OBSERVATOIRE FRANÇAIS DES DROGUES ET DES TOXICOMANIES

2008 NATIONAL REPORT (2007 data) TO THE EMCDDA by the Reitox National Focal Point

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

ENGLISH VERSION

REITOX

Contributions.

Under the supervision of Jean-Michel COSTES (jean-michel.costes@ofdt.fr).

Contributors to the chapters:

Chapter 1: J.-E. Adès, E. Janssen.
Chapter 2: A. Cadet-Taïrou, S. Legleye, O. Le Nezet, S. Spilka.
Chapter 3: C. Mutatayi.
Chapter 4: I. Evrard, A. Cadet-Taïrou, JM Costes, E. Janssen
Chapter 5: I. Evrard, C. Palle, A. Cadet-Taïrou, E. Janssen
Chapter 6: A. Cadet-Taïrou, T. Canarelli, E. Janssen
Chapter 7: A. Cadet-Taïrou, T. Canarelli, E. Janssen
Chapter 8: I. C. Chiltz
Chapter 9: I. Obradovic
Chapter 10: A. Cadet-Taïrou, E. Lahaie, A. Toufik, M. Gandilhon, C. Chiltz.

Proof reading

J. M. Costes, H. Martineau.
The members of the OFDT's Scientific Committee.

Key point.

Sentencing statistics:
Ivana Obradovic (ivana.obradovic@ofdt.fr), Chloé Chiltz (chloe.chiltz@ofdt.fr), Hélène Martineau (helene.martineau@ofdt.fr)

Contents.

SUMMARY

It was against the backdrop of a difficult financial climate that on July 9, 2008, the president of the Interministerial Mission for the Fight against Drugs and Drug Addiction (Mission Interministérielle de Lutte contre les Drogues et la Toxicomanie, MILDT), Etienne Apaire, unveiled the governmental programme for the fight against drugs for the period 2008-2011, drawn up to accompany the Addiction Plan (see NR 2007). From an institutional viewpoint, we should mention the publication of a second decree-law concerning the financing of the Centres for Treatment, Assistance and Prevention of Addiction (Centres de soins, d'accompagnement et de prévention en addictologie, CSAPAs), which include the Specialised Centres for Drug Addicts (Centres spécialisés de soins pour toxicomanes, CSSTs), and the Outpatient Alcoholism Treatment Centres (Centres de cure ambulatoire en alcoologie, CCAAs).

The year 2007 made it possible to finalise the processing and use of several surveys carried out among the general population, and in particular the 2005 Health Barometer (second part). The only new aspects available during the first half of 2008 were the first results from the HBSC survey concerning health and drug use among the 11-15 age group. The 2007 ESPAD survey is still being analysed. The 2008 ESCAPAD project has been successfully carried through, with the publication of the first results scheduled for early 2009.

The ReLION 2007 data has confirmed the trend towards targeted prevention in educational environments (third part). The year 2007 also saw the launch of the first cannabis outpatient clinics, one of the MILDT's showcase measures. These are paid awareness-building courses proposed to young drug users arrested by the police, as an alternative to taking the matter before the courts.

The fourth part offers a new estimate of the number of problem drug users (according to EMCDDA's definition) during 2006. We also present the results from the first CAARUD survey. As an exhaustive national survey, it accompanies the useful contributions made by the PRELUD survey. This survey confirms the somewhat ambiguous role of HDB, which is often cited by patients as the most problematic substance (causing medical, psychological or social problems). The survey also made it possible to observe the widening gap between older users, who are aware of harm reduction issues and younger users, who are more inclined to take risks (including the sharing of injection equipment).

France is still characterised by the high prevalence of HDB used as an opioid substitute method with, however, a number of changes being noted: while three quarters of opioid users receiving treatment at the start of the 2000s were using Subutex®, methadone has been increasingly making a comeback since 2004, and now covers the needs of almost 30% of users undergoing treatment. For its part, the share of morphine sulfate is believed to be marginal (under 5%). Access to methadone in prisons appears to be a reality.

With the exception of DRAMES, (describing the poly-drug use patterns observed), for 2007 we have no new data concerning the mortality levels for each of the various uses of illegal substances. New analyses are currently underway. Since December 2007, we have noted an increase in the number of deaths caused by opioid overdoses in eastern France, concerning a section of the population unknown to the specialised treatment centres. Regarding comorbidity, the data confirms a slowdown in the number of new cases of contamination by HIV and hepatitis C among the drug injecting population (please also see part seven).

The results shown in the eighth part confirm a continued increase in the number of drug law offences up until 2007, with cannabis remaining the leading substance resulting in arrests. The same applies for convictions, even if the only data available to us dates from 2006. It should be noted that this data is accompanied by a specific in-depth explanation (point 13 at the end of the report).

The prevention of offences (in the ninth part) chiefly focuses on saliva tests aimed at detecting the presence of illegal substances among drivers. These tests have been approved by the government for widespread use, which should begin in 2008, despite the reservations of the medical community concerning their effectiveness.

The tenth part discusses the significant increase in seizures of illegal substances by the Police, Gendarmerie and Customs departments. At the same time, the TREND data confirms an increase in retail prices of the main drugs, even if it is difficult to establish a simple cause and effect relationship between reduced supply and the impact on prices in the street.

The 2008 selected issue focuses on arrest and sentencing statistics for drug law offences (*Sentencing Statistics*, Direct link). The first part discusses the French legal framework for drug law offences in terms of the trafficking, dealing and use of illegal substances. The second part includes a presentation of the main sources of information (the Ministry of the Interior and the Ministry of Justice). The third part presents an overview of the latest available statistics.

PART A: NEW DEVELOPMENTS AND TRENDS

1. National policy and background information

National policy: background information

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

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

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

The list of substances covered by the 1970 law (order dated February 22, 1990 establishing the list of substances considered as narcotics) is constantly evolving and regularly includes the addition of new substances recognised as posing a danger by order of the Ministry of Health, following proposals from the general manager of the French Health Products Safety Agency (Agence française de sécurité sanitaire des produits de santé, AFSSAPS)[1].

For a brief presentation of the penal aspects of drug use in France, please refer to the article by (Barré, 2008)[2].

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

In July 2008, the president of the MILDT, Mr Etienne Apaire, presented the Addiction Plan for 2008-2011.

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

The social and cultural context: The vast majority of the population supports the existing measures provided under the harm reduction policy (substitution treatment, the free distribution of syringes, etc.) and generally remains committed

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

2 http://www.cesdip.org/IMG/pdf/EDP_no_105.pdf

to prohibitive anti-drugs measures (opposing the authorisation for cannabis or heroin use under certain conditions, and opposed to the unrestricted sale of cannabis (Legleye et al. (2008)).When the use of illicit drugs is envisaged for therapeutic purposes and under medical control, half state that they would be favourable to the issuing of heroin and three-quarters agree to the medical prescription of cannabis on medical grounds for certain major illnesses.

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

The population will be interviewed once again concerning these issues in late 2008, as part of the Survey on Representations, Opinions, and Perceptions Regarding Psychotropic Drugs (EROPP)

1.1 The legal framework

The law of March 5, 2007 concerning the prevention of delinquency

The law of March 5, 2007 concerning the prevention of delinquency (NOR: INTX0600091L), focuses on the treatment of delinquency among minors, and also includes measures concerning drug use. As an example, judges now have the possibility of ordering medical treatments for drug users. The judge may also issue an additional sentence requiring the offender to attend a training course aimed at building awareness of the dangers of drug use, at the cost of the offender (for further details, please see 9.2).

Furthermore, the law dated March 5, 2007 introduces tougher penalties for cases involving "direct incitation of a minor to transport, hold, propose or transfer drugs" (including up to 10 years' imprisonment and a fine of €300,000). Penalties for offences carried out under the influence of drugs or in a state of drunkenness have also been toughened-hardened?.

Changes to the list of products classified as narcotics

Recently, the following have been classified as narcotics:

- Substances containing aliphatic, cyclic or heterocyclic alkyl nitrates or their isomers intended for users, when not covered by a marketing authorisation (Decree number 2007-1636 of November 20, 2007[3]);

- Oripavine (Decree dated 28/02/2008 published in the *Journal Officiel* on 07/03). This is the French implementation of an international decision made by the UNO following a recommendation from the WHO. Oripavine is an alkaloid derived from poppies, which can easily be converted into thebaine and other synthetic opiates.

- Following the recommendations of the Council, BZP was classified as a narcotic in France in May 2008.

A benchmark for harm reduction activities

The second decree, concerning the operation and financing of Centres for Treatment Assistance and Prevention of Addiction (centres de soins, d'accompagnement et de

3 http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000341445&dateTexte=20080216&fastPos=1&fastReqId=1735414378&oldAction=rechTexte

prévention en addictologie, CSAPA) dates from January 24, 2008. Firstly, it is intended to clarify the budgetary and accounting rules for the CSAPAs and to ensure anonymity for the patients of the centres. Secondly, it makes it possible to repeal the various rules concerning the Outpatient Alcoholism Treatment Centres (Centres de cure ambulatoire en alcoologie, CCAAs) and to modify the rules applicable to the CCAAs and the specialised centres for drug addicts (Centres spécialisés de soins aux toxicomanes, CSSTs) in order that these may be applied to the CSAPAs.

Improved cooperation to fight drug trafficking

Please see below a presentation of the governmental programme.

1.2 The institutional framework, strategies and policies

On July 9, 2008, the MILDT's manager Etienne Apaire, presented the governmental programme for the fight against drugs for the period 2008-2011, intended to accompany the Addiction plan (please see NR 2007). This new plan includes 193 measures covering many aspects of drug addiction. The allocated budget is €87.5 million, which is additional to the financing currently underway.

A key theme of the plan is the focusing of prevention on problem drug use, with universal prevention taking a back seat. The emphasis is placed on:

- Prevention, and in particular the central role played by parents;
- Awareness-building messages aimed at avoiding or at least delaying experimentation, particularly with alcohol (among the measures envisaged we should mention a ban on selling alcohol to minors, a ban on consuming alcohol on the public highway around educational establishments and a ban on fixed-price or "all you can drink" offers or "freebies") ;

Where punishments are concerned, efforts to stamp out sources of supply will include:

- An intensification of the fight against cannabis (particularly "home growing") and the misuse of psychotropic medicines;
- Increased international police cooperation , including countries of the Union for the Mediterranean;
- Tougher economic penalties for traffickers.

E. Apaire also stressed the need to beef up the partnership between the various ministries, including the ministries of the Interior (for the fight against drug trafficking), Employment (for prevention - as 20% of reported accidents are due to drug use), Health and Education (for measures carried out in schools), the Budget and Justice (for the administration of confiscated assets) and Research (in order to set up an addictology research sector in France). The plan will be assessed following its application in 2011.

1.3 Budgetary aspects and public expenditure

The *Loi organique relative aux lois de finances* (the "*organic law pertaining to finance laws*" or "LOLF") of August 1, 2001 brought about a profound reform of the way the State is managed. The State's overall budget is now subdivided into 34 missions, 133 programmes and almost 580 actions whereas previously it was defined on a ministry by ministry basis. There now exists a "drugs and drug abuse" programme (as part of the "health" mission) under the responsibility of the president of the MILDT. For the overall implementation of this programme and the related activities, the MILDT is basing its work on three public interest

groups (*groupements d'intérêt public* or "GIPs") these being the DATIS GIP, the OFDT GIP and the CIFAD GIP (Interministerial training centre for the fight against drugs).
Like all public budgets, since January 1, 2006 the financing of the MILDT has been covered by the organic law pertaining to finance laws (*Loi organique relative aux lois de finances* or LOLF[4]). The MILDT's activities are now focused on three main themes:

Table 1.1. Credits specifically related to interministerial activities aimed at fighting drug addiction, voted for as part of the financing law and implemented in 2006-2007.

Activities	2006	2007	2008
1. Interministerial cooperation for the preventive, health-related and repressive aspects	30.63	31.95	24.58
2. Experimentation with new partnership schemes	5.50	3.05	0.50
3. International cooperation	1.20	1.50	1.50
Total	**37.33**	**36.50**	**26.58**

In million euros. Sources: MILDT; Ministry of Finance.

The 2008 budget saw a significant reduction of more than 27% compared to the previous financial year. In volume terms, this reduction chiefly concerns the first activity. For its part, the budget allocated to activity No.2 was divided by six. The 2009 budget has not yet been voted upon.

1.4 The social and cultural context

In particular, it was tobacco and alcohol which caught the attention of the French media during the period studied - the former at the time the ban was introduced on smoking in cafes, restaurants and other public places on January 1, 2008, and the latter chiefly due to the excess alcohol use of young people and the planned ban on alcohol sales to minors. Alcohol was in the news again when the French results for the HBSC (*Health Behaviour of School Children*) survey were first published in April 2008, following the example of the Figaro, whose headline on the 11th was *"l'initiation à l'alcool commence dès 11 ans"* ("youngsters start drinking as early as 11").

Where illicit drugs are concerned, cannabis provided the main source of interest for the French press.

"Le cannabis mérite-t-il tant de haine ?" ("Does cannabis really deserve its bad reputation?"), asked the cultural magazine *Technikart* in its September 2007 issue, while on the cover of its October 2007 edition, the *Phosphore* monthly magazine for 15- to 25-year-olds poses the question *"Faut-il avoir peur du cannabis ?"* ("Should we be afraid of cannabis?"). Finally, as shown by a news bulletin published on June 26, 2008 by AFP when a monograph was published by the European Monitoring Centre for Drugs and Drug Addiction, cannabis has now become a source of disagreement. Apart from the recurrent debates concerning the harmful characteristics of the product, the theme of cannabis trafficking is raised on several

4 The "LOLF" reforms the order of 1959 and organises the state's budgetary procedure based on two separate goals: a commitment to performance where public management is concerned and greater transparency with regard to budgetary information in order to allow inspection by Parliament. Please see the website of the Ministry of the Economy and Finance for an overall presentation of the budgets and the main activity reports:
http://www.minefi.gouv.fr/themes/finances_etat/budget/index.htm
for the publication of the 2006 budget ;
http://www.performance-publique.gouv.fr/cout_politique/depenses_etat/2007/TSDEPMSNFICHE_MSNSA.htm
for the health budget;
http://www.performance-publique.gouv.fr/performance/politique/pdf/2007/DBGPGMPGM136.pdf
for the specific budget allocated to drugs and drug addiction.

occasions. A study by the OFDT into the estimated earnings of dealers from trading in cannabis was featured in an article published in *Le Figaro* (December 3, 2007) and subsequently in Le Monde (February 15, 2008). At the same time, a working note from the OFDT concerning the estimated expenditure generated by cannabis use provided an opportunity for the February 12 issue of Le Figaro to return once again to this theme, with the headline "tout ado fumeur de haschich risque de devenir dealer" ("All hashish smoking teenagers risk becoming dealers").
The media are also interested in the introduction of paid awareness-building courses for smokers. First mentioned in October 2007 (including in *Le Parisien* of October 11 which interviewed the MILDT's new president Etienne Apaire), these courses were presented by *Le Monde* (January 8, 2008) as "the government's new anti-drug weapon". The official announcement of their introduction came on May 11, 2008 (*Journal du Dimanche*). On July 10, 2008, while discussing the introduction of the new plan, *Le Monde* devoted a new article to the subject, backed by firsthand accounts.

More generally, the presentation of the governmental programme to fight against drugs and drug addiction (2008-2011) has tended to highlight those actions aimed at the very youngest users. "The government is counting on building greater awareness among parents," explained *Le Monde's* headline. Several weeks earlier, while announcing the unveiling of the plan during a visit to a Parisian secondary school, Prime Minister François Fillon had already mentioned "a long battle against drugs" and the role parents are expected to play (AFP bulletin dated June 2, 2008, and *Le Figaro* of June 3, 2008).

