OBSERVATOIRE FRANÇAIS DES DROGUES ET DES TOXICOMANIES

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DRUGS AND DEPENDENCE

INDICATORS AND TRENDS IN 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).

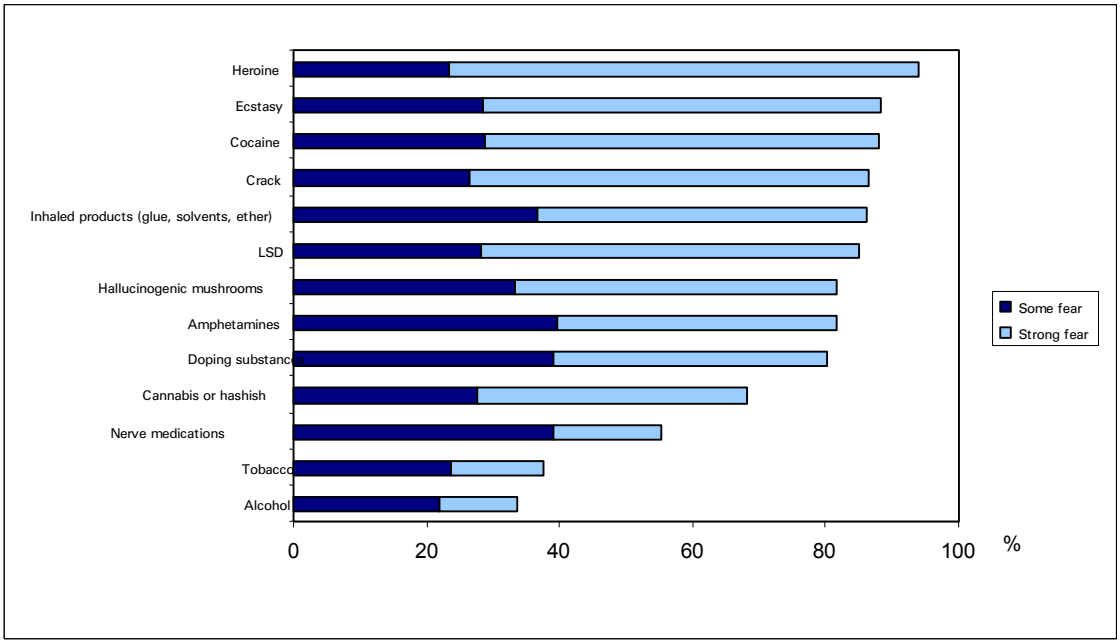
Regarding health risks, heroin and cocaine are considered immediatlely dangerous by a very large majority (85%). Experimentation with ecstasy is least often perceived as dangerous (76%). For more than half of the 15-75-year-olds, cannabis is harmful as soon as it is tried, but one third considers that 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

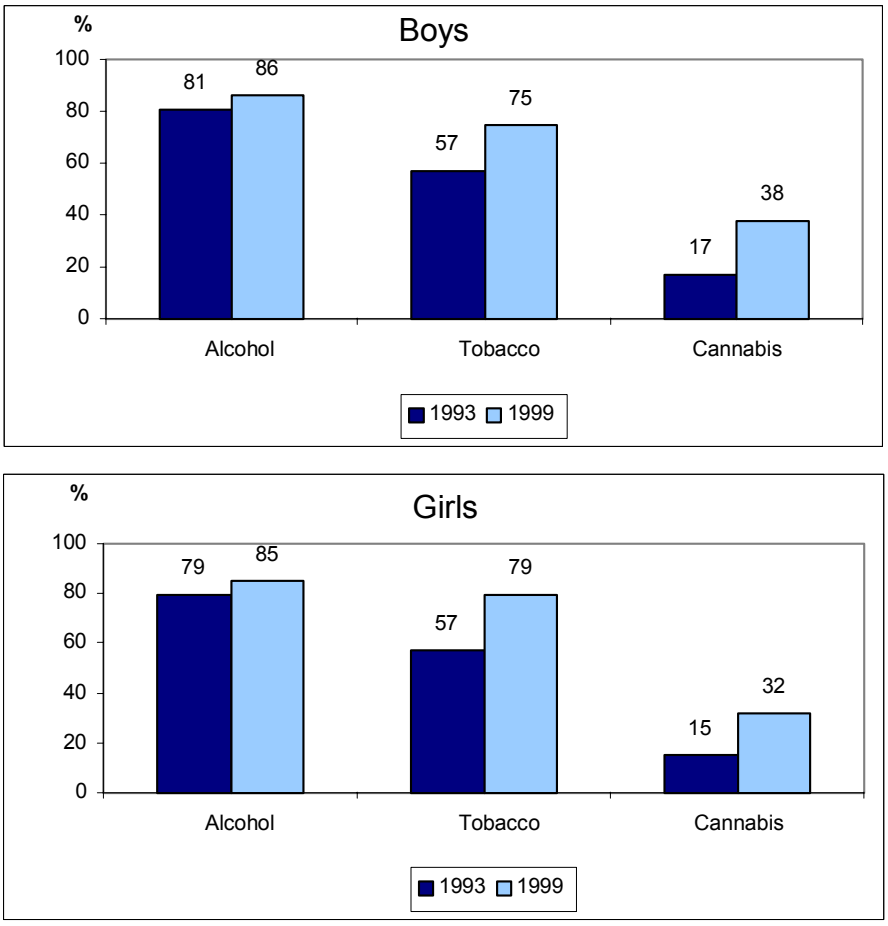
Source: ESCAPAD 2000, OFDT

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].

