because if the user is taking other substances, he may be arrested for use of these other substances.

The halt in the sharp decline in arrests in 2000 might mark a minimum threshold or may be the consequence of the new interest in this substance, as reported by the systems for observation in the field.

Characteristics of users questioned

Just after users of cocaine or crack, arrested heroin users are the oldest group: 28.3 on average in 2000 as against 29.6 for cocaine users, 31.3 for crack users and, on the other hand, 21.8 for cannabis users.

The trend for the age of arrested heroin users to rise, observed for the last ten years, continued in 2000. The proportion of minors is still very low (1.4% in 2000), close to that recorded for arrested users of cocaine or crack (2.0%) and markedly lower than that of cannabis users (15.1%).

As for other substances, the distribution of heroin users according to socio-professional category is connected with age: students or high-school pupils are rare (5% in 2000) compared to cannabis users (33%). On the other hand, those without paid occupation represent half of arrested heroin users. From this point of view, their profile is close to that of arrested cocaine users in 2000.

As for other substances, only one arrested heroin user in ten is foreign in nationality. Among these foreigners, the main nationalities represented are Algerians (187 in 2000), Moroccans (174) or Portuguese (86).

Supply and trafficking of opiates

The international and national supply of opiates is examined mainly through seizures recorded by international and national services. The local supply is determined by observations made in the field.

International trafficking and supply routes to France

Since the second half of the 1980s, between 80 and 90% of heroin used in Europe and France has its origin in opium produced in Afghanistan (INTERPOL, 2000). Between 1994 and 1998, production in this country was between 2,000 and 3,200 tonnes annually. In 1999, it was 4,500 tonnes and in 2000, it was 3,200 tonnes (UNODCCP, 2000). Following the prohibition declared by the *Taliban*, production will not exceed a few hundred tonnes in 2001. However, it is estimated that stocks have been built up in Afghanistan and outside of this country and that they should make it possible for supply to be maintained at the same level in 2001 and 2002 (Labrousse, 2001).

Opium and morphine base which, up till the middle of the 1990s, were mostly transformed into heroin in Pakistan and Turkey, are now also processed in Afghanistan, as well as in the Caucasian and Central Asian countries (INTERPOL, 2000). Similarly the heroin supply route to Europe, which used to be through the Balkans, has diversified over routes crossing Central Asia, Caucasus, Russia and the Eastern countries (INTERPOL, 2000).

Quantities of heroin seized in Western Europe from 1993 to 1999
(in tonnes)

1993	1994	1995	1996	1997	1998	1999
7.3	8.3	8.9	10.2	9.7	13.6	12.6

Sources: UNODCCP

As for transit through European countries, 47% of heroin seized in France came from the Netherlands (as against 35% in 1999), the country that is still the main region of origin, for the tenth consecutive year.

Quantities of heroin seized in France, from 1990 to 2000
(in kg)

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
405	561	328	386	661	499	617	415	344	203	444

Source: FNAILS, OCRTIS

In 1999, the law enforcement services had carried out 2,684 seizures, for a total weight of 203kg and, since 1997, these two indicators had been falling. However, in 2000, the quantities seized have more than doubled in relation to the preceding year, while the number of operations increased by 5%. The percentage of quantities intended for France is also rising. The conclusions that can be drawn from this increase can only be relative, with regard to arrests for use that are continuing to fall, even if the fall is a lot less marked than the preceding year (see below).

Also, during 2000, law enforcement services seized 5,560 pills of opiate-based medicines or those used frequently by heroin addicts. The main substances concerned were Subutex®, Temgesic®, Rohypnol® and methadone. There were also 14 arrests of small traffickers dealing in these substances

Traffickers questioned by the police in France

Like the previous indicators of supply, the number of persons arrested for trafficking heroin rose (by 9%) between 1999 and 2000 [28]. On the other hand, their proportion of the total number of arrests for trafficking is continuing to fall.

Arrests for heroin trafficking from 1990 to 2000

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Heroin	2 572	2 640	3 162	3 395	3 562	3 329	3 451	1 979	1 356	1 126	1 228
All products	5 198	5 303	5 982	6 451	7 179	7 107	8 412	6 560	5 541	5 506	6 531
As % of total:	49.5	49.8	52.9	52.6	49.6	46.8	41.0	30.2	24.5	20.5	18.8

Source: FNAILS, OCRTIS

Among the traffickers arrested in 2000, 219 are considered to be international traffickers, involved in import and export activities, 768 are considered to be local traffickers and 241 are considered to be dealers.

Just over 60% of heroin traffickers arrested in 2000 were French. The next two most represented nationalities in heroin trafficking are, in 2000 as in 1999, Moroccans and Algerians, which correspond to 17% of the total number of traffickers and to 45% of foreign traffickers.

Local supply: availability, price and quality

The availability data and price data presented here comes from the TREND [33] monitoring system and the quality data, relating to concentration of active principle in seizure samples, from police and customs laboratories

Availability

The development of the substitution policy, during the second half of the 1990s affected the market in heroin. Public street dealing has declined, whilst selling from homes or in private places has increased. Some small traffickers have changed to sell other substances, in particular cocaine. Thus, even if heroin remains more or less available over all the metropolitan sites of the TREND system, it has become much more difficult to find in the traditional selling places. The same goes for morphine sulphates (Skenan® et Moscontin®), due to the decrease in medical prescription of these substances.

The availability of methadone remains very limited because its presence is still extremely marginal on the illegal market. On the other hand, Subutex® is the only opiate whose availability without medical prescription seems to be both large and increasing over recent years.

On the techno dance scene, the availability of heroin is rising slightly. It is used, by a small minority of users, in order to accompany coming down from stimulants but also, as a primary product, for its opiate effects. Rachacha is available in a seasonal cycle. It is found more easily in summer than in winter, and most of the time, on a small scale, at raves and techno dance events. The other opiates are hardly present.

In the overseas departments, heroin is rare, apart from in Guyana, where it has a more significant presence. Subutex® is not widely available without a medical prescription, except in Reunion.

Price

The price of heroin seems to be going down slightly but there is a significant degree of variation according to location.

In metropolitan France, the average price of ‘white’ heroin hydrochloride in 2000 was lower than 650F per gram and the price of ‘brown’ heroin base is lower than 400F. In Guyana, the latter price was recorded at

Cayenne and a price of between 300 and 400F at Kourou, while at Saint-Laurent, a border town with Surinam, a price between 100 and 200F. In Reunion, the same gram is worth 500 to 600F.

On the illegal market, the average price in metropolitan areas of an 8mg Subutex® pill is in the order of 40F. In Guyana and Reunion, the price of the same pill goes up to about 50F.

On the metropolitan TREND sites, the average price of a 60mg vial of methadone fluctuates between 50 and 100F.

Quality

The level of concentration of the active ingredient of the heroin hydrochloride or heroin base shows a slight fall between 1999 and 2000. The accumulated percentage from samples with the highest level of purity (from 50 to 100%), as well as those with an average level of purity (20 5o 50%) fell by 13%. For the lowest purity category (0% to 20%), a rise of 6% was observed. These results must be interpreted with caution due to the fact that they depend on seizures carried out and therefore on police practices.

Level of purity in samples of heroin seized by the national police and customs, from 1998 to 2000

	1998		1999		2000	
	Numbers	%	Numbers	%	Numbers	%
0-20 %	574	72 %	299	69 %	441	73 %
20-50 %	143	18 %	78	18 %	98	16 %
50-100 %	78	10 %	52	13 %	69	11 %
Total	795	100 %	429	100 %	608	100 %

Source: TREND, OFDT (data supplied by the Lyon forensic science laboratory and the Paris interregional customs laboratory)

Geography showing the consumption of opiates

Regional approach

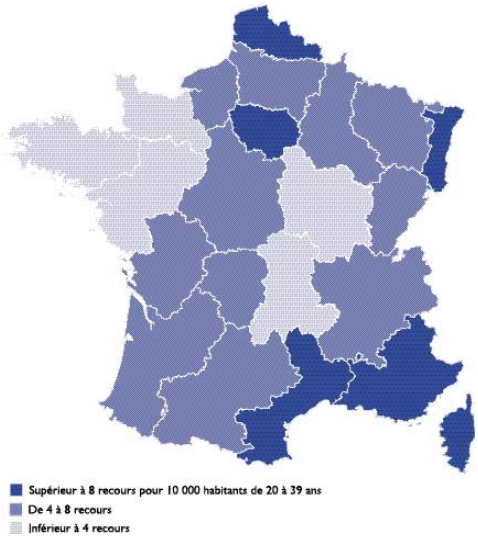
The numbers surveyed in the general population are too low to be able to represent the geographical aspect of heroin use.

The health and social or legal consequences of heroin use in the regions is covered using the data on registrations in November [17] and that about arrests.

Demands for treatment

Where requests for treatment are concerned, there are three regional groups to be differentiated: The first (in black on map), characterized by a high number of registrations per inhabitant, is composed of regions traditionally affected by drug addiction: Corsica is firmly at the top (15 registrations per 10,000 inhabitants aged 20-39), followed by Ile-de-France, Nord-Pas-de-Calais, Languedoc-Roussillon, Provence-Alpes-Cote d'Azur and Alsace (10 to 11 registrations per 10,000 inhabitants for these different regions). The second group (in grey on map) includes regions where the number of registrations is close to the national average. The remaining regions (in white) are those where then number of registrations per inhabitant is low relative to the national average.

Registration for opiate use in 1999, by region *{378a}*



Higher than 8 registrations per 10,000 inhabitants aged 20-39

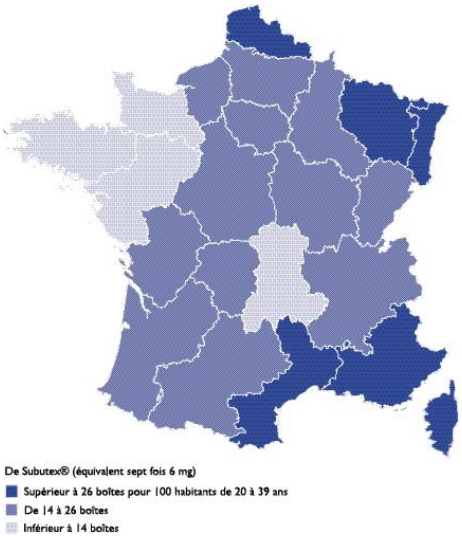
Between 4 and 8 registrations

Less than 4 registrations

Source: DREES/DGS

Regional distribution of registrations connected with opiates per inhabitant is very close to that obtained for sales of Subutex® per inhabitant. Alsace and Languedoc-Roussillon, firmly ahead in the group with about 50 boxes per 100 inhabitants aged 20 to 39 as against the national average of 24, are in this category. Ile-de-France and Corsica fall within the national average. Sales per inhabitant are significantly lower than the national average for the Pays de Loire region (7 boxes per 100 inhabitants aged 20 to 39) and Brittany (10 boxes).

Sales of Subutex® in 2000, by region *{378b}*



Subutex® (equivalent seven times 6mg)

Higher than 26 boxes per 100 inhabitants aged 20 to 39

Between 14 and 26 boxes

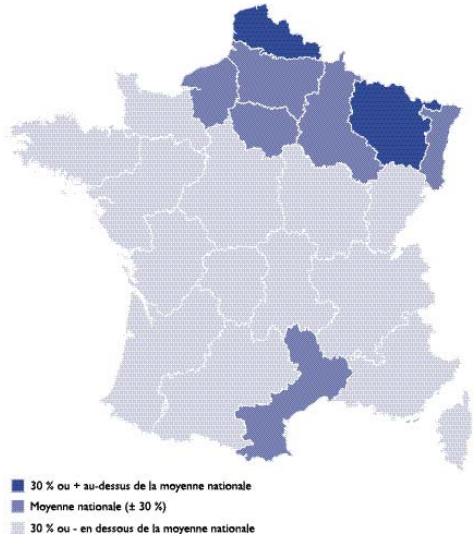
Lower than 14 boxes

Source: SIAMOIS 2000, InVS

Arrests

In comparison to the other substances, arrests for heroin use and use with dealing appear more concentrated geographically. Apart from Languedoc-Roussillon, all regions recording the highest arrests of heroin users are located in the North or the East of France. Nord-Pas-de-Calais and Lorraine stand out particularly with 9 and 6 arrests per 10,000 inhabitants respectively, with the national average at 3.4 [28]. For a significant proportion, heroin comes into France via the North, which partly explains the high number of arrests in the northern regions, and more specifically, the border regions.

Arrests of heroin users in 2000, by region *{378c}*



30% or more above national average

National average

30% or more below the national average

National average: 3.4 arrests per 10,000 inhabitants aged 20 to 39

Source: FNAILS 2000, OCRTIS

European approach

For better knowledge of the situation of France in relation to its European neighbours from the point of view of heroin use and its consequences, the data studied comes from the Annual Report 2000 from the OEDT, as well as from other information received by that body; This data is complemented by that of the ESPAD survey of young people still in education in thirty European countries (Hibell, *et al.,* 2001).

Consumption in the general population

In the overall adult population, heroin seems only rarely consumed in the European Union, with France at about the same level as the other countries, with lifetime incidences going from 1 to 2% for all adults.

Amongst young people still in education, experimentation with heroin among 16 year old pupils seems to be lower than elsewhere in Europe, for boys and girls equally (Hibell *et al.,* 2001), as it is about 1% as against the average of 3%. The largest levels within the European Union concern Italy, United Kingdom and Portugal. Over Europe as a whole, the countries of the East (Rumania, Latvia and Poland in particular) seem to be far more affected. Heroin is currently very frequently taken by smoking.

Demands for treatment

In 1999, in the majority of the countries of the European Union, requests for treatment (as primary product) are, as in France, in the majority connected with opiate use. Only the Northern countries (Sweden, Finland) and the Flemish region of Belgium form the exception, with a proportion of about 20 and 30% of opiates among registrations. In these three cases, amphetamines take the top place in terms of registrations. In Italy and Greece, the proportion of opiates exceeds 80%. On the other hand, it is lower (just over 60%) in Germany and the Netherlands.

Arrests

In some countries (Portugal, Luxembourg and Italy), heroin is the most frequently involved substance among drug-related arrests as a whole[5], whilst in the majority of countries of the European Union, including France, cannabis appears most often (OEDT, 2000).

In 1999, heroin represents 6% of arrests for use/possession of narcotics in France, a proportion close to that observed in Austria and in Ireland (8%). However, heroin is the most frequently involved substance in arrests for use/possession in Germany (with 19% of cases), in Portugal (39% as only substance) and in Luxembourg (47% of cases). United Kingdom and Italy are in an intermediate situation with proportions of 10 and 12 % respectively.

Except for the United Kingdom, the relative proportion of heroin is lower in 1999 than in 1995 among arrests for use/possession of narcotics as for all drug-related arrests.

For example, France counted 26% of arrests for use/possession connected with heroin in 1995, while Austria and Germany counted 21% and 30% respectively.

[5] The term 'drug-related arrest' has very different definitions depending on the country. The grounds for the arrest and the substance involved are not always recorded.

For further information

■ BARROW (S.), USAGES DE DROGUE ET COMORBIDITES PSYCHIATRIQUES. SYNTHÈSE DES RECHERCHES AMÉRICAINES [DRUG USE AND PSYCHIATRIC COMORBIDITIES. SUMMARY OF AMERICAN RESEARCH], 1999, 80 P. (DOCUMENTS DU GDR PSYCHOTROPES, POLITIQUE ET SOCIÉTÉ/DOCUMENTS OF THE RESEARCH GROUP ON PSYCHOTROPIC SUBSTANCES, POLITICS AND SOCIÉTY, N° 3).

■ BAUDIER (F.), ARÈNES (J.) (DIR.), BAROMETRE SANTE ADULTES 95/96, VANVES, CFES, 1997, 288 P.

■ BECK (F.), PERETTI-WATEL (P.), EROPP 99: SURVEY ON REPRESENTATIONS, OPINIONS AND PERCEPTIONS RELATING TO PSYCHOACTIVE SUBSTANCES, PARIS, OFDT, 2000, 203 P.

■ BECK (F.), LEGLEYE (S.), PERETTI-WATEL (P.), REGARDS SUR LA FIN DE L'ADOLESCENCE : CONSOMMATIONS DE PRODUITS PSYCHOACTIFS DANS L'ENQUÊTE ESCAPAD 2000, [VIEWS OF THE END OF ADOLESCENCE: CONSUMPTION OF PSYCHOACTIVE SUBSTANCES IN THE ESCAPAD 2000 SURVEY] PARIS, OFDT, 2000, 220 P.

■ BECK (F.), LEGLEYE (S.), PERETTI-WATEL (P.), 'DROGUES ILLICITES: PRATIQUES ET ATTITUDES', 'ILLEGAL DRUGS: PRACTICES AND ATTITUDES] IN GUILBERT (P.), BAUDIER (F.), GAUTIER (A.) (DIR.), BAROMÈTRE SANTÉ 2000, VANVES, CFES, 2001, (TO BE PUBLISHED).

■ BECK (F.), LEGLEYE (S.), PERETTI-WATEL (P.), ALCOOL, TABAC, CANNABIS ET AUTRES DROGUES ILLICITES PARMI LES ÉLÈVES DE COLLÈGE ET DE LYCÉE : ESPAD 1999 [ALCOHOL, TOBACCO, CANNABIS AND OTHER ILLEGAL DRUGS AMONG COLLEGE AND HIGH-SCHOOL STUDENTS: ESPAD 1999] FRANCE, VOLUME II, PARIS, OFDT, 2001, (TO BE PUBLISHED).

■ BELLO (P.-Y.), TOUFIK (A.), GANDILHON (M.), TENDANCES RÉCENTES, RAPPORT TREND, [RECENT TRENDS, TREND REPORT] PARIS, OFDT, 2001, 167 P.

■ COMMISSION NATIONALE DES STUPÉFIANTS ET DES PSYCHOTROPES/NATIONAL COMMISSION ON NARCOTICS AND PSYCHOTROPIC DRUGS, 'RÉSULTATS DE L'ENQUÊTE OFFICIELLE SUR LA SPÉCIALITÉ SUBUTEX® (BUPRÉNORPHINE)' [RESULTS OF OFFICIAL SURVEY OF SUBUTEX® (BUPRENORPHINE), IN MINUTES NO. 45 OF THE MEETING OF 22ND FEBRUARY 2001, 19 APRIL 2001, P. 3-4 (INTERNAL REPORT).

■ CHOQUET (M.), LEDOUX (S.), HASSLER (C.), ALCOOL, TABAC, CANNABIS ET AUTRES DROGUES ILLICITES PARMI LES ÉLÈVES DE COLLÈGE ET DE LYCÉE : ESPAD 1999 [ALCOHOL, TOBACCO, CANNABIS AND OTHER ILLEGAL DRUGS AMONG COLLEGE AND HIGH-SCHOOL STUDENTS: FRANCE, TOME I, PARIS, OFDT, 2001, (TO BE PUBLISHED).

■ COULOMB (S.), DUBURCQ (A.), MARCHAND (C.), PÉCHEVIS (M.), ÉVOLUTION DE LA PRISE EN CHARGE DES TOXICOMANES : ENQUÊTE AUPRÈS DES MÉDECINS GÉNÉRALISTES EN 2001 ET COMPARAISON 92-95-98-2001, [DEVELOPMENT OF REGISTRATION OF DRUG ADDICTS: SURVEY OF GENERAL PRACTITIONERS IN 2001 AND COMPARISON OF 92-95-98-2001] PARIS, OFDT, 2001, 56 P. + ANN. (INTERNAL REPORT).

■ DE PERETTI (C.), LESELBAUM (N.), LES LYCEENS PARISIENS ET LES SUBSTANCES PSYCHOACTIVES : EVOLUTIONS [PARIS HIGH-SCHOOL STUDENTS AND PSYCHOACTIVE SUBSTANCES: DEVELOPMENTS], PARIS, OFDT/INRP-PARIS X, 1999, 170 P.

■ EMMANUELLI (J.), PROGRAMMES D'ECHANGES DE SERINGUES ET REDUCTION DES RISQUES CHEZ LES USAGERS DE DROGUES DANS LE MONDE DEVELOPPE : ETAT DES LIEUX ET MISE EN PERSPECTIVE [SYRINGE EXCHANGE SCHEMES AND RISK REDUCTION AMONG DRUG USERS IN THE DEVELOPED WORLD: CURRENT STATUS AND CONCLUSIONS], 2001, 79 P. (DOCUMENTS OF CESAMES, N° 8).

■ EMMANUELLI (J.), CONTRIBUTION A L'EVALUATION DE LA POLITIQUE DE REDUCTION DES RISQUES [CONTRIBUTION TO THE EVALUATION OF RISK REDUCTION POLICY]

■ SIAMOIS: DESCRIPTION, ANALYSE ET MISE EN PERSPECTIVE DES DONNEES DE VENTES OFFICINALES DE SERINGUES ET DE PRODUITS DE SUBSTITUTION EN FRANCE DE 1996 A 1999 [SIAMOIS : DESCRIPTION, ANALYSYS AND CONCLUSIONS USING OFFICIAL SALES DATA FOR SYRINGES AND SUBSTITUTION PRODUCTS IN FRANCE FROM 1996 TO 1999] (2 VOLUMES), SAINT-MAURICE, INVS, 2000, 55 + 93 P.

■ FHIMA (A.), HENRION (R.), LOWENSTEIN (W.), CHARPAK (Y.), 'SUIVI A DEUX ANS D'UNE COHORTE DE PATIENTS DEPENDANTS AUX OPIACES TRAITES PAR BUPRENORPHINE HAUT DOSAGE (SUBUTEX®)' [TWO-YEAR MONITORING OF A GROUP OF OPIATE-DEPENDENT PATIENTS, TREATED USING HIGH-DOSE BUPRENORPHINE

(SUBUTEX®)], ANNALES DE MEDECINE INTERNE/INTERNAL MEDICINE REPORT, VOL. 152, SUPP. N° 3, 2001, P. IS26-IS36.

■ HIBELL (B.), ANDERSSON (B.), AHLSTROM (S.), BALAKIREVA (O.), BJARNASSON (T.), KOKKEVI (A.), MORGAN (M.), THE 1999 ESPAD REPORT: ALCOHOL AND OTHER DRUG USE AMONG STUDENTS IN 30 EUROPEAN COUNTRIES, STOCKHOLM, CAN, 2000, 362 P.

■ INTERPOL (INTERNATIONAL POLICE ORGANIZATION), RAPPORT SUR LA SITUATION DE L'HEROÏNE DANS LE MONDE/REPORT ON THE WORLDWIDE HEROIN SITUATION, LYON, INTERPOL, 2000, 50 P.

■ LABROUSSE (A.), 'AFGHANISTAN', DROGUE TRAFIC INTERNATIONAL/INTERNATIONAL TRAFFICKING IN DRUGS, N° 2, 2001, P. 3.

■ MOREL (A.), 'TRAITEMENTS DE SUBSTITUTION A LA BUPRENORPHINE', [SUBSTITUTION TREATMENTS USING BUPRENORPHINE] TOXIBASE DOCUMENTATION REVIEW, NO. 2, 2000, P. 1-37.

■ OCRTIS (OFFICE CENTRAL POUR LA REPRESSION DU TRAFIC ILLICITE DES STUPEFIANTS/CENTRAL OFFICE FOR LAW ENFORCEMENT RELATING TO TRAFFIC IN ILLEGAL NARCOTICS), USAGE ET TRAFIC DE PRODUITS STUPEFIANTS EN FRANCE EN 2000 [USE AND TRAFFICKING OF NARCOTIC SUBSTANCES IN FRANCE IN 2000], PARIS, MINISTERE DE L'INTERIEUR, 2001, 114 P.

■ OEDT (OBSERVATOIRE EUROPEEN DES DROGUES ET DES TOXICOMANIES/EUROPEAN OBSERVATORY OF DRUGS AND DRUG ADDICTS), RAPPORT ANNUEL 2000 SUR L'ETAT DU PHENOMENE DE LA DROGUE DANS L'UNION EUROPEENNE, [ANNUAL REPORT 2000 ON THE DRUGS SITUATION IN THE EUROPEAN UNION], LUXEMBOURG, EUROPEAN COMMUNITY OFFICIAL PUBLICATIONS OFFICE, 2000, 50 P.

■ OFDT, (OBSERVATOIRE FRANÇAIS DES DROGUES ET DES TOXICOMANIES/FRENCH OBSERVATORY OF DRUGS AND DRUG ADDICTION), DROGUES ET TOXICOMANIES: INDICATEURS ET TENDANCES, [DRUGS AND DRUG ADDICTION: INDICATORS AND TRENDS] PARIS, OFDT, 1999, 270 P.

■ PEZOUS (A.-M.), FERRAND (I.), NUSS (P.), LES URGENCES COMME OBSERVATOIRE DES COMPLICATIONS AIGUËS DES NOUVEAUX MODES D'USAGE ET DES NOUVELLES DROGUES, [EMERGENCIES AS A MEANS OF MONITORING THE ACUTE COMPLICATIONS OF NEW MODES OF USE AND NEW DRUGS] PARIS, OFDT, 2001, (TO BE PUBLISHED).

■ RICHARD (D.), SENON (J.-L.), HAUTEFEUILLE (M.), FACY (F.), 'L'HEROÏNE', [HEROIN] TOXIBASE DOCUMENTATION REVIEW, NO. 2, 1998, P. 1-27.

■ RONFLE (E.), THIRION (X.), LAPIERRE (V.), PRADEL (V.), MASUT (A.), MICALLEF (J.), COUDERT (C.), SANMARCO (J.-L.), MABRIEZ (J.-C.), 'SUBSTITUTION PAR LE SUBUTEX®: LES 2/3 DES PATIENTS SONT OBSERVANTS. UNE ETUDE EN MEDECINE GENERALE DANS LES BOUCHES-DU-RHONE', [SUBSTITUTION USING SUBUTEX® : 2/3 PATIENTS ARE COMPLIANT. A STUDY IN GENERAL MEDICINE IN BOUCHES-DU-RHONE] LA REVUE DU PRATICIEN – MÉDECINE GÉNÉRALE/THE GENERAL PRACTITIONER'S REVIEW – GENERAL PRACTICE, VOLUME XV, NO. 521, 8 JANUARY 2001, P. 23-28.

■ SORBE (G.), RÉSEAU MG TOX. 4 YEARS OF SUBUTEX®, MG TOX (RÉSEAU DÉPARTEMENTAL DE GÉNÉRALISTES POUR LA PRISE EN CHARGE DES TOXICOMANIES/DEPARTEMENTAL NETWORK OF GENERAL PRACTITIONERS FOR REGISTRATION OF DRUG ADDICTS) CHARENTE-MARITIME, 2000, 13 P. (UNPUBLISHED).

■ TELLIER (S.), LA PRISE EN CHARGE DES TOXICOMANES DANS LES STRUCTURES SANITAIRES ET SOCIALES EN NOVEMBRE 1999, [REGISTRATION OF DRUG ADDICTS WITH HEALTH AND SOCIAL ORGANIZATIONS IN NOVEMBER 1999] PARIS, DREES, 2001, 47 P. (WORKING DOCUMENT NO. 19).

■ THIRION (X.), BARRAU (K.), MICALLEF (J.), HARAMBURU (F.), LOWENSTEIN (W.), SANMARCO

■ (J.-L.), 'TRAITEMENTS DE SUBSTITUTION DE LA DEPENDANCE AUX OPIACES DANS LES CENTRES DE SOINS: LE PROGRAMME OPPIDUM DES CENTRES D'EVALUATION ET D'INFORMATION SUR LA PHARMACODEPENDANCE', [SUBSTITUTION TREATMENTS FOR OPIATE DEPENDENCE IN DRUG CARE CENTRES : THE OPPIDUM PROGRAMME OF THE CENTRES FOR EVALUATION AND INFORMATION ON DRUG DEPENDENCE] ANNALE DE MEDECINE INTERNE/INTERNAL MEDICINE REPORT, VOL. 151, SUPP. A, 2000, P. A10-A17.

■ TOUZEAU (D.), BOUCHEZ (J.), 'LA METHADONE', [METHADONE] TOXIBASE DOCUMENTATION REVIEW, N° 2, 1998, P. 1-12.

■ UNODCCP (UNITED NATIONS OFFICE FOR DRUG CONTROL AND CRIME PREVENTION), AFGHANISTAN: ANNUAL OPIUM POPPY SURVEY 2000, ISLAMABAD, UNDCP, 2000, 27 P.

■ UNODCCP (United Nations Office for Drug Control and Crime Prevention), Tendances mondiales des drogues illicites 2001, [World trends in illegal drugs] New York, United Nations, 2001, 282 p.

LSD, mushrooms and other hallucinogenic drugs

Reference points

Consumption

Experimentation and actual consumption of LSD, mushrooms and other hallucinogenic drugs is relatively limited in the general population. The consumption of these drugs is primarily limited to young adults and to the party context where it has been increasing in recent years.

Within the adult population, the level of experimentation with LSD is weak among 18-44 year-olds (1.5% for women and 3.5% for men) and relatively higher at the two extremities of the age bracket. This is the result of the combination of a higher level of experimentation among the current young generation and that born during the 1970s. Among young people, experimentation varies between 1% and 5% depending on gender and age.

The consumption of hallucinogenic mushrooms is, relative to LSD, more frequent among young people whose level of experimentation reaches almost 9% (boys of 19 years).

As for all illicit drugs, fewer women declare having experimented with LSD and hallucinogenic mushrooms.

The consumption of LSD and hallucinogenic mushrooms is frequently noted in a context associated with the consumption of other licit and illicit drugs, primarily alcohol, tobacco and cannabis. This is particularly the case in party contexts, where these products may be associated with stimulants, particularly ecstasy.

Healthcare and social consequences

LSD and hallucinogenic mushrooms are at the origin of a marginal number of health or social care cases.

To date, and to the best of our knowledge no serious healthcare consequences of the use of LSD and hallucinogenic mushrooms have been recorded, even though these drugs, due to their hallucinatory nature, may potentially result in injury.

Criminal consequences

Following a net increase during the first half of the 1990s, the number of cases of police interrogation for use or use/dealing of LSD have stabilised at a level which remains marginal by comparison with the total number of cases of police interrogation (approximately 200). In contrast, cases of police interrogation in relation to hallucinogenic mushrooms became more and more numerous in the second half of the 1990s, although their number is still limited (approximately 150).

Supply and trafficking

Following substantial growth in the first half of the 1990s, seizures of LSD have reduced considerably, despite a definite increase recorded in 2000. This does not necessarily mean that LSD is less available, as field observations lead to the formulation of an opposite finding: LSD and other hallucinogenic drugs, such as anaesthetics diverted from their medical or veterinary use (primarily ketamine) are quite available, particularly in some party environments.

Consumption of hallucinogenic drugs by the French population

The consumption of LSD and hallucinogenic mushrooms by the French population is described on the basis of survey results from representative samples of the young or adult populations. The trends that emerge from these surveys are corroborated by information from the field, both in the profile of consumers and their modes of use.

As the consumption of LSD is rare, both in the adult and adolescent populations, only experimentation is considered here. Experimentation with hallucinogenic mushrooms in the adult population is too low a phenomenon for reliable study, because the question was not explicitly asked in the reference survey [3].

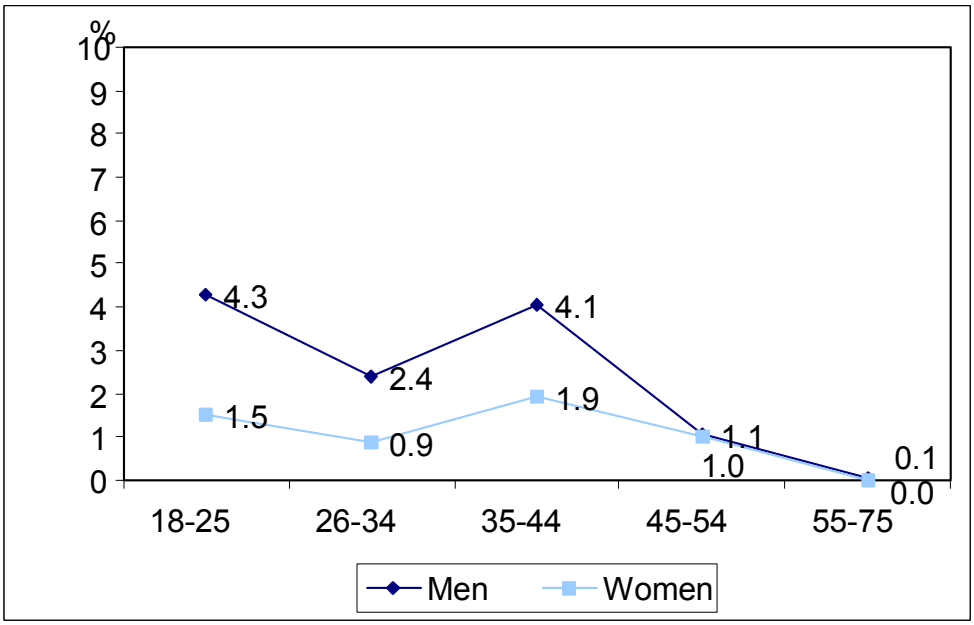
Experimentation by the general adult population

In the general adult population, experimentation with LSD is rare and primarily involves young adults [3]. Consumption is predominantly masculine. While there is a threshold among men in their forties, with experimentation being much more frequent below 44 years, the contrast is less marked among women. Contrary to other drugs, experimentation with LSD particularly concerns men of 42-43 years of age (born in 1957 and 1958): they reach a prevalence of 7%. As none of them had recently consumed, this use had taken place previously, very probably at the end of the 1970s.

During the 1990s, a relative stability appeared. Among 18-44 year-olds, between 1995 and 1999, use of LSD during life had increased from 1.2% to 1.5% among women, and reduced from 3.7% to 3.5% among men.

Above 44 years, the experimentation rate for this drug becomes very low.

Frequency of experimentation with LSD in the general adult population in 2000, by gender and age *{351a}*



Source: Health Barometer 2000, CFES, OFDT production

Among adults, experimentation with LSD is observed in all social environments. Although there is an insufficient number of experimenters from which to draw up a precise socio-demographic profile, some features can be detected: they are significantly more numerous among the unemployed (4.5%) and students or

school-goers (3.6%). On the other hand, the level of education, or level of household income did not allow a differentiation of this experimentation. Experimentation with LSD is more habitual among persons showing signs of potential dependence on alcohol or tobacco. In addition, it is also more frequent among persons living alone than for couples. These ratios remain when age and gender are checked.

Experimentation by adolescents

Among school-going young people, 0.9 % of girls and 1.7 % of boys from 14 to 18 years of age admitted having already taken LSD during their lives [7]. Experimentation with hallucinogenic mushrooms is much more widespread (2.0% of girls and 4.5% of boys).

Experimentation with hallucinogenic drugs has been increasing since 1993, when only 0.9% of girls and 2.6% of boys were involved [5]. This development is significant for both genders.

Frequency of experimentation with LSD or hallucinogenic mushrooms among school-going 14-18 year-olds in 1993 and 1999, by gender

(in %)

	Girls	Boys
1993	0.9	2.6
1999	2.5	5.0

Sources: INSERM 1993: ESPAD 1999, INSERM/OFDT/MENRT

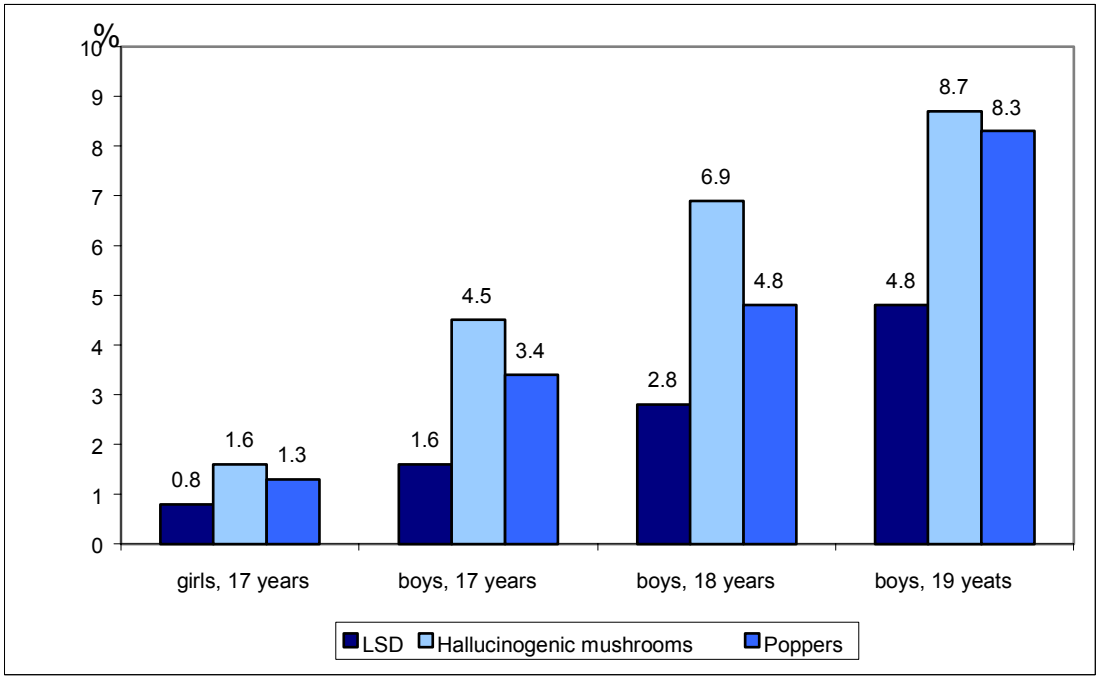
The growth is also visible for LSD thanks to a survey done in secondary schools in Paris in 1983, 1991 and 1998. It showed that 1.7% of students had already tried LSD in 1998 against 0.4% in 1991 and 0.5% in 1983 (De Peretti et al. 1999).

At the end of adolescence, prevalence is higher among boys than girls, and increases with age between 17 and 19 years [8]. Among young persons who had consumed during the year, less than one-third had done so more than once or twice.

Experimentation and consumption of *poppers* is at a level comparable to that for ecstasy and hallucinogenic mushrooms [8]. As for the majority of other drugs, consumption is more frequently masculine and depends on age. The majority of users admitted to consuming only once or twice per annum and those who admitted to more than ten represent 13% of the total: this proportion is low by reference to that observed for cannabis but greater than for the majority of the other drugs.

As the consumption of *poppers* was only rarely directly covered by the surveys, it is not possible to produce a trend of its development over time. The levels observed in ESCAPAD (*Enquête sur la santé et les consommations lors de l'appel de préparation à la défense*: Survey on health and consumption during the Defence Preparation Day), however, underline the interest in making this drug appear explicitly in surveys of young persons [8].

Frequency of experimentation with LSD, hallucinogenic mushrooms or poppers among young people at the end of adolescence in 2000, by gender and age *{351b}*



Source: ESCAPAD 2000, OFDT

At the end of adolescence, young persons who have left the school system are more numerous in having experimented with LSD, hallucinogenic mushrooms or *poppers* than the others [8]. Among students, age and gender (the fact of being a boy) are associated with experimentation with LSD and hallucinogenic mushrooms or *poppers*. At school, the fact of being in a professional channel is only associated with experimentation with mushrooms and *poppers*. Thus when gender, age and school year repetition are checked, the fact of having left the school system multiplies the chances of having experimented with hallucinogenic mushrooms, LSD or *poppers* by 2.4, 3.8 and 1.5 respectively. Moreover, young people who have already used these drugs are markedly more regular consumers of alcohol, cannabis and tobacco, than the others.

Experimentation with LSD only involves a small proportion of young people who have already attended techno parties (5.5%). That for *poppers* is approximately once and a half times higher (7.5%), while that for hallucinogenic mushrooms is approximately twice as frequent (11.5%), which simply reflects the prevalence of these drugs in the adolescent population. Experimentation among young people who have never attended one of these parties is approximately seven times less frequent (0.7%) for LSD and 2.3% for hallucinogenic mushrooms or *poppers*). Thus, among students, with gender, age, professional channel and school year repetition checked, the young people who attended such a party are seven times more likely to have experimented with LSD (five times more likely for hallucinogenic mushrooms and three times more likely for *poppers*). These ratios are more marked in young people who have left the school system [8].

Observations in the field

The data given here are taken from the TREND observation structure [33].

Profile of consumers

During decade of the 1990s, and more especially during the second half thereof, we saw a sustained spread, in the techno party environment, of numerous natural or synthetic hallucinogenic drugs such as LSD, ketamine, GHB, hallucinogenic mushrooms, nitrous oxide, etc. In the overseas Departments, on the other hand, the use of hallucinogenic drugs, whether natural or synthetic, has remained rare and market exchanges are relatively non-existent.

While the profile of LSD, mushroom or nitrous oxide users appears to be similar to that of ecstasy users, the profile of regular consumers of ketamine is comparatively more marked by marginality and rebellion. The majority of these users frequent, in effect, unauthorised events (*teknivals* and *free-parties*).

Even if LSD is consumed outside the techno environment, this remains the main focus of consumption.

Consumers of hallucinogenic mushrooms do not belong only to the techno sphere and do not inevitably consume in a party context.

Modes of use

The methods of administration of hallucinogenic drugs are many and varied. However, they are mostly taken orally (as is the case for LSD), through the nasal duct or by inhaling. The practice of injecting is very rare. For example, ketamine, most often available and sold in its original form, which is an injectable liquid, is sniffed after transformation by the great majority of consumers.

For GHB, two methods of administration have been identified: the nasal duct, used for the powder form, and orally, used for both the powder and liquid forms. The most common method of administration of hallucinogenic mushrooms is orally (ingestion). A small minority smoke them. As for nitrous oxide, this is taken by inhaling from a balloon.

Health and social consequences of the use of hallucinogenic drug

Use of hallucinogenic drugs leads some of the consumers into having recourse to the medico-social care system. The number and characteristics of the persons taken into care in the medico-social institutions due to their dependence on (or abuse of) hallucinogenic drugs, are described first. The consequences of hallucinogenic drug use, in terms of morbidity, are dealt with in the second section. The data shown is, in the majority of cases, collected from users by the care institutions.

Demands for treatment

LSD and the other hallucinogenic drugs are little represented in care cases: 0.4% as the primary drug and a little less than 1% as the secondary drug. These proportions did not change between 1997 and 1999. A higher, but nevertheless comparable, proportion was found in the three emergency services surveyed during 1998: the use of hallucinogenic drugs is referred to in the case of a little more than 3% of drug-user patients counted (Pezous *et al.,* 2001).

Characteristics of persons in care.

The characteristics of users are drawn from the cases of care for hallucinogenic drug use as a primary drug only. The secondary drugs referred to, are, in the majority of cases, associated with opiates, due to the preponderance of this family of drugs in care cases. The characteristics of users mentioning hallucinogenic drugs as a secondary drug are very similar to those of opiate users, which aspect is described elsewhere.

In November 1999

The persons taken into care for hallucinogenic drug use are, on average, older than cannabis or ecstasy users (28 years as against 25 and 24 years respectively). In relation to age, they show characteristics somewhere between those for cannabis or ecstasy users and opiate users. They differ from the latter by a relatively high proportion of cases of first care (almost 43%), men (almost 93%) and pupils or students (17%). They are different from cannabis users by a having a proportion of substitution treatment and persons having practised injection that is clearly much higher (approximately 29% in both cases), and by the low number of persons sent by the justice (almost 6%)

A secondary drug is often mentioned (75% of cases), first ecstasy (23% of cases), then cannabis (14%), opiates (11%), followed by amphetamines (7%). According to this data, persons taken into care for LSD use are more numerous, in relative terms, in having consumed ecstasy during the last thirty days (almost 20% of them).

Profile of care cases related to hallucinogenic drugs and opiates (as a primary drug) in 1999

	Hallucinogenic drugs	Opiates
Number of cares cases (primary drug)	86	13 613
% of first-care cases	42.7	29
Average age	28	31.5
% under 25 years	41.2	13
% of men	89.5	76
% of persons sent by the justice	5.8	6
% of persons employed	31.2	39
% of pupils and students	15.7	2
% of persons receiving Minimum Insertion Income (RMI)	15.2	31
% of persons having opiates as a 2nd drug	11.6	10
% of persons receiving substitution treatment	28.6	75
% of persons having used the intravenous duct (currently or previously)	29.1	73
% of persons having used the intravenous duct within the last 30 days	6.3	19

Source: Survey on the care of drug addicts in November 1999, DREES/DGS

Development 1997-1999

The characteristics of persons taken into care for hallucinogenic drugs use have remained stable between 1997 and 1999.

Morbidity and mortality

Even more than for other substances, persons under the influence of hallucinogenic drugs can be the victims of accidents. These products may also provoke serious psychiatric problems (depression, paranoiac states).

No case of death directly related to hallucinogenic drugs has, however, been recorded in France, neither by INSERM (*Institut national de la santé et de la recherche médicale*: National Institute for Health and Medical Research) for deaths due to dependence on hallucinogenic drugs (LSD and derivatives, psilocybine or mescaline) or by OCRTIS (*Office central pour la répression du trafic illicite de stupéfiants*: Central Office for the Repression of Drug-related Offenses) for overdoses detected by the police services.

Criminal consequences of the use of hallucinogenic drugs

The use of hallucinogenic drugs, as for all illicit drugs, may result in police interrogation and criminal proceedings. Only the cases of police interrogation can be described. Sentences and imprisonment that do not refer to the drug in question cannot be dealt with here.

Police interrogation for use in 2000

Cases of police interrogation for use or use/dealing in hallucinogenic drugs are rare in France, as in 2000 they only represented 0.4% of all cases of police interrogation of users. The drugs most frequently in question in these types of arrests were LSD, with up to 218 cases of police interrogation, and mushrooms, with approximately 150 cases [28].

Cases of police interrogation for use and use/dealing in hallucinogenic drugs in 2000

	LSD		Hallucinogenic mushrooms		All drugs included
	Number	% in line	Number	% in line	Number
Simple use	150	0.2	144	0.2	83,385
Drug dealing	68	0.7	10	0.1	10,954
Total	218	0.2	154	0.2	94,339

Source: FNAILS 2000, OCRTIS

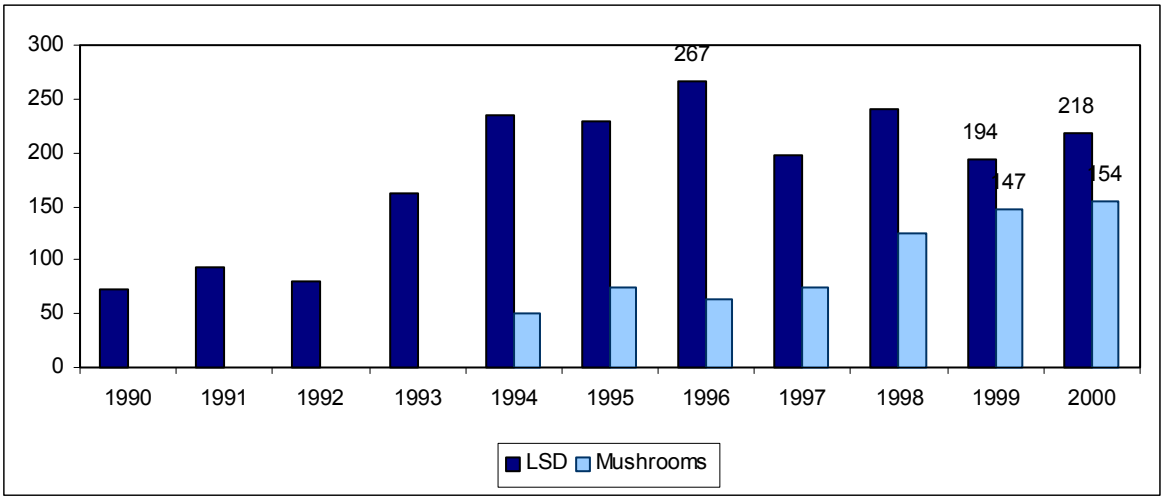
Development in cases of police interrogation for use since 1990

Until 1996, cases of police interrogation for LSD use were rising strongly; they had practically multiplied by four between 1990 and 1996. The trend appears to have reversed from 1997 although it is difficult to interpret as the data are fluctuating: -26% in cases of police interrogation in 1997 over the previous year and –20% in 1999, but an increase of 22% in 1998 and 12% in 2000.

In the long term, it can be determined that the cases of police interrogation of LSD users regularly show substantial fluctuations, reflecting a trend close to that found for consumption. In vogue at the beginning of the 1970s, LSD was the reason for a not negligible share of cases of police interrogation of users (up to 15% in 1973 with 390 cases). This drug appears to have been subsequently abandoned and the cases of police interrogation fell throughout the 1980s. In 1990, the 72 cases of police interrogation for LSD recorded represented no more than 0.25% of the cases of police interrogation for use or use/dealing. Finally, and although still in a minority, they increased in a notably in the 1990s. This increase must be compared with the renewal of interest in LSD indicated by the different observation structures.

The first cases of the arrest of users of hallucinogenic mushrooms were mentioned in 1994. Although initially stable, this type of police interrogation is increasing substantially. Virtually all the cases recorded relate to the simple use of hallucinogenic mushrooms.

Cases of police interrogation for use or use/dealing in hallucinogenic drugs from 1999 to 2000 *{354a}*



Source: FNAILS, OCRTIS

Characteristics of users questioned

With cannabis users, LSD and mushroom users are the youngest users interrogated by police: 23.2 and 22.8 years respectively on average in 2000 against 21.8 for cannabis users. Their average age is close to that of ecstasy users interrogated by police who had an average age of 23.3 years in 2000.

As regards their gender or nationality, the profile is identical to that of the other users interrogated by police: a majority of men (89% for LSD and 92% for mushrooms) and French nationals (94% and 90% respectively).

The LSD users interrogated by police essentially fall into four socio-professional categories and their profile is close to that of the ecstasy or amphetamine users who were interrogated: in order of importance, users without a declared or determined profession (39%), manual workers (26%), pupils-students (16%) and employees (15%). Persons interrogated by the police for the use of hallucinogenic mushrooms in 2000 were primarily students or pupils (63 users out of 154 recorded that year), and about twenty employees or manual workers. The others had no declared profession.

Supply and trafficking of hallucinogenic drugs

The international and national supply of hallucinogenic drugs is examined mainly via the seizures made by the international and national services. Local supply is described from field observations.

International trafficking and supply routes to France

In 1999, 460,000 units of LSD were seized, throughout the world, except in Africa, which is an equivalent quantity to those recorded for the two previous years (UNODCCP (*Office des Nations unies pour le contrôle des drogues et la prévention du crime*: United Nations Office for the Control of Drugs and the Prevention of Crime), 2001a). With 141,000 units, Europe recorded approximately one-third.

By comparison to other drugs, the quantities of LSD seized appear to be relatively minimal in 1999: 124,000 units for the whole of Western Europe, reported by about twenty countries, in particular the United Kingdom (67,400 units), Germany (23,000 units), France (almost 10,000 units) and Italy (5,500).

Quantities of LSD seized in Western Europe, from 1993 to 1999

(in thousands of units)

1993	1994	1995	1996	1997	1998	1999
1 143	387	592	424	446	161	124

Source: UNODCCP

In 2000, a little more than 20,000 doses of LSD were seized by the law enforcement services in France, double the quantity for the previous year. The number of operations carried out also doubled in this period.

Quantities of LSD and hallucinogenic mushrooms seized in France, from 1990 to 2000

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
LSD (in doses)	30,669	27,482	128,359	430,617	74,004	70,217	74,780	5,983	18,680	9,991	20,691
Mushrooms (in kg)	0.3	1.1	3.4	1.0	1.1	5.5	1.5	1.6	4.8	5.6	11.3

Source: FNAILS, OCRTIS

By comparison to the levels reached in 1994-1996, seizures of LSD have fallen substantially in recent years. However, the substantial annual fluctuations prevent the drawing of any conclusions on trends.

In 2000, approximately one-third of the LSD seized, in a single seizure, came from Switzerland and was mainly intended for the French or Italian markets. The Netherlands is the more conventional origin for LSD although numerous quantities are of indeterminate origin. The quantities of hallucinogenic mushrooms seized are even more marginal, but, overall, are strongly increasing.

Traffickers questioned by the police in France

The seventeen traffickers interrogated by the police for LSD in France in 2000 only represent 0.3% of all cases of police interrogation for trafficking, with all drugs included. Their number was mainly decreasing until 1999. They are, however, very low and primarily involve small traffickers.

Cases of police interrogation for trafficking in LSD, from 1990 to 2000

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
LSD	25	28	41	29	34	32	27	10	12	11	17
All drugs	5,198	5,303	5,982	6,451	7,179	7,107	8,412	6,560	5,541	5,506	6,531

Source: FNAILS, OCRTIS

Moreover, OCRTIS (*Office central pour la répression du trafic illicite de stupéfiants*: Central Office for the Repression of Drug-related Offenses) recorded 4 cases of police interrogation of traffickers of hallucinogenic mushrooms in 2000.

Local supply: availability, price and quality

The data given here are taken from the TREND observation structure [33].

Availability

The supply of hallucinogenic drugs in France has increased in recent years, particularly in the party environment monitored by the TREND structure. In addition to the traditional drugs such as LSD and hallucinogenic mushrooms, we saw the spread of nitrous oxide, two anaesthetics, ketamine and GHB, and more recently inhibitors such as DMT, 2C-B, DOB, etc.

Small trafficking in LSD is discreet, and appears, in general, to be the work of a fringe of the very marginalized roving population for whom this drug, due to its ease of manufacture and concealment, has become a source of income. The sale of LSD by some small traffickers of cannabis, ecstasy and other stimulant and hallucinogenic substances has also been observed.

Strictly speaking, there is no organised small trafficking in the French variety (psilocybine) of hallucinogenic mushrooms. Most often, they are supplied or sold directly by the collectors themselves. The other varieties are mostly bought in the Netherlands or Switzerland where they are freely sold.

The ketamine - classified as a narcotic by the decision of 8th August 1997 - available on the illegal market comes partly from international trafficking and partly from internal illegal trafficking, essentially from medical and veterinary sources.

Despite the interest it generates among many potential users, the availability of GBH, in the party environment, remains very limited. It is most often reported as rare or unavailable. GHB is generally bought through the Internet or from small-scale producers.

Nitrous oxide is a legal drug used in medicine, the food industry and in home cooking. It is available on the market in food refill capsules or "drop" bottles for medical or industrial use. These "drop" bottles are almost always stolen from hospitals or clinics.

Price

The price of an LSD tab has remained stable in the party environment for a number of years. It ranges from 30F to 60F.

In the harvest season, the price of psilocybine reaches approximately 100 F for 100 units whereas Mexican and Hawaiian varieties are generally sold at 100 F for 20 units or between 100f and 200F per gram.

Balloons filled with nitrous oxide are sold at a price of 10F per unit.

The average price of a gram of ketamine varies depending on the sites and regions, but is generally around 250F to 300F.

Finally, a gram of GHB powder is sold at around 100F and the small-scale producer phial containing the equivalent of 5g in liquid form is sold for between 300F and 500F.

Quality

In 2000, the SINTES (*Système d'identification national des toxiques et des substances*: National system for the identification of drugs and substances) database listed 128 samples sold as LSD, which actually contained LSD in 33% of cases. Cannabinol was found in 34% of the samples, MDMA in 16%, caffeine in 1%, amphetamines in 2% and medications in 9%. Finally, 26% of the sample contained no active ingredient.

Of the 10 samples sold as ketamine and recorded in the SINTES database, 8 were in powder form and 2 in liquid form. Analysis showed ketamine in 8 of these samples, cocaine in 1, Paracetamol® in 1 and one sample had no active ingredient. There were absolutely no amphetamine derivatives.

The database also contains the results of the analysis of 8 samples sold as GHB, 3 in powder form and 5 in liquid form. GHB was actually present in 7 of these 8 samples, with the last containing no active ingredient.

Geography showing the consumption of hallucinogenic drugs

Regional approach

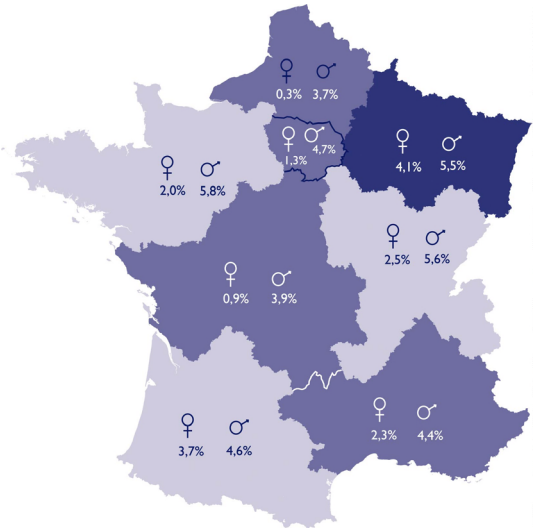
The geographic data on the consumption of hallucinogenic drugs are drawn from the survey conducted on young people at the end of adolescence, during the Defence Preparation Day [8].

As regards cases of care in the regions for the use of hallucinogenic drugs, the figures are so low that it would be risky to comment on their regional breakdown. Only the figures for police interrogations are commented on, even though breaking them down on a geographic basis is equally difficult.

Consumption by adolescents

Experimentation with hallucinogenic drugs (mushrooms and LSD) is particularly strong in the North-East region (4.8% against 3.2% in all of the other regions at 17 years). This is followed by the South-West (4.2%), the Centre-East (4.1%) and the North-West (4.0%), in the middle; then come the South-East (3.3%) and the Parisian region (3.0%); finally the Centre-West (2.4%) and the North (2.0%) complete the market [8].

Prevalence of experimentation with hallucinogenic mushrooms or LSD at 17 years in 2000, by region *{358a}*



Inter-regional comparisons with age and gender checked

Source: ESCAPAD 2000, OFDT

Experimentation with *poppers* appears to be fairly uniform on French territory. It is, however, particularly low in the South-West region (0.9% against 2.4% in all of the other regions at 17 years) [8].

Police interrogation

The 218 cases of interrogation for use or use/dealing in LSD recorded in 2000 by the police services were spread throughout France. At maximum, about twenty cases were recorded in some regions. As the numbers are so low and the breakdown varies from one year to another, it is not possible to draw reliable conclusions.

The majority of hallucinogenic mushroom users were interrogated in the north of France (27 interrogated in the North and 12 in Pas-de-Calais) or in the central regions (10 in Aveyron and 12 in Puy-de-Dôme). These are probably the areas of greatest availability (natural or related to importation).

European approach

In order to compare the situation in France with those of its European neighbours, from the point of view of the consumption of LSD or other hallucinogenic drugs and its consequences, the data was taken from the annual report for 2000 of the *Observatoire européen des drogues et des toxicomanies* (OEDT: European Observatory for Drugs and Drug Addiction, 2000) and other information collected by that organisation. The data is augmented by the ESPAD (European School survey Project on Alcohol and other Drugs) survey on school-going young people in thirty European countries.

Consumption

There appears to be little consumption of hallucinogenic drugs in the general adult population in the European Union, but the information on these drugs coming from surveys on the general population remains fragmented.

In the school-going population, experimentation with hallucinogenic drugs (other than mushrooms) by French pupils of 16 years of age appears quite low, for both boys and girls, as it amounts to 1% against an average of 2%. The highest rates occur in the United Kingdom and the Czech Republic, where they reach approximately 5% (Hibell *et al.*, 2001).

Demands for treatment

As in France, the share of treatments requests related to hallucinogenic drugs as a primary drug did not exceed 0.5% in the majority of the European Union countries at the end of the 1990s.

Police interrogation

Conversely to cannabis or heroin, hallucinogenic drugs do not appear to be the primary drug in question in cases of police interrogation related to drugs[1] in European Union countries (OEDT (*Observatoire européen des drogues et des toxicomanies*: European Observatory for Drugs and Drug Addiction), 2000). There were very few cases of police interrogation for the use of possession of LSD in 1999 (at maximum, they represented 2% of cases, as in Austria). France is therefore in a situation which is comparable to that of the other countries covered, with 0.2% of cases of use/possession related to LSD in 1999.

[1] The term "cases of police questioning related to drugs" may have a very different definition depending on the country. The reason for questioning and the drug are not always reported.