During his speech, the Prime Minister was naturally focusing on cannabis, but also on cocaine. And with good reason: this latter substance is the second most frequently mentioned substance by the media. The growth in cocaine distribution throughout Europe had been widely commented on when the annual EMCDDA report was published (in the AFP and Reuters bulletins of November 22, 2007). For its part, *Le Monde* devoted almost a page to this drug on March 2, 2008, with the headline title reminding us that "cocaine use is becoming commonplace". One of the advantages of this issue was that it also discussed the various opportunities open to those drug users keen to kick the habit. Just a few days after *Le Monde,* the subject of cocaine was raised again by *Le Parisien* (March 5). In an interview, Etienne Apaire replied to the question: "Will we one day see cocaine in our junior schools?" by explaining, "This is a risk that cannot be ruled out".

For its part, the weekly magazine *L'Express* devoted its cover page spread to "Cocaine alert" (March 13). This special feature totalled no fewer than 12 pages, beginning with a report from Latin America.

These subjects related to drug trafficking and seizures can still be found in the newspapers. "Record seizures of cocaine by the customs in 2007" stated *le Figaro* on March 19, while for its part *le Point* focused on "the white gold of the inner-city blacks". The question of drug mules is also often discussed. The case of a young girl from Saint Matin who died in Orléans particularly touched the nation's heart: *"Morte à 15 ans, 47 boulettes dans le ventre"* ("Dead at 15 years old with 47 packets in her stomach") announced the Journal du Dimanche on March 30. A month later, it was the turn of the Nouvel Observateur (May 1) to report on these "couriers of death".

Other substances are also the subject of articles from time to time, possibly tied in with the day's news events. For example, in January (January 7) *le Parisien* devoted a double page spread to hallucinogenic mushrooms, discussing the death of a young French woman in Amsterdam and the fact that the Netherlands may ban the open sale of these substances. During April (April 25), the death of a man who had consumed GHB (among other things) during a party provided an opportunity for *Libération* to issue a page spread entitled *"le GHB: de la drogue du violeur à la dragué dure"* (GHB: from date rape drug to killer narcotic).

Finally, during the summer of 2008 the circulation of a press release concerning the risks related to the use of heroin provided a source for several articles. On August 6, *le Parisien* pointed out that "heroin use is on the rise again among young people" while on August 27, 2008, *le Monde* expressed its concern that "more and more young people are hooked on heroin".

2. Drug use

Drug use: the general context

Five levels are usually used in order to categorise the intensity of an individual's drug use. These levels have been drawn up based on indicators used internationally:

- Experimentation: refers to the fact that the individual has used the product at least once during his/her life;
- Occasional use: use at least once a year;
- Monthly use: use at least once during the previous month;
- Recent use: use at least 10 times during the last 30 days;
- Daily use: use every day.

Drug use among the general population: France has several surveys intended to identify this use:

- For the adult population: the *Baromètre Santé* (the "Health Barometer" from the National Institute for Prevention and Health Education – INPES, a four-year survey); *Enquête sur les représentations, opinions et perceptions relatives aux psychotropes*. (Survey of representations, opinions and perceptions regarding psychotropic drugs or "EROPP") carried out every three years by the OFDT) [Standard table Standard table no.1].

- For the school-age population: European School survey Project on Alcohol and other Drugs (ESPAD) carried out every four years (INSERM-OFDT) [Standard table Standard table no.2]. The *Health Behaviour in School-aged Children* (HBSC) provides data on drug use among schoolchildren aged 11, 13 and 15 years old.

- For youths: the Survey on Health and Use on Call-up and Preparation for Defence Day (ESCAPAD) carried out by the OFDT involving young people aged 17 to 19 years old. Among other things the survey makes it possible to question young people who left the educational system early [standard table no.30].

Cannabis is the most frequently consumed illegal product in France and its use has significantly increased over the last 10 years. In 2005, three adults out of 10 in the 15-64 age group had already experimented with cannabis, with fewer than one in 10 using it on an occasional or regular basis. Cannabis use concerns all sections of society even if a number of trends can be observed. Cannabis use tends to be slightly higher among pupils and students, single people, the unemployed and, (among the employed), in the intermediate professions, and far less among workers. However, differences between the various socio-professional categories are not particularly great when considered overall.

Declared experimentation with illicit drugs other than cannabis remains marginal. As an example, it is estimated that there are 12.4 million people experimenting with cannabis, 1.1 million with cocaine, 900,000 with ecstasy or 360,000 with heroin. However, the slight increase in the levels of experimentation among the 18-44 age group with cocaine (3.3% vs. 3.8%), hallucinogens (3.0% vs. 3.6%), and ecstasy between 2002 and 2005 clearly bears witness to the increasing distribution of these substances. For their part, the levels of experimentation with heroin have remained stable over the last decade.

Regardless of the substance considered, males living in major urban centres have a higher propensity to experiment. People experimenting with illicit drugs are very often unemployed or living on scant material resources, with the notable exception of those experimenting with cannabis who tend to be better integrated socially.

At 17 years of age, after tobacco, alcohol and cannabis (53.2% among boys and 45.6% among girls) and psychotropic medicines, the products most frequently experimented with are: poppers (5.5%), hallucinogenic mushrooms (3.7%), inhalation products and ecstasy (3.5%) and, to a lesser extent, cocaine (2.5%), amphetamines (2.2%) and LSD (1.1%), (source: ESCAPAD 2005 (Legleye et al., 2008).

Drug use among specific groups: the most recent investigations carried out involving prostitutes (men, women and transsexuals) have shown that the recent use of illicit drugs, with the exclusion of cannabis, concerns only a minority ((CAGLIERO & LAGRANGE, 2004; DA SILVA & EVANGELISTA, 2004)). However, it appears to be more frequent among men and transsexuals (recent use of poppers 13%, compared to 11% for ecstasy, 7% for cocaine and 2% for heroin) than among women (recent use of heroin: 5%).

Among the homeless population, the data tends to be patchy. We know however that all the substances are available and consumed. Users living on the street "have intoxication practices which are significantly different from those of less marginalised addicts. Due to a lack of money or ideas for sources, they tend to consume whatever they come across on a day-to-day basis […]" ((Solal & Schneider, 1996)). Estimates of the prevalence of the use of illicit drugs during the last few months vary from 10% to 21% or even 30% according to the age, income level, cause of vagrancy or help centres visited, (Amosse et al., 2001; Kovess & Mangin Lazarus, 1997; Observatoire du Samu social de Paris, 1999). The drugs most frequently consumed apart from alcohol and tobacco are cannabis and cocaine.

A recent study into alcohol use among the homeless population offers an insight into the levels of alcoholism experienced among the different categories of person using the various accommodation and warm food distribution services. It highlighted the diversity of use practices among this population group, according to the type of accommodation and resources available, and the age, sex and nationality of the respondents. The great diversity of social situations encountered corresponds to a wide variety of behaviour patterns where alcohol is concerned ((Legleye et al., 2008).

In the "techno/party" environment, a quantitative study (known as the "TREND Electronic Music Survey") involving an ethnographically structured sample of 1,496 people was held in 2004 and 2005 at five French sites. It made it possible to measure the prevalence of drug use among 4 sub-groups[5] found in this environment, but also to study their practices and representations. It sheds light on the frequency of cocaine use (35% during the last 30 days) and that of ecstasy (32 %) in addition to the daily use of cannabis (40%). The use of cocaine or ecstasy more than once a week concerns 18% of those persons encountered in the "techno/party" environment and 26% in the "alternative" environment. The

5 This concerns the "alternative" group (rave and free parties); the Urban group (music bars) comprising people who are better integrated socially and which contains a higher percentage of students, the Clubbing group, (night clubs dedicated to electronic music), mostly comprised of a hedonistic population group devoting a major budget to going out and clothing, and the Select group (clubs practising admission by recommendation or bars requiring "suitable clothing") attracting a "chic and trendy" clientele with a higher standard of living than the other groups. .

number of people experimenting with heroin is higher than expected: 23 % among the whole population group surveyed and 41% in "alternative" circles ((REYNAUD-MAURUPT et al., 2007)).

Although epidemiological knowledge of drug addictions in professional environments is naturally hindered by a range of obstacles (whether ethical, technical, financial, time-related, regulatory, cultural or practical), a certain amount of information is available to enable us to assess such use. In 1995, a study focusing on anonymous urine samples from 1,976 employees in the Nord Pas de Calais revealed that 17.5% of staff were consuming at least one psychoactive substance including up to 40% of staff in safety and security posts, (Fontaine, 2006). For most users well integrated within their professional environment, their drug use is hidden from their work colleagues and, as far as possible, the drugs are consumed outside working hours, (Fontaine, 2006).

A qualitative study published in 2006 also focused on the users of hallucinogenic plants and mushrooms. (REYNAUD-MAURUPT, 2006).

Attitudes to drugs and drug users: The tool used to assess the attitude of the French population to drugs and drug users is the *Survey on representations, opinions and perceptions regarding psychotropic drugs* (EROPP). This survey makes it possible to measure the perceived level of information concerning drugs, substances known and recognised as being drugs, and the estimated danger levels of the substances. The survey also studies public opinions as to the manner in which drug addicts are represented.

In 2002, 61% of French people stated that they believe they are well-informed about drugs, a figure slightly up on 1999. In reply to the question: "What are the main drugs of which you are aware, even if only by name?", the French mentioned an average of 3.8 products. The product most frequently mentioned was cannabis (82%), followed by cocaine (60%), heroin (48%), and ecstasy (37%) (Legleye et al., 2008).

The product considered most dangerous by the French population is heroin, followed far behind by ecstasy and cocaine, alcohol and tobacco and, finally, cannabis (only 2% of those interviewed considered cannabis to be the most dangerous substance). This ranking varies very little according to the age, sex or socio-professional category of the respondent. The perceived danger level of cannabis varies with age and sex, and more particularly according to the respondent's proximity to the product ((Legleye et al., 2008)).

The next survey is expected in late 2008.

2.1 Drug use among the general population

No new information available.

2.2 Drug use among youths and schoolchildren.

The *Health Behaviour in School-aged Children* (HBSC) survey is carried out in 41 countries or regions throughout the Western world. In France, this survey is co-ordinated by the medical department of the Toulouse local education authority, with the cooperation and support of the INPES and the OFDT. In 2006, for the second time it surveyed schoolchildren aged 11, 13 and 15 attending schools in mainland France concerning their health-related

behaviour and their use of psychoactive substances. The results shown here are taken from (Legleye et al., 2008).

The product for which experimentation is most frequently declared (table 2.1) is alcohol. It is followed by tobacco, episodes of alcoholic drunkenness, cannabis and, lastly, other drugs. The circulation of alcohol appears to begin at an early age as 59% of 11-year-olds stated that they had already consumed alcohol while barely 8% stated that they had already smoked a cigarette. Consequently, the rise in the level of experimentation observed among the 11 and 15-year-olds is low for alcohol (being multiplied by 1.4 between the two generations) but high for tobacco and drunkenness (the ratio is 1 to 7) and very high for cannabis (with a ratio of 1 to 25). The level of experimentation with tobacco remains high at 15 years old (54.5%) despite the significant falls recorded throughout the rest the teenage and adult population over recent years.

Overall, those experimenting with these substances have a higher tendency to be male, although there are a number of major exceptions observable according to the type of product and the age of the teenagers. Consequently, for licit substances (including alcoholic drunkenness), the over-representation of males is significant at 11 years old although the variation between the sexes diminishes at 13 and 15 years of age. When all is said and done, although boys begin experimenting earlier and girls later, experimentation by females tends to be far more intense, at least up until the age of 15. For tobacco, there is even a slightly higher propensity for experimentation by girls at this age.

Table 2.1. Experimentation with tobacco, alcohol and cannabis according to sex and age (%).

	Age	Boys	Girl	Sex ratio	All	Ratio 13/11 and 15/13	Ratio 15/11
Alcohol	11 y.o.	64.0	53.9	1.2 ***	59.1		
	13 y.o.	73.8	71.1	1.0 ns	72.4	1.2	
	15 y.o.	84.3	83.0	1.0 ns	83.7	1.2	1.4
Tobacco	11 y.o.	10.0	5.2	1.9 ***	7.6		
	13 y.o.	30.1	28.5	1.1 ns	29.3	3.9	
	15 y.o.	52.4	56.7	0.9 *	54.5	1.9	7.2
Drunkenness	11 y.o.	8.6	3.7	2.3 ***	6.2		
	13 y.o.	16.7	14.5	1.2 ns	15.5	2.5	
	15 y.o.	43.8	37.6	1.2 **	40.8	2.6	6.6
Cannabis	11 y.o.	1.5	0.7	2.1 ns	1.1		
	13 y.o.	5.5	4.2	1.3 ns	4.8	4.4	
	15 y.o.	29.7	25.3	1.2 *	27.5	5.7	25.0

Key: *, **, *** and ns: chi-2 test for a comparison of the sexes, respectively significant at the thresholds 0.05, 0.01, 0.001 and non-significant. Source: HBSC 2006, processed by the OFDT.

At the age of 11, less than one youngster out of two (41%) stated that they had never experimented with any psychoactive substances whatsoever. This proportion of non-experimenters declines significantly with age, to just 13% at the age of 15. These high levels are chiefly due to alcohol. If alcohol is removed from the equation, experimentation with psychoactive substances remains extremely marginal. A major change occurs after the age of 13: almost 6 youngsters out of 10 at the age of 15 (56%) have already experimented with tobacco or an illicit drug, and almost 3 out of 10 (28%) state that they have already used a licit substance (tobacco or alcohol) and at least one illicit drug.

Ill and misused drugs.
With the exception of cannabis, experimentation with illegal or misused drugs remains rare (table 2.2). The most common products are solvents and inhalants accounting for 5% of experimenters, followed by cocaine or crack (2.7%), amphetamines, "medicines for getting high" (as they are referred to in the questionnaire) all hovering around the 2% mark, and lastly heroin and LSD, which are both below the 1% level. The residual category of "other products" is mentioned by 7.5% of young people although their content remains unknown. In particular, as already mentioned, the nature of these products is not known, (i.e. – whether they are psychotropic, illegal or overlapping with other product categories, and particularly with cannabis, which is known by a range of different names locally, according to its nature, its source and its quality).

Table 2.2. The use level of illegal or misused products at the age of 15 over the last 12 months (%).

	Boys	Girls	Sex ratio	All
Inhalation products	4.7	5.3	0.9 ns	5.0
Cocaine & crack	2.8	2.6	1.1 ns	2.7
Amphetamines	2.7	1.8	1.5 ns	2.2
Medicines for getting high	1.1	3.1	0.3***	2.0
Ecstasy	1.3	0.8	1.6 ns	1.1
Heroin	1.2	0.9	1.3 ns	1.0
LSD	0.5	0.6	0.8 ns	0.5

Key *, **, *** and ns: chi-2 test chi-2 test for a comparison of the sexes, respectively significant at the thresholds 0.05, 0.01, 0.001 and non-significant. Source: HBSC 2006, processed by the OFDT.

For all of these products, the sex ratio is close to one and the variation between the sexes is non-significant, even for ecstasy and amphetamines (1.6 and 1.5 respectively), with the exception of "medicines for getting high", for which there is a higher propensity for experimentation among girls, as is the case for psychotropic medicines in general during the teenage years, Legleye et al. (2008). The insignificant nature of the variations is chiefly due to the low numbers of experimenters concerned at this age, (an age at which the distribution process is still largely incomplete). As such, this result is similar to that observed for experimentation with cannabis at the age of 11, which is rare, with users of both sexes.

2.3 Drug use within specific groups

New migrants (national report/specific population groups)

Since 2002, observers working for the TREND scheme have reported the presence of an increasingly numerous population group drawn from the "new" migrants, attending low threshold facilities.
That year, four sites (the Paris region, Lyon, Marseille and Metz) reported the emergence of a group of users chiefly originating from Eastern Europe, visiting the "reception centres" and the "syringe exchange programmes" (PES). At the time, observers of the urban[6] environment described a population group which mainly comprised young people living in extremely precarious circumstances. They differed from the usual "clientele" due to their age, their lack of knowledge of harm reduction information and their violent behaviour, encouraged among

[6] The urban environment defined by TREND chiefly covers low threshold facilities (reception centres and syringe exchange programmes) and open areas (the street, squats, etc). Most of the persons encountered in this environment are problem users of illegal drugs whose living conditions are highly precarious.

other things by high levels of alcohol use. Two subgroups were observed within this particular population group:

- Users who had started their use in France beginning with high-dose buprenorphine (Subutex®) generally obtained on the black market;
- Users arriving in France having already started use in their home country, with this latter subgroup being characterised in particular by the high prevalence of heroin and amphetamines administered by injection.