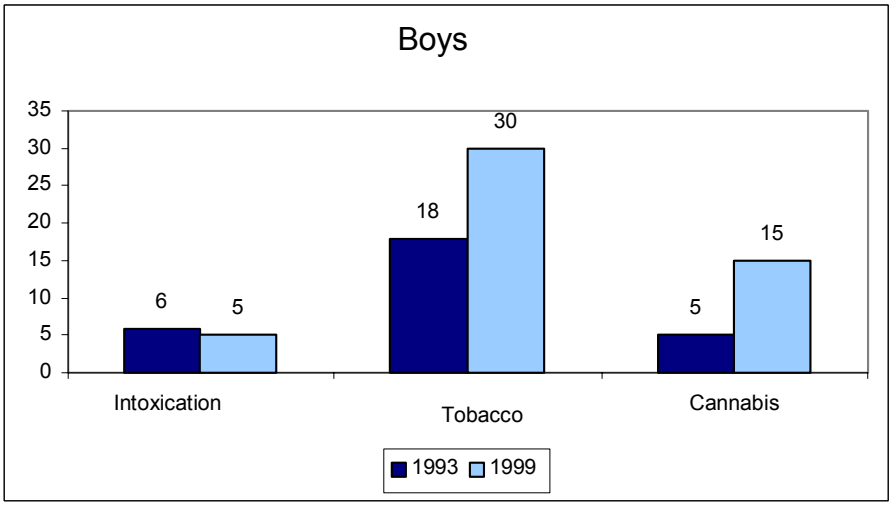
Frequency of experimentation with alcohol, tobacco and cannabis at 16 years in 1993 and 1999, by sex {220a1&2}

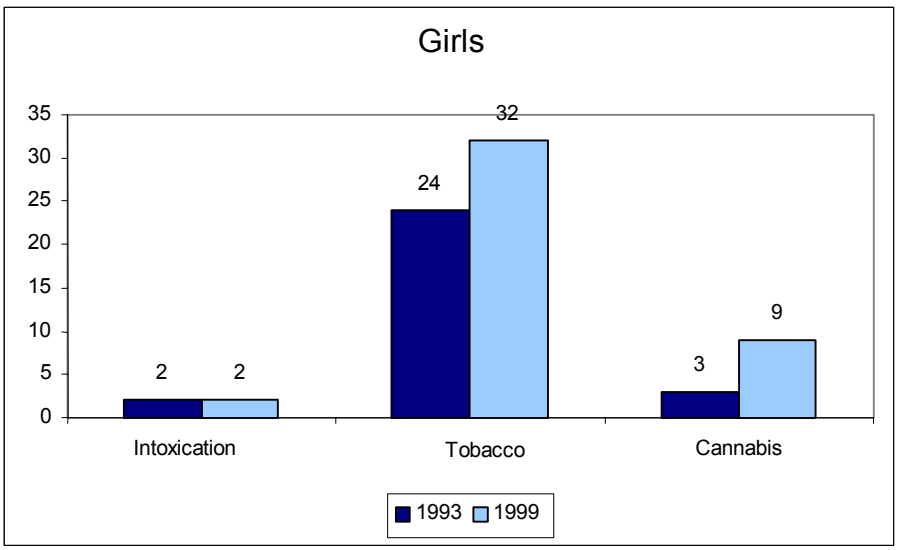


Sources: INSERM 1993 ; ESPAD 1999, INSERM/OFDT/MENRT

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.

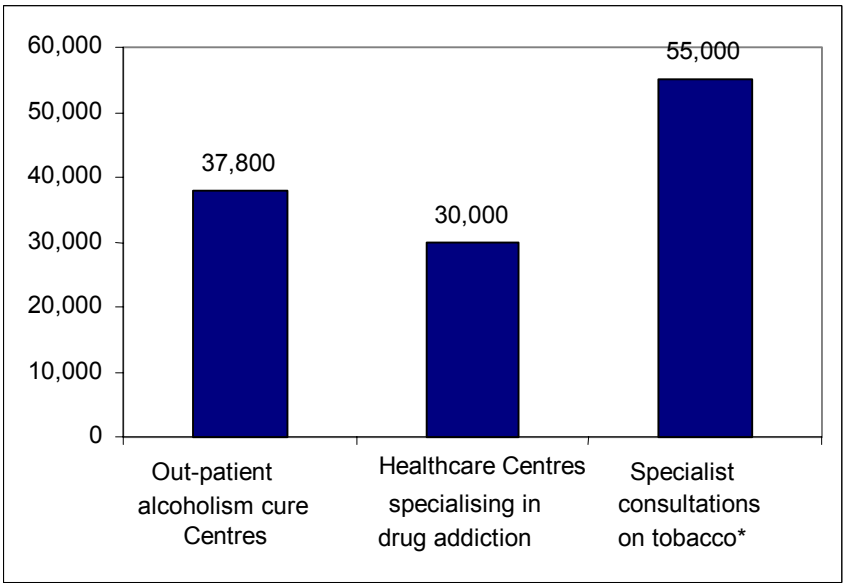
In order to provide a rough estimate of the importance of the different drugs in request of treatment, the number of persons received into the various types of specialised structure was initially put into perspective. Taking account of the multiplicity and heterogeneity of illicit drugs, the cases of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

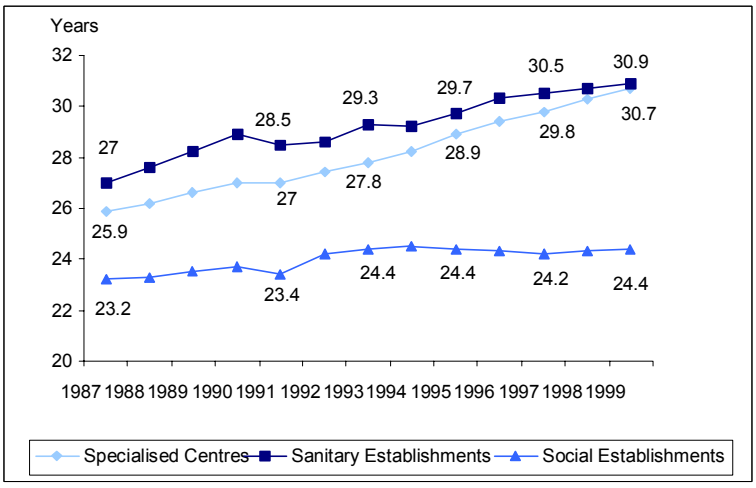
In November 1999, there were a little less than 27,000 cases of care in the healthcare and social structures that responded to the survey [17]. By comparison with 1997, the increase in the number of cases was 6%.