For further information

- BAUDIER (F.), ARÈNES (J.) (DIR.), ADULT HEALTH BAROMETER 95/96, VANVES, CFES, 1997, P. 288
- BECK (F.), LEGLEYE (S.), PERETTI-WATEL (P.), A LOOK AT THE END OF ADOLESCENCE: CONSUMPTION OF PSYCHOACTIVE DRUGS IN THE ESCAPAD 2000 SURVEY, PARIS, OFDT, 2000, P. 220
- BECK (F.), LEGLEYE (S.), PERETTI-WATEL (P.), "ILLICIT DRUGS: PRACTICES AND ATTITUDES", IN GUILBERT (P.), BAUDIER (F.), GAUTIER (A.) (DIR.), HEALTH BAROMETER 2000, VANVES, CFES, 2001, (TO BE PUBLISHED).
- BECK (F.), LEGLEYE (S.), PERETTI-WATEL (P.), ALCOHOL, TOBACCO, CANNABIS AND OTHER ILLICIT DRUGS AMONG COLLEGE AND SECONDARY SCHOOL STUDENTS: ESPAD 1999 FRANCE, VOLUME II, PARIS, OFDT, 2001, (TO BE PUBLISHED).
- BELLO (P.Y.), TOUFIK (A.), GANDILHON (M.), RECENT TRENDS, TREND REPORT, PARIS, OFDT, 2001, P. 167
- CHOQUET (M.), LEDOUX (S.), ADOLESCENTS, NATIONAL SURVEY, PARIS, INSERM, 1994, P. 346
- CHOQUET (M.), LEDOUX (S.), HASSLER (C.), ALCOHOL, TOBACCO, CANNABIS AND OTHER ILLICIT DRUGS AMONG COLLEGE AND SECONDARY SCHOOL STUDENTS: ESPAD 1999 FRANCE, VOLUME I, PARIS, OFDT, 2001, (TO BE PUBLISHED).
- DE PERETTI (C.), LESELBAUM (N.), PARISIAN SECONDARY SCHOOL PUPILS AND PSYCHOACTIVE SUBSTANCES: DEVELOPMENTS, PARIS, OFDT/INRP-PARIS X, 1999, P. 170
- HIBELL (B.), ANDERSSON (B.), AHLSTROM (S.), BALAKIREVA (O.), BJARNASSON (T.), KOKKEVI (A.), MORGAN (M.), THE 1999 ESPAD REPORT: ALCOHOL AND OTHER DRUG USE AMONG STUDENTS IN 30 EUROPEAN COUNTRIES, STOCKHOLM, CAN, 2000, P. 362
- OCRTIS (OFFICE CENTRAL POUR LA RÉPRESSION DU TRAFIC ILLICITE DES STUPÉFIANTS: CENTRAL OFFICE FOR THE REPRESSION OF DRUG-RELATED OFFENCES), USE AND TRAFFICKING OF NARCOTIC DRUGS IN FRANCE IN 2000, PARIS, MINISTRY OF THE INTERIOR, 2001, P. 114
- OEDT (OBSERVATOIRE EUROPÉEN DES DROGUES ET DES TOXICOMANIES: EUROPEAN OBSERVATORY OF DRUGS AND DRUG ADDICTION), ANNUAL REPORT 2000 ON THE STATE OF THE DRUG PHENOMENON IN THE EUROPEAN UNION, LUXEMBOURG, EUROPEAN COMMUNITY PUBLICATIONS OFFICE, 2000, P. 50
- PEZOUS (A.-M.), FERRAND (I.), NUSS (P.), EMERGENCIES AS A MEANS OF OBSERVING THE ACUTE COMPLICATIONS OF NEW METHODS OF USE AND NEW DRUGS, PARIS, OFDT, 2001, (TO BE PUBLISHED).
- SUEUR (C.), BENEZECH (A.), DENIAU (D.), LEBEAU (B.), ZISKIND (C.), "HALLUCINOGENIC SUBSTANCES AND THEIR THERAPEUTIC USES", TOXIBASE DOCUMENTARY REVIEW, NO. 4, 1999, P. 1-28 (PART 1), NO. 1, 2000, P. 1-35 (PART 2).
- TELLIER (S.), THE CARE OF DRUG ADDICTS IN THE HEALTHCARE AND SOCIAL STRUCTURES IN NOVEMBER 1999, PARIS, DREES, 2001, P. 47 (WORKING DOCUMENT NO. 19).
- UNODCCP (OFFICE DES NATIONS UNIES POUR LE CONTRÔLE DES DROGUES ET LA PRÉVENTION DU CRIME: UNITED NATIONS OFFICE FOR THE CONTROL OF DRUGS AND THE PREVENTION OF CRIME), WORLD TRENDS IN ILLICIT DRUGS 2001, NEW YORK, UNITED NATIONS, 2001, P. 282

Psychotropic medications

Reference points

Sales

During the 1990s, the sales of psychotropic medications increased, a trend which was most marked for antidepressants (+ 70%).

In 1999, these sales represented 6% of the total city market, amounting to a turnover of approximately seven billion francs.

Consumption

In the **general adult population**, the consumption indicators have remained relatively stable over the last ten years for anxiolytic agents and hypnotics. On the other hand, there was an upward trend in the consumption of antidepressants.

14% of men and 25% of women had recently used psychotropic medications. Regular consumption of sleeping tablets and tranquillisers alone was recorded for 9% of adults.

Medications stand out from all the other psychoactive drugs due to the fact that they are consumed more frequently by women than by men. For both genders, consumption increases with age.

Among **young persons**, experimentation with these drugs outside the medical prescription framework showed a very clear increase during the 1990s, particularly for boys. Consumption levels nevertheless remained higher for girls: at 17 years of age, 29% of girls had already experimented (11% for boys), and 13% of girls had consumed during the previous month (4% for boys).

The majority of consumption is done in the context of a medical prescription. In the general population, as among young people, self-prescription from the family medicine cupboard is found in a little more than 15% of cases; voluntary misuse “to drug oneself” is very rare. However, the consumption of some of these medications by problematic drugs users is frequently reported by observers in the field.

Consumption of psychotropic medications by the French population

The consumption of psychotropic medications in the French population is described on the basis of survey results from representative samples of the young or adult populations.

Three main classes were studied in the surveys of the general population: hypnotics (sleeping tablets or sedatives), anxiolytic agents (tranquillisers) and antidepressants.

The 1990s saw the appearance, on the antidepressant market, of serotonin and noradrenaline uptake inhibitors (the best known of which is Prozac®). As neuroleptics are rarely the subject of a question in surveys of the general population, they are excluded from the psychotropic medications in this part, except where they were explicitly referred to (as will be seen their prevalence is low).

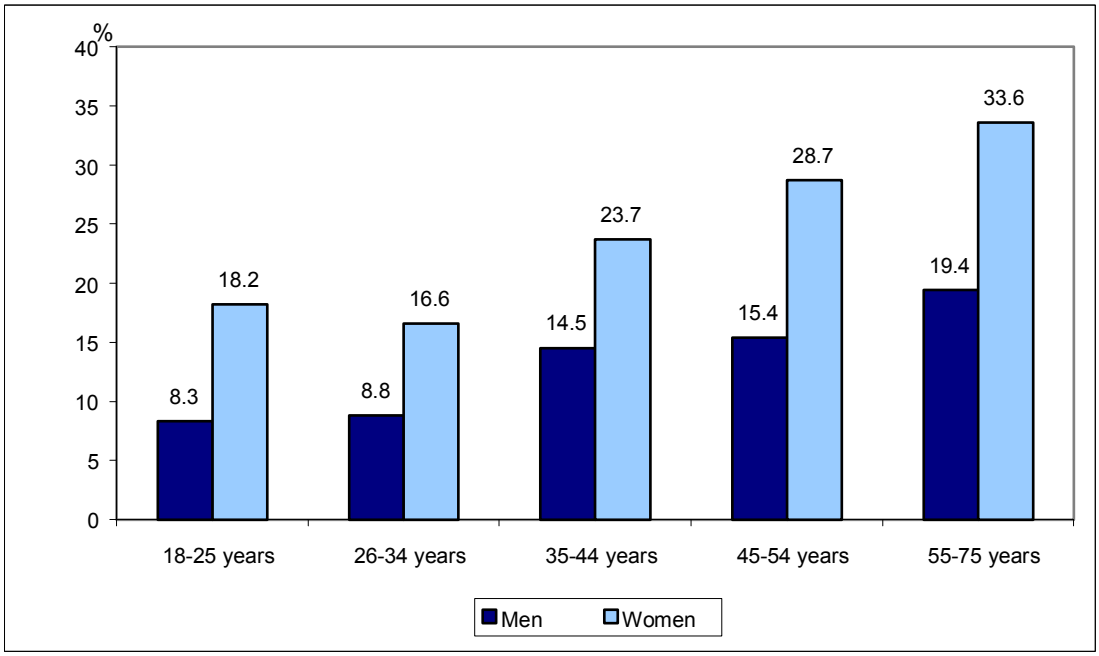
The uses covered here are recent use (having consumed a psychotropic medication during the last twelve months) and regular use (having consumed at least once per week for at least six months (Guignon *et al*., 1994); having consumed within the last seven days [2] or at least once per week during the last thirty days [3]). The question of experimentation (having consumed a psychotropic medication during life) is only asked in surveys on adolescents.

Consumption by the general adult population

Recent use

In the general adult population, the recent use of psychotropic medications involved 14.1 % of men and 25.3 % of women. More precisely, 6.0% of men and 12.4% of women had recently used antidepressants, the figures being 11.7% and 20.3% respectively for the category covering hypnotics and anxiolytic agents. This type of consumption increases with age, while always remaining higher among women. Among 55-75 year-olds, approximately one woman in three had consumed psychotropic medications during the previous twelve months, against one man in five [3].

Frequency of use of psychotropic medications in the general adult population in 2000, by gender and age *{361a}*



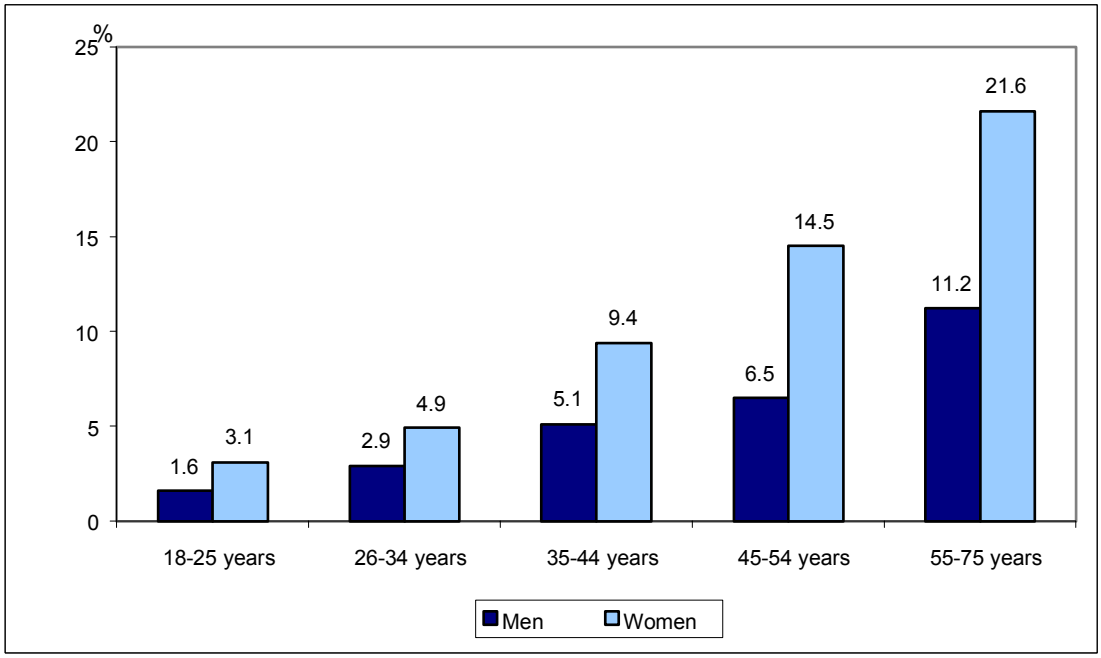
Source: Health Barometer 2000, CFES, OFDT production

Among the individuals who had consumed a hypnotic or anxiolytic agent during the year, 70.5% had also taken them during the previous thirty days, and half of those had taken them on a daily basis [3].

Regular use

In 1999, 9.1% of adults from 18-75 years admitted having consumed hypnotics or anxiolytic agents during the week preceding the survey. The difference between feminine and masculine consumption is accentuated after 45 years. Among 55-75 year-olds, approximately one woman in five had consumed hypnotics or anxiolytic agents once a week in the last thirty days, against one man in ten. [3].

Frequency of the regular consumption of hypnotics or anxiolytic agents in the general adult population in 2000, by gender and age *{361b}*



Source: Health Barometer 2000, CFES, OFDT production

In 1991, information on regular use by type of psychotropic medication was more detailed. The most consumed medications belonged to the anxiolytic class (7.3% of adults). Hypnotics were used by 3.6% of adults and more especially by older persons, while antidepressants were used by 2.0% of adults, particularly by women and younger persons. Neuroleptics, consumed by 0.7% of adults, were mostly consumed by men. Regular consumers of psychotropic medications therefore represent 11.3% of the population (the sum of the proportion of users of each type of drug being greater than the global proportion because some persons consume a number of types of drug) (Guignon *et al.*, 1994).

Of all the prescriptions established on a given day in 1996, approximately 11% included the prescription of at least one psychotropic medication. This consumption had been taking place for at least five years for 57% of these users [26].

In 1996, anxiolytic agents were present in two-thirds of the prescriptions which included at least one psychotropic medication. This was followed by hypnotics and antidepressants (34% and 30% of prescriptions) and then by neuroleptics (8%). Almost one quarter of the prescriptions included at least two types of drug.

Anxiolytic agents are most often prescribed by general practitioners, who represent approximately 85% of the prescribers of psychotropic medications and who initiate the treatment in 50% to 60% of cases. Psychiatrists are mainly at the origin of prescriptions for neuroleptics and antidepressants. This result is also shown by the analysis of the prescriptions reimbursed by the *Caisse nationale d'assurance maladie des travailleurs salariés* (CNAMTS: National illness insurance fund for salaried employees, 2000) which provides information on prescribers. As for all medications, those examined here are mainly prescribed by general practitioners (between 85% and 90% of them). However, antidepressants are also prescribed by psychiatrists: 11.7% for Prozac and 13.5% for Deroxat. These two proportions are high, as the proportions for all other medications are lower than 1%.

Problematic or non-prescribed use.

Although it is difficult to distinguish excessive use, or use which reveals dependence for all use, a number of methods can be explored. The first is based on the appropriateness between pathologies and prescriptions. In 1996, those doctors who had issued prescriptions which included at least one psychotropic medication on

the day of the survey were asked, by questionnaire, as to the pathologies at the origin of the prescription of psychotropic medications. Psychotropic medications were used in more than 80% of cases for psychological problems, associated in 17% of cases with an organic context (for example cardiac problems resulting in anxiety). In 13% of prescriptions, no organic or psychological context was recorded.

On the question of dependence, if the duration of the prescriptions is mainly complied with, it is essential that the prescriptions are renewed often and the cessation of this treatment is considered in fewer cases when the person is old and an attempt at withdrawal may result in failure [26].

The context in which hypnotic or anxiolytic agents, consumed during the last twelve months, were acquired, gives an indication of the type of use. In three-quarters of cases, they had been prescribed by a doctor. They may also have come from the remainder of an old prescription for that person (12.1%) or for a member of the family (4.7%) or have been provided by a pharmacist (7.3%). Hypnotic sleeping tablets or tranquillising anxiolytic agents are very rarely obtained from another person (2.2%) [3].

Some medications are sometimes taken to "drug oneself"; 0.7% of adults had done so during their lives (among these, one-third had used an anxiolytic agent, one-third a hypnotic, 13% an antidepressant, 12% codeine and 6% a neuroleptic) and 0.1% had done so during the year [3].

The consumption of antidepressants appears to be very often linked to a diagnosis of depression (only 0.5% of those who take them had no apparent reason) and part of the population is not treated although, without doubt, they should be. In effect, among the persons who admitted to being depressed, half admitted having consumed an antidepressant the night before the survey and among those who felt they were not depressed, but were recorded as such by the answers to specific questions, only 13% had. (Le Pape and Lecomte, 1999).

Profile of recent consumers

Widows and persons seeking employment are more frequently users of psychotropic medications than the overall population. Conversely to that which is seen for all medications, fewer persons with a higher level of education are found among users of psychotropic medications (Guignon *et al*., 1994).

The use of psychotropic medications is often associated with the use of alcohol and tobacco among men and is much rarer among women. Three-quarters of masculine users of psychotropic medications also consume alcohol and tobacco, while only four women in ten do so (Guignon *et al.,* 1994).

Developments

Between 1993 and 1999, the regular use of hypnotic or anxiolytic agents has proved to be stable, with the same population structure, the proportion of interviewees haven taken them during the last seven days increasing from 8.9% (1993) to 9.2% (1995), and then reducing to 8.7% (1999) for those having taken them at least once a week during the last thirty days [1] [2] [3]. In 1995, between 18 and 34 years of age, the percentage of female consumers was barely greater than male consumers, while above 35 years of age, there were at least twice as many women as men. The difference between the genders is accentuated among the youngest adults, as it now exists from 18 years onwards [2] [3].

Comparison of the results of the health survey of 1991 with that conducted on out-patients in 1996 confirms that the percentage of persons using hypnotics, anxiolytic agents and neuroleptics was of the same order in both surveys. On the other hand, there was a clear upward trend in the consumption of antidepressants: 17% in 1991 (Guignon *et al.*, 1994) against 30% in 1996 [26].

Experimentation and consumption by adolescents

Experimentation

Experimentation with psychotropic medications is relatively common behaviour at the end of adolescence, insofar as it is ahead of that for all drugs, except alcohol, tobacco and cannabis. As is the case for adults, experimentation is clearly more feminine (29% among girls against 10.6% among boys, at 17 years of age).

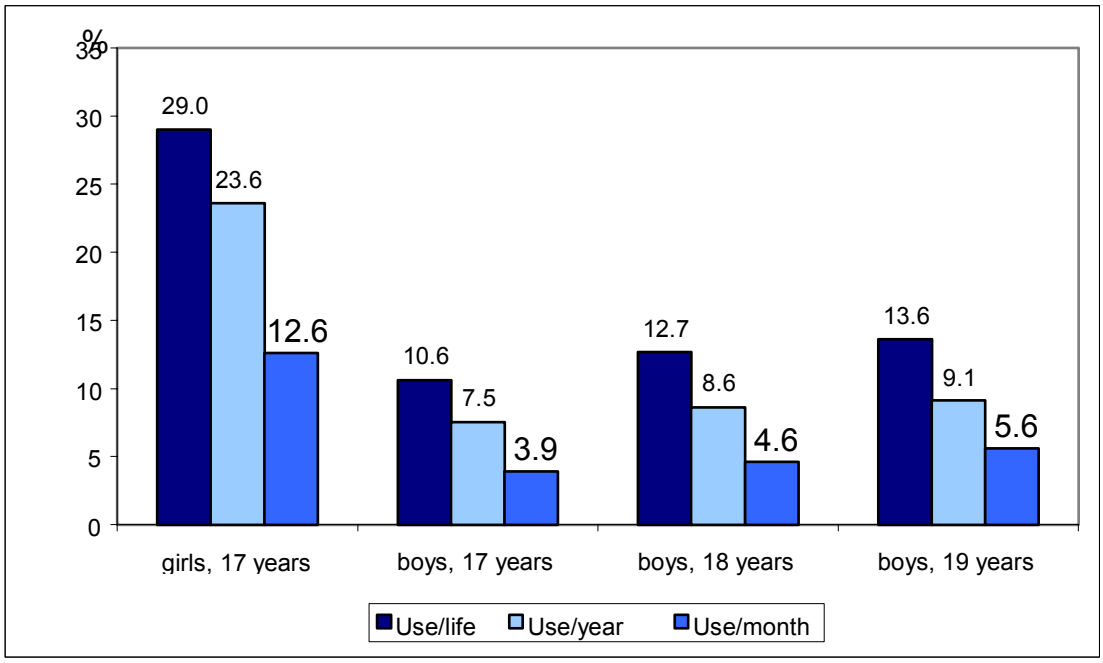
At that age, psychotropic medications are experimented with, on average, at 15 years of age by girls and at 14.6 years of age by boys [8].

Among girls, between 14 and 18 years of age, the proportion of experimenters of psychotropic medications increases with age, while among boys, it is stable [6] [7]. This age effect among girls is found particularly when the medication is taken without medical advice [7].

Current use

At 17 years of age, the difference between the genders remains steady for recent use [8].

Frequency of experimentation and recent use of psychotropic medications among young people at the end of adolescence in 2000, by gender and age *{361c}*



Source: ESCAPAD 2000, OFDT

At 17 years of age, almost three times as many girls as boys had taken "medications for the nerves", irrespective of the period of reference. On the other hand, the breakdown of the number of uses during the year is identical for both genders: 40% of those who consumed during the year admit to one or two uses, and 30% to more than ten. With age, gender and school year repetition checked, the fact of having left the school system has no influence on the consumption of medications, neither during life nor during the year. Among young people who have left the school system, only gender is associated with consumption, while among students, the channel and school year repetition are important: pupils in the professional channel, with all other thing being equal, are approximately 20% less likely to have experimented or used, with school year repetition, to the contrary, increasing the chances by almost 15% [8].

In 1997, 8.7% of 12-19 year-olds had taken a psychotropic medication during the month (7% an anxiolytic agent, 3.5% a hypnotic) [6].

Developments

Since the beginning of the 1990s, there appears to have been an increase in the declarations of the use of psychotropic medications, seen among boys whether they had a prescription or not, and among girls for non-prescribed use [5] [7]. The survey conducted in 1997 did not allow a distinction to be made between these two types of use, but showed that 10% of pupils had taken such medications more or less regularly, and 20% had done so on an exceptional basis (Ballion, 1999).

Frequency of experimentation with psychotropic medications among school-going young persons in 1993 and 1999, by gender

(in %)

	1993		1999	
	Girls	Boys	Girls	Boys
Prescribed	27.1	11.5	23.7	15.8
Non-prescribed	7.7	2.6	17.4	11.0
Total	29.0	12.1	28.9	20.0

NB: the question asked in 1993 related to the last twelve months and that asked in 1999 related to life. These figures include all pupils irrespective of age. The totals are not the sum of the two practices, as the same individual can be involved in both.

Sources: INSERM 1993 ; ESPAD 1999, INSERM/OFDT/MENRT

Observations in the field

There are a large number of psychotropic medications which are likely to be misused. The brand names frequently referred to by the TREND (*Tendances récentes et nouvelles drogues*: Recent trends and new drugs) structure are Tranxene® (dipotassic clorazepate), Stilnox® (zolpidem), Imovane® (zopiclone), Rivotril® (clonazepam), Artane® (trihexyphenidyle), Rohypnol® (flunitrazepam) and Valium® (diazepam). They are mostly drugs of the benzodiazepine family.

Three medications for which the recording structure allowed the collection of pertinent information are covered here: two benzodiazepines (Rohypnol® and Valium®) and Artane®, an anti-Parkinson's drug.

Rohypnol® and Valium®

Rohypnol® (a hypnotic) and Valium® (an anxiolytic agent) are two medications which are used outside the medical context by very marginalized drug users with serious social difficulties (squatters, prostitutes, the homeless and wanderers) Rohypnol® is sought on the one hand, for its uninhibiting and invincibility effects (the "Rambo" effect"), and on the other as a drug associated with the use of opiates (buprenorphine, heroin) and/or alcohol. Valium® is used for similar reasons (coming down, sedation).

The main method of administration observed for Rohypnol® and Valium® is oral consumption. Cases of injection of Valium® have also been reported.

While Rohypnol® appears to be freely available in the majority of the TREND sites, the same is not true for Valium®, whose availability is much more variable. New, more restrictive measures in relation to the prescription and supply of Rohypnol® – which came into effect in February 2001 – will probably change the availability of this psychotropic medication.

Artane®

The use of Artane®[1] is rarely observed, with the exception of three sites covered by the TREND structure (Paris, Seine-Saint-Denis and the Island of Réunion).

The profile of user of this medication is similar to that of benzodiazepine users, essentially marginalized persons. The effects sought are euphoria, hallucinatory delirium and the absence of inhibitions. Artane® is often associated with alcohol, which maximises the effects. The main method of administration is oral. Rare cases of injection have, nevertheless, been reported.

It should be noted that in Paris, Artane® is obtained directly from persons for whom this medication had been prescribed or from small traffickers, as is the case for other medications. In Reunion, however, more substantial cases of trafficking have been observed, from the neighbouring island of Madagascar.

[1] Trihexyphenidyle is a synthetic anticholinergic anti-Parkinson's drug whose two therapeutic indications are Parkinson's disease and Parkinson's neuroleptic syndrome.

Sales of psychotropic medications

Aside from surveys of the general population, the use of medications can be approached through sales data, which come directly from the manufacturers [10], or the city pharmacies [11]. The latter data, which is the only regionalised data, is used for the geographic analysis. We have limited ourselves here to an examination of the four classes of psychotropic medications used: hypnotics, anxiolytic agents, antidepressants and neuroleptics.

The limitations of the sales data are the same as in the case of alcohol and tobacco, as they do not allow a differentiation between exceptional consumption by regulars and those uses which resulted in dependence.

For psychotropic medications normally provided under medical prescription, it is possible to refer to the data resulting from the examination of the prescriptions presented to the social security organisations for reimbursement (*CNAMTS (Caisse nationale d'assurance maladie des travailleurs salariés*: Salaried Employees National Illness Insurance Fund), 2000).

Out-patient or hospital sales in 1999

Due to the counting methods, in units of sale, which is heavily dependent on the packaging of each drug, the comparison of the sales of one category of drug with another is not possible. For this reason, the analysis is essentially centred on developments in sales.

In 1999, the turnover for the four classes of psychotropic medications examined reached more than 6 billion francs for sales in city pharmacies and almost 500 million francs for sales in hospital [10].

The sales in city pharmacies of anxiolytic agents, hypnotics and, to a lesser degree, antidepressants are not of the same order as those for neuroleptics. The latter appear to be most often prescribed in hospital. In terms of turnover, the order is different as it is antidepressants which generate the largest turnover (more than 3 billion francs in 1999), almost three times more than that for neuroleptics or anxiolytic agents. They are also more expensive drugs.

Sales of psychotropic medications and turnover in 1999, by class of drug
(in thousands of units and francs)

	Units of sale		Turnover	
	in city pharmacies	in hospital	in city pharmacies	in hospital
Antidepressants	53,832	1,595	3,044,194	73,097
Neuroleptics	29,234	3,648	1,095,952	254,666
Anxiolytic agents	74,683	2,792	1,096,150	61,512
Hypnotics	73,094	2,766	877,321	105,502

Due to the different packaging sizes, it is not appropriate to add the units sold in city pharmacies to those sold in hospitals

Source: AFSSAPS

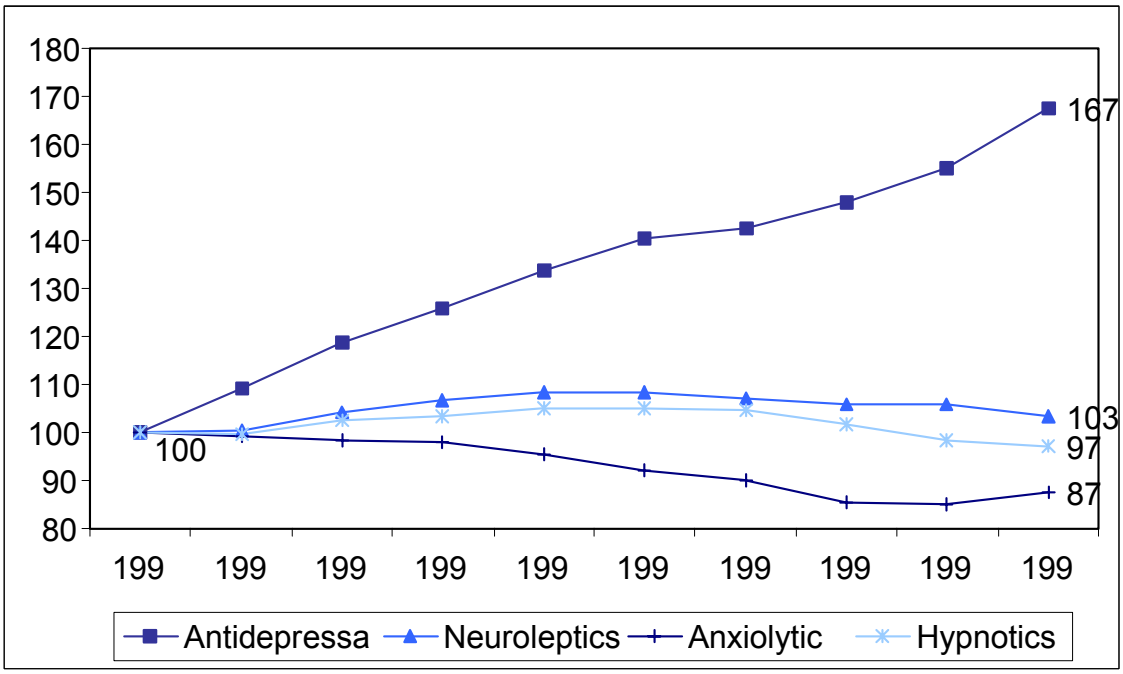
Analysis of the prescriptions reimbursed by the *Caisse nationale d'assurance maladie des travailleurs salariés* (CNAMTS: Salaried Employees National Illness Insurance Fund, 2000) also confirms the importance of the situation of antidepressants in the list of medications consumed in France.

Two antidepressants appear among the ten drugs most frequently presented for reimbursement in 1999: Prozac® and Deroxat®[2]. The first was already classified among the first five drugs in 1993 (CNAMTS, 2000, p. 6).

Developments in sales since 1990

The last decade was marked by the strong increase in the volume of sales of antidepressants (+67%). After a period of minor increase during the first half of the decade, the sales of neuroleptics and hypnotics have been reducing and have virtually reached the 1990 level. Finally, sales of anxiolytic agents have shown an opposite trend; reducing until 1998, they increased by approximately 3% in 1999, but are still, however, below the 1990 level.

Sales of psychotropic medications in city pharmacies from 1990 to 1999, by class of drug *{364a}*
(base of 100 in 1990; in thousands of units of sale)



Source: Sales of psychotropic medications, AFSSAPS

The variations in sales may be related to very different factors such as the developments in packaging, prices or even the placing on the market of new molecules. The withdrawal of a drug, the launch of another or recommendations of moderation are also factors that may influence sales.

Thus, the increase in hypnotics during the first half of the 199s was due to the placing on the market of new packaging with fewer tablets (a box of seven instead of twenty). This measure related to benzodiazepines or related drugs and was encouraged by the health authorities to encourage better use of these drugs. The other psychotropic medications were not subject to packaging modifications which were likely to result in an automatic increase in the number of boxes sold.

The increase in the sales of antidepressants was largely related to the placing on the market of a new type of antidepressant, which was more expensive than the preceding ones. Selective serotonin uptake inhibitors moreover amounted, in 1999, to 57% of the sales of antidepressants in units of sale and to 69% of turnover. As a reminder, these proportions were 15% and 30% in 1990.

Finally, an increase in the price of neuroleptics and the arrival of new specialities favoured the growth in this class of medication, at least until 1997 (ONPCM, (Observatoire national des prescriptions et

[2] At the same level as Vastarel®, Tahor® or Di-Antalvic®.

consommations des médicaments: National Observatory of prescriptions and the consumption of medications) 1998, p. 22).

Health and social consequences of the use of psychotropic medications

The consumption of psychotropic medications may be accompanied in some patients by misuse, abuse and addiction. Persons in these situations may seek assistance from professionals in the healthcare structures or in free practice. The only available figures come from the surveys on the care of drug users in the healthcare institutions. The measurement of care in the city medical services is very difficult as the borderline between the therapeutic uses of psychotropic medications on the one hand, and misuse, abuse and addiction on the other hand, is difficult to establish.

By comparison with the previous data (surveys and sales), the care data is closer to the subject examined in this report, which is the misuse of psychotropic medications (excluding medications with an opiate base), that is to say use which takes place outside the strict context of a medical prescription. This approach does not exclude, however, the cases of problematic use under prescription, due, in particular, to the potential for dependence on these substances.

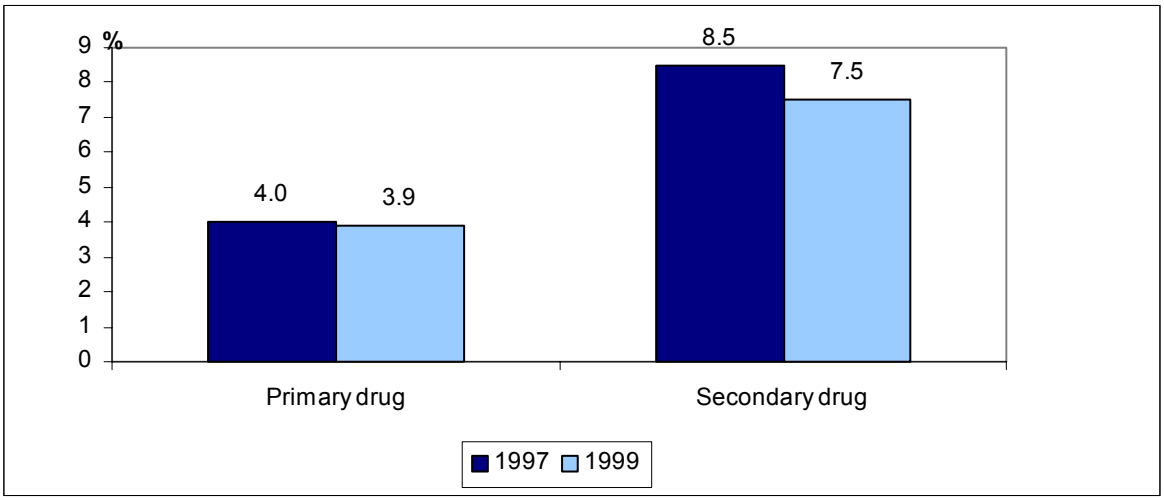
Demands for treatment

In November 1999, psychotropic medications (excluding those with an opiate base) were at the origin of a little less than 4% of care cases related to the use of drugs as a primary drug and 7.5% as a secondary drug [17]. The great majority of the drugs in question were benzodiazepines (70% to 80% of care cases for this group of drugs[3]). Much more often referred to as secondary drugs than as primary drugs, medications are, as are all drugs, very often associated with opiates in care cases, due to the overall weight of opiates in the reasons for care.

The trend between 1997 and 1999 was toward the stabilisation, even reduction, of the share of these care cases in the entirety of care cases.

[3] The other medications referred to were barbiturates, with a small representation, antidepressants and the category of other tranquillisers.

Share of psychotropic medications in the entirety of drug user care cases in 1997 and 1999 *{363a}*



This is the entirety of care cases in the specialist establishments and the healthcare establishments, excluding double counting, with at least one drug referred to as the origin of care (see methodological appendix).

N = 18,075 in 1997 and N = 19,564 in 1999

Source: Survey on the care of drug addicts in November 1997 and 1999, DREES/DGS

While the share of medications as the primary drug in care cases is relatively low, the recent consumption of medications (during the last seven days) appears much more often in the consumption of users. Taking the example of benzodiazepines, the consumption of these substances is reported among 25% of users attending the healthcare structures included in the coverage of the OPPIDUM (Observation des produits psychotropes ou détournés de leur utilisation médicamenteuse: Observation of psychotropic medications or those diverted from their medicinal use) survey in October 1999, a figure which has remained almost stable since 1995 [18]. These medications were prescribed by doctors in almost four out of five cases.

Having regard to the extent of the consumption of psychotropic medications in France, the number of care cases related to medications in the healthcare institutions seems low. General practitioners, the main prescribers of psychotropic medications, are probably the first involved in the care of patients having difficulty with their consumption of psychotropic medications. However, there is no data that allows precise measurement of this.

Characteristics of persons in care.

As for all the drugs dealt with in this report, the characteristics of users are drawn from the cases of care for a primary drug. Psychotropic medications at secondary product level are dealt with in the chapters covering each of the different drugs.

In November 1999

The users taken into care in the healthcare institutions for the use of medications as the primary drug have the specificity of being, on average, a little older than the others and above all of forming the group with the greatest proportion of women (almost 40%). This strong feminine representation is consistent with the results of the surveys on the consumption of psychotropic medications in the whole population which show that more women than men consume these substances. They remain, nevertheless, a minority of the care cases related to medications.

It must also be underlined that the proportion of persons with paid employment is particularly low in these cases, a characteristic found equally among men as among women.

Profile of care cases related to psychotropic medications and opiates (as a primary drug) in 1999

	Medications	Opiates
Number of cares cases (primary drug)	766	13,613
% of first-care cases	32.4	28.7
Average age	32.5	31.5
% under 25 years	17.3	12.8
% of men	60.6	75.9
% of persons sent by the justice	4	6.2
% of persons employed	22.6	38.9
% of pupils and students	5.5	2
% of persons receiving Minimum Insertion Income (RMI)	26.9	30.9
% or persons with opiates as a secondary drug	13.2	-
% of persons receiving substitution treatment	29	74.9
% of persons having used the intravenous duct (currently or previously)	35.5	73
% of persons having used the intravenous duct within the last 30 days	9.5	18.7

Source: Survey on the care of drug addicts in November 1999, DREES/DGS

The most frequently mentioned secondary drugs in these cases were alcohol (25% of cases), medications (13.5%), opiates (13%) and cannabis (10%).

The characteristics of this group of persons taken into care for the use of benzodiazepines are therefore substantially different to those of opiate users.

Developments

The characteristics of persons taken into care for their use of psychotropic medications have not, overall, developed between the months of November 1997 and 1999, except for an increase in the proportion of persons receiving substitution treatment, which increased form 20% to 29% between these two dates, and a minor increase in the share of men (from 58.2% to 60.6%). Among the secondary drugs associated with psychotropic medications as the primary drug, the share of alcohol has tended to increase while that of medications and opiates has reduced.

Morbidity and mortality

The taking of benzodiazepines in association with other substances, in particular, with high-dosage buprenorphine or methadone, may cause respiratory problems which are likely to result in death. According to the OCRTIS (Office central pour la répression du trafic illicite des stupéfiants: Central Office for the Repression of Drug-related Offences) statistics on overdoses detected by the police services, 35 deaths were related to the use of medications. These were essentially substitution medications (Subutex® or methadone) or opiate-based medications (Skenan®, Temgesic®), used alone or together. These cases are covered in the chapter on opiates. The deaths for which toxicological analysis revealed the presence of benzodiazepines are therefore of the order of ten in 2000 (of a total of 120 deaths). Benzodiazepines always appear as an associated drug, either with other medications, or, more rarely, with narcotics [29].

Tranquillisers prescribed to relieve stress or anxiety generally have the effect of removing inhibitions, which may lead users to take uncalculated risks, and in some cases to appear aggressive. As in the case of alcohol, they encourage acting out and may have consequences in terms of delinquent behaviour (particularly when driving). Longer term use of tranquillisers may also result in depression. In the absence of data on these aspects, the consequences of the use of tranquillisers in healthcare and social terms cannot be measured.

Geography showing the consumption and sales of psychotropic medications

Regional approach

The geographic data on consumption are drawn from the Health Barometer [3], and the survey conducted on young people at the end of adolescence, during the Defence Preparation Day [8]. This analysis can be completed by that of the sales by city pharmacies [11]. As regards cases of care in the regions for the use of psychotropic medications, the figures are so low that it would be risky to comment on their regional breakdown.

Consumption in the general population

Among 15-44 year-olds, the use of psychotropic medications during the last twelve months appears to be relatively uniform throughout French territory. Only the Provence-Alpes-Côte d'Azur (with Corsica) and the Franche-Comté regions are higher than the rest of France, while the Ile-de-France is lower. Among those over 45 years of age, only Basse-Normandie and Bretagne appear to consume less than the others.

Consumption at the end of adolescence

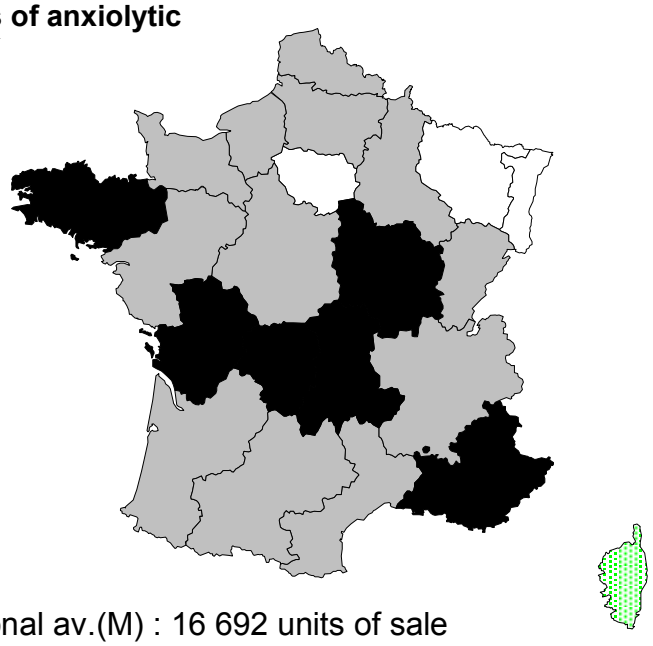
Experimentation with psychotropic medications at 17 years of age is fairly uniform throughout French territory, in particular among girls where no region differs significantly from any other. It appears to be at a minimum in the North-West region (25.2% against 28.1% for all the regions), while for boys, the difference here is significant (7.1% against 10.0% for all the other regions). The highest proportions are recorded in the Centre-East for both boys (12.3%) and girls (33.0%), while the Parisian region is distinctive only for boys [8].

Sales

Some similarities, but mostly geographic contrasts were observed between the sales of anxiolytic agents, hypnotics and antidepressants in the city pharmacies in France during 2000:

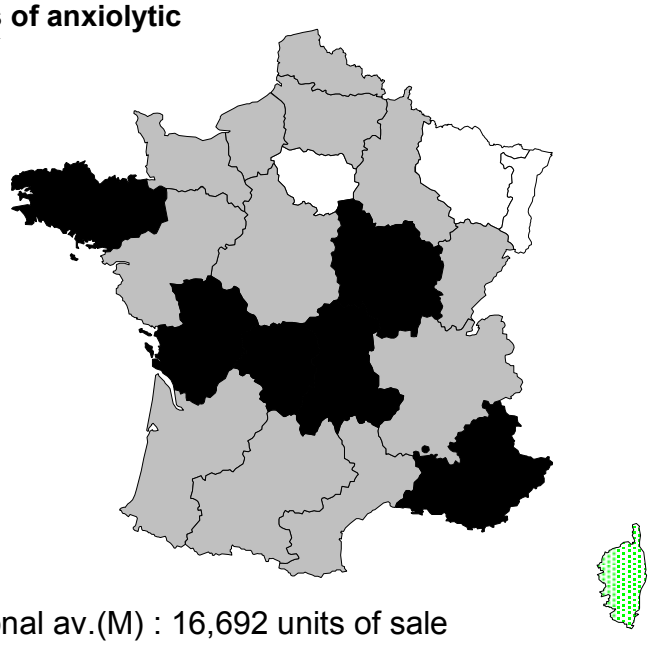
Sales of anxiolytic agents in 2000, by region *{365a}*

Sales of anxiolytic



national av.(M) : 16 692 units of sale

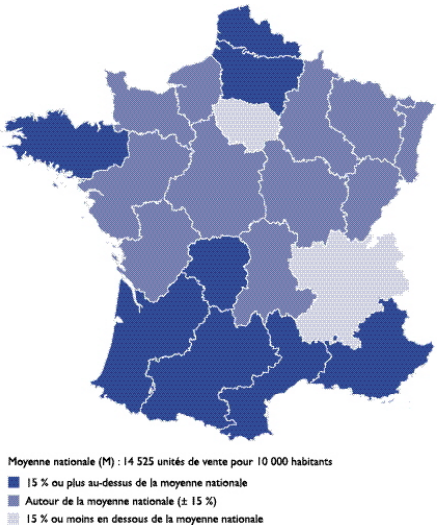
Sales of anxiolytic



national av.(M) : 16,692 units of sale

National average: 16.692 units of sale of anxiolytic agents for 10,000 inhabitants from 15 to 75 years of age.
Source: Sales in city pharmacies 2000, IMS-Health [11]

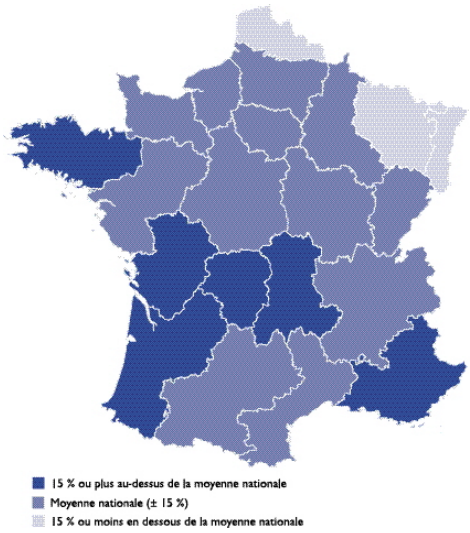
Sales of hypnotics in 2000, by region *{365b}*



National average: 14,525 units of sale of hypnotics for 10,000 inhabitants from 15 to 75 years of age.

Source: Sales in city pharmacies 2000, IMS-Health [11]

Sales of antidepressants in 2000, by region *{365c}*



National average: 13,405 units of sale of antidepressants for 10,000 inhabitants from 15 to 75 years of age.

Source: Sales in city pharmacies 2000, IMS-Health [11]

Irrespective of the category of psychotropic medications examined, the region of Limousin is characterised by strong sales, probably related to the size of the population of older persons in this region. It is followed by Bretagne and Provence-Alpes-Côte-d'Azur, regions which also appear among the large consumers of medications, irrespective of the class considered. At the opposite end of the scale, Alsace, Lorraine and the Ile-de-France region record relatively low sales of psychotropic medications when compared with their population [11].

In a more general way, the strong similarities between the sales situation for antidepressants and for anxiolytic agents must be noted, with substantial regional disparities. Sales of hypnotics are distributed more throughout the territory.

European approach

In order to compare the situation in France with those of its European neighbours, from the point of view of cocaine consumption and its consequences, the data was taken from specific analyses or from the ESPAD (European School survey Project on Alcohol and other Drugs) survey on school-going young people in thirty European countries (Hibell *et al.*, 2001).

France is one of the countries with the highest consumption of medications (Chambaretaud, 2000). Psychotropic medications are not exempt from this rule, with France ahead of all of its neighbours, particularly Germany, the Benelux countries, the United Kingdom, Spain and Italy. It was, however, behind Denmark in 1994 (Legrain et al., 1997).

Within the school-going population and among the thirty countries covered by the ESPAD survey, use during life of tranquillisers or sleeping tablets by French students of 16 years of age placed France among the leading countries, with or without prescription, for both boys and girls. When use with a prescription is examined, France, with 18%, is situated in second place behind the Czech Republic (25%) and at the same level as Croatia. The European Union countries are around the average of 10%. For tranquillisers or sleeping tablets taken without a prescription, the situation is little different, with France, at 12%, being situated in third position behind the Czech Republic and Poland (18%) and at the same level as Lithuania (Hibell *et al.*, 2001).

For further information

BALLION (R.), THE DEVIANT BEHAVIOUR OF PUPILS, PARIS, OFDT/CADIS, 1999, P. 243

BAUDIER (F.), ARÈNES (J.) (DIR.), ADULT HEALTH BAROMETER 95/96, VANVES, CFES, 1997, P. 288

BAUDIER (F.), JANVRIN (M.-P.), ARENES (J.), YOUNG PERSONS HEALTH BAROMETER 97/98, VANVES, CFES, 1998, P. 328

BECK (F.), LEGLEYE (S.), PERETTI-WATEL (P.), A LOOK AT THE END OF ADOLESCENCE: CONSUMPTION OF PSYCHOACTIVE DRUGS IN THE ESCAPAD 2000 SURVEY, PARIS, OFDT, 2000, P. 220

BECK (F.), LEGLEYE (S.), PERETTI-WATEL (P.), "ILLICIT DRUGS: PRACTICES AND ATTITUDES", IN GUILBERT (P.), BAUDIER (F.), GAUTIER (A.) (DIR.), HEALTH BAROMETER 2000, VANVES, CFES, 2001, (TO BE PUBLISHED).

BECK (F.), LEGLEYE (S.), PERETTI-WATEL (P.), ALCOHOL, TOBACCO, CANNABIS AND OTHER ILLICIT DRUGS AMONG COLLEGE AND SECONDARY SCHOOL STUDENTS: ESPAD 1999 FRANCE, VOLUME II, PARIS, OFDT, 2001, (TO BE PUBLISHED).

CAVALIE (P.), RAUSS (A.), ANALYSIS OF THE SALES OF MEDICATIONS TO PHARMACIES AND HOSPITALS IN FRANCE. 1988-1999, SAINT DENIS, AFSSAPS, DEPARTMENT OF MEDICAL-ECONOMIC STUDIES AND SCIENTIFIC INFORMATION, 2001, P. 86

CHAMBARETAUD (S.), "THE CONSUMPTION OF MEDICATIONS IN THE MAIN INDUSTRIALISED COUNTRIES", DREES STUDIES AND RESULTS, NO. 47, 2000, P. 1-8.

CHOQUET (M.), LEDOUX (S.), HASSLER (C.), ALCOHOL, TOBACCO, CANNABIS AND OTHER ILLICIT DRUGS AMONG COLLEGE AND SECONDARY SCHOOL STUDENTS: ESPAD 1999 FRANCE, VOLUME I, PARIS, OFDT, 2001, (TO BE PUBLISHED).

CAISSE NATIONALE DE L'ASSURANCE MALADIE DES TRAVAILLEURS SALARIÉS (CNAMTS: SALARIED EMPLOYEES NATIONAL ILLNESS INSURANCE FUND), MEDICAM: MEDICATIONS REFUNDED BY THE GENERAL ILLNESS INSURANCE SYSTEM IN 1999, PARIS, CNAMTS, 2000, P. 33

GUIGNON (N.), MORMICHE (P.), SERMET (C.), " THE REGULAR CONSUMPTION OF PSYCHOTRIPIC DRUGS" , INSEE PREMIÈRE, NO. 310, 1994, P. 1-4.

HIBELL (B.), ANDERSSON (B.), AHLSTROM (S.), BALAKIREVA (O.), BJARNASSON (T.), KOKKEVI (A.), MORGAN (M.), THE 1999 ESPAD REPORT: ALCOHOL AND OTHER DRUG USE AMONG STUDENTS IN 30 EUROPEAN COUNTRIES, STOCKHOLM, CAN, 2000, 362 P.

LE MOIGNE (P.), ANXIOLYTIC AGENTS, HYPNOTICS : THE SOCIAL FACTORS OF CONSUMPTION, 1999, P. 50 (GDR DOCUMENTS PSYCHOTROPIC DRUGS, POLICY AND SOCIETY, N° 1).

LE PAPE (A.), LECOMTE (T.), PREVALENCE AND MEDICAL CARE OF DEPRESSION IN 1996-1997, PARIS, CREDES, 1999, P. 100 P. (COLLECTIVE REPORT NO. 1277).

LEGRAIN (M.), LECOMTE (T.), "THE CONSUMPTION OF PSYCHOTROPIC DRUGS IN FRANCE AND SOME EUROPEAN COUNTRIES", BULLETIN OF THE NATIONAL ACADEMY OF MEDICINE, VOL. 181, NO. 6, 1997, P. 1073-1087.

LEMOINE (P.), " PSYCHOTROPIC MEDICATIONS: THE BIG DEAL? ", TOXIBASE REVIEW, NO. 1, MARCH 2001, P. 2-12.

ONPCM (OBSERVATOIRE NATIONAL DES PRESCRIPTIONS ET CONSOMMATIONS DES MÉDICAMENTS: NATIONAL OBSERVATORY OF PRESCRIPTIONS AND THE CONSUMPTION OF MEDICATIONS), STUDY OF THE PRESCRIPTION FOR AND CONSUMPTION OF ANTIDEPRESSANTS BY OUT-PATIENTS, PARIS, MEDICINES AGENCY, PHARMACOLOGIAL-ECONOMIC STUDIES AND INFORMATION DIVISION, 1998, P. 33.

TELLIER (S.), THE CARE OF DRUG ADDICTS IN THE HEALTHCARE AND SOCIAL STRUCTURES IN NOVEMBER 1999, PARIS, DREES, 2001, 47 P. (WORKING DOCUMENT NO. 19).

ZARIFIAN (E.), THE PRICE OF WELFARE: PSYCHOTROPIC DRUGS AND SOCIETY, PARIS, ODILE JACOB, 1996, P. 282

ZARIFIAN (E.), GENERAL MISSION IN RELATION TO THE PRESCRIPTION AND USE OF PSYCHOTROPIC MEDICATIONS IN FRANCE, PARIS, MINISTRY OF SOCIAL AFFAIRS, HEALTH AND THE CITY, 1996, P. 402.

Doping substances

Introductory remarks

This chapter deals with the question of psychoactive drug consumption to improve one's performance, whether it's concerning doping in the strictest sense of doping, i.e. use of prohibited drugs or procedures, mostly by sportsmen (see chapter relative to legal framework), or, in its larger sense, of taking any drug the user thinks might improve performances.

Because of the broadness of this field of study, compared to the other developed studies of consumption in this report, entry by substance is not the most adapted here, because the doping behaviours are characterized, above all, by a practice (Researched effects or personal reasons characterise doping: increasing one's capacities, performances, etc.). Thus, in terms of drugs, other than those pertaining to the list of prohibited substances defined by the Youth and Sports Ministry ([1]), it is necessary to take into account certain narcotics, psychotropic drugs, and also common medications, and abundantly consumed substances (coffee), etc.

The position adopted here thus navigates between these various notions (sports doping, consumption to improve one's performances, and consumption of prohibited doping substances, etc.). In this chapter, variety and ambiguity of definitions is considered. Finally the mobilised sources shape up the maintained approach.

Generally speaking, the mass expertise on doping and sports practicing achieved in 1998, underlined the lack of epidemiological data necessary for measuring the phenomenon of doping in France [CNRS (, 1998]. The studies carried out since seem to focus, essentially, on the links between sports practicing and use of drugs ([2]). This is particularly what the European seminar, organized in December 2000, has revealed ([3]). This chapter concerns the image of this field of study that is still under construction, and finally, doping, as tackled by the media through (isolated) case recalling of professional sportsmen, is minimally discussed here.

[1] *List of French specialty medical products containing prohibited substances and/or subjected to certain restrictions within the framework of the regulation against doping.*

[2] See : Aquatias *et al*., 1999 ; Beck *et al*., 2001 ; Choquet *et al*., 1998 ; Lowenstein *et al*., 2000.

[3] European seminar « Sports Practicing for young people and risk behaviours » organised within the framework of the French presidency on the 5th and 6th of December 2000 (2001).

Reference points

In this field, more than any other, the limited numbers of available data make it impossible to establish an undisputable statement. Only some fragmented elements can be presented. Putting them into perspective does not make it possible to file a precise report on the phenomenon of doping in France.

Consumption

- In adults, 6% took at least one substance to improve their physical or intellectual performances during the past twelve months. Mainly, they are common prescribed drugs, like vitamins, and not prohibited drugs indicated on the list, to be exact.
- In adult amateur sportsman, the consumption of doping substances does not seem to be totally marginal: between 3 and 10% according to studies.
- In young people, 11% of school students tried, at least once in their lives, a drug to improve physical or intellectual performances. Here it is a matter of common prescribed drugs, rather than doping substances. These consumptions concern boys more than girls. They are related to sports practicing and depend on the nature of this sports activity; track and field sports and combat sports are particularly concerned.

Anti-doping fight

- The number of anti-doping tests increased significantly these last few years (9,500 in 2000). The presence of doping substances has increased in 3.7% of the cases. This figure is stable during the last few years. The main substances detected are cannabinoids, salbutamol (Ventoline®), corticosteroids and stimulating agents. Solely available, this indicator is, nevertheless, insufficient to track the evolution of the doping behavioural significances.

Drug consumptions in order to improve performances

The consumption of psychoactive substances in the French population, for the purpose of improving performances, is described throughout the results of the revealing survey made on samples representing young or adult populations. In adults, the uses considered here are recent use (to have consumed a drug to improve performances during the last twelve months) and, in adolescents, experimentation (to have consumed a drug to improve performances during life).

Consumption by the general adult population

Among the 15-75-year-olds, 5.9 % took at least one drug to improve physical or intellectual performances during the last twelve months. This behaviour is slightly more female-oriented (6.5% as opposed to 5.3 in men). As is clear from the investigations, seeking improvement in performances reveals contrasting behaviours, as indicated in the following table, but corresponds especially to the use of vitamins [3].

Frequency of use, during the past twelve months, of drugs consumed to improve performances in a general adult population in 2000

(in%)

During the past twelve months, have you consumed drugs to improve your results or your physical or intellectual performances?	
Vitamins	2.9
Medications for the memory	0.7
Nutrition complements	0.8
Magnesium-zinc-phosphorous	0.7
Phytotherapy and homeopathy	0.3
Anti-asthma agents	0.3
Anti pain	0.2
Amphetamines	0.1
Other*	0.2
Unidentified substances	0.6
Total	5.9

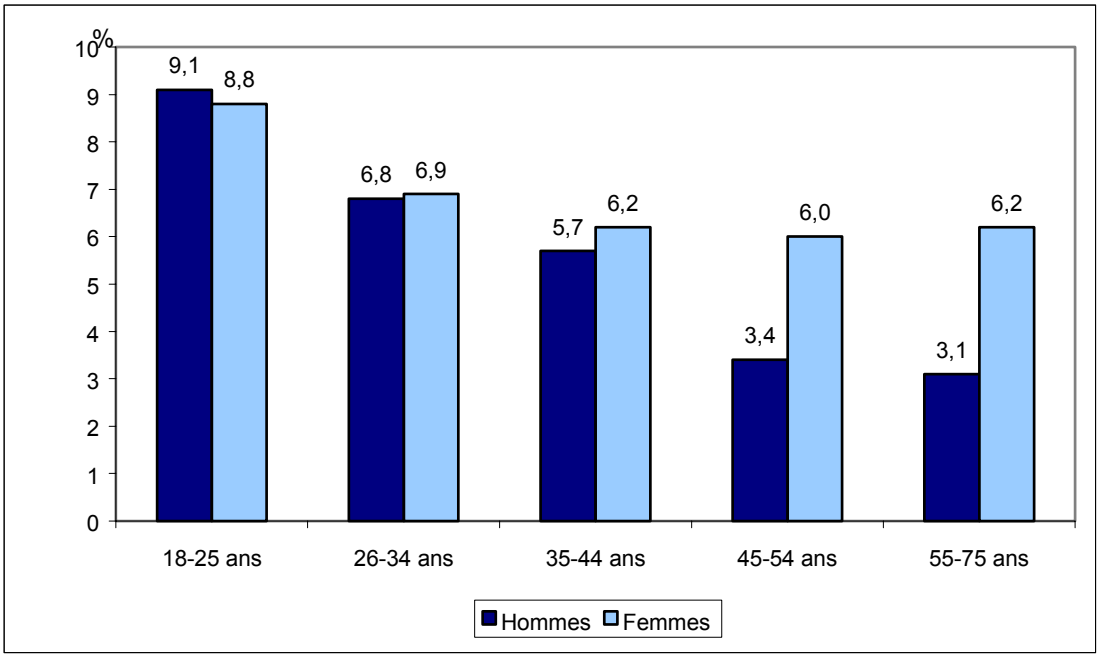
NB : it was possible to list many drugs

** This category contains narcotics (n = 6), doping substances (n = 10) and miscellaneous drugs (n = 6).*

Source : Health barometer 2000, CFES (Comité français d'éducation pour la santé: French Centre for Health Education), exploitation OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction)

If the prevalence for men, during the past twelve months, decreases continuously with age, it is not the case for women for whom the prevalence remains stable between 26 and 75 years of age [3].

Frequency of use, during the past twelve months, of drugs consumed to improve performances in a general adult population in 2000, by sex and age *{381a}*



Source : Health barometer 2000, CFES (Comité français d'éducation pour la santé: French Centre for Health Education), exploitation OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction)

Consumption among adult sportsmen

Very few surveys were conducted directly relating to sportsmen, amateurs or professionals. The topic is considered highly delicate, because doping is against sports ethics.

A recent synthesis of the existing epidemiological data on this topic yielded that the percentage of amateur adult sportsmen, announcing their consumption of doping substances for the purpose of improving their performances, varies between 3.1 and 9.5%, according to two French studies (Laure, 2000b), one of which pertains to approximately 2000 amateur sportsman in Lorraine, questioned in 1996 (Middleton, 1999).

This study equally shows that it is especially the competitors who use these drugs (10.8% amongst them), but those participating in leisure sports don't abstain, either (4.8%). Resorting to doping is related to the level of the sports competition: 17.5% of high-level athletes announce resorting to doping as opposed to 10.3% of sportsmen from lower levels. Finally, 5.8% of graduate sports teachers in Lorraine (1994-1997) confessed doping during the past twelve months averaging 1 to 6 times (30% further speculate that without doping, a sportsman has no chance to succeed and that 10% of doping medications helps and is harmless to health). The main drugs used for doping are the stimulating agents (44.9% substances listed), narcotics (27.5), corticosteroids (11.6%), or other substances (16%) (Laure, 2000a).

Consumption by adolescents

At the end of adolescence, 4.5% of young people questioned have already taken a drug to improve physical or sporting performances during their lifetimes. For corticosteroids, anabolic steroids, and other hormones, the observed prevalence is very week [8].