Following this observation, they went on to report a diversification in the origin of these migrants, including in particular the emergence of users from Asia (China), in addition to north and sub-Saharan Africa.

In addition to the East Europeans, a specific investigation carried out in 2005[7], focusing on the question of "new"[8] migrant populations made it possible to identify new groups originating from North and sub-Saharan Africa, and from Asia (particularly China). Unlike drug users from Eastern Europe, Chinese immigration is a highly structured form of immigration aimed at supplying labour to the undeclared labour markets. These migrants are generally employed within their home community. In 2005, the portion of this population group using drugs became increasingly visible in Paris, particularly by those involved with the "methadone bus" as that year they made up approximately 7% of new arrivals in the programme. Staff reported that virtually all those people they dealt with were relatively young men consuming white heroin which appears to be extensively available within the Asian communities. This drug use often began back in China. Unlike most of the drug users from Eastern Europe, these users are not poly-drug users, and use only heroin. Additionally, they may also be differentiated by their chosen administration method which most often takes the form of "chasing the dragon"[9] and by their work-based integration within their community, guaranteeing them decent living conditions compared to the massive marginalisation experienced by East European migrants.

When we examine socio-demographic characteristics, drug users from North Africa display numerous similarities with those from Eastern Europe and Caucasia. This tends to be a rather young and chiefly male population group, often living in precarious circumstances from both a legal and social viewpoint. The two population groups also share many similarities where use is concerned. Observers of the urban environment in the Paris region and in Marseille report poly-drug use chiefly dominated by the presence of psychotropic medicines such as Subutex®, Rohypnol® and Rivotril® combined with alcohol and cannabis. However, the two population groups do differ on two particular points. Firstly, the administration method used, with newcomers from North Africa showing a higher propensity for oral administration, and secondly the level of social isolation, which is lower for the North Africans than for the East Europeans. Among other things, this can be explained by the extensive presence of their home communities in France, which provides at least a basic level of solidarity enabling the more vulnerable users to avoid drifting into extreme situations of marginality. Moreover, the cultural links with France, in particular where language is concerned, encourages faster integration and easier provision of social and health assistance.

However, despite these differences in origin, a certain number of common dominators characterise migrant populations of drug users: their age (18-30), the fact that they are chiefly male, their drug use "career" which often begins in their country of origin, and their precarious living conditions. Beyond these common characteristics, numerous differences exist when we examine their drug use patterns whether in terms of the substances

[7] The report covering this specific investigation will be available on the OFDT website in October.
[8] "New" in the "most recent arrival" sense.
[9] A method which involves inhaling the fumes generated by burning heroin.

consumed or the manner in which they are administered. The same applies regarding precariousness. Although the majority of these young men (considering all origins together) are in the country illegally, it appears that the presence (or otherwise) of a home community plays a decisive role in determining whether or not the migrant will be able to integrate socially in the host country. Consequently, it would appear that it is the drug users from Eastern Europe who comprise the most destitute group and consequently the group most difficult to treat for professionals operating in the field. Their use and living conditions are very similar to those of the most marginalised "native" users seen by the low threshold facilities.

2.4 Attitudes to drugs and drug users

EROPP survey.
No new information available.

3. Prevention

General context

The legal framework:

Drug prevention is only partially covered by French legislation. In this particular field, it is chiefly the use, advertising or accessibility conditions for alcohol and tobacco[10] which are targeted by the law. Since November 2006, the ban on smoking in collective areas (the Evin law) has been extended to all areas welcoming the public (including workplaces) but with a dispensation until February 2008 for recreational areas and restaurants[11]. Very few legal texts deal with the prevention of the use of illicit drugs. The law which forms the bedrock of the fight against drugs in France (law no. 70-1320 of December 31, 1970) does not mention it. In 2004, for the first time ever, a law stated that *"information should be provided concerning the consequences of drug use on health, regarding in particular the neuropsychological and behavioural effects of cannabis in primary and secondary schools*(...)" [12]. It also established a minimum frequency of "*one annual session per uniform age group*". In this context, since 1990 the circulars issued by the Ministry of Education have laid down the main guidelines with regard to drug prevention, as part of a more general objective of preventing risk-inducing behaviour.

A new factor was added in 2007 with the delinquency prevention Law of March 5, 2007, which introduced awareness-building courses for arrested drug users, intended to warn them of the dangers of using narcotics. Its application decree was published in 2007, although the circular describing the schedule of conditions for this new scheme was only published in 2008[13].

Political coordination at a central and local level:

The task of initiating and coordinating prevention policy in the drugs field is handled by the MILDT. National guidelines are laid down in the governmental programme of which it is the depositary.

The *government's action plan against illicit drugs, tobacco and alcohol (2004-2008)*, and the 2003-2008 five-year prevention plan from the Ministry of Education[14] introduce the principle of harmonising and extending drug prevention activities by means of a prevention programme implemented throughout the school syllabus (from primary school onwards).

The 2008-2011 plan describes prevention activities centred on problem use with universal protection taking a back seat. The focus in particular is placed on:

• Prevention, and especially the central role played by parents;

[10] Law.91-32 of January 10, 1991 concerning the fight against tobacco and alcohol addiction, *Official Journal* dated January 12,1991, p. 4148 (NOR: SPSX9000097L), Law no.2003-715 banning the sale of tobacco to people under the age of 16 (JO dated August 3, 2003). Decree no. 2006-1386 of November 15, 2006 defining the conditions for the application of the ban on smoking in collective areas, NOR:SANX0609703D.

[11] Smoking rooms meeting strict standards may be installed except in educational establishments, health establishments and areas frequented by minors, which must be fully non-smoking. Only recreational facilities and restaurants benefitted from a waiver (until February 2008) to give them time to meet the standards.

[12] Public health planning law number no.2004-806 of August 9, 2004, NOR: SANX0300055L.

[13] Decree no 2007-1388 of September 26, 2007 issued for the application of the law 2007-297 of March 5, 2007 concerning the prevention of delinquency and modifying the Penal Code and the Code of Criminal Procedure, and Circular CRIM 08-11/G409.05.2008 concerning the fight against drug addiction and dependency of May 9, 2008 (NOR JUS D0811637 C.

[14] Introduced via circular no.2003-210- of December 11, 2003; NOR: MENE0302706C.

• Awareness-building messages aimed at avoiding or at least delaying experimentation, particularly with alcohol (among the measures envisaged we should mention a ban on selling alcohol to minors, a ban on consuming alcohol on the public highway around educational establishments, and a ban on fixed-price or "all you can drink" offers or "freebies");

Other action plans also contribute to following these national guidelines in the drug prevention field. This is the case with the National action plan to combat cancer for 2003-2008 (which has generated genuine momentum and a call to provide funding for actions aimed at combating tobacco) but also the 2007-2011 plan for the treatment and prevention of addictions by the Ministry with responsibility for health. This latter plan focuses in particular on early screening and user guidance schemes (please see the section on "Selective Prevention").

In each Ministry concerned, a particular service or department (which operates as the MILDT's point of contact) handles the coordination of prevention targets, working as an interface between the central and decentralised authorities. The implementation of national guidelines at a local level is therefore based on the state's decentralised authorities and institutions but also on "Drug and Dependencies Project Leaders (known as "CPDDs") appointed among the staff of each *préfecture*, who are the MILDT's local representatives.

Under the coordination of the MILDT, the project leader defines and organises the prevention policy for the department. To do so, he is allocated funds specifically assigned to dependency prevention and the training of professionals. He consults the local institutions (state departments, legal authorities, local authorities[15] and if possible the main associations), in order to coordinate the various objectives of the key public players and to determine the necessary financing.

At the same time, regional and multi-sector coordination schemes concerning health or the fight against social exclusion (PRSP), security or urban policy (CLS, CEL)[16] also allow for the allocation of public funds. Additionally, the identification of priority areas requiring intervention (ZUS or ZEP[17]), drawn up based on socio-economic indicators, the quality of housing or educational data (including the proportion of struggling or grant-assisted pupils) makes it possible to concentrate additional resources on disadvantaged sections of society.

In the educational environment, school principals annually draw up preventive measures to be implemented among their pupils. Although they benefit from a certain degree of autonomy in this area, they nevertheless receive recommendations from their local education authority according to the ministerial guidelines laid down. Most secondary schools have a "health and citizenship educational committee" (CESC) involving the educational community and external key players (associations and institutions, etc) to coordinate prevention activities within the establishment.

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

Since 1999, the fight against drugs has been widened to include legal psychoactive substances such as alcohol, tobacco and psychotropic medicines. It is based on two key principles: early intervention vis-à-vis young people in

[15] Autonomous, decentralised departmental or regional authorities, possessing their own powers in areas such as health, social childcare assistance or child protection.

[16] PRSP: Regional public health programmes which have replaced the Regional health programmes (PRS) and the programmes for access to preventive measures and health care for people in vulnerable situations (PRAPS); CLS: Local security contracts; CEL: Local educational contracts.

[17] ZUS: Sensitive urban areas; ZEP: Priority education areas.

order to delay, as far as possible, the age at which they begin consuming these products, and an intervention method which seeks not only to prevent use but also to limit abuse.

Drug prevention has always been considered as a logical extension of the common duties and services guaranteed by the state or delegated to the associations, based on the notion of proximity (concerning both decision-making and direct intervention activities). Consequently, most of the addiction prevention work concerns "universal prevention" and is carried out in educational environments where it involves most of the educational community in both the coordination and implementation of the actions undertaken. "Selective" or "indicated" prevention is chiefly handled by specialised associations. (It should be noted that the terms "universal", "selective" or "indicated" prevention are not commonly used in France).

The prevention of drug use is characterised by a low level of state intervention where concrete activities are concerned. Nevertheless, in 2006 a practical guide to intervention in educational environments was distributed by the Ministry of Education and the MILDT (please see the "Universal Prevention" section). Additionally, thanks to the various initiatives aimed at boosting professionalization in this field and harmonising the principles underpinning prevention activities, a number of approaches have gained ground including a willingness to go beyond the information stage where prevention is concerned; interactive initiatives; and the development of psychosocial skills, etc. However, the "modus operandi" for psychosocial skills is still fairly vague for a number of key players.

Schemes aimed at providing assistance to decision-makers and professionals:

The National Institute for Prevention and Health Education (INPES) handles the performance of assessments, the development of prevention practices and the implementation of national programmes (particularly media campaigns).

The Drug and Addiction Information and Resource Centres (*Centres d'information régionaux sur la drogue et les dépendances* or CIRDDs) provide technical support to project leaders in the drug and dependency field and to the authorities. They provide documentation and methodological advice for the drafting of projects and also have an observational role, particularly in the prevention field.

The Committee for the approval of prevention resources (coordinated by the MILDT) supplies its advice concerning the quality of the tools and resources submitted to it aimed at improving the reliability and coherence of the anti-drugs message conveyed.

In order to be represented in public debates and to encourage dialogue among professionals, the various specialised associations are organised into federated organisations (FNES, ANPAA, ANIT FFA and CRIPS[18]). All of these associations organise training activities, series of conferences, think tanks or documentary networks related to the prevention of the use of psychoactive substances.

The monitoring of prevention activities today:

[18] FNES: Fédération nationale des comités d'éducation pour la santé (National Federation of Health Education Committees - www.fnes.info); ANPAA: Association nationale de prévention en alcoologie et addictologie (National Association for the Prevention of Alcoholism and Addiction founded in 1872, www.anpaa.asso.fr); ANIT: Association nationale des intervenants en toxicomanie, (National Asssociation of Drug Addiction Workers, www.anit.asso.fr); FFA: Fédération française d'addictologie (French Federation of Addictology - www.addictologie.org); CRIPS: Centres régionaux d'information et de prévention du sida, (Network of Regional Information and AIDS Prevention Centres) www.lecrips.net/reseau.htm).

The ReLION scheme for the monitoring of local preventive activities was trialled in nine of the 26 French regions in 2007 thanks to the CIRDD network (Centres for information and resources on drugs and dependencies), at the initiative of the MILDT. Coordinated by the OFDT, this system seeks to gather simple indicators in order to identify the key characteristics of local prevention activities concerning alcohol, tobacco, psychotropic medicines, illicit drugs or performance enhancing products.

The national report supplies a detailed methodology for this survey, known as "ReLION" (*Recensement local d'indicateurs pour l'Observation nationale des actions de prévention liée aux drogues licites et illicites - Collection of local indicators for the national observation of prevention activities concerning legal and illicit drugs).* The methodological details and the results of the survey are also available at the following address: *www.ofdt.fr/relion*.

The ministerial and regional authorities, including in particular the Ministry of Education and the authorities concerned with the application of the law were informed in advance of this survey, and most provided support.

In most of the regions concerned, this survey was supported by the local educational bodies and the authorities with responsibility for the application of the law. Nevertheless, participation by the various bodies was voluntary. The reply rate in 2007 (16%) was considered modest by the decision-makers and led to them considering new options regarding the conditions under which the respondent organisations would be included in their sample (particularly the educational establishments) and institutional support for the survey. These significant modifications to the methodology will be discussed as from September 2008 onwards but will certainly lead to a postponement of the next survey (which was initially scheduled for the first quarter of 2009).

3.1 Universal prevention

In France, universal prevention remains the predominant approach used to prevent the use of legal or illicit drugs. According to the ReLION 2007 survey (*please see above: "The monitoring of prevention activities today"*), 86.5% of the activities identified fall under the heading of universal prevention, and in 8 out of 10 cases these actions were performed in educational establishments.

The year 2007 saw no new developments in the field of universal prevention. The national guidelines in this area remain those described in the *government's action plan against illicit drugs, tobacco and alcohol (2004-2008)*, and the *2003-2008 prevention and education programme* from the Ministry of education, described in greater detail in the previous national report.

Universal prevention activities aimed at communities

This aspect of drug prevention saw no particular developments in 2007.

Universal prevention aimed at families

This aspect of drug prevention saw no particular developments in 2007.

3.2 Selective prevention

The 2007 ReLION survey provided an estimate of the percentage of activities covered by the heading "selective prevention" in France. Of the nine regions covered by the 2007 ReLION survey, 13.5% of the 2,378 activities identified were aimed at persons handled by the social or legal institutions (please see the data supplied in the previous national report).

The recreational environment

No new developments.

"At risk" groups

The main change occurring in the field of selective prevention in 2007 concerns the launch of awareness building courses via the delinquency prevention Law of March 5, 2007. These courses are intended to build awareness of the dangers of narcotics use for drug users following their arrest (please also see the "the prevention of offences and criminality related to drug use" section). Nevertheless, the application decree for these courses was not published before the end of 2007, with the first courses scheduled for the following year. The Attorney General may propose this course to any person arrested for drug use aged at least 13 years of age, as an alternative to legal proceedings or as a "penal arrangement"[19] or as an addition to any punishment issued. The goal of these awareness-building courses is to make the drug user fully aware of the harmful consequences of drug use both for himself (i.e.: his health) and for society, in order to encourage him to change his drug use habits. The cost of the course is borne by the drug user (they barely exceed the cost of any fine handed down for third-degree infractions, i.e. €450) except in special circumstances determined following an examination of the user's family and social situation. The courses are issued by specialist approved associations to groups of between 7 and 12 people, with adults and minors being kept apart. The planned duration of the course is two days (which can be either continuous or held over a maximum period of two months) comprising a maximum of 2 x 6 hours. These awareness-building courses will be subject to a national assessment.

3.3 Indicated prevention

Since February 2005, 250 "outpatient cannabis abuse clinics" announced in the governmental programme opened throughout France. Aimed at young people in difficulty as a result of their use of cannabis or other drugs and at their families, these reception and support centres are anonymous and free of charge. These clinics are covered by the RECAP information system (Recueil commun sur les addictions et les prises en charge, coordinated by the OFDT, see part 5 on TDI) used in the CSSTs and the CCAAs. However, they have been the subject of a specific survey (Obradovic 2006), commented on in the previous national report and repeated in 2007 (awaiting publication).