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

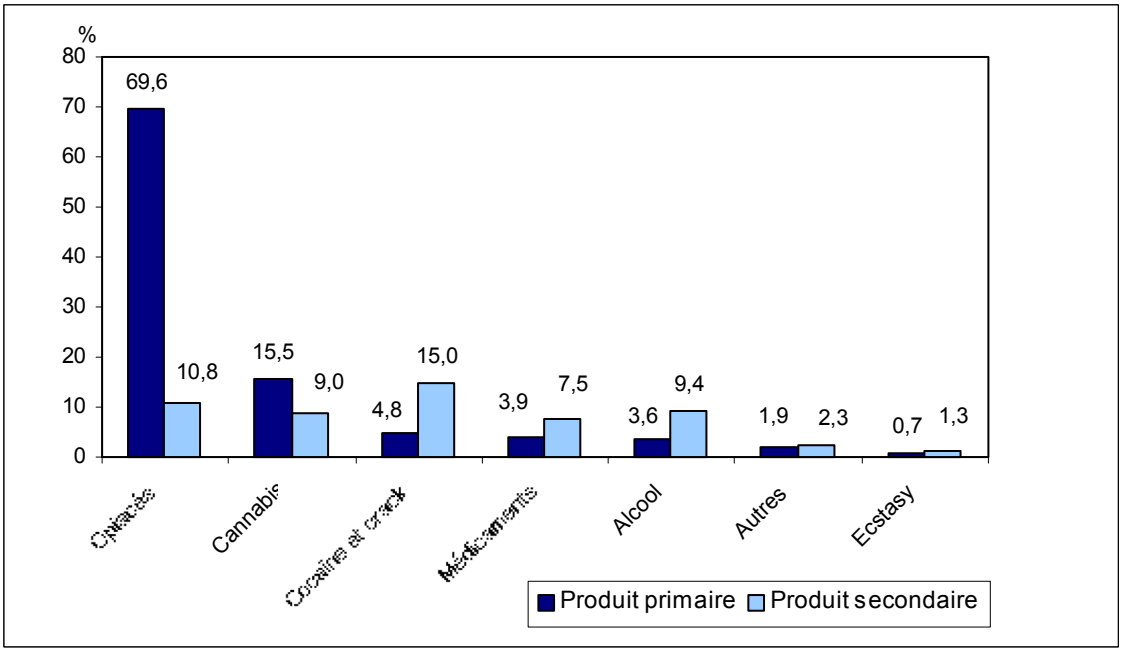
treatments, the share of cases related to opiates exceeds 80%. The figures taken from a survey for a one-month period tend, however, to overestimate the number of these users. These patients, often receiving substitution treatments, attend these healthcare structures more regularly than others, and, 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.

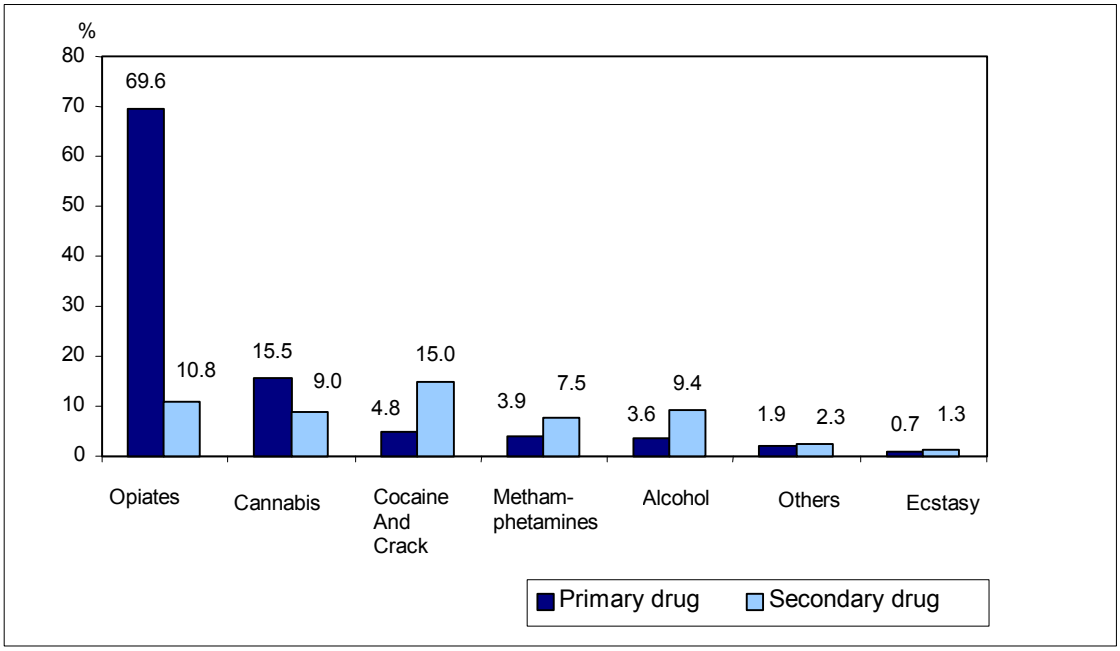
Far behind the opiates, cannabis is the second drug represented in care cases for primary drugs. Its users are considerably different from opiate users, the first being on average five years younger than the second. But cannabis is also mentioned as a secondary drug, most often at the same time in cases 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%).

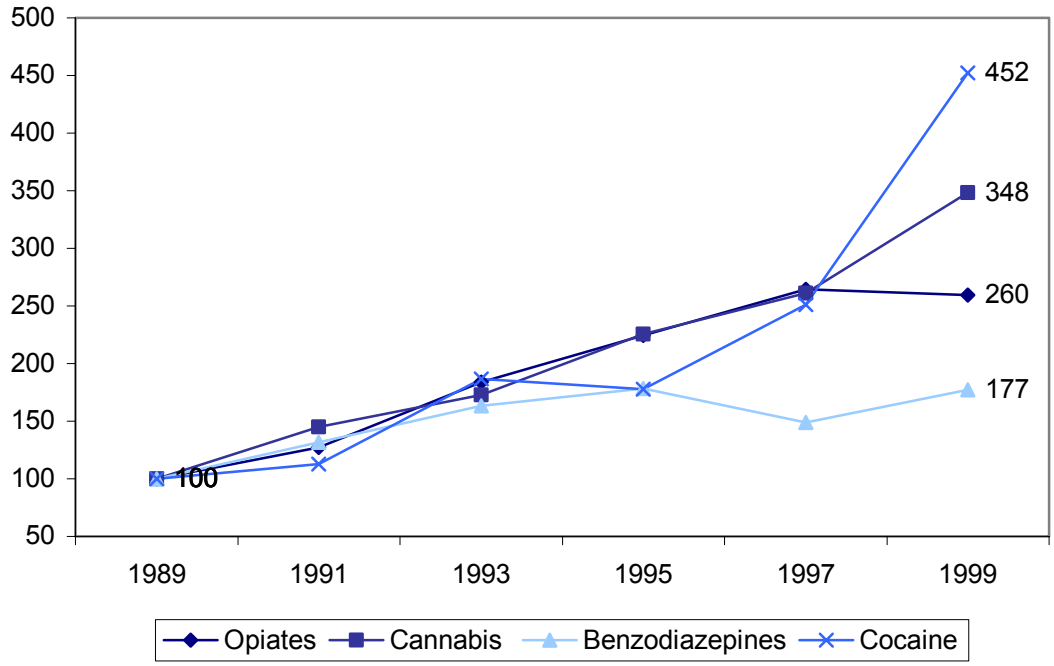
These average percentages vary depending on the drugs at the origin of the care. Substitution treatment was present in three cases out of four for cases related to opiates, one case in two for those related to cocaine

(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.