Frequency of experimenting with a drug to improve physical or sporting performances in young people at the end of the adolescence in 2000

(in%)

In the course of your life, have you taken before a drug to improve your physical or sporting performances?	
Stimulating agents (amphetamines, cocaine, a high dosage of caffeine)	1.5
Corticosteroids	0.3
Anabolic steroids	0.3
Other hormones	0.2
Other	3.2
Total (all substances mixed)	4.5

Source : ESCAPAD 2000, OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction)

This prevalence varies according to sex and age: at the age of 17, it rates 2.1% for girls, and 4.7% for boys. At the age of 18, it reaches 5.6%, and 6.1% at the age of 19. It is also more significant for adolescents who have an intense extra-curricular sports activity, since it reaches 7.8% for those who participate in more than eight hours of sports weekly. Regarding the various categories of disciplines, among the 4.0% of those surveyed who practice musculature (or body-building), 10.2% have already taken a doping substance (as opposed to 4.3% for the rest of those questioned), this very significant relation remains valid for girls as for boys [8].

Among young school students, 0.7% reveal having already consumed anabolic steroids and 0.3% have consumed anabolic steroids more than five times during their lifetimes. The prevalence concerns the boys (1.1%) more than the girls (0.4%), but increases with age. The weekly sports practicing of students who have already taken anabolic steroids is 6.9 hours. One in five reveals not to have practiced sports in the course of the year [7].

For the question: 'During your lifetime, have you ever taken a drug to improve your physical, sporting or intellectual performances', 11.0% of young school students named at least one drug, but 5.0% did not specify which drug. The drugs mentioned the most are vitamins.

Frequency of experimenting with drugs to improve physical, sports, or intellectual performances in young school students in 1999

(in%)

During your lifetime, have you ever taken a drug to improve your physical or sporting performances?	
Vitamins	2.6
Medications for the memory	1.0
Amphetamines and other excitant	0.8
Proteins and energising beverages	0.7
Narcotics and alcohol	0.3
Magnesium-zinc-phosphorous	0.3
Phytotherapy and homeopathy	0.3
Peptide hormones	0.1
Other	0.4
Not specified	5.0
Total	11.0

Categories that concern at least 0.15 of the students has been included in the category 'Other'. This is the case of benzodiazepines, corticosteroids and betablockers.

Source : ESPAD 1999 ; INSERM (Institut national de la santé et de la recherche médicale: National Institute for Health and Medical Research)/OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction)/MENRT

These different categories of drugs, owing to the diverse profiles of consumption, can be grouped into two principal types: Common prescribed drugs or socially integrated (a group that includes vitamins, medications for the memory, proteins and energising beverages, magnesium/zinc/phosphorous, phytotherapy and homeopathy and concerns 4.5% of the students), and drugs classified on the list of prohibited doping substances and methods subjected to certain restrictions (a group that includes amphetamines and other excitant, narcotics and alcohol, peptide hormones, benzodiazepines, corticosteroids and betablockers and concerns 1.% of the students), the category 'Other', which is very heterogeneous, has been left aside.

Frequency of experimenting with common prescribed drugs 'doping' substances, according to the profile of young school students in 1999

(in%)

		Common prescribed drugs	'doping' substances
Boy		4.5	2.0
Girl		4.5 (ns)	0.8 (2)
14 years old		4.3	1.4
15 years old		3.7	0.9
16 years old		3.4	1.3
17 years old		4.1	1.4
18 years old		6.2	1.5
19 years old		5.4 (2)	1.7 (ns)
Cannabis use:	yes	4.6	2.6
	no	4.4 (ns)	0.7 (2)
Regular use of alcohol:	yes	4.6	4.3
	no	4.5 (ns)	1.0 (2)
Cannabis regular use:	yes	4.2	4.8
	no	4.6 (ns)	1.1 (2)
Regular use of tobacco:	yes	3.6	2.3
	no	4.9 (1)	1.0 (2)
Practicing sports:	yes	5.3	1.6
	no	3.2 (2)	0.9 (2)

ns, (1), (2) : respectively, non-significant, significant with threshold 0.01 and significant with the threshold 0.001.

Source : ESPAD 1999 ; INSERM (Institut national de la santé et de la recherche médicale: National Institute for Health and Medical Research)/OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction)/MENRT

Common prescribed or socially integrated drugs are connected with older individuals, but equally among girls and boys. The use of cannabis (experimenting or regular) and of alcohol seems without incidence, contrary to the regular use of tobacco that turns out to be negatively correlated. Practicing sports and, particularly, joining a club, is a factor that determines the consumption of this type of drug.

For drugs classified on the list of prohibited doping substances and methods subjected to certain restrictions, the profile of students having consumed such substances during their lifetimes is different than the preceding profile: this behaviour is rather masculine, but does not differ by age, nor by the school year results. It is well linked to practicing sports and to the use of all observed psychoactive substances, including the regular use of tobacco [7].

An upcoming study concentrates on the link between taking drugs and a classification in six groups, created from the intensity of practicing of each group of discipline and between the global weekly duration (Faugeron *et al*., 2002).

Frequency of experimenting with a drug to improve performances according to the profile of young sportsmen school students in 1999

(in%)

	Common prescribed drugs	'Doping' substances
Sports practicing weak or nil (n = 4 994)	3.5	0.8
Regular practicing of dance and gymnastics (n = 1 182)	5.3	0.7
Recreational practicing of individual sports (n = 2 481)	6.3	1.2
Intensive practicing of collective sports (n = 2 207)	4.1	1.8
Intensive practicing of martial arts (n = 499)	5.8	1.8
Intensive practicing of track and file sports and combat sports (n = 507)	8.9	3.0

Source: ESPAD 1999; INSERM (Institut national de la santé et de la recherche médicale: National Institute for Health and Medical Research)/OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction)/MENRT

Having recourse to this typology, globally confirms the link between the intensity of sports practicing and consumption of drugs to improve performances, except for intensive mass sports practicing, which leads to a lower consumption of common prescribed or socially integrated drugs. Overall, intensive practicing (the three final classes) favours taking drugs of the doping type, and particularly those for the track and field and combat sports (pupils of this class are masculine in majority), showing a tie to a specific body.

To put it into perspective, the toll-free number 'Listen Doping', instituted on the 24th of November 1998, recorded, in its April 1999 report, 2,640 calls received. Three quarters of the callers were men, and 44% were adolescents or preadolescents. They were divided as follows: sportsmen (45%), supporters (10%), trainers (7%), managers (5%), and others (33%). Requests are principally made for *creatine*, a drug of which consumption does not appear in the revealing survey.

Frequency of drugs evoked at the time of 'Listen Doping' calls in 1999

(in%)

Creatine	45
Cannabis	24
Energetic drugs, amphetamines	15
Anabolic steroids	10
Cocaine	8
Medications	4

Source : 'Listen Doping' 1999

In the second report of the toll-free number 'Listen Doping' on the 31st of October 1999, the main sports mentioned were cycling (45%), musculature and weight lifting (28%), athletics (18%) and football (9%). In the ESPAD survey, cycling and athletics seem to be linked to taking drugs, but not necessarily strongly linked to doping substances. As for boxing, musculature and weight lifting, same as for the football and rugby, the link to consumption of doping substances is more evident, but the intensity of practicing these mass sports does not appear to be linked to taking common prescribed drugs. 'Institutional' approaches are then complementary to the 'general population' approaches.

Frequency of the disciplines mentioned on the line 'Listen Doping' according to the use of common prescribed drugs and ' doping' substances in 1999

(in%)

	Common prescribed drugs	'Doping' substances
Cycling/athletics:		
no	3.7	1.0
yes, from time-to-time	5.3	1.5
yes, regularly	6.7	2.0
yes, in competition	7.4 (2)	2.7 (1)
Boxing/weight lifting/musculature:		
no	4.2	1.1
yes, from time-to-time	6.7	3.3
yes, regularly	7.7	2.2
yes, in competition	5.1 (2)	6.6 (2)
Football/rugby:		
no	4.5	0.9
yes, from time-to-time	4.8	1.6
yes, regularly	4.3	1.6
yes, in competition	3.8 (ns)	3.3 (2)

ns, (1), (2) : respectively, non-significant, significant with threshold of 0.01 and significant with the threshold of 0.001.

Source : ESPAD 1999 ; INSERM (Institut national de la santé et de la recherche médicale: National Institute for Health and Medical Research)/OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction)/MENRT

On the other hand, in a survey in Midi-Pyrénées, 7.1% of the adolescents say they have taken a doping substance or 'maybe doping', which represents a prevalence of 8.5% among sportsmen. This behaviour is more masculine (10.65 against 3.8% in girls) and progresses with age in boys (7.9 between those of ages 13-15 and 15.6% between those of ages 18-20) (Pillard *et al*., 2000).

Opinions regarding doping

When asking 15-75-year-old people about their fears to try a doping substance, only once, only 7.0% will not be afraid at all, and 10.6% probably won't have fears. This level is the same for amphetamines, creating less fear than all other illicit drugs except cannabis, but definitely more that psychotropic medications, tobacco or alcohol [9].

An IFOP/Youth and Sports Ministry survey asked the opinion of the French people, 970 adults, in November 1998, regarding the measures adopted in the framework of the anti-doping fight.

Proportion of opinions in favour of few propositions on doping

(in%)

Are you in favour of the following measures :	Yes
The fight must be led on the European and universal level	86
An obligatory medical follow up must be implemented for high level sportsmen	84
Judiciary pursuits of purveyors must be reinforced	76
An independent council must be created	73
The physician must be forced to forbid a sportsman who uses doping substances from practicing	72
Sanctions against doped sportsmen must be extended	65

Source : IFOP/Youth and Sports Ministry, 1998

Questions about doping were also posed to 503 adolescents, 11-15-year-olds, during a CSA survey. This survey was conducted through face-to-face discussions from the 21st of October till the 24th 1998.Young adolescents were relatively tolerant to sportsmen who dope, and about a quarter of them said they were ready to try a drug to improve their performances.

Answer frequencies to the question: What will be your attitude if you hear about a substance that will allow you to improve your sport?

(in%)

I would not take it no matter what	73
I would take it if I was certain it is not dangerous	13
I would try it at least once to see	10
Don't know	4

n = 359 regular sports practitioners

Source : CSA ; 1998

Answer frequencies to the question: What would be your reaction if it were proven that one of your favourite sportsmen was taking doping substances?

(in%)

I would be disappointed; I would stop admiring him	66
I would understand a great effort is asked of them so that they have to take some substances to make it	27
Don't know	7

Source : CSQ ; 1998

Answer frequencies to the question: To you, a sportsman who dopes, is:

(in%)

A cheater	47
A professional who wants to be even better	32
A victim	17
Don't know	4

Source : CSA ; 1998

Answer frequencies to the question: According to you, what should be the best regulation regarding doping?

(in%)

Completely prohibit all doping substances	52
Prohibit only drugs that could be dangerous to the health of sportsmen	33
Inform the sportsmen about the dangers of doping substances and leave them free to choose	14
Don't know	1

Source : CSA ; 1998

Health and social consequences of the use of doping substances

Taking into consideration the health and social care responsibilities for the users of doping substances, is a field that remains, as yet, inadequately documented. To explain it, many non-exclusive statements could be set forward:

- These drug users are not distinguished from those being taking care of.
- If they are being taking care of, it remains confidential.
- The specialised arrangements for taking care of them is not yet developed.

The data presented comes out from punctual investigation and is usually local. It furnishes the first elements of awareness, but cannot be extrapolated. As for the morbidity of death related to the use of doping products, other than the anecdotal cases told in the press, the scope of the information is fragmented, and if the existence of encountered risks seems undeniable, they are not yet quantified in a scientific manner (Gallien, 1998).

Amplitude and characteristics of the care

The creation of care agencies to fight against doping is recent (it was decided by the legislator in 1999.) and care agencies do not offer, for the moment, data on the responsibilities toward doping. This is the reason that the most active persons are still general practitioners, pharmacists, and centres specialised in drug addiction care (CSST: Drug Addiction Treatment Centre).

According to two French studies, conducted on 300 professionals, one-third were self-employed general practitioners (Laure, 2000a, p. 261), and one-third of the drugstore pharmacists (Laure, 2000a, p. 263) said they were confronted with one demand related to sports doping in the past twelve months.

To physicians, the clients in concern were either confirmed consumers of prohibited substances, persons seeking advise for future use, or persons requesting a prescription (Laure, 2000a, p. 261). The pharmacists' clients requested either information regarding a drug, or delivery of the drug itself. Most of the time, requests concerned anabolic steroids (Laure, 2000a, p. 263).

In 1997, an analysis of the clients of two CSSTs (Drug Addiction Treatment Centre) revealed the presence of many sportsmen among consumers, of heroin in particular. Some of them confessed consuming heroin during the period of practicing sports, sometimes along with doping substances (amphetamines, anabolic steroids). It is possible that word-of-mouth amplified the phenomenon in these centres; stemming from, of

course, former sportsmen (CRIPS (Centre régional d'information et de prévention du Sida: Regional Information and Prevention Centre for AIDS); Toxivar, 1997).

We can equally mention the help system, 'Listen Doping', from which results were presented earlier.

Anti-doping fight

The French legislation concerning the fight against doping, distinguishes between sportsmen, users of doping substances, and purveyors of these substances. The first encounter of sports sanctions comes following the disciplinary procedures conducted by the federations, the second is equally submissive to criminal sanctions.

Acts for the fight against doping versus drug users, are gauged by anti-doping tests, and versus purveyors, are gauged by more classic penal indicators.

As for all illicit substances, the data obtained gives insight into the trafficking of doping substances. But, the picture is still incomplete; there was no structured provisioning sequence in France, beforehand.

As a matter of fact, the majority of the doping substances are medications that have been misused; they can be prescribed by physicians and sold in pharmacies. It seems that the majority of sportsmen acquire the substance from pharmacies, with the help of medical prescriptions (Gallien, 1998). A study conducted in 1997, on 186 amateur sportsmen who admitted doping, specify that 61% were supplied by physicians, 20% supplied by the black market, 15% from supporters, and 4% by other means (Laure, 2000a, p. 318).

Anti-doping tests

In 2000, the Minister of Youth and Sports reckoned 9,457 eliminations taking place during the 1,636 anti-doping tests, on more than 60 different sports federations. The presence of doping substances was revealed in approximately 350 of these eliminations, i.e. in 3.7%. (Youth and Sports Ministry, 2001b), noting that these tests were quite often conducted in the direction of sports disciplines, for which the probability of doping is strongest. Thus, in 2000, 22% of the eliminations concerned cycling, 11% athletics, 6% football, etc.

The positive analyses of the year 2000, revealed the presence of different substances:

Frequency of the detected substances at the time of the anti-doping tests in 2000
(in%)

Main substance detected	
Cannabinoids	23
Salbutamol	22
Corticosteroids	20
Stimulating agents	19
Anabolic steroids	10
Other*	6
Total (N = 323)	100

** Local anaesthetics, narcotics, diuretics, betablockers and beta2-agoniste (other than salbutamol)*

Source : Youth and Sports Ministry

The main substances detected are cannabinoids, salbutamol (substance which makes up Ventoline® in particular), corticosteroids, and stimulating agents. The presence of anabolic steroids is more rare (but remains stable from one year to the next). Cannabis is found in nearly all tested disciplines and usually corresponds to the only prohibited substance discovered (Youth and Sports Ministry, 2001b).

In 1999, it was equally specified that sanctions were pronounced in 80% of the cases in which the analyses proved positive to prohibited tests, with the exception of the cases when the matter was during training. These sanctions range from one month to one firm year. The remaining 20% of sanctions has placed those using prohibited and authorised substances under certain conditions (medical prescription, threshold not to be surpassed, etc.), which are given instead of a calmative, or for a medical prescription accepted by the disciplinary commission (Ministry of Youth and Sports, 2000).

In spite of the perceived increase in eliminations since 1996, and in 2000 in particular, during the preparations for the Olympic games in Sydney, the percentage of positive cases remains visibly stable, around 3.5%.

Number and results of the antidoping tests conducted in France from 1996 to 2000

	1996	1997	1998	1999	2000
Number of fulfilled* eliminations	5,483	5,228	7,113	7,726	9,457
% of positive cases	3.5	3.6	2.5	3.6	3.7
in men	3.9	4.0	2.9	4.0	-
in women	2.2	2.3	1.2	2.5	-

** A physician delegated to conduct an anti-doping test can make many eliminations (between 4 and 8 on average).*

Source : Youth and Sports Ministry

This percentage is still more significant in men than in women. It is usually slightly higher in foreign sportsmen, i.e. non-licensed by the French federation, than in French sportsmen.

'The efficiency of the anti-doping fight does not rely on multiplying the number of tests conducted, but on improving their goal (especially a better follow-up on sportsmen during their training period) and, in particular, on the detection, the sensitivity, and the margin of the results of the collected specimen' (CNRS 1998).

As a matter of fact, the limitations of this source as an indicator of the prevalence of doping in the sports environment are several and hold to:

- The difficulty to detect certain substances and procedures (taking into consideration the duration of the elimination and, therefore, the detection of substances—half-life—and the fact that sportsmen know how to hide their consumption and play within the legal thresholds)
- The accuracy of the tests: they are usually conducted at great sports events, and consumption can easily be reduced during these periods
- The small number of tests compared to the number of licensed sportsmen.

Customs action

Customs can take action on two levels: when it stops certain prohibited substances in France, and when in the presence of persons holding large quantities of certain substances, even if the substances are authorised.

By doing so in 1998, Customs Services registered 48 offences that led to the capturing of approximately 50,000 doses of 'products of anabolic steroids effects'. Most of these arrests were made during traffic tests, mainly at the Belgian, Spanish and Swiss borders. Mainly, the acts concerned sportsmen and body-builders. (DGDDI (Délégation générale à la lutte contre la drogue et la toxicomanie : General Delegation for the Fight Against Drugs and Drug Addiction), 1999).

These results are greatly declining, compared to 1997, in which 61 offences were recorded and 105,280 doses seized. However, compared to 1994, the growth is evident, in numbers of infractions as well as in the quantities seized (Halba, 1999, p. 43).

Geography showing the consumption of doping substances

Only the European approach is treated here. For the French references, the actual investigations throughout the entire population are too weak to represent the geographical aspect of substance consumption for the purpose of improving performances. Responsible or relative data for the anti-doping fight are not analysed geographically.

Furthermore, it is difficult to compare the French situation to its European neighbour's from the point of view of doping substances consumption and its consequences. As a matter of fact, the investigation data from the entire population in European Union countries cannot be used, because it is partial and diverse. Finally, the only data that are actually comparable are those from the ESPAD investigations (conducted on young 15-16-year-old pupils in 30 European countries. They concern the use of anabolic steroids throughout the young pupils' lifetimes (Hibell, *et al*., 2001).

In the heart of the school population and among thirty countries questioned in the ESPAD investigations, the lifetime usage of anabolic steroids by French students of the age 16 ranks France slightly below average, for boys as well as girls. The prevalence is about 1% on average, being higher in boys (about 2%); it is easier to compare only the two. France, with 1%, is behind Greece and Ireland (3%) as well as Norway, Sweden, United Kingdom and Portugal (2%). The countries in which the use by boys is more common are Poland (6%) and Cyprus (5%) (Hibell, *et al*., 2001).

For further information

■ Sports practicing for youngsters and risk behaviours Acts of the European seminar of the 5th and 6th of December 2000, Paris, Youth and Sports Minister, MILDT (Mission interministérielle de lutte contre la drogue et la toxicomanie: Interministerial Mission for the Fight Against Drugs and Drug Addiction), 2001, p. 106.

■ Aissi (F.), 'Doping', Toxibase documentary journal, n° 4, 1996, p. 1-31.

■ Aquatias (S.), Desrues (I.), Leroux (M.), Stettinger (V.), Valette-Viallard (C.), Sports Activities, risk practicing, use of doping and psychoactive substances: research on modern practicing of sports, Paris.

■ RESSCOM, Youth and Sports Ministry, 1999, p. 270.

■ Beck (F.), Peretti-Watel (P.), EROPP 99 : survey on representations; opinions and perceptions related to psychotropic drugs, Paris, OFDT, 2000, p. 203.

■ Beck (F.), Legleye (S.), Peretti-Watel (P.), a look at the end of adolescence: consumptions of psychoactive substances in the ESCAPAD survey 2000, Paris, OFDT, 2000, p. 220.

■ Beck (F.), Legleye (S.), Peretti-Watel (P.), 'Sports practicing and use of psychoactive drugs, from adolescence to adult age', Tendency, n° 13, 2001, p. 1-4.

■ Beck (F.), Legleye (S.), Peretti-Watel (P.), 'Illicit drugs : practicing and attitudes'; in Guilbert (P.), Baudier (F.), Gautier (A.) (dir.), Health Barometre 2000, Vanves, CFES, 2000, (to be published).

■ Choquet (M.), Bourdessol (H.), Arvers (P.), Guilbert (P.), De Peretti (C.), youngsters; Sport, risk behaviour, Paris, Youth and Health Ministry, 1998, p. 157.

■ CNRS (Centre national de la recherche scientifique), Collective expertise: doping and sports practicing, synthesis report, CNRS, 1998, link valid on the 19th Oct. 2001, p. 20. (http://www.cnrs.fr/SDV/dopagetexte.html).

■ CRIPS Provence-Alpes-Côte d'Azur, Sport, doping and addictive behaviours: documentary file, CRIPS PACA, 2000, link available on 19th Oct. 2001, p. 7.

(http://www.crips.asso.fr/webpaca/jdpaca/sport/dopage.htm).

■ DGDDI (Direction générale des douanes et droits indirects), Customs in 1988, Paris, Economy, Finance and Industry Ministry, 1999, p. 34.

■ Faugeron (C.), Kokoreff (M.), Society with drugs : stakes and limits, Ramonville-Sainte-Ag*ne, Erès, (to be published in 2002).* Gallien (C.L.), The doping in question, National French Olympic and Sports Committee, 1998, link available on the 19th Oct. 2001, p. 60.

(http://www.franceolympique.com/dossiers/dopage/dopage_questions.htm).

■ Halba (B.), Doping and sport, Paris, Milan, 1999, 63 p. (Coll. The essentials Milan).

■ Hibell (B.), Andersson (B.), Ahlstrom (S.), Balakireva (O.), Bjarnasson (T.), Kokkevi (A.), Morgan (M.), The 1999 ESPAD report: Alcohol and Other Drug Use among Students in 30 European Countries, Stockholm, CAN, 2000, p. 362.

■ Laure (P.), Doping and society, Paris, Ellipses, 2000a, p. 447.

■ Laure (P.), 'Doping: epidemiological data', Medical press, vol. 29, n° 24, 2000b, p. 1,365-1,372.

■ Lowenstein (W.), Arvers (P.), Gourarier (L.), Porche (A.S.), Cohen (J.M.), Nordmann (F.), Prevot (B.), Carrier (C.), Sanchez (M.), 'Sports and physical activities in the precedents of persons faced with addiction charges. 1999 report on the study financed by the Youth and Sports Ministry (France)', Annales of an intern physician, vol. 151, 2000, p. A18-A26.

■ Middleton (O.), 'Young sportsmen, doping and physicians', THS journal vol.1, hors-série spécial jeunes, 1999, p. 19-21.

■ Youth and Sports Ministry, Antidoping fight, Internet file, 2001a, link available on the 19th of October 200, (http://www.jeunesse-sports.gouv.fr/francais/mjsluttedop.htm).

■ Youth and Sports Ministry; Sports management, Public and sportsmen protection office (DS/5), Antidoping testes in France. Presentation of the statistics 2000; Youth and Sports Ministry, 2001b, p. 30.

■ Youth and Sports Ministry, Sports management, Public and sportsmen protection office (DS/5), presentation of the statistics 1999 about anti-doping tests, Youth and Sports Ministry, 2000, p. 36.

■ Pillard (F.), Grosclaude (P.), Navarro (F.), Godeau (E.), Rivière (D.), 'Epidemiological research on sports doping in the school environment in the Midi-Pyrénées region in 1999: preliminary results', BEH (Bulletin épidémiologique hebdomadaire), no. 42, 2000, p. 185-186.

■ Toxivar, Acts of the Sport conference, doping and addictive behaviours organized by Toxivar, IRFFD (Institut régional de formation aux fonctions de direction), 1997, link available on the 19th Oct., 2001 p. 18.

(http://cafdes2004.free.fr/dwld/toxicomanie/Sport%20et%20dopage.htm).

Tobacco

Reference points

Sales

- Tobacco sales have been in steady decline since 1991, the year that the Evin Law was passed. Nevertheless, a reversal of this trend began to appear in 1997. In subsequent years a slight increase in sales can be seen.
- In France, the turnover in tobacco sales represents 83 billion francs, 75% of which goes to the State in the form of taxes.

Consumption

- For the general adult population, a global downturn in consumption was noticed in the 1990s; however, this downturn masks an increase in consumption by women.
- In the general adult population, experimentation with tobacco is very widespread among both men (88%) and women (76%), while figures for current use stand at 39% of men and 30% of women. Those who consume tobacco every day—a figure that decreases sharply with age—represent 33% of men and 26% of women.
- Among young people, between the end of the 1970s and the start of the 1990s, consumption by 12-18-year-olds followed a global trend downward; however, from the start of the 1990s, a visible increase appeared among 14-18-year-olds, both in experimentation and in daily use.
- Experimentation with tobacco is a very common experience in late adolescence. More than three quarters of young people state that they have already tried tobacco, and experimentation is a little more common among women (79% of girls as opposed to 76% of boys, at age 17). At 17, five out of ten young people have smoked at least one cigarette during the previous month, and four out of ten have smoked on a daily basis (42 % of boys and 40 % of girls).
- Apart from alcohol, tobacco is the psychoactive product with which experimentation occurs at the earliest age, about 14 on average.

Health and social consequences

- Tobacco is the psychoactive product resulting in the most serious health consequences. It is considered to be responsible for 60,000 deaths per year, or more than one death in nine. The main tobacco-related pathologies are cancers of the upper lung/larynx tract, cardio-vascular diseases and respiratory diseases. It is estimated that smoking is a risk factor for nearly one in six hospital admissions.
- At the present time, this death rate is largely a male phenomenon: men account for 95% of the 60,000 tobacco-related deaths. Yet, this characteristic is changing over time with the increase in female tobacco consumption, which seems to be catching up with levels observed among men. For women, tobacco-related mortality is increasing, and will continue to rise over the next twenty years—faster than for men.
- Treatments for smoking are still comparatively marginal, bearing no relation to the seriousness of the health consequences cited above. The number of smokers treated in general practices, or by specialist organizations, is in the realm of tens of thousands. The most widely used method is the use of nicotine substitutes.

- People have been able to purchase these tobacco replacement products without a medical prescription since the end of 1999. Consequently, sales of these products underwent an appreciable rise in 2000, when the number of people concerned was estimated at 100,000 per month. The corresponding turnover for these sales is 628 million francs.

Consumption of tobacco by the French population

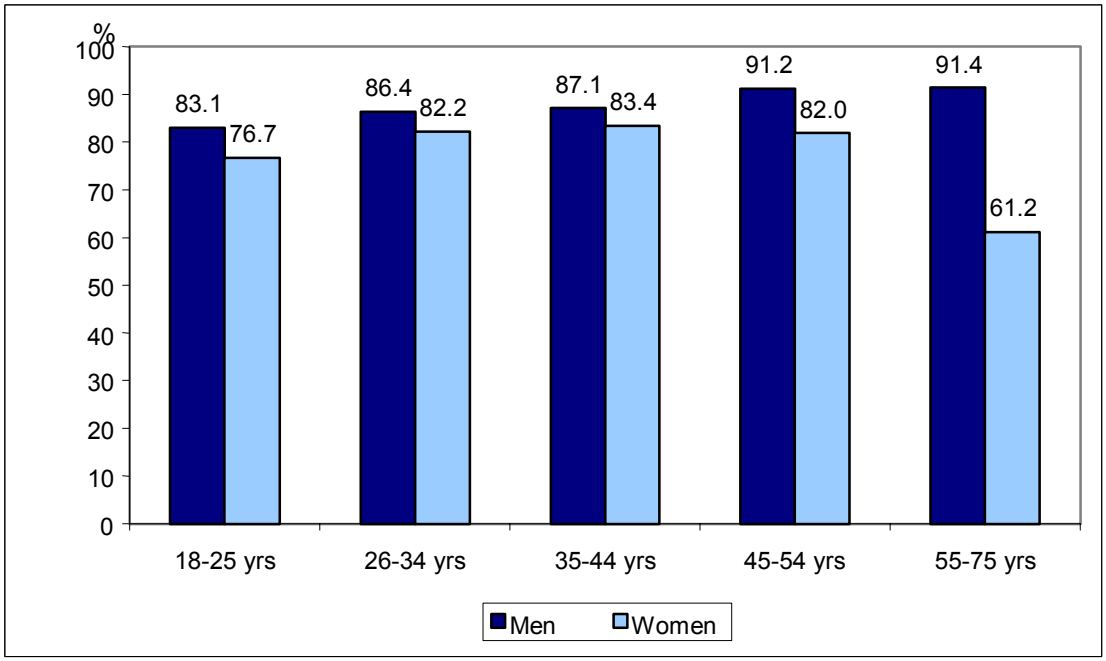
Tobacco consumption in the French population is determined from the results of declarative surveys of representative young or adult population samples. The types of usage considered here are experimentation (at least one cigarette consumed during the subject's life), current use (might only be smoking from time-to-time), and daily use (smoking at least one cigarette per day).

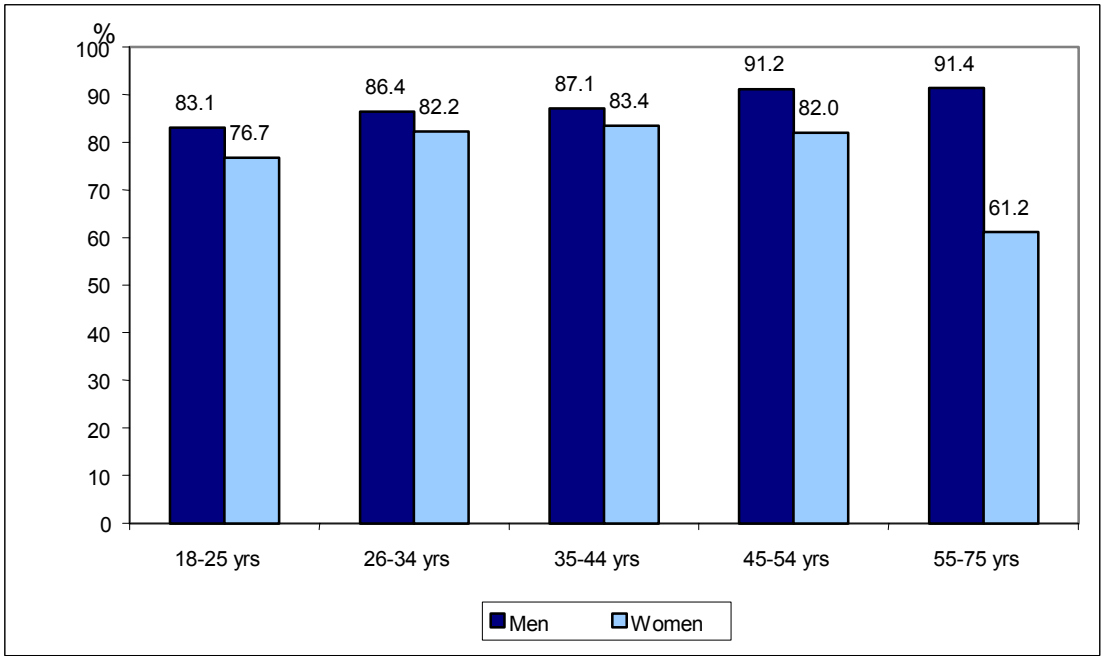
Consumption by the general adult population

Experimentation

In the general adult population, experimentation with tobacco is more widespread among men (88.4 %) than women (76.0%). It is only in the over-55 age group of women that experimentation is noticeably less common, representing a generational difference [3].

Frequency of tobacco experimentation in the general adult population in 2000, by sex and age *(391a)*

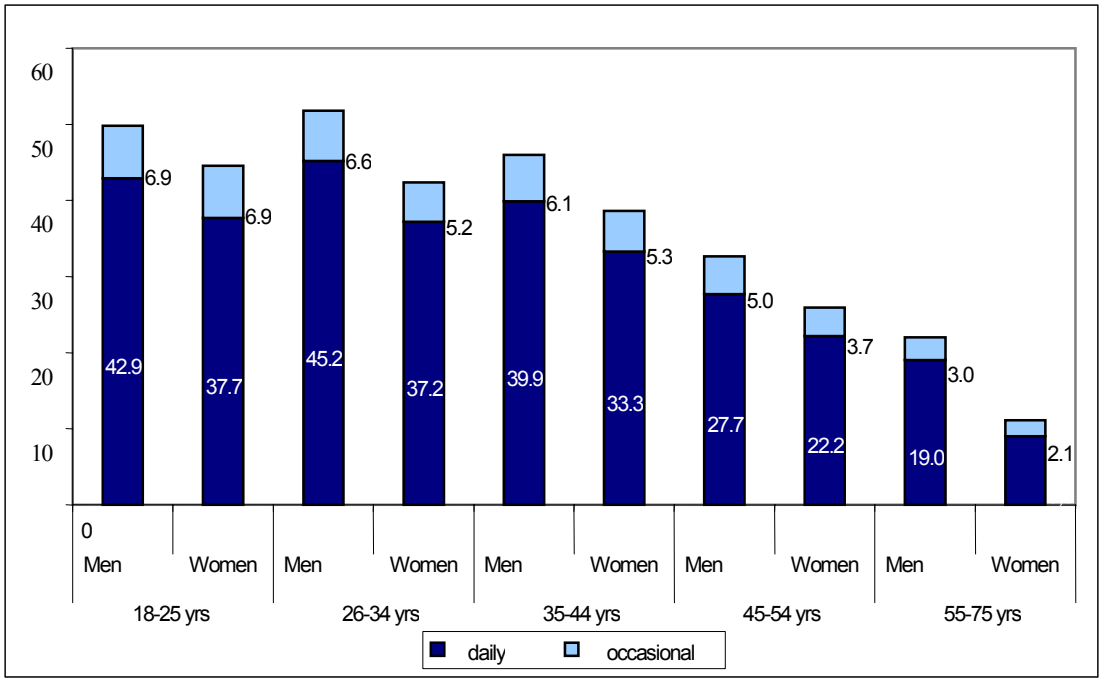




Source: ***Baromètre Santé 2000, CFES (Comité français d'éducation pour la santé : French Centre for Health Education), used by OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction)***

Current consumption

Frequency of current tobacco consumption in the general adult population in 2000, by sex and age *(391b)*



Source:
Baromètre Santé 2000, CFES(Comité français d'éducation pour la santé : French Centre for Health Education), used by OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction)

As regards current consumption, 38.6% of men and 30.3% of women state that they smoke 'only from time-to-time'[1]. Daily consumption of tobacco involves 33.2 % of men and 26.0 % of women. It decreases sharply with age [3]. About 13 million daily smokers were counted [4]. According to various surveys, the average number of cigarettes smoked per day by daily smokers is about 14: 15 for men, 13 for women (for the purposes of this calculation, by convention, one cigar is equal to 2 cigarettes, one pipe to 5 cigarettes) [25] [3].

Among current smokers, 45% consume between 1 and 10 cigarettes per day, and 39% smoke between 11 and 20. Consumption higher than forty cigarettes per day is rare, with only 1% of smokers declaring this level of consumption. The cigarette is by far the most used means of tobacco consumption, to the extent that pipes and cigars are used as their main product by less than 2% of smokers [4].

10% of daily smokers smoke their first cigarette within five minutes directly after waking, 23% between six and thirty minutes after waking, 17% between half-an-hour and one hour, and 50% after more than an hour after waking. The first cigarette of the day is smoked earlier, on average, by men and by older smokers. The earliness of the first daily cigarette has a strong relationship to the quantity consumed: 39.5% of those who smoke their first cigarette within the first five minutes of the day smoke more than 20 a day, as opposed to only 1% of those who do not smoke in the first hour after waking. Those who smoke immediately upon waking experimented with tobacco at a younger age (42% smoked before the age of 15, as opposed to the 31% who did not smoke within the first hour of waking) and became regular smokers at an earlier age. Higher numbers of these smokers also smoke in no-smoking areas wherever they are [3].

[1] Repeating the terms of the question.

Among the 9 million individuals smoking at least 10 cigarettes a day, 5.3 million come up as positive for the Fagerström mini-test, which shows signs of dependency (smoking at least 20 cigarettes a day or smoking the first cigarette within half-an-hour after waking) [3].

Profiles of current smokers

Unemployment is the occupational circumstance most associated with smoking tobacco, as 52% of unemployed people are smokers. Among employed men in 2000, 45% of manual workers smoke, 37% of employees in intermediate occupations, 31% of managers, and 25% of farmers.

Plans and attempts to give up

Among current smokers, 58.4% show a desire to stop smoking, with similar proportions for both men and women, and higher proportions between the ages of 26 and 54; however, in one out of two cases, the plan to give up is postponed to an unspecified date, and this phenomenon is even more marked when daily consumption is high. Only 30.9% consider the possibility of consulting a doctor about giving up (this proportion is higher for women, and increases with age). Stopping abruptly, using willpower alone (50.8%), stopping by gradually reducing consumption (28.3%), and using nicotine patches (19.6%) are the methods most often considered. Acupuncture (7.7%), nicotine gum (5.6%), psychotherapy (4.0%) and other medical methods (2.6%) receive mention. Men, using willpower alone, most often cite stopping abruptly. Among those who have stopped or tried to stop for at least one week at some point in their lives, the main reasons given are: awareness of health consequences of smoking (20.2%), fear of becoming ill (14.8%), pregnancy or birth (13.9%), fatigue (13.1%), wanting to be in good physical condition (11.9%), and the price of cigarettes (9.8%)—this last reason being mentioned by young people in particular [3].

Passive smoking and respect for no-smoking areas

71.6% of adults state that other people smoking bother them. Non-smokers mention this twice as much as current smokers (81.2% as opposed to 43.3%). Women state that they are 'very bothered' more frequently than men (43.4% as opposed to 33.6 %) [3].

The no-smoking areas most respected by adults are public transport (Only 4.8% of smokers asked, admitted to smoking there.), followed by restaurants (10.8%), the workplace (15.5%) and bars and cafes (18.5%). Women who smoke, state less often than men that they do so at their workplace (12.7% as opposed to 17.4%) or in bars and cafes (14.6% as opposed to 21.7%) [3].

Perceptions of the dangers of tobacco

For 46.7 % of the 18-75-year-olds, smoking tobacco is dangerous to the health from the first time that it is tried, for 8.2%, the danger starts with smoking tobacco from time-to-time, and 43.2% consider that this danger starts when one smokes tobacco on a daily basis. Among the last group, in terms of the number of cigarettes per day, 20% consider that it becomes dangerous to smoke tobacco at the level of one cigarette per day, 13% at two to four cigarettes per day, 19% at five or more, 22% at ten or more and 13% at twenty or more. Women perceive that the danger starts with experimentation more often than men do; the youngest people have a greater tendency to equate it to daily usage.

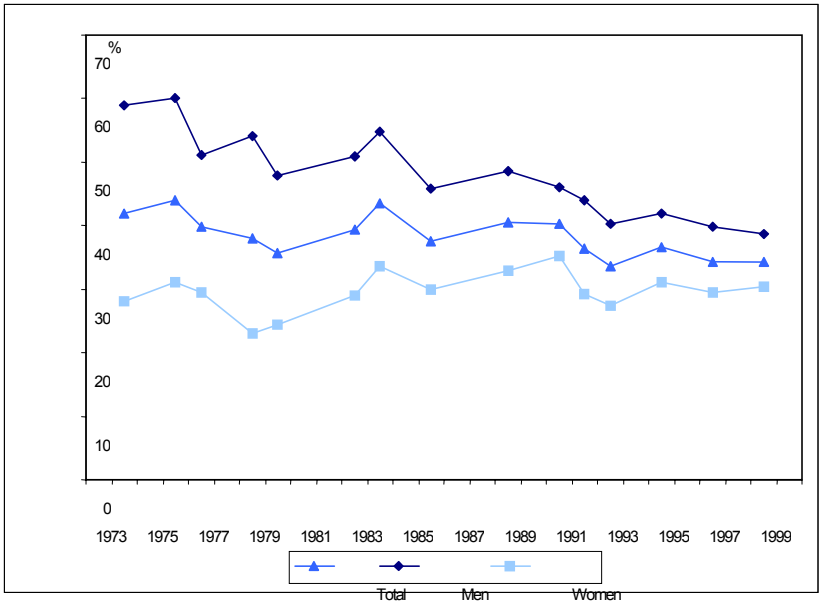
Among smokers, 49.6% consider that it is dangerous to smoke tobacco daily, and 41.9% as soon as it is tried. Although smokers might consider the danger at a higher level of consumption, they are aware of being more exposed to specific health problems; more often than non-smokers, they fear that they will suffer from diseases caused by tobacco (52.9% as opposed to 13.7%) and respiratory diseases (36.8% as opposed to 25.6%). Conversely, they do not fear cancer and heart disease in general [3]. It should be noted that these figures differ from those obtained, when the question bears directly on the daily number of cigarettes regarded as a dangerous level of smoking, to which question 21% stated spontaneously that smoking tobacco is dangerous for the health as soon as it is tried [9].

Developments

From the start of the 1970s, a global downturn in consumption is seen, although it masks a certain increase in consumption by women, particularly in recent years. In the 18 to 75 population, the percentage of

smokers has remained constant, around 40% from the mid-1970s to the start of the 1990s. The proportion of smokers has decreased noticeably since, and in 1999, represented 36% of the adult population. The impact of the tobacco part of the Evin Law of 1991 during the 1990s seems to have contributed to this decrease, which can also be seen in the development of the sales data over this period (Baudier *et al.*, 1998, p.164).

Proportion of smokers among over-18-year-olds in various surveys from 1975 to 2000, by sex *(391c)*



Sources: CFES (Comité français d'éducation pour la santé: French Centre for Health Education) surveys

Consumption by adolescents

Experimentation

Experimentation with tobacco is a very common experience in late adolescence. More than three quarters of young people asked, state they have already tried tobacco, and this proportion reaches 84.0% for boys at 19. At 17, experimentation with tobacco is slightly more widespread among girls (79.4 % of girls as opposed to 76.0% of boys).

For the given age and sex, the cigarette is the tobacco product that is tried after alcohol usage. This first use takes place, on average, at about 14, [8].

Current use

At 17, five out of ten young people have smoked at least one cigarette during the previous month, and, of these, eight out of ten have smoked on a daily basis (in total, 41.9 % of boys and 40.2 % of girls). Girls claim lower consumption slightly more frequently: 10.5% of them say that they smoke less than one cigarette a day as opposed to 7.7% of boys. Among the latter, at 19, 53.7% admit to smoking daily [8].

Proportion of daily smokers among late adolescents in 2000, by sex, age, and number of cigarettes smoked per day, during the previous thirty days
(% on line)

	1 to 5	6 to 10	11 to 20	20+
Girls, age 17	35.3	37.4	20.9	6.4
Boys, age 17	31.8	38.0	23.4	6.8
Boys, age 18	25.5	37.0	28.0	9.5
Boys, age 19	23.2	35.8	32.1	8.9

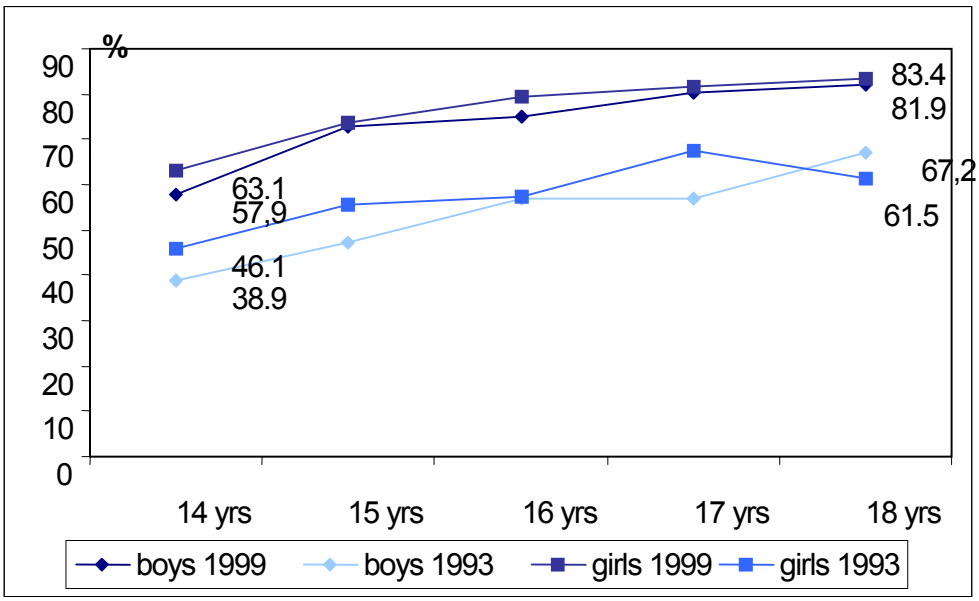
Source: ESCAPAD 2000, OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction)

At 17, the profile of the male daily smokers, in relation to the average number of cigarettes smoked per day, is not very different from that of the female smokers. Unlike any other drugs, male and female consumption is similar, both in frequency and in intensity. A tendency to increase intensity of consumption appears with age—three-quarters of boys aged 18-19, who smoke daily, consume more than five cigarettes per day [8].

Developments

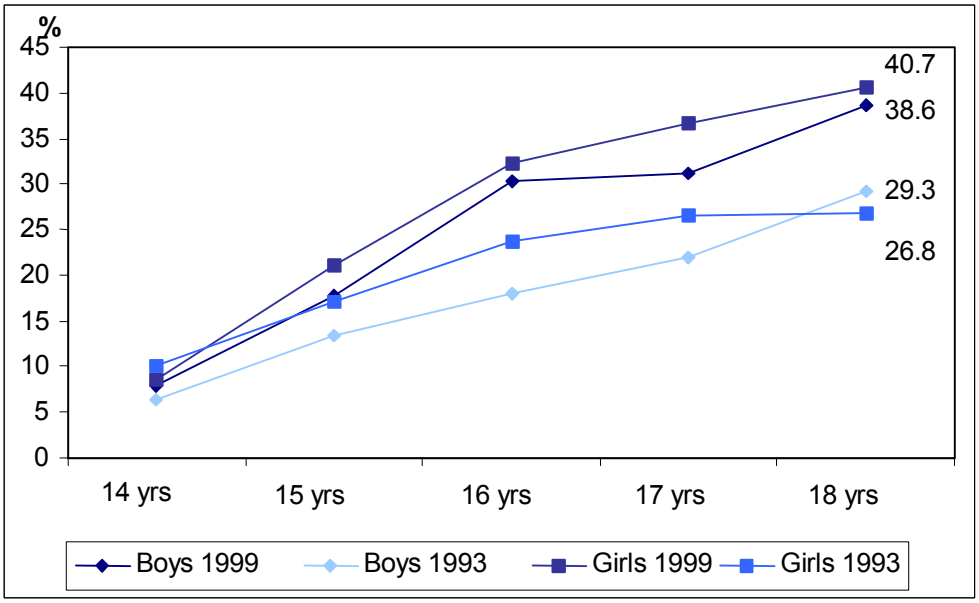
Between 1977 and the start of the 1990s, the joint results of various surveys showed a global downturn in tobacco consumption among 12-18-year-olds (Baudier *et al*., 1998, p.164). However, from the start of the 1990s, a visible increase appeared among 14-18-year-olds, both in experimentation and in daily use, at all ages within this group, and for boys and girls alike [5] [7]. The CFES (Comité français d'éducation pour la santé: French Centre for Health Education) Baromètre Santé jeunes, 1997, provides a point of comparison here, which confirms the trend; at every age and for both sexes, experimentation with tobacco in 1997 was at an intermediate level, between the levels observed in 1993 and 1999 [6].

Frequency of tobacco experimentation among young people at school in 1993 and 1999, by sex and age *(391d)*



Source: INSERM 1993; ESPAD 1999, INSERM-OFDT-MENRT (INSERM - Institut national de la santé et de la recherche médicale: National Institute for Health and Medical Research)

Frequency of tobacco daily use in school age young people in 1993 and 1999, by sex and age *(391e)*



Source: INSERM 1993; ESPAD 1999, INSERM-OFDT-MENRT (INSERM - Institut national de la santé et de la recherche médicale: National Institute for Health and Medical Research)

Tobacco sales in 2000

Tobacco products are sold in metropolitan France through a network of nearly 34,000 licensed sellers. The figures for these sales come from the main tobacco distributor in France: Altadis (formerly Seita). Some turnover and tax system data, relating to tobacco, are also presented.

In conjunction with these sales, an illegal market is developing. The scale of this illegal market is difficult to estimate, but some approximation can be determined by using the figures for customs seizures.

Tobacco sales

In contrast to tobacco production, importing and distribution, the retail sale of tobacco is still a State monopoly, entrusted to customs administration since 1993, and carried out through the licensed sellers. But, national sales data comes from Altadis, which is responsible for nearly 95% of tobacco product distribution in France[2].

Tobacco sales in 2000

In the year 2000, sales of tobacco rose to nearly 92,000 tonnes (CDIT: Centre de Documentation et d'Information sur le Tabac; Centre for Tobacco Information and Documentation, 2001). The main tobacco product sold is the cigarette, with 82.5 billion units sold in 2000, far ahead of cigars or cigarillos (1.7 billion units). Sales of smoking tobacco represent 7,170 tonnes.

Tobacco sales in France in 2000, by product type
(in metric tonnes or million units)

Total cigarettes (in million units)	% of mild cigarettes	% of light cigarettes	Cigars and cigarillos (in million units)	Smoking tobacco (in tonnes)	Total tobacco sales (in tonnes)
82, 513	82.5 %	36.5 %	1, 710	7, 170	91, 750

** The data is presented in million units According to CDIT, 1 cigarette = 1 cigar = 1 cigarillo = 1g, making the total for tobacco sales 91,750 tonnes*

However, according to another existing convention, 1 cigar = 4g and 1 cigarillo = 1.6g: in this case, the total for tobacco sales is 116,794 tonnes in 2000 (C. Hill).

Source: Altadis (formerly SEITA) 2000, CDIT

More than eight out of ten cigarettes sold are mild, and 'light' cigarettes (less than 10mg tar) represent slightly more than a third of cigarettes sold.

By relating cigarette sales to the number of consumers who state that they currently smoke (15 million[3]), we arrive at an estimate of 15-cigarettes-per-day average and per current smoker, in 2000.

Overall, tobacco sales in 2000 fell by 1.4% in relation to 1999, but this development differed depending on the product concerned: a slight decline in cigarette sales (-1.4%), particularly of brown cigarettes, a rise in sales of cigars or cigarillos (+2.4%), and a larger decline in sales of smoking tobacco (-2.9%), due essentially to the decline in sales of pipe tobacco (-10.4%). If the change in cigarette sales observed in 2000 fit into a long-term trend, the development in sales of smoking tobacco is a newer phenomenon.

[2] The other distributors are highly specialized, particularly in cigar sales.

[3] See estimates of number of occasional tobacco consumers (section relating to Interdisciplinary/Transverse approach)

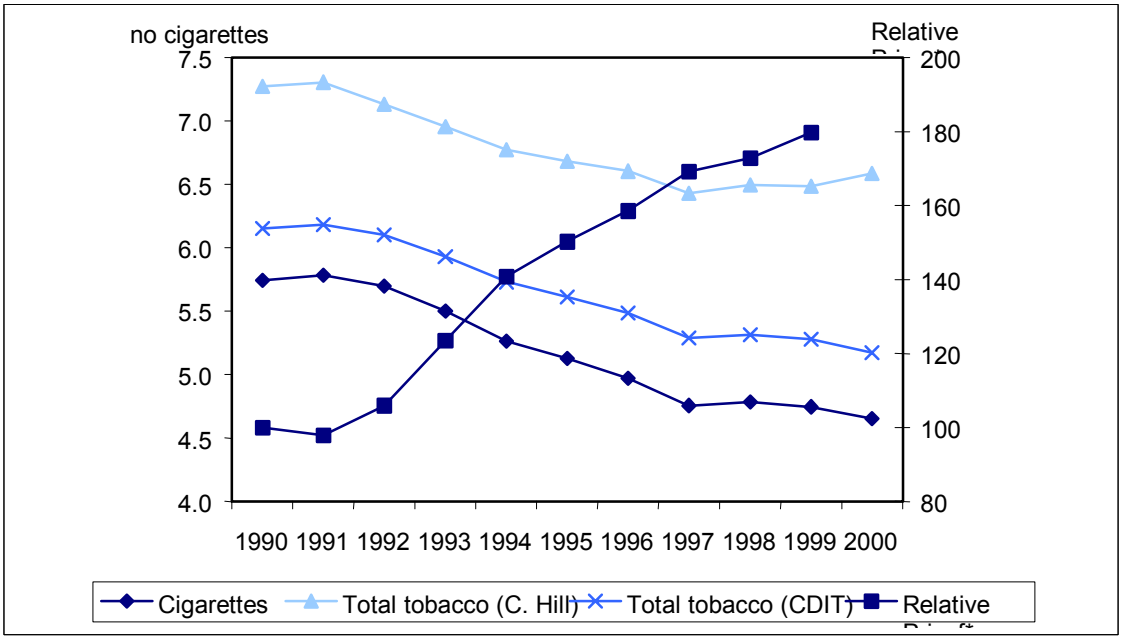
The comparative development in cigarette sales and in their relative price since 1970[4] clearly allows the effect of public policies to be observed: the Veil Law in 1976 was followed by a period of stabilization in sales and prices. The decline in sales and the rise in prices are sharper and more lasting, following the passing of the Evin Law in 1991 (see below).

Tobacco sales since 1990

Cigarette sales fell throughout the last decade: from 5.7 cigarettes per-person average per day in 1990 to 4.7% in 2000. This downward trend affects all the tobacco products after the peak in sales in 1991. But, it slowed down, and even disappeared, from 1997.

In parallel, since 1991, the price of a cigarette has increased eleven times. It has gone from 10.80F on 30th September 1991, for the best-selling packet of mild cigarettes in France, to 21.00F on 3rd January 2000 (CDIT, 2000). According to data from INSEE: Institut national des statistiques et des études économiques (National Institute for Statistics and Economic Studies), the tobacco price index practically doubled between September 1991 and December 1996 (74 points more than inflation) (Anguis et al.*, 1997, p.1).*

***Tobacco sales and relative price of packet in France from 1990 to 2000** (393a)*



To assess the total quantities of tobacco sold in France, there are two existing conventions: for tobacco manufacturers, 1 cigarette = 1 cigar = 1 cigarillo = 1g (CDIT); For some researchers, 1 cigarette = 1g, 1 cigar = 4g and 1 cigarillo = 1.6g (C. Hill) These differences in calculation explain the position of the two curves and the reason for the highest curve not showing the decrease recorded in 2000 for the majority of tobacco products (weight of cigars within total sales).

Source: Altadis (formerly SEITA) (sales,1990-2000); INSEE (Institut national des statistiques et des études économiques: National Institute for Statistics and Economic Studies) (population 1990-2000)

The declining sales is usually explained as the consequence of the Evin Law, implemented from 1992 onwards, and, in particular, changes that it brought about in the sale price of cigarettes in France (via the increase in the amount of taxes collected by the State[5]). Usually, an inverse development is recorded between the price of cigarettes and their sales (sensitivity of consumption to price). According to INSEE (Institut national des statistiques et des études économiques: National Institute for Statistics and Economic Studies), a rise of 1% in the price of tobacco results, after three years, in a decline of 0.3% in consumption (Anguis *et al.*, 1997).

[4] For further details, refer to the previous edition of the report (OFDT, 1999).

[5] For a more precise description of the mechanism, see: Recours, 1999; Anguis *et al.*, 1997.

Thus, the increase in the price of a packet of cigarettes from the start of the 1990s would have a definite impact on the decrease in consumption. The effects of the ban on advertising are more controversial.

The slowdown of declining prices in 1997 might explain the slight recovery of consumption. It is also possible that cigarette sales increased at the time of the football World Cup in 1998, an event that attracted many tourists to France.

Although the cause of declining tobacco sales since 1991, particularly of cigarettes, is quite well documented (effect of sharp, repeating tobacco price increases), it is difficult to discover changes in consumer behaviour: a decline in quantities consumed, a decline in the number of new consumers and/or the fact that some existing consumers have given up. These explanations do not exclude each other.

Sales data for the different tobacco products from 1990 onwards also reveals:

- A loss of interest in brown cigarettes, to the benefit of milder brands;
- General growth for 'light' products (i.e. less than 10mg of tar, in accordance with the legislation) despite the slight fall recorded in 2000. These cigarettes represent 36.5% of sales in 2000, as opposed to 26.5% in 1990;
- The sharp rise in sales of rolling tobacco: nearly 2,500 tonnes in 1991 as opposed to approximately 5,600 in 2000. It would seem that the successive increases in the price of cigarettes has led to some consumers moving away from cigarettes sold in packets to the less expensive rolling tobacco (CDIT, 2000, p.9). The recent stabilization in these sales might be explained by the large increases in the price of this product, larger than those of cigarettes (CDIT, 2001, p.8);
- A phenomenon also recorded for sales of cigarillos, which increased regularly since 1993, i.e. since the first large increases in cigarette prices.

Turnover and Tax for Tobacco Products

All sales made in 2000 represent nearly 86 billion francs, (13 billion euros), 75% of which goes to the State in the form of taxes, 17% to manufacturers and wholesale distributors, and 8% to licensed sellers (CDIT, 2001). The proportion represented by taxes on cigarette packet prices increased sharply in the 1990s.

The turnover in tobacco products has risen in relation to 1999, more for cigarettes and cigars than for rolling tobaccos (respectively 3.4%, 3.1% and 0.9%). This increase is explained, in part, by the rise in tobacco prices in January 2000 (increase higher than inflation).

Tax on cigarettes is particularly complex, in particular, because it depends partly on the price of the best-selling cigarette (in this case, Marlboro®), which varies with the tax. This price breaks down as follows, on 1st January 2001:

Breakdown of sale price of a cigarette packet of (highest demand price category) on 8th January 2001

	In Francs	As % of retail sale price
Licensed seller	1.76	8.00
Producer and distributor	3.5222	16.01
State tax revenue	16.7178	75.99
Including:		
usage rights (1)	12.9778	58.99
VAT and BAPSA	3.74	16.9998
Retail sale price	Fr 22	100 %

(1) Usage rights can be broken down into: specific part (+Fr 41.79 for 1000 cigarettes) and proportional part (55.19% of retail sale price).

(2) BAPSA: Budget annexe des prestations sociales agricoles – Supplementary budget for agricultural social security benefits.

Source: CDIT (http://www.cdit.fr/fiches/decompo.html)

On 1st January 2001, 75.99% of the price of a best-selling cigarettes packet (Marlboro®) corresponds to taxes. This proportion becomes 76.3% on average, when all categories of cigarettes sold in France are considered (CDIT, 2001).

The distributors working with the Customs and Excise Department, in particular, fix the price of cigarettes. It is then passed on to the licensed sellers.

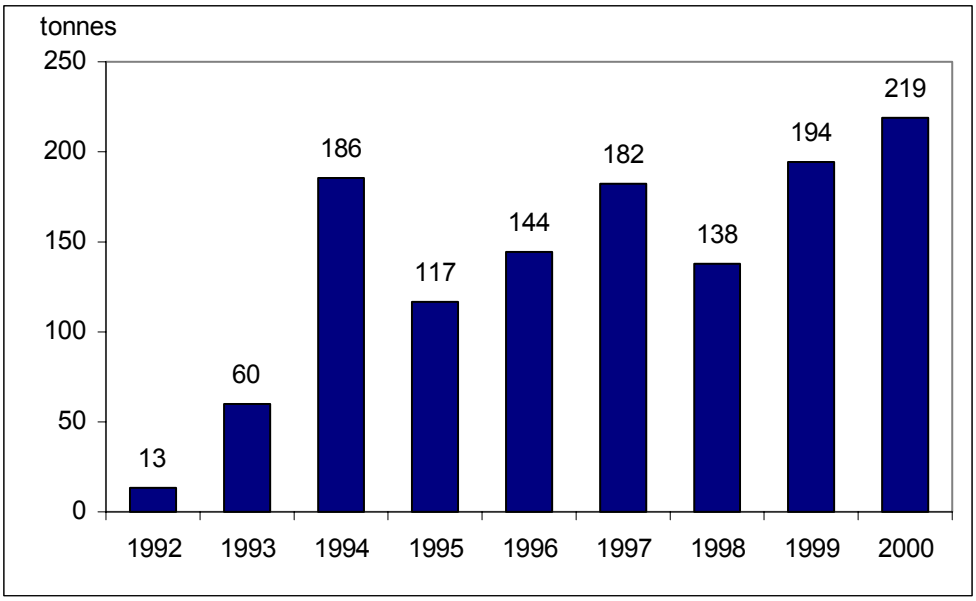
In the face of the price increase policy decided by the public authorities, the tobacco-producers reacted by decreasing the price per packet, then by increasing the number of cigarettes per packet (which works to decrease the average price per cigarette). As a response to this strategy, the public authorities first set up a flat-rate tax of 10F per packet, which has the effect of reducing the producer's profit margin when the packet price falls. This tax was recently adapted and increased for packets of more than twenty cigarettes.