According to this latter survey, in spring 2007 a total of 274 "clinics for young users" were reported as being active and approved by the regional Prefects (compared to 266 in 2005). Eight out of ten (78%) replied to the second survey (2007) of users seen in the clinics. They stated that in a given month they had welcomed 2,938 users and 844 persons categorised as friends or family of drug users (attending either alone or accompanied). Eight out of ten of those using the scheme came to the clinic alone, with just one person in five visiting the clinic accompanied (by one or several of their friends or family).

Users welcomed in the cannabis abuse clinics are estimated at some 16,600 people during the first year (from March 2005 to March 2008 - source: SIMCCA). An additional analysis

[19] A procedure which makes it possible for the Attorney General to propose one or several measures to a person who has admitted to having committed an offence or infraction punishable by a term of imprisonment equal to or less than 5 years. .

based on two successive years' results from the survey for a given month and the SIMCCA report have made it possible to assess the total number of users (chiefly of cannabis) seen during the first two years of the scheme (from March 2005 to March 2007) at roughly 30,000 people, not counting their friends and family.

The governmental programme to fight drugs and drug addiction (2008-2011), which incorporates the objectives of the Addiction plan from the Ministry of Health (2007-2011), aims to increase the number of young people benefiting from the outpatient cannabis abuse clinics to a total of 120,000 people.

Among the users (who account for 78% of the group), the average age is 23.2 years old and in 2007 (as in 2005) the vast majority were boys (81%). Compared to the use levels recorded in 2005, the use frequency for cannabis seems to be declining (45% daily users in 2005 compared to 38% in 2007) and the higher levels of daily use noted among girls stands out more clearly than in 2005 (43% vs. 37% among the boys, a difference of six percentage points compared to 2 points in 2005).

Most of the users seen in the clinics are young adults aged between 18 and 25 (57%), while 17% are minors and more than a quarter (26%) are aged over 25. On average, the girls appear to be older than the boys (at 24.2 years of age vs. 23.0 years), which seems to be due to the mostly spontaneous recourse to the clinics (35% among girls vs. 19% among boys), a factor which appears to be closely linked to age. For their part, the boys are mostly referred to the clinics by the legal system (55% of boys vs. 21% of girls) making the legal system the main referrer (with 48% of reasons for entering these clinics being due to legal referrals) far ahead of other reasons (voluntary self-referral: 22%, pressure from the family: 14%, referral by a doctor or health professional: 7%, other: 9%).

Among those attendees referred by the justice system, who are mostly male (92%), almost 9 out of 10 are adults (88%). Referral by the legal system accounts for approximately 60% of attendees in the 18-25 age group. Employed people tend to be overrepresented among the attendees referred by the legal system between the ages of 18 and 25, when compared to unemployed or inactive people. It is also among the attendees referred by the legal system that we find the lowest levels of daily cannabis use (27%) while more than half of the attendees coming forward voluntarily (53%) or following medical referral (54%) stated that they smoke cannabis on a daily basis.

The attendees referred by the legal system also stand out for their reasons for cannabis use, which are far more likely to be hedonistic in nature ("looking for a good time, looking for fun and sharing"). The attendees referred by the legal system are far less likely to smoke the product in order to relieve anxiety ("therapeutic" use) and are less likely to feel that they have become dependent upon the product.

Among those users entering an outpatient cannabis abuse clinic for the first time (slightly over half of the attendees for a given month), 54% are referred by the justice system. Among those attending for the second time, this figure increases to 58%. After the third session, the proportion of users referred by the justice system declines, falling to under 30% for the sixth and subsequent sessions (compared to 36% among those attendees attending of their own accord). The length of time that the drug user spends within the scheme therefore depends on the reason for his initial reason for entering the outpatient cannabis abuse clinic.

Almost half of first-time outpatients come back for a second session stating that they have reduced the frequency of their cannabis use (while 47% report unchanged use levels and 3% state that they have increased their use). However, it should be pointed out that a non-negligible percentage appear to have increased their alcohol and/tobacco use at the same time. Conversely, half of the outpatients dropped out of the monitoring scheme and were not

seen again. The dropout rate appears to be highest after the first session (51%), with this rate declining throughout the treatment programme at the outpatient cannabis abuse clinic, except after the third session when we observe a new dropout peak (43% of dropouts). Indeed the "third session barrier" appears to be a decisive one as it is also at this stage that the percentage of outpatients stating that they have reduced their cannabis use between sessions is highest, rising to 57% of attendees who remained in the scheme after the third and fourth sessions.

4. Problem use

Problem use: general context

Estimated prevalence: Several estimation methods have been used in France in order to produce a national estimate of the prevalence of problem heroin and cocaine use in 1999, (Costes, 2007). The number of problem opiate or cocaine users ranges from 150,000 to 180,000, which corresponds to prevalence levels among the 15-54 age group of between 3.9 per mil and 4.8 per mil [standard table n° 7].

In 2005 and 2006, the New Multicentric OFDT Study (NEMO) was carried out in order to produce local estimates of the prevalence of the problem use of opiates, cocaine, other stimulants and hallucinogens in six French urban areas (Lille, Lyons, Marseille, Metz, Rennes and Toulouse) and in an overseas *département* (Martinique). The provisional results from this survey cited prevalence levels within the 15-64 age group varying from 7.6 per mil in Rennes to 10.8 per mil in Lille. These local estimates, which are calculated using the capture-recapture method, will be used in order to update the national estimate of the prevalence of problem drug use at the end of 2007. In 1999, the prevalence levels for the use of opiates and cocaine (heroin, Skenan®, Subutex®, methadone and cocaine) varied from 15.3 per thousand persons aged 15-59 years old in Nice to 6.5 per thousand persons aged 15-59 years old in Toulouse. (CHEVALLIER, 2001) [standard table n° 8].

Currently, several tools exist which are approved in the French language, making it possible to assess the abuse or harmful use of cannabis among teenagers or young adults. These are two tests translated from English, and a specific cannabis test designed at the OFDT: the CAST (*Cannabis Abuse Screening Test*).

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

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

In 2006, a specific survey (PRELUD) was carried out among drug users attending low threshold structures (reception centres and syringe exchange programmes). Carried out in nine urban areas (Bordeaux, Dijon, Lyons, Lille,

Marseille, Metz, Paris, Rennes and Toulouse), this survey followed on from the so-called "front line" survey carried out up until 2003 on the 12 sites included in the French Monitoring of Recent Trends programme (TREND). It makes it possible to accurately describe the profiles of users attending low threshold facilities. The 2006 data was compared to the 2003 data for these nine sites.

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

From 2006 onwards, a compulsory and exhaustive survey spanning a given week (Ena-Caarud) was carried out among those organisations recognised as CAARUDs (Reception and harm reduction support centres for drug users): see Toufik, (2008). Calculated on an exhaustive basis, it confirms the prevalence of each product as a percentage of overall use. Above all, it demonstrates the high percentage of women among the younger generations and the high levels of equipment sharing (other than syringes) among younger users (Toufik et al., 2008)

Additionally, since 1999 France has operated a scheme for identifying and monitoring emerging trends, related to illegal or misused psychotropic substances (the TREND scheme). The observations from this scheme are focused on population groups with a high prevalence of use. It is chiefly based on qualitative (mainly ethnographic) and quantitative information gathering tools deployed by a network of seven local coordination groups (in Bordeaux, Lille, Lyons, Marseille, Metz, Paris, Rennes and Toulouse) run by the OFDT. All of this data is analysed by the local coordinating groups and compared nationally among them, as well as being compared to other available data sources.

In 2006 and 2007, the scheme noted the spread of drug use (excluding cannabis) to increasingly diverse sections of society. This trend has continued where cocaine is concerned, which is today consumed by people of increasingly varied social profiles. This process seems to have been underway for several years now with regard to the use of opiates (substitute products and heroin) which sometimes concern people well integrated socially and those from the "techno" environment in which it was previously culturally taboo. Where users are concerned, the qualitative data points to a higher prevalence of female users among young people (Reynaud-Maurupt et al., 2007), Cadet-Taïrou et al., 2008, Toufik et al., 2008).

The misuse of HDB continues to be reported (including injection, snorting, dealing, getting high, poly-drug use and use for non-substitution purposes[20]) probably facilitated by the availability of the product on the urban black market; (P-Y. Bello et al., 2004; Pierre-Yves Bello et al., 2003; Cadet-Taïrou et al., 2007; Escots & Fahet, 2003). Synthetic stimulants (chiefly MDMA and amphetamines) are seeing their powdered and crystal forms gaining in popularity among users at the expense of tablets, which are now seen as less "trendy". Additionally, these are also being encountered more frequently among urban street users. The use of natural or synthetic hallucinogens continues to gain ground gradually among users of psychoactive products with the exception of LSD which witnessed an upsurge in both availability and use in 2006 and 2007, and GHB which is now becoming commonplace among the gay festive community.

[20] First use and first dependency (Bello, P-Y. et al. 2004b; Bello, Pierre-Yves et al. 2003; Cadet-Taïrou et al. 2007; Escots et al. 2003)

Since 2001, recent injecting has decreased while snorting seems to be becoming more widespread. Consequently, heroin users today more frequently start off by snorting, and may then begin injecting at a later stage than was previously the case. The situation has been rather less clear since 2005: the decline in the number of "recent injectors" has ceased in the specialised centres and harm reduction centres, with ethnographic data pointing to younger groups of users with more precarious lifestyles, in which injection is believed to be on the rise. (Cadet-Taïrou et al., 2007; Centre d'évaluation et d'information sur la phamacodépendance (CEIP) de Marseille, 2006).

Among those people who injected during the month gone by, it appears that in 2006 a non-negligible percentage continued to share injection equipment. In the CAARUDs (so-called "low threshold" or "front line centres), 20.4% shared one or several components vital to injection (syringes, preparation water, rinsing water, recipients or filters). (The Ena Caarud survey, Toufik et al, 2008). The Prelud survey even revealed a "sharer" level of 30% among recent injectors (syringes, spoons or filters). Among the snorters, 30% also shared their straws; (Cadet-Taïrou et al., 2007).

New developments in the field of use are described in [Standard table number 17].

4.1 Estimated prevalence and incidence

An estimate of the number of problem drug users (PDUs according to EMCDDA's definition which includes injectors in addition to regular users of opiates, cocaine and amphetamines) in six French cities was carried out in 2006. This study, entitled NEMO (the New Multicentric OFDT Study), had a twofold objective: Drawing up the local estimation of the number of users, and providing a basis for extrapolation at a national level (mainland France). Three methods were used. The first was based on treatment data, the second on arrest data and the third on indirect indicators.

Table 4.1. Estimates of the number of problem drug users (as defined by the EMCDDA) in France, 2006.

Method based on	Number of users	Percentage
Treatment data	271683 [195443-347926]	7.0 [5.0-9.0]
Arrest data	190270 [136876-243666]	4.9 [3.5-6.3]
Indirect data	263708 [189264-338169]	6.8 [4.9-8.7]

95% Confidence intervals are shown in brackets. Prevalences are shown per 1,000 inhabitants aged 15-64 years old. The figures for the "arrest" data are known for their high level of variability, and the resulting estimate should therefore be seen as a lower limit. If we include the two other estimates, with relatively similar thresholds, the number of drug users is significantly higher than indicated in the previous available data (with 150,000 to 180,000 IV users estimated in 1999, equal to a percentage of 4.3 per thousand inhabitants aged 15-64, OFDT 2005). It should be noted that this estimate concerns users during the benchmark year. It does not concern more specific uses such as lifetime prevalence or the daily categories for example.

4.2 The profiles of users receiving treatment

The profile of those persons receiving treatment shown in this paragraph corresponds to that of new patients having started treatment in 2006, exclusively via the outpatient treatment centres.

In 2007, 125 outpatient CSSTs participated in RECAP, equivalent to 63% of all outpatient treatment centres. The data shown below concerns almost 36,000 patients who began a programme of treatment in one of these centres during the year.

Those persons receiving treatment for the first time in their life (referred to as "first-time outpatients") accounted for 32% of all new patients seen. For the other patients, these were new requests for treatment or a renewal of treatment following a break in contact with the treatment centre in excess of six months. The percentage of first-time outpatients among all patients should be taken with caution since information concerning the existence of previous treatments is unknown in 33% of cases.

In the use descriptions shown below, it has to be borne in mind that among all replies to the question concerning the main drug used, approximately 5.8% of respondents replied "no product consumed".

Patients receiving treatment (All treatments): Profile

The breakdown by age is shown in Table 4.1 below:

Table 4.1. Breakdown of patients by age (as a %), in 2007.

Age	All treatments	First treatments
< 20 y.o.	12.5	20.3
20-24 y.o.	24.6	32.9
25-29 y.o.	21.1	22.2
30-34 y.o.	14.8	10.9
35-40 y.o.	12.4	6.7
40 and over	14.2	6.8
Total	100.0	100.0

Source: RECAP / OFDT – 2007.

Among the new patients, 81% were male and aged on average 29.1 years old, with three-quarters being aged between 15 and 35. The most extensively represented age group is that of the 20-24-year-olds (accounting for a quarter of patients) with the under 25s accounting for 41% of the total. Almost one patient out of seven was aged over 40.

A third of the patients seek a consultation at their own initiative (34%) while another third (32%) are referred by the justice system or the police. This is followed by requests for treatment suggested by a member of the family or a friend (9%), and those referred by another specialist centre for drug users (5%). The results concerning the origin of the consultations are shown in Table 4.2.:

Table 4.2. Breakdown of patients by treatment origin (as a %), in 2007.

Origin of the treatment	All treatments	First treatments
Patient's own initiative	33.9	23.6
Family or friend	8.9	8.9
Other specialised centres for drug users	5.4	1.5
General practitioners	7.3	6.1
Hospital or other medical establishment	4.5	3.5
Social services	4.7	4.1
Police, courts or court-ordered treatment	32.2	48.1
Other	3.1	4.1

Source: RECAP / OFDT – 2007.

Patients most frequently live with their parents or alone (39% and 27%) and most often live in stable housing (77%). Nevertheless, 19% of them stated that they live in precarious housing conditions, and the rest in institutions (prisons or clinics).

Table 4.3. Breakdown of patients by professional situation (as a %), in 2007.

Professional situation	All treatments	First treatments
Regular employment	26.5	29.2
Student, secondary school pupil	14.2	19.8
Economically inactive	20.1	13.6
Unemployed	22.9	19.3
Other	16.3	18.1
Total	100.0	100.0

Source: RECAP / OFDT – 2007.

Regarding their socio-professional situation, economically inactive or unemployed patients accounted for a total of 43%, while just over a quarter (26%) have a regular job and 14% are still at school or students (please see table 4.3). Where the patients' educational profiles are concerned, 64% of people treated in the CSSTs in 2007 had reached secondary school level. A total of 4% of users had not got past primary school level and 32% stated that they had an educational level above the *baccalauréat* (A-level/High School Diploma).

Drug use

Table 4.4 features a detailed breakdown of patients and their average ages according to their declared main drug in 2007.

Almost half of the patients (49%) sought help from the treatment centres in 2007 for problems related to cannabis use. Their average age was 25. Most of them (54%) declared that they used cannabis on a daily basis. For 18% of them, cannabis use is frequent (between 2 and 6 days a week), for 13% of them the substance was used once a week or less, while occasional users accounted for 15% of the total number. This data is virtually identical to the findings from 2006.

This is followed by problems related to the use of opiates, identified as the main drug by 38% of patients, the average age of whom was 31 years old. In all, 78% of them took heroin, with

methadone accounting for just over 3% and other opiates (including HDB)[21] 18%. Among the opiate users, almost 80% consumed the substances on a daily basis and 12% took them regularly (i.e. several days a week). The opiates are generally snorted (52%) and injected (25%).

Table 4.4. Breakdown (as a %) and average age of patients according to the main drug taken, 2007.