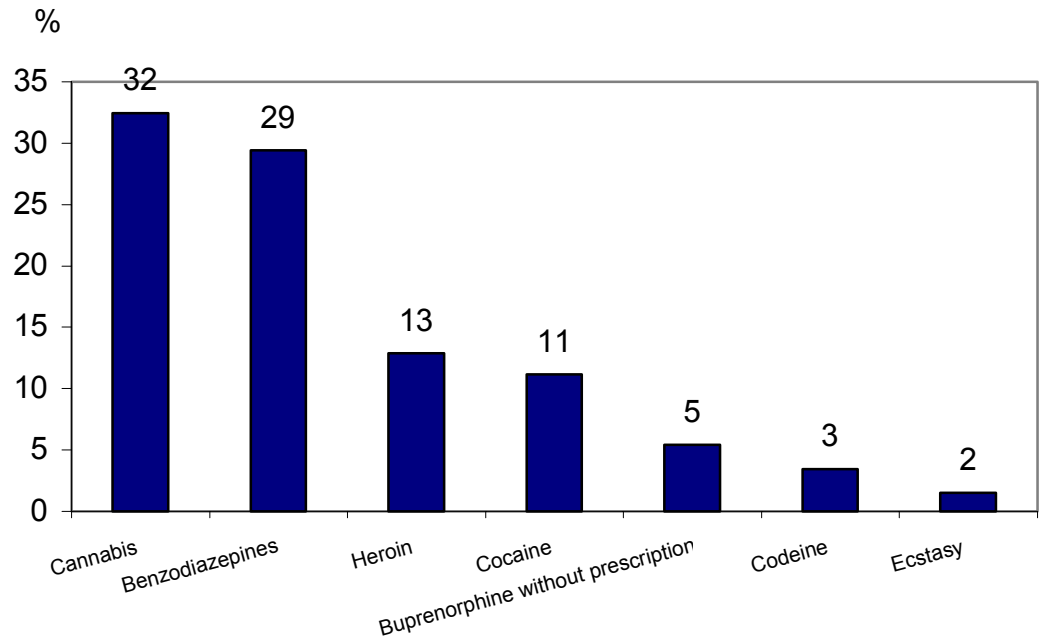
These substances also appear much more frequently amongst the recently consumed drugs (see the section hereunder on drugs consumed).

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

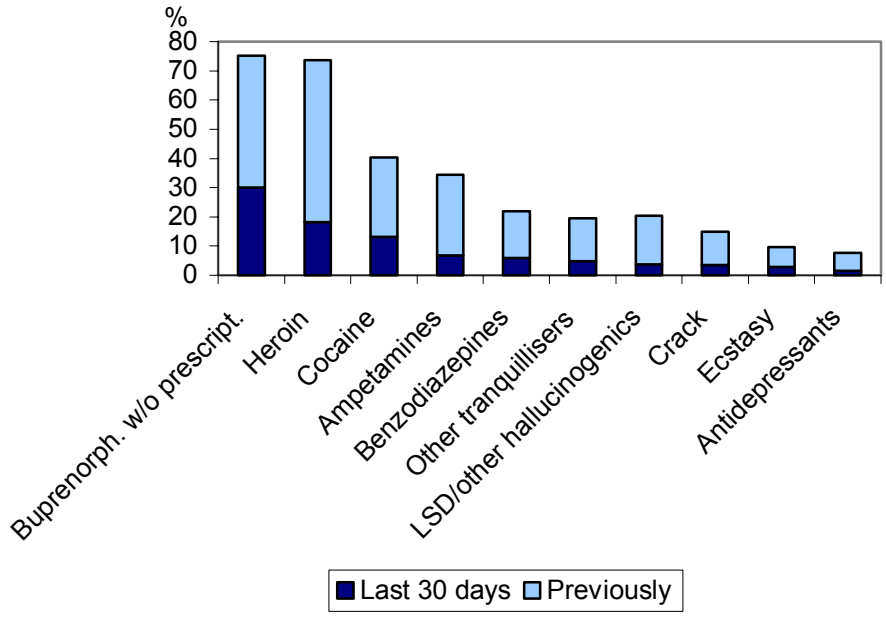
The practice of injection, irrespective of the drug involved, is at the origin of the primary health consequences suffered by drug users (infectious diseases of a viral or bacterial origin, increased risk of overdose, anaphylactic shock, abscesses, etc.) (Emmanuelli, 2000). This is why the observation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