Tobacco Trafficking and Smuggling

The sales data above does not account for the whole supply of tobacco in France, as the quantities in circulation in the illegal market must also be considered.

During the year 2000, customs in France seized 219 tonnes of tobacco, which represents an approximate increase of 13% in relation to the previous year (The Customs and Excise Department, 2001). If the year 1998 is not included, when there was a sharp drop in seizures of tobacco, the trend was upward throughout the course of the 1990s.

Seizures of tobacco in France from 1992 to 2000 *(393b)*



Source: The Customs and Excise Department

Due to the existence of an advanced network of licensed sellers and the sales monopoly, smuggling should be limited in France (MILDT: Mission interministérielle de lutte contre la drogue et la toxicomanie: Interministerial; Mission for the Fight Against Drugs and Drug Addiction - 1998). The majority of seizures involve small quantities, which implies that the trafficking is mainly 'tourist' in nature. But, France is also a transit country, since a significant proportion of the seizures carried out on French territory were on their way to another country. During the year 2000, there was a continued decline in seizures at the Franco-Andorran border and, more significantly, at the Pyrenean border, with a corresponding rise at the Nord-Pas-de-Calais region (at the approaches to the Channel Tunnel in particular). The United Kingdom is still the main destination for cigarettes seized in France (60% in 2000). Finally, the customs department observed the increase in seizures of smoking tobacco (20 tonnes in 2000, as opposed to 12 the year before), which is still, nevertheless, a small figure in comparison to those of cigarettes (The Customs and Excise Department, 2001).

Cigarette smuggling is increasing in France but also, more generally, in Western Europe. It seems to be favoured by fiscal measures taken in these countries (in particular, price increases) and the fact that sanctions are less severe than those for other trafficking types (MILDT: Mission interministérielle de lutte contre la drogue et la toxicomanie: Interministerial; Mission for the Fight Against Drugs and Drug Addiction - 1998).

Tobacco Production

In 2000, tobacco production in France represents 25,350 tonnes (or 3.6 times less than the quantities sold) for a turnover of 698 million francs. This output, spread throughout 5,300 plantations, is highly centralised in geographical terms, with the majority of production taking place in the Southwest (Aquitaine and Midi-Pyrenees).

It is difficult to comment on the development in production over ten years, because there are large variations between individual years. In decline, at least since 1998, it is restricted, nonetheless, by the quotas imposed by the European Union: 26,079 tonnes.

Health and social consequences of tobacco consumption

Tobacco consumers have the opportunity of asking the medical sector, whether specialist or general practice, for treatment of their dependence and/or for help with giving up. Giving up smoking can also be achieved without any medical help, since nicotine substitutes, in particular, are freely available for sale. The scale of this treatment is, therefore, observed via several studies of tobacco dependence treatment consultations attendance, surveys of doctors, and sales of substitutes.

Tobacco consumption produces significant health consequences, in terms of both morbidity (triggering of certain pathologies) and mortality (a factor connected with some deaths). These questions will be dealt with later.

Scale and characteristics of care

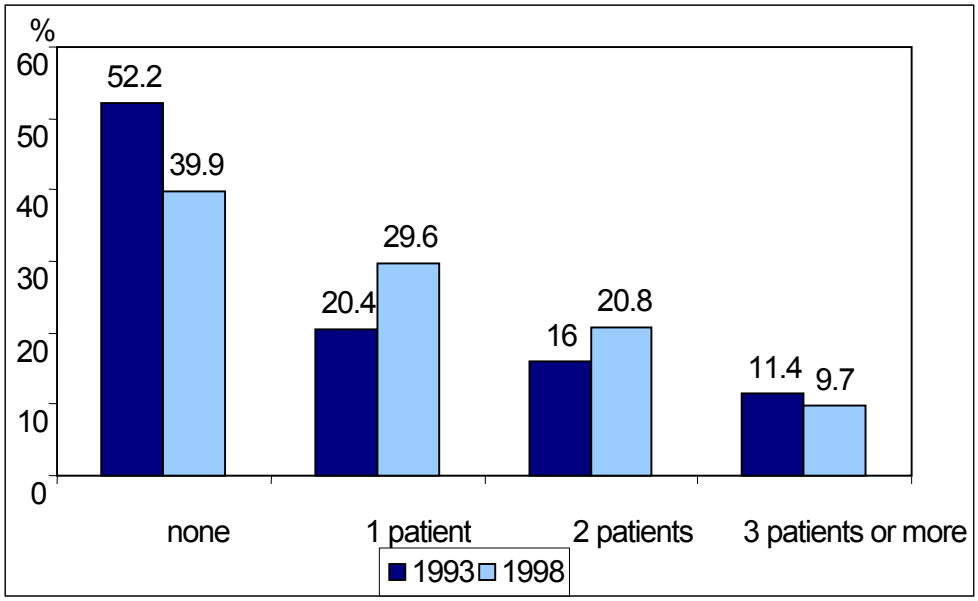
Unlike the drug addiction care sector, in France there is no system of long-term registration of tobacco dependence treatment consultations. Specific surveys have only recently been set up and do not yet cover all the structures in question. Data in general medicine is still more compartmentalised.

Treatment in general medicine

In October 1998, the consensus conference on smoking cessation emphasised the fact that few smokers in France benefit from the help of their doctors for giving up smoking. The reasons set forward by doctors, and re-transcribed at the conference, relate to: lack of time, resistance of the patient to tackling tobacco dependence, lack of training in the details of treatment, and claiming a specific remuneration for acts of prevention. At that time, doctors also contributed to a certain scepticism regarding the effectiveness of their actions on patients' tobacco dependence (ANAES—Agence Nationale d'Accréditation et d'Evaluation en Santé: National Agency for Health Accreditation and Evaluation - 1998, p.10).

In the same year, a survey conducted among 2000 doctors in general practice in France indicated that 60% of them offered consultations for giving up smoking. This proportion is higher in relation to 1993, when 48% of doctors offered this type of consultation (Baudier *et al.*, 1995), which is, perhaps, a sign that the practice is becoming more common and/or that demand is higher.

Doctors in general practice in relation to the number of patients received during the last seven days in the context of giving up smoking in 1993 and 1998 *(392a)*



Source: Baromètre Santé doctors in general practice 98/99, CFES [21] (2000, p.98)

The average number of patients received for consultation in relation to tobacco dependence was 1.9 patients per week in 1998, as opposed to 2.2 in 1993 (This difference is not significant in statistical terms.). The weekly number of smokers who had consulted a doctor in general practice in 1998 was estimated at about 100,000.

The patients concerned only represent 1.9% of the patient-base of these doctors in 1998, a figure that is slightly less than that for 1993, when it was 2.2 (Baudier *et al*., 1995; Arènes *et al*, 1999). There are several explanations set forward for this decrease: higher uptake of smokers by specialist structures, treatment considered too heavy and/or too time-consuming by doctors, decrease in the number of people asking for the service due to the general decrease in the number of tobacco consumers (Arènes *et al.*, 1999, p. 105).

The method for stopping smoking most often proposed by doctors in general practice is the patch: 65% of doctors advocated this in 1998 as opposed to 45% in 1993. The growth in prescription patches explains the declining implementation of the abrupt stopping method, using willpower alone (recommended by 32% of doctors in 1993 as opposed to 19% in 1998).

More than nine out of ten doctors state that they managed the patients' dependence alone in 1998 (similar proportion to that of 1993). Nevertheless, recourse to a specialist structure is more frequent in 1998 than in 1993: 9% of doctors in 1998 worked in liaison with a specialist structure, as opposed to 5% in 1993. Finally, a limited number of doctors do not offer treatment but entrust their patients to the specialist sector (2.1% in 1998 as opposed to 1.3% in 1993).

Attendance at tobacco dependence consultations

For the second consecutive year, a survey of a single given week was conducted in the specialist sector for giving up smoking. In 2000, nearly 55,000 smokers would have been received for the first time by a specialist structure for giving up tobacco, two-thirds in hospital smoking consultations, and the other third in non-hospital structures. The estimate for 2001 should be approximately 66,000 new patients.

In January 2001, the number of patients seen in these consultations during the survey week increased in both types of structures, but the average number of patients per consultation remains stable (12 in the hospital environment and 11 in other structures) (Dautzenberg *et al.*, 2001; Jean-François *et al.*, 2001).

According to patient totals, the percentage of new patients decreased in the hospital environment (44% in 2000 as opposed to 36% in 2001). It rose in non-hospital consultations (37% in 2000 as opposed to 43% in 2001).

These results, although they should be interpreted with caution, because the sample populations are not highly representative, are close to those obtained by another study conducted in 1999, in 321 locations, for consultations for stopping smoking assistance, whether in hospital or not [24]. By extrapolating the figures obtained in these structures (36,500 new patients per year), the authors of the study arrived at an estimate of 55,000 smokers having used the consultation service for stopping smoking assistance in 1999 (Dautzenberg *et al*, 1999).

This study also specified that in approximately a quarter of the consultation locations, the stopping smoking requests are in the context of illness treatments, resulting from smoking.

The main technique prescribed in these services is the use of nicotine substitutes (in 9 out of 10 services) and, much more rarely, acupuncture or group dynamics.

Sales of Nicotine Substitutes

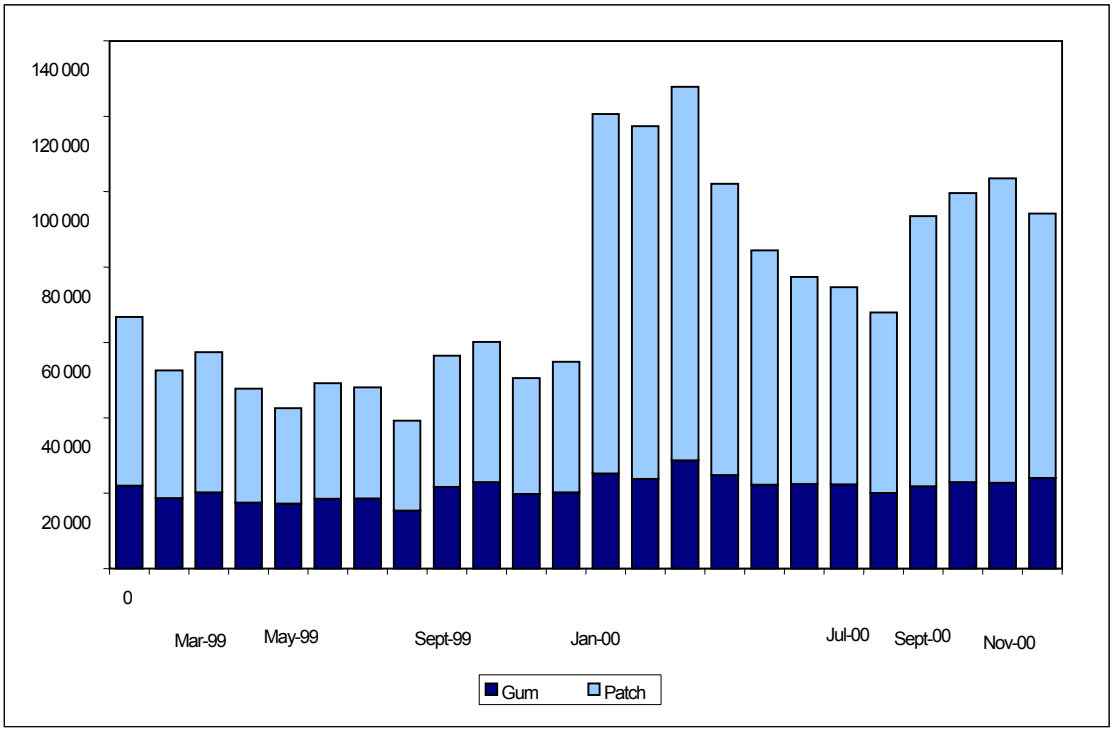
Since 5th December 1999, all products containing nicotine, and intended for stopping smoking use, can be purchased in chemists' shops[6], over the counter and without prescription. This is particularly relevant for patches and chewing gums, which are the widely used substitutes.

The availability of free-sale nicotine substitutes has allowed this market to considerably increase its sales and turnover.

In 1999, this market represented a total of 326 million francs, including three-quarters corresponding to sales of patches. In 2000, it totalled 628 million, including more than 80% from sales of patches. In sale units, the market has doubled between 1999 and 2000, especially for patches [11]. Converting this data into patient numbers means that problems relating to the different product presentations, and their potential variations, can be avoided.

[6] Originally, only the 2mg dosage gum was available in chemist's shops without a medical prescription.

Estimate of number of patients under treatment with nicotine substitutes in 1999 and 2000 *(392b)*



The monthly data for sales from chemists' shops, presented in sale units [11], is converted into days of treatment, then into numbers of patients, using the following formulae:

- *One patch = 1 day of treatment (presented in the form of a box of 7 or 28 patches) and a box of gum = 7 days of treatment (average presentation in 50 to 60 pieces of gum per sale unit)*
- *Period of treatment of 30 days on average (Dragos et al., 2001, p.105)*

Source: IMS (data provided by OFT-Pharmatrend)

In terms of changes, the increase in the estimated number of patients using patches was particularly large in the first months of the year 2000, i.e. from the time that substitutes became available over the counter. This variation is probably explained by the effect of the announcement of de-listing and the effect of the mass media campaign that accompanied this. The recovery recorded from September onwards could be connected to the post-summer 'good resolutions'. Also, this data confirms that patches are used as the main substitution method in France.

Throughout 2000, the number of persons having at least started a nicotine substitute treatment is estimated at slightly more than a million, two times the figure for 1999 (Dragos *et al*, 2001).

Morbidity and mortality

Using estimates of attributable smoking risks, applied to the general mortality data, by cause, can approximate mortality related to tobacco. Morbidity is more difficult to estimate, because, if the risk of occurrence for certain pathologies among smokers is known, the total case numbers diagnosed for each illness in France, is not. Surveys carried out in the hospital environment, however, do introduce certain elements of knowledge.

Morbidity and relative risks

Smoking is a risk factor in the origin of a certain number of pathologies, such as lung and throat cancers, cancer of the upper lung/larynx tract (together with alcohol), and chronic bronchitis. It is also a risk factor in the origin of a significant proportion of a large number of diseases: cancer of the oesophagus and of the bladder, circulatory disorders, etc.

The table below shows the increase in the risk of occurrence of the main diseases related to a tobacco smoker in comparison to a non-smoker:

Risk of occurrence of certain pathologies in a smoker relative to a non-smoker

Cancers	
Lung, larynx	10
Mouth, pharynx	6
Oesophagus	3.5
Bladder	3
Pancreas	2
Circulatory disorders	3
Ischaemic cardiopathies	2.2
Chronic bronchitis	10

Reading: the risk of occurrence of cancer of the lung/larynx is 10 times greater in smokers than non-smokers.

Source: INSERM-SC8 INSERM (Institut national de la santé et de la recherche médicale: National Institute for Health and Medical Research) (Recours, 1999)

Also, smoking tobacco holds specific risks for women (risk of cancer of the neck of the uterus, and risk to the cerebro-vascular system from the combination of smoking and oral contraceptives), plus those specific to pregnant women and to infants born to smoking mothers (babies' lower average birth weights, and greater probabilities of SIDS).

In general, the increase in the risk of occurrence of these pathologies varies in relation to how long ago the smoking took place and the frequency of smoking, but also depends on the number of cigarettes smoked and the depth of smoke inhalation (Recours, 1999, p.6).

Since the cases diagnosed are not automatically recorded for all these pathologies, it is not possible to make an overall quantitative estimate of tobacco-related morbidity.

However, it is possible to get a rough idea of the impact of tobacco on recourse to hospitalisation. In a survey conducted in 1991-1992 in the hospital environment, no one was hospitalised for tobacco dependence, but tobacco was noted as a risk factor in 16% of cases (Com-Ruelle *et al.*, 1997).

Passive smoking

Research into the risks related to passive smoking has been the object of major scientific investment for several years. The conclusions of a working group on this topic have just been produced (Dautzenberg, 2001). They emphasise the fact that the available data now allows for the assertion that passive exposure to tobacco smoke leads to an increase in the risks of:

- Lung cancer (+26% in comparison to non-exposed non-smokers) and coronary incidents (+25%, this is the largest cause in terms of numbers of victims) among adults;
- Lower respiratory infections (+72% if the mother smokes), repeated ear infections (+48% if both parents smoke) and asthma attacks in children;
- Intra-uterine growth retardation and low birth weight (even if the mother does not smoke, but is subjected to smoke by her family) for babies.

- SIDS (doubled risk).

  It is basically in children and pregnant women that the risks of passive smoking have been highlighted. The effects of exposure in the workplace have not been well documented yet.

In 1999, the National Academy of Medicine estimated the number of deaths linked to passive smoking at 2,500-3,000 per year (Dautzenberg, 2001).

Mortality and causes of death

Smoking tobacco must be one of the main reasons why the annual increase in life expectancy at birth of the French population started slowing down in the 1960s (Nizard, 2000). Also, the increase in smoking among women could be partly responsible, with the reduction in alcohol-related mortality in men, for the narrowing of the gap between the life expectancies of both sexes.

In 1995, tobacco consumption is estimated to be responsible for 60,000 deaths per year, i.e. more than one death in nine. About two-thirds of these deaths can be considered as premature deaths (Kopp *et al*., 2000, p. 62). These estimates are obtained from the relative risks of deaths related to tobacco.

Total number of deaths and proportion of deaths attributable to tobacco in 1995, by cause and sex

	Total number of deaths among men*	Proportion attributable to tobacco (in %)	Total number of deaths among women*	Proportion attributable to tobacco (in%)
Infectious				
Respiratory tuberculosis	386	50 %	236	0 %
Cancer				
Mouth and pharynx	4, 457	74 %	703	13 %
Oesophagus	3, 947	53 %	666	13 %
Pancreas	3, 341	38 %	3, 030	4 %
Larynx	2, 210	87 %	151	29 %
Trachea, bronchi, lungs	20, 323	85 %	3, 603	19 %
Neck of the uterus	0		764	6 %
Bladder	3, 242	50 %	1, 106	13 %
Kidney and urinary tract	2, 054	39 %	1, 211	6 %
Cardio-vascular				
Hypertension	2, 244	19 %	4,077	1 %
Ischaemic cardiopathy (under 65)	5, 259	43 %	938	11 %
Ischaemic cardiopathy (65 years +)	20, 664	21 %	20,179	0 %
Cardiac arrest	1, 611	42 %	2, 204	2 %
Cardio-vascular disease	18, 128	11 %	25,354	1 %
Arteriosclerosis	684	24 %	619	3 %
Aneurism of aorta	2, 074	63 %	872	11 %
Arthritis	2, 684	68 %	2, 565	4 %
Respiratory system				
Pneumonia, flu	7, 681	36 %	8, 715	0 %
Chronic bronchitis, emphysema, chronic Lung disease	8, 462	88 %	5, 581	14 %
Digestive system				
Gastroduodenal ulcer	787	49 %	807	2 %

** In the population aged 25 and over*

Reading: among men, 50% of deaths by respiratory tuberculosis are attributable to smoking.

Source: National register of causes of death 1995, INSERM-SC8 [18] and (Hill, 1998, p. 69)

The main causes of death attributable to smoking tobacco are cancers, in particular those of the lungs and the upper lung/larynx tract, cardio-vascular diseases and chronic respiratory diseases.

The level of mortality is very different in relation to sex, since men are currently the most affected: 95% of the 60,000 tobacco-related deaths concern men. So, 21% of mortality among men and 1% of mortality among women, for all ages combined, might be attributed to tobacco, with these proportions at maximum for the 45-64-year-olds.

The length of tobacco use among the men explains the inequality recorded between the sexes. But, given the increase in use by women for several decades, this gap will surely narrow very quickly. The consequences of smoking tobacco in terms of morbidity and mortality are measured in the long-term, and the current data reflect the occurrences of smokers who began their consumption of tobacco 25-30 years ago.

Taking into account the current changes in tobacco consumption, forecasts predict 165,000 deaths in 2025, i.e. a doubling in male deaths and female deaths ten times greater (Recours, 1999, p.11).

The level of tobacco consumption (average daily dose) and the length of this practice are very major risk factors, but the second of these should have a far greater impact on the risk of certain pathological occurrences. For example, for the risk of bronchial cancer, doubling the dose of tobacco doubles the risk, but doubling the period of consumption multiplies the risk by twenty (Hill, 1998, p.67). Certain studies indicate that it is the vascular risk related to tobacco that is most significantly influenced by the duration of using tobacco.

Geography showing the consumption and sales of tobacco

Regional Approach

Geographical data on tobacco consumption is available from the informational survey conducted among young people at the end of adolescence, during National Service Day [8]. Sales data can be added to this general approach for consumption. In comparison, sales of nicotine substitutes give a view of the geographical distribution of smokers wishing to stop smoking.

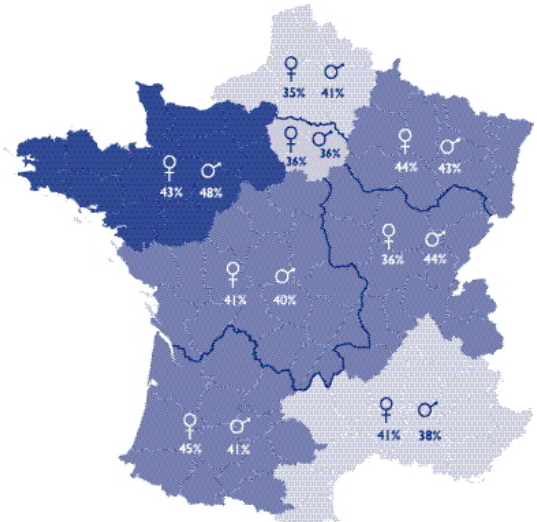
Consumption among the general population

Among the 15-44-year-olds, daily use of tobacco seems to be quite uniformly distributed throughout the French territory. Aquitaine, however, is a region that has above average figures for consumption; whereas the North and Alsace show lower than average figures [3].

> 17-years-olds' experimentation with tobacco appears to be more frequent in the Northwest (83% of girls, 80% of boys), rarer in the Paris region (77% and 71%), and in the Southeast (77% and 71%). The regional disparities are more pronounced for boys than for girls. The gap between the two sexes is less than 1 point in the North and the Northeast, more pronounced in the Paris region (nearly 7 points), in the Southwest (6 points), and in the Eastern Central area (5 points) [8].

The disparities are slightly more marked for daily smoking than for experimentation: the incidences are lower than average for both sexes in the Paris region (36% for girls, 36% for boys), for girls in the North (35%), and for boys in the Southeast (38%). Daily smoking is more widespread for boys in the Northwest (48%). The gap between girls and boys varies widely: +4 points in the Southwest, -8 points in the Eastern Central area [8].

Incidence of daily use of tobacco (at least one cigarette per day in the previous thirty days) among 17-year-olds in 2000, by region *(394a)*



Interregional comparisons with controlled age and sex

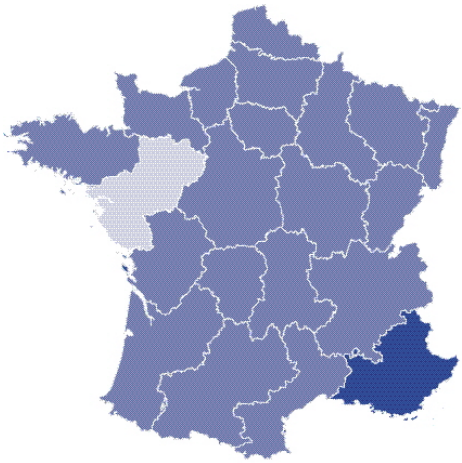
Source: ESCAPAD 2000, OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction)

Cigarette sales

Sales of cigarettes are relatively homogenous over the whole of the territory. Two regions are distinguished very clearly from the others, however:

- The Provence-Alpes-Cote d'Azur region, which is characterised by high sales, particularly in relation to the national average (23,660 thousand cigarettes sold per 10,000 inhabitants as opposed to a national average of 19,000).
- Conversely, the Pays de la Loire region is distinguished by relatively low sales in comparison with those of the other regions (15,600 thousand cigarettes for about 10,000 inhabitants).

Cigarette sales in 1999, by region *(394b).*



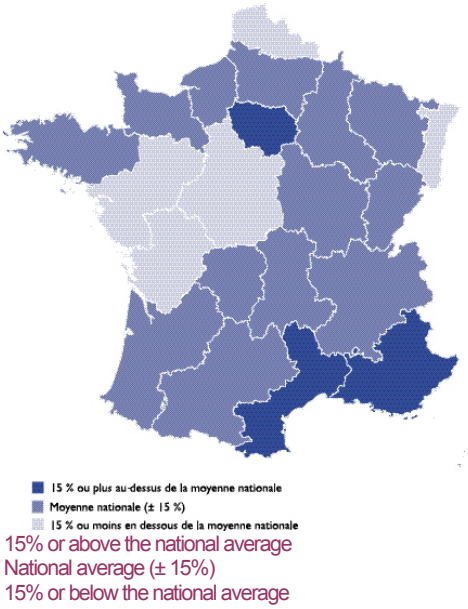
National average: 1,901 cigarettes per inhabitant aged 15 to 75

Source: Altadis (formerly SEITA) 1999, CDIT

Sales of nicotine substitutes

The majority of sales of nicotine substitutes in 2000 took place in the most populated French regions. In relation to the population of the region, the geographical distribution of these sales is slightly different, with areas of high sales such as Ile-de-France and the whole of South-eastern France (PACA and Languedoc-Roussillon). Conversely, five regions differ from the national average, recording low sales of substitutes.

Sales of nicotine substitutes in 2000, by region *(394c).*



National average: 811 substitutes per 10,000 inhabitants aged 15 to 75
Source: IMS Health

The sales of nicotine substitutes are geographically scattered more widely than are cigarette sales. The differences between the regions are more marked.

Areas of high or low sales of substitutes are larger in relation to those of cigarette sales, but the PACA region shows up as a region of high consumption of both cigarettes and substitutes, and, conversely, the Pays-de-Loire region shows up as an area of low consumption of both products.

European Approach

To understand France's situation in relation to its European neighbours, from the point of view of tobacco consumption and its consequences, the data studied comes from a conference organised in 1999 by the European Network for the prevention of tobacco dependence (Joossens *et al.,* 1999). This data is supplemented by that from the ESPAD survey conducted among young people at school in thirty European countries (Hibell *et al*, 2001), as well as by the HBSC survey (WHO, 2000).

Consumption

Among adults, at the end of the 1990s, France held a midway position within the European Union: for the proportion of regular smokers, it was in 7th place for men and 9th place for women. The highest proportions were found in Greece (49%) and Spain (45%) for men and in Denmark and the Netherlands for women (Jossens *et al.,* 1999).

In terms of the number of cigarettes smoked per day and per adult, France was in 11th place among the countries of the European Union with four cigarettes, with the highest consumer being Greece (8.3), far ahead of Spain (5.3) (EUROSTAT, 1999).

Within the school population and among the thirty countries investigated in the ESPAD survey, daily use of tobacco by French schoolchildren aged 16 ranks France among the top countries, for boys (6th with 30%) as for girls (3rd with 33%), above all the other countries of the European Union. The top countries are Greenland, Bulgaria and Russia (with 57%, 40% and 38% daily smokers, respectively) (Hibell *et al.,* 2001).

This data confirms the major trends established in 1997 among schoolchildren aged 11, 13 and 15 (WHO, 2000).

Health consequences

The WHO has estimated the health consequences for tobacco consumption in Europe. Thus, in terms of mortality, France is ranked midway with 34% of deaths of men aged 35 to 69 attributable to tobacco in 1995, and 4% for women in the same age group. At the extremes, Sweden appears with 16 and 13%, respectively, and Hungary with 45 and 18% (Greece with 39 and 4% for Western Europe) (Recours, 1999, p.14).

Sales

For the countries of the European Union, the categorisation established according to sales of cigarettes in relation to total population (smokers and non-smokers) ranks France, with 1,400 cigarettes sold per inhabitant in 1999 (3.9 per day), in 11th place amongst the countries with the highest consumption, at a level close to that recorded for the United Kingdom or Belgium[7]. The lowest sales are found in Sweden (1.7 cigarettes per inhabitant per day) and the highest in Greece with 7.7 cigarettes sold per day in relation to the total population. The average for the countries of the European Union was 5.2 in 1999.

In regard to the average price of a cigarette packet, France ranked midway (a packet of cigarettes is most expensive in the United Kingdom and least expensive in Spain). It is interesting to note that the categorisation of countries in accordance with the price of a cigarette packet does not correspond proportionally to that of cigarette sales.

[7] Source: trade associations, trade press, Euromonitor, quoted by Tobacco Europe, September 2000, p.10 (data published at: http://www.tabac-info.net/NAVBAR/themes/default.htm).

For further information

- Aliaga (C.), 'Le tabac: vingt ans d'usage et de consommation' (Tobacco: twenty years of use and consumption), INSEE 1, no. 808, 2001, p. 4.
- ANAES (Agence nationale d'accréditation et d'évaluation en santé: National Agency for Health Accreditation and Evaluation), Arrêt de la consommation du tabac (Stopping smoking). Consensus Conference, Paris, EDK, 1998, p. 413.
- Anguis (M.), Dubeaux (D.), 'Les fumeurs face aux récentes hausses du prix du tabac' (Smokers faced with recent tobacco price rises), INSEE Première, n° 551, October 1997, p. 1-4.
- Arènes (J.), Guilbert (P.), Baudier (F.) (dir.), Baromètre Santé médecins généralistes 98/99, (French GP survey) Vanves, CFES, 1999, p. 218.
- Baudier (F.), Arènes (J.) (Dir.), Baromètre Santé adultes 95/96, (French adult health survey) Vanves, CFES, 1997, p. 288.
- Baudier (F.), Dressen (C.), Grizeau (D.), Janvrin (M.P.), Warszawski (J.), Baromètre Santé 93/94. Résultats de l'enquête périodique sur la santé des Français, (Results of the periodical survey of the health of the French) Vanves, CFES, 1995, p. 168.
- Baudier (F.), Janvrin (M. P.), Arenes (J.), Baromètre Santé jeunes 97/98, (French young people health survey Vanves, CFES, 1998, p. 328.
- Baudier (F.), Orlandini (C.), Guionet (M.), Oddoux (K.), 'La consommation de tabac des adultes en France: évolution au cours des 10 dernières années', (Tobacco consumption among adults in France: developments over the last 10 years) BEH (Bulletin épidémiologique hebdomadaire: Weekly Epidemiological Bulletin), no. 48, 2000, p. 213-214.
- Beck (F.), Legleye (S.), Peretti-Watel (P.), Regards sur la fin de l'adolescence : consommations de produits psychoactifs dans l'enquête ESCAPAD 2000, (Views of late adolescence: consumption of psychoactive products in the ESCAPAD 2000 survey) Paris, OFDT, 2000, p. 220.
- Beck (F.), Legleye (S.), Peretti-Watel (P.), Alcool, tabac, cannabis et autres drogues illicites parmi les élèves de collège et de lycée: ESPAD 1999, (Alcohol, tobacco, cannabis and other illicit drugs among high school and college attendees) France, volume II, Paris, OFDT, 2001, (to be published).
- CDIT (Centre de documentation et d'information sur le tabac: Centre for tobacco information and documentation), 'Le tabac en France en 1999', (Tobacco in France in 1999) Tabac news, n° 21, 2000, p. 1-16.
- CDIT, ' Le tabac en France en 2000 ', (Tobacco in France in 2000) Tabac news, no. 22, 2001, p. 1-16.
- CFES (Comité français d'éducation pour la santé: French Centre for Health Education), La santé en chiffres: tabac, (Health in figures: tobacco) Vanves, CFES, 2001, p. 18.
- Choquet (M.), Ledoux (S.), Hassler (C.), Alcool, tabac, cannabis et autres drogues illicites parmi les élèves de collège et de lycée: ESPAD 1999 France, (Alcohol, tobacco, cannabis and other illicit drugs among high-school and college attendees: ESPAD 1999) volume I, Paris, OFDT, 2001, (to be published).
- Com-Ruelle (L.), Dumesnil (S.), L'alcoolisme et le tabagisme chez les hospitalisés, (Alcohol and tobacco addictions among hospital patients) Paris, CREDES, 1997, p. 173 (Coll. rapport no. 1164).
- Conseil national de l'évaluation, Commissariat général du Plan, La loi relative à la lutte contre le tabagisme et l'alcoolisme. Rapport d'évaluation, Paris, Documentation française, 2000, p. 555 (The law relating to the fight against tobacco and alcohol addiction. Evaluation report).
- Dautzenberg (B.) (dir.), Tabagisme passif, (Passive smoking) Paris, DGS, 2001, p. 109.

- Dautzenberg (B.), Brücker (G.), Borgne (A.), Josseran (L.), Dragos (S.), Fernandez (C.), Jean-François (M.), 'Évolution de l'activité des consultations de tabacologie non-hospitalières entre 2000 et 2001', (Development of non-hospital tobacco specialist consultation activity between 2000 and 2001) BEH (Bulletin épidémiologique hebdomadaire: Weekly epidemiological bulletin), n° 22-23, 2001, p. 103-104.

- Dautzenberg (B.), Brûcker (G.), Borgne (A.), Nadal (J-M.), Bourdillon (F.), ' L'activité des consultations non-hospitalières de tabacologie en 2000 ', (Non-hospital tobacco specialist consultation activity in 2000) BEH (Bulletin épidémiologique hebdomadaire: Weekly epidemiological bulletin), n° 43, 2000, p. 191.

- Dautzenberg (B.), Youssi (D.), Mélihan Cheinin (P.), Combret (P.), 'Les consultations d'aide à l'arrêt du tabac en France', (Consultations for assistance with stopping smoking in France) BEH (Bulletin épidémiologique hebdomadaire: Weekly epidemiological bulletin), n° 51, 1999, p. 213-215.

- The Customs and Excise Department (Direction générale des douanes et droits indirects), La douane en 1998, (Customs, 1998) Paris, ministère de l'Économie, des Finances et de l'Industrie, 1999, p. 34.

- The Customs and Excise Department, Bilan de la douane en 2000, (Customs report, 2000) Paris, ministère de l'Économie, des Finances et de l'Industrie, 2001, (to be published).

- Dragos (S.), Dautzenberg (B.), 'Estimation du nombre de fumeurs traités avant et après dépistage des substituts nicotiniques', (Estimate of number of smokers treated before and after delisting of nicotine substitutes) BEH (Bulletin épidémiologique hebdomadaire: Weekly epidemiological bulletin), n° 22-23, 2001, p. 105-106.

- EUROSTAT, Annuaire statistique 1999, (1999 Statistical record) Bruxelles, Office des publications officielles des Communautés européennes, 1999, p. 530.

- FNORS (Fédération nationale des observatoires régionaux de la santé), 'Le tabac et ses conséquences sur la santé', (Tobacco and its consequences for health) in FNORS, La santé observée dans les régions de France, Paris, FNORS, 2000, chap. 8.2, p. 1-10.

- Hibell (B.), Andersson (B.), Ahlstrom (S.), Balakireva (O.), Bjarnasson (T.), Kokkevi (A.), Morgan (M.), The 1999 ESPAD report: Alcohol and Other Drug Use among Students in 30 European Countries, Stockholm, CAN, 2000, p. 362.

- Hill (C.), 'Mortalité attribuable au tabagisme, bénéfice pour la santé de l'arrêt du tabac, et absence probable de bénéfice d'une réduction de la consommation', (Mortality attributable to tobacco smoking, benefits for the health of stopping smoking, and probable absence of benefit of a reduction in consumption) in ANAES, Arrêt de la consommation du tabac. Conférence de consensus, Paris, EDK, 1998, p. 67-73.

- Hill (C.), 'Tabac et risque de cancer', (Tobacco and the risk of cancer) THS La Revue, n° 2, June 1999, p. 28-31.

- Jean-François (M.), Fernandes (E.), Dautzenberg (B.), 'Évolution de l'activité des consultations de tabacologie hospitalières entre 2000 et 2001', (Development of hospital tobacco specialist consultation activity between 2000 and 2001) BEH (Bulletin épidémiologique hebdomadaire: Weekly epidemiological bulletin), n° 22-23, 2001, p. 101-103.

- Joossens (L.), Sasco (A.), Certaines l'aiment 'légère'. Le tabagisme féminin dans l'Union européenne. (Some like it 'light'. Female tobacco smoking in the European Union) Rapport européen, Brussels, Réseau européen pour la prévention du tabagisme, (European network for prevention of tobacco dependence) 1999, p. 66, on-line from 19 October 2001 (http://www.ensp.org/fr/contact/default.htm, 'rapport' section).

- Karsenty (S.), Slama (K.), Hirsh (A.), 'Le tabagisme en France avant et après la loi Évin de 1991', (Tobacco smoking in France before and after the Evin Law of 1991) in Conseil national de l'évaluation, Commissariat général du Plan, La loi relative à la lutte contre le tabagisme et l'alcoolisme. (The law relating to the fight against tobacco and alcohol addiction) Evaluation report, Paris, Documentation française, 2000, p. 337-349.

- Kopp (P.), Fenoglio (P.), Le coût social des drogues licites (alcool et tabac) et illicites en France, The social cost of legal drugs (alcohol and tobacco) in France) Paris, OFDT/ARMI, 2000, p. 277.

- Lagrue (G.), Cormier (S.), 'La dépendance tabagique', (Tobacco dependence) Revue documentaire Toxibase, no. 2, 1999, p. 1-14.

- MILDT (Mission interministérielle de lutte contre la drogue et la toxicomanie: Interministerial Mission for the Fight Against Drugs and Drug Addiction), La contrebande de cigarettes, (Cigarette smuggling) July 1998, p. 3 (internal memo).
- Nadal (J.-M.), Bourdillon (F.), Dautzenberg (B.), Ménard (J.), 'L'activité des consultations hospitalières de tabacologie en 1999', (Hospital tobacco specialist consultation activity in 1999) BEH (Bulletin épidémiologique hebdomadaire: Weekly epidemiological bulletin), no. 43, 2000, p. 189-191.
- Nizard (A.), 'Les effets sur la mortalité de quelques maux contemporains: sida, hépatite, alcool et tabac', (Effects on mortality of some contemporary ills: AIDS, hepatitis, alcohol and tobacco) Population, vol. 55, n° 3, 2000, p. 503-564.
- Oddoux (K.), Peretti-Watel (P.), Baudier (F.), 'Tabac', (Tobacco) in Baromètre Santé 2000, Vanves, CFES, 2001, (to be published).
- OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction), Drogues et toxicomanies: indicateurs et tendances, (Drugs and drug addiction: indicators and trends) Paris, OFDT, 1999, p. 270.
- Recours (A.), Politique de santé et fiscalité du tabac. (Tobacco taxation and health policy) Report to Monsieur the Prime Minister, Paris, Mission parlementaire sur la fiscalité du tabac, 1999, p. 56.
- (www.ladocfrancaise.gouv.fr/BRP/notices/994001479.html).
- WHO (World Health Organization), Health and Health Behaviour among Young people. Health Behaviour in School-Aged Children: a WHO Cross-National Study (HBSC). International report, Copenhague, WHO, 2000, p. 132 (Health Policy for Children and Adolescents Series no. 1).

Multi-drug use

Reference points

Multi-drug use

- Among adults, repetitive multi-drug use (the consumption of at least two drugs) of alcohol, tobacco and/or cannabis involves more than 15% of the population aged from 18 to 44 years. This behaviour is encountered much more frequently among persons who have experimented with at least on illicit drug (primarily cannabis). In addition, cannabis consumers are often also consumers of alcohol and tobacco; this consumption may be concomitant.

- Among young people, repetitive multi-drug use – primarily tobacco, cannabis and alcohol – is also more frequent due to the higher level of cannabis consumption: it involves almost one young person in four at the end of adolescence. This behaviour is mainly masculine and the frequency increases with age.

- In the party environment and among dependent users or abusers of illicit drugs, multi-drug use is a huge phenomenon. Its function is the regulation of the effects of different psychoactive substances: sedatives, stimulants or hallucinogenic drugs.

Health and social consequences

- More than half the drugs users who have recourse to the healthcare system are dependent multi-drug users. Opiates occupy a central position in this multi-drug use. They are associated with cocaine, cannabis, psychotropic medications and alcohol.

- In the area of illicit drugs, and by the clandestine nature of the market, the drugs consumed may contain a number of psychoactive substances whose interaction is little known and potentially dangerous. Moreover, in the case of ecstasy, it is estimated that one-third of the tablets consumed contain a number of psychoactive substances.

- In 2000, 45% (54 cases) of deaths from overdoses detected by the police services showed the presence of a number of drugs. This percentage has increased in recent years.

Multi-drug use in the French population

In surveys of the general population multi-drug experimentation means having experimented with a number of psychoactive drugs. Most of the time, the study is limited to the three most common drugs: tobacco, alcohol and cannabis. In this sense, a person who admits having smoked a cigarette and drank a glass of alcohol during his life is a multi-drug experimenter. Multi-drug consumption means having consumed, with a certain frequency, a number of psychoactive drugs; and most often, it is also the consumption of tobacco, alcohol and cannabis which is examined.

This analysis, based on a standard interview using disjointed questions, which are not inter-related ("Have you ever used cannabis?", and then "Have you ever drank alcohol?"), ignores the issue of consecutive or concomitant use, which is successive most of the time. Other questions, on the contrary, are aimed at precisely recording the simultaneous or concomitant use of drugs (referred to here by the term "mixture"). The most efficient way of obtaining information on this theme consists of asking an open question and recording the names of the drugs consumed on such occasions. The question was formulated in this way in two recent surveys, one of the adult French population [3], and the other of young people at the end of adolescence [8]. In the European survey on school-going young people [7], they were asked a closed question where they had to tick the number of times, during their lives, on which they had used alcohol with cannabis on the one hand, and alcohol with medications on the other hand. The thresholds used for the definition of indicators of repeated use are set out in each section.

Finally, another approach to multi-drug use is set out on the basis of observation data on recent trends in the urban and party environments [33].

Multi-drug consumption in the general adult population

Multi-drug experimentation

As alcohol and tobacco are very widely experimented with by those over 18 years, multi-drug experimentation is essentially examined from the point of view of illicit drugs. In addition, as the prevalence of experimentation with these drugs is very low after 44 years, only the 18-44 age bracket is examined here. Two additional indicators are also provided.

The first is the average number of substances tried by experimenters of a given drug. Those experimenting with cannabis admit, on average, to having experimented with 1.4 substances of the eight listed (cannabis, amphetamines, cocaine, LSD, heroin, ecstasy, medications "to drug oneself" and inhaled drugs), which is relatively low compared to the overall situation. From this point of view, they are close to experimenters of inhaled drugs, but, on the opposite end of the scale, heroin and ecstasy experimenters had tried more than half of the illicit drugs examined (4.7 and 4.2 respectively) [3].

The second indicator is the share of experimenters with a given substance, who had tested another, which allows the determination of the most frequent multi-drug experimentation. Thus, almost three-quarters (72%) of those who had tried heroin had already used cocaine, and almost four out of ten experimenters with ecstasy were also amphetamine experimenters, and vice-versa. Experimentation with medications "to drug oneself" is very close to that for "hard drugs" (heroin, ecstasy, cocaine, etc.).

Structure of multi-drug experimentation with illicit drugs in the general adult population from 18 to 44 years in 2000, by drug

(% in line and average number)

Experimentation with	Cannabis	Amphetamines	Cocaine	LSD	Heroin	Ecstasy	Medications[1]	Inhaled drugs	Number of drugs taken[2]
Cannabis	n = 2 099	4.4	7.1	7.4	3.4	4.3	2.7	9.7	1.4
Amphetamines	82.3	n = 113	45.1	53.1	25.7	36.6	18.6	25.7	3.9
Cocaine	94.1	32.3	n = 159	48.4	34.0	30.8	16.4	26.4	3.8
LSD	96.9	37.3	47.8	n = 161	29.8	30.9	21.0	29.6	3.9
Heroin	95	39	72	64	n = 75	35	23	41	4.7
Ecstasy	96	45	52	53	28	n = 94	18	26	4.2
Medications [1]	86	32	39	52	26	26	n = 66	36	3.9
Inhaled drugs	70.5	10,1	14.5	16.6	10.7	8,3	8,3	n = 289	2.4
All 18-44 year-olds	32,1	1.7	2.4	2.5	1.2	1.4	1.0	4.4	0.47

[1] The precise title is "medications to drug oneself".

[2] On average, for all the drugs shown in the table

Reading the table (heroin line): the sample consists of 75 heroin experimenters (n=75). Of these, 95% had also consumed cannabis, 39% amphetamines, etc. On average these persons had already tried 4.7 different illicit drugs (including heroin).

Source: Health Barometer 2000, CFES, OFDT production

While almost all experimenters with illicit drugs had already smoked cannabis, only a small group of users of relatively rare drugs, including "traditional hard drugs", are particularly involved in multi-drug experimentation. Conversely, experimenters with substances which appear relatively frequently, such as inhaled drugs and particularly cannabis, appear to rarely try other drugs.

Multi-drug use

For the adult population, there are two reasons why the study of the multi-drug use of alcohol, tobacco and cannabis was limited to a restricted age bracket: on the one hand, the fact that it related to the most frequently consumed drugs, the other illicit drugs being very rare; and on the other hand the fact that experimentation with cannabis virtually ceases above 45 years of age. The type of multi-drug use used was therefore the repeated consumption of at least two of the three products, and, at minimum: one cigarette per day, the consumption of alcohol three times during the last week and ten uses of cannabis during the last twelve months.

Repeated multi-drug use involved 15% of the population aged from 18 to 44 years. The "alcohol-tobacco" association is the most frequent, followed by "tobacco-cannabis", "alcohol-tobacco-cannabis" and "alcohol-cannabis". The cannabis users are younger than the average, the opposite of the others: in effect, the repeated consumption of alcohol increases with age. The majority are men, especially when the two substances most consumed by men, alcohol and cannabis, are taken together.

Repeated multi-drug use of tobacco, alcohol and cannabis in the general adult population from 18 to 44 years, in 2000

Repeated multi-drug use of…	As a % of 18-44 year-olds % in line (numbers)	% of men % in line	Average age In years
Alcohol-tobacco	9.6 % (627)	70.0 %	33.5
Tobacco-cannabis	3.4 % (222)	67.1 %	24.5
Alcohol-tobacco-cannabis	1.7 % (109)	82.6 %	27.1
Alcohol-cannabis	0.4 % (27)	80.8 %	25.4
All 18-44 year-olds	100.0 % (6,535)	48.5 %	31.4

Source: Health Barometer 2000, CFES, OFDT production

The greatest proportion of experimenters with illicit drugs is found among cannabis users: tobacco and alcohol consumers have tried 0.7 on average, while the others have tried almost two (1.8 to 2.3 for multi-drug users of the three drugs). These results reflect, in greater part, the spread of cannabis and these other substances in the population. LSD and cocaine are most frequently experimented with by repeated multi-drug users of tobacco, alcohol and cannabis.

Repeated multi-drug consumption of tobacco, alcohol and cannabis in the general adult population from 18 to 44 years, in 2000

(% in line and average number)

Repetitive multi-drug use of…	Experimentation with…								Number of drugs taken [2]
	Cannabis	Amphet amines	Cocaine	LSD	Heroin	Ecstasy	Medications [1]	Inhaled drugs	
Alcohol-tobacco	49.8	1.9	3.7	3.7	1.9	1.3	1.4	6.4	0.7
Tobacco-cannabis	100.0	11.7	16.7	18.6	10.4	16.2	7.2	18.9	2.0
Alcohol-tobacco-cannabis	100.0	12.8	26.6	25.7	13.8	18.3	9.2	20.2	2.3
Alcohol-cannabis	100	11	22	19	7	15	0	7	1.8
All 18-44 year-olds	32.2	1.7	2.4	2.5	1.1	1.4	1.0	4.4	0.5

[1] The precise title is "medications to drug oneself".
[2] On average, for all the drugs shown in the table

Source: Health Barometer 2000, CFES, OFDT production

Simultaneous taking of a number of drugs

Among 18-44 year-olds, 19.2% admit having taken at least two psychoactive drugs at the same time ("mixtures"). In 90% of cases it is alcohol and cannabis; in the other cases, most of the time, they are mixtures with an alcohol and(or) cannabis base with cocaine, medications or LSD added in.

Almost three-quarters of repetitive multi-drug users admit having already made such "mixtures", especially those who use cannabis (more than four-fifths, against a little less than half for the others). The make-up of these mixtures does not vary a lot: it is also, in 90% of cases, alcohol and cannabis or alcohol and(or) cannabis with another drug, most often cocaine or ecstasy. Medications rarely come into the make-up of this consumption (less than 2% of cases, primarily with alcohol or cannabis), and other illicit drugs are referred to very rarely [3].

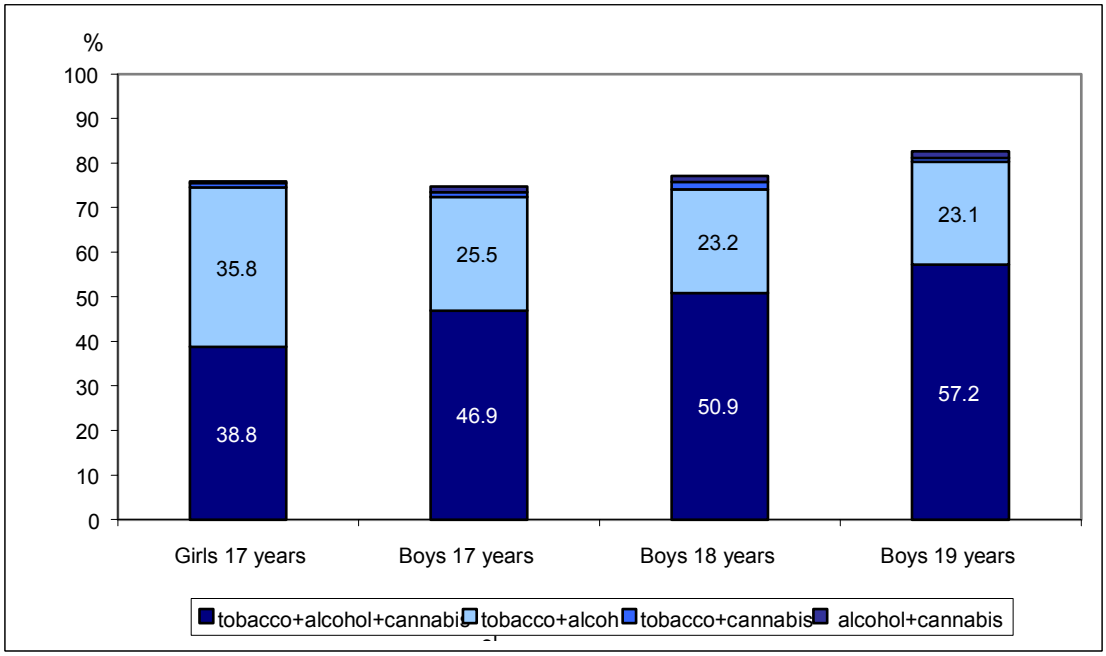
Multi-drug use by adolescents

Multi-drug experimentation

At the end of adolescence, almost 80% of young people had experimented with a number of psychoactive substances. In the majority of cases, this was alcohol, tobacco or cannabis. Experimentation with the latter is rarely isolated, even though, for those who have never smoked tobacco, there is a handful of young persons,

almost exclusively boys. This confirms that cannabis users make a clear distinction between the two drugs, even though cannabis is almost exclusively consumed with tobacco, which implies that a fraction of its users may actually use it without tobacco.

Frequency of multi-drug experimentation with tobacco, alcohol and cannabis among young people at the end of adolescence in 2000, by gender and age *{301a}*



Source: ESCAPAD 2000, OFDT

The main difference between boys and girls of 17 years of age is due to an under-representation of the latter in the category of experimenters with the three drugs: this illustrates the fact that less girls consume cannabis. Among boys, those who have consumed neither alcohol, tobacco nor cannabis are found in fairly similar proportions, and only the category covering the three drugs increases with age, showing that experimentation in adolescence is very common.

Experimentation with cannabis, more than for tobacco, is related to intoxication and psychoactive substances other than medications, with the strongest prevalence during life occurring among those experimenting with the three products. Conversely, almost all adolescents (93.4%) who had experimented with at least one stimulant (ecstasy, cocaine, amphetamines and LSD) had consumed alcohol, tobacco and cannabis.

As in the adult population, a more detailed study, restricted to experimentation with illicit drugs and young people of 17 years of age, allows a distinction to be made between three groups of different experimenters from the point of view of the number of experimentations with: cannabis, amphetamines, cocaine, LSD, heroin, ecstasy, medications "to drug oneself", hallucinogenic mushrooms and *poppers* (the latter product being one whose sale is regulated).

The first group is that of experimenters with medications "for the nerves" and above all cannabis, which are both the most numerous and those who have tried the least number of other drugs (1.7 and 1.4 respectively, on average); this is followed by the group of experimenters with ecstasy, hallucinogenic mushrooms or poppers, who have tried a little less than half of the nine drugs covered here; finally, the group of experimenters with amphetamines, LSD, cocaine or heroin, who are both the least numerous and who have tried the most substances (on average more than 5). In this last group, the experimentation is especially intricate. In effect, in almost half the cases, an experimenter of one of these drugs has also experimented with the three others.

Structure of multi-drug experimentation with illicit drugs at 17 years, in 2000, by drug
(% in line and average number)

Experimentation with…	Cannabis	Amphetamines	Cocaine	LSD	Heroin	Ecstasy	Medications[1]	Mushrooms[2]	*Poppers*	Number of drugs taken [2]
Cannabis	***n = 4 518***	1.9	2.0	2.6	1.4	4.5	23.0	6.9	5.0	1.4
Amphetamines	86	***n = 92***	50	49	38	66	55	63	43	5.3
Cocaine	94	54	***n = 88***	57	42	68	55	57	38	5.3
LSD	95.2	36.7	41.1	***N = 115***	28.4	69.4	49.1	57.9	42.0	5.0
Heroin	96	57	61	56	***n = 61***	69	55	68	45	5.8
Ecstasy	94.7	31.6	31.0	43.4	21.8	***n = 199***	43.3	48.5	29.4	4.2
Medications[1]	51.5	2.6	2.4	3.0	1.8	4.2	***n = 1 925***	4.7	4,1	1.7
Mushrooms	98.5	20.5	17.4	23.2	14.3	32.4	31.7	***n = 295***	27.2	3.5
Poppers	93.4	16.9	14.1	21.4	11.7	24.5	34.6	33.9	***N = 227***	3.4
All 17 year-olds	45.5	1.0	0.9	1.2	0.6	2.1	19.9	3.1	2.4	1.4

[1] The precise title is "medications to drug oneself".

[2] On average, for all the drugs shown in the table.

Reading the table (heroin line): the sample consists of 61 heroin experimenters (n=61). Of these, 96 % had also consumed cannabis, 57 % amphetamines, etc. On average these persons had already tried 5.8 different illicit drugs (including heroin).

Source: Health Barometer 2000, CFES, OFDT production

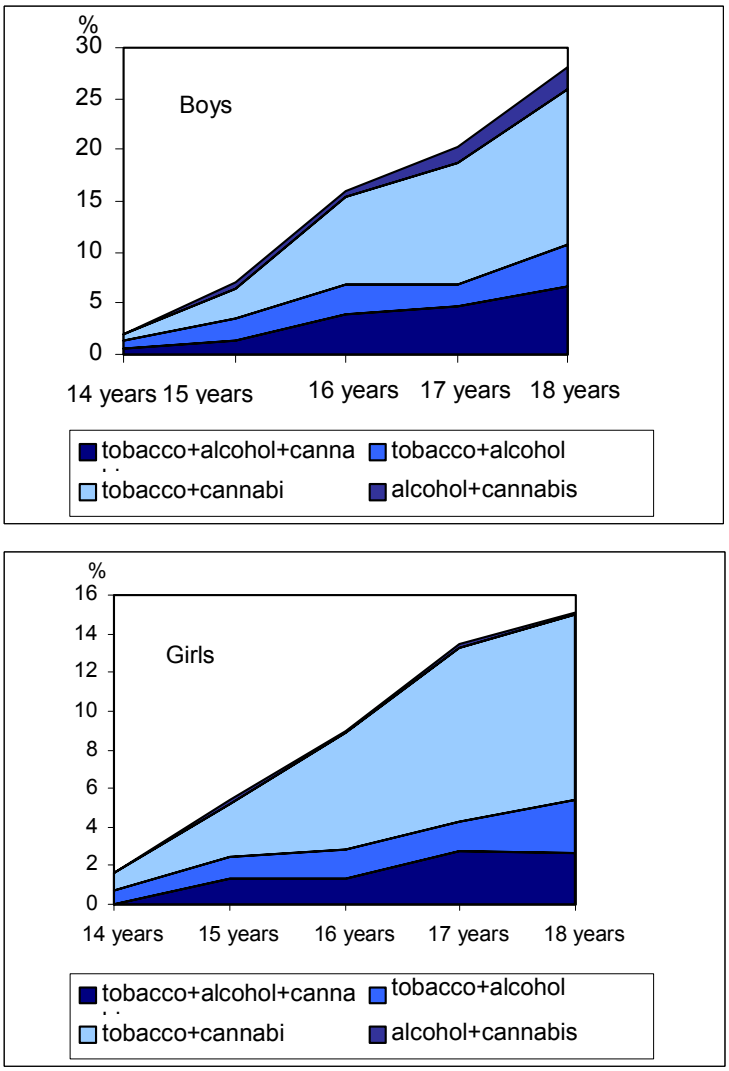
As for adults, there is therefore a small group of experimenters of a relatively large number of illicit drugs, and cannabis again appears as the substance almost universally experimented with by illicit drug users [8].

Repetitive multi-drug use

Repetitive multi-drug use is defined here as the accumulation of repetitive consumption of alcohol (more than ten times per month), tobacco (at least one cigarette during the last thirty days) and cannabis (more than ten uses during the year). As in the case of adults, four types are considered (for two or three of these drugs).

In the school environment, at 14 years, 2% of boys admitted consuming at least two drugs in a repetitive manner, as against 18% at 18 years. For girls, these percentages went from 2% to 15% [7].

Frequency of repetitive multi-drug use among school-going young people in 1999, by gender and age *{301b}*

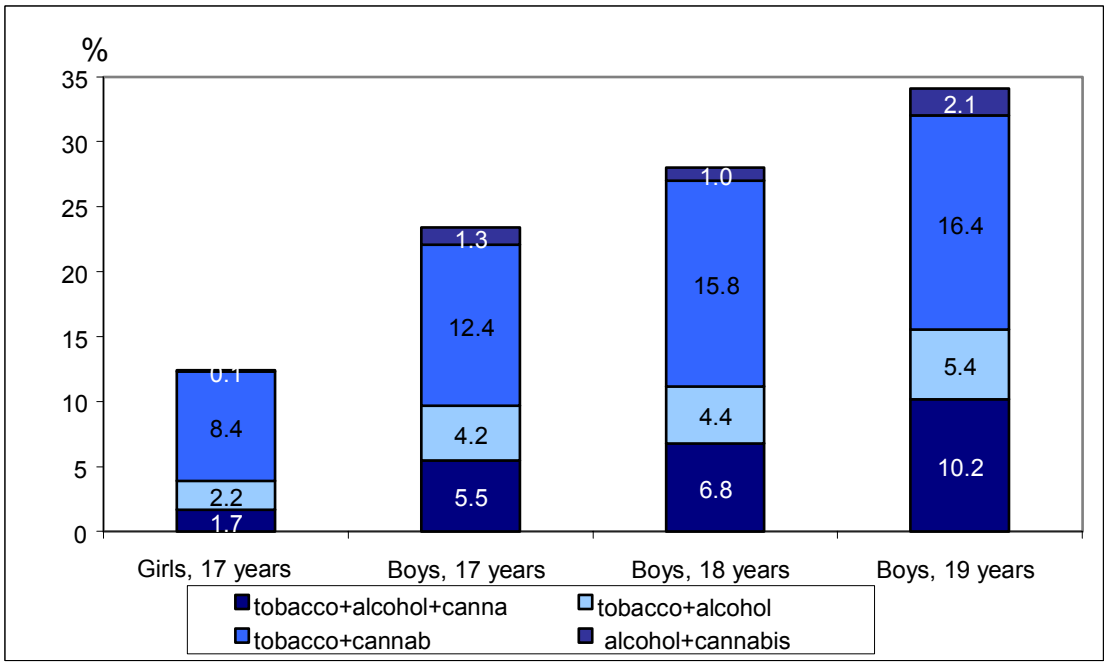


Source: ESPAD 1999, INSERM/OFDT/MENRT

For boys, between 14 and 18 years of age, the alcohol-tobacco combination changes little, moving from 1% to 4%. The three others increase much more, in particular the tobacco-cannabis combination which becomes more common with age and involves 15% of boys of 18 years of age.

For girls, the different types of multi-drug use also increase with age, but are always less frequent than for boys. As is the case for boys, the tobacco-cannabis combination is predominant, moving from 1% at 14 years of age to 10% at 18 years of age [7].