Main drug	All treatments		First treatments	
	%	Av. age	%	Av. age
Heroin	31.1	30.6	22.7	27.6
Methadone	1.3	33.1	0.5	30.3
Other opiates	7.2	34.4	3.2	32.5
Cannabis (all)	49.4	25.1	65.8	23.8
Barbiturates	0.1	31.5	0.1	29.0
Benzodiazepines	1.6	36.3	0.6	36.5
Other hypnot. and tranquilizers	0.5	36.0	0.4	35.1
Cocaine	5.2	31.8	4.2	29.8
Crack	1.3	37.7	0.5	36.3
Amphetamines	0.3	28.2	0.3	25.4
MDMA and other derivatives	0.5	27.5	0.5	26.1
Other stimulants	0.0	27.5	0.0	32.0
LSD	0.3	31.1	0.2	32.7
Other hallucinogens	0.1	29.9	0.1	22.3
Volatile inhalants	0.3	27.7	0.4	27.7
Other substances (all)	0.9	33.0	0.5	29.9

Source: RECAP / OFDT – 2007.

Cocaine is the third main drug, being mentioned by more than 5% of patients, with an average age of 32 years old. Cocaine users declared that they use it every day (37%) or frequently (24%). The cocaine is snorted (66%) or smoked (18%) and, as shown in previous data, it is also injected by a non-negligible percentage of patients (14%).

Among all patients seeking treatment in 2007, more than three quarters (77%) stated that they had never used injection as an administration method. Those patients having used intravenous administration can be broken down into two groups: 13% of them had not used this method recently and 10% stated that they had injected during the month preceding the interview. Those who used injection during the month gone by are mostly opiate users (82%): 52% are heroin addicts and 26% declared other opiates (including HDB) as their main drug. Nevertheless, a non-negligible number of people using injection as an administration method are receiving treatment for cocaine use (8%).

First-time outpatients (First treatments): user profiles

Those patients being treated for the first time in their lives (first-time outpatients) can be distinguished from other patients by a number of different demographic and socio-economic characteristics.

On average they tend to be younger (26 years old compared to 29.3 years old for the other patients), 60% (vs. 36%) being aged under 25. They are more likely to be living with their parents (50% vs. 38%) and less often to be living alone (20% vs. 29%). Most live in stable

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

housing (86% vs. 75%). Many of them have a steady job (27% vs. 23%) or are still at school/university (23% vs. 13%). Despite this, their educational level does not differ from that of the other patients. First-time outpatients are characterised by a far higher proportion of sessions following a referral by the justice system (44% vs. 24%) and a lower percentage of spontaneous requests for treatment (27% vs. 39%).

Drug use

Following the launch of the "clinics for young users" in 2005, it should come as no surprise to see cannabis being mentioned as the main drug by the majority of first-time outpatients. In 2007, 62% of them stated that they chiefly consume cannabis. The place occupied by cannabis among treatment requests is consequently higher among patients seen for the first time in their lives by the CSSTs, than for other patients (66% vs. 43%). First-time outpatient cannabis users are characterised by use frequencies which are lower than for other cannabis users. They are more likely to be occasional users (14% vs. 9%) and are less likely to be daily users (50% vs. 64%).

After cannabis, opiates are most often declared as the main drug by patients receiving treatment for the first time in their lives (27% vs. 56%) followed by cocaine (5% vs. 8%). Among opiate users, the first-time outpatients tend on average to be younger than the other patients (with an average age of 28 vs. 33 years old). Their use patterns also differ from those of other opiate users. As already noted in 2006, their use frequencies tend to be higher: daily users are more numerous (81% vs. 76%), with fewer occasional users (4% vs. 6%). An analysis of the use methods shows that injection is less frequently used by first-time outpatients (14% vs. 31%) who tend to favour snorting (65% vs. 46%).

Patients attending a consultation for the very first time for cocaine use have an average age of 28 years old (vs. 33 years old for other cocaine addicts treated by the CSSTs). Fewer first-time outpatient cocaine users use this drug on a daily basis (33% vs. 38%) and they also use it less often intravenously (5% vs. 23%).

As shown by an analysis of use patterns by product groups, those persons welcomed by the CSSTs for the first time in their lives tend to use intravenous administration less often than patients who have already received treatment. Thus, in 2007, 92% of first-time outpatients (considering all products together) had never used injection as an administration method (vs. 62% among the other attendees).

Conclusion

The 2007 recap data clearly shows the heterogeneousness of the drug users welcomed by the outpatient CSSTs. Two main groups can be distinguished: firstly, patients welcomed for problems related to their cannabis use and secondly patients receiving an opiate substitution treatment and declaring a problem with opiates and/or cocaine.

The profile of the patients treated in 2007 is very similar to that of the patients seen in previous years. Nevertheless, a number of differences should be pointed out: their average age is slightly higher (28.3 years old vs. 27.9 years old), they are more likely to live alone (27.4% in 2007 compared to 26.3% in 2006 and 24.8% in 2005). They have a higher tendency to state that they are unemployed (23%, 25% and 22% respectively). The patients seen in 2007 by the CSSTs have a higher tendency to be referred there by the justice system or the police (32% vs. 29% and 26% in 2005) and are less often referred by another social/health organisation (15% in 2007, 17% in 2006, and 21% in 2005). The percentage of first-time outpatients among all new patients is declining (30% vs. 32% for 2006 and 34% in 2005). The prevalence of cannabis among treatment requests is increasing (49% vs. 47%

and 48%) while the percentage of cocaine and opiates remains unchanged (45% in 2007 vs. 48% and 46%). Cannabis use is less likely to be daily (54% vs. 57%).

The high prevalence of cannabis among treatment requests in 2007, which was all the more noticeable within the first treatments subgroup, can be explained by the existence of specialised clinics for young users of cannabis or other products[22] within numerous CSSTs. Furthermore, the large number of young cannabis users referred to the CSSTs by the justice system constitutes another factor explaining the prevalence of cannabis among treatment requests. It should be noted that 29% of cannabis users take the product on a less frequent or occasional basis.

Treatment requests for the problem use of opiates remain high and tend to concern older people. Recent injection (during the month gone by) is used to administer the main drug by 10% of users. Nevertheless, if we exclude cannabis use as the main drug, the proportion of patients choosing injection as the administration method during the month gone by exceeds 20%.

These average figures obtained from all patients and from the first treatments subgroup nevertheless mask a number of disparities (between the sexes in particular) concerning the products consumed and use methods. Thus, the prevalence of cannabis among treatment requests from girls tends to be lower and that of opiates, cocaine and psychotropic medicines tends to be higher. Compared to the boys, girls are more likely to opt for snorting, eating or drinking as a ppatern use and less likely to inhale or smoke.

4.3 Data obtained from low threshold structures

Recurrent surveys carried out among users of low threshold structures provide the only quantitative source of regular information about the active user populations to be found in town centres, trafficking locations or squats.

Up until 2006, only a single survey (known as PRELUD) made it possible to monitor and track these sections of the population. Since 2006, a compulsory and exhaustive survey spanning a given week (Ena-Caarud) has been carried out in all centres recognised as CAARUDs (*Centres d'accueil et d'accompagnement à la réduction des risques pour usagers de drogues* – Reception and harm reduction support centres for drug users) (Toufik, 2008).

The survey was carried out between November 20 and 26 in all 114 centres having received prefectural authorisation, located in 23 regions and 66 *départements*. The number of completed questionnaires totalled 3349, corresponding to a reply rate of 79.8% (Toufik, 2008).

The average age of the users was 33.4 years old (median: 33 years old). Four users out of ten were aged between 30 and 39 years old and more than nine out of ten were situated in the 20-49 age group. The sex ratio was 1 woman for 4 men (21.3% vs. 78.7%).

Female users tend to be slightly younger than male (31.2 years old vs. 33.9 years old). While 29.4% of them are aged under 25, this is the case for only 14.8% of men. They also tend to

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

be proportionally more numerous among the younger users: 55% of users under 20 and 30% of the 20-24 age group are women.

More than a quarter of the respondents (26.2%) are homeless while 18.8% live in temporary accommodation. More than half of the users live off social benefits, particularly the *RMI* (38.2%). A minority (22.7%) mention an income from employment (15.5%) or from unemployment benefits (7.2%).

More than 9 users out of 10 are dependent upon the general Social Security system either directly (30%), accompanied by top-up mutual insurance (for more than 13% of them), by means of the CMU (*Couverture Maladie Universelle* - Free, state-provided health cover, 51.6%) or the ALD (*Arrêt de longue durée* - Long term sickness cover, 4.8%). While 2.3% of users are covered by the AME (*Aide médicale d'Etat* - State medical aid scheme), more than 7% mentioned no protection whatsoever (Toufik, 2008).

Use

On average, leaving aside tobacco[23], each user declared having consumed 2.5 products during the last month. Opiates remain the most frequently consumed products. These are followed by stimulants (46.7%), cannabis (49.7%), alcohol (36.8%), non-opioid medicines (13.8%) and lastly hallucinogens (8.6%). Substitution medicines were only mentioned in the case of misuse, (Toufik, 2008).

Table 4.5. Products stated as being consumed during the last month by users attending the CAARUDs in 2006, N=3329

Substance	Percentage of users	Substance	Percentage of users
Opiates	56.7%	Hallucinogens	8.6%
HDB*	28.6	LSD	6.0
Heroin	25.7	Ketamine	2.3
Morphine sulfate*	10.1	Mushrooms	2.1
Methadone *	4.6	GHB	0.1
Opium	1.1	Poppers	0.9
Codeine	0.8	Datura	0.6
Stimulants	46.7%	Salvia	0.2
Cocaine	28.4	DMT/ayahuasca	0.1
Crack/free base	14.0	Non-opioid medicines	13.8%
Ecstasy	9.3	Benzodiazpines**	13.3%
Amphetamines	6.6	Artane	1.3
Methamphetamine	1.2	Other medicines	0.8
Cannabis	49.7%	Alcohol	36.8%

* Misuse (including injecting, snorting & smoking)
**Rivotril,; Rohypnol; Valium; Xanax; Tranxene; Temesta
Several products may be mentioned. The total therefore exceeds 100 %
Source: Ena-CAARUD 2006, OFDT / OFDT, DGS

Use methods

Among those people interviewed, 68.7% had used intravenous administration methods at least once during their life. At the age of 15, 8.8% of intravenous drug users (IDUs) had already started injecting and 40.6% at the age of 18. At the age of 30, 95% of IDUs had

[23] Users were asked to mention the products they had consumed during the last month.

started injecting. Among those people who had injected at least one product during their life, 73% had injected during the last month (recent injectors) equivalent to 50.2% of the entire sample. Women are proportionally less numerous than men when it comes to recent injection (46.5% vs. 51.2%). It is among the 20-24 age group and the 25-29 age group that recent injection is most frequent (at 52.4% and 51.2% respectively).

Half of injecting drug users (52.6%) claims they have never shared syringes during their lives while 23% of injectors have "almost never" resorted to sharing. The others (22.3%) shared their syringes "occasionally" (16.9%) or "regularly" (5.4%).

Among the recent injectors, 20.4% acknowledge that they have shared one or several items of injection equipment: 8.3% syringes, 13.3% preparation water, 8.5% rinsing water, 13.9% the spoon and 10.9% cotton buds or filters.

A multivariate analysis shows that with the exception of syringes, the prevalence of equipment sharing during the preceding month was chiefly related to the age of the injectors (the younger the user the higher the propensity to share), (Touffik, 2008).

5. Treatments

Treatments: general context

Where treatments are concerned, the strategy of the public authorities is to offer a diverse range of therapeutic solutions and services making it possible to offer each person the solution best adapted to his circumstances, and to constantly improve the quality of treatment. Three schemes contribute to treating users of illicit drugs: the specialised addictology treatment scheme (provided through medical/social establishments), the general healthcare system (hospitals and GPs) and the harm reduction system.

1. The specialised scheme

Since the early 1970s, the treatment of addictions to illicit drugs has been the responsibility of specialised centres. These centres were expanded following the adoption of the 1970 law which included a number of measures guaranteeing free and anonymous treatment for all users of illicit drugs washing to receive treatment. Virtually all of the French *départements* today have at least one Specialised Drug Treatment Centre (CSST).

Originally financed by the state, and since January 1, 2003 by the social insurance bodies as medical-social establishments, these centres have the task of jointly providing medical, social and educational services, which includes help with rehabilitation and social integration

Three types of CSST can be distinguished:

- Out-patient treatment centres (numbering 216 in 2006);
- Treatment centres with collective accommodation (numbering 40 in 2006);
- Treatment centres in penal establishments (numbering 16 in 2006).

The out-patient CSSTs are designed to meet the out-patient withdrawal requirements of patients. They can also organise and support patients wishing to undergo drug withdrawal treatments in hospital. Where substitution treatments are concerned, since 1993/1994 and until quite recently (2002) the doctors working in a CSST were the only doctors authorised to initiate methadone treatments, with repeat prescriptions subsequently being issued by community physicians. Patients can also be prescribed high-dose buprenorphine (HDB) via a CSST. Additionally, patients can seek support and guidance via a scheme (psychotherapeutic -type support) and social integration assistance.

In France, the concept of "Drug-free treatment" is not really used and it is difficult to equate this to a given type of institutional treatment. However, the new five-year plan for the period 2004-2008 recommends the development of substitution-free programmes and in particular "therapeutic communities".

2. Treatment via the general healthcare system

The development of the specialised treatment system does not make it possible to meet all of the treatment needs expressed by users of illicit drugs. Since the 1990s, the focus has been placed on improving the reception of patients suffering from addiction problems by the general healthcare system (hospitals and general practitioners).

2.1 Hospitals

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

provision of hospital beds for withdrawal along with the preparation of medical-psychological-social assessments.

Created by the circular dated April 3, 1996, the liaison and addictology treatment teams, which usually comprise three people including one hospital doctor, have the task of training and assisting teams of care staff in hospitals, drawing up therapeutic protocols, and working with hospitalised patients and emergency patients. They carry out prevention, information and awareness-building activities within the care establishment. In 2003, around 100 health establishments had actively liaison teams. However, most of their work is devoted to addiction problems involving alcohol and tobacco.

The town-hospital networks were also established by means of the circular dated April 3, 1996. In 1998, a total of 67 networks were listed, located throughout the country. In 2002, a total of 114 addiction networks were listed, of which 107 were in mainland France. They are jointly financed by credits from the health insurance system and from the state.

Finally, it should be noted that since 2002, a doctor practising in a health care establishment is authorised to prescribe methadone.

2.2 General practitioners

General practitioners today play a key role in France when it comes to prescribing opioid substitution treatments. Since 1996, they have had the possibility to prescribe HDB to opioid dependent patients. They may also issue prescriptions for methadone after a methadone treatment programme has been initiated for the patient by a CSST.

Furthermore, the general practitioners are the first to intervene regarding patients just beginning their use of illicit drugs. With this in mind, the public authorities plan on introducing special training for general practitioners to enable them to spot these users and to familiarise them with the therapeutic solutions best suited to the situation.

Based on data from the *Caisse primaire d'assurance maladie* (CPAM), covering 13 different towns and cities, it has been established that 35% of general practitioners had prescribed substitute treatments during the second half of 2002. However, the prescription activity (whether this concerns methadone or HDB) is often concentrated on a limited number of doctors. The average "standard dose" received by a patient undergoing substitute treatments with Subutex® is 9.6 mg (with a recommended maximum of 16 mg/day); it stands at 98.4 mg for a patient receiving methadone (with a recommended maximum of 100 mg/day, (Cadet-Taïrou et al., 2007)).

3. The harm reduction scheme (please see the panel in chapter 7 "Response to health problems")

Standard table n°21 provides information concerning various treatments practised in France and their availability. The Structured Questionnaire no. 27 supplies additional information about the available treatment programmes.

Fighting addiction using opioid substitution treatments is a relatively recent phenomenon in France (1993) and was motivated by the need to combat the HIV epidemic.

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

The prescription of substitute treatments using methadone by community physicians (following the initiation of a programme of treatment by a specialised establishment) was authorised in 1995. A new estimate of the number of persons

receiving methadone substitution treatments via community physicians based on sales data (SIAMOIS / OFDT) was carried out in 2007 and reported a total of 18,607 patients (methadone 60 mg).