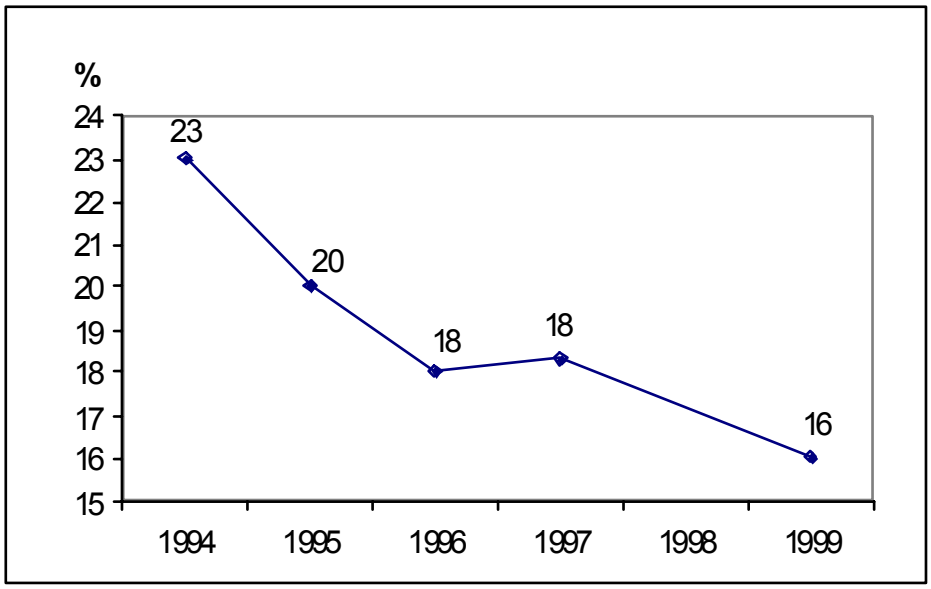
Prevalence of HIV

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}*

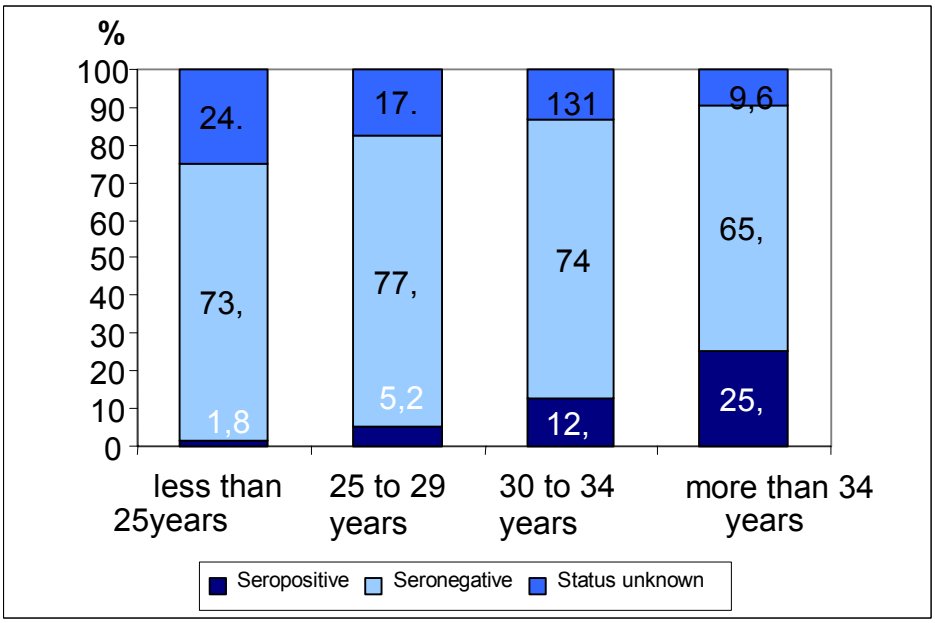


Source: Survey on the care of drug addicts in November, DREES/DGS

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

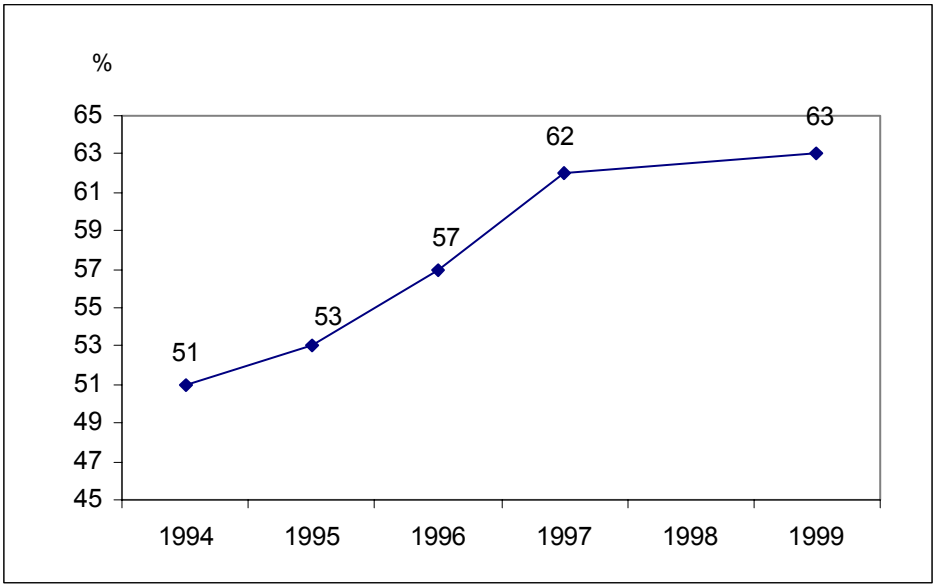
Hepatitis C

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

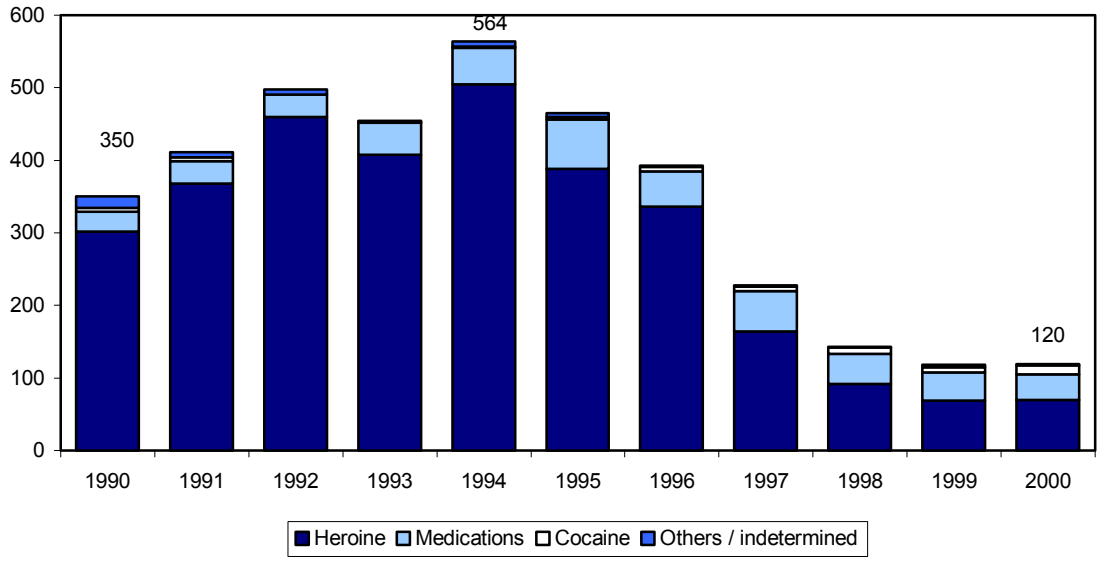
[19] (Décès en relation avec l'abus de médicaments et de substances: Deaths Related to the Abuse of Medicaments and Substances) monitoring structure, as supplied by the CEIP, the Centres d'évaluation et d'information sur la pharmacodépendance: Drug Addiction Evaluation and Information Centres.