Frequency of repetitive multi-drug use among young people at the end of adolescence in 2000, by gender and age *{301c}*



Source: ESCAPAD 2000, OFDT

At 17 years of age, the difference between the genders is essentially due to the predominance of the repetitive use of tobacco alone among girls (28% of the total). The only repetitive multi-drug use that exceeds 3% among girls of 17 years of age is the tobacco-cannabis combination. With age, it is primarily the association of the three drugs that increases among boys. Thus, one boy in ten has a repetitive use of the three products at 19 years of age.

The link between intoxication and multi-drug use is very strong, and includes those combinations that do not involve the repetitive use of alcohol. The differences are less marked for experimentation with psychotropic medications, even though they are still significant: the more adolescents have experimented with these medications, the more they are repetitive multi-drug users. Conversely, experimentation with stimulants, hallucinogenic mushrooms or inhalants (*poppers* and inhaled drugs) is always higher in the combinations that involve the repetitive use of cannabis [8].

Simultaneous taking of a number of drugs ("mixtures")

When questioned at school, less than one young person out of ten, from 14 to 18 years of age, (8.4%) admitted having already taken alcohol with medications ("mixture") during life, and a quarter admitted to having taken alcohol with cannabis. The number of admitted uses of the alcohol-medications mixture is relatively small (less than 1% of those who have already done so admit to more than ten times), the opposite of the alcohol-cannabis mixture (76% of experimenters of cannabis have already taken it, and 9% have taken it more than 10 times) [7].

At the end of adolescence, 5.8% of young people have admitted at least one simultaneous use of psychoactive drugs. "Mixtures" of two ingredients are more numerous (80%), ahead of mixtures of three drugs (17%), with mixtures of four and five ingredients being much rarer. The drug most referred to is cannabis, which is present in 99% of cases, ahead of alcohol (43%). The question ("During your life, have you ever taken a number of drugs together?") *a priori* excluded "mixtures" containing alcohol, by implicitly making reference to a table listing psychoactive substances other than alcohol and tobacco: this suggests that the interaction between alcohol and the other drugs is particularly common. This is followed by ecstasy (present in 16% of the mixtures referred to), mushrooms, LSD, *poppers*, cocaine and inhaled drugs (5%).

However, in total, 28% contained stimulants (ecstasy, amphetamines, cocaine or LSD). As in the case of adults, medications were rarely referred to (only one declared "mixture") [8].

Mixtures most frequently referred to by young people at the end of adolescence, in 2000

Precise combination of the mixture	No. of references	As a % of the mixtures referred to
Cannabis-alcohol	261	31 %
Cannabis-mushrooms	98	12 %
Cannabis-other drugs	60	7 %
Cannabis-*poppers*	55	7 %
Cannabis-ecstasy	54	6 %
Cannabis-LSD	38	5 %
Cannabis-inhaled drugs	27	3 %
Cannabis-cocaine	20	2 %

Source: ESCAPAD 2000, OFDT

Observations in the field

Multi-drug use of psychoactive substances is a phenomenon found in the areas examined by the TREND (*Tendances récentes et nouvelles drogues*: Recent Trends and New Drugs) structure, both in the urban and party environments.

This confirmation of a largely known phenomenon must be interpreted by taking the rationality of behaviour into account. In this interpretative context, the concept of "consumption regulation", defined as the combined use of drugs for the purpose of modifying the effects of other substances already consumed, and which may be concomitant or spread over time, is preferred to multi-drug use

In the area of illicit drugs, it may happen that users may, without their knowledge, consume a number of drugs at the same time. This is particularly frequent in the specific case of ecstasy, as shown by the analysis of the content of the samples collected in France.

Effects sought and the regulation of consumption

Forty different associations of psychoactive substances, all coming within the context of consumption regulation, were counted by the structure's observers.

The functions and objectives of the concomitant or sequential use of psychoactive substances

Regulation function	Objectives	Concomitant or sequential use of two psychoactive substances
Maximisation of the effects	Accelerate and magnify the high	1) Laughing gas for LSD; 2) Laughing gas for ecstasy; 3) Cannabis for ecstasy
	Maximise the effects	1) Benzodiazepines for opiates; 2) GHB for ecstasy; 3) Cannabis for opiates; 4) Ketamine for LSD
	Prolong the effects	1) Ecstasy for Ketamine; 2) Cocaine for ecstasy; 3) Alcohol/cannabis for LSD
	Boost the effects	1) Speed for LSD; 2) Speed for ecstasy; 3) Speed for LSD; 4) GHB for ecstasy; 5) Laughing gas for ecstasy
Balancing the effects	Add an ingredient	1) Ecstasy for LSD (*love* ingredient); 2) Speed for ecstasy (*speed* effect)
	Mask an ingredient	1) LSD for ecstasy; 2) Cocaine for ecstasy
	Offset the effects	1) Cocaine for ketamine; 2) Cocaine for alcohol (and vice versa); 3) Speed for alcohol (and vice versa)
Control the negative effects	Reduce a strong high	1) Opiates for stimulants; 2) Cocaine for ecstasy or LSD; 3) Cannabis for stimulants; 4) Alcohol for LSD; 5) Cannabis for LSD
	Soften the coming down	1) Benzodiazepines for stimulants; 2) *Rachacha* for hallucinogenic drugs; 3) Cocaine for LSD; 4) Cannabis for crack and speed; 5) GHB for ecstasy; 6) Alcohol for LSD; 7) Ecstasy for LSD; 8) Cannabis for LSD; 9) Opiates for stimulants
	Cancel and neutralise the effects	1) Cocaine/speed for LSD (neutralise the "scattered thoughts" effect); 2) Cocaine for ecstasy.
Alternatives	Dealing with shortages	1) Between opiates (Neocodion® for heroin)
	Substitute the effects	1) Cannabis with speed to avoid taking LSD or ecstasy

Source: TREND 2000, OFDT [33]

The associations of drugs can be classified on the basis of their respective objectives and grouped into four functions:

- the function of maximising the effects, which consists of obtaining the maximum "positive" effect by associating a number of substances. This is not simply a quantitative accumulation but a qualitative modification of the effects;
- the function of balancing the effects, when the effects are mutually corrected so as to allow the user to adapt, at any time, the effects felt to changes in context or to his or her desire to experience different states;
- the function of controlling the "negative" effects of one or more psychoactive substances, the purpose being to retain the "positive" effects only. This function particularly relates to the phase known as the "descent", during which the "positive" effects of the substance disappear and are replaced by negative effects (feeling of illness, withdrawal);
- the "alternative" function which relates to the need to replace a drug while retaining the effect, for reasons related either to the lesser availability of the replaced drug or a change in how it is perceived.

Involuntary multi-drug use: the ecstasy case

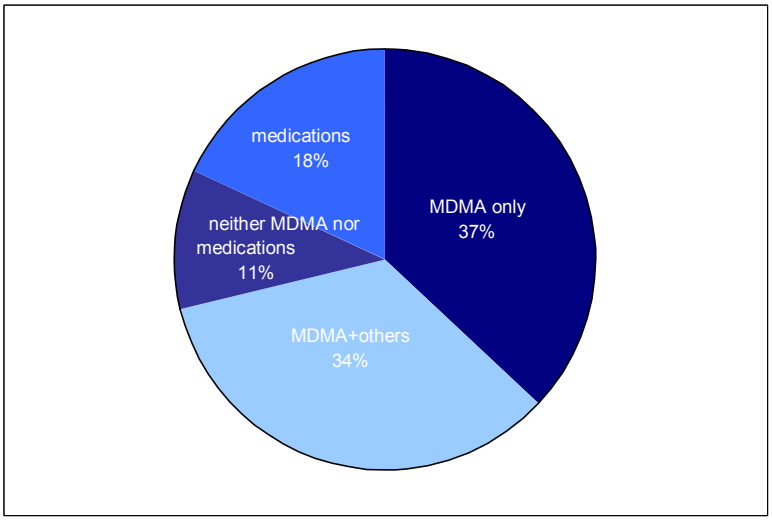
The SINTES (*Système d'Identification National des Toxiques Et Substances*: National Identification System for Toxic Substances) database allows the making of a special analysis of the problem of substances sold as "ecstasy" and which do not always contain MDMA. This analysis is possible thanks to the collection

of context elements by the healthcare and social partners, particularly the names, supposed contents and effects sought.

During 2000, 442 samples, thought by users to be *ecstasy* or MDMA, were collected. Following analysis, it appeared that these samples actually contained MDMA in 78% of cases, while in 15% of cases it was medicinal substances, MDA (in 6% of cases), caffeine (5%), amphetamines (5%), MDEA (2%) and finally, 8% of the samples had no active ingredient.

A specific analysis of 262 samples sold as ecstasy and collected during the first six months of 2000 revealed that only one-third of the samples contained MDMA as the single active ingredient. Other active ingredients, particularly medications, were found in two-thirds of the cases.

Breakdown of the samples sold as ecstasy based on their content, in 2000 *{302a}*



N = 262

Source: SINTES 2000, OFDT

Health and social consequences of multi-drug use

Dependence on a number of drugs and their association in use makes care cases more complex. Withdrawal, particularly from opiates, is more difficult when the same person regularly consumes a number of drugs. The phenomenon of multi-drug use, described by professionals in the drug user healthcare sector, is however, difficult to measure in surveys. Although the term is often used, there is no consensus on its definition. The approaches proposed below should, therefore, be considered as a contribution to the debate.

Demands for treatment

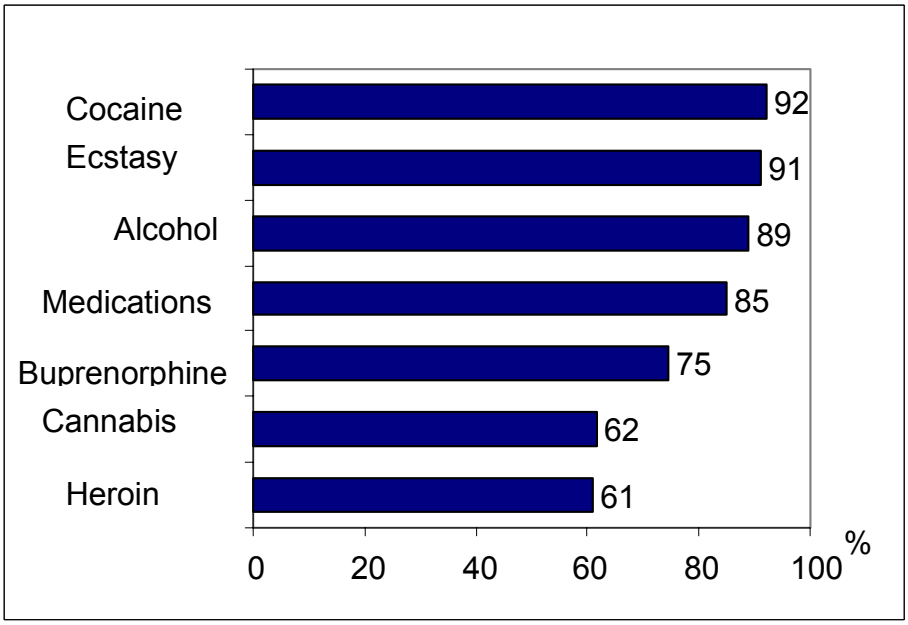
Taking account of the data available from the surveys of users attending the healthcare structures, multi-drug use can be approached in two ways: based on the drugs at the origin of care, or the drugs consumed in the recent period (week or month depending on the surveys). To differentiate between the two approaches, multi-drug addiction is used for the first case and multi-drug use for the second. Multi-drug addiction characterises the situation of users where more than one drug is the origin of care and multi-drug use that of users who admit to having recently consumed more than one drug.

Multi-drug addiction

On the basis of the results of the survey conducted in November 1999, multi-drug addiction appeared in a little more than one case in two (56%). This percentage had increased slightly over that of the November 1997 survey (54%).

The share of multi-drug addiction varies according to the drug. Cocaine, ecstasy and alcohol are associated with another drug in approximately 90% of care cases. For cannabis and the opiates, this percentage is 60%. Medications, primarily benzodiazepines and buprenorphine without a medical prescription, occupy an intermediary position.

Frequency of multi-drug addiction among drug users in 1999, based on the drug at the origin of care *{303a}*



Reading the graph: when it appears as the drug at the origin of care (primary or secondary), cocaine is associated with another drug in 92% of cases, ecstasy in 91% of cases, etc.

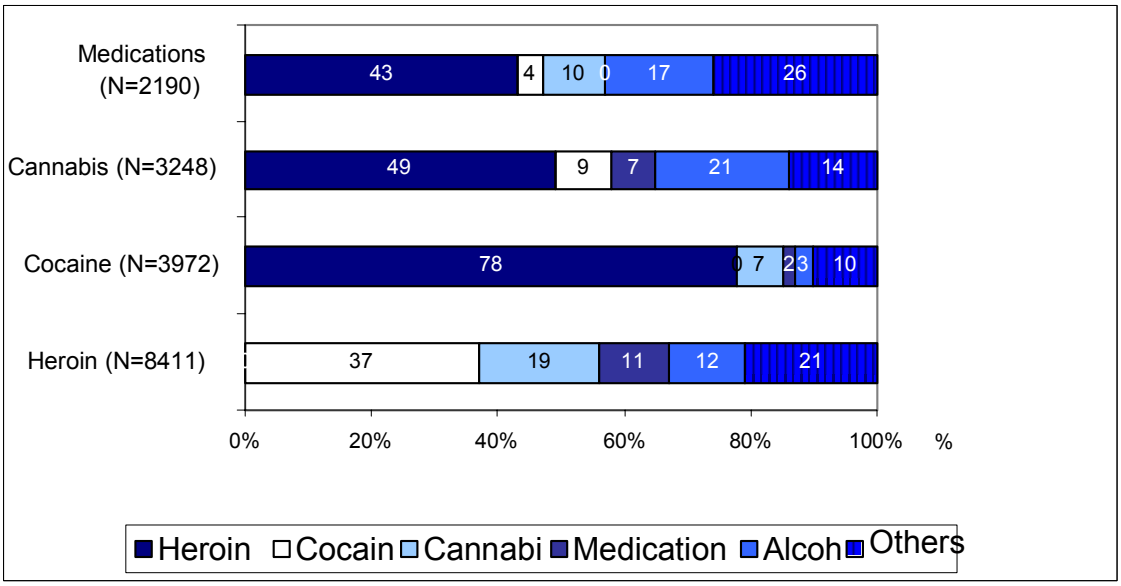
Source: Survey on the care of drug addicts in November 1999, DREES/DGS

The relatively low proportion of multi-drug addiction for cannabis is explained by the presence of young users of this drug who have much fewer problems with a second drug than older users.

As regards heroin, this drug is often cited as being at the origin of care for users receiving substitution treatment, who, for the most part, do not have a difficulty with other drugs.

Taking account of the considerable overall weight of opiates, and in particular heroin, in the drugs at the origin of care, this latter substance is strongly associated with all the others. This association is, however, very intense when cocaine is referred to. The importance of the links between cannabis and alcohol and between medications and alcohol must also be noted.

Associations of psychoactive substances in multi-drug addiction among drug users in 1999, based on the drug at the origin of care *{303b}*



Reading the graph: As the 1st or 2nd drug at the origin of care, medications are associated with another drug in 2,190 cases; 43% relate to heroin, 4% to cocaine, 10% to cannabis, 17% to alcohol and 26% to other drugs.

Source: Survey on the care of drug addicts in November 1999, DREES/DGS

In the survey whose results are used here, only two drugs at the origin of care could be referred to, which has, without doubt, had the effect of minimising the weight of some associations. Moreover, it would also be interesting to know the substances actually consumed over a recent period. The multi-drug addiction approach therefore needs to be completed by an approach based on the drugs consumed.

Multi-drug use

In all of the cases of care in the specialised establishments and the healthcare establishments, consumption within the last thirty days is cited in approximately 60% of cases[1]. Reference to two drugs only appears in 30% of cases and three drugs appear in 20% of cases. Among persons having consumed at least one substance during the last thirty days, the average number of drugs consumed is 1.7. In cases of multi-drug use (at least two drugs consumed), the substances which are most often involved are cannabis (53%), alcohol (40%), heroin (33%), benzodiazepines (27%) and cocaine (225). This classification is found in major part in the frequency of associations between products in which cannabis, alcohol and heroin are the most often referred to.

[1] Users receiving substitution treatment or who have recently withdrawn may not have had any use during the previous month

Association of two psychoactive substances used during the last thirty days among drug users receiving care, 1999

(in %)

Alcohol and cannabis	21
Heroin and cannabis	13
Heroin and cocaine	12
Benzodiazepines and alcohol	10
Benzodiazepines and cannabis	10
Cocaine and cannabis	7
Heroin and alcohol	7
Heroin and benzodiazepines	5
Heroin and buprenorphine	5

Reading the table: of 6,823 cases which referred to at least two drugs having been consumed during the last thirty days, the association of alcohol and cannabis appears in 21% of cases, heroin and cannabis in 13% etc. Only the most frequent associations are shown. The percentages in the column cannot be added.

Source: Survey on the care of drug addicts in November 1999, DREES/DGS

The frequency of association varies depending on the product examined. Cannabis, due to its overall weight in consumption, appears to be heavily linked to all substances. This association is, however, particularly strong for ecstasy: when this product is referred to, cannabis is associated in 51% of cases. Use of cocaine is very strongly associated to that of heroin (in 44% of cases) and that of alcohol to cannabis (405 of cases).

Association of psychoactive substances used during the last thirty days among drug users receiving care, in 1999

(in %)

	Heroin N = 3 273	Cocaine N = 1 875	Benzodiazepines N = 2 404	Cannabis N = 6 718	Ecstasy N = 335	Alcohol N = 3 688
Heroin	-	44	15	13	21	13
Buprenorphine without prescription	10	9	11	5	5	6
Cocaine	25	-	8	7	24	7
Benzodiazepines	11	11	-	10	4	18
Cannabis	27	27	27	-	51	40
LSD and other dysleptics	1	2	1	1	11	1
Ecstasy	2	4	1	2	-	2
Amphetamines	1	2	1	1	4	1
Alcohol	14	13	28	22	16	-

Reading the table: of the 3,723 cases which refer to the consumption of heroin during the last 30 days, buprenorphine without a medical prescription was also consumed in 10% of cases, cocaine in 25% of cases, benzodiazepines in 115 of cases etc. As one substance may be associated with two others, the figures in the column cannot be added. In order not to make the table unwieldy, it does not include all the possible substances.

Source: Survey on the care of drug addicts in November 1999, DREES/DGS

The OPPIDUM (*Observation des produits psychotropes ou détournés de leur utilisation médicamenteuse*: Observation of psychotropic drugs or those diverted from their medicinal use) survey, conducted at the same time (October 1999) on a sample of approximately 2,000 users seen in the healthcare structures, gave very similar results on the frequency of association of cocaine and heroin. On the other hand, there were not negligible differences for the associations with benzodiazepines, alcohol and cannabis. It is possible that in the survey conducted in the month of November, the attention given to the recording of licit or common use was less and that this resulted in greater attention being paid to more visible and more easily detectable use. The weight of benzodiazepines and medications is probably underestimated in the survey.

Association of psychoactive substances consumed during the last seven days among drug users receiving care, in 1999

(in %)

	Cocaine N = 239	Benzodiazepines N = 511	Heroin N = 261	Cannabis N = 657
Benzodiazepines	28	-	17	25
Cocaine	-	13	34	15
Heroin	37	9	-	15
Alcohol	26	27	21	25

Reading the table: of the 230 cases which refer to the consumption of cocaine during the last seven days, benzodiazepines were also consumed in 28% of cases, heroin in 37% of cases, alcohol in 26% of cases, etc. A substance shown in the column can be simultaneously associated with a number of other substances; the sum of the percentages in the columns can therefore be greater than 100%; moreover, in order to overload the table, only substances with substantial numbers are shown.

Source: according to OPPIDUM 1999, CEIP

Morbidity and mortality

During 2000, of the 120 deaths from overdose detected by the police services, 38 revealed the presence of a number of substances (approximately one-third of them). As heroin was most frequently detected as being at the origin of overdoses, it was also found in 18 of the 38 deaths in which a number of drugs were detected. The other mixtures generally recorded involved the associations of medications often used by heroin addicts: methadone, Subutex, Skenan, Tranxene, etc.

The deaths from overdose in which a number of drugs were detected represent an increasingly substantial share of deaths from overdose in France.

For further information

■ ARÈNES (J.), GUILBERT (P.), BAUDIER (F.), GENERAL PRACTITIONER HEALTH BAROMETER 98/99, VANVES, CFES, 1999, P. 218.

■ BECK (F.), LEGLEYE (S.), PERETTI-WATEL (P.), A LOOK AT THE END OF ADOLESCENCE: CONSUMPTION OF PSYCHOACTIVE DRUGS IN THE ESCAPAD 2000 SURVEY, PARIS, OFDT, 2000, P. 220

■ BECK (F.), LEGLEYE (S.), PERETTI-WATEL (P.), ALCOHOL, TOBACCO, CANNABIS AND OTHER ILLICIT DRUGS AMONG COLLEGE AND SECONDARY SCHOOL STUDENTS: ESPAD 1999 FRANCE, VOLUME II, PARIS, OFDT, 2001, (TO BE PUBLISHED).

■ BELLO (P.Y.), TOUFIK (A.), GANDILHON (M.), RECENT TRENDS, TREND REPORT, PARIS, OFDT, 2001, P. 167

■ CHOQUET (M.), LEDOUX (S.), HASSLER (C.), ALCOHOL, TOBACCO, CANNABIS AND OTHER ILLICIT DRUGS AMONG COLLEGE AND SECONDARY SCHOOL STUDENTS: ESPAD 1999 FRANCE, VOLUME I, PARIS, OFDT, 2001, (TO BE PUBLISHED).

■ CHOQUET (M.), HASSLER (C.), LEDOUX (S.), BECK (F.), PERETTI-WATEL (P.), CONSUMPTION OF PSYCHOACTIVE SUBSTANCES AMONG SCHOOL-GOING 14-18 YEAR-OLDS: INITIAL RESULTS OF THE 1999 ESPAD SURVEY, DEVELOPMENTS 1993-1999", TRENDS NO. 6, 2000, P. 1-6.

■ CHOQUET (M.), LEDOUX (S.), ADOLESCENTS, NATIONAL SURVEY, PARIS, INSERM, 1994, 346 P.

■ COSTES (J.-M.), "RECENT TRENDS IN THE CONSUMPTION OF PSYCHOACTIVE DRUGS AND THE COMPOSITION OF SYNTHETIC SUBSTANCES", TRENDS, NO. 7, 2000, P.1-4.

■ GUILBERT (P.), BAUDIER (F.), GAUTIER (A.) (DIR.), HEALTH BAROMETER 2000, VANVES, CFES, 2001, (TO BE PUBLISHED).

■ HIBELL (B.), ANDERSSON (B.), AHLSTROM (S.), BALAKIREVA (O.), BJARNASSON (T.), KOKKEVI (A.), MORGAN (M.), THE 1999 ESPAD REPORT: ALCOHOL AND OTHER DRUG USE AMONG STUDENTS IN 30 EUROPEAN COUNTRIES, STOCKHOLM, CAN, 2000, 362 P.

■ PALLE (C.), TELLIER (S.), "ILLICIT DRUG USERS TAKEN INTO CARE BY THE HEALTHCARE SYSTEM IN NOVEMBER 1997", DREES, STUDIES AND RESULTS, NO. 59, APRIL 2000, P. 1-8.

■ TELLIER (S.), THE CARE OF DRUG ADDICTS IN THE HEALTHCARE AND SOCIAL STRUCTURES IN NOVEMBER 1999, PARIS, DREES, 2001, 47 P. (WORKING DOCUMENT NO. 19).

THE LEGAL FRAMEWORK AND STRUCTURES

LEGAL FRAMEWORK AND RECENT ORIENTATIONS IN PUBLIC POLICY ON THE FIGHT AGAINST DRUGS

Legal framework

Devoted to a description of the legal framework for the fight against drugs in France, this part will cover, in succession, the laws in relation to illicit drugs, then those covering licit drugs, separating the cases of alcohol, tobacco and psychotropic drug medications, and finally products at the origin of doping behaviour in the sporting environment.

As the development of the legal framework was largely described in the previous edition of the 'Indicators and Trends' report (OFDT, 1999) this is a simple reminder of the broad lines of the legal provisions in effect[1].

Illicit drugs

The legal framework in relation to illicit drugs is primarily set by the law of 13th December 1970. Numerous implementing texts have subsequently completed this initial framework.

Law of 31st December 1970

The law of 31st December 1970(1) constitutes the legal framework on which French policy on the fight against drugs has been based for thirty years. This law represses the use and trafficking of narcotics, and clearly distinguishes these two aspects. Since 1970, the law enforcement of trafficking has been strengthened on a number of occasions through increasing the penalties incurred or creating new offences (supply and transfer for personal use, money laundering). On the other hand, the texts on the deterrence of use, a subject of unceasing debate, have not changed throughout these years.

This relative permanence in the legislative situation should not conceal, however, the quite marked developments in the implementation of the law, as expressed, more or less, in the memorandums and other texts drafted by the authorities responsible for justice and health.

The law of 1970 has been the subject of numerous presentations and analyses. Schematically, its objectives are as follows:

Severely deter trafficking;

Criminally sanction the use of narcotics—previously only use in society was deterred—while at the same time offering a therapeutic alternative;

ensure free care and anonymity for users seeking care.

The list of narcotic drugs covered by this law was established by decision of the Minister responsible for health, on a proposition from the Director General of the French Agency for the Sanitary Safety of Healthcare Products, in accordance with international regulations.

As regards trafficking, the penalties provided are particularly heavy, and greater than those for the majority of offences. The police services intervention procedure is an exception from common law: custody may last four days instead of 48 hours and searches are permitted at night.

[1] The references to the main legislative and regulatory texts are set out in the form of notes at the end of this chapter

Article L3421-1 of the Public Health Code prohibits the illicit use of narcotics with a maximum sentence of one year's imprisonment and/or a fine. In other respects, under the terms of article L3411-1, the user is placed under the supervision of the health authority. These texts underline the double status of the user, who is considered by the legislator to be both delinquent and ill.

The user may avoid prosecution if he agrees to the mandatory treatment offered to him by the prosecutor.

Recent developments in the legislation

For the user, the memoranda from the Ministries of Justice and Health have, as in the past, placed the emphasis more on the therapeutic alternatives or, on the contrary, on deterrence where use was associated with trafficking. The successive laws voted since the end of the 1980s essentially relate to the prohibition of trafficking and the acts related to narcotics trafficking, either by increasing the penalties provided or by creating new offences.

Thus, with the **law of 16th December 1992**[2], the penalties may go as far as life imprisonment and a fine of 50 million francs for certain trafficking. In parallel, emphasis will be placed on the prohibition of money laundering or the false justification of the resources of traffickers (**law of 31st December 1987**[3]; **law of 23rd December 1988**[4]; **law of 12th July 1990**[5]; **law of 13th May 1996**[6]). The last law also hid the fact of being unable to justify resources corresponding to the user or narcotics trafficker's lifestyle ('procuring of drugs').

Moreover, the manufacturing and sale of 'precursor' products likely to be used for the manufacture of narcotics were controlled (**law of 19th June 1996**[7]).

Finally, in the context of road safety measures, the law of 18th June 1999[8] provides for the systematic testing of drivers involved in fatal accidents for the presence and dosage of narcotics. On the basis of these analyses, a study should allow the evaluation of the role of narcotics in the occurrence of these types of accident. The conclusions are expected at the end of 2004.

Alcohol

For tax and public order reasons, the sale and distribution of alcoholic drinks have been regulated for a number of centuries, but public health concerns, which sometimes clash with economic and social interests (wine growers, producers and distributors constituting a pressure group), are much more recent: the 1960 ordinances on the fight against alcoholism[9], and the Evin Law of 10th January 1991[10], in particular.

Alcohol and trade

The manufacturing and sale of beverages are regulated by the Licensed Premises Code and the Public Health Code, and certain alcoholic beverages are prohibited (for example, aperitif beverages with a wine base of more than 18 proof, spirits of more than 45 proof, and bitters and other beverages of more than 30 proof).

In licensed premises (cafes, *brasseries*, restaurants, refreshment bars, etc.), the sale and consumption are also subject to authorisation. Only establishments with an IV license are authorised to offer all the beverages. The regulation, particularly in respect of this type of establishment, is very strict: prohibition on the opening of a new establishment—only changes in ownership and transfers are allowed; protected and super-protected zones in which the licenses cannot be transferred or must be suppressed. These provisions carry criminal sanctions.

However, in a balancing movement, the legislation has recently adopted more liberal measures; the methods for calculating the size of protected zones were modified when the 'Forum des Halles' in Paris was examined; in the name of the sociability and policy of the city, restrictive provisions are applied to new built-

up areas; refreshment bars in stadiums, prohibited by the Evin Law of 10th January 1991, were subsequently authorised, under conditions which were less restrictive (law of 30th December 1998[11]). The requirements of public order and health are yielding to the weight of economic interests.

Alcohol and advertising

The same applies to advertising in favour of alcoholic beverages, which has been regulated since 1941. The advertising, depending on the type of beverage, can be strictly limited; an ordinance of 1960 also prohibited advertising for all alcoholic beverages in stadiums. In 1980, the Court of Justice of the European Communities condemned discriminatory legislation that authorised advertising for rum, but prohibited it for whisky. When the restrictions were barred, it was necessary to wait for the Barzach Law of 30th July 1987[12], until new legislation was implemented, in particular, the prohibition of all advertising on television and in sports grounds, and regulation of advertising messages. A memorandum subsequently gave a very liberal interpretation of it.

The Evin Law of 10th January 1991 reversed the principle so that propaganda or advertising, whether direct or indirect, in favour of alcoholic beverages, is now prohibited, except:

In the written press, except in publications aimed at young people

By radio broadcasting

In the form of posters and signs

By issue by producers

In favour of traditional festivals and fairs devoted to local beverages, etc

Every sponsorship operation with the effect of advertising in favour of these beverages is also prohibited. Patronage operations may only give rise to advertising under certain conditions.

The content of advertising messages is regulated and it must state that, 'alcohol abuse is dangerous to health'.

Originally, posting was only authorised in production facilities, but in the absence of a regulatory definition of these, posting was completely liberalised, everywhere, even in stadiums, where it was previously prohibited. The only restriction still in effect relates to advertising in the cinema, as in the case of television, which was previously prohibited.

Violation of these prohibitions carries criminal penalties: a fine of Fr 500,000 and up to 50% of the expenses devoted to the illegal operation. Termination of the advertising may be ordered.

Associations in the fight against alcoholism can take civil action. They have an essential role in cases in which proceedings are undertaken, because, despite the number of offences that may be discovered, public authorities rarely prosecute.

Alcohol and public order

Obvious intoxication in a public place is a 2nd-class offence, carrying a Fr 1,000 fine. The person is brought, at his expense, to the closest station or to a safe room, and kept there until sober. Under the new Penal Code of 1994, the penalties provided may go as far as imprisonment in the case of a further offence.

Intoxication in a sports arena, since the law of 6th December 1993[13], constitutes an offence that may be punished with a prison sentence, particularly in the case of violence.

Alcohol and road safety

Driving under the influence of alcohol has been prohibited since 1965. The law of 9th July 1970[14] instituted, for the first time in France, a legal alcohol level. Above 0.40 mg/l of expired air (checked by breathalyser), or 0.8 g/l of blood (blood analysis), it is an offence punishable by two years' imprisonment. From 0.25 to 0.5 (or 0.4 to 0.8 in the case of blood analysis), it is a 4th-class offence. Additional penalties, in particular suspension or cancellation of driving licenses, or the loss of points [insurance], are also provided.

If an accident involving injury has occurred, the penalties increase and may reach ten years' imprisonment in case of involuntary homicide with deliberate breach of safety or traffic regulations.

A new deterrence measure was introduced by the **law of 12th July 1978[15]**, which instituted alcohol checks, even in the absence of such offences or accidents.

At the beginning of the 1980s, the strengthening of checks and the penalties for driving under the influence of alcohol seemed to be indispensable in the eyes of the public powers. Thus, **the law of 8th December 1983[16]** fixed a single alcohol level threshold at 0.8 g/l of blood (or, for expired air, a rate equivalent to 0.4 mg/l). Every driver reaching this rate may be penalised with a fine and/or a prison sentence (set at two years in 1987). A new step was made with the law of 17th January 1986[17] that provided for the immediate withdrawal of driving licenses for 72 hours, in the case of presumed intoxication. The prefect may suspend the license for a period of six months. In the 1990s, the regulation revised the tolerance threshold for alcohol downwards when driving, moving the tolerated alcohol level to 0.5 g/l of blood. A rate between 0.5g/l and 0.9 g/l is punishable by a fine of Fr 900 and the removal of 3 points from the driving license. Above 0.8g/l of blood, this is an offence punishable by withdrawal of 6 points, a fine, a prison sentence and the withdrawal of the driving license (decree of 29th August 1995[18]).

Alcohol and the healthcare obligation

Alcohol is often a factor that triggers or aggravates offensive or criminal behaviour (road criminality, violence, murder, sexual abuse, etc.). Yet, the alcoholic state or intoxication constitutes only in very few cases an offence, or an aggravating circumstance. Nevertheless, the alcoholism of the perpetrator of an offence can be taken into consideration, to impose an obligation of healthcare, particularly in the case of suspended sentencing, testing or conditional release.

Tobacco

The State, a long-time manufacturer and distributor, receives substantial taxes on the sale of tobacco—the economic interests linked to production and distribution are important. In addition, the requirements of public health have only recently been taken into account, even though tobacco represents a greater risk to health than the other substances.

The **law of 9th July 1976[19]** (known as the 'Veil Law') was the first French law in the fight against nicotine addiction. Previously, the few texts existing showed concerns with hygiene in closed places (in particular, rooms reserved for sporting activities, public establishments, etc.). The law of 1976 only permitted tobacco advertising in the written press. The sponsorship of sporting events, with the exception of some automobile races, is prohibited. Packages must carry a health message. In other respects, prohibitions on smoking must be established for places assigned to community use where this practice could have dangerous consequences for health.

However, the law was rapidly circumvented by creative advertising. In 1988-1989, expenditure on tobacco advertising amounted to more than 300 million francs, and that of sponsorship of automobile sports 350 million.

At the end of the 1980s, the statistics in relation to the growing development of the number of premature deaths related to tobacco only increased the concern of professionals, the scientific and medical community and the public authorities. In March 1990, the government announced the strengthening of its participation in the public health area, which resulted in the passage of the law of 10th January 1991[20] (known as the 'Evin Law') in relation to the fight against alcoholism and nicotine addition. The Evin law strengthened the restrictive nature of the law of 1976 in terms of public health, in particular by prohibiting smoking except where it was explicitly authorised. The law placed emphasis on prevention and public information, and the protection of consumers by forbidding tobacco prices to be included in the calculation of consumer price indices. The main legislative developments were as follows:

- A prohibition on tobacco advertising and sponsorship, except for tobacco shop signs and small posters within these establishments. However, exceptions were subsequently introduced for the televised retransmission of mechanical sport competitions, which take place in countries where tobacco advertising is authorised, and for professional publications. Offences are punishable by a Fr 500,000 fine and up to 50% of the expenditure devoted to the illegal operation. Termination of the advertising may also be ordered.
- Display of a health message on packaging, with the statement 'seriously damages health'. Offences are also punishable with criminal penalties.
- Prohibition on smoking in places assigned to public use. Offences are 5th-class offences (Fr 10,000 fine) for operators and 3rd-class (Fr 3,000) for smokers.
- As in the case of alcoholism, associations in the fight against smoking can take civil action, and are often very active in the follow-up of offences.
- Finally, tobacco is no longer taken into account in the price indices, which has allowed a regular increase in price that results in a reduction in consumption[2].

Since then, the text of the law of 1991 has been amended twice: the first related to the prohibition of tobacco advertising. This legislative change occurred with the passage of the **law of 27th January 1993[21]**. It determined that, until such time as a European regulation intervened, the retransmission of mechanical sport competitions, which take place in countries where tobacco advertising is authorised, could be permitted by the television channels. Other relaxations were allowed in some publications (specialised or published by professional organisations for their members).

The second change was introduced by the law of 18th January 1994[22] in relation to public health and social protection, which emphasised the prevention of smoking. It introduced the obligation that a specific healthcare message be carried on tobacco product packaging. Until then, this obligation had been limited to cigarette packets.

The maximum authorised tar content has continued to be reduced since 1991: from 15 mg per cigarette to 12 mg on 1st January 1998 (in accordance with the provisions of the Evin Law).

It should be noted, in other respects, that Community texts also aim to limit or prohibit tobacco advertising and impose health messages. Their drafting has caused conflict with important lobbies

[2] See the chapter on tobacco.

Psychotropic medications

Unlike the smoking or alcohol regulations, which relate to a single product, that governing the abuse of, or dependence on pharmaceutical drugs, must cover a huge diversity of substances, from substitution drugs (buprenorphine, methadone) to tonics on free sale, and the psychotropic drugs of List I (toxic) and List II (dangerous). The differences between these products are considerable and lead to different regimes.

The public authorities intervene at three different levels (Caballero *et al.*, 2000, p. 340 *sq.*):

That of common pharmaceutical law, which defines the basic rules of medicinal consumption.

That of the regulation of poisonous substances, which is aimed at preventing the misuse and abuse of psychotropic medications and certain narcotics.

That of anti-doping legislation, which prohibits the use of doping drugs in sports competitions.

Basic rules of medicinal consumption

Pharmaceutical products are subject to numerous restrictions. They must have an authorisation to be placed on the market (AMM). Obtaining the AMM involves a tortuous procedure. The administration has the power to grant or refuse the authorisation sought by the manufacturer. Once the AMM has been obtained, the drug is subject to the national drug monitoring system and its distribution is accomplished through the pharmacist monopoly. Advertising for these products is subject to authorisation, or is regulated. For numerous specialities, for the patient to obtain the medication, a signed prescription must be obtained from a doctor.

Regulation of poisonous substances

The international classification of controlled substances is based on the classification tables defined by the Unique Convention of 1961, and the Vienna Convention of 1971. The first provided four tables: Tables I and II of substances for medical or pharmaceutical use, Table III for exemptions and Table IV for substances with no therapeutic interest. Originally, the majority of classified substances were of natural origin (morphine, codeine, cocaine, etc.) but a new generation of synthetic drugs has appeared. It is for this reason that the classification adopted by the international Vienna Convention excluded substances already subject to international control from its field of application. Psychotropic drugs are therefore broken down into four tables:

International classification of psychotropic substances defined by the Vienna Convention of 1971

	Therapeutic value	Health risk	Type of substance
Table I	Very limited or non-existent	Very serious	Approximately 25 hallucinogenic substances including LSD, MDMA, MDA, mescaline, psilocybin, and cathinone
Table II	Low to average	Serious	Approximately 15 substances, essentially amphetamines
Table III	Average to high	Serious	8 substances (5 barbiturates, 1 stimulant and 2 analgesics, pentacozine and buprenorphine)
Table IV	Low to high	Low but not negligible	Approximately 60 substances (stimulants, hypnotics, tranquillisers, anti-epileptics, analgesics)

Source: Vienna Convention of 1971 (cited in: Caballero et al., 2000, p. 372)

The conditions for the prescription and delivery of medications are distinguished by four scenarios: medications available without medical prescription, medications on list II (renewable medical prescription), medications on list I (mostly non-renewable medical prescription), and medications requiring the use of a legally controlled medical prescription. Narcotic medications and those of lists I and II belong to the list of poisonous substances. The list of narcotic medications includes, among others, the major morphine-based analgesics (for example: Skenan®, Moscontin®). List I includes, among others, the minor analgesics (Di-Antalvic®, Dicodin®), buprenorphine (Subutex®) and tranquillisers (such as Valium® and Tranxène®). List II includes, among others, anti-inflammatory drugs (for example: Ibuprofen®, Apranax®).

Breaches of the prescription and delivery rules may be sanctioned in two ways. On the one hand, the texts of the Public Health Code provide criminal penalties, while on the other hand, the professional ethics rules of the medical and pharmaceutical professions provide for disciplinary sanctions. Both types of sanction are independent and may be cumulative, with the criminal sanction taking precedence over the disciplinary sanction.

Doping in the sporting environment

France was one of the first European countries to take legislative measures against doping behaviour in the high-level sporting environment. It is also one of the only countries to have specific legislation on doping behaviour in the sporting area—the Minister for Youth and Sports being responsible for coordinating action.

The legislation on doping is aimed at avoiding damage to the sports ethic, and the physical and sporting integrity of athletes, through the use of substances and all means that artificially increase performance, with a view to, or during, a competition.

The list of substances and prohibited procedures is currently fixed by the Ministerial decision of 2nd February 2000 which restates the International Olympic Committee list, following the Strasbourg convention. It prohibits:

Substances: stimulants, narcotics, anabolic steroid agents, etc.

Procedures: blood doping, pharmacological, chemical and physical manipulation

Some substances, such as alcohol, cannabinoids, local anaesthetics, corticosteroids and beta-blockers are subject to restrictions.

The Herzog Law of 1st June 1965[23] had instituted criminal penalties for both users and those facilitating doping. It was not effective.

The Bambuck Law of 28th June 1989[24] decriminalised use, introduced disciplinary sanctions and implemented a prevention structure with a national commission. Its application also ran into difficulties, particularly due to cumbersome procedures.

In other respects, an agreement against doping was signed in Strasbourg on 16th November 1989 by the member states of the Council of Europe.

The current texts result from the **law of 23rd March 1999[25] (known as the 'Buffet Law')** in relation to the protection of the health of athletes and the fight against doping.

Faced with a spread of doping, both medically assisted doping of the highest-level athletes and doping by young and amateur athletes, in all sports, the law had a number of objectives:

Protecting the health and physical integrity of athletes to avoid the phenomena of drug dependence and premature deaths

Putting a stop to cheating, as the financial interests at stake are very substantial

Restoring ethics in sport, fighting against an attack on fundamental social values.

Doping and prevention

To prevent doping, the Buffet Law created a high authority, the *Conseil de prévention et de lutte contre le dopage* (CPLD: the Council for the Prevention and the Fight Against Doping), which proposes all useful measures to prevent and combat doping. It also has a power of sanction.

Medical care agencies for the fight against doping, which organise anonymous consultations and offer medical follow-up, were set up.

In addition, medical surveillance of athletes is ensured through a medical examination by the creation of an individual record, recording the absence of contra-indications to practice sport, which are necessary for the issue of a license for participation in competition and, especially high-level athletes.

Doctors who detect signs showing the practice of doping must inform the doctor in charge of the medical care agency.

Doping and deterrence

Checks are made by ministerial decision, or at the request of the federations, with examinations and sampling by approved doctors, who have the right of access to premises (after informing the prosecutor who may also object), and also seizure with judicial authorisation.

In the case of offences, athletes are subject to disciplinary sanctions, by federations or the CPLD, which may go as far as definitive banning from competition.

Doctors who do not transmit information on doping signs of found by them can also be punished by disciplinary means.

Criminal penalties are provided, in the case of impediment of checks or violation of bans (6 months imprisonment/Fr 50,000 fine), and for the prescription, transfer or administration of a prohibited substance or procedure, facilitation of, or incitement to use (5 years/Fr 500,000 and 7 years/Fr 1 million when the acts are committed by an organised gang, or with respect to a minor). Additional penalties of confiscation, publication of the decision and the closure of establishments are also provided.

Federations, such as the CPLD, may exercise the rights acknowledged in civil action.

In other respects, certain doping drugs are also classified as narcotics or poisonous substances, and are covered by these regulations or the Customs Code.

The reorganised structure for the fight against drugs should be more effective. The specialists remain pessimistic, however, faced with, on the one hand, sophisticated doping by high-level athletes, which is difficult to prove, and, on the other hand, with weight doping with which amateurs who wish to improve themselves have taken, or young over-trained athletes from whom results and performances are required. The financing of clubs, conventions or sponsorships by equipment manufacturers often depends on the latter.

Recent orientations in public policy

This part sets out the broad lines of the orientation defined in the three-year plan on the fight against drugs, and the prevention of drug dependence (1999-2001), which is currently being implemented.

The important developments in the public action in the fight against licit and illicit drugs since the 1990s are described at a later stage. The developments prior to the law of 1970 were covered in the previous 'Indicators and Trends' report (OFDT, 1999).

Orientations of the three-year inter-ministerial Plan (1999-2001)

The *Mission interministérielle de lutte contre la drogue et la toxicomanie* (MILDT: Interministerial Mission for the Fight Against Drugs and Drug Addiction) is responsible for ensuring, on behalf of the Interministerial Committee for the Fight Against Drugs and Drug Addiction, the implementation of the orientations of public policy decided by the latter. On the basis of orientation proposals developed by the MILDT, the government adopted a three-year plan for the fight against drugs and the prevention of drug dependence during the Interministerial Committee of 16th June 1999 (MILDT, 2000).

This plan put forward certain findings:

The modes of consumption of psychoactive drugs is changing.

Users are increasingly adopting a behaviour of polydrug use (consumption of a number of substances, for example: ecstasy and alcohol).

The care structure is spread unequally over the national territory.

In the matter of drugs and drug addition, there is no common culture among the different participants.

The social and professional accompaniment during care remains inadequate.

Based on these findings, the plan defined broad orientations. A number of main thrusts appeared, in particular:

The development of the observation of licit and illicit drug consumption phenomena by emphasising social science work (studies and research), and the organisation of knowledge to clarify public policies.

The distribution of reliable, scientifically validated, data to the public at large, to achieve the necessary responses on the status of the phenomenon.

Improvement of prevention action against all psychoactive drug consumption behaviour (and not only the products).

The development, among all professionals and participants in the prevention field, of a common reference culture on psychoactive drugs, in order that public policies and the new orientations adopted would be understood and shared by those required to implement them.

The distribution of the policy on the reduction of risks and damage regarding all consumption behaviours.

The implementation of early health and social care (before consumers of psychoactive substances become dependent) as an appropriate accompaniment to consumers of psychoactive drugs.

The integration of public health logic into public safety, based on an appropriate criminal policy, whether in relation to users questioned by police, or those placed in detention.

A strengthening of the fight against trafficking, based on the diversification of means of actions, whether the fight is against local or international trafficking, against money laundering, or the approach utilising chemical precursors.

The development of an international action by France based on a global approach that balances the reduction of supply and demand against the reduction of risks. This resulted in a redefinition of geographic priorities.

With the new memorandum from the **Prime Minister of 13th September 1999**[26], the principle and necessity of local coordination was reaffirmed. The tasks entrusted to the heads of the 'drugs and drugs dependence' project were specified and strengthened—a process for the delegation of the credits and actions was put in place:

> Chosen from among the staff of the prefecture (director of the prefect's office, sub-prefect in the city) or the heads of the devolved State services, the head of [the] project will lead local policy in the area of the fight against drugs and drug dependence, and coordinate the actions of the different State services in the department. He will receive a task letter from the prefect, which will confirm his legitimacy with his colleagues and institutional partners. The principal policy motivator is the Steering Committee for the fight Against Drugs and the Prevention of Drug Dependence. This authority is chaired by the prefect, assisted by the head of project. It must meet each quarter.
>
> The heads of the devolved services involved, the legal authorities and the representatives of the territorial collectivities, must also meet this regularly to coordinate their actions and determine financing.
>
> (MILDT Internet site: www.drogues.gouv.fr)

All of these recent orientations in public policy gave rise to the implementation of actions and public structures, which consisted of a mixture of human, administrative, or financial resources. In order to calculate the achievements and results from these general orientations, monitoring and evaluation processes were put in place, at both national and local levels. The main conclusion that can be drawn from this is set out in the chapter devoted to institutional structures and their implementation.

Recent developments in prevention

During the 1990s, the political debate on prevention had a certain formalisation: it was based on an approach in terms of psychoactive substance consumption behaviour, which replaced the more instrumental policy—based on drugs—in operation since 1970. In this, the political discourse corroborated the practice of numerous professionals who had already decided not to focus their intervention on a drug. The change in the concept of prevention (and subsequently its objectives) was induced by certain developments observed over the last ten years in the practice of use, and the social perception of drugs.

The expansion of new substances and new uses, in particular the development of multidrug consumption

The increase in the number of socially well-integrated users, or those who apparently have a controlled use

The growing social acceptance of the issue of drugs, insofar as it is not prejudicial to the individual or his/her associates

The development of a health concept based on the responsibility of the individual, since the appearance of AIDS.

The plan of 14th September 1995 concerning the fight against drug addiction[27] announced the development of a reference text on the objectives and modes of action for the prevention of the use of drugs: the Parquet Report (Parquet, 1997). This work set out the basis for a discussion on prevention that aimed at federalising the logic of the various participants in prevention, both public and private. Its coherency came from this.

Discussion on prevention: Parquet Report (1997)

The Parquet Report stressed that developments in the drug problem–outlined above—required more pragmatic solutions: a message of prevention based exclusively on abstinence, as had been discussed over the past twenty years, could no longer be sustained. However, the progress made in understanding the neurobiological mechanisms linked to the absorption of substances that act on the psyche revealed a metabolism common to various licit and illicit drugs. The scientific literature also underlined the psychosocial and environmental factors that were common to these various consumptions.

The report therefore proposed a prevention message that not only encouraged reflection on consumption behaviour, but also on the similarities of the mechanisms of drug dependence. It targeted psychoactive substances—a generic term that covers illicit drugs, alcohol, tobacco, and psychotropic medications. The behaviour approach made a distinction between use, abuse or harmful use, and drug dependence, which was already present in the international reference classifications (in particular the 10th version of the International Classification of Illnesses—CIM 10—of 1992, or the 4th version of the mental problems, diagnostic and statistics manual—DSM—of 1994). The definitions have the advantage, in effect, of integrating a psychopathological and behavioural breakdown approach as opposed to the habitual behaviour of the subject.

While the traditional objective—which consisted of avoiding any first-use of psychoactive substances—should be maintained, the process must go beyond it by averting the progress from use, to harmful use or drug dependence. The first strategy of prevention consists of intervening on the basis of programme logic, in order to establish the diversified objectives, appropriate to the specific requirements of populations. The explicit statement of these objectives ensures that the actions are not fragmented. In this scheme, evaluation facilitates the complementation of existing efforts, and the study of the appropriateness of the preventative response regarding the reality of the 'drugs' phenomenon. Finally, the development of a common culture favours the continuity and cohesion of the discussions undertaken by the different interlocutors, who are involved in the field of prevention: the State services, the professionals, the media, the consumer groups, or other community groups.

Prevention in the MILDT three-year plan 1999-2001

Prevention is a major thrust of the current three-year plan, as witnessed by its title: 'Three-year plan for the fight against drugs and the prevention of drug dependence'. The MILDT, in its programme text, incorporated the majority of the 'professional ethics' and organisational recommendations prescribed by the Parquet Report.

The interministerial orientations in the matter of prevention are summarised as follows:

Contributing to the professionalism of participants in prevention. If numerous actions have been undertaken in the field of prevention, they have remained dependant on the goodwill and dynamics of local participants, without any particular capability being required. The first objective is to provide professionals with the necessary tools to identify risk behaviour at an early stage.

Develop the Health and Citizenship Education Committees (CESC) in school establishments[3]. These expansions should allow the young to receive at least one prevention programme during their school programme.

Improve access to listening structures for adolescents and their parents.

Reaffirm the preventative objectives in relation to the judicial treatment of drugs users (memorandum of 17th June 1999[28]).

Develop a preventative approach in specific contexts, such as the intervention of groups of pairs in sporting associations, and the implementation of a risk reduction policy during concerts, festivals or *rave* parties, which also involve the consumption of alcohol.

In addition, this plan stressed the need for local coordination in the application of its orientations.

Departmental prevention programmes

The three-year plan announced an administrative organisation of local public action in relation to prevention, which gave momentum to the coordination of actions supported by the devolved services of the State and by the associations. It took shape through the departmental prevention plans, which must define, at a local level, the main thrusts outlined by the three-year plan. The development (definition of assessable objectives, identification of capable participants, etc.) was entrusted to the 'drugs and drug dependence' project head of each department, who was supported in this by the Steering Committee for the Fight Against Drugs and the Prevention of Drug Dependence (an organisation which brings together the representatives of the devolved services of the State, territorial communities, social organisations and other professionals). In particular, it had to complete this programme in close co-operation with the local representatives of the Minister for Education and the Minister for Youth and Sports, in order to ensure a continuity of preventative measures in all aspects of the life of young people, at whom this policy is primarily aimed.

In 2001, 18 department programmes were implemented, 11 were published, 5 will come into effect this year, and 34 are in the process of preparation. Finally, 5 departments have not yet begun the preparation of the programme. The state of progress of the remaining 32 departments is not known at this date.

City, CLS and CEL contracts

In parallel with the departmental prevention programmes, there are lateral framework contracts that allow the handling of the 'drugs question' through the broader approaches of global education and integrated development.

The objective of city contracts is the 'development of a balanced city, allowing the harmonious integration of all its constituents[29]'. Instituted in 1993, with the XIIth City Plan (2000-2006), the city contracts are the single framework for consultation through which the State, the local communities and their partners are involved in the implementation of territorial policies against the devaluation of territories, and all forms of

[3] See the section on the "national Education" prevention systems.

social and urban exclusion. They define the local policy framework within which other structures of common law—that concur in whole, or in part with their objectives—must operate. In this way, the local safety contracts (CLS) and the local education contracts (CEL) formalise and establish the operational basis of the 'prevention and safety' and 'education' facets of the city contract.

The CLS, drafted by the local district Councils for the prevention of delinquency, are co-signed by the mayor, the prefect and the prosecutor, to which may be added the Chairman of the General Council, and the Chief Education Officer[30]. The 'drugs and drug dependence' project heads participate in the preparation and implementation of the CLS, with respect to questions of their domain.

Uniting institutions (among others, the academic inspections and the departmental divisions for youth and sports), parents, associations and the elected representatives concerned, the CEL[31] defines the responsibilities of each to achieve the local education project. They must guarantee the coherence of the measures taken, and participatory mode involving young people and associating families with projects. The strategic approaches encouraged by the CEL correspond, in a general way, to the consolidation of protection factors that are known to avoid the use or harmful use of psychoactive substances: for example, the knowledge and control of one's body through various physical and sporting activities, and health education; improvement in school results; education in community life and citizenship.

In 2001, 71% of city contracts included a specific 'Drugs and Drug Dependence' facet, which is found in 54% of the CLS, and 21% of the CEL. These contracts often consist (in a lesser measure for CEL) of partnership frameworks for the implementation of the departmental policy for the prevention of drug dependence.

Integration of the 'drugs and drug dependence' question into City policy contracts in 2000

	Share of the contracts in which the 'drugs and drug dependence' project heads participate in the steering committee	Share of the contracts which constitute additional financing for the 'drugs and drug dependence' preventative actions
City contracts	57 %	68 %
Local safety contracts	47 %	25 %
Local education contracts	29 %	21 %

Source: OFDT-MILDT (OFDT, 2001)

Since 1998, the Regional Health Policy Committees have united the financial partners around these projects, and, in this way, aim to ensure coherence in orientation, in particular in relation to prevention The 'city health workshops' instituted in December 1999, and tested in Seine-Saint-Denis and in the Provence-Alpes-Côte d'Azur region, constitute another area of consultation between the State, the territorial communities and the inhabitants, for the implementation of actions in neighbourhoods identified as priorities, in the area of primary prevention, access to healthcare and taking into care, or accompaniment toward health.

Regional programmes in relation to health and access to healthcare.

Numerous healthcare structures and prevention actions in relation to dependence are integrated into the measures developed by the *programmes régionaux de santé* (PRS: regional healthcare programmes) or *programmes d'accès à la prévention et aux soins pour les personnes en situation de précarité* (PRAPS: programmes for access to prevention and healthcare for persons in precarious situations, one in each region). PRAPS are different to the PRS in that they are imposed by the law[32] for a period of three years, while for the

PRS, which are not so imposed, the themes are defined annually on the basis of specific needs identified in the region. Seven PRAPS have defined prevention and the taking into care of dependants, as a priority objective. For at least 11 of the 26 first generation PRAPS (2000 to 2002), alcohol is a priority theme—also designated by the PRS. These two types of programme associate the departmental and regional levels of the social and healthcare sectors (State services, local communities, regional hospital agencies, social organisations, mutual insurance companies, etc.). They apply the same programme logic. The direction of work suggested by the departments is submitted to the Regional Health Policy Committees, who set the priorities and ensure the complementation of the different structures: PRAPS, PRS, regional-healthcare organisation planning, welcome-accommodation-insertion planning, departmental insertion programmes, etc.

Recent developments in healthcare policy

During the 1990s, the socio-healthcare orientation in relation to the fight against drug addiction underwent substantial changes, which are reflected, in particular, in the adoption of the policy of risk reduction and substitution. The change in direction essentially occurred with the adoption of the plan of 21st September 1993[33], although it was initially tackled with great prudence. It recommended, in particular:

- An improvement in the care of drug users, not only in the specialised structure, but also in the general healthcare structure (increase in the number of accommodation places, improvement in hospital care, and the formation of city-hospital drug-addiction networks, joining city and hospital professionals in the care of drug addicts;
- The development of the risk reduction structure
- The implementation of substitution treatments.

The majority of the recommendations made in 1993 were subsequently confirmed and developed. In effect, the plan of 14th September 1995 represented the continuation of the guidelines of the previous plan, as does that for 1999-2001, currently in process (MILDT, 2000).

Improvement in care

The orientation in relation to healthcare policy, defined in the 1999 three-year plan, places particular emphasis on early socio-healthcare, centred more on harmful use (before the consumers become drug dependant)—diversified and appropriate to the needs of persons with addictive behaviour in relation to one or more psychoactive drugs. Moreover, it meant being able to offer responses that were no longer based on drugs, but on consumption behaviour. As defined in the new prevention orientation, the healthcare approach must be capable of providing responses as a function of the concepts of the use, abuse or harmful use and drug dependence—irrespective of the drugs consumed (alcohol, psychotropic medications and illicit drugs).

With this new orientation, the plan showed that progress would need to be made in two directions:

- Improve the organisation of the existing care structure, in order to increase the possibilities of reception, medico-psycho-social monitoring, and healthcare for persons with addictive behaviour, and also develop national coverage of the structure.
- Give the healthcare service a better coherence, in order that the actions of prevention, healthcare and placement are better articulated and coordinated.

In this regard, a number of measures were taken: some related to the organisation of healthcare without drug addiction being specifically addressed; others attacked the dysfunctions found in the care of drug-addicted patients, particularly at the level of the hospital structure (including the psychiatric structures and out-patient medicine). The application text

recently adopted and set out below, strengthen, in their broad lines, the previous provisions by the public authorities, in relation to the treatment of drug addiction.

With the **memorandum of 15th June 1999** in relation to the organisation of hospital care for drug-addicted persons[34], the health authorities wished to firstly recall the principles of reception and care in public healthcare establishments, already stated in the 1996 memorandum, in relation to the care of drug addicts[35]: the hospital must be able to offer drug-addicted patients global care that responds to their somatic and psychic problems, and, at the same time, be able to develop specialised care, based more on liaison teams and addiction care. This new memorandum drew particular attention to the following five objectives: improvement in hospital emergency care; the development of the possibility of hospitalisation for drug addition withdrawal, assessment and care; the beginning or continuation of the monitoring of problems linked to drug dependence by orienting the patient toward adequate and capable structures; the training of hospital personnel; and finally, the development of tools for observing hospital activity in the matter of drug addiction.

The **memorandum of 8th September 2000** in relation to the organisation of hospital healthcare[36], once more, drew on the liaison teams and addiction care to improve the reception and care in hospital of persons with harmful use, or dependence on one or more psychoactive substances. With this memorandum, the health authorities wish to bring together, in time, teams working in the fields of alcohol dependence, drug addiction and tobacco science, within hospital establishments. This should allow the targeting of responses against the person and his/her behaviour—not only the drugs. It is also aimed at favouring cooperation, exchange of knowledge and the harmonisation of therapeutic means, and tools. Through coming together, the health establishments will be integrated into the general care structure for drug addiction, to better respond to the demands made on them, and to promote medico-psycho-social follow-up.

Improvement in care in the prison environment

The improvement of the healthcare and social structure implemented for persons with addictive behaviour also occurred through the reorganisation of their care within the prison environment. As a consequence, it is therefore necessary to refer here to the latest developments in the application texts defined by the healthcare, hospital and penitentiary supervisory authorities jointly with the MILDT, for a new organisation of services involved in detention, whether healthcare, socio-educational or supervision. The **interministerial letter** of 2001[37], therefore established the orientation in relation to the improvement of the health and social care of persons detained, who show a dependence on licit (particularly alcohol), or illicit drugs, or with abusive consumption. It aims at a much greater coordination of the services called on to intervene, both inside and outside prison, and a better organisation of local intervention methods, by associating all of the participants involved with a clearly defined project, and a specially designated manager.

The objectives sought from this reorganisation were the following:

The systematic reporting of all situations of abuse and/or drug dependence, irrespective of the psychoactive drug

Offering care appropriate to the needs of the detained person

Developing prevention, particularly that of the risks associated with the consumption of drugs

Encouraging penalty adjustments

Preparing for release.