As access to substitution treatments through specialised centres proved to be insufficient when it comes to meeting needs, a second means of treatment was set up in parallel to methadone treatments. Based on HDB, these treatments were launched from 1996 onwards. The requirements for initiating and prescribing treatment are more flexible than those for methadone: the HDB-based treatment can be prescribed by any doctor with no specific professional criteria applying, the maximum prescription period being 28 days broken down into separate seven-day periods unless expressly stated otherwise. In 2005, between 75,087 and 87,253 people received Subutex®. Three years earlier, it had been estimated that of all of the patients receiving Subutex®, approximately 65% were enrolled on a medical treatment programme, while 28% were receiving prescriptions for substitute products illegally and 6% were obtaining these treatments with the key aim of reselling the products afterwards. (Cadet-Taïrou et al., 2007).

In addition to the beneficial effects noted since the introduction of substitute treatments (including a positive impact in both the health and social fields) undesirable consequences (almost exclusively related to HDB) have also been observed. This misuse is essentially a result of the flexible prescription system for the product. Examples of misuse include the injection of HDB, including for those patients undergoing health surveillance, a form of use outside the scope of the medical protocols (use for non-substitution reasons) and the use of the product in combination with other products (benzodiazepines, alcohol, etc).

The treatment and harm reduction measures provided for incarcerated drug users are described in chapter 9.

5.1 Measures

No new information available

5.2 "Drug free treatment"

No new information available

5.3 Medical treatments (substitution, withdrawal)

5.3.1. Withdrawal treatments provided or monitored by staff from the CSSTs.

In 2006, an average of approximately 17 patients per centre underwent withdrawal treatments provided via out-patient care at an out-patient CSST (table 5.1), and almost 13 patients underwent withdrawal in hospital with the support of the centre. The data in table 5.1 shows a significant increase in the number of withdrawal treatments between 2003 and 2004. However, this change is certainly linked to a change in the wording of the questions following the adoption of a new report in 2004. Nevertheless, we have been witnessing an upward trend since the late 1990s. This change must be taken in perspective as the total number of people seen by the specialised centres has also increased since the late 1990s.

Table 5.1. Total number of patients having undertaken a withdrawal treatment via a CSST (out-patient care), 1998-2006.

	1998	1999	2000	2001	2002	2003	2004	2005	2006
Average number of patients (per CSST) having undertaken out-patient withdrawal treatments provided by the CSST	6.8	5.7	6.2	8.4	10.6	11.0	16.8	16.1	17.5
Average number of patients (per CSST) having undertaken withdrawal treatment in hospital, supported by the CSST (per centre)	na	na	na	na	na	na	10.3	13.2	12.8

Source: Analysis of the standard activity reports from the out-patient CSST's-2005, DGS/OFDT.

Guide: on average, for each CSST 6.8 patients underwent out-patient withdrawal treatments provided by the CSST in 1998. Note: the calculation was carried out by excluding those centres organising more than 150 withdrawal treatments or which did not answer questions concerning their activity. The total number of patients having undertaken a withdrawal treatment is calculated by extrapolating the average number of people undergoing withdrawal treatments vis-à-vis all CSSTs having a monitoring system for patients undergoing withdrawal treatments of fewer than 150. To this figure we have added the total for those centres excluded from the previous calculation due to the scope of their monitoring system for patients having undergone withdrawal.

Based on the data supplied by the CSSTs, we can estimate the number of patients having undertaken withdrawal treatments in 2006 at somewhere between 8000 and 9000.

Substitution treatments among patients attending front line centres

At the time of the 2006 PRELUD survey, 60% of users declared that they were undergoing a medically prescribed substitution treatment. In the case of just under two thirds of these, this concerned HDB, while a third (32.4%) had been prescribed methadone. Finally, a minority (4%) declared a morphine sulfate-based treatment.

Those users receiving a substitution product tended on average to be older than those not receiving them. Although the average age of the latter stood at 32.1 years old, this figure rose to 33.6 years old for users receiving a substitution treatment based on HDB, to 34.7 years old for those receiving methadone and to 35.2 years old for the recipients of morphine sulfate.

In 79.4% of cases for morphine sulphate, 59.0% of cases for HDB but only 16.4% of cases for methadone, the medicine used for substitution purposes was also mentioned among the products consumed outside the scope of a programme of treatment. Thus, among those drug users receiving morphine sulphate and HDB, it appears that it is the prescribed medicine itself which is cited as the product causing the most problems by the drug users (66.2% and 42.2% respectively). Indeed, among the active drug users interviewed via the CAARUDs, a majority were using injection as the administration method and less often resorted to snorting or smoking. On the other hand, among those persons receiving methadone, this medicine is mentioned in only a small number of cases (9.5%). It is mainly outstripped by heroin (24.3% and cocaine/crack (19.5%). Unlike the two other substitution medicines, methadone (when used outside the scope of a programme of treatment) is almost exclusively taken orally (96.5%) (Toufik et al., 2008).

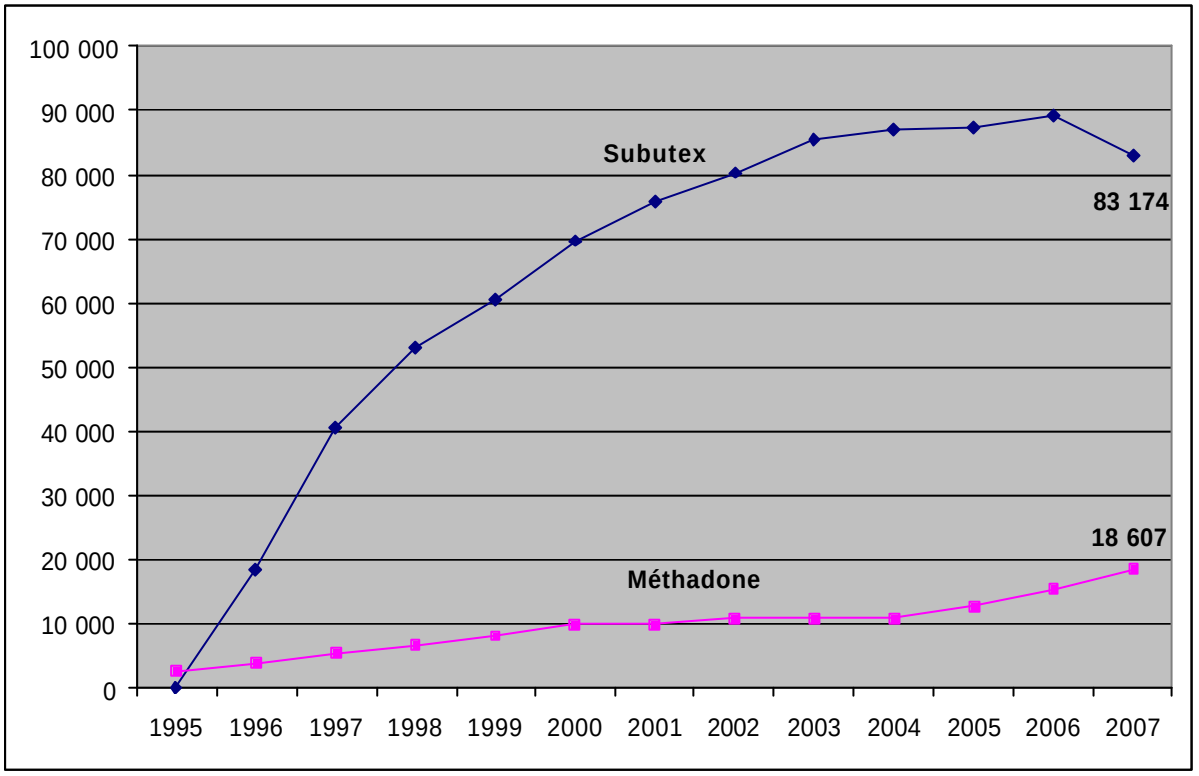
The issuing of substitution treatments

Two medicines are used for opioid substitution treatments: methadone (for which a programme of treatment by prescription may only be initiated by the CSSTs and healthcare establishments), and High Dose Buprenorphine (HDB) or Subutex®, which can be prescribed right away by any doctor. Following its launch on the market in 1996, HDB has quickly become the leading treatment for opioid dependency in France in volume terms.

In 2007, HDB still represented 80% of substitution treatments even if methadone's share continued to rise based on Siamois data. Easier access to methadone was also one of the recommendations from the Substitution Treatments Consensus Conference held in June 2004. Since 2006, Subutex® is no longer the only product available as generic HDB specialities are now becoming available on the market.

Graph 5.1 below shows the estimated number of patients treated in France using HDB and methadone. The data is derived from refunds issued by the Social Security system, based on two separate hypotheses (with a lower and upper limit).

Graph 5.1. Opioid substitution treatments: the number of drug users treated with high-dose buprenorphine (Subutex®) and methadone – 1995-2006.



Sources: GERS/SIAMOIS/InVS and CNAMTS/ OFDT estimates.

However, it should be pointed out that a certain portion of the buprenorphine prescribed is misused, and is not always consumed as part of a programme of treatment. According to data from the health insurance system dating from 2002, out of 79,000 patients having received at least one prescription, it can be estimated at 65% of these were enrolled on a medical treatment programme, that 28% received prescriptions of substitution products illegally and that approximately 6% obtain prescriptions for these treatments (usually from several doctors) occasionally with the aim of reselling the products afterwards.

Substitution treatments administered within hospitals

A survey carried out in 2007 by the OFDT (Obradovic & Canarelli, 2008) in order to assess the impact of circular number 2002/57 dated January 30, 2002 concerning the first prescription of methadone by doctors practising in healthcare establishments (in hospitals and penitentiaries) made it possible to demonstrate that access to methadone had increased in both of these environments.

The part of the survey carried out in hospital environments revealed the key role played by general practitioners in providing opiate dependent drug users with access to specialised treatments, both "upstream" by referring their patients to the hospitals to receive treatment, and "downstream" by continuing the patient's treatment after he leaves hospital. The importance of an effective interface between the various partners in the drug treatment process in order to avoid the patient abandoning the substitution treatment after leaving hospital was another important aspect emerging from this survey.

Substitute treatments administered in penal establishments

Please see 9.1

6. Health-related consequences

Health-related consequences: general context

Deaths caused by drug use:

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

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

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

- By drug dependency (CepiDc-INSERM) [Standard table no. 5]. This category concerns all deaths for which the death certificate mentioned drug dependency. For reasons related to the nature of the information circuit, it is not particularly effective at recording overdoses, which are often listed in the group "unknown cause of death". The number of deaths through drug dependency fell between 1995 and 2000 (the year in which the WHO international pharmacopoeia, 10th revision was implemented) and remained unchanged between 2000 and 2005.

- With the presence of psychotropic substances in the blood: the DRAMES scheme (Décès en relation avec l'abus de médicaments et de substances - AFSSAPS) lists those cases of death for which a legal inquiry was launched. Two retrospective studies were carried out for the years 1998 and 2002, in addition to a forward looking study in 2002 with 7 medico-legal toxicology laboratories volunteering to take part. Subsequently, 16 laboratories were included in 2003 and 2004. A reduction in the number of recorded deaths was noted in 2003 (64 compared to 131 in 2002), followed by a slight increase in 2004 (91 cases). With regard to the substances encountered, in line with the findings of the OCRTIS data, cocaine was found to have increased sharply in prevalence during 2004, achieving prevalence identical to that of heroin which for its part, was declining. The role of substitution treatments concerned 38% of recorded deaths in 2004 with methadone being identified in more than three quarters of cases ((Arditi & al, 2006). In 2005, the DRAMES data revealed 66 cases of fatal overdoses: heroin was responsible for most deaths (23 cases). Cocaine was responsible for 7 deaths (compared to 20 in 2004) but the number of cases combining heroin + cocaine is rising (11 cases compared to 2 in 2004). In line with the findings of the OCRTIS data, the percentage of deaths involving substitution treatments fell in 2005, concerning 19.6% of deaths, with methadone being identified in virtually all cases (11 cases out of 12). Data collected in 2006 confirm these trends.

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

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

Morbidity related to drug use:

1. Infectious diseases account for the bulk of somatic morbidity cases observed. Prevalence estimates among drug users are based on:

- The declared prevalence of HIV, hepatitis B and hepatitis C: the so-called "November survey" carried out among patients visiting the CSSTs ((TELLIER, 2001), the survey being replaced by data derived from the RECAP scheme from 2005 onwards, in addition to the survey carried out among the users of "front line" structures ((P-Y. Bello et al., 2004; Pierre-Yves Bello et al., 2003) [Standard table no.9] itself replaced by the PRELUD survey from 2006 onwards. Based on the RECAP data for 2006, the prevalence of HIV among patients having already injected and of known serology is almost 9% and that of hepatitis C is 52%.

– The biological prevalence of HIV and hepatitis C (blood samples) among drug users, thanks to the Coquelicot survey (Jauffret-Roustide & al, 2006). This study, which is eventually intended to become a national information system, highlights the variations between the declared and measured prevalence figures for hepatitis C, particularly among the youngest patients. It also shows that high risk practices continue, creating conditions favourable for the spread of hepatitis C and HIV.

– The biological prevalence of HIV and hepatitis C (saliva samples) among drug users of front line centres: the PRELUD survey which got underway in February 2006 in five French towns and cities. The results from this study are currently pending.

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

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

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

3. Other pathologies related to drug use: there currently exists no systematic data collection scheme concerning other pathologies which may accompany or arise as a result of drug use (other infectious complications, cardiovascular problems, trauma, etc). The survey carried out as part of the TREND scheme involving users of "front line" centres provides indications concerning their perception of their state of health in addition to the appearance of certain pathologies (P-Y. Bello et al., 2004; Pierre-Yves Bello et al., 2003). Pathological phenomena tend to be more frequent among people living in extremely precarious conditions. One third of those surveyed stated that they felt that their state of physical health was bad or extremely bad. Almost 70% stated that they suffered from tiredness during the month gone by, 44% from weight-loss, 4% from an overdose and 2% from jaundice. The frequency of declared injection-related complications was also calculated

4. Driving: the law dated February 3, 2003 introduced a new offence for any driver found to have narcotics in his blood following a blood analysis. Drivers now risk two years' imprisonment and a fine of €4500. The penalties may be increased up to 3 years' imprisonment and a fine of €9000 if alcohol has been consumed simultaneously. The screening of the driver is now compulsory in the event of a fatal accident but may also be carried out for any road traffic accident, any infraction of the Highway Code or when there are reasonable grounds for suspecting that narcotics have been taken (OFDT, 2005).

6.1 Mortality related to drug use

Trends

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

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

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

Year	OCRTIS	DRAMES	CépiDc*
2000	120	101	202[a]
2001	107	NA	246[a]
2002	97	74	234[a]
2003	89	64	225[a]
2004	69	86	252[a]
2005	60	68	299[a]
2006	92	168	NA

NA: not available. [a]ICD 10 codes used: F11-16, F18-19, X42.
Source: OCRTIS, DRAMES, CépiDc, various reports.

The DRAMES mortality data cannot be compared with the other information sources, the variations in the number of deaths being due to the increasing number of laboratories participating in the data submission scheme. To the 168 overdose deaths recorded in 2006 we may also add 9 deaths indirectly related to the use of psychoactive substances (drowning, falls, etc). The data from the police (OCRTIS) confirms the increasing trend where fatal overdoses are concerned, previously identified via the register of deaths (INSERM-CépiDc).

The main purpose of the DRAMES data is not to provide an exhaustive overview of the number of fatal overdoses, but rather to monitor the types of substances encountered, with particular attention being paid to medicines. Most of the deceased were males (82%) with an average age of 33.

Table 6.2. The causes of overdose deaths in France, DRAMES 2006.

Causes	N
Illegal substances	95
Legal opioid medicines	18
OST	51
Other	4
In combination with:	
THC	37.5%
Psychotropic Medicines	47.0%
Ethanol (0.5 g/l)	44.6%

Source: DRAMES 2006.

95 deaths were caused by the use of illegal substances. In 54 cases, this concerned the use of a single substance (heroin: 38 cases; cocaine: 13 cases; MDMA: 2 cases; LSD: 1 case). 41 cases involved a combination of substances, these chiefly being heroin and cocaine (10 cases, to which should be added 11 cases involving a combination of heroin and another substance). A total of 18 cases of overdoses were recorded involving a combination of cocaine and another substance (cocaine and heroin: 3 cases; cocaine and morphine: 5 cases; cocaine and methadone: 4 cases; cocaine and HDB: 2 cases, cocaine and MDMA: 2 cases and finally one death caused by cocaine-tramadol and another by a mixture of cocaine, morphine and MDMA).