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.

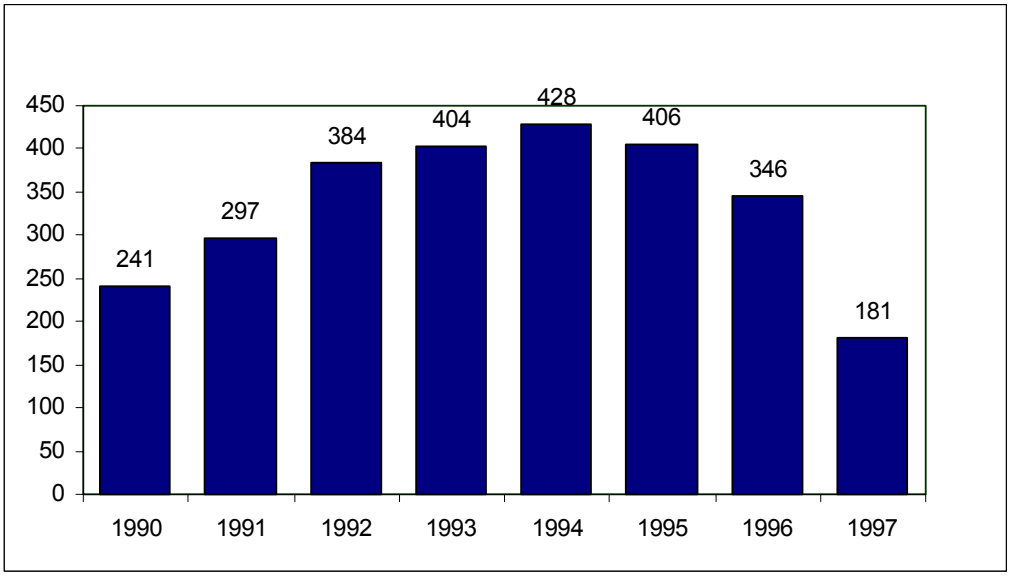
Other measurements of drug-related deaths

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.

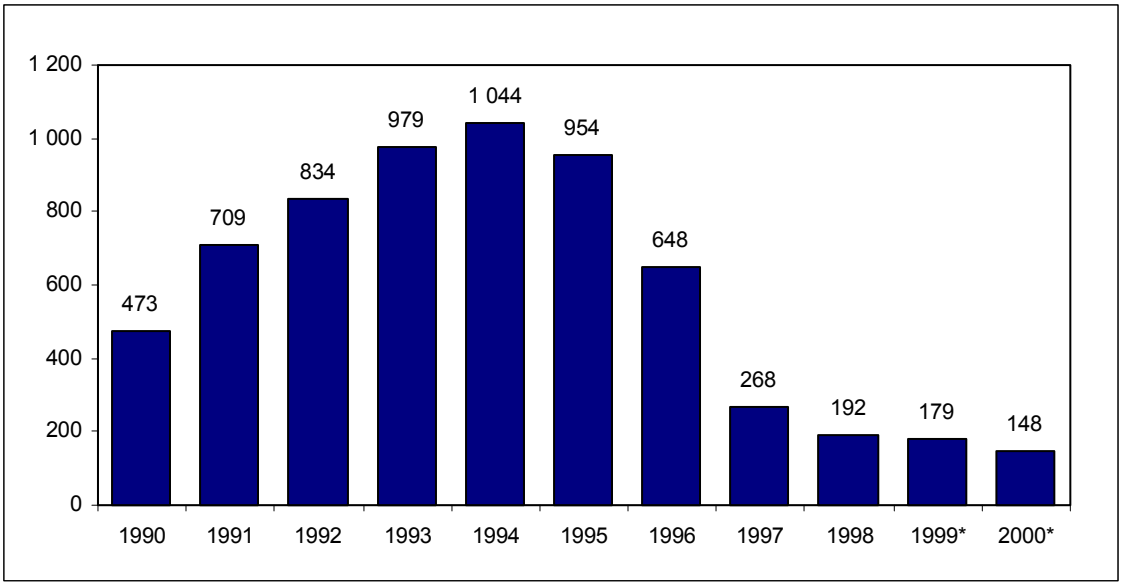
Deaths from AIDS by intravenous drug users.