The process undertaken was based on the mobilisation of all of the partners involved in each penitentiary establishment, including external partners. Within each establishment, it is foreseen that a project group will be made responsible for developing and applying the new care protocols in the prison environment, in accordance with the objectives fixed by the specifications attached to the interministerial letter.

To ensure the accompaniment of this measure, and the success of the project, the administrations involved took the necessary steps to ensure that an evaluation process would be undertaken.

Strengthening of the policy for the reduction of risk and damage

The policy on the reduction of risk and damage for all consumption behaviour is a direction that is a clear priority of the 1999 plan. With **the memorandum of 13th March 2000**[38], the objective of the public authorities is to support actions for the reduction of risk aimed at drug users. They are insufficient in number and do not appear to be well spread over the French territory. New credits were proposed by the authorities, either to contribute to the strengthening of existing 'low threshold' programmes (syringe exchange programmes, reception centres, *Sleep-in*), or to promote the setting up of new programmes or structures, particularly in urban zones not already equipped, or the installation of syringe distributors in public places.

Development of the substitution policy

The interministerial plan of 1999 renewed its support for the development of the substitution policy regarding persons dependent on opiates. New provisions, aimed at reducing the disparities between methadone and buprenorphine, in terms of the duration and method of prescription, monitoring and delivery, required that the authorities involved re-examine the respective application protocols to define more appropriate directions. The following are the regulatory developments for the two available treatments: methadone and buprenorphine.

Regulatory framework for substitution treatments in France, in 2000

Clauses	Buprenorphine	Methadone
Date of effective entry into effect	Beginning of 1996	1994
Inclusion criteria	Opiate dependence evaluated by the physician	Opiate dependence evaluated by the physician + urinary check (testing for opiates other than methadone)
Prescription	Initiation and follow-up by city medical services or CSST Primary prescription and continuation of treatment is possible in the penitentiary environment	Initiation by CSST then possible follow-up by the city medical services Primary prescription possible in the penitentiary environment if internal or external CSST exists Continuation of treatment in the penitentiary environment Initiation of treatment in hospital environment envisaged
Maximum period of prescription	28 days	14 days
Dose	Maximum recommendation of 16mg/day but no restriction	Maximum recommendation of 100 mg/day but no restriction
Delivery	Delivery in the pharmacy in all cases Delivery broken down into maximum periods of 7 days with the possibility of asking that the treatment be delivered once for a period of 28 days maximum	Administration supervised by CSST or provision of medication for up to 14 days Maximum period of delivery in the pharmacy of 7 days
Urinary checks	Not required	1 or 2 per week for the first 3 months, then 2 per month Decision by the doctor if followed up by the city medical services Always done in CSST
Payment for care	Common law if followed-up by the city services	Gratuity then common law if taken over by the city services

Source: DGS (information provided by France Lert)

Since the decision of 20th September 1999, in relation to the application of the narcotics regulations to certain medications with a buprenorphine base[39], the maximum delivery of buprenorphine has been broken down into maximum periods of 7 days, with the possibility for the doctor to request that the treatment be delivered once for a period of 28 days maximum, and this for particular reasons in relation to the situation of the patient.

The **decision of 8th February 2000**, in relation to the breaking down of the delivery of medications with a methadone base[40], fixes the extending of the prescription period for this medication from 7 to 14 days, but with a maximum breakdown of the delivery by the pharmacy of 7 days.

A project being developed envisages the extension of the authorisation to put on the market (AMM) to allow primary prescription by doctors working in health establishments.

In an extension of the global approach, new substitution measures in relation to tobacco have been defined. Since January 2001, nicotine substitutes have been on open sale throughout the French territory.

Recent developments in criminal policy

For a detailed description of the judicial policy implemented in France since the law of 1970, we must refer back to the previous edition of the 'Indicators and Trends' report (OFDT, 1990). Three memoranda established in 1999 have led to a significant development in the area of the fight against trafficking, and in that, of the judicial response to drug addicts.

Recent provision in relation to trafficking

In June 1999, the Minister for Justice sent new directives regarding the fight against trafficking, which are set out in **the memorandum of 17th June 1999**[41], to the Republic's prosecutors. This memorandum first examined the conditions for improving the coordination of public actions, and recalling the central role played by the *Office central pour la deterrence du trafic illicite de stupéfiants* (OCRTIS: Central Office for the Repression of Drug-related Offences), and asked the public prosecutor's offices to implement a structure for the coordination of law enforcement services at the local level.

The memorandum then dealt with the question of measures aimed at targeting the assets of traffickers. It recalled that confiscation related to all of the assets for the most serious of trafficking offences, and not only the drugs involved in the offence. It also recalled that the prosecutor has the power to take stern measures with a view to allowing confiscation of assets of a person under indictment. It found that due to the lack of powers to identify the assets of traffickers, and in the absence of prior aggressive measures, confiscation only applied, in most cases, to goods seized during police questioning. The memorandum invited the public prosecutor's offices to use the law on 'drug procurement[42]', which allows indictment of a person who is in regular contact with users, or a trafficker if he/she is unable to justify the origin of his/her resources or lifestyle.

Finally, the **memorandum of 11th October 1999 from the Minister of the Interior**, in relation to strengthening of the fight against the use and local trafficking of narcotics[43] should, on the one hand, regarding the fight against use, develop prevention measures in the school environment and take appropriate measures (police questioning, police custody, judicial proceedings, etc.) and, on the other hand, promote consultation between the different administrative and judicial authorities, and encourage the use of available judicial tools to improve the effectiveness of the fight against local trafficking. This memorandum fits within the perspective of the direction defined for law enforcement and judicial action in the 1999-2001 three-year plan (MILDT, 2000).

Recent provisions in relation to use

In June 1999, The Minister for Justice sent the prosecutors a new directive regarding the judicial response to drug addicts.

The memorandum of 17th June 1999 was based on the principal idea of the necessity to individualise decisions in justice regarding the use of drugs, which made the diversification of possible responses and, in particular, alternatives to prosecution and imprisonment indispensable. This text is not limited to users of illicit drugs, but also concerns persons having difficulty with alcohol. According to this memorandum, fixed imprisonment for a user who has committed no connected crime should only be used as a last resort. In giving the objective of flexibility in the judicial decision, the Minister for Justice also sought implementation of methods to better know the health and social situation of drug users, to ensure systematic health and social

orientation of the person subject to trial, when this is necessary (rapid social inquiry, more substantive personal file, etc.).

Regarding police interrogation and custody of simple users, the memorandum specifies that these should be reserved for persons who could cause damage to themselves, or to others. The memorandum demanded the banning of police interrogation in the immediate proximity of 'low threshold' structures. It also demanded that substitution treatments be continued during periods of police custody.

The memorandum recommended that mandatory treatment be refocused on its original purpose. This measure should be aimed at heroin addicts and other users with a massive or repeated use of illicit drugs, by which the drug dependence makes health measures necessary.

The pre-sentencing phase (between the start of proceedings and the hearing) should be used to make the accused aware, and encouraged to begin a process of healthcare.

During the sentencing and post-sentencing phases, the memorandum recommends the development of measures for the postponement of penalties, with testing. This measure sets a precise deadline for the accused, to help him stabilise over time and undertake a process of becoming responsible.

The stay of execution with testing constitutes the principal 'alternative sanction' proposed by the jurisdictions. This measure must also take into account all of the situational difficulties encountered by the convicted person and is based on the implementation of socio-educational follow-up by the probation services.

Although conditional freedom, subject to the obligation of healthcare, has been used less and less, it was re-launched so that the preparation of imprisoned users for release could be better improved. The measure of semi-freedom, also little used up to now, was recommended in the memorandum, to prepare for release of the freed inmate.

Regarding minors, a judicial response can be made, in the context of criminal or civil proceedings, through educational assistance.

The memorandum recalls, in particular, that numerous educational responses may be applied in the context of the order of 2nd February 1945 in relation to delinquent childhood[(44)]: supervised freedom, placement under judicial protection, placement in an educational or healthcare establishment.

The departmental Agreements on Justice-Health objectives (CDO) constitute the principal instruments of application of the memorandum of 17th June 1999.

In effect, these agreements, defined by the interministerial memorandum of 14th January 1993[(45)], allow for the improvement of the care of drug users and the promotion of actions for the prevention of the use of psychoactive substances in the context of judicial measures.

In 1999, this structure had been developed for extension to all French departments, and incorporated into the renewed framework for judicial policy in relation to users. This development results from the will to

strengthen the partnership between the judicial authorities and its services on the one hand, and the departmental socio-healthcare authorities on the other, in order to promote alternative measures to prosecution, to systemise the health and social orientation regarding consumers of psychoactive drugs, and improve the care of drug users at all stages of the criminal procedure, irrespective of the judicial status of the drug consumed (narcotics, alcohol, misused medications).

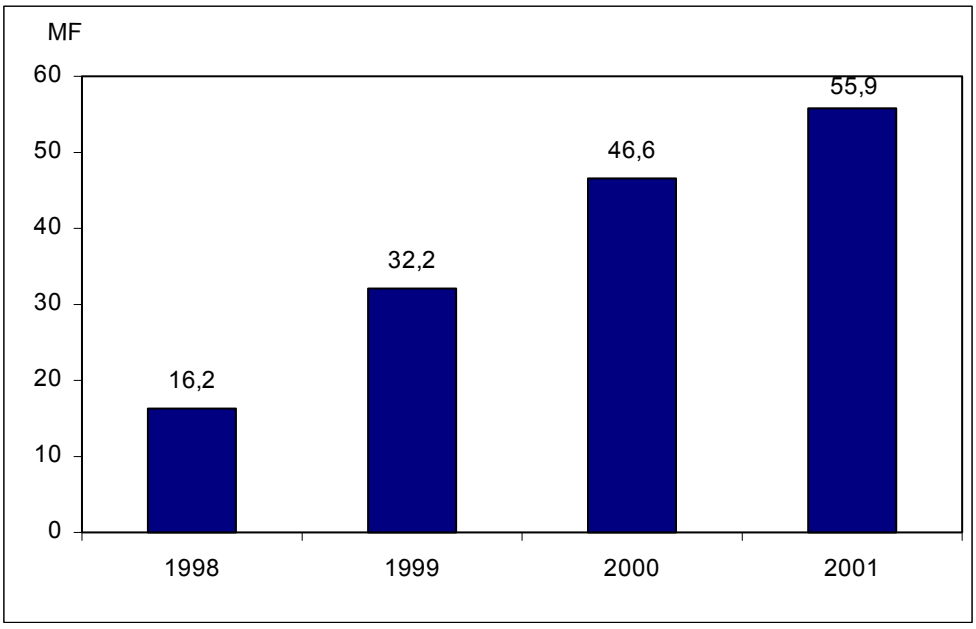
These agreements are signed by the prefects of departments and the prosecutors of the Republic. The 'drugs and drug dependence' project heads are responsible for the coordination and organisation of the structure. For their part, the prosecutors must act in close liaison with the services of the Ministry of Justice. The interministerial missives previously delegated by the MILDT to the Ministry of Justice were then progressively redeployed toward the departmental objective agreements structure. The expenses for medico-social stays, traditionally devoted to mandatory treatment, relate from now on to any healthcare or social intervention made in the context of these agreements. The healthcare authorities, in particular, were asked to delegate these directives to healthcare and social orientation offices set up in the courts, or close by.

Assessment of the implementation of the departmental objective agreements

Until 1998, the CDO was linked to the geographic priority set out in the city policy, that is, 30 departments. From 1999, the coverage of the programme has progressively extended, reaching 93 departments in 2001.

There has also been a large increase in the expenses devoted to the departmental objective agreements: they have more than tripled since 1998 (increasing from Fr 16.6 million to Fr 59.7 million).

Expenses devoted to the departmental objective agreements, from 1998 to 2001 {124a}



Source: MILDT

Regarding the public in care, persons who were the subject of pre-sentencing measures were proportionally greater in 1999 than in 1998 (38% and 25% respectively). The taking into care of minors is the other dominant element in the report for 1999, as they amounted to 3,000 that year, while there were less than 100 in 1998 (MILDT, 2001).

In addition, in 1999, minors represented 20% of the public taken into care through the CDO, inmates and released persons represented 31%, and persons subject to pre-sentencing measures, 38%. Among all the measures put forward in the context of the CDO, it is appropriate to note that mandatory treatment represents a minority of the measures (5.9%), while other alternatives to prosecution (warning, classification with social, educational or health orientation, etc.) are in the majority, with 26% of the measures. Finally, the alternatives to imprisonment (community service order and stay of execution) correspond to 12% of the measures put forward.

Structures and means used in the fight against drugs

Observation, research and training structures

Observation structures

Observatoire français des drogues et des toxicomanies (OFD: French Observatory of Drugs and Drug Addiction)

The OFDT is the principal observation organisation on the national level. Since 1998, it has had the task of developing a sentinel network to observe recent trends in consumption—conducting regular epidemiological surveys of the general population, and implementing a global framework for the evaluation of public policies.

The observation activity of the OFDT is, therefore, organised as a function of three main work directives:

The monitoring and improvement of indicators: On the basis of this directive, the OFDT analyses the existing indicators (in relation to alcohol, tobacco and illicit drugs), and issues proposals to improve the quality and reliability of the sources in different ministries and other organisations. It also involves the consolidation of the existing general-population monitoring structure by integrating questions that are of interest to its field of observation.

The monitoring of recent trends: '*The objective is to know, in real time, the developments in consumption, their modes and consequences, and the nature of the drugs in circulation*' (1999-2001 Work orientations). To do this, a double structure has been implemented: on the one hand, a surveillance network, which plays an information role in relation to the development in the contexts of use, takes existing structures into account (TREND) [33]; on the other hand, a structure for the collection and analysis of the drugs in circulation (SINTES) [32].

The evaluation of public policies: for the OFDT, this means defining a global framework for the evaluation of public policies; developing methodologies and expertise using, where necessary, foreign works; implementing and monitoring the evaluation of public actions, and *ad hoc* and rapid studies within the general plan.

Other observation and research structures

The **Observatoires régionaux de santé** (ORS: Regional Health Observatory) participates at the local level in the observation of the drugs and drug-dependence phenomenon, on the basis of the specific work they do (observation, studies and research). The work done by ORS Midi-Pyrénées, ORS Ile-de-France and ORS Provence-Alpes-Côte d'Azur on psychoactive drugs and the socio-healthcare situation of users must be particularly referred to.

The **Institut national de veille sanitaire** (InVS: National Health Watch Institute) is a public establishment that was created to strengthen the health safety and monitoring structure in France. It replaces the National Public Health Network, and is under the authority of the Minister for Health. The general task of the InVS is to monitor, on an ongoing basis, the state of health of the population and its development. This task is based more specifically on the activities of epidemiological monitoring, the evaluation of risks, and the observation of health. The InVS has a database named 'Information system on the accessibility of medicinal injection and substitution materials' (SIAMOIS), in which information on the sales of syringes and substitution drugs in the 23,000 French pharmacies, is listed. This system allows annual collation of this sale data with the indicators on the use of drugs, and morbidity and mortality related to this use. SIAMOIS, therefore, contributes to the evaluation of the policy on the reduction of health risks among users of intravenous drugs.

Coordinated by the French Agency for the sanitary safety of healthcare products (AFSSAPS), the six **Centres d'évaluation et d'information sur la pharmacodépendance** (CEIP: Centres for the Evaluation and Information on Pharmacodependency) are responsible for the collection and evaluation of clinical data on

pharmacodependency, and on the abuse of psychoactive substances. They evaluate the risk to the public health, conduct research, and contribute to information in their area of competence, and also have a task of expertise and advice. Work and surveys are done at the request of the AFFSSAPS.

In addition to these public organisations, some associations or organisations financed by industry participate in the production and distribution of information: *l'Institut de recherches scientifiques sur les boissons (IREB: The Institute for Scientific Research on Beverages), l'Office français de prévention du tabagisme (OFT: The French Office for the Prevention of Smoking), etc.*

Research structure

The three-year plan for the fight against drugs and the prevention of dependence (1999-2001) makes the improvement and distribution of available knowledge in these fields a priority objective. In addition to the support given to thematic research, one of the principal objectives is to contribute to the structuring and networking of different teams working in the field of psychoactive substances.

In addition to the research structure described below, the role played by national research organisations, such as the *Institut national de la santé et de la recherche médicale* (INSERM: National Institute for Health and
Medical Research)), the *Institut national de recherche agronomique* (INRA: National Institute for Agronomic Research), the *Institut national de recherche et d'étude sur les transports et la sécurité* (INRETS: National Institute for Transport and Safety Research and Study), and the *Centre national de la recherche scientifique* (CNRS: National Centre for Scientific Research) must be acknowledged. Finally, the University, through which the financing of personnel salaries and the recurring unit budgets, allows the undertaking of basic and explicative research in all the disciplines dealing with psychoactive drugs, the phenomena of dependence and the social consequences which result therefrom, must be acknowledged.

Structure and organisation of the research structure

The research structure has been implemented provisionally and coordinated by the MILDT, to ensure the transition to the OFDT. The latter must, in effect, ensure, in due course, its tasks according to the methods now being defined. The current structure consists of a steering committee encompassing the principal institutions involved in this field: the Ministry of Research, the General Health Department, the principal public scientific and research establishments (CNRS, INSERM, INRA, INRETS, IHESI, GIP-Justice).

A scientific council consisting of 22 members was designated for a period of approximately two years to ensure the organisation and programming of research during this period. The supervisory authorities of the steering committee then ratify its opinions.

The MILDT ensures the programming, structuring and financing of the research. This task involves one, or more annual requests for proposals (RFPs), in respect of the projects submitted by the laboratories, research organisations and independent researchers.

In 2000, the MILDT launched one aimed at promoting scientific work on the use and/or dependence on licit and illicit psychoactive substances, including alcohol, tobacco, and psychotropic medications, and psychoactive drugs used with a view to improving the performance of individuals (psychotropic drugs, synthetic drugs, doping substances). At the end of consultation, 22 projects had been retained.

The request for proposals is sent to all scientific disciplines and projects. Innter- or multi-disciplinary approaches are particularly encouraged. That for 2001, jointly with INSERM, is currently in the process of consultation.

In 1999, a joint MILDT/INSERM/CNRS RFP was launched and 28 research projects were retained. Finally, a MILDT/INSERM/NWO[4] (France-Netherlands) RFP took place in 2000, and allowed the selection of five research projects from French-Dutch teams.

In other respects, the MILDT, in co-operation with the Ministries for Higher Education and Research, supports doctoral research through the financing of ten allocations to 'drug-dependent behaviour' targeted research. These are thesis works on the use of, and/or dependence on, licit or illicit psychoactive substances. The selection of allocations and the monitoring of research projects are ensured by the MILDT scientific Council, in liaison with the thesis directors.

Financing is currently dispersed between the different ministerial departments mobilised on the question of drugs and drug dependence. The level of expenditure devoted to research is, therefore, difficult to identify. Nevertheless, the MILDT research budget amounts to 5 million francs for the year 2000.

Collective reporting

INSERM has implemented a procedure that allows it to provide a summary of the latest scientific knowledge, to respond to questions raised by persons responsible for public action.

Two community reports are being prepared. The first report covers alcohol, and is being accomplished in two stages: the first, in association with the French Committee for Health Education, covers the health risks related to the consumption of alcohol. The second relates, in a larger sense, to all of the social risks related to the consumption of alcohol (beginning in September 2001).

The second community report relates to cannabis: context of use, its action mechanisms, and its effects on health. The results will be published in September 2001. The next community report will cover tobacco and will begin in 2002.

INSERM had previously produced a report on ecstasy. An *ad hoc* multidisciplinary group of researchers and clinicians had been set up in 1997. The conclusions of this report were made public in June 1998, in the form of a report, the first part of which is an analysis of international scientific, biological and clinical data on ecstasy (MDMA). The second part is essentially devoted to an analysis of the consumption of this substance in the French context[5]

Other research structures

The task of the *Agence nationale de la recherche sur le Sida* (ANRS: National Agency for AIDS Research) is to stimulate, coordinate, evaluate and finance research on the HIV infection, and, since the 1st

[4] NWO (Nederlandse Organisatie voor Wetenschappelijk Onderzoek), a Dutch scientific organisation.

[5] *Ecstasy : biological and clinical data on the contexts of use*, Paris, INSERM (Institut National de la Santé et de la Recherche Médicale - National Institute for Health and Medical Research), 1998, 345 p. (Coll. Collective report).

Alcohol. Effects on health, Paris, INSERM, 2001, 360 p. (Coll. Collective report).

Cannabis. What effects on behaviour and health?, paris, INSERM, 2001, (to be published) Coll. Expertise collective).

January 1999, clinical and therapeutic research in the field of hepatitis C. Its particular function is to take into account all of the scientific disciplines. The different research sectors coordinated by ANRS cover all of the current concerns: biological research (virology, molecular biology, immunology and cellular biology), vaccine research, clinical research through and outside of therapeutic tests, epidemiological research, and research on the sciences of man and society. Since 2000, the ANRS has launched two annual RFPs, their fields covering all research on HIV/AIDS, research on any other retrovirus that would be relevant to the understanding of the physiopathology of HIV infection, and in the field of hepatitis C, clinical research, and public health research on therapeutic testing.

Set up in 1993, the *Programme hospitalier de recherche clinique* (PHRC: Hospital Programme for Clinical Research) contributes to medical research in the field of public health, and seeks to encourage hospital-university teams to operate their care activities with a research perspective. By providing these teams with their own financial means, the objective was to allow them to form essential relations with upstream research partners, whether industrial or academic teams, under the financial authority of the Ministry of Education and Research, and in particular certain university laboratories and those establishments with a scientific and technological vocation: the CNRS, and, above all, INSERM, with more than 300 units, widely installed in the *Centres hospitaliers universitaires* (CHU: University Hospital Centres).

More recently, a mixed research unit was set up (CNRS/University) in the human and social sciences area, on the question of drugs and drug dependence.

Training structure

In the matter of drugs and the prevention of drug dependence, the participants may come from various institutional organisations: devolved State services, territorial communities, etc. They may also come from association, education, social or other sectors specialising in the reception of drug, alcohol or tobacco users.

To contribute to the creation, on the basis of validated knowledge, of a common culture among all participants (professionals in prevention, education, care and law enforcement), training actions are organised on the basis of three principal aims:

Encouraging the integration of various ministries into the drug addiction problem through initial and on-going training.

A diploma in additional specialised studies in addiction was created in 1999, in order that the expertise acquired in drug addiction and alcoholism would have universal recognition. Ongoing training courses were organised in 2000 by the Ministry of Agriculture for internship supervisors, and for teachers in initial training. Five inter-academic meetings were initiated by the Ministry of Education, in cooperation with the MILDT, to accompany, in particular, the development of the *Comités d'éducation à la santé et à la citoyenneté* (CESC: Health and Citizenship Education Committees)

Training police officers, *gendarmes*, penitentiary personnel and customs officers likely to mix with drug users.

The Ministries of the Interior, Defence, Justice (Penitentiary Administration), Economy and Finance (General Department of Customs and Indirect duties) gave their agreement to the methods of integration, in the initial and/or ongoing training, and for a minimal training on the public health stakes. The content of the finalised module was sent to the Ministries in February 2001. The module is also being tested at four sites in order to deliver specific training to professionals in the judicial protection of young people confronted with the problem of young consumers.

The content of the initial training of the *Policiers formateurs antidrogue* (PFAD: Police Anti-Drug Trainers) and the *Formateurs relais antidrogue* (FRAD: Gendarme Anti-Drug Relay Trainers) was revised in 2000 (see below). In addition, 'drugs and drug addiction' customs agents were designated in every regional department.

Provide the same training to all participants in prevention:

An inventory was made of the main initial and ongoing training of all State professionals and this allowed, in particular, the development of a common base of knowledge to be provided to State personnel. This base was tested during an interministerial training session. With the memorandum sent to departmental project heads in December 2000, the organisation of interministerial training at regional or departmental level now has a common framework.

The plan for the fight against smoking includes measures aimed a strengthening the involvement of health and education professionals. For this purpose, the plan includes a training and awareness programme. Training on the evaluation of tobacco dependence and on stopping smoking is provided for general practitioners. The objective set out in the plan is to train 3,000 doctors each year. Pharmacists may also obtain training from professional organisations, in liaison with industry. Finally, the Ministry of Education provides training to members of the educational community of colleges and secondary schools, to make them aware of risk behaviour.

Information structures

Telephone help lines

Drugs, alcohol and tobacco information service, national telephone helpline

The national social telephone service, ***Drogues alcool tabac info service*** (***Drugs, alcohol and tobacco information service)***, or DATIS (previously *Drogues info service* (*Drugs information service*)) has been in existence in France since 1990. It is now accessible with a short number: 113. Under the authority of the MILDT, the service is a public interest grouping. DATIS is open to the general public and professionals, is accessible 24/7, free, anonymous and confidential. The role of the service is to facilitate requests for help, access to information and care while guaranteeing:

Listening, support and advice on problems related to use

Information on drugs, the effects, the risks related to use; the law and the healthcare structure

Orientation toward competent organisations in the fields of prevention, healthcare, benefits and the reduction of risks.

Since December 1999, DATIS has two headings on the drugs and drug-dependence Internet site (www.drogues.gouv.fr): *'Your Questions/Our Answers'*—an area for dialogue, and *'Useful Addresses'*, to consult the national directory of specialised structures. The service is shared over six sites: a national centre in Paris (24/7) and five regional centres (Lille, Strasbourg, Lyon, Marseilles and Toulouse).

In 2000, the service received 60,000 requests for help and information. A large proportion of the calls (40%) were requests for information, most often in relation to products (DIS, 1999). The service also responds to request for support (20%) and advice (18%). Almost 15% of calls gave rise to a direction toward the healthcare services. Among the callers, 32% were users and 38% based their call on consumption, real or imagined, by somebody among their close friends. A quarter of the calls were information requests from the general public, 5% were requests from professionals. The under-25s represented two-thirds of callers (64%). More women than men contacted this service.

The five drugs most often referred to by callers were: cannabis (57 %), heroin (20 %), alcohol (12 %), cocaine (7 %) and medications (8 %) (DIS, 1999). The main development in 2000 was that cocaine came ahead of medications in the order of concern of callers. Most often, alcohol and tobacco were said to be combined with other drugs.

Other telephone help lines

DATIS co-exists with other telephone help services that had been operating in the field of licit psychoactive substances before the expansion of the area of responsibility of DATIS, (such as, *Écoute dopage:* doping listening service, and *Tabac infos service*: Tobacco information service). There are also services that integrate the problem of 'psychoactive substances' into their field of operation, (such as, *Fil santé jeunes (Youth Health Line)*, 0–800–235–236, or *Sida info service (AIDS Information Service)*, 0–800–840–800). There are also local initiatives, for example, devolved services, or associations such as *Narcotics Anonymous*.

In November 1998, the Ministry for Youth and Sports started ***Écoute dopage*** (***Doping listening service***), a confidential green (free) line: 0–800–15–2000. Reception is provided by sports psychologists who advise on

risk behaviours—addictive or not—and direct the callers who wish it to appropriate healthcare, based on a network of doctors and specialists operating in healthcare centres. The global approach of this service is to present doping as a risk behaviour comparable to others by relaying non-specific calls to the appropriate structures, such as DATIS, or the Youth health line.

Since November 1998, the Ministry of Employment and Solidarity has operated a telephone help line, ***Tabac info service*** (Tobacco Information Service) (0–803–309–310) in cooperation with the *Comité français d'éducation pour la santé* (CFES: French Centre for Health Education) and the *Office français de prévention du tabagisme* (OFT: French Office for the Prevention of Tabagism). An Internet site, www.tabac-info.net is also available. This line, aimed at the general public, is in support of the anti-smoking campaign of the *Caisse nationale d'assurance maladie des travailleurs salariés* (CNAMTS: National Salaried Workers' Health Insurance Fund). Callers cannot only obtain general information on tobacco, but also on the various aids and methods for withdrawal that are available. They will also be offered a guide on tobacco withdrawal.

In 2000, the Tabac Info Service received almost 30,000 calls (from 50 to 100 per day). The content of the calls made between October and December 2000 was mostly oriented toward stopping smoking and withdrawal methods:

Products and methods for stopping smoking: 39 %

General questions on tobacco: 31 %

Consequences of stopping smoking: 5 %

Risks related to tobacco consumption: 6 %

Passive smoking: less than 1%

Rights of smokers and non-smokers: 1 to 2 %.

The majority of calls came from smokers who called on their own behalf (76%). Next, came calls from ex-smokers (11%) and non-smokers (6%). Among the 55% of callers who gave their age, the majority were between 30 and 49 years, and 2% to 3% were younger than 20 years. There was an almost equal share of men and women (51% and 49% respectively).

Information and documentation structures

Toxibase, national documentation network for drugs

Toxibase (a '1901 law' association, essentially financed by the State) is a national network operated by professionals in the field who work in the area of drug addiction, and who have built, in some cases since 1986, a documentary resource on the subject.

The nine Toxibase documentation centres are open to a wide public: decision-makers, professionals and individuals. Their activities at the local or regional level make them places/resources of information on addictive behaviour. Their area of responsibility covers all addictions—related to psychoactive substances and others (gambling, Internet, etc.)—and to polydrug use.

The Toxibase bibliographical database today includes some 25,000 reference works, articles, reports, theses, acts of congress or brochures, in French and in English. Toxibase produces a quarterly documentary review—completely revised in 2001—including, in particular, subject files written by specialists, and with documentary headings. The network also maintains a database of articles (with bibliographical references) covering this field, from the daily and weekly newspapers, both national and regional. In addition, to meet the most common requests, Toxibase publishes a series of practical sheets.

Finally, for a number of years, Toxibase has been collecting specialised prevention tools related to psychoactive substances, and primary prevention. The database describes almost 300 French-language tools, with indexation and a descriptive summary.

Information centres on drugs and drug dependence

In 1999, the first seven *centres d'information et de ressources sur les drogues et les dépendances* (CIRDD: Information and Resource Centres on Drugs and Drug Dependence) were set up under the framework of the three-year Plan. In 2000, there were 28, with ten of a regional or interdepartmental scope. Mostly set up on the basis of existing resources, the majority of the CIRDDs are administered by the departmental and regional Health Education Committees; four are Toxibase centres. In 2000, 31 departments benefited from the support of a CIRDD. The number of these structures should increase further in 2001, the objective of the three-year Plan being the putting in place of 40 CIRDDs covering the entire national territory.

Their function is to provide technical support to the institutional participants and to professionals in the departments, in the implementation of local actions, particularly prevention, training or healthcare. Currently, the CIRDDs are primarily investing in their task of documentation and information, and in supporting the 'drugs and drug dependence' project heads, especially the development of the departmental prevention programme. Some CIRDDs are already monitoring the structures and actions implemented locally, or are providing advice on project development.

Internet site www.drogues.gouv.fr

All the publications and services of the information structures detailed above are available from the public service drugs information service Internet site, www.drogues.gouv.fr, launched in December 1999. The site is operated by the MILDT in partnership with CFES, DATIS, OFDT and Toxibase. Each has editorial responsibility for the information it places in the various headings

The site is part of the MILDT strategy on the updating of knowledge. It makes validated scientific knowledge, which is regularly updated, on all licit or illicit psychoactive substances, accessible to researchers, decision-makers, specialist or non-specialist professionals, and the general public, at the same time. The site visit rate has increased, in concert with the communication campaigns of the MILDT. A new version of the site is being developed for 2001.

Prevention structures

The multisector nature of the drugs problem is, in itself, an explanatory factor for the multiplicity of organisations involved in the field of prevention. The fact that no law—even that of 1970—deals directly with the question of prevention has left ministries free to organise public action through numerous application texts, and has probably caused, in large part, the private initiatives in this field.

If the political desire for global prevention[6] was only recently displayed, in practice the professionals involved in the matter of prevention have long attempted to put the different consumptions into perspective. For all that, the definition of global prevention, and its articulation through specific prevention[7]—between a global behavioural approach and making actions on specific themes coherent to achieve an overall effect—is not done easily. In other respects, the multisector origin of consumption behaviours leads directly to a wider reflection on the social phenomena listed in the table of policy concerns: risk behaviours, exclusion and delinquency. Therefore, one part of the prevention of dependence is based on the generalised programmes of lateral structures (City contract and their elements, PRAPS and PRS). This integration reduces the visibility of the global prevention structures and complicates every effort to assess this subject.

This chapter, therefore, only explores the structures that are clearly identified as related to the field of drugs and drug addiction. It deals exclusively with the prevention of psychoactive substances; however, for convenience the single term 'prevention' is used hereafter. It begins with a general picture of prevention today. The principal coordination and intervention agencies supported by the ministries concerned with this field are described in the second part.

General summary of prevention

Difficulties persist in painting a picture of the prevention of dependence in France, because, other than the experimental APPRE programme (launched in 2000) whose coverage is not exhaustive (see Methodological Indicators), there is no source of centralised information on this question.

Action takers

According to the activity reports of the 'drugs and drug dependence' project heads, the great majority of prevention actions take place in the school environment. The cultural association and professional environments are close behind. Although the three-year plan emphasises the need to develop measures for the reduction of risks in the party environment, there are very few actions covering this area at this moment in time.

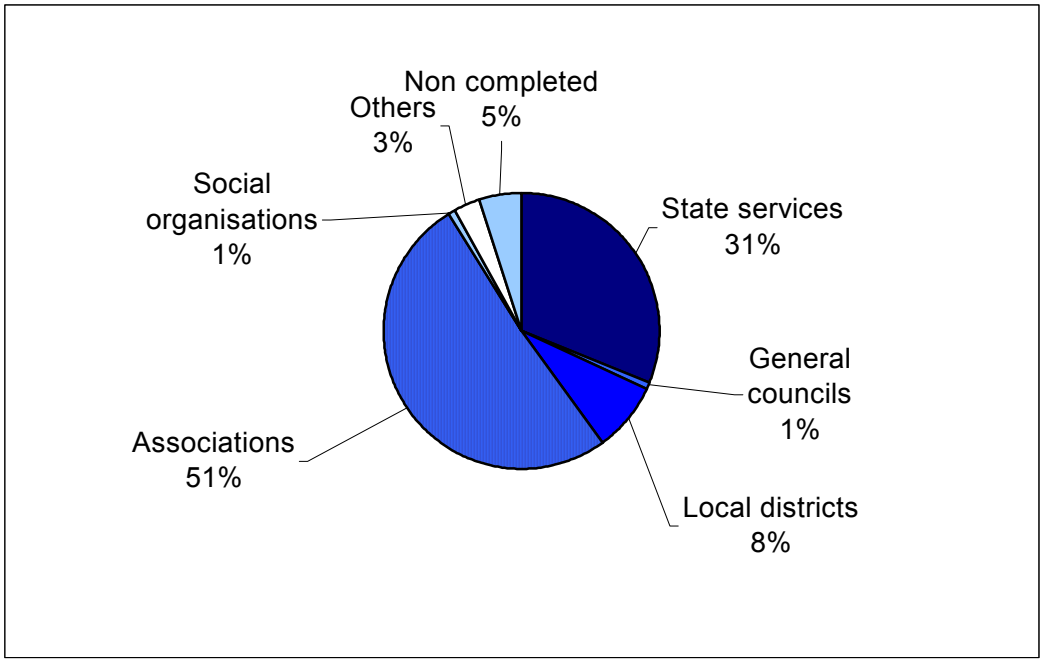
In 1999, half of the preventions were launched by the association sector, the second largest promoter being the State, with almost one-third of the actions taken [27]. Almost six times out of ten, they related to national

[6] Prevention of consumption behaviour and prevention related to all psychoactive substances.

[7] Prevention specific to one or more psychoactive substances

education, due to the concentration of prevention actions in the school environment. In 2000, approximately 497,400 students in colleges or public secondary schools (almost a quarter of French students and secondary-school pupils) benefited from a prevention action, either directly, or indirectly related to psychoactive substances (OFDT, 2001).

Breakdown of structures that initiated prevention actions in 1999 {410a}



Source: APPRE 1999, OFDT [27]

Approaches

It is estimated that a little more than three-quarters of the prevention actions implemented in 1999 covered all psychoactive substances [27]. Approximately one in five were based on a principle of examining the behaviour and aptitude of persons, without any substance in particular being examined. Of the actions centred on specific 'drug' themes, the great majority dealt with the themes of alcohol (approximately 80%), tobacco (20%) and cannabis (10%).

Breakdown of prevention actions specific to one drug, according to the substance targeted, in 1999
(in %)

Alcohol	82
Tobacco	20
Cannabis	11
Medicaments	6
Cocaine and derivatives	5
Synthetic drugs	4
Heroin and derivatives	2
Doping substances	1

Source: APPRE 1999, OFDT [27]

The prevention strategy was based on work on the vulnerability factors in one action in ten, protection factors in one quarter of these, and both aspects in two-thirds of cases.

Partnerships

There is a strong partnership connection in prevention. In effect, two-thirds of the actions involved at least two partners (1 in 5 having at least 5), with the State and its services in first place, whether for financing (61% of actions), the implementation of actions (25%), or on the basis of expertise (32%).

The associations are involved as often as the State services (25% of actions) in the implementation of actions. In effect, the 'prevention specialists' and the 'parties intervening in drug addiction'—belonging, in the majority, to the association environment—are the main professional corps participating in prevention actions (in 30% to 40% of actions) [27]. General practitioners and nurses (school personnel mainly), psychologists and educators and finally the *gendarmerie* are involved in prevention actions, in similar proportions (20% of actions) [27].

The social organisations are the fourth key player. Although they have relatively little involvement in the financing of actions (5% of cases), they are most often cited as a participant in their implementation (12%).

Financing

In the field of prevention, the State services are the primary financiers, both in terms of the budgetary volume allocated (approximately 60%) and in terms of the numbers cases to which financing was granted (approximately 45% of the different cases of financing or co-financing). The territorial communities (mainly the general councils, and then the local districts) follow thereafter, providing approximately 20% of the funds devoted to prevention, and representing a little more than one-third of budgetary resources [27]. The MILDT annually delegates a budgetary envelope to the 'drugs and drug dependence' project heads—in the context of their departmental prevention programmes—and to the ministries involved in the question, on the basis of the proposals submitted by them. In 2000, the interministerial budget allocated to the 'drugs and drug dependence' project heads for the purposes of prevention amounted to 47 million francs. The total of the widespread financial resources devoted to this field could not be calculated. Nevertheless, the analysis done on the activity reports of 70 departments suggests a breakdown of financial resources of the order of 60% and 40%, between the interministerial sources and the widespread sources allocated to prevention, respectively.

The disbursements that had been made up to then will, in the future, be integrated into the departmental plan.

Breakdown of financial resources destined for prevention actions, in 1999
(in %)

State: MILDT and other state sources	61
General councils	13
Local districts	8
Regional councils	1
Others	6
Associations	4
Private funds, sponsors	4
European Commission	2

Source: APPRE 1999, OFDT [27]

Interministerial structures

In parallel with its important role in the financing of prevention, the MILDT is more directly involved in this field through its strategy of communication and technical support to the participants in prevention.

The MILDT media campaign 'Know more, risk less'

Through its three-year plan, the MILDT announced an aggressive policy of updating the knowledge of the entire population (general public and professionals) in relation to the use, harmful use and dependence related to all psychoactive substances. It intends, therefore, to develop the distribution of clear and credible messages on these themes, based on validated scientific knowledge.

The MILDT communication plan, implemented in partnership with the *Comité français pour l'éducation à la santé* (CFES: French Centre for Health Education), was set up for a period of three years, in 1999. It is also coordinated with the actions being taken by the *Caisse nationale d'assurance maladie des travailleurs salariés* (CNAMTS: Salaried Employees National Illness Insurance Fund) on the questions of alcohol and tobacco. In concrete terms, this strategy involves:

- The creation and putting on line, at the end of 1999, of an information Internet site 'drogues.gouv.fr' in partnership with the CFES, DATIS, OFDT and Toxibase
- The *'First interministerial meetings'*, a seminar on 10th December 1999, which brought together the institutional and professional, particularly on the prerequisites necessary for the transmission of knowledge
- The launch of a collection of four knowledge booklets *'Drugs: Know more'*, 70,000 copies of which were distributed to professionals
- The distribution, at the beginning of 2000, of the general public information book *'Drugs: know more, risk less'*, sold by newspaper sellers (one million copies) and distributed free (three million copies) by pharmacies, surgeries, different associations and State services (for example, 360,000 copies distributed to administrative, executive and health personnel, secondary schools and colleges and in documentation centres and libraries); the national distribution was backed-up by a televised publicity campaign on all the national channels (April-May and October-November 2000); the book is now sold in bookshops; in total, up to the first quarter of 2001, some 4 million copies had been distributed or sold.
- The launch, at the end of 2000, of five series of brochures (flyers) on alcohol, cannabis, ecstasy, tobacco and cocaine, aimed at young people and created in partnership with the risk reduction users associations; two other documents are being drafted: one on drugs and driving and the other in relation to amphetamines.

For 1999 and 2000 the budget for this action amounted to 26 million francs. The work undertaken in 2001 was aimed at consolidating this approach of updating the knowledge of the entire public. This also means that the MILDT must initiate more targeted communication strategies. Two publicity campaigns must be developed in this sense: one reaffirming the educational role of adults, and the other on risk behaviour, in particular in the party environment.

The Commission for the validation of prevention tools

The prevention of use and dependence related to psychotropic substances is characterised by a diversity of approach and a disparity of the supports used. For this reason, the MILDT proposed an accompanying procedure to provide technical support to the designers of tools for the prevention of dependence, and to share among all participants the prevention practices that appeared to be the best in a given context. At the end of 1999, it then coordinated the implementation of a consultative organ on the quality of such tools. The validation procedure implemented is operated by a permanent secretariat provided by the MILDT, and a validation commission of fifteen members (institutional representatives, professionals and experts). The permanent secretariat has an advice function. The commission meets approximately five times per year and issues an opinion on the tools presented to it: tools that accompany a prevention action, or are the result thereof, support for training of participants in prevention, etc. This opinion also determines the assignment of the MILDT label.

Examination of the files results from a voluntary action by the promoters of tools, requests from State services, or 'drugs and drug dependence' project managers who have been requested to finance a prevention project. Thus, all the tools that receive support must pass through this procedure. Since its formation, 11 tools have been validated, representing one-third of the number submitted to the commission for examination[8].

'Education' structures

In school establishments, prevention is organised on the basis of local initiatives by administrative and specialised teams, as a function of the priorities defined at the academic and departmental levels, and within the establishment. In addition to the organisational structure, represented by the health and Citizenship Education Committees, there is no model prevention structure that applies to all establishments. However, the National Education Programmes must, in the future, be integrated into the departmental prevention programmes.

National and devolved steering of the policy of promoting health for students.

The question of dependence prevention falls within the policy of promoting health for students as defined by the Minister for Education, and coordinated and evaluated by the *Direction de l'enseignement scolaire* (DESCO: the Department of Academic Education). The latter operates the network of technical counsellors (doctors and nurses), chief education officers and academic inspectors, making them aware of the broad orientations of the ministerial policy. It also defines the national protocol on the organisation of care and emergencies in schools, and local public education establishments.

The technical, academic or departmental counsellors are associated with the development, and implementation of regional or departmental structures, in relation to health and prevention for school-going

[8] A list of them is provided on www.drogues.fr.

populations: the programme for access to prevention and healthcare[46], the programme for the prevention of dependence, etc.

Health and citizenship education Committees

The *Comités d'éducation à la santé et à la citoyenneté* (CESC: Health and Citizenship Education Committees), initiated in 1990 as social environment committees, have the objective of ensuring the coordination of prevention and education for life in the community, within primary and secondary public establishments, providing general or professional education. Since 1995, these structures have been co-financed by the MILDT and National Education. Their constitutive text[47] endorses the adoption of a global approach to the handling of difficulties encountered by young people, implying the prevention of all forms of dependence. This approach is in accordance with the principle of a global approach to prevention in the MILDT three-year plan. This memorandum also suggested the principle of the generalisation of the CESC in the national territory. The committees are based on the head of the community educational establishment, and participants in social life and the neighbourhood (associations, institutional participants, etc.), in order to create a link between the school and its environment. In concrete terms, the CESC must determine operational objectives for the establishment projects, marked out in time and location, appropriate to the locally identified real health problems. Educators prepare the transition between primary school and college in both cycles. In this context, *ad hoc* meetings are arranged to define the protocols to prevent problems of violence and drug addiction among pre-adolescents (pupils at the end of the primary cycle). A report on the different actions envisaged is returned to the respective chief education officers.

In the 1999-2000 school year, the number of CESCs in public secondary establishments increased by 35% over the previous year. In June 2000 there were 4,530, shared among 65% of secondary schools, 60% of technical schools and 55% of colleges. Thanks to the CESC that operated as a network that same year, six public establishments out of ten (4,687) were able to benefit from such a structure (as opposed to five out of ten in the previous year). Among these, 843 were installed in priority education zones (versus 549 in 1999) and 235 were classified as 'sensitive establishments', a respective coverage of 84% and 77% of the establishments involved. Moreover, in 2000, 510 primary schools, 23 private establishments (primary and secondary) and 34 regional agricultural education establishments have a CESC.

Breakdown of health and citizenship education Committees (CESC) in 1999/2000

	Number of CESC	Coverage rate*	Development since the 1998/1999 school year
Colleges	2 868	55 %	+ 29 %
Secondary schools	983	65 %	+ 52 %
Technical schools	679	60 %	+ 40 %
Total	4 530	58 %	+ 50 %

Recorded in June 2000

** as opposed to the number of establishments*

Source: DESCO- Ministry of Education

The collection of Education 'Indicators'

In November 1999, the Secondary Schools and Colleges Department (Ministry of Education), in cooperation with the MILDT, published a new collection of 'References for the prevention of risk behaviour in school establishments' and 'References for the prevention of risk behaviour in elementary schools'. In total, 800,000 copies were distributed in 2000.

'Students, participants in prevention'—a programme of prevention by pairs

From 1997 to 1999, the Ministry of Education undertook an experimental action in the filed of prevention of risk behaviour entitled: 'Students, participants in prevention'. This experimental phase resulted in the publication of an information leaflet and recommendations aimed at teams who wished to become involved in this action. The purpose of this programme is to engage student relays in the co-management of prevention actions, and to train them for it. These students are trained in the role of organisers and messengers of prevention, and to position themselves as a 'self-help pair', and establish a counselling and relay relationship. They intervene under the supervisions of reference adults who ensure that they do not substitute themselves for the competent professionals, by taking charge of their friends' serious problems.

According to the conclusions of the evaluation done in 1999 (Ballion, 2000), this programme should be more oriented toward the establishments involved in a global policy of health and citizenship education, and included in a move toward the involvement of the students in the life of the establishment.

'Health and Social affairs' structures

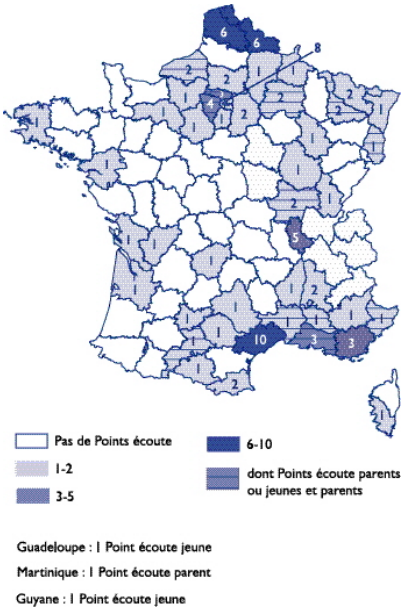
Counselling centres, structures for reception and counselling in neighbourhoods

The 1999-2001 three-year Plan recommends the extension of the Counselling Centres, the Reception and Counselling Centres, by, above all, improving their accessibility—that is to say their geographic distribution and their modes of operation (lengthening of operating hours, for example).

The Counselling Centres are financed by the addictive practices Office of the General Health Department (SD6B). However, numerous Reception Points and Counselling Centres are financed in other contexts, particularly that of the City policy. Their action is based on a principle of the global prevention of drug addiction and marginalisation, in which drugs problems are handled in the framework of urban social development[(48)]. Locally, the Counselling Centre teams work in close partnership with the local districts, in order to negotiate the installation of their structures as close as possible to where they are needed, and to mobilise the linked participants at the neighbourhood level.

The special objective of the young peoples' Counselling Centres is to capture the young public, between 18 and 25 years, and removed from institutions, especially those deprived on a family and social level, and who risk falling into marginality and delinquency. They aim to provide a response to emergency situations related to emotional distress, familial and social, and to help the access of young people to a social service. The parents' Counselling Centres receive families and organise interviews in order to prevent, or stop deterioration in the parent-child relationship, and eventually make contact with the healthcare structure.

Number of counselling Centres (young people, young people and parents, parents) in 2000, by department {410b}



Source: DGS

In the context of the law and application texts of 1998 and 1999 on social exclusion[49], an additional Fr 12.50 million was added to the initial budgets—a total of Fr 43.80 million—for the creation or strengthening of these structures. Twenty-six 'young peoples' Counselling Centres existed in 1995, 62 at then end of 1997, and 75 at the end of 1999. In 2000 there are 100 Counselling Centres in 53 departments, equivalent to a global amount of Fr 42.60 million. Among these 100 structures, 26 are identified as 'young peoples and parents' or 'parents' Counselling Centres (versus 16 'parents' Counselling Centres in 1999). The flexibility of the constitutive text generated diversified approaches and methods of action. An evaluation, conducted in October 1999, showed four main action strategies within the 40 Counselling Centres who participated in the study: an approach with a 'community' inclination (associating the public with the identification of needs and strengthening local solidarity); one with a 'psycho clinical' inclination (an individual approach based on the 'subject problem'); a 'social and educational' approach (accompaniment, access to rights, working on the capability of persons); and one with a 'mediation' inclination (Jacob *et al*., 2000).

The young peoples' Counselling Centres, set up at the same time as the Counselling Centres, work on the urgent social problem (wandering and exclusion) among young people, and are also called on to handle the problems of dependence. The General Health department and the General Social Action Department are currently working on the possibilities of setting up a single type of structure based on these Counselling Centres and 'young peoples' counselling Centres.

French Centre for health Education and its departmental delegations

The *Comité français d'éducation pour la santé* (CFES: French Centre for Health Education) is a 1901 law association placed under the authority of the minister responsible for health. Since its creation in 1972, it devotes a substantial part of its resources to national communication campaigns (four to six per year). The question of psychoactive substances is dealt with among other public health subjects: AIDS, sleep, ill-treatment, etc. One hundred CODES and CRES— department and regional delegations of the CFES—relay this information, and communication action at the local level through local actions, in the form of training, organisation of conferences, documentation, publication and distribution of methodological works, and brochures. These structures are also involved in reporting on developed projects.

By the nature of its tasks, the CFES works in partnership with numerous institutions and ministries. It is a cooperative centre of the World Health Organisation (WHO) for tobacco and alcohol. The CFES has also developed an important research function through different surveys on the general population, such as the Health Barometer.

The National Association for the Prevention of Alcoholism and its departmental delegations

The *Association nationale pour la prévention de l'alcoolisme* (ANPA: National Association for the Prevention of Alcoholism) is a 1901 law association whose main financiers are the alcoholism out-patient cure centres (38 % of cases) and the General Health Department (32 %). It covers the majority of the associations engaged in prevention, and care related to the problematic use of alcohol. Since the start of the 1980s, ANPA has integrated the 'alcohol risk' into an approach of global prevention by tackling the subject not only in its specificity, but by also replacing it as an aggravating factor in other risk behaviours.

In each department, a *Comité départemental de prévention de l'alcoolisme* (CDPA: Departmental Committee for the Prevention of Alcoholism) extends the activities of the ANPA. Their involvement is based on the triptyque 'prevention, treatment, social accompaniment'. Beside their involvement in prevention, in the school and extra-curricular environments, the training of relay agents of different status (teachers, social workers, etc.) is the aim of the work of the ANPA and its local variations. Finally, the network is also engaged in the reduction of the risks of social non-adaptation that are inherent in the alcoholism phenomena, and the facilitation of access to health care.

'Youth and Sports' Structures

National and regional steering

The actions on the prevention of dependence taken by the Ministry for Youth and Sports are coordinated by the department of Youth, and popular education. They have the following operational institutional relays:

- The regional and sub-departments of Youth and Sports in which a person-resource is responsible for questions of the prevention of dependence
- The department youth councils (19 in 1999, 27 in 2000), in which the young can put forward their proposals to the public authorities in relation to actions to be implemented in all the fields that concern them (training, employment, health, etc.)
- The national training establishments
- The agencies of the youth information network (1,500 public reception structures for information on all aspects of daily life).

The budget given by the MILDT is delegated 80% to the sub-departments, which are closely associated with the development of departmental programmes for prevention, and include their action in this context. In 1997, the extensive services of this ministry supported approximately 600 local actions (information-awareness, cultural or sporting activities of a preventive nature, production of pedagogical tools, training), most often organised by the participating associations. In the last few years, the devolved services have particularly supported prevention actions within holiday centres and leisure centres without accommodation.

Twenty per cent of the interministerial budget (MILDT) was used for the implementation of actions on a national scale. In particular, since 2000, the Department of Youth and Popular Education and the Ile-de-France Regional Information and Prevention Centre for AIDS have designed a training programme (8 stages) that has allowed the inclusion of more than one hundred executives from the devolved services, establishments and agencies of the youth information network. This interdisciplinary training was open to

professionals working in contact with young people, sports doctors, doctors responsible for the fight against doping, school nurses, documenters of the 'youth information' network, etc. Specific training sessions—adapted to local contexts and needs—were organised in Martinique and Guadeloupe, aimed primarily at local participants.

'A la carte prevention'

The Ministry of Youth and Sports also supported the development of the '*á la carte* prevention' structure designed and managed by the AREMEDIA association. This is based on an interactive programme (distributed through a data communications terminal) that can be asked about one's own risk-taking. It provides diagnosis elements and practical information. Being anonymous, this structure allows the collection of quantitative and qualitative data that is likely to be used for epidemiological analyses or appropriate prevention strategies. In the context of a pilot project, this structure has been installed in fifteen agencies of the youth information network, since the beginning of 2001.

Biological monitoring of high-level athletes

In the context of its policy on the protection of the health of athletes and prevention of doping, the Ministry of Youth and Sports implemented, in 2000, a structure designed to facilitate conditions for the medical monitoring of athletes. In addition, laboratories authorised to make the specialised biological examinations that are the basis of this structure, are spread over the territory, so as to take account of the geographic dispersion of athletes. Moreover, to alleviate the difficulties in payment for the examinations, the ministry covers the total cost of this preventive biological monitoring.

This structure for the prevention of doping verifies that there is no contra-indication to the practice of competition sport, and that the training and competition loads are well tolerated by the athlete. It consists of three or four annual blood tests, done by the laboratories on the list established by the General Health Department. It is not an anti-doping control programme—no disciplinary sanction may result from it—and the monitoring is done with the clear consent of the athlete.

Tested in 1999, on athletes pre-selected for the Olympic games in Sydney in 2000, and on cycling teams in the context of a pilot project, biological monitoring is today aimed at all athletes on the lists of the National Commission of High-Level Athletes.

Law enforcement structures

Mission de lutte antidrogue (MILAD: Anti-Drugs Mission) is responsible for the coordination of the departments and services of the national police in the fight against the use and trafficking of narcotics. It also organises and operates the national prevention structure. The objective of the actions it leads is the initiation of a local prevention dynamic in which the local police can be involved. It is also responsible for unifying the opinions of the Ministry of the Interior, in accordance with the three-year Plan.

The MILAD roving campaign

The MILAD directly manages a roving information and drug addiction prevention campaign, aimed especially at the school community. It consists of a highly visible road 'train' (numerous vehicles and a 38-tonne truck), fitted out to receive the public (30 to 40 persons) and operated by officers of the MILAD, assisted by local anti-drug police trainers. In 2000, 34,000 students were met inside the establishments. Meetings with the pedagogical teams were held in advance.

Since 1995, during the summer period, the MILAD road 'train' has visited tourist sites. The police generally met young people there, but also met parents, who generally expressed a strong demand for information. For these campaigns, MILAD has had different partners: in 1999, the Ministry of Youth and Sports, on the theme of doping, in 2000, the National Association for the Prevention of Alcoholism (ANPA). During this last campaign, the operators met approximately 20,000 persons during the months of July and August. To respond to the demand, mainly from National Education, a second road 'train' will be put into service at the end of 2001.

Police anti-drug trainers

The Central Administration of Public Security (463 police stations) manages the greatest number of specialised police known as 'police anti-drug trainers (PFAD)' (270 PFAD). The PFAD were initially given the task of the ongoing training of their colleagues but, since 1998, the MILAD has re-oriented their action toward school establishments, in particular in the context of the Health and Citizenship Education Committees. In the perspective of health and citizenship education, they advise on licit and illicit drugs, the consumption behaviours related to these drugs, their individual and social consequences, the provisions of the law in the area of trafficking and use, and on the various care structures. In 2000, the PFAD achieved approximately 5,000 prevention actions and met almost 177,000 students.

Anti-drug relay trainers of the national gendarmerie

The Anti-Drug Relay Trainers (FRAD), created in 1990, are non-commissioned officers of the judicial police who have the task of prevention, in parallel with their normal service. The approach is aimed at making the public responsible and the wish to demystify the drug phenomenon by denouncing the social impact of trafficking and the role of traffickers and dealers. Their action is aimed, as a priority, at young people in colleges and secondary schools, but also at their parents, social managers, and the military. In addition to illicit drugs, the FRAD have also tackled the subject of licit psychoactive substances, mainly alcohol and medications. In 2000, there were 450 FRAD, in general four or five per department. They achieved some 20,000 interventions involving almost 480,000 persons, of which were 310,000 school-going 'young people' (from college to university). The FRAD are associated with the steering committees of numerous CESC (approximately half).

However, the primary function of the FRAD is to train the *gendarmerie* investigators in the matter of prevention and deterrence, more particularly on methods of communication, the progression from use to trafficking, and the techniques of use, to better detect them. The organisation of a network and the operation of drug connections are also examined.

'Drugs and prevention' agents of the customs service.

Until 2001, the actions by the customs service in the matter of the prevention of drug dependence was limited to the organising of local *ad hoc* events. Although this aim was not a priority, the General Department of Customs and Indirect Duties (DGDDI) nevertheless wished to structure the context of its actions.

To this effect, a 'drugs and prevention' agent was clearly identified in each of the 40 regional departments of the customs service, and a training session was organised in June 2001 for these agents, with the support of the MILDT. The objective is that these customs agents can participate in actions, coordinated at the departmental level by the 'drugs and drug dependence' project heads, involving different prevention participants.

Health and social care structures

This section describes the broad lines of the structures for the reception and care of health and social problems related to the use of illicit drugs, and the structure for the fight against alcoholism and smoking.

The specialised structures are described first: first, the *centres spécialisés de prise en charge des usagers des drogues illicites* (CSST: specialised centres for the care of illicit drugs users) and the structures for the reduction of risks, and second, the *dispositif spécialisé de lutte contre l'alcoolisme* (CCAA: Specialised Structure for the Fight Against Alcoholism), which is also responsible for consultations to assist in stopping smoking.

This is followed by a description of the structures of common law, implemented by public health establishments, to lead the task of reception and care of the addictions in which the hospitals are involved (drug addiction, alcohol and tobacco). The section closes with a brief description of the organisation of the socio-health care structure for inmates, describing licit and/or illicit drug addictive behaviours.

The available information covers essentially the number of existing structures, and also the human resources mobilised within each of them.

Specialised socio-health and risk reduction structure

This structure comprises the structures financed by the General Health Department (DGS) for the purpose of the fight against the use of drugs. As previously outlined in the section devoted to recent developments within health policies, the authorities concerned with the final objective of improving care wish to bring together the structures and teams working in the areas of drug addiction, alcoholism and tobacco science.

Specialised centres for the care of illicit drugs users: CSST

Since the decree of 29th June 1992[50], all the structures specialising in the care of illicit drugs users financed by the State have been designated with the generic name of *centres spécialisés de soins aux toxicomanes* (CSST – Specialised Centres for the Care of Drug Addicts), with or without accommodation.

Their task is to jointly ensure, since the decree of 1992, medico-social care and social and educational care, including assistance in insertion or re-insertion. More particularly, the centres must guarantee:

- The reception, orientation and information of drug addicts and their families
- Withdrawal and accompaniment of withdrawal when done in the hospital environment
- Support for the family environment
- To accomplish these tasks, the care centres must develop a therapeutic project for a period of five years, fixing therapeutic and socio-educational objectives and establishing the methods for the achievement and evaluation of its objectives.
- The orientation Note of 5th November 1998[51] from the General Health Department set out the developments to be taken into account to revise CSST projects. This orientation meant:

- Entering into partnership relations with the health and social professionals of the common law structure, with general practitioners in particular
- Decompartmentalising the specialised structure and the psychiatric sector to better take into account the psychiatric co-morbidities
- Taking polydrug consumption and the new modes of use into account (consumptions associated with alcohol and ecstasy).
- The CSST may be managed by associations or by public health establishments.
- In 2001, the number of CSST amounted to 263, of which two-thirds were managed by the association sector. They are installed in 90 French departments.
- *A distinction made be made between three major types of structures:*
  - Out-patient care centres, numbering 201
  - Care centres with collective accommodation, numbering 46
  - Care centres in the penitentiary environment, numbering 16.