6.2 Infectious diseases related to drug use

The HIV infection monitoring programme: new AIDS cases

Following the introduction of compulsory HIV notification in March 2003, 17,277 cases of HIV infection have been declared. In 2006, the number of HIV-positive declarations was estimated at 6,300, which was down compared to previous years (7,000 and 6,700 respectively in 2004 and 2005).

In 2007, contamination by intravenous drug use (IDU) accounted for only 2% of new infections. The most frequent contamination method continues to be heterosexual intercourse (53% of cases), particularly among women (79% of cases), followed by homosexual sexual intercourse (25% of cases accounting for 41% of contaminations among men).

Table 6.3. The discovery of HIV infection in 2003-2007, broken down by contamination method (France, data from 30/06/07).

	Women		Men		Total	
Contamination method	n[a]	%	n[a]	%	n[a]	%
Heterosexual intercourse	5,311	79	3,902	37	9,213	53.3
Homosexual intercourse	-	-	4,317	41	4,317	25
Drug injection	76	1	271	2.6	347	2
Other	64	1	85	0.8	149	0.9
Unknown	1,301	19	1,950	18.6	3,251	18.8
Total	6,752	100	10,525	100	17,277	100

a: Number of provisional, non-rectified cases within the declaration periods
b: 111 mother-to-child transmissions, 27 homosexual drug users, 9 transfusion recipients and 2 haemophiliacs contaminated during the 1980s.
Source: the compulsory notification system for HIV infection, InVS (data from 30/06/07).

The number of new AIDS cases among intravenous drug users has been continuously falling since the mid-1990s. Although at the time they accounted for a quarter of those persons diagnosed with AIDS, in 2006 they accounted for no more than 9%, although this percentage increased in 2007.

Table 6.4. New AIDS cases among intravenous drug users (IDU), 1998-2007.

	1998	1999	2000	2001	2002	2003	2004	2005*	2006*	2007*
IDU	357	309	246	258	204	172	167	117	86	24
Total new AIDS cases	1,948	1,835	1,732	1,673	1,637	1,476	1,377	1,273	974	193
IDU as a %	18.3	16.8	14.2	15.4	12.4	11.6	12.1	9.0	8.8	12.4

*: Provision, non-rectified data from 30/06/07
Source: AIDS monitoring system, InVS (Data from 30/06/06).

The PRELUD data

Carried out every two years, the front line drug users' survey (*Première ligne usagers de drogues* or PRELUD) seeks to monitor practices and use regarding psychotropic substances in a population group with a high prevalence of drug use. It is carried out on a voluntary basis, in the so-called 'front line" centres which have gone on to become CAARUDs (*Centres d'accueil et d'accompagnement à la réduction des risques pour usagers de drogues* – Reception and harm reduction support centres for drug users). In 2006, on five of the nine

sites taking part in the PRELUD survey (Dijon, Lyons, Metz, Rennes and Toulouse), a saliva sample test was proposed to each drug user in order to identify antibodies pointing to the presence of HIV and hepatitis C infection. This so-called PRELUD "bio" survey revealed that among all the persons interviewed, the prevalence of HIV infection stood at 8.5%. The percentage of people testing positive for the disease among those claiming to be infection-free was 5.0 %[24].

Table 6.5. Estimated prevalence of HIV infection based on saliva samples taken from users of front line centres participating in the Prelud Bio survey according to injection status and age.

			Has injected at least once during his/her life		Has injected or snorted at least once in his/her life
			No	Yes	
		All	N = 136	N = 348	N = 467
All	N = 484	8.5%	9.6%	8.0%	8.8%
< 25 y.o.	N = 134	6.0%	-	5.6%	6.2%
25 to 34 y.o.	N = 211	7.1%	-	5.5%	7.4%
> 34 y.o.	N = 139	13%	-	13%	13%

Source: PRELUD 2006, Trend / OFDT

The data based on the user's own declarations (the only data currently available in order to track changes in France) obtained in the nine towns involved revealed a fall in the declared levels of contamination by the AIDS virus between 2003 and 2006.

Table 6.6. Changes in the number of people declaring themselves as being HIV-positive in the front line centres between 2003 and 2006.

	N 2003	N 2006	2003	2006	2006 standardised*
< 25 y.o.	143	201	4.9%	0.5%	0.3%
25-34 y.o.	305	359	8.2%	4.2%	4.3%
> 35 y.o.	221	314	16.3%	12.1%	13.8%
All	669	874	10.2%	6.2%	7.1%

Source: Première ligne2003, PRELUD 2006, Trend/OFDT.

* Based on the weighting of the sites (2003) and age groups.

With regard to the biological data concerning the hepatitis C virus, in 2006 the PRELUD "bio" survey reported a hepatitis C prevalence of 32%. Among injectors, the estimated prevalence rises to 42%. The percentage of people testing positive among those claiming to be infection-free was 8.5%.

[24] It appears risky to attempt to make a comparison with the results derived from the "Coquelicot" survey:
- The population group is different (in one case we are dealing with injectors and "snorters" encountered in a range of structures, and in the other case only users of front line structures, who are on average five years younger;
- The method is different (concerning both the biological and participant selection aspects);
- The cities surveyed are also different.

Table 6.7. Estimated prevalence of hepatitis C infection based on saliva samples taken from users of front line centres participating in the Prelud Bio survey according to injection status and age.

		All	Has injected at least once in his/her life		Has injected or snorted at least once in his/her life
			No		
	Particip.	N=500	N=138	N=362	N=483
All	N=500	32%	7%	42%	33%
< 25 y.o	N=138	13%	-	16 %	14%
25-34 y.o.	N=214	31%	-	44 %	32%
> 34 y.o.	N=148	51%	-	63 %	53%

Source: PRELUD 2006, Trend/OFDT.

The declaration data points to a reduction in the prevalence of hepatitis C infection among the youngest users:

Table 6.8. Changes in the number of people declaring themselves as being infected with hepatitis C in the front line centres between 2003 and 2006

	N 2003	N 2006	2003	2006	2006 standardised*	2006 Injectors/lifetime
< 25 y.o.	131	193	17.6%	8.4%	8.8%	12.2%
25-34 y.o.	299	344	45.8%	29.4%	28.1%	40.9%
> 35 y.o.	213	273	55.9%	54.4%	52.3%	64.5%
All	643	852	43.4%	34.0%	33.5%	44.6%

Source: PRELUD 2006, Trend/OFDT. * based on the weighting and age groups of the sites: 2003.

However, this phenomenon is not the result of a reduction in injection among the latter. Indeed, among drug users aged below 25, the percentage of people having injected at least once during their lives increased from 51% in 2003 to 59% in 2006, while the percentage of people stating they had injected more than 10 times during their lives increased over the same period from 41% to 50%.

However, we are also witnessing an increase in screening frequency among younger users, with screening being more frequent in 2006 than in 2003, which may be responsible for changes in the respondents (as only those having undergone screening can answer the question). Among the under 25s, the percentage of users who have never undergone screening fell from 39% to 25% between 2003 and 2006.

ENa-CAARUD data

This national survey, carried out for the first time in late 2006 involving users of the 114 centres authorised to operate as "CAARUDs" seeks to accurately describe the diversity and use practices of a significant population of current drug users. In particular, it provides information on the infection status declared by the users interviewed in these centres (HIV and hepatitis C). In 2006, the majority of drug users underwent screening tests (84% for HIV and 81% for hepatitis C) and among these, 7.3% stated that they were HIV-positive and 35% infected with hepatitis C.

According to their statements, there are twice as many HIV-positive persons among the intravenous drug users than among non-injectors 8.7% vs. 3.7%) and more than six times as

many are infected with hepatitis C (47.2% vs. 7.6%). Women have a much higher tendency to state that they are HIV-positive than men (9% vs. 6.6%) which is chiefly explained by the differences in declared prevalence between men and women among non-injectors (HIV 6.1% vs. 3.3%). While declared HIV infection remains low among the youngest users (probably due to the harm reduction policy deployed from the late 1980s onwards) the declared hepatitis C contamination levels remain high:

Table 6.9. Changes in the number of persons declared as being HIV and hepatitis C positive in front line centres

	<20 y.o.	20-24	25-29	30-34	35-39	40-44	45-49	50+
HIV	0%	3%	3%	3%	8%	14%	19%	9%
Hepatitis C	7%	16%	23%	36%	42%	47%	48%	44%

Source: PRELUD 2006, Trend / OFDT.

The vast majority of HIV positive individuals (88%) consulted a doctor during the last 12 months for this disease and just under 7 people out of 10 were treated (68.5%). Where hepatitis C is concerned, 67% consulted a doctor during the same period but unlike HIV, only 22% received treatment for this illness.

RECAP data

No new information available

6.3 Psychiatric comorbidities

No new information available

6.4 Other comorbidities related to drug use

No new information available

77. Responses to health-related problems

Responses to health problems: general context

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

The prevention and treatment of infectious illnesses related to drug use:

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

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

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

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

- The unrestricted sale of syringes in pharmacies (sold without prescription since 1987);
- Vending machines selling "Stéribox®" type injection packs (with a total of 225 in 2002) or intended for the recovery of used syringes (153 in 2002);
- Association-run syringe exchange programmes (SEPs) of which there were 130 operational in 2006 (CAARUD data, Toufik et al., 2008);
- "Reception" or contact centres for drug users (40 en 2001);

Overall, the harm reduction scheme covers most of France.

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

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

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

The prevention of infectious illnesses is also planned and supervised for drug users in prisons (please see chapter 9).

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

7.1 The prevention of drug-related deaths

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

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

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

Among patients attending low threshold structures (CAARUDs): PRELUD data from 2006.

The vast majority of users have already been screened for AIDS and hepatitis C infections. However, when high-risk practices persist, such screening needs to be repeated regularly or serves no purpose. Nevertheless, for more than half of those who have already undergone screening for HIV or hepatitis C, their tests now date back more than six months.

Table 7.1. Screening tests for hepatitis C undertaken by users attending front line centres: Prelud 2006.

When were you last tested?	< 25 y.o. (N=252)	From 25 to 34 y.o. N=(409)	> 34 y.o. (N=356)	All (N=1017)
Not tested	23 %	16 %	12 %	16 %
Less than 3 months ago	22 %	21 %	22 %	22 %
Between 3 and 6 months ago	13 %	15 %	13 %	14 %
More than 6 months ago	38 %	45 %	50 %	45 %
Don't know	3.2%	3.2 %	3.4%	3.2%
All	100%	100%	100%	100%

Source: PRELUD 2006, Trend/OFDT

More than half of the CAARUD attendees have never started a course of vaccinations against hepatitis B. However, the younger the users are, the higher the likelihood that they will have started at least one course of vaccinations.

Table 7.2. The number of declared vaccination injections against hepatitis B by users of front line centres, 2006

	All N = 960	< 25 y.o. N = 230	From 25 to 34 y.o. N = 390	> 34 y.o. N = 370
0 injection	47 %	38 %	42 %	60 %
1 injection	19 %	26 %	20 %	12 %
2 injections	13 %	13 %	14 %	17 %
3 injections	21 %	23 %	24 %	15 %
All	100 %	100 %	100 %	100 %

Source: PRELUD 2006, Trend / OFDT

The Ena Caarud data

The majority of users have undertaken a screening test for HIV (84.4%) and hepatitis C (81.4%). No significant differences exist between men and women. Youngest and oldest users are those least likely have taken these tests. Among the under-28 group, almost half of drug users have never taken either of these tests. This is the case for just under a quarter of the 50+ age group.

Among those having taken an HIV test, the median period elapsed since the last negative test result (or the last test for which the results are not known by the user[25]) was eight months (average 15.3 months). Among the 86.4% of users able to clearly state the month and year, the test dates back six months for 45.1% of them, between six months and one year for 24.1% and more than a year for 32.9%.

Where hepatitis C is concerned, the median period since the last negative test was also six months (average 11.5 months). Among the 75.9% of users able to clearly state the date of their last test, this was less than six months ago for 26.9% of them, between six months and one year ago for 46.6% and more than one year for 26.4% (Toufik et al., 2008).

Among those users interviewed, 44% stated that they have been vaccinated against hepatitis B, although not knowing whether this was a complete vaccination or not. The 20-34 age group appears to be better covered where vaccinations are concerned as in this age group the coverage level was almost half compared to 3 or 4 out of 10 for the other age groups (Toufik et al., 2008).

Treatment.

The vast majority (87.8%) of HIV positive users consulted a doctor during the last 12 months for this illness, and just under 7 out of 10 (68.5%) received treatment.

[25] The length of time since the last test is not taken into account when the person is declared positive since he no longer undergoes screening tests.

A majority (67.8%) of hepatitis C positive users consulted a doctor during the same period. Unlike HIV however, only a minority (22.5%) received treatment for this illness (Toufik et al., 2008).

7.3 Treatments related to psychiatric comorbidities.

No new information available

7.4 Other treatments targeting health aspects related to drug use

No new information available

8. Social consequences

Social consequences: general context

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

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

Among the homeless, drug addiction predates the individual's marginalisation, (Dabit & Ducrot, 1999; Declerck & Henry, 1996; La Rosa, 1998). On the other hand, exclusion generates a keen sense of loss of status which is liable to push an individual towards drug addiction when he has not already deliberately opted for marginalisation. In the case of alcohol, it emerges that the most extreme uses observed among the homeless population are linked to the most extreme cases of insecurity. The proportion of persons with major risks of alcohol problem use appears much greater in the homeless population than in the population as a whole, in particular in the most difficult social situations (Legleye et al., 2008). But substance abuse may also be a means of coping with the violence of life on the streets: "recourse to psychoactive drugs emerges as a means of coping with problems, and this recourse in itself brings further difficulties, precipitating instability sooner" (JACOB et al., 2000).

Crime and offences linked to drug use: according to the applicable French laws relating to substance use, anyone who consumes and/or is in possession of and/or is involved in drug trafficking is liable to a criminal penalty, including imprisonment. The simple drug user may therefore be the object of arrest, followed or not by conviction and possible incarceration (please see the description of the legal framework in chapter 1 and a description of the alternatives to legal action and substitution orders in the panel featured in chapter 9).

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

Arrests for infringements of the Drug Law are classed in two broad categories: simple use and trafficking (subdivided into dealing, local trafficking and international trafficking, standard table no. 11).

Convictions recorded by the National Criminal Records Bureau (CJN) show sentencing of people taken to court for Infringements of the Drug Law. A conviction may include several offences but, conventionally, the convictions are presented according to the principal offence. The statistical categories used are as follows: illicit drug use, being helped to use by others, possession/acquisition, production/dealing/trafficking, supply, possession and acquisition, importation/exportation, other infringements of the Drug Law.

Driving after taking drugs

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

Use in jail [Standard table no. 12]: A study carried out in 2003 shows that 33% of people entering jail declare long-term, regular use of illicit drugs or misuse of detoxification drugs in the year preceding incarceration (Mouquet & al, 1999). In the general population, 6% of 18-25 year olds and 2% of 26-44 year olds consumed illicit drugs in 2002 (Legleye et al., 2008). These figures show a clear over-representation of drug users in comparison with the general population.

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

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

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

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

Social cost of drugs: Public spending on all drugs has reached 1,159.12 million euros for the year 2003; most of this was on illicit drugs (80%), while the smallest portion was consigned to tobacco (5%). Ultimately, the proportion of spending attributable to the fight against licit and illicit drugs was 0.33% of total public spending in 2003. The social cost of alcohol, tobacco and illicit drugs was 2.37%, 3.05% and 0.18% of GDP respectively for the year 2000 (Kopp & Fenoglio 2006).

8.1 Social exclusion

Please see the characteristics for the CAARUD users (point 4.3).

8.2 Crime and drug-related offences

Information provided by the Ministry of the Interior ((OCRTIS 2007): Arrests for drug-related offences.