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.*

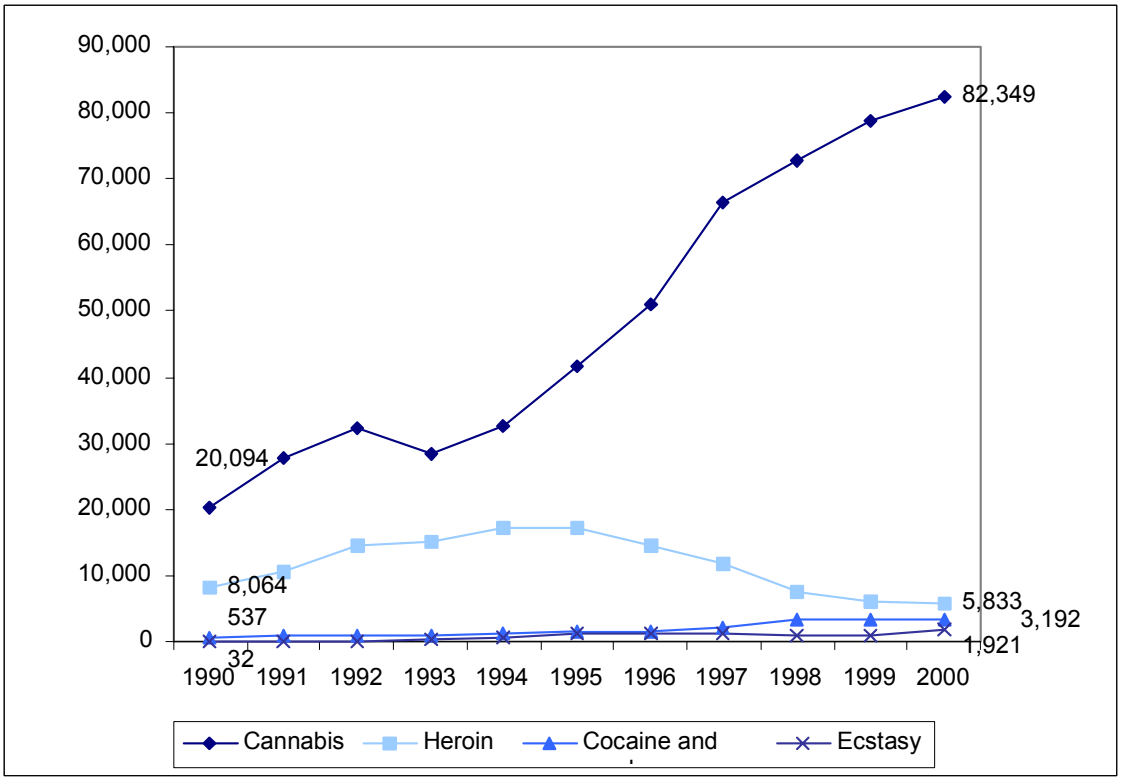
Source: FNAILS 2000, OCRTIS

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.

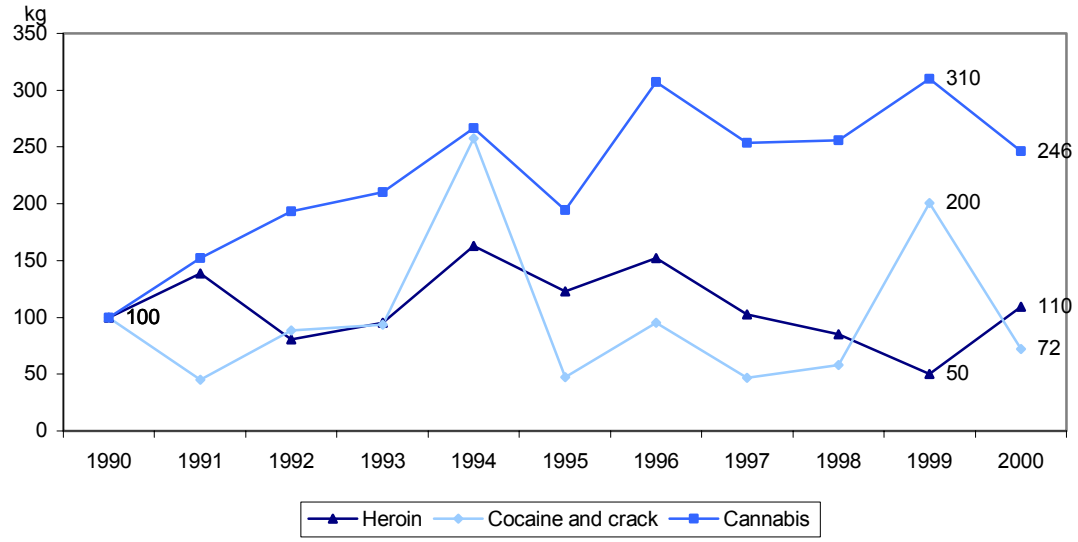
For the first time since 1996, the quantities of heroin seized have grown steadily in 2000. It should be noted, however, that the reduction in 1999 and the increase in 2000 are related to minor variations in the number of major operations involving more than 5 kg. The number of such seizures fell from 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.

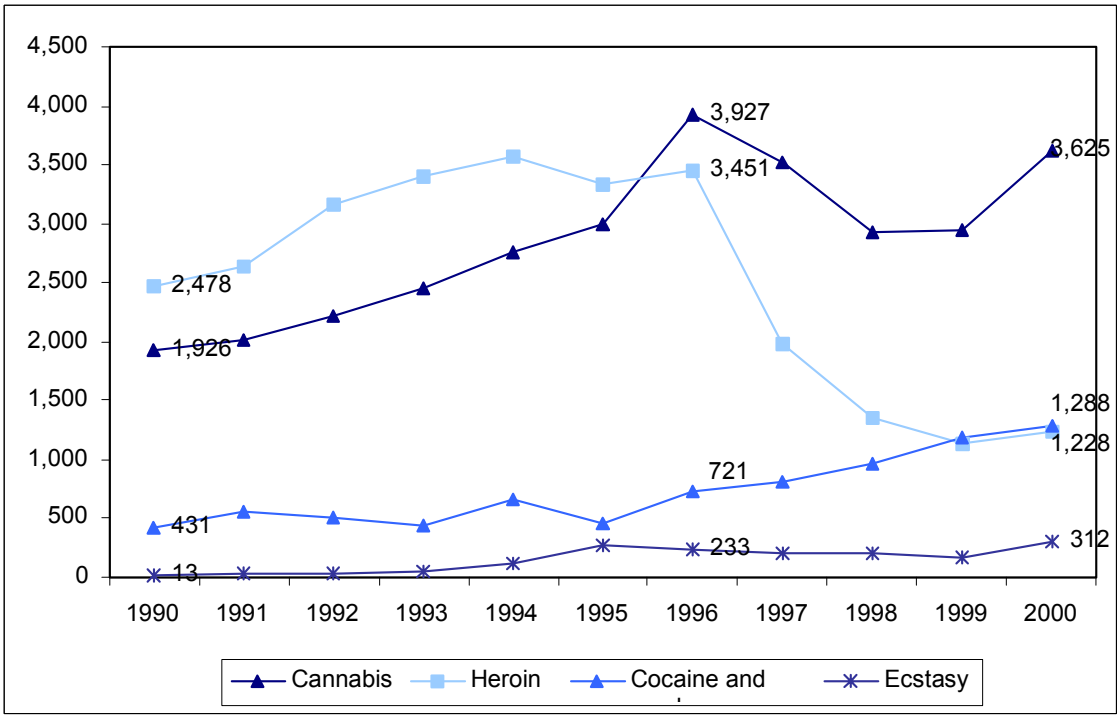
In the cases of police interrogation of small traffickers (local trafficking or dealing activities), cannabis occurs slightly more often (it appears in 60% of cases). But, the main difference is the fact that the cases of international trafficking appear to be strongly related to cocaine.