Number and type of structures specialising in drug addiction, in 2001

Specialist out-patient care centres	201
Within which there are reception offices	85
Specialist care centres with collective accommodation (ex- residential centres)	(569 financed places)
Specialist centres in the penitentiary environment	16
The CSST, either out-patient or with accommodation can manage:	
Specially adapted flat-relay networks	86
	(Approximately 422 places)
Transition or emergency accommodation structures (collective or individual)	18
	(Approximately 134 places)
Reception family networks	20
	(Approximately 116 places)

Source: DGS/SD6B

The **out-patient care centres** ensure the reception and orientation of all persons with a problem related to drug dependence, medical consultations, nursing care, psychological monitoring and social and educational accompaniment appropriate to each situation. They can offer support to the family environment and the friends of persons concerned with drug use. They also provide withdrawal as an outpatient and accompaniment of withdrawal in the hospital environment, and substitution treatments.

The outpatient centres are asked to make particular efforts in the following areas:

- The promotion of risk reduction and access to care
- The improvement of their social function
- The strengthening of the care of drugs users in the prison environment.

Associations manage two-thirds of the outpatient care centres; the others are under hospital management. Their number has increased from 183 centres in 1998, to 201 in 2001. These centres manage outpatient reception offices: these are structures managed by the specialised centres but situated in a different geographic location. Their number has increased from 56 offices in 1998 to 85 in 2001.

This expansion was possible due to reorganisation of the service by the departmental health and social affairs departments with the support of the General Health Department. In addition, the revision of the therapeutic projects, some of which had not been attached to the medical services, allowed departmental, regional, and national redeployment.

In the **centres with collective accommodation** (also known as residential therapeutic centres), drug users are care for from the medico-psychological and socio-educational point of view by a multi-disciplinary team (doctors, psychiatrists, nurses, psychologists, educators and social welfare personnel). The objective of care is the restoration of personal equilibrium and the social insertion of the residents. Associations manage almost all of the centres with accommodation.

In 2001, there were 46 centres. Four centres were closed between 1999 and 2000. In 2001, the reception capacity of these centres, therefore, reduced by 19%, from 679 places in 1998 to 569. In parallel, the accommodation service was diversified.

These centres also organise collective activities outside the centre and accompaniment for external events. The social care also comprises a strong involvement of the family or friends of residents.

Passing through these therapeutic centres originally consisted of a step upstream of withdrawal, during which the patient undertook not to consume any drug, including medications. This approach has been changed by the introduction of substitution treatments and the intensification of social order problems. The therapeutic centres were encouraged, in accordance with the decree of June 1992[52] and the orientation note of November 1998[53], to review their therapeutic project and re-frame their activity: softening of their reception and accommodation conditions, co-operation with the local medical team for patient care, better taking into account of the patient's social and professional needs.

Specialist centres for the care of outpatient drug addicts or with accommodation can manage specially adapted flat-relay networks, transition accommodation structures or reception family networks.

The **specially adapted flat networks**, numbering 86 in 2001, are aimed at allowing drug users to recover their autonomy. They should now be reserved for persons in serious health or social difficulty. These structures should also contribute to strengthening the emergency and transition accommodation capacity, a method of care allowing the user to 'pause', stabilise a withdrawal or a substitution treatment, and have stable accommodation. The type of accommodation also receives drugs users released from prison or benefiting from an alternative measure to imprisonment. The specially adapted flat networks have approximately 422 accommodation places.

The emergency or transition accommodation structures offer short stays of one to four weeks, which are modulated as a function of the person's health or social needs. A socio-educational and/or healthcare accompaniment is also provided. This type of accommodation is especially reserved for person suffering serious de-socialisation and those released from prison, or in the context of an alternative measure to imprisonment. In 2001, 147 places were offered by the existing 18 structures.

The reception family networks were instituted at the end of the 1970s. Staying with a reception family responds to various situations and occurs at different times in the lifestyle of the drug addict. In 2001, there were 20 networks of reception families. In 1999, they represented a resource of 215 families and 348 users were received. The type of beneficiaries (single, with a child, withdrawn, receiving substitution, in the hands of the law, etc.) and the periods of stay (from a weekend to 9 months) vary. Reception by a family is oriented toward regaining autonomy and it may be a step in the professional re-insertion of drug addicts. It allows them a steady return to 'normal' life by confronting the received persons with tasks, times and attitudes in a non-institutional context. In parallel, the therapeutic follow-up of the drug addict is ensured by the CSST associated with the reception family.

In total, according to the figures of the General Health Department, the capacity of the specialist collective accommodation structure is approximately 1,250 places in 2001.

The care centres in the penitentiary environment, previously 'drug care agencies', operate in the prison environment and number 16. The CSST in prison are directly concerned by the new orientations of the General Health Authority, the hospital management and care organisation Division, the penitentiary administration Division and the MILDT in the context of the interministerial note of 2001 in relation to the improvement of the health and social care of inmates showing a dependence on licit or illicit drugs or with abusive consumption(54). This letter provides for the implementation of new protocols for the care of dependent persons within each penitentiary establishment. The process undertaken was based on the mobilisation of all of the partners involved in each penitentiary establishment, including the CSST[9]. In other respects, a certain number of CSST outside the establishment are signatories to an agreement to provide services in the context of the departmental objective agreements programme. This programme organises healthcare for imprisoned users, their preparation for release and their monitoring after release.

Risk reduction structure

The risk reduction structure, which is developed as a complement to the CSST, is based on a small number of prevention actions aimed at facilitating access to injection equipment and the distribution of preventive messages among a high-risk population. Since 1987, syringes have been sold in pharmacies without a medical prescription. Syringe exchange programmes and automatic distributors complement the supply through pharmacies. The prevention kits allow access to single syringes.

A mix of associations outside the specialist structure develops the majority of risk reduction actions, often benefiting from financial support from the State or local collectives. This structure is mainly financed by the State, but also by the illness insurance funds from their national prevention funds for health education and information in the context of the local application of national themes.

The structure is built on the following complementary actions:

- The free sale of syringes in pharmacies
- Automatic dispensing devices which issue prevention kits
- The associated syringe exchange programmes
- Contact places for drugs users or reception centres.

[9] For more information, please refer to the section on recent developments in healthcare policy.

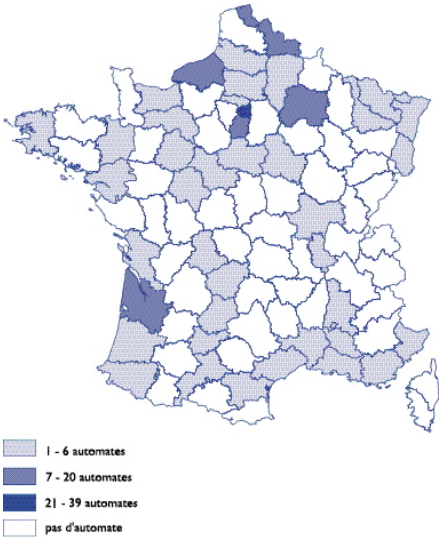
The + ® and Kap® Kits are associated prevention kits for intravenous drugs users. These 'street model' kits are distributed free by associations supported by public expenditures in the context of their actions on AIDS prevention or risk reduction among drug users. They contain two syringes, two swabs, two doses of sterile water for injection, a condom, two recipients for heating and dilution, two dry swabs and two sterile filters, an official message referring to the legal sale of syringes in the context of prevention, the *AIDS information service* and *Drugs Information Service* green numbers, advice on use and an information leaflet on the local relays for daily assistance.

The pharmaceutical **Stéribox2®,** with the same contents as the + ® Kit, is sold within the official network since October 1999. Its distribution is encouraged by a State subvention (2 F per kits), which allows its distribution at the recommended price of Fr 7. The Stéribox2® is also aimed at intravenous drug users. This kit, which replaces the Stéribox®, (already on sale since 1994) contains two more cupules and two more sterile cotton wool swabs than the old model. The Stéribox2® allows not only the avoidance of the risk related to the sharing of injection equipment through contamination by the AIDS and hepatitis viruses, but also abces. In 1999, the annual rate of sale, in France, of Stéribox® per 1,000 inhabitants from 20 to 39 years was 168, an increase of 6% over 1998. From 1996 to 1999 the sales of Stéribox® increased steadily, reaching 2.8 million units in 1999.

Prevention kits are also provided through **automatic dispensing devices** on public roads. 277 were installed on French territory in 2001 and available 24/7, and consist of:

- Automatic distributors of prevention kits (+ ® or Kap® Kit in a cardboard box)
- Electronic or mechanical syringe collectors (for one syringe, one token)
- Simple syringe collectors (syringe bins) and mechanical distributors (for one syringe, one token)
- Electronic exchangers (for one syringe, one + ® or one Kap® Kit)
- Prevention terminals or Totem® (multi-purpose street furniture which may contain a mechanical syringe collector, a mechanical Kit distributor, a condom distributor, an information panel).

Number of automatic dispensing machines in June 2001, by department {410c}



Source: DGS/SD6A

The installation of automatic dispensing machines, encouraged by the public authorities, is a decision, which comes within the competence of mayors. The investment expenditure necessary for these installations may be fully covered by the State, with the local districts covering operating expenditure.

Number and type of risk reduction structures, in 2001.

Number of syringe exchange programmes operating:	
In pharmacies	15
In mobile structures	40
In fixed specialised structures	41
Number of "contact places" or reception centres	42
Number of *"sleep-ins"*	2
Number of methadone buses	2
Number of local teams	4

Source: DGS/SD6A

The **syringe exchange programmes** distribute singles syringes or prevention kits (+ ® or Kap® Kit). The exchange of syringes began to operate at the end of the 1980s, on the initiative of humanitarian associations such as *Médecins du Monde*. Since then, their number has continued to increase: there were less than ten syringe exchange programmes in 1993, 16 were financed in 1994, 61 in 1996 and 86 at the end of 1997 and almost one hundred in 2001. These programmes can operate from fixed locations (associations, pharmacies) or can be mobile (bus, street teams). In 2001, 15 programmes are operating in pharmacies, 40 in mobile structures and 41 in specialises fixed structures (in reception centres, for example). The distribution of injection equipment and condoms supports the creation of links, encourages the reduction of risk behaviour and offers the possibility of orientation toward social or care services.

The 'contact places' or **reception centres**, created at the end of 1993 are places of first reception of drug users in precarious situations. These services offer, in addition to the services of the syringe exchange programme, material help (showers, food, washing machines, etc), nursing care, counselling and social and/or judicial services. This activity may take various forms: provision of syringes, distribution of tokens or vouchers to be exchanged in a pharmacy. Two 'reception centres' as first reception places, were set up in 1993. Their number increased rapidly, reaching 34 at the end of 1999 and 42 in 2001. They are operated by multi-disciplinary teams of four to five persons, financed by the State, and generally in cities with more that 100,000 inhabitants.

The '***sleep-ins***' offer overnight accommodation to dependent drug users in serious precarious situations. When staying in these structures, users may have access to health and social consultations. The first '*sleep-in*' officially opened its doors in 1995. In 2001, there are two '*sleep-ins*' with 30 places (Paris and Marseilles) Tow more are being installed in Paris and Lille.

The methadone bus is a 'need-appropriate threshold' structure, which facilitates access to methadone in the context of a move toward substitution and taking account of social problems. It is a mobile and roving structure, which aims at creating demand (by going to the user), in order to facilitate access to the therapeutic and social circuits by a strongly marginalized public who have little or no contact with the care structures. The bus must also ensure relay toward the socio-healthcare structures of common law. Currently, there are two methadone buses in operation: the first experience in Paris dates from 1998. Patients remain, on average, three months with the bus. In 2000, somewhere between 100 and 120 drug users had recourse to it every day. In the same year a new structure was installed in Marseilles.

In 2000 alone, the risk reduction structure—based on the participation of users (knowledge of needs, contact with users, education by pairs)—was strengthened through the opening of six new reception centres,

four syringe exchange programmes and a methadone bus. The support of associations and the active role of users or ex-users within the first-line teams are essential. These participants on the ground can create a link with the active drug users who are most resistant to institutions. These are reception or prevention agents, person-relays who know their city or neighbourhood and inhabitants particularly well. They also know how the market operates, the places and consumption modes and the habits of life, communication codes, the sociable ties and forced relations between drug users. They bring an expertise to the professional socio-healthcare teams (specialised educators, social workers, doctors or nurses) working within these structures.

The pharmacist also plays a major role in the area of risk reduction among drug users, as he is the main distributor of syringes and condoms: of 19 million syringes distributed in 1999, pharmacists sold 90% either singly or in prevention kits (2.8 million Stéribox® sold in 1999) and more than 50 million condoms in the year. Numerous pharmacies have accepted the installation on shop fronts, of the Distribox® (Stéribox® distributors). Moreover, a number of networks of pharmacists have implemented syringe exchange and kit exchange programmes in their pharmacies with associations on the ground, thanks to public financing.

The role of local elected representatives is essential, through their mediation and insertion tasks, in the installation of prevention programmes, which are integrated into the core of city life.

The installation of new risk reduction structures is often badly received by local residents who are frequently unwilling to see the gathering, in a single location, of drug addicts in difficulty and marginalised. The **local teams** are pilot structures for mediation with inhabitants, shopkeepers, pharmacists, etc. in the neighbourhood. In addition, these teams were given the objective of improving the care of users. They play a role of mediator between the local residents, the town hall, the police services, justice and health. The street work is essentially developed by specialist educators present in a number of neighbourhoods in the district. They are responsible for meeting drug users to inform them and encourage linking up with the healthcare and social structure. Co-ordinators organise the 'first-line' street work as a function of the problems notified to them. In total, four local teams were set up in the cities of Paris (in the 10th, 13th, and 18th districts) and Montpelier (one team). A similar project, financed by the city, was also launched in Marseilles.

The risk reduction structure in the penitentiary environment is based primarily on information and prevention actions aimed at all the inmates:

- Distribution of an information and prevention brochure to every entrant
- Facilitation of access to condoms, particularly in the medical services
- Regular distribution of bleach at 12°chl. by the penitentiary administration.

Specialist care structure in the field of alcoholism: CCAA

The specialist care structure in the field of alcoholism comprises primarily the *Centres de cure ambulatoire en alcoologie* (CCAA- Alcoholism out-patient cure Centres) called '*Centres d'hygiène alimentaire et d'alcoologie (CHAA)*' before 1st January 1999. These centres are responsible for the care and social accompaniment of anybody showing a risk consumption or dependence on alcohol; this action must be done in liaison with the other upstream and downstream health and social participants. Since 1st January 1999, thus structure is financed by the illness insurance schemes, whereas it was previously financed mainly from the State budget for prevention and care. Since the amendment of the law of 29th July 1998[55] the alcoholism centres benefit from a precise definition of their tasks, judicial recognition and stable financing.

In addition, the structure for the fight against alcoholism is completed by the structures responsible for prevention[10].

The private or public sectors manage the alcoholism centres. Different types of relations may exist between these structures and, for example, the same judicial entity managing one or more CCAA or a structure for the prevention of alcohol managing one or more alcoholism centres.

Number and type of judicial entities specialised in alcoholism, by field of activity

	1996	1997	1998
Healthcare and social (CCAA)	41	45	36
Prevention, healthcare and social (prevention structures and/or CCAA)	112	125	116

Source: DGS (extracted from the activity reports of the CCAA)

The activity of the specialised structures is often de-centralised, in different locations most easily accessible to users, open either fulltime or for a limited time. These places of activity cover various forms of organisation, from substantial permanent to shifting structures.

The number of alcoholism centres has remained stable at approximately 250 since 1994. The locations open for less than 20 hours per week are considered more as offices or outpatients clinics. The global opening time per week is estimated at approximately 12,000 hours.

'Alcoholism care centres' are installed in three penitentiary establishments to strengthen the actions of the psychiatry services.

In 1998, there were 375,332 care cases in the CCAA, with 239,492 social interventions by 89,733 consultants. The list of consultants active in 1998 can be estimated at 100,000. These figures show a clear progression since 1994 (352,564 care cases, 190,442 care interventions and 86,500 consultants). 47% came for the first time in 1998, a lower proportion than the 1997 and 1996 ratios, which can be interpreted as a trend to less good recruitment or better 'loyalty'.

The number of salaried professionals in the specialised structure can be estimated at 1,700 persons (1,687 in 1997). The majority operate in this sector on a part-time basis, with the number of equivalent full-time salaries being 900 in 1998 (925 in 1997), of which approximately 36.6% personnel from the healthcare sector and 16% from the social sector. The share of healthcare personnel is tending to increase.

Specialised structure for tobacco science

For persons in precarious situations who wish to stop smoking but who do not have adequate resources to make this move, it is possible to benefit from medical care, including the free provision of nicotine substitution medications. This is offered to them in the context of consultations provided by the health

[10] For more information, please refer to the previous section devoted to prevention structures.

examination centres of the National Salaried Workers' Health Insurance Fund, and the progressively by the CCAA.

Common law structure

The common law socio-healthcare structure also participates in the care of addictions, as a complement to the specialised structure: on the one hand, hospitals, as regards emergencies and consultations (somatic problems, withdrawal, etc.) and on the other hand, the free doctors monitoring patients presenting addictive behaviours.

The current structure is oriented more toward a network operation in order to provide care which is more appropriate to the needs of patients and ensure much greater co-ordination of interventions. It is therefore interesting to have an appreciation of the addiction networks, which could be recorded.

Care of tobacco addicts

There are currently fifty **tobacco withdrawal assistance centres** who care for the most addicted smokers and persons who have already suffered a pathology related to tobacco. The 1999 plan for the fight against tobacco from the Ministry of Employment and Social Affairs provided for the creation of 150 new centres in 2000 and an expansion in 2001-2002. The centres in operation were mandated to respond to a quality reference and to offer at least three in-patient medical days per week, and an office staffed by a nursing staff including an emergency telephone response.

The 1999 plan implemented a special structure for pregnant women. Among other measures relating to the training of professionals and prevention, the plan provided for the movement to an individual interview of forty minutes, done at the start of pregnancy and used to warn of the dangers of tobacco and to encourage pregnant women to stop smoking.

The structure for assisting in withdrawal in healthcare establishments was strengthened by the creation or development of **hospital consultations and tobacco science coordination units**[56] (UCT) These coordination units were created to develop a liaison to 'fight against tobacco addiction' and to implement, within the hospital, locations for training healthcare professionals, training procedures, information and the prevention of nicotine addiction. The units were integrated with the drug addiction and alcoholism liaison teams, where they existed.

Outpatient consultations are available to all, hospitalised persons or outpatients, while ensuring that the care is essentially directed toward the most addicted persons or those who are most difficult to assist due to their addiction and their psychological, socio-professional or family problems. In 2001, there were 261 hospital tobacco science consultations as opposed to 214 in 2000.

Care of alcohol dependency and excessive consumptions of alcohol

In parallel with the specific structure, other structures and other professionals participate in the care of alcoholism: hospital, cure and post-cure centres, and free doctors and associations of previously ill persons who provide personal, family and social support.

Prior to the publication of the memorandum of 10th September 1996[57], encouraging the development of alcoholism liaison teams in hospitals, the Reynaud-Parquet report (Reynaud *et al*., 1999) listed fifty alcoholism units with, on average, 10 to 40 beds. These teams were essentially in regional hospital ex-centres. In total, they had a little over one thousand beds receiving 20,000 patients per annum. The report had

underlined the absence of planning of their spread and the fragility of these structures, which had no administrative registration. It also showed the weaknesses in the care of alcoholic patients in hospitals. According to the authors, the diagnosis of excessive alcoholism was only made in half of the cases. The complications resulting from alcoholism were treated, but without this being the most frequent, by the implementation of dependence treatment. Orientation toward specialised structures (CCAA) was proportionately very low. The role played by psychiatry in the care of persons in difficulty with alcohol was not clearly defined. In the majority of hospitals, care of ill alcoholics was not organised in a coherent manner. In order to improve the hospital care of persons with an harmful use or dependence on one or more substances (including alcohol), the memorandum of 8th September 2000 from the Department of hospital management and organisation of healthcare and the General Health Department in relation to the organisation of hospital care for persons with addictive behaviours[58] provided a financial envelope of 38 million francs for the creation or strengthening of addiction liaison teams in hospitals.

The census of alcoholism liaison teams, recently done by the Department of hospital management and organisation of care, gives a clear picture of the development of the hospital structure for the care of alcoholism and its adaptation to the needs of patients. In 1999, there were 96 alcoholism liaison teams, of which 46 were set up since 1996. Physicians practising in hospitals, nurses, psychologists, secretaries, social workers, care assistants, dieticians, etc. are the main categories of personnel assigned to these teams. Medical time varies considerably from one team to another, the extremes ranging from 0.10 fulltime equivalent, to 1, and exceptionally 2, depending on the importance of the teams. The same variation is found for nursing personnel.

As regards the **care follow-up and alcoholism re-adaptation centres** (still known as post-cure centres), the Reynaud-Parquet Report listed 25 centres, generally managed by associations, comprising 375 beds for men, 160 beds for women and 274 mixed beds, a total of 807 beds. These structures have the capacity to receive 8,000 patients per annum.

Care of drug addictions

The hospital services within the healthcare establishments are responsible for the care of dependent persons. This priority was recently recalled by the previously mentioned memorandum of 8th September 2000 in relation to the organisation of hospital care for persons with addictive behaviours. The hospitals were also called to develop the possibilities of hospitalisation for assessment, care and withdrawal, currently considered as inadequate.

The care of drug addiction within the healthcare establishments is based on the implementation of liaison and partnership:

- Creation or strengthening of the coordination work of the addiction liaison and care teams
- Seeking a partnership with a specialised structure, psychiatric structures and out-patient medicine
- Creation of strengthening of city-hospital networks.

Drug addiction liaison teams were created following the memorandum of 3rd April 1996[59], which designated an envelope of 47 million francs for new hospital projects. At the end of 1997, 46 liaison teams were financed, 63 in 1998 and 69 in 1999. For 2000, a national envelope of 38 million francs was destined for the creation and/or strengthening of addiction liaison teams in hospitals.

Numerous organisational modalities are possible within hospital services: creation of an addiction unit, a federation of activities or a liaison team attached to a service. The healthcare establishments, which do not have the capacity to set up a liaison team, can develop another appropriate mode of organisation (for example, the signing of agreements between establishments).

The multi-disciplinary personnel received specific training: a part-time hospital physician, from two to three full-time equivalents of non-medical personnel (nurse, psychologist, social worker, dietician, for example) and medical secretarial time. The composition of the team should be appropriate to the needs.

The creation of city-hospital-drug addiction networks was also provided for in the memorandum of April 1996. In 1998, there were 67 city-hospital networks, spread over the entire national territory. They are financed jointly from the illness-insurance and State expenditures.

As regards care by the city medical services, it appears that 'non-network' doctors meet, on average, fewer patients, more, however, since the putting on the market of high-dosage buprenorphine. Some interventions due to militant doctors or those engaged in the fight against exclusion[11].

Care of addictive behaviours in the prison environment

The care of addictive behaviours of inmates (including those related to alcohol consumption) is based on the psychiatric sector team involved in the penitentiary establishment, in close liaison with the somatic care teams and the CSST.

The penitentiary establishments entrusts the somatic and psychiatric care of inmates to a hospital unit installed in the penitentiary environment and attached to a nearby hospital, more often known as *the Unité de consultations et de soins ambulatoires* (UCSA: Outpatient care and consultation unit) More particularly, the tasks of prevention, organisation of care and the continuity of care after release falls on these units. It is necessary to indicate that since the law of 18th January 1994(60), care in all penitentiary establishments is ensured by hospital teams from within the common law structure. In this context, each penitentiary establishment is linked by a protocol to a nearby healthcare establishment. An additional protocol is agreed when another healthcare establishment provides psychiatric care.

Since the decision of 14th March 1986(61), there are also *Services médico-psychologiques régionaux hospitaliers* (SMPR: Regional medico-psychological hospital services) covering all of the imprisoned population. The 26 existing SMPR come from the psychiatric sectors in the penitentiary environment. As previously indicated, 16 SMPR have an ex-'drug addiction agency', a structure created in 1987 by the specifications of 3rd November 1987(62). Since the decree of 29th June 1992(63), the drug addiction agencies have had the status of CSST in the penitentiary environment. The doctors responsible for SMPR must, in addition to being responsible for the direct operation of their own service, provide an advisory and coordination role for all the psychiatry services involved in the penitentiary environment. A new reorganisation of the care of dependent persons in the penitentiary environment is provided for in the context of the interministerial letter of 2001, in relation to the improvement of the health and social care of inmates presenting a dependence on licit or illicit drugs or with abusive consumption[12].

According to the data from the latest available survey for the imprisoned population (Mouquet *et al*., 1999), approximately 60% of entrant show a problem related to alcohol and/or drugs consumption and

[11] Please refer to the part devoted to the health and social consequences in the "Opiates" chapter.

[12] For more information, please refer to the section on recent developments in healthcare policy.

require appropriate care. According to a survey by the Department of hospital management and the organisation of healthcare[13], the recourse to substitution treatment in the penitentiary environment is not widespread and reflects the manifest resistance of some medical teams. Interruptions to substitution remain substantial: 19% in 1999 against 21% in 1998. The situation is more favourable for patients benefiting from methadone treatment on entry, where stoppages amounted to 10% against 21% for buprenorphine. Ten establishments alone prescribe 50% of substitution treatments; with substitution prescriptions being done most often in the context of continuation of a previous treatment and 21% establishments have no inmate receiving substitution treatment. Buprenorphine is used much more often than methadone and covers 84% of treatments. Inmates receiving substitution represent approximately 3.3% of the imprisoned population (2.8% on buprenorphine and 0.5% on methadone). The Percentage of inmates benefiting from substitution treatment varies from 0% to 16.5% depending on the establishment.

Since 1977, this structure is complemented by the *Unités pour sortants* (UPS—Release Units), a structure for preparation for release aimed at imprisoned persons showing a dependence problem. Initiated in 1992 through the 'intermediary neighbourhood for released persons' of the prison for persons awaiting trial in Fresnes, seven more UPS were created in penitentiary centres in Lyon, Strasbourg, Marseilles, Metz, Nice and in the in the women's prison for persons awaiting trial in Fresnes. In concrete terms, the UPS are special units in prisons, to which, in general one month before their release, inmates showing dependence problems are assigned. They benefit from group activities (sports, theatre, others), employment assistance training and administrative assistance (accommodation, others). These units use the group dynamic to make 'the trainees' work on self-confidence, self-respect and respect for others. The management and operation of the UPS are done by CSST in the penitentiary environment.

[13] DGS-SD6B / DHOS-O2, *Survey on substitution treatmetns in the penitentiary environment*, Ministry of Employment and Social Affairs, Nov. 1999 (not published).

Law enforcement structures

To ensure that the law is respected, the public policies depend on various structures in the fight against the supply and use of drugs. The majority of them are grouped in one of the following three Ministries: the Ministry of the Interior, the Ministry of Defence, and the Ministry of the Economy and Finance.

The judicial authority ensures not only the development of mandatory treatment, through its public prosecutor's offices in relation with the departmental health and social affairs departments, but also the deterrence of trafficking in narcotics and the laundering of drug money though the Criminal Courts and the Assize Courts.

Structure coordinated by the national police

Within the national police, the fight against the trafficking of narcotics is the fruit of the activity of specialised services: the *Office central pour la répression du trafic illicite de stupéfiants* (OCRTIS: Central Office for the Repression of Drug-related Offences), a service of the Central administration of the criminal investigation department has the role of centralising all information which will facilitate the research and prevention of the illicit trafficking of narcotics drugs and coordinating all operations aimed at reducing this trafficking.

There are also regional criminal investigation departments whose role is the fight against trafficking within the scope of their territorial competence. When a matter of national or international trafficking arises it is handled by OCRTIS.

The Central administration for public security also has the task of fighting against local trafficking and use. This task is done through the narcotics brigades that were set up at the local level.

Finally, the *Office central pour la répression de la grande délinquance financière* (OCRGDF: Central Office for the Repression of Grand Financial Delinquency) has the task of fighting against large-scale offences of nature, particularly economic and financial offences—money laundering. The files entrusted to it are transmitted by the *service du traitement du renseignement et action contre les circuits financiers* (TRACFIN: Service for the Handling of Information and Action Against Financial Networks), of the Ministry of Economy and Finance. This organisation is charge with collecting declarations of suspicion about suspect transactions operated by the financial institutions.

In terms of means, the number of police staff devoting all their activity to the fight against offences against the legislation on narcotics was estimated at 2,000 persons in 1995 (Kopp *et al*., 1998). Other police officers devote a not negligible portion of their time but this is more difficult to determine, and, on the basis of the hypotheses of the study, the total number of police staff on the equivalent full-time reached almost 6,500 persons.

Structure coordinated by the national gendarmerie

The problems related to the fight against drugs and the use of drugs is monitored at the central level by a senior officer of the criminal investigation department of the Central Administration of the national gendarmerie. On-the-ground coordination is done by the coordination organisation Bureau, which is directly supervised by the central administration.

Contrary to the national police, there are no specialised structures at the local level. Thirty research sections have authority under the scope of the Court of appeal and 302 research brigades, situated at the departmental or district level, participate in the fight against drugs trafficking, either on their own initiative, or reinforcing the 3,600 territorial brigades in the State.

The national gendarmerie is also active in the area of prevention of trafficking and use through the 25 brigades for the prevention of juvenile delinquency, which have approximately 475 anti-drug rely trainer non-commissioned officers, part of whom are assigned to these same brigades.

The numbers of the national gendarmerie devoted to these tasks is difficult to establish in the absence of specialised services. The study by P. Kopp and C. Palle (1998), nevertheless, estimated 2,000 on the equivalent of full-time.

Structure coordinated by the general department of customs and indirect duties

The customs administration intervenes, upstream of the other law enforcement services, in the context of its general tasks of customs clearance and the surveillance of the flows of merchandise, persons and capital, particularly when checking the means of transport. Its action in the fight against fraud is primarily oriented against the networks of international traffickers and may cross the framework of border zones.

In the matter of the fight against fraud and since the 1st January 1993, the customs structure has been reorganised around two main axes: the strengthening of checks at the external borders of the European Union and the implementation of mobile units, responsible for monitoring and checking the movements of travellers and goods throughout the territory.

The customs personnel who participate directly or indirectly in the fight against narcotics represent a full-time equivalent number of 2,000 persons, from a total number of 20,000 agents.

Structure for the control of drugs precursors.

The *Mission nationale de contrôle des précurseurs chimiques* (MNCPC: National Mission for the Control of Chemical Precursors), which is supervised by the Ministry of the Economy and Finance, has the function of organising and coordinating co-operation between the administrative and industrial participants.

In this perspective, the MNCPC has proposed, in particular, that an accompanying document be created for the most sensitive precursors during their transport within the European Community. Finally, the MNCPC takes individual and collective awareness actions with companies in the form of seminars to remind industrial participants of their regulatory obligations and their duty of vigilance. In this the MNCPC depends on a list of 22 chemical substances which are among the most sensitive in the classification established at the international level by the United Nations convention of 1988 devoted to the fight against the illicit trafficking of narcotics and psychotropic substances.

Judicial structure related to the trafficking and use of narcotics.

The magistrates of the public prosecutor's offices (prosecutors and substitutes) decide the follow-up to be given to offences detected by the police and gendarmerie, who direct the action of the criminal investigation

department. The most serious acts give rise to the opening of an investigation, the inquiry then being directed by an investigating magistrate before the court, or sometimes the assize court for trafficking by organised gangs, is called to rule on the culpability and sanctions. Penalties are executed by the penitentiary administration, in a closed or open environment (stay of execution with testing, in particular); judicial youth protection educators monitor minors.

At the Ministry of Justice, the office for the fight against organised crime, the trafficking of narcotics and money laundering ensure the organisation and coordination of public action.

For some years now, liaison magistrates are assigned to the French embassies in European countries and the United States. With their foreign colleague assigned to Paris, they facilitate international judicial co-operation, particularly in the area of the fight against narcotics.

In the context of procedures implicating narcotics users, the magistrates of the public prosecutor's offices are in close contact with the appropriate healthcare or social authorities, in particular through the implementation of mandatory treatments, as an alternative to prosecution. When prosecution is undertaken, the penalties imposed by the court most often aim at allowing care when this appears necessary, ensuring social re-insertion and reducing the risks of further offences. The execution of penalties is monitored and arranged by parole judges in relation with the insertion and probation services of the penitentiary administration.

When the user is a minor, it is the juvenile judge who decides the educational assistance or penal measures to be applied. The educators of the Youth judicial protection service take charge of these educational measures in respect of minors who are consumers of psychoactive drugs.

With the exception of some substitutes, there are no specialised structures in the fight against offences against the narcotics legislation within the justice services. In the equivalent to full-time, the number of magistrates who devote their activities to the fight against offences against the narcotics legislation was estimated at 200 in 1995, to which should be added 400 justice staff. There are 3,400 staff and socio-educational personnel in the penitentiary administration who devote their time to this same activity.

The Health-Justice Departmental Conventions on Objectives define the local priorities in judicial policy in respect of illicit drug users.

Expenditure devoted to the fight against drugs and the prevention of dependence

The OFDT recently published a study by P. Kopp and P. Fenoglio (2000) on the social cost of licit and illicit drugs. This presents and analyses, in particular, the expenditure by public administrations, whether direct or indirect expenditure. One part of this data, that in relation to the cost of morbidity and mortality related to drugs, are set out in the chapter 'Transversal approach', in the section 'Healthcare and social consequences'. For this reason, only the development in the expenditure of the different budgets of the administrations devoted directly to the fight against drugs and the prevention of dependence is covered here.

The principal expenditure in terms of the fight against drugs is made from the budget of the Minister for Employment and Solidarity. To the previous expenditures, those related to the prevention of AIDS among drugs users, which partially correspond to the risk reduction structure (chapter 47-18: 'Programmes and structures in the fight against AIDS').

As regards specific expenditures, the budget of the Ministry of Employment and Solidarity includes two chapters in relation to the fight against drugs:

- Chapter 47-15 ('Programmes and structures for the fight against addictive practices') connected with the Health Policy.
- Chapter 47-16 ('Interministerial action in the fight against drug addiction'). One part of the 'interministerial' expenditures is transferred to the interministerial partners, and another part to devolved expenditures (local actions, CDO, CIRDD). The remaining expenditures are used to finance the other activities of the MILDT (financing of associations, GIP, others).

Expenditures specifically linked to the fight against drugs, voted in the initial finance law, from 1990 to 2001

(in millions of francs)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Inter-ministerial expenditures	250	250	247	247	237	216	231	231	295	237	278	298
Health and city expenditures	353	439	440	461	485	619	690	751	780	816	867	1,223
Total	603	689	687	708	722	835	921	982	1,074	1,052	1,145	1,521

Source: MILDT (data from 1990 to 1998 published in: Cour des comptes, 1998)

'Health' expenditures

The 'health' expenditures (see the preceding table) increased by 34% between 1992 and 1996. This increase was faster than that of all State expenses, which progressed by slightly less than 10% (excluding debt servicing) over this period.

'Interministerial' expenditures

Mostly stable between 1992 and 1997, the 'interministerial' expenditures increased substantially in 1998 and 2000. In 1999, they reduced, due to the substantial carryover from the previous year (see preceding table).

The increase in the expenditures for the departmental objective agreements, for the actions of the 'drugs and drug dependence' project heads (local actions) and the information and resource Centres for drugs and drug dependence, have increased considerably since 1998. The generalisation of these structures in the majority of departments is at the origin of this increase in capacity.

Use of the 'health' expenditures devoted to the fight against addictive practices, from 1999 to 2000
(in millions of francs)

Structure implemented	1998	1999	2000
CSST global operation provision	641.3	646.8	659.0
Methadone reimbursement	19.9	19.9	18.8
'City' part of the 51 drug addiction-city-hospital networks	6.5	7.0	7.0
Young peoples and parents counselling Centres	33.9	42.3	43.8
Insertion assistance workshops	11.6	11.9	12.0
Units for released persons	5.0	5.0	5.2
So-called 'low threshold' structures	15.5	19.8	20.7
Local mobile teams	-	1.5	3.0
Emergency accommodation for drug users in seriously	-	-	20.7
Precarious situations			
Health care intervention in party locations	3.0	3.0	3.5
Training	4.7	3.4	3.0
Total	741.4	760.6	775.9

** chapters 47-15, articles 40 and 60*

Source: MILDT

Transferred interministerial expenditures, from 1992 to 2000
(in millions of francs)

	1992	1994	1996	1998	1999	2000
Health, social affairs	59.5	45.9	68.1	65.5	66.2	21.9
National education and research	11.9	12.9	12.0	19.5	22.5	19.5
Youth and sport	10.1	9.2	17.2	13.7	16.9	14.9
Interministerial delegation in the city	2.8	9.2	10.5	13.2	–	–
Justice	22.8	18.4	18.4	18.5	20.2	4.7
Interior (police)	23.8	27.6	19.0	18.5	16.5	8.6
Defence (gendarmerie)	9.8	11.5	8.8	10.7	9.6	7.2
Economy and finance (customs)	24.1	22.5	16.0	15.4	15.3	6.7
Foreign affairs	10.8	9.2	6.0	7.4	12.2	9.5
Co-operation	2.5	2.7	2.0	1.6	–	–
Others	0.8	0.9	–	0.6	1.6	1.8
MILDT own activities	55.1	48.0	52.5	77.7	110.6	183.3
Total	234.0	218.0	230.5	249.1	293.7	278.1

The differences between the tables for the amount of the same item are explained by the carrying forward of expenditures voted in the initial finance law (particularly for part of the interministerial expenditures for 1998 carried forward to 1999).

Source: MILDT

MILDT devolved interministerial expenditures, from 1998 to 2000
(in millions of francs)

Structure	1998	1999	2000
CDO	16.2	32.2	45.0
Local actions	3.0	24.6	41.3
CIRDD	–	12.5	11.0
Total MILDT decentralised credits	19.2	57.9	97.3
Total MILDT credits	77.7	120.4	183.4

Source: MILDT

'AIDS' expenditures

To the previous expenditures, those related to the prevention of AIDS among drugs users, which correspond fairly closely to the risk reduction structure. These expenditures were evaluated at 100 million francs in 2000, an increase of 60 million francs over 1995.

For additional information

- ANGEL (P.), RICHARD (D.), VALLEUR (M.) (Dir.), Drug addictions, Paris, Masson, 2000, p. 276.
- BALLION (R.) *Students, participants in prevention*, Paris, Sociological analysis and information centre 2000, p. 80, valid 19th Oct. 2001, (www.eduscol.education.fr/D0058/accueil.htm).
- BERGERON (H.), *The State and drug addiction:* the story of a French peculiarity, Paris, PUF, 1999, p. 370 (Coll. Sociologies).
- CABALLERO (F.), BISIOU (Y.), *Drugs Law*, 2nd edition, Paris, Dalloz, 2000, p. 827.
- National Council for Evaluation, Plan general Comissariat, *The law in relation to the fight against tabagism and alcoholism* Evaluation report, Paris, Documentation française, 2000, p. 555.
- Court of Auditors, *The structure for the fight against drug addiction*; report to the President of the republic following the responses of administrations, collectivities and interested organisations, Paris, Official Journal, 1998, p. 248 (coll. Special public report, no. 4367).
- CESONI (M.L.), The incrimination of narcotics use in seven European legislations 2000, p. 144 (Documents on Psychotropic drugs, Policy and Society, n° 4).
- DIS (Drugs Information Service), *Rapport on 'observations 1998/1999*, Paris, DIS, 1999, p. 106
- JACOB (E.), JOUBERT (M.), TOUZE (S.), *Evaluation of young peoples and/or parents Counselling Centres*, Paris, OFDT/RESSCOM, 2000, p. 262.
- KOPP (P.), FENOGLIO (P.), *The social cost of licit (alcohol and tobacco) and illicit drugs in France*, Paris, OFDT/ARMI, 2000, p. 277.
- KOPP (P.), PALLE (C.), *Towards the analysis of the cost of illegal drugs*, Paris, OFDT/ARMI, 1998, p. 80.
- LAURE (P.), *Doping and society*, Paris, Ellipses, 2000, p. 447.
- MILDT (Interministerial Mission for the fight against drugs and drug addiction), *Three-year plan for the fight against drugs and the prevention of dependence 1999-2000-2001*, Paris, Documentation française, 2000, p. 226.
- MILDT), *Departmental objective agreements,* National assessment for 1999/2000 2001, p. 5 (internal note).
- MOUQUET (M.C.), DUMONT (M.), BONNEVIE (M.C.), 'Health on entry to prison: a cumulation of risk factors', *DREES Survey and Results*, no. 4, January 1999, p. 1-10.
- OFDT (French Observatory of Drugs and Drug Addiction), *Drugs and drug addiction: Indicators and trends*, Paris, OFDT, 1999, p. 270.
- OFDT, Activity reports of 'drugs and drug dependence' project heads: *summary Year 2000*, Paris, OFDT, 2001, p. 65 (internal report).
- PARQUET (P.J.), *For a prevention policy in the matter of consumption behaviours of psychoactive substances*, Vanves, CFES, 1997, p. 107.
- POLOMÉNI (P.), *'Addiction networks' Report*, Paris, MILDT/DGS/DHOS, 2001 (to be published).
- REYNAUD (M.), PARQUET (P.J.), *Persons in difficulty with alcohol: use, harmful use, dependence: proposals,* Mission report 1998, Vanves, CFES, 1999, p. 293.

SIMMAT-DURAND (L.), *The fight against drug addiction: from legislation to regulation*, Paris, L'Harmattan, 2001, p. 248 (Coll. Logiques sociales).

(1) Law No. 70-1320 of 31st December 1970 in relation to the health measures in the fight against drug addition and the repression of the trafficking and use of poisonous substances, OJ of 2nd January 1971

(2) Law no. 92-1336 of 16th December 1992 on the entry into effect of the new penal code, OJ of 27th December 1992 (NOR: JUSX92400040L)

(3) Law no. 87-1157 of 13th December 1987 in relation to the fight against the trafficking of narcotics and modifying certain provisions of the penal code, OJ of 5th January 1988 (Nor: JUSX8700015L).

(4) 1989 Finance law No. 88-1149 of 23rd December 1988, article 84, JO of 28th December 1988, p.16320 sq. (NOR: ECOX880121L).

(5) Law no. 90-614 of 12th July 1990 in relation to the fight against money laundering, OJ of 14th July 1990, p.8329-8332 (NOR: ECOX9000077L).

(6) Law no. 96-392 of 13th May 1996 in relation to the fight against money laundering and narcotics trafficking and on international co-operation on seizures, OJ of 14th May 1996, p. 7208 sq. (NOR: JUSX9400059L) and CRIM memorandum no. 96-11G of 10th June with comments on the law of 13th May 1996 in relation to the fight against money laundering and narcotics trafficking and on co-operation (NOR: JUS D 96 30084C).

(7) Law no. 96-542 of 19th June 1996 in relation to the control of the manufacture and sale of substances, OJ of 20th June 1996, p. 9207 sq. (NOR: INDX9500023L).

(8) Law no. 99-505 of 18th June 1999 on various measures in relation to road safety and offences against the agents of transport network operators, OJ of 19th June 1999, p. 9015 sq. (NOR: EQUX9800010L).

(9) Order 60-1253 of 29th November 1960 modifying the licence code and the measures in the fight against alcoholism.

(10) Law no. 91-32 of 10th January 1991 in relation to the fight against tobacco addiction and alcoholism, OJ of 12th January 1991, p.4148 (NOR: SPSX9000097L).

(11) 1998 Finance amendment law no. 98-1267 of 30th December 1998, article 21 modifying articles L.49-1-2 of the licensed premises code and measures against alcoholism.

(12) Law no. 87-588 of 30th July on various social order measures, OJ of 31st July 1987.

(13) Law no. 93-1282 of 6th December 1993 in relation to the safety of sporting events (NOR: MJSX9300141L).

(14) Law no. 70-597 of 9th July 1970 instituting a legal rate of alcoholemia and making general the testing by breathed out air, JO of 10th July 1970.

(15) Law no. 78-732 of 12th July in relation to the prevention of driving a vehicle under the influence of alcohol, OJ of 13th July 1978, p.2785.

(16) Law no. 83-1045 of 8th December 1983 in relation to the control of the alcoholic condition, OJ of 9th December 1983, p. 3550.

(17) Law no. 86-76 of 17th January 1986 on various social order provisions, OJ of 18th January 1986, p. 888.

(18) Decree 95-962 of 29th August 1995 modifying articles R 233-5, R 256 and R 266 of the road safety code.

(19) Law no. 76-616 of 9th July 1976 in relation to the fight against tobacco addiction, OJ of 10th July 1976, p. 4148.

(20) See legislative reference no. 10.

(21) Law no. 93-121 of 17th January 1993 on various social order provisions, OJ of 30th January 1993, p. 1576 (NOR: SPSX9200178L).

(22) Law no. 94-43 of 18th January 1994 in relation to public health and social protection (NOR: SPSX9300136L).

(23) Law no. 65-412 of 1st June 1965 aimed at the repression of the use of stimulants during sporting competitions, OJ of 2nd June 1965, p. 4531.

(24) Law no. 89-432 of 28th June 1989 in relation to the repression of doping of animals taking part in sporting events and competitions (NOR: SPOX8800141L).

(25) Law no. 99-223 of 23rd March 1999 in relation to the protection of the health of athletes and the fight against doping (NOR: MJSX9800040L). Codifiée dans le code de la santé publique article L3611-1 sq.

(26) Prime minister's memorandum no. 4,982/SG of 13th September 1999 in relation to the fight against drugs and the prevention of drug dependence, OJ of 17th September 1999, Health BO no. 99-37 of 2nd October 1999 (NOR: PRMX9903743C).

(27) DGLDT (Délégation générale à la lutte contre la drogue et la toxicomanie - General Delegation for the Fight Against Drugs and Drug Addiction), Government Programme of 14th September 1995, 1995 (internal report).

(28) DACG-DAP-DPJJ memorandum of 17th June 1999 in relation to the judicial response to drug addicts, not published in the OJ (NOR: JUSA9900148C).

(29) Prime Minister's memorandum no. 14-154 of 31st December 1998 in relation to city contracts 2000-2006, OJ of 15th January 1999 (NOR: PRMX9903379C).

(30) Memorandum of 28th October 1997 in relation to the implementation of local safety contracts, OJ of 30th October 1997 (NOR: INTK9700174C).

(31) Memorandum SCOB9801882C, RLR: 514-3 ; 524-0, MEN (DESCO)-MCC-MJS no. 98-144 of 9th July 1998 in relation to the planning of the time and activities of children: implementation of the local education contract and extra-curricular rhythms, BOEN of 16th July 1998, no. 29, p. 1602.

(32) Law no. 98-657 of 29th July 1998 on the orientation in relation to the fight against exclusion, article 71, OJ of 31st July 1998 (NOR: MESX9800027L).

(33) DGLDT (Délégation générale à la lutte contre la drogue et la toxicomanie - General Delegation for the Fight Against Drugs and Drug Addiction), Government plan for the fight against drugs of 21st September 1993, 1993 (internal report).

(34) GS-SP3/DH-EO2 memorandum no. 346-99 of 15th June 1999 in relation to the organisation of hospital healthcare for drug addicted persons, health BO no. 99-33 of 4th September 1999 (NOR: MESH9930358C).

(35) DDGS/DH/MTAS memorandum no. 96-239 of 3rd April 1996 in relation to the orientations in the care of drug addicts in 1996, BO no. 96-16 of 25th May 1996 (NOR TASP9630145C).

(36) DHOS-O2/DGS-SD6B memorandum no. 2000-460 of 8th September 2000 in relation to the organisation of hospital healthcare for persons with addictive behaviour, health BO no. 2000/38 of 18th September 2000 (NOR: MESH0030387C).

(37) DGS/DHOS/DAP/MILDT interministerial note of 9th August 2001 in relation to the improvement of the health and social care of persons detained who show a dependence on licit or illicit drugs or with abusive consumption.

(38) DGS-SD6A memorandum no. 2000-158 of 13th March 2000 in relation to the orientations for the policy for the reduction of risks among drug users for 2000.

(39) Decision of the State Secretariat for health and social action of 20th September 1999 in relation to the application of the narcotics regulations to certain medications with a buprenorphine base, OJ of 24th September 1999 (NOR: MESP9922898A).

(40) Decision of the State Secretariat for health and social action of 8th February 2000 in relation to the breaking down of the delivery of medications with a methadone base, OJ of 16th February 2000, health BO no. 2000/7 of 4th March 2000 (NOR: MESP0020467A).

(41) DACG memorandum no. CRIM-99.7/G1 170699 of 17th June 1999 in relation to the fight against the trafficking of narcotics (NOR: JUSD9930090C).

(42) Law no. 96-392 of 13th May 1996 in relation to the fight against money laundering and narcotics trafficking and on international co-operation on seizures and the confiscation of the products of crime, article 222-39-1 of the penal code (NOR: JUSX9400059L).

(43) Memorandum of 11th October 1999 in relation to the strengthening of the fight against the use and local trafficking of narcotics (NOR: INTC9900206C).

(44) Order 45-174 of 2nd February 1945 in relation to delinquent childhood.

(45) nterministerial letter of 14th January 1993 in relation to the implementation of agreements on the objectives of the fight against drug addiction (see also: Memorandum of 22nd January 1993 on the implementation of agreements on objectives and services).

(46) IDSG-SP2 memorandum no. 99-110 of 23rd February in relation to the implementation of the programme for access to prevention and healthcare for persons in a precarious situation (NOR: MESP9930076C).

(47) Memorandum No.98-108 of 1st July 1998 in relation to risk behaviour and social environment committees, BOEN of 9th July 1998 (NOR: SCOE9801172 C).

(48) DAS-DSF1 memorandum no. 97-280 of 10th April 1997 in relation to the implementation of counselling Centres for young people and/or parents, financed by chapter 47-15, Labour BO no. 97/17/

(49) Law no. 98-657 of 29th July 1998 on the orientation in relation to the fight against exclusion, OJ of 31st July 1998 (NOR: MESX9800027L).

(50) Decree no. 92-590 of 29th June 1992 on the specialised centres for the care of drug addicts, OJ of 2nd July 1992, p. 8752 sq. (NOR : SANP9201106D).

(51) DGS-SP3 orientation note no. 98-659 of 5th November 1998 in relation to the revision of the therapeutic projects of the specialised centres for the care of drug addicts, BOMES no. 947 of 5th November 1998 (NOR: MESP9830471N).

(52) Decree no. 92-590 of 29th June 1992 on the specialised centres for the care of drug addicts, OJ of 2nd July 1992, p. 8752 sq. (NOR : SANP9201106D).

(53) Law no. 98-657 of 29th July 1998 on the orientation in relation to the fight against exclusion, OJ of 31st July 1998 (NOR: MESX9800027L).

(54) See legislative reference no. 37.

(55) See legislative reference no. 37.

(56) DH-EO2/DGS memorandum no. 2000-182 of 3rd April 2000 in relation to the fight against tabagism in healthcare establishments and the strengthening or creation of hospital consultations on tobacco science and tobacco science coordination units.

(57) DH-EO4 memorandum no. 557 of 10th September 1996 in relation to the forming of alcohology liaison teams in hospitals.

(58) DHOS-O2/DGS-SD6B memorandum no. 460 of 8th September 2000 in relation to the organisation of hospital care for persons with addictive behaviours.

(59) DGS/DH memorandum no. 230 of 3rd April 1996 in relation to orientations in the care of drug addicts in 1996 (NOR: TASP9630145C).

(60) Law no. 94-43 of 18th January 1994 in relation to public health and social protection, first title in relation to public health, chapter II: care in the penitentiary environment and the social protection of inmates, 19/01/1994, p. 960-977 (NOR: SPSX9300136L).

(61) Decision of the departmental council for mental health, no. 86-802 of 14th March 1986 in relation psychiatric sectorisation in the penitentiary environment, (articles 3 to 7), BO 1988, No. 23b.

(62) DGS/1354/2D specifications of 3rd November 1987 in relation to drug addiction agencies,BO 1988, no. 23b.

(63) Decree no. 92-590 of 29th June 1992 in relation to the specialised centres for the care of drug addicts, OJ of 2nd July 1992, p. 8752 sq.

Appendices

General bibliography

- *Alcohol. Effects on health,* Paris, INSERM (*Institut national de la santé et de la recherche médicale*: National Institute for Health and Medical Research) 2001, p. 360 (Coll. Collective report).
- *Cannabis. What are its effects on behaviour and health?* , Paris, INSERM (*Institut national de la santé et de la recherche médicale*: National Institute for Health and Medical Research), 2001, (Coll. Collective report), (to be published).
- *Ecstasy: biological and clinical data on the contexts of use*, Paris, INSERM (*Institut National de la Santé et de la Recherche Médicale*: National Institute for Health and Medical Research), 1998, p. 345 (Coll. Collective report).
- ANGEL (P.), RICHARD (D.), VALLEUR (M.) (dir.), *Drug addictions*, Paris, Masson, 2000, p. 276
- BECK (F.), PERETTI-WATEL (P.), *EROPP 99 : survey on the representations, opinions and perceptions in relation to psychotropic drugs*, Paris, OFDT, 2000, p. 203
- BECK (F.), LEGLEYE (S.), PERETTI-WATEL (P.), *A look at the end of adolescence: consumption of psychoactive drugs in the ESCAPAD 2000 survey*, Paris, OFDT, 2000, p. 220
- Beck (F.), Legleye (S.), Peretti-Watel (P.), *Alcohol, tobacco, cannabis and other illicit drugs among college and secondary school students: ESPAD 1999 France*, volume II, Paris, OFDT, 2001, (to be published).
- Bello (P.Y.), Toufik (A.), Gandilhon (M.), *Recent trends, TREND report*, Paris, OFDT, 2001, p. 167
- BERGERON (H.), *The State and drug addiction: the story of a French peculiarity*, Paris, PUF, 1999, p. 370 (Coll. Sociologies).
- CABALLERO (F.), BISIOU (Y.), *Drugs law*, *2nd edition*, Paris, Dalloz, 2000, 827 p.
- CFES (*Comité français d'éducation pour la santé*: French Centre for Health Education), *Prevention of smoking 2000-2003*, Vanves, CFES, 2000, p. 67 (Technical files).
- Choquet (M.), Ledoux (S.), Hassler (C.), *Alcohol, tobacco, cannabis and other illicit drugs among college and secondary school students: ESPAD 1999 France*, volume I, Paris, OFDT, 2001, (to be published).
- National Council for Evaluation, Plan general Commissariat, *The law in relation to the fight against nicotine addiction and alcoholism Evaluation report*, Paris, Documentation française, 2000, p. 555
- DUPREZ (D.), KOKOREFF (M.), *The world of drugs: use and trafficking in neighbourhoods*, Paris, Odile Jacob, 2000, p. 393
- EHRENBERG (A.) (dir.), *Drugs and pyschotropic drug medications: border problems*, Paris, Esprit, 1998, p. 264 (Coll. Company).
- FAUGERON (C.) (dir.), *Drugs in France: policies, markets, uses*, Geneva, Georg, 1999, p. 279
- GIBIER (L.), *The care of drugs users*, Paris, Doin, 1999, p. 341
- GOT (C.), WEILL (J.) (dir.), *Alcohol in figures, consumption and consequences: indicators in France*, Paris, Seli Arslan, 1997, p. 350
- Group on co-operation in the fight against the abuse and illicit trafficking of narcotics (Pompidou Group) (dir.), *Road traffic and drugs,* Strasbourg, Council of Europe, 2000, p. 384
- GUILBERT (P.), BAUDIER (F.), GAUTIER (A.) (dir.), *Health Barometer 2000*, Vanves, CFES, 2001, (to be published).
- KOPP (P.), FENOGLIO (P.), *The social cost of licit (alcohol and tobacco) and illicit drugs in France*, Paris, OFDT/ARMI, 2000, p. 277
- LAURE (P.), *Doping and society*, Paris, Ellipses, 2000, p. 447
- MILDT (*Mission interministérielle de lutte contre la drogue et la toxicomanie*: Interministerial Mission for the fight against drugs and drug addiction), *Three-year plan for the fight against drugs and the prevention of dependence 1999-2000-2001*, Paris, Documentation française, 2000, p. 226

- MILDT (*Mission interministérielle de lutte contre la drogue et la toxicomanie*: Interministerial Mission for the fight against drugs and drug addiction), *Know more. Risk less. Drugs and drugs dependence, the information book*, Paris, MILDT, 2000, p. 146
- OCRTIS (*Office central pour la répression du trafic illicite des stupéfiants*: Central Office for the Repression of Drug-related Offences), *Use and trafficking of narcotic drugs in France in 2000*, Paris, Ministry of the Interior, 2001, p. 114
- OEDT (*Observatoire européen des drogues et des toxicomanies*: European Observatory of Drugs and Drug Addiction), *Annual Report 2000 on the state of the drug phenomenon in the European Union*, Luxembourg, European Community Publications Office, 2000, p. 50
- OFDT (*Observatoire français des drogues et des toxicomanies*: French Observatory of Drugs and Drug Addiction), *Drugs and drug addiction: indicators and trends*, Paris, OFDT, 1999, 270 p.
- OGD (*Observatoire géopolitique des drogues* – Drugs geopolitical observatory), *The world drugs geopolicy 1998/1999*, Paris, OGD, 2000, p. 262 (www.ogd.org).
- PARQUET (P.-J.), *For a prevention policy in the matter of consumption behaviours of psychoactive substances* , Vanves, CFES, 1997, p. 107
- REYNAUD (M.), PARQUET (P.-J.), LAGRUE (G.), *Addictive practices: use, harmful use and dependence on psychoactive substances. Report to the Director General for Health*, Paris, Odile Jacob, 2000, p. 273
- RICHARD (D.), SENON (J.-L.), *Dictionary of drugs, drug addiction and dependence*, Paris, Larousse, 1999, p. 433
- ROQUES (B.), *The danger of drugs: report to the State Secretariat for Health*, Paris, Odile Jacob/Documentation française, 1999, p. 318
- TELLIER (S.), *The care of drug addicts in the healthcare and social structures in November 1999*, Paris, DREES, 2001, p. 47 (Working document no. 19).
- ZARIFIAN (E.), *The price of welfare: psychotropic medications and society*, Paris, Odile Jacob, 1996, p. 282

Methodological indicators

The following is a short description of the primary sources used in this report. Where possible, reference is made to a publication which gives more detailed information on the data used. Reference may also be had to the directory of statistical sources available on the website: www.drogues.gouv.fr.

Surveys of the general population

1 - Adult Health Barometer 93/94, Comité français d'éducation pour la santé (CFES: French Centre for Health Education)

The adult Health Barometer 93/94 is a telephone survey, done in November and December 1993, on a random sample of 1,950 persons aged from 18 to 75 years. This sample was adjusted in order that it would be representative, at a national level, for this age bracket. The adult Health Barometer asks interviewees about their behaviour, their knowledge and their attitude to health.

For additional information: BAUDIER (F.), DRESSEN (C.), GRIZEAU (D.), JANVRIN (M.-P.), WARSZAWSKI (J.), *Health Barometer 93/94. Results of the periodic survey on the health of the French population,* Paris, CFES, 1995, p. 168

2 - Adult Health Barometer 95/96, Comité français d'éducation pour la santé (CFES: French Centre for Health Education)

The adult Health Barometer 95/96 is a telephone survey, done in November and December 1995, on a random sample of 1,993 persons aged from 18 to 75 years. This sample was adjusted in order that it would be representative, at a national level, for this age bracket. The adult Health Barometer asks interviewees about their behaviour, their knowledge and their attitude to health.

For additional information: BAUDIER (F.), ARÈNES (J.), *Adult Health Barometer 95/96*, Vanves, CFES, 1997, p. 288

3 - Adult Health Barometer 2000, Comité français d'éducation pour la santé (CFES: French Centre for Health Education)

The Health Barometer 2000 is a telephone survey of the general population, based on a random sample, done between October and December 1999 and co-ordinated by the *Comité français d'éducation pour la santé* (CFES: French Centre for Health Education), in partnership with the *Fédération nationale de la mutualité française* (French National Federation of Mutual Insurance), *the Haut Comité de la santé publique* (High Committee on Public Health), the *Mission interministérielle de lutte contre la drogue et la toxicomanie* (Interministerial Mission for the Fight Against Drugs and Drug Addiction) and the *Fédération nationale des observatoires régionaux de santé* (National Federation of Regional Health Observatories).

This multi-thematic survey covers the behaviour and opinions of the French in relation to health. The sample, which included 13, 685 individuals from 12 to 75 years of age, is representative at the national level.

For additional information: GUILBERT (P.), BAUDIER (F.), *Health Barometer 2000*, Vanves, CFES, 2001, (to be published).

4 - Continuous survey on household living conditions 2000, INSEE (Institut national des statistiques et des études économiques: National Institute for Statistics and Economic Studies)

This four-monthly survey by the Household living conditions division of the INSEE poses a question in relation to the consumption of tobacco in one of the three annual surveys, when a health-specific module is included. Done on a face-to-face basis by INSEE researchers, it covers a sample of 8,000

households. The question in relation to the daily use of tobacco and the quantity consumed is put to approximately 11,000 individuals aged 15 years and over. The data were collected in May, 2000.