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 %)

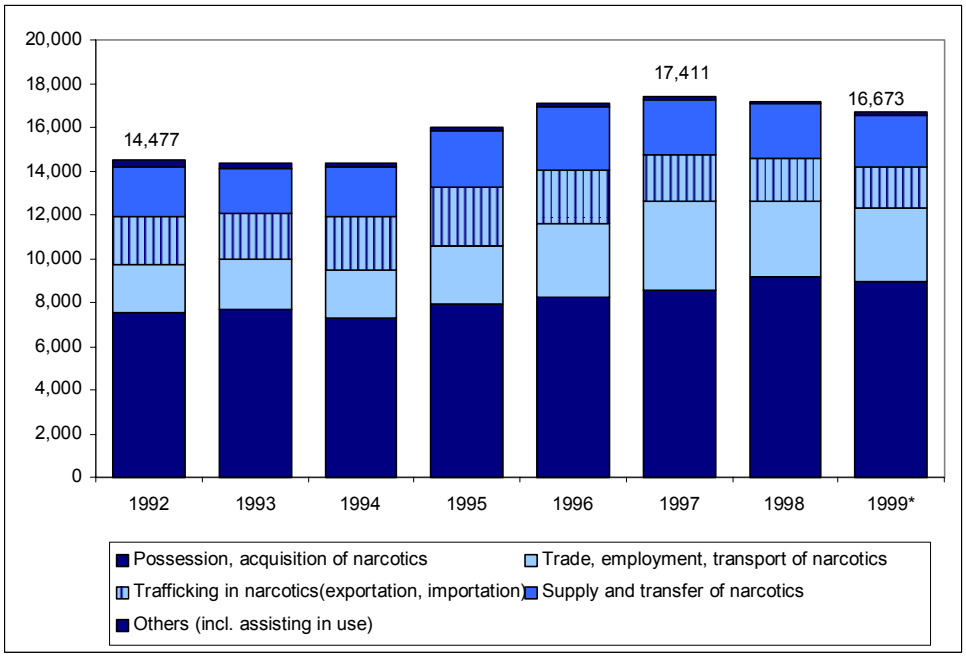
(1) 'Other penalties': Penalty of substitution, educational measure and exemption from penalty
(2) Reading note: 49.2 % of penalties of imprisonment for possession/acquisition as the principal offence are fixed-term.

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.

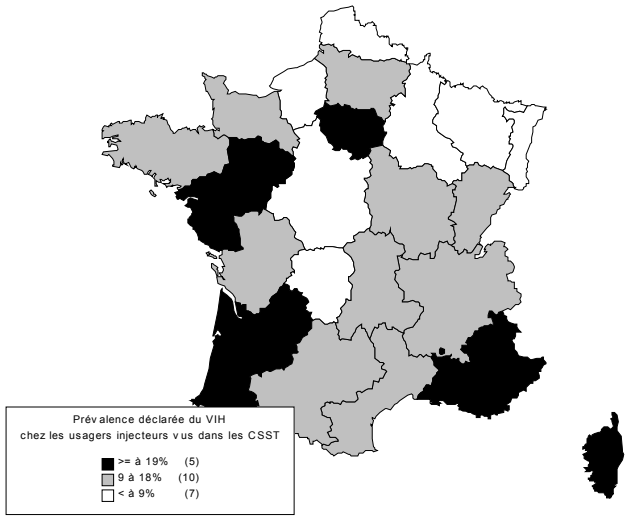
In all regions, the cases of care for a primary drug, related to the number of inhabitants, are more numerous for the opiates than for the other drugs The number of cases per inhabitant related to opiates is, however, particularly high in the regions in the Mediterranean perimeter, Ile-de-France, Alsace 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}*



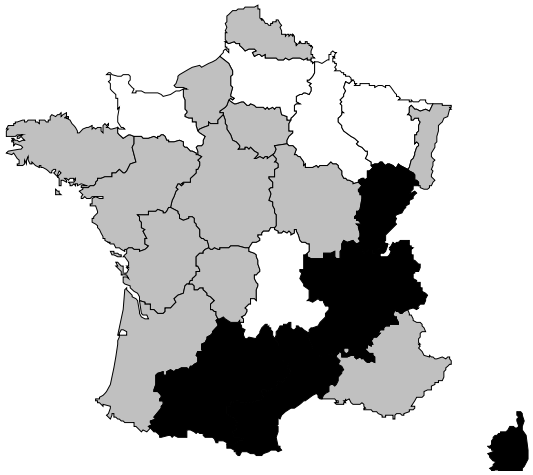
Source: Survey on the care of drug addicts in November 1999, DREES/DGS

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}*

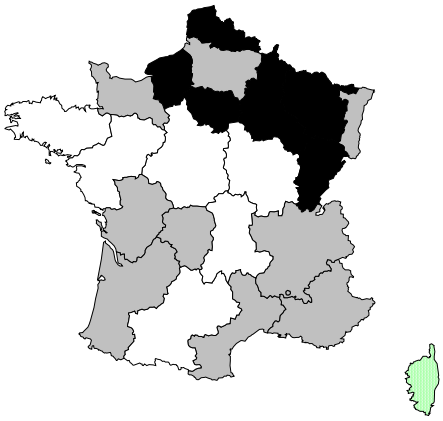


Source: Survey on the care of drug addicts in November 1999, DREES/DGS

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].

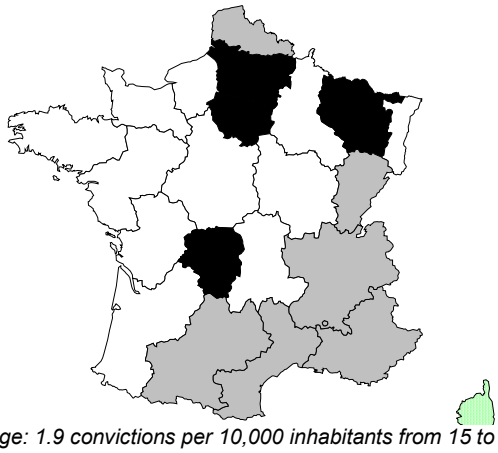
Cases of police interrogation for use alone and use/dealing in 1999 by region *{360a}*



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.

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