For additional information: Aliaga C., "Tobacco: twenty years of use and consumption" *INSEE première*, no. 808, 2001, p. 4

5 - Survey on the health of adolescents, INSERM-U169 (INSERM: Institut national de la santé et de la recherche médicale: National Institute for Health and Medical Research)

The survey on the health of adolescents was done in 1993 on a representative sample, on a national basis, of school-going young persons in the public secondary cycle (colleges and secondary schools) aged from 11 to 19 years (n = 12,391). The replies were collected in a questionnaire completed by the student (auto-questionnaire).

The non-response rate for questions related to the consumption of drugs was between 1% and 3%. This related to the consumption during life of seven product classes: hashish, cocaine, heroin, amphetamines, inhaled drugs, hallucinogenic drugs, medications taken "to drug oneself".

For additional information: CHOQUET (M.), LEDOUX (S.), *Adolescents, national survey*, Paris, INSERM, 1994, p. 346

6 - Young persons Health Barometer 97/98, Comité français d'éducation pour la santé (CFES: French Centre for Health Education)

The young persons Health Barometer 97/98 is a telephone survey, done in November and December 1997, on a random sample of 4,115 young persons aged from 12 to 19 years. This sample was adjusted so that its structure by age, sex, region of residence and type of habitation would be representative, at the national level, for the age bracket covered.

The young persons Health Barometer provides information in relation to the behaviour, knowledge and attitudes of adolescents in relation to health. The questions in relation to the consumption of illicit drugs were only put to adolescents aged from 15 to 19 years (2,675 individuals).

For additional information: BAUDIER (F.), JANVRIN (M.-P.), ARENES (J.), *Young persons Health Barometer 97/98*, Vanves, CFES, 1998, p. 328

7 - European School Survey Project on Alcohol and Other Drugs 1999 (ESPAD), INSERM/OFDT/MENRT

This survey, under the aegis of the Swedish Council for information on alcohol and other drugs and the Council of Europe (Pompidou group), conducted in the school environment by self-administered questionnaire, took place in 1999 in thirty European countries (with a core of common questions and optional modules)

The French part of this survey was conducted by INSERM (*Institut national de la santé et de la recherche médicale*: National Institute for Health and Medical Research) (under the scientific management of Sylvie Ledoux and Marie Choquet, U472) in partnership with the OFDT (*Observatoire français des drogues et des toxicomanies*: French Observatory of Drugs and Drug Addiction) and the Ministry of Education, Research and Technology. The fieldwork was done between March and May 1999. The French sample amounted to 11,870 students drawn by lot from each class (2 classes in each of the 300 selected establishments, from the fourth to the final year) across all the public and private educational establishments. The young persons each completed an auto-questionnaire, in class, in the presence of a health professional (duration: 1 hour).

For additional information: CHOQUET (M.), LEDOUX (S.), HASSLER (C.), *Alcohol, tobacco, cannabis and other illicit drugs among college and secondary school students:* ESPAD *1999 France,* volume I, OFDT Report, (to be published at the end of 2001).

BECK (F.), LEGLEYE (S.), PERETTI-WATEL (P.), *Alcohol, tobacco, cannabis and other illicit drugs among college and secondary school students: ESPAD 1999 France,* volume II, OFDT Report, (to be published at the end of 2001).

8 - Survey on health and behaviour during the Defence Preparation Day 2000 (ESCAPAD), Observatoire français des drogues et des toxicomanies (OFDT : French Observatory of Drugs and Drug Addiction)

The OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction) has set up an annual survey that takes place during the Defence Preparation Day and which covers the entire metropolitan territory. Once a year, on the Wednesday and Saturday of a given week, all the young persons present on these days (in the 250 centres throughout the territory) devote twenty minutes to completing a self-administered questionnaire on health, lifestyle and the consumption of psychoactive substances.

When this survey was first conducted, in May 2000, only 92 blank questionnaires were returned, and after checking the age, sex and the consistency of the answers to the primary questions on the consumption of psychoactive substances, 13,952 questionnaires were usable. The JAPD (*Journée d'Appel et de Préparation à la Défense*: Defence Preparation Day) is aimed at young persons of 17 years of age, while slightly older young persons (essentially 18-19 year-olds) can repeat the day. As the JAPD began later for girls than for boys, the 2000 sample includes girls of 17 years of age and boys from 17 to 19 years of age. For the 2001 exercise, this survey was extended to the Dom.

For additional information: BECK (F.), LEGLEYE (S.), PERETTI-WATEL (P.), *A look at the end of adolescence: consumption of psychoactive drugs in the ESCAPAD 2000 survey*, Paris, OFDT, 2000, p. 220

9 - Survey on the representations, opinions and perceptions in relation to psychotropic drugs 1999 (EROPP), Observatoire français des drogues et des toxicomanies (OFDT: French Observatory of Drugs and Drug Addiction)

This is a telephone survey conducted by the OFDT (Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction). The data was collected by the BVA survey institute between 30th March and 10th April 1999 , from approximately 2,000 persons aged from 15 to 75 years. This quota sample (based on sex, age, the profession of the head of household, the region of residence and the size of the urban centre. The interviewees were asked about their knowledge in relation to psychoactive substances, their perception as to the danger of these drugs, their own experiences of consumption, on the presence of users among their close friends, but also on their opinions in relation to heroin users and the public policies actually implemented or which might be envisaged. This survey will be repeated in 2002.

For additional information: BECK (F.), PERETTI-WATEL (P.), *EROPP 99 : survey on the representations, opinions and perceptions in relation to psychotropic drugs*, Paris, OFDT, 2000, p. 203

Sales data

10 - Sales of medications by manufacturers to wholesalers, Agence française de sécurité sanitaire des produits de santé (AFSSAPS: French Agency for the Sanitary Safety of Healthcare products)

The professionals in every firm in the pharmaceutical industry are required to declare their turnover and sales to the AFSSAPS (*Agence française de sécurité sanitaire des produits de santé*: French Agency for the Sanitary Safety of Healthcare products) every year. These are statistics of deliveries by manufacturers to wholesale distributors, in metropolitan France only.

Sales are expressed in “units of sale” (the number of boxes of medications sold) which causes a problem due to the differences in packaging from one product to another and one year to another. The sales and turnover for medications destined for the hospital environment are differentiated from those destined for city pharmacies due, in particular, to the packaging methods used for very different drugs.

The main difference with the sales volume of pharmacies (data from IMS Health *(Information médicale et statistique sur la santé*: Medical and Statistical Information on Health)) comes from the stocks held by them, which are apparently quite small. Only the AFSSAPS (*Agence française de sécurité sanitaire des produits de santé*: French Agency for the Sanitary Safety of Healthcare products) figures provide information on sales in hospitals.

The data available for 2001 are: the sales and turnover in the city (pharmacies) or the hospital for all

classes of medications (based on the ATC[1] international directory classification) from 1988 to 1999. Only the major therapeutic classes are covered here (see the definition of "psychotropic medication" in the glossary).

For additional information: CAVALIÉ (P.), RAUSS (A.), *Analysis of the sales of medications to pharmacies and hospitals in France. 1988-1999*, Saint Denis, AFSSAPS, Department of medical-economic studies and scientific information, 2001, p. 86.

11 - Sales of medications by pharmacies, IMS Health (Information médicale et statistique sur la santé : Medical and Statistical Information on Health)

IMS Health (*Information médicale et statistique sur la santé*: Medical and Statistical Information on Health) is a private company which sells data to the pharmaceutical industry. Those used here represent the recorded sales of 8,500 pharmacies in France (coverage rate of approximately 40%), computerised (that is to say those applying the direct payment system) and connected to a system managed by IMS which records all sales made in these pharmacies. These data are then extrapolated to the level of each department (the pharmacies participating in the data collection are selected so as to obtain a representative situation for each department).

The sales data are presented in "units of sale" (the number of boxes sold). The packaging problem, which changes depending on the type of drug, occurs here also. On the other hand, it appears that the packaging does not change much for the same product

The data are coded in accordance with the classifications of the ATC international directory.

The data used in this report correspond to the sales (by unit of sale) by department, of the four major therapeutic classifications corresponding to psychotropic medications (see the glossary).

For additional information: unpublished data, supplied on request to the OFDT.

12 - Information system on the accessibility of medicinal injection and substitution materials (SIAMOIS: Système d'information sur l'accessibilité au matériel officinal d'injection et à la substitution), Institut de veille sanitaire (InVS: National Health Monitoring Institute)

The information System on the accessibility of medicinal injection and substitution materials, initiated by the General Health Department and developed by the National Health Monitoring Institute, was set up in 1996 to monitor trends in relation to the access to sterile injection materials available in the pharmacies and to substitution medications. These data are transmitted by the Group for the production and development of statistical studies for the pharmaceutical industry. When these data are related to the 20-39 year-old population, in which 80% of drugs users are found, indicators are obtained which allow the making of comparisons at a regional and departmental level.

Moreover, SIAMOIS (*Système d'information sur l'accessibilité au matériel officinal d'injection et à la substitution*: Information system on the accessibility of medicinal injection and substitution materials) allows the collation, on an annual basis, of this data with the number of new cases of Aids related to the injection of drugs (InVS, *Institut de veille sanitaire*: National Health Monitoring Institute), the cases of police interrogation for the use of heroin and cocaine (OCRTIS, *Office central pour la répression du trafic illicite de stupéfiants*: Central Office for the Repression of Drug-related Offences) and the number of deaths from overdoses (OCRTIS).

For additional information: EMMANUELLI (J.), *Contribution to the evaluation of the SIAMOIS risk reduction policy*: *description, analysis and putting into perspective of the official sales data for syringes and substitution drugs in France from 1996 to 1999*, (2 volumes), Saint-Maurice, InVS, 2000, p. 55 and 93

[1] The medications are classified by their location of action (organ or group of organs), their therapeutic purposes, their pharmacological effects and their chemical characteristics.

Records

13 - National register of the causes of death, Institut national de la santé et de la recherche médicale, service commun n° 8 (INSERM-SC8: National Institute for Health and Medical Research, common service No. 8)

The SC8 service of INSERM *(Institut national de la santé et de la recherche médicale:* National Institute for Health and Medical Research) has, since 1968, been recording the total number of deaths on French territory. The information on the causes of these deaths comes from the death certificate completed by the doctor when certifying the death. They are coded by INSERM on the basis of the medical classification of illnesses (CIM). The strike by public health medical inspectors from November 1998 to April 2000 resulted in the medical death certificates not being transmitted to INSERM, which is why the latest data available is up to 1998 only.

Three CIM-9 codes allow the extraction of deaths directly related to drug addiction: drug addiction (CIM-9 code 304), drug abuse without addition (305) and psychoses due to drugs (292).

All the deaths related to drug addiction in France are not included in these three categories, because, on the one hand, it is not inevitably referred to on the death certificate and, on the other hand, (and above all) cases of overdoses are considered as suspect deaths and the determination of the cause therefore requires additional examination. As a result, if the results of the examinations conducted are not conveyed to INSERM, or arrive after too long a time, the death is classified as cause unknown (heading "badly defined symptoms, signs or morbid status"; code 799.9 of CIM-9). Some of the deaths from overdoses registered by OCRTIS (*Office central pour la répression du trafic illicite de stupéfiants*: Central Office for the Repression of Drug-related Offences) are probably recorded in this category.

The variable of this database are:

- the date and place of birth, sex, nationality, matrimonial status and socio-professional category of the deceased person;
- the principal or initial, immediate and associated cause of death[2]; the first is the most common used;
- the circumstances, location and date of death and the speciality of the doctor certifying death.

For additional information: http://sc8.vesinet.inserm.fr:1080 (link valid from 19th October 2001)

14 - Aids monitoring system in France, Institut de veille sanitaire (InVS : National Health Monitoring Institute)

The Aids monitoring system, implemented in 1982, is based on mandatory reporting by physicians (decree of 10th June 1986). It is estimated that 80% to 90% of Aids cases are notified.

The essential available variables relate to the age of the person contracting Aids at the time of diagnosis, the method of contamination (including the use of injected drugs) and the department of residence of the patient.

Deaths from Aids are also subject to mandatory reporting. The National Health Monitoring Institute records them according to the year of occurrence and the cause of the Aids infection. There is also a delay in the declaration of these deaths, and the data are being progressively corrected for this. The coverage rate is estimated to be between 75% and 85%.

Due to industrial action by the public health medical inspectors of the DDASS, the transmission to the InVS of the statements of the mandatory reporting of illnesses was not done from November 1998 to April 2000. These files were subsequently recorded, but it is possible that exhaustivity was not ensured or that this disruption discoursed some clinicians from reporting new cases of Aids.

For additional information: The situation as regards Aids in France is published every six months in the weekly epidemiological Bulletin (http://www.rnsp-sante.fr/).

CAZEIN (F.), PINGET (R.), LOT (F.), DAVID (D.), PILLONEL (J.), LAPORTE (A.), "Recent Aids Trends in France (January 1998-June 2000)", BEH *(Bulletin épidémiologique hebdomadaire : Weekly epidemiological bulletin)*, no. 52, 2000, p. 8-235.

[2] The initial cause: illness or trauma at the origin of the series of morbid events which resulted in death; the immediate cause: terminal illness, trauma or complication which directly resulted in death; the possible additional causes correspond to the appreciable morbid statuses which contributed to the death, but which are not part of the series of events described as the immediate or initial cause of death

InVS *(Institut de veille sanitaire*: National Health Monitoring Institute), "Surveillance of Aids in France: The situation after two years of interruption", BEH *(Bulletin épidémiologique hebdomadaire : National Health Monitoring Institute)*, no. 38, 2000, p. 8-169.

Health and social statistics and surveys

15 - Consultations in the centres de cure ambulatoire en alcoologie (CCAA: Alcohol Out-patient Treatment Centres), Association nationale de prévention de l'alcoolisme (ANPA: National Association for the Prevention of Alcoholism)

This is an epidemiological survey conducted each year by the CCAA (*centres de cure ambulatoire en alcoologie*: Alcohol Out-patient Treatment Centres) managed by the *Association nationale de prévention de l'alcoolisme* (ANPA: National Association for the Prevention of Alcoholism) in partnership with the medical health epidemiological team from INSERM (*Institut national de la santé et de la recherche médicale*: National Institute for Health and Medical Research).

Throughout the year information is collected from every new drinker consulting the aforementioned structures (socio-demographic data, previous history, clinical assessment, information in relation to alcoholism, type of request, etc.).

The majority of the centres participating in this study use a standard software for patient file management, which allow the automatic extraction of the epidemiological data processed by INSERM.

In 1999, information was collected from 17,500 new consultations.

For additional information: ANPA (*Association nationale de prévention de l'alcoolisme*; National Association for the Prevention of Alcoholism), *Consultation in the CCAA* (*centres de cure ambulatoire en alcoologie*: Alcohol Out-patient Treatment Centres) *in 1999*, Paris, ANPA, 2000, p. 52.

16 - Use of the standard activity reports of the dispositif spécialisé de lutte contre l'alcoolisme (CCAA: Specialised Structure for the Fight Against Alcoholism), Direction générale de la santé (DGS: General Health Department)

Since 1994 the DGS (*Direction générale de la santé*: General Health Department) has produced a standard activity report for the specialist alcoholism structures financed by the State until 1998, and subsequently by social security since 1999. The purpose of this information collection is to monitor the activities of the structures and the number and characteristics of the patients received.

The epidemiological data is not collected on a patient-by-patient basis but for all of the persons received in the structure. A limited number of questions relate to socio-demographic aspects, to alcoholism and to the manner of direction to the structure.

In 1998, 178 of the 210 recorded legal entities returned a questionnaire. These structures declared having received 90,000 consultations (drinkers or the family of drinkers) of which a little more than 40% were new consultations, which are the only ones described in more detail.

For additional information: *The specialist structures for the fight against alcoholism in 1998:* information from the standard reports, Paris, Office of mental health, drug addiction and dependence, General Health Department, Ministry of Employment and Social Affairs, May 2000, p. 17

17 - Survey on the care of drug addicts in the healthcare and social system, Direction de la recherche, des études, de l'évaluation et des statistiques (DREES : Department of Research, Studies, Evaluation and Statistics)/Direction générale de la santé (DGS : General Health Department)

The purpose of this survey, created at the end of the 1980s, is to monitor the number and characteristics of drug users taken into care in the drug addiction specialist care structures (essentially the centres *spécialisés de soins pour toxicomanes* (CSST: Specialised Centres for the Care of Drug Addicts), the healthcare establishments (regional hospital complexes, hospital complexes and hospitals, hospital complexes specialising in psychiatry and other similar establishments) and a certain number of structures who intervene in the social area (CHRS, Prevention clubs and teams).

This survey was conducted in the month of November every year until 1997, and again in 1999, but was not done in 1998. It was developed within the Ministry of Employment and Social Affairs by the

SESI, which became the DREES in 1999, in liaison with the DGS.

In the specialist drug addiction structures, all users of illicit drugs or misused psychotropic medications taken into care during the month of November must be integrated into the survey, whether this care began in the month of November or earlier. The non-specialist structures (healthcare and social establishments) must include persons in care for drug addiction or the misuse of illicit drugs during the last few months. In the healthcare establishments, the survey only covers persons who are partially or fully hospitalised. Those suffering exclusively from alcohol dependence should not be taken into account.

The information collected covers the socio-demographic characteristics of persons in care, over the user's career (first recourse, origin of care), on the HIV and HCV pathologies and on the drugs. The questionnaire makes a distinction between the drugs at the origin of care (maximum two drugs) – this question is not asked in the social establishments – and the drugs consumed during the last thirty days (maximum three drugs).

In the context of this report, the drug at the origin of care given as the first is denominated the primary drug and that given as the second as the secondary drug. These concepts are used in the interests of convenience, as the terms "drug at the origin of care no. 1 and no. 2" are too long. This choice also results from the examination of the data. In effect, until 1996 the questioning related to the primary drug and the associated drugs and examination of the figures shows a string continuity in the results for the primary drug (until 1996) and for the drug at the origin of care given as the first (since 1997). In addition, the drug at the origin of care no. 1 (primary) allows the distinction of different profiles, while drug no. 2 (secondary), always predominantly associated with opiates due to the weight of these substances in care cases, returns, irrespective of the drug, the profile of an average opiates user. An analysis based on the drug at the origin of care which is given first was, therefore, chosen in this report.

The healthcare establishments which come within the aegis of the Public Assistance (the Paris Hospitals) were only questioned over a week, which necessitated the estimation of the care cases for the month, using a corrective co-efficient.

A question on simultaneous care by non-specialist healthcare establishments and the establishments specialising in drug addiction ensured the elimination of some of the double-counting. A person attending a number of CSST or a number of healthcare establishments during the month may, on the other hand, be counted a number of times.

The drug addiction survey of November 1999 covered almost 27,000 care cases (excluding double counting) in all of the establishment surveyed, of which a little more than 22,000 (excluding double counting) were in the specialist and healthcare establishments. The analyses of the requests for treatment by drug shown in this report cover approximately 19,500 care cases which mention at least one drug as the origin of care. The 2,500 cases without information on the drugs correspond to non-answers or to drug users who were taken into care by the healthcare establishments for a reason other than drug addiction (infectious illnesses, for example).

For additional information: TELLIER (S.), *The care of drug addicts in the healthcare and social structures in November 1999*, Paris, DREES, 2001, p. 47 (Working document no. 19).

18 - Observation des produits psychotropes ou détournés de leur utilisation médicamenteuse (OPPIDUM: Observation of psychotropic drugs or those diverted from medicinal use), Centres d'évaluation et d'information sur la pharmacodépendance (CEIP: Drug Addiction Evaluation and Information Centres)

The OPPIDUM programme is a system for the epidemiological monitoring of the development of the consumption of narcotics and psychotropic drugs (illicit drugs or the misuse of medications) organised in the form of an annual multi-centre survey of the structures for the reception and care of drug addicts. This programme was developed at the beginning of the 1990s by the *Centres d'évaluation et d'information sur la pharmacodépendance* (CEIP: Drug Addiction Evaluation and Information Centres) network.

The protocol of this survey provides for the inclusion of every patient who is dependent on, or an abuser of, psychoactive substances, or is receiving substitution treatment, presenting themselves to the reception and care structures during the month of October. The information collected relates to the characteristics of the subject (socio-demographic data, associated addictive behaviour, participation in substitution treatment) and on each of the drugs used during the last seven days (description of the drug, how it was obtained and consumed, the effect sought and signs of addiction).

In 1999, sixty-seven reception and care structures participated in the survey, including about forty CSST, seven hospital liaison teams, four general practitioners and a certain number of other structures. A little more than 2,000 patients were covered by the survey, with approximately 4,000 psychoactive substances consumed.

For additional information: THIRION (X.), BARRAU (K.), MICALLEF (J.), HARAMBURU (F.), LOWENSTEIN (W.), SANMARCO (J.-L.), " Substitution treatments for opiate addiction in healthcare centres: the OPPIDUM programme of the Drug addiction evaluation and information Centres" *Internal medicine annual,* vol. 151, Supp. A, 2000, p. A10-A17.

19 - Décès en relation avec l'abus de médicaments et de substances (DRAMES; Deaths related to the abuse of medications and substances), Centres d'évaluation et d'information sur la pharmacodépendance (CEIP: Drug Addiction Evaluation and Information Centres)

Controlling and financing organisation: *Agence française de sécurité sanitaire des produits de santé* (AFSSAPS: French Agency for the Sanitary Safety of Healthcare products).

The DRAMES database, which is currently being completed, is a national system for the recording of deaths related to the abuse of substances or psychotropic medications.

It records the deaths due to the abuse of medications and substances notified to the CEIP by the partner services of these structures (anti-poison centres, emergency services, medico-psychological services, healthcare centres, medico-legal institutes, police scientific laboratories). The deaths recorded are those caused by the user themselves or to third parties.

A feasibility study on the systematic recording of these deaths by the CEIP network was launched by the AFSSAPS, in partnership with OCRTIS and legal experts in pharmacological toxicology. It covered the years 1998 and 2000.

The information recorded on a standardised form provides information on: the characteristics of the subjects concerned (previous history, pathology, age, gender, state of development of the abuse), the circumstances of death (voluntary or accidental, collective or solitary) and the results of the autopsy and the analyses done.

The DRAMES register should be operational on 1st January 2002.

For additional information: *Reports on the first drug addiction workshops,* Biarritz, 1999 (being published).

20 - Survey on the care of drug addicts by general practitioners, Bureau d'études évaluation médicale, médico-sociale, santé publique (EVAL: Office for medical, medico-social and public health evaluation studies)

This survey, conducted on four occasions (1992, 1995, 1998 and 2001) by the EVAL company, covers the care of drug addicts by general practitioners.

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

In 1995, 1997 and 2001 the sample covered approximately 300 general practitioners throughout France, thirty of whom were practising in a medico-social centre.

The samples were constructed by drawing lots from France Telecom lists with a pre-established replacement procedure in case of refusal.

The four surveys were conducted by telephone interview and the four questionnaires used the same questions in greater part. The doctors were asked about their activity in the year preceding the survey. The 1995-1997-2001 comparisons cover the entire sample.

The refusal rate for the four surveys was 25%, 29%, 25% and 37% respectively. On each occasion, the doctors who refused to participate in the survey answered a brief questionnaire so that they could be compared with those who agreed to participate. In all the surveys, the non-participants cared for fewer drug addicts than did participants. A higher proportion of non-answers in 2001 resulted in certain corrections having to be made to take account of fewer cases of care among non-respondents.

For additional information: COULOMB (S.), DUBURCQ (A.), MARCHAND (C.), PÉCHEVIS (M.), *Developments in the care of drug addicts : survey of general practitioners in 2001 and 1992-1995-1998-2001 comparison*, Paris, OFDT, 2001, p. 56 (internal report).

21 - General Practitioner Health Barometer, Comité français d'éducation pour la santé (CFES: French Centre for Health Education)

Renewed on four occasions since 1992, this survey is done by telephone with a representative sample of general practitioners in free practice.

In 1998, 2.073 were interviewed, which is approximately 1 doctor in 30. The refusal rate was 23.4%. In 1994, the sample size was 1,013 with a refusal rate of 29.2%.

All of the data was corrected to take account of the structure of the population of general practitioners in France.

The questionnaire covered the personal behaviour of doctors, their opinions and attitudes to prevention and patient education, vaccination, HIV and hepatitis C, patients over 65 years of age, cancer and the treatment and care of addiction problems.

As regard the last theme, the questions covered:

- the number of heroin addicts cared for each month, the type of substitution treatment offered and the doctor's opinions in relation to the drug,
- the number of patients in care for the treatment of nicotine addiction or alcoholism, and the tobacco withdrawal methods recommended.

For additional information: ARÈNES (J.), GUILBERT (P.), BAUDIER (F.) (dir.), *General practitioner Health Barometer 98/99*, Vanves, CFES publications, 1999, p. 218.

22 - Survey on hospital tobacco consultations, Direction de l'hospitalisation et de l'organisation des soins (DHOS: Department of hospital management and healthcare organisation) – Ministry of Health

This survey was done on two occasions, in a given week in January 1000 and 2001, on tobacco consultations in the public and private healthcare establishments recorded by the *Office français de prévention du tabagisme* (OFT: The French Office for the Prevention of Smoking). The list was updated and completed by the public health medical inspectors form each department.

In 2000, 150 responses were received from the 214 identified hospital consultations (70%). Among the respondents, 94% were public structures (against 63% of non-respondents: the sample was not representative for this criteria). In 2001, 206 consultations centres, from a total of 261 recorded, responded to the survey.

The questionnaire, sent by post, related to the number of patients which had come during the week for a consultation on tobacco, making a distinction between first consultations, withdrawal follow-up, pregnant women and hospitalised patients; the waiting periods; the diagnosis tools used; information in relation to the structure (particularly personnel resources).

For additional information: JEANFRANÇOIS M., FERNANDES E., DAUTZENBERG B., " Development in hospital tobacco consultations between 2000 and 2001" , *BEH (Bulletin épidémiologique hebdomadaire: Weekly epidemiological bulletin)*, no. 22-23, 2001, p. 101-103.

23 - Survey of non-hospital tobacco consultations, Office français de prévention du tabagisme (OFT: French Office for the Prevention of Smoking)

In parallel with the survey conducted in the hospital environment, the *Office français de prévention du tabagisme* (OFT: French Office for the Prevention of Smoking) records the locations of non-hospital tobacco science consultations and conducted a survey of them, also in a given week (January 2000 and January 2001). The same questionnaire as for the survey of hospital managements was sent to them by post.

In 20000, of the 153 locations selected by the OFT, only 58 replied. The low rate of participation (38% despite posted reminders) means that the result must be carefully analysed. The non-responses generally came from private agencies for which tobacco withdrawal is only a sideline.

In 2001, 148 locations were identified and the response rate was 57%, higher than that for 2000.

For additional information: DAUTZENBERG (B.), BRÜCKER (G.), BORGNE (A.), JOSSERAN (L.), DRAGOS (S.), FERNANDEZ (C.), JEAN-FRANÇOIS (M.), " Developments in the area of non-hospital tobacco science consultations between 2000 and 2001 », *BEH (weekly epidemiological bulletin)*, no. 22-23, 2001, p. 103-104.

24 - Survey of consultations to assist in stopping smoking in 1999, Office français de prévention du tabagisme (OFT: French Office for the Prevention of Smoking)

Consultations on stopping smoking were identified by different organisation in June 1998 with a view to producing a specialised yearbook. Only those with a regular frequency were retained.

In July, 1999, 321 consultation centres to assist in stopping smoking, among which were 201 tobacco science consultations, were surveyed. They are primarily installed in hospitals (CHU - *Centre hospitalier universitaire*: University Hospital Centre or general hospitals), but also in public prevention structures or even private structures (particularly private agencies). For this reason, a substantial part of the consultations took place in the pneumology services or in general medicine.

The questionnaire, completed between December 1998 and May 1999 covered the identification of the structure and to a series of 23 questions in relation to its operation. By the 21st July 1999, 321 questionnaires had been collected.

For additional information: DAUTZENBERG (B.), YOUSSI (D.), MÉLIHAN CHEININ (P.), COMBRET (P.), "Consultations to assist in stopping smoking in France », *BEH (Bulletin épidémiologique hebdomadaire: Weekly epidemiological bulletin)*, no. 51, 1999, p. 213-215.

25 - An inventory of tobacco withdrawal 98, Comité français d'éducation pour la santé (CFES: French Centre for Health Education) and the Caisse nationale d'assurance maladie des travailleurs salariés (CNAMTS: Salaried Employees National Illness Insurance Fund)

This telephone survey, conducted in August 1998, covered a sample of 2,006 individuals of 18 years of age and over, and representation was ensured by quota (age, gender, profession of the head of the family) after stratification by regions of residence and category of city.

For additional information: IFOP *(Institut français d'opinion publique*: French Institute of Public opinion), *An inventory of tobacco withdrawal. Detailed results,* Vanves, CFES/CNAMTS, 1998, p. 56

26 - CANAM (Caisse nationale d'assurance maladie des professions indépendantes: National Illness Insurance Fund for independent professions) Survey on the consumption of psychotropic drugs by out-patients, Régime d'assurance maladie des professions indépendantes (Illness Insurance Scheme for independent professions)

This survey was based on the recording of all prescriptions containing at least one psychotropic medication, in six regions (Centre, Ile-de-France, Lorraine, Midi-Pyrénées, Pas-de-Calais, Poitou-Charentes) and conducted on a given day in February 1996. The drugs sought were psychotropes of any kind.

Of 25, 378 prescriptions examined, 2,952 prescriptions with at least one psychotrope were analysed.

For additional information: CANAM (*Caisse nationale d'assurance maladie des professions indépendantes*: National Illness Insurance Fund for independent professions), *The prescription of psychotropes for out-patients*, Saint-Denis, CANAM, 1997, p. 7.

27 - Actions et programmes de prévention – recensement (APPRE: Prevention Actions and Programmes - census), Observatoire français des drogues et des toxicomanies (OFDT: French Observatory of Drugs and Drug Addiction)

Tested in 2000, APPRE is a programme launched by the MILDT (*Mission interministérielle de lutte contre la drogue et la toxicomanie*: Interministerial Mission for the Fight Against Drugs and Drug Addiction) which records all the prevention actions against use, abuse or dependence related to psychoactive drugs, undertaken on the 1999 expenses. Thanks to questionnaires distributed to "drugs and drug dependence" project heads, this system allowed the OFDT (the project manager) to collect information on 539 actions. The thirty French departments who participated were fairly well spread throughout the French territory (rural or urban zones) and the prevalence reported are considered as representative of the general situation.

For additional information: data collected by the OFDT which has not yet been published.

Criminal statistics

28 - Fichier national des auteurs d'infractions à la législation sur les stupéfiants (FNAILS: National Record of Drug Law Offenders), Office central pour la répression du trafic illicite de stupéfiants (OCRTIS: Central Office for the Repression of Drug-related Offences)

All the proceedings for offences against the narcotics legislation established by the police and gendarmerie service in France (including the Overseas Departments) are recorded in FNAILS. As regards the activities of the customs services, FNAILS does not generally take into account customs offences which are not subject to proceedings.

In parallel, OCRTIS is the recipient of the majority of the corresponding proceedings (excluding the gendarmeries and Ile-de-France). They are used to re-qualify some data provided by the police services (which explains a certain difference between these statistics and those for crimes and offences produced by the police services[3]).

FNAILS has information in relation to:

- cases of police interrogation, broken down into simple use, use/dealing, local trafficking and international trafficking;
- seizures;
- deaths from overdoses.

In all cases, the drug referred to is the "dominant drug", which is that mainly consumed by the user, or that held in the largest quantity by the trafficker. When this rule cannot be applied, the "hardest" drug is used: heroin comes ahead of cocaine, which comes ahead of cannabis, etc.

The variables available to describe the cases of interrogation are: the type of offence, the primary drug in question and the characteristics of the persons involved (gender, professional category and nationality).

The variables in relation to seizures are: the quantity seized, the number of operations undertaken, the drug in question and the countries of origin and destination when they can be identified.

For additional information: OCRTIS (Office central pour la répression du trafic illicite des stupéfiants: Central Office for the Repression of Drug-related Offences), *Use and trafficking of narcotic drugs in France in 2000*, Paris, Ministry of the Interior, 2001, p. 114

29 - Deaths from overdose detected by the police services, Office central pour la répression du trafic illicite de stupéfiants (OCRTIS: Central Office for the Repression of Drug-related Offences)

OCRTIS records all the deaths from overdose which are brought to the knowledge of the police services. These are overdoses in the strictest sense together with various fatal accidents directly and immediately related to the conditions of administration of the drug.

In the case of a suspect death (crime, accident, suicide, sudden death, overdose), the doctor certifying the death prevents interment so that a judicial procedure can be started. When this procedure is opened, and when the suspected cause is death from overdose, OCRTIS receives a telex and the case is entered in the personal database. The report is subsequently received by OCRTIS. Moreover, when the drug at the origin of the overdose is not given, OCRTIS contacts the service that provided the information in order to ascertain the result of the toxicological analyses. In rare cases, the recorded cause of death is revealed not to be the overdose.

The variables recorded deal with the socio-demographic characteristics of the deceased person, the location of death (public roadway, home, hospital, others) and the drugs in question.

For additional information: OCRTIS (Office central pour la répression du trafic illicite des stupéfiants: Central Office for the Repression of Drug-related Offences), *Use and trafficking of narcotic drugs in France in 2000*, Paris, Ministry of the Interior, 2001, p. 114

[3] Ministry of the Interior, Central administration of the criminal investigation department, *Aspects of criminality and delinquency detected in France in 2000 by the police services and units of the gendarmerie*, Paris, Documentation française, 2001, p. 200.

30 - Casier judiciaire national (CJN: National Criminal Record register), Sous-direction de la statistique, des études et de la documentation (SDSED: Statistics, studies and documentation Sub-division) – Ministry of Justice

The information on convictions has been produced, since 1994, from the national criminal record register. It outlines the different offences sanctioned in the convictions pronounced by the judges, the type of proceedings, the type of penalty, the duration and amount thereof and the characteristics of the persons convicted (age, gender and nationality).

As the decision given against a person may be due to a number of offences, it is appropriate to make reference to the concept of principal offence and associated offences.

The principal offence is, in principle, the most serious, although it may also happen that the offences are listed in the order of the facts provided in the report. In the principal offence statistics, therefore, many offences of use are hidden when they are not put at the top of the list of offences. Analysis of the associated offences allows the calculation of all the convictions which include at least one offence of use, irrespective of where it appears on the list of offences. It also allows the presentation of the most frequent associations of offences and the penalties pronounced for each case of association.

Convictions should not be confused with persons convicted. A person who is convicted twice during the year is counted twice in the conviction statistics.

For additional information: Ministry of Justice, General Administration and Equipment Division, Statistics, studies and documentation Sub-division, *Justice Statistical yearbook. 2001 Edition*, Paris, Documentation française, 2001, p. 339.

Ministry of Justice, General Administration and Equipment Division, Statistics, studies and documentation Sub-division, *Convictions in 1999,* Paris, Ministry of Justice, 2001, to be published (Coll. Justice studies & statistics).

31 - Fichier national des détenus (FND: National Prisoners Register) and Quarterly statistics of the imprisoned population, Direction de l'administration pénitentiaire (DAP: Penitentiary Administration Division)

Since 1993, the statistics on the execution of penalties has been established from the *Fichier national des détenus* (FND: National Prisoners Register). This file allows the recording of the flow of cases of imprisonment for the year, that is the number of persons entering or leaving the penitentiary establishment between the 1st January and the 31st December in any year. Only the offence in first place on the committal order is taken into account. As for convictions, this offence is, in principle, the most serious, but it may also be that which was first detected.

The national register also allows the determination of the number of persons present in the penitentiary establishments on a given date. This number is a result of the flows of persons entering and leaving the penitentiary establishments during the year and during previous years. The imprisoned population thus described includes all the individuals (accused and convicted) detained on a given date in the penitentiary establishments in France (Overseas Departments and Metropolitan France).

The quarterly statistics, based on a manual collection, also provide a description and an enumeration of the imprisoned population, on the 1st of each quarter. The level of detail is lower, but the recording is considered more accurate, particularly as regards the structure of the population on the basis of the grounds for detention (the change of status from accused to convicted is not necessarily recorded in the FND (*Fichier national des détenus*: National Prisoners Register).

For additional information: Ministry of Justice, General Administration and Equipment Division, Statistics, studies and documentation Sub-division, *Justice Statistical yearbook. 2001 Edition*, Paris, Documentation française, 2001, p. 339.

Quarterly statistics of the population in care in the closed environment. Situation on 1st January 2001, Paris, Ministry of Justice, Penitentiary Administration Division, Office of studies, forecasting and the budget, 2001, p. 55 (no. 86).

Specific observation structures

32 - Système d'identification national des toxiques et des substances (SINTES: National Identification System for Toxic Substances), Observatoire français des drogues et des toxicomanies (OFDT: French Observatory of Drugs and Drug Addiction)

This system is the product of the grouping of four databases. It contains the physical and chemical description of samples of synthetic substances seized by the law enforcement services and analysed by the police scientific laboratories, the laboratories of the customs services and the laboratory of the IRCGN (national gendarmerie), or collected in various environments (party environment, private evenings, night establishments) by the participants in prevention, healthcare or by researchers and analysed by two hospital toxicological laboratories (Fernand-Widal Hospital in Paris and the Salvator Hospital in Marseilles). The partners involved in the healthcare or prevention process also collect epidemiological data in relation to the contexts of consumption and the profiles of the users of the samples collected.

There is no doubt that all of this data only partly reflects the reality in relation to the consumption of synthetic substances in France. The representativeness of all of the substance analysed is, in effect, difficult to determine, given the illicit nature of this consumption. This database nevertheless has the advantage of grouping a large part of the data collected on a systematic and national basis by the structures which are close to the ground, whether they are part of the law enforcement system or the socio-healthcare system.

For additional information: Bello (P.Y.), Toufik (A.), Gandilhon (M.), *Recent trends, TREND report*, Paris, OFDT, 2001, p. 167

33 - Tendances récentes et nouvelles drogues (TREND: Recent Trends and New Drugs), Observatoire français des drogues et des toxicomanies (OFDT: French Observatory of Drugs and Drug Addiction)

TREND was set up in 1999 with a perspective of complementarity with existing sources. This structure endeavours to detect emerging phenomena, to understand the contexts and methods of use and the various implications of the use of drugs and to monitor developments. Observation takes place in two consumption environments:

- the urban environment, based on 13 sites (Paris, Lille, Toulouse, Bordeaux, Marseille, Dijon, Metz, Rennes, Lyon and the departments of Seine-Saint-Denis, Martinique, Réunion and Guyana), covering the psychoactive substance user population, mainly characterised by "problematic" consumption practices, who are in contact with the healthcare and reception structures, particularly those known as "low threshold".
- the party environment, which means primarily party consumption by the population attending locations where a certain style of music, known as techno, is played, and night establishments.

For additional information: Bello (P.Y.), Toufik (A.), Gandilhon (M.), *Recent trends, TREND report*, Paris, OFDT, 2001, p. 167

Glossary

2C-B (4-bromo-2.5-dimethoxyphenethylamine): drug, belonging to the phenethylamine family, whose effects are close to those of MDMA and LSD, giving physical energy and hallucinations at the same time.

4-MTA (4-methylthioamphetamine): drug – still little known – which has a relatively minor stimulant effect, without generating hallucinations or visual distortions. 4-MTA gives a feeling of calm without euphoria. Its effects are fairly long and last approximately 12 hours. 4-MTA is classified in the narcotics list since the decision of 16th November 1999.

Pure Alcohol: theoretic quantity of alcohol expressed in alcohol in 100 % (or in 100°).

AOC (appellation d'origine contrôlée: Appellation of origin): this is a regulatory category of wine; classification in this category requires compliance with a certain number of conditions, particularly the production regulations.

Control of structure effects: Thanks to statistical modelling (logistical regression) it is possible to analyse a criteria " with all other aspects being equal", by erasing the possible influences of other factors.

Premature death: death occurring before a certain age, above which the observed probability of death becomes higher.

DMT (dimethyltryptamine): powerful hallucinogenic drug with a short period of action (20 to 45 minutes) which is consumed in two forms, natural (DMT is present in around one hundred plants) or synthetic.

DOB (2.5-dimethoxy-amphetamine): drug, belonging to the amphetamine family, whose hallucinogenic properties are similar to those of LSD. The effects may last from 6 to 30 hours.

Healthcare establishments: in the survey of the care of drug addicts in the healthcare and social structures conducted in the month of November, this category includes all the public general hospital establishments or those specialising in psychiatry, private psychiatric hospitals acting as public and nursing homes for mental illnesses.

Specialist establishments: in the survey on the care of drug addicts in the healthcare and social structures conducted in the month of November, this category includes all the *centres de soins spécialisés aux toxicomanes* (CSST: Specialised Centres for the Care of Drug Addicts) and a very low number of structures receiving mainly drug users.

Attributable fraction: the percentage of cases of a pathology or cases of death for a given cause which is the consequence of other events or behaviour, which means, in this report, resulting from the consumption of drugs. The calculation of an attributable fraction (FA) introduces the relative risk of occurrence of a pathology or a death (RR) (see the definition of relative risk in this list) and the percentage of users (P) and non-users (Q) of a drug in a given population. The calculation of FA is done on the basis of the following formula:

$$FA = (Q + P \times RR-1)/(Q + P \times RR)$$

Expressed in other terms, by using the example of alcohol, this means that knowing the additional risk (RR) of having a cirrhosis among intensive users of alcohol (by comparison with the rest of the population) and knowing the proportion of intensive users of alcohol (P) in the French population, together with those persons who do not have an intensive use of alcohol (Q), a proportion of cirrhoses related to the consumption of alcohol can be deduced.

Free -party: a gathering of techno music followers, often organised without authorisation from the public authorities, generally lasting one or two days.

GHB, Gamma OH (gamma-hydroxybutyrate): an anaesthetic reserved for hospital use. Outside the medical context it is also known under the name of "liquid ecstasy". It comes in the form of a colourless or coloured liquid or as a white crystalline powder. Its use results in a feeling of euphoria and freedom from inhibitions. Its effects are rapidly felt and last form 1 hour and 30 minutes to 2 hours.

Principal offence: for convictions, this is the first offence recorded on the criminal record, in the most serious criminal category. While the majority of jurisdictions record the offences in order of seriousness, some have adopted a chronological order of detection of crimes. For cases of imprisonment, this is the offence recorded in first place on the committal order.

Mandatory treatment: this term designates a measure provided in the context of the law of 31st December 1974 allowing the public prosecutor to suspend proceedings against a narcotics user who accepts being taken into care by the healthcare and social system. For the period of treatment, the user benefits from classification without follow-up. In case of refusal or stopping of treatment, the proceedings can be re-commenced.

Ketamine: an anaesthetic reserved for hospital or veterinary use. By decision of 8th August 1997 (Official Journal of 20th August 97), ketamine and its salts, with the exception of their injectable preparations, are classified as narcotics. The ketamine accessible to consumers in France comes in four forms: phial (pharmaceutical preparation); colourless liquid in various form of packaging; white powder; and tablets.

Khat: khat is a plant which originally came from of oriental Africa and the Arabic peninsula and whose leaves are used as a nerve stimulant. They are generally chewed or taken by infusion. The principal alkaloid in the plant is cathinone, which acts as a stimulant of the central nervous system and whose effects are similar to those of amphetamines.

MDMA (3.4-methylenedioxymetamphetamine): drug belonging to the methamphetamine family. Its period of action is from 4 to 6 hours. MDMA produces a number of stimulant effects: increase in cardiac rate, respiratory acceleration, excessive energy and hyperactivity. This drug is classified in the narcotics list since the decision of 9th July 1986.

Psychotropic medications: the following classes of medications are included in this category:

- hypnotics (or sleeping tablets) and sedatives which induce sleep;
- anxiolytic agents (or tranquillisers) used to combat anxiety;
- antidepressants prescribed for cases of depression;
- neuroleptics (or antipsychotics) mainly used for the treatment of psychoses.

Mescaline: The main active ingredient in peyotl and other hallucinogenic plants. Its effect last approximately 12 hours and are similar to those of LSD.

Multi-drug use: means the fact of consuming at least two psychoactive drugs. In general, multi-drug use refers to a given level of use: or example, multi-drug experimentation or repetitive multi-drug use.

Repetitive multi-drug use: means the repetitive use of at least two of the three most common drugs, which are, alcohol, tobacco and cannabis.

Multi-drug experimentation: means the fact of having experimented with at least two psychoactive drugs during life.

Relative price: tobacco price index compared with the general price index.

Primary drug: the drug at the origin of care referred to first, a priori that which causes the most problems for the user.

Secondary drug: the drug at the origin of care referred to in second place.

Nitrous oxide: a gas discovered in 1772, used as an anaesthetic in medicine and a propellant in aerosol sprays. The euphoric effects of this drug have been known since the XIX century. After 8 to 10 seconds inhaling it, this gas produces dizziness and excitement. Its period of action is very short: 2 to 3 minutes.

Rachacha : opium residue made on a small scale, smoked.

Relative risk: this compares the risk in the exposed group with that of the non-exposed group; it compares the number of illnesses and/or deaths among persons exposed to the risk factor with those observed among non-exposed persons.

Open drug scene: a place of sale and consumption of drugs where inhabitants and non-user citizens are confronted with the use and trafficking, in public, of illicit drugs.

Significant: this refers to a difference between two percentages when the probability due to chance is low (5%).

Passive smoking: exposure (often involuntary) to tobacco smoking in the environment.

Teknival : gathering of techno music followers often organised without the authorisation of the public authorities. A teknival (techno party) may last up to seven days and involve between five and fifteen thousand people.

DETA test: a group of four questions originally used by clinicians to detect alcohol users with a risk of dependence. This test is often used now in epidemiological surveys with the purpose of determining a number and proportion of alcohol users with a risk of dependence.

Users interrogated by police: the category “users interrogated by police” includes cases of interrogation for use and use/dealing.

VDQS (vins délimités de qualité supérieure: superior quality wines) : a regulatory category of wine, and classification therein requires compliance with a certain number of conditions at the level of production of the wine.

List of acronyms

2C-B	4-bromo-2.5-dimethoxyphenethylamine
ACSF	Analyse du comportement sexuel des Français: Analysis of the French population's sexual behaviour
AFSSAPS	Agence française de sécurité sanitaire des produits de santé: French Agency for the Sanitary Safety of Healthcare products (ex- Medicines Agency)
AMM	Autorisation de mise sur le marché: Authorisation to be placed on the market
ANAES	Agence nationale d'accréditation et d'évaluation en santé: National Health Accreditation and Evaluation Agency
ANPA	Association nationale de prévention de l'alcoolisme: National Association for the Prevention of Alcoholism
ANPE	Agence nationale pour l'emploi: National Employment Agency
ANRS	Agence nationale de la recherche sur le Sida: National Agency for AIDS Research
AOC	Appellation d'origine contrôlée: Appellation of origin
APPRE	Actions et programmes de prévention – recensement:: Prevention Actions and Programmes - census
AREMEDIA	Association de recherche européenne pour la médecine et l'informatique interactive: European Research Association for medicine and interactive information technology
ARMI	Association de recherche sur les marchés informels: Informal Markets Research Association
BO	Bulletin official: Official Bulletin
BOEN	Bulletin officiel de l'Éducation nationale: Official Bulletin of National Education
CADIS	Centre d'analyse et d'intervention sociologique: Centre for sociological analysis and intervention
CAN	Centralförbundet för alhohol- och narkotikaupplysning / Conseil de l'information sur l'alcool et les autres drogues (Suède): Council for Information on Alcohol and other Drugs (Sweden)
CANAM	Caisse nationale d'assurance maladie des professions indépendantes: National Illness Insurance Fund for independent professions
CCAA	Centres de cure ambulatoire en alcoologie: Alcohol Out-patient Treatment Centres (ex-CHAA)
CDD	Contrat à durée déterminée: Fixed-term contract
CDIT	Centre de documentation et d'information sur le tabac: Tobacco Documentation and Information Centre
CDO	Convention départementale d'objectifs: Departmental Objective Agreement
CDPA	Comité départemental de prévention de l'alcoolisme: Departmental Committee for the Prevention of Alcoholism
CEIP	Centre d'évaluation et d'information sur la pharmacodépendance: Drug Addiction Evaluation and Information Centre
CEL	Contrat éducatif local: Local Education Contract
CESAMES	Centre de recherche psychotropes, santé mentale et société (CNRS Paris V) (ex -GDR)
CESC	Comité d'éducation à la santé et à la citoyenneté: Health and Citizenship Education Committees
CESDIP	Centre de recherches sociologiques sur le droit et les institutions pénales: Centre for sociological research on the law and the criminal institutions

CESES	Centre européen pour la surveillance épidémiologique du Sida: European Centre for the Epidemiological Monitoring of AIDS
CFES	Comité français pour l'éducation à la santé: French Committee for Health Education
CHAA	Centre d'hygiène alimentaire et d'alcoologie: Food and Alcohol Hygiene Centre (see CCAA)
CHG	Centre hospitalier général: General Hospital Centre
CHU	Centre hospitalier universitaire: University Hospital Centre
CIM 10	Classification internationale des médicaments de l'Organisation mondiale de la santé: International Classification of medications by the World Health Organisation 10^{th} revision
CIRDD	Centre d'information et de ressources sur les drogues et les dépendances: Information and Resource Centres for Drugs and Drug Dependence
CJN	Casier judiciaire national: National Criminal Record register
CLS	Contrat local de sécurité: Local Safety Contract
CNAMTS	Caisse nationale de l'assurance maladie des travailleurs salaries: Salaried Employees National Illness Insurance Fund
CNRS	Centre national de la recherche scientifique: National Centre for Scientific Research
CODES	Comité départemental d'éducation pour la santé: Departmental Committee for Health Education
CPLD	Conseil de prévention et de lutte contre le dopage: Council for the Prevention and Fight against Doping
CREDES	Centre de recherche, d'étude et de documentation en économie de la santé: Centre for the Research, Study and Documentation of the Health Economy
CRES	Comité régional d'éducation pour la santé: Regional Committee for Health Education
CRIPS	Centre régional d'information et de prévention sur le sida: Regional Information and Prevention Centre for AIDS)
CRPS	Comité régional des politiques de santé: Regional Committee for Health Policies
CSA	Conseil supérieur de l'audiovisuel: Higher Council for the audio-visual industry
CSST	Centre spécialisé de soins pour toxicomanes: Specialised Centres for the Care of Drug Addicts
DACG	Direction des affaires criminelles et des grâces: Department of Criminal Affairs and Pardons
DAGE	Direction de l'administration générale et de l'équipement: General Administration and Equipment Division
DAP	Direction de l'administration pénitentiaire: Penitentiary Administration Division
DATIS	Drogues alcool tabac info service: Drugs, Alcohol and Tobacco Information Service (ex-DIS)
DCPJ	Direction centrale de la police judiciaire: Central Administration of the Criminal Investigation Department
DCSSA	Direction centrale du service de santé des armées: Central Management for the Military Health Department
DDASS	Direction départementale des affaires sanitaires et sociales: Departmental Management for Health and Social Action
DDJS	Direction départementale de la jeunesse et des sports: Departmental Division for Youth and Sports
DESCO	Direction de l'enseignement scolaire: Department of Academic Education
DGDDI	Direction générale des douanes et droits indirects: General Department of Customs and Indirect Duties
DGGN	Direction générale de la gendarmerie nationale: Central Administration of the National Gendarmerie
DGLDT	Délégation générale à la lutte contre la drogue et la toxicomanie: General Delegation for the Fight Against Drugs and Drug Addiction (see MILDT)
DGS	Direction générale de la santé: General Health Department
DGS-SD6A	Direction générale de la santé - Sous-direction santé et société - Lutte contre le VIH: General Health Department – Health and Society sub-division – Fight against HIV (ex-SP2)
DGS-SD6B	Direction générale de la santé - Sous-direction santé et société - Pratiques addictives: General Health Department – Health and Society sub-division – Addictive practices (ex-SP3)
DH	Direction des hôpitaux: Hospitals Division (see DHOS)

DHOS	Direction de l'hospitalisation et de l'organisation des soins: Department of hospital management and healthcare organisation (ex-DH)
DHOS-O2	Direction de l'hospitalisation et de l'organisation des soins: Department of hospital management and healthcare organisation - Organisation of the regional supply of healthcare and specific populations (ex-DH-EO2)
DIS	Drogues infos service: Drugs Information service (see DATIS)
DMT	Dimethyltryptamine
DOB	2.5-dimethoxy-amphetamine
DPJJ	Direction de la protection judiciaire de la jeunesse: Youth Judicial Protection Division
DRAMES	Décès en relation avec l'abus de médicaments et de substances: Deaths Related to the Abuse of Medications and Substances
DREES	Direction de la recherche, des études, de l'évaluation et des statistiques: Department of Research, Studies, Evaluation and Statistics
DRJS	Direction régionale de la jeunesse et des sports: Regional Division of Youth and Sports
DSM	Diagnostic and Statistical Manual of Mental Disorders
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction (OEDT)
EPCV	Enquête permanente sur les conditions de vie des ménages: Continuous survey on household living conditions
EROPP	Enquête sur les représentations, opinions et perceptions sur les psychotropes: Survey on the Representations, Opinions and Perceptions in relation to Psychotropic drugs
ESCAPAD	Enquête sur la santé et les consommations lors de l'appel de préparation à la défense: Survey on health and consumption during the Defence Preparation Day
ESPAD	European School survey Project on Alcohol and other Drugs
EVAL	Bureau d'études évaluation médicale, médico-sociale, santé publique: Office for medical, medico-social and public health evaluation studies
FNAILS	Fichier national des auteurs d'infractions à la législation sur les stupéfiants: National Record of Drug Law Offenders
FND	Fichier national des détenus: National Prisoners Register
FNORS	Fédération nationale des observatoires régionaux de la santé: National Federation of Regional Health Observatories
FRAD	Formateurs relais antidrogues: Anti-drug relay trainers
GAPP	Groupe d'analyse des politiques publiques: Public Policy Analysis Group (CNRS - Centre national de la recherche scientifique: National Centre for Scientific Research)
GDR	Groupement de recherche psychotropes politique et société: Psychotropic drugs Policy and Society Research Grouping (CNRS) (see. CESAMES)
GHB	Gamma-hydroxybutyrate
GIP-Justice	Groupement d'intérêt publique: Public Interest Grouping - Justice
HBSC	Health Behaviour in School-aged Children
IFOP	Institut français d'opinion publique: French Institute of Public opinion
IHESI	Institut des hautes études de la sécurité intérieure: Institute for the Higher Study of Internal Security
ILS	Infraction à la législation sur les stupéfiants: Offence against the Narcotics Legislation.
IMS Health	Information médicale et statistique sur la santé: Medical Information and Statistics on Health
INRA	Institut national de recherche agronomique: National Institute for Agronomic Research
INRETS	Institut national de recherche et d'étude sur les transports et la sécurité: National Institute for Transport and Safety Research and Study
INRP	Institut national de recherche pédagogique: National Institute for Pedagogic Research
INSEE	Institut national de la statistique et des études économiques: National Institute for Statistics and Economic Studies
INSERM	Institut national de la santé et de la recherche médicale: National Institute for Health and Medical Research

INTERPOL	Organisation internationale de la police criminelle (also OIPC): International Police Organisation
InVS	Institut de veille sanitaire: National Health Monitoring Institute (ex-RNSP)
IREB	Institut de recherches scientifiques sur les boissons: Institute for Scientific Research on Beverages
IREP	Institut de recherche en épidémiologie de la pharmacodépendance: Institute for the Research and Study of Drug Addiction
JO	Journal officiel: Official journal
LSD	Acide lysérgique diéthylamide: Lysergic diethylamide Acid
MDA	Tenamfetamine
MDEA	N-ethylenamfetamine
MDMA	Methylene-dioxy-3.4-metamphetamine
MENRT	Ministère de l'Éducation nationale, de la Recherche et de la Technologie: Ministry of Education, Research and Technology
MF	Million de francs: Million francs
MILAD	Mission de lutte antidrogue: Anti-Drugs Mission
MILDT	Mission interministérielle de lutte contre la drogue et la toxicomanie: Interministerial Mission for the Fight Against Drugs and Drug Addiction
MNCPC	Mission nationale de contrôle des précurseurs chimiques: National Mission for the Control of Chemical Precursors
MTAS	Ministère du travail et des affaires sociales: Ministry of Employment and Social Affairs
NOR	Système normalisé de numérotation des textes officiels publics: Standardised System for the Numbering of Public Official Texts
OCRGDF	Office central pour la répression de la grande délinquance financière: Central Office for the Deterrence of Serious Financial Delinquency
OCRTIS	Office central pour la répression du trafic illicite de stupéfiants: Central Office for the Repression of Drug-related Offences
OEDT	Observatoire européen des drogues et des toxicomanies: European Observatory of Drugs and Drug Addiction
OFDT	Observatoire français des drogues et des toxicomanies: French Observatory of Drugs and Drug Addiction
OFT	Office français de prévention du tabagisme: French Office for the Prevention of Smoking
OGD	Observatoire géopolitique des drogues: Drugs Geopolitical Observatory
OICS	Organe international de contrôle des stupéfiants: International Organisation for the Control of Narcotics
OMS	Organisation mondiale de la santé: World Health Organisation
ONISR	Observatoire national interministériel de sécurité routière: National Interministerial Observatory for Road Safety
ONIVINS	Office national interprofessionnel des vins: National Interprofessional Office for Wines
ONPCM	Observatoire national des prescriptions et consommations des medicaments: National Observatory of prescriptions and the consumption of medications
OPPIDUM	Observation des produits psychotropes ou détournés de leur utilisation médicamenteuse: Observation of psychotropic drugs or those diverted from medicinal use
ORS	Observatoire régional de santé: Regional Health Observatory
ORSMIP	Observatoire régional de santé Midi-Pyrénées: Midi-Pyrénées Regional Health Observatory
PACA	Provence-Alpes-Côte d'Azur: Provence-Alps-Cote d'Azur
PDI	Programme départemental d'insertion: Departmental Insertion Programme
PFAD	Policier formateur antidrogue: Police anti-drug trainers
PHRC	Programme hospitalier de recherche clinique: Hospital Programme for Clinical Research
PMJ1	Bureau des études, de la prospective et du budget, Sous-direction des personnes placées sous main de Justice: Office for Studies, Forecasting and the Budget, Sub-division for persons in the hands of the law

PRAPS	Programme d'accès à la prévention et aux soins pour les personnes en situation de précarité: Programme for access to prevention and healthcare for persons in precarious situations
PRS	Programme régional de santé: Regional Health Programme
RESSCOM	Recherches et évaluations sociologiques sur la santé, le social, et les actions communautaires: Research and sociological evaluation of health, social and community actions
RMI	Revenu minimum d'insertion: Minimum Insertion Income
RNSP	Réseau national de santé publique: National Public health Network (see InVS)
SCERI	Service de la communication, des études et des relations internationals: Communication, Studies and International Relations Service
SDSED	Sous-direction de la statistique, des études et de la documentation: Statistics, Studies and Documentation Sub-division
SEDAP	Société d'entraide et d'action psychologique: Society for Self-help and Psychological Action
SEITA	Service d'exploitation industrielle des tabacs et allumettes: Service for the industrial use of tobacco and matches (now Altadis)
SESI	Service des statistiques, des études et des systèmes d'information: Statistics, Studies and Information systems Service (see DREES)
SIAMOIS	Système d'information sur l'accessibilité au matériel officinal d'injection et à la substitution: Information system on the availability of sterile injection equipment
SIDA	Syndrome immunodéficitaire acquis: Acquired Immunodeficiency Syndrome
SINTES	Système d'identification nationale des toxiques et des substances: National Identification System for Toxic Substances
SMPR	Service médico-psychologique régional hospitalier: Regional hospital medico-psychological service
SOFRES	Société française d'enquêtes et de sondages: French survey and polling company
STRDJ-DRJ	Service technique de recherches judiciaires et de documentation / Division recherche judiciaire: Technical service for judicial research and documentation / Judicial research division
THC	Tetrahydrocannabinol
TIG	Travail d'intérêt general: Community Service Order
TRAFCIN	Traitement du renseignement et action contre les circuits financiers: Service for the Handling of Information and Action Against Financial Networks
TREND	Tendances récentes et nouvelles drogues: Recent Trends and New Drugs
VAT	Taxe à la valeur ajoutée: Value Added Tax
UCSA	Unité de consultations et de soins ambulatories: Out-patient Consultation and Care Unit
UCT	Unités de coordination de tabacologie: Tobacco Science Co-ordination Units
UNODCCP	United Nations Office for Drug Control and Crime Prevention / Office des Nations unies pour le contrôle des drogues et la prévention du crime
UPS	Unités pour sortants: Units for released persons
VADS	Voies aérodigestives supérieures: Upper aerodigestive tract
VDQS	Vin délimité de qualité supérieure: Superior quality wine
VHB	Virus de l'hépatite B: Hepatitis B Virus (HBV)
VHC	Virus de l'hépatite C: Hepatitis C Virus (HCV)
VIH	Virus de l'immunodéficience humaine: Human immunodeficiency virus (HIV)
WHO	World health organization / Organisation mondiale de la santé