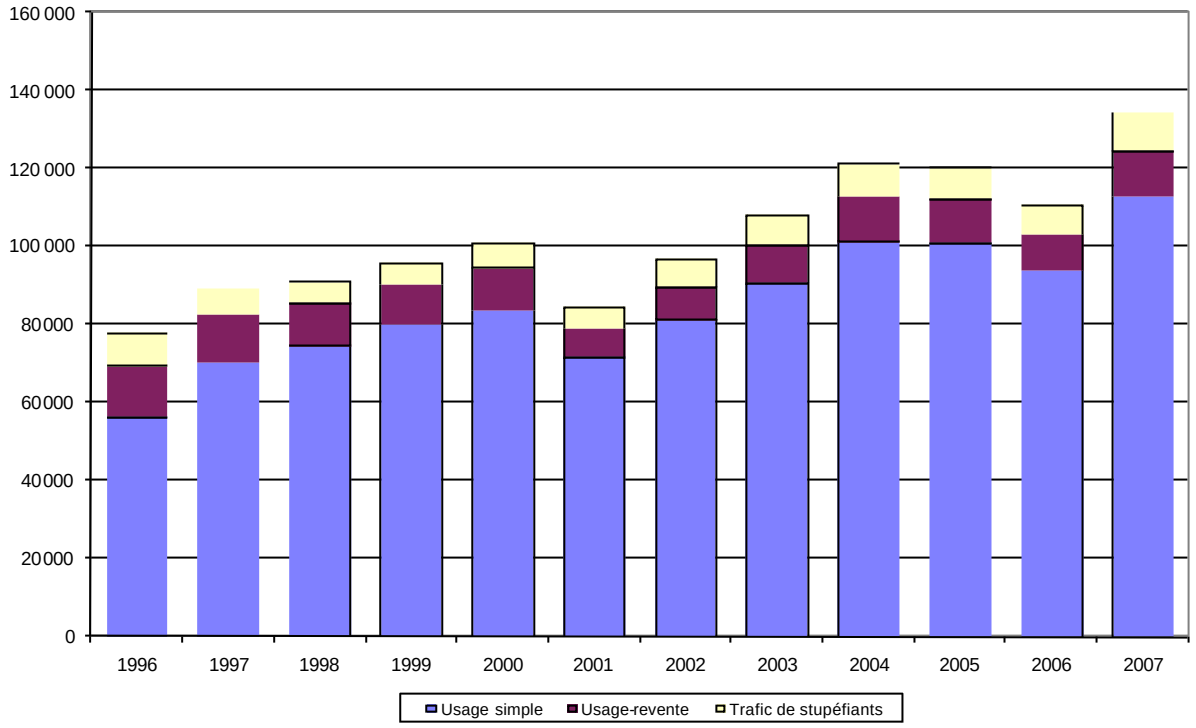
General data:
Arrests for drug-related offences made by the police, gendarmerie or customs rose by 22% in 2007 (Office central pour la répression du trafic illicite des stupéfiants (OCRTIS), 2005). This increase concerned all categories of arrests but was higher for cases of trafficking (+35%) and use/dealing (+23%) than for simple use (+20%).

Grounds for arrest:
Simple drug use remains the main reason for arrest, accounting for a total of 112,923 arrests, i.e. 85% of arrests for drug-related offences in 2007, a figure which has remained virtually unchanged since 1998.

We should also note 11,548 arrests for use/dealing, the second most important reason for arrest (accounting for 8.6% of all arrests for drug-related offences).

Arrests for trafficking comprised 1,651 arrests for international trafficking and 8,198 arrests for local trafficking (equivalent to 7.3% of all arrests for drug-related offences).

Graph 8.1. Arrests for drug-related offences since 1996.



Source: FNAILS, OCRTIS
(Simple use, Use/Dealing, Narcotics trafficking)

The products involved.

Cannabis remains the main product concerned when we consider arrests for drug-related offences, regardless of the grounds for the arrest: 86.3% of arrests for use, 61.5% of cases of use/dealing and of trafficking.

Table 8.1. Arrests for drug-related offences (by product), 2007

	Use	% in column	Use/dealing and trafficking	% in column	Total	% in column
Cannabis	97 460	86.3%	13 154	61.5%	110 614	82.4%
Heroin	6 438	5.7%	2 952	13.8%	9 390	7.0%
Cocaine	4 043	3.6%	3 116	14.6%	7 159	5.3%
Crack	494	0.4%	269	1.3%	763	0.6%
Ecstasy	751	0.7%	388	1.8%	1 139	0.8%
Medicines (1)	332	0.3%	245	1.1%	577	0.4%
Amphetamines	294	0.3%	109	0.5%	403	0.3%
Mushrooms	142	0.1%	10	0.0%	152	0.1%
Other (2)	2 969	2.6%	1 154	5.4%	4 123	3.1%
Total	112 923	100%	21 397	100%	134 320	100%

(1) Subutex®, methadone, skenan®, rohypnol®, others.

(2) Khat, methamphetamines, LSD, opium, morphine, solvents, others

Source: OSIRIS, OCRTIS.

Overall, cannabis is followed by heroin and cocaine with arrests for heroin being more frequent among users than is the case the cocaine (5.7% vs. 3.6%) while arrests for use/dealing and trafficking are more frequent for cocaine (14.6% vs. 13.8%).
Where France is concerned, we should point out the (relatively) high level of arrests for the misuse of medicines (particularly Subutex®, but also unidentified products: this concerned users who are unable to produce a valid medical prescription) and for hallucinogenic mushrooms.

Regarding the products, the increase in the number of arrests (+21.6%) concerns all products:

- The rise in the number of arrests for use, use/dealing and trafficking of heroin: underway since 2005, this upward trend continued throughout 2006 and 2007 with 33% more arrests (+30% among the users arrested, +41% among the user/resellers and dealers). These figures appear to mark the end of the downward trend noted throughout the 1990s. At the same time, we are also seeing an end to the increase in age of the heroin users arrested.
- Cocaine is also a product occurring increasingly frequently among arrests: +37% among the users arrested, and +22% among the user/resellers and traffickers (cocaine is the main drug found among international dealers, more than half of whom are arrested in the Parisian airports).
- Arrests for amphetamines are also on the rise, following a slight fall in 2006, totalling 403 arrests in 2007, of which 294 were for use (+54%) and 109 for use/dealing and trafficking (+40%). Arrests for cannabis reached a record number of 110,614 arrests in 2007 following a slight fall in 2006. This increase concerns arrests for simple use (+17%) and also for use/dealing and trafficking (+20%).
- The fall in the number of arrests for ecstasy seen since 2005 continued in 2007 (-8%), with arrest figures falling from 2,084 arrests in 2005 to 1,139 in 2007.
- Arrests for crack fell significantly in 2006, but increased by 16% in 2007 with 763 arrests, chiefly concentrated in the French overseas *départements* and the Paris region.
- This year, we should note the significant increase in arrests for other substances (LSD, khat, GHB, ketamine, opium, morphine and other unspecified substances), that, however the product is not specified in.

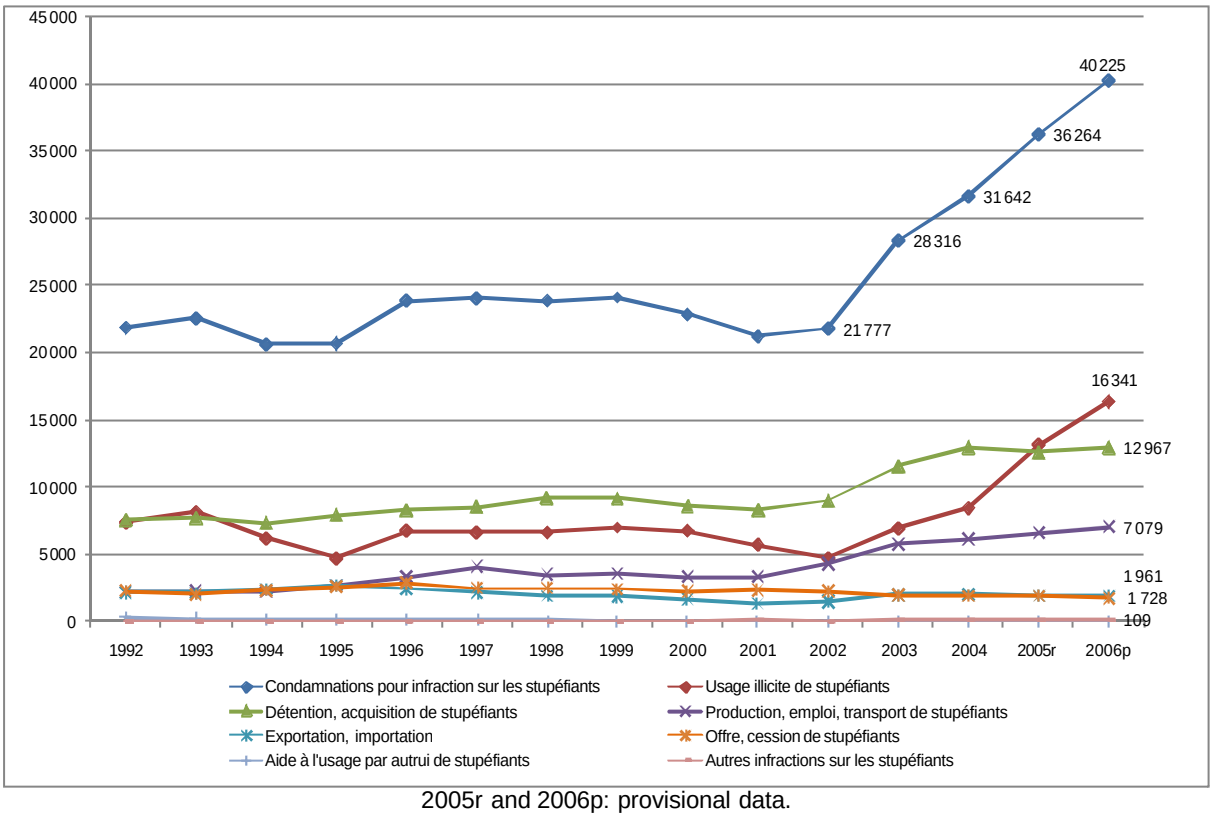
Information from the Ministry of Justice: sentencing data.

Sentencing statistics are published two years after the sentences are issued (Justice, 2007). Consequently, the following information is from the year 2006 and is not officially considered as being definitive.

A total of 40,225 sentences were issued in 2006 for drug-related offences (as the main offence)[26], this figure being 11% higher than in 2005.

[26] A sentence may cover several offences (something which is commonplace with regard to drug-related offences). The main offence is that entered in first position in the crime register although this does not always signfy that this is the most serious offence committed. If we take into account those offences entered in second position we arrive at a total of 101,000 penalties issued for drug-related offences for 2004. No information is yet available for 2005.

Graph 8.2. Sentences for drug-related offencesissued in France



2005r and 2006p: provisional data.
Source: Data from the Ministry of Justice's Statistical Directory

Sentences for drug-related offences	Illegal use of narcotics
Possession/acquisition of narcotics	Production/ dealing/trafficking of narcotics
Exportation/Import ation	Proposed sale or transfer of narcotics
Assisting others in using narcotics	Other drug-related offences

The increase shown concerns all drug-related offences, and in particular those most frequently brought before the courts:

- In 2006, 16,341 sentences were issued for use (i.e. 25% more than in 2005 and 93% more than in 2004). Accounting for 40.6% of offences for which sentences were issued, narcotics use became the leading offence for which sentences were handed down.

- The possession and acquisition of narcotics concerned 12,967 sentences, putting this category in second place as a percentage of all sentences (accounting for 32% of all narcotics sentences).

- Sentences for the production, dealing or trafficking of narcotics totalled 7,079 in all, a fall of 8%.

- Trafficking (importation/exportation) was cited as the main offence in 1,961 sentences.

Overall, in 2006 when a drug-related offence was cited as the main offence it resulted in a prison sentence in 63% of cases (imprisonment or a partial suspended sentence in half of the cases), a fine in 25% of cases and a substitute sentence in 7% of cases (day-fines or community service).

Dismissals of charges are rare, accounting for fewer than 1% of all sentences issued. Educational measures (a total of 1,538 were issued in 2006) account for 4% of sentences for drug-related offences.

Information from the Ministry of Justice: Imprisonment figures.

Stock data: on 31/12/2006, among 41,920 sentenced prisoners, 5,751 were sentenced for drug-related offences (as their main offence), accounting for 14% of the total prison population.

Flow data: Since 2003 and the cessation of the statistical analysis of the National Detainees register (*Fichier National des Détenus* - FND), the data presented by the Ministry of Justice has been extracted from the quarterly statistics from the Prisons Authority, which no longer makes it possible to analyse the flow of prisoners (the throughput of prisoners during the year).

Driving after using narcotics: checks and penalties in 2005-2006[27].

Reminder of the current law.

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

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

Screening in 2007

No new data available

Offences for which sentences were issued in 2007.

No new information available

Sentences in 2006

In 2006, 5,207 sentences were issued, this being 56% more than in 2005. In all, 49% of these sentences resulted in a prison sentence (of which only 11% resulted in actual

[27] Ministère de l'Intérieur (…), *Bilan du comportement des usagers de la route, année 2006*, 77 p. (http://www.interieur.gouv.fr/rubriques/a/a7_statistiques_securite_routiere); special extract from the National Crime Register by the Sub-Department for Statistics, Surveys and Documentation.

imprisonment, either partially or totally). Approximately 34% resulted in a fine and 16% in an alternative penalty (probably driving licence withdrawals).

These penalties are similar to those for driving under the influence of alcohol, although fines tend to be rarer and alternative penalties more frequent.

The penalties are less severe than for driving under the influence of narcotics alone or for refusing to take a test. However, they are stiffer in the event of injury (9 out of 10 sentences result in imprisonment) and in particular in the event of manslaughter which leads to a prison sentence (with actual imprisonment in 42% of cases, for an average period of 10.7 months)

Table 8.4. Sentences for drivers using narcotics in 2006.

	All sentences	Prison sentences	Fines	Alt. penalties	Educational measures	Charges dismissed
All offences by drivers having used narcotics	5 207	2 556	1 795	823	16	17
Driving a vehicle after taking narcotics	4 021	1 708	1613	676	11	13
Driving a vehicle under the influence of narcotics + alcohol	934	643	162	124	4	1
Injury or manslaughter caused by a driver having taken narcotics	201	176	9	11	1	2
Refusal by the driver of a vehicle to undergo analyses or tests	48	26	9	12	0	1

Source: Ministry of Justice – Sub-Department for Statistics, Surveys and Documentation – Special extract from the National Crime Register

8.3 Use in prison

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

8.4 Social cost

No new information available.

9. Responding to social problems

Responding to social problems: an overview

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

Within the various facilities, social assistants and specialised educators work with users to facilitate the reintegration process.

See also Structured Questionnaire No. 28 [social integration].

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

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

Aid for users in prison [28]:

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

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

- Harm reduction: there is no provision in French law for making injecting equipment available in prison, in contradiction with article D-273 of the criminal procedure code which states that detainees must not have at their disposal any object, medicine or substance that could be used for or facilitate suicide,

[28] For practical purposes the medical and social treatment of drug users in prison is dealth with in this chapter, although references are included in chapters 5, 6 and 7 covering these aspects among non-incarcerated drug users.

aggression or escape. A Penitentiary Administration circular has allowed free and systematic distribution of bleach to detainees since 1996.

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

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

Theoretically, substitution medicines can be prescribed to prisoners in the same way that they can be prescribed to the rest of the population, in order to start or continue a programme of treatment based on Subutex® (since 1996) or methadone (since the issuing of circular number 2002/57 dated January 30, 2002). All penal establishments are required to provide substitution treatments to inmates when they arrive in the establishment (under the terms of circular DGS/DH/DAP dated December 5, 1996). The Ministry of Health has carried out four successive surveys concerning substitution treatments (March 1998, November 1999, December 2001 and February 2004) which show that access to substitution treatments for heroin-addicted detainees remains more difficult than outside prison, despite the fact that the percentage of the prison population receiving substitute treatments has increased: 2% in 1998, 3.3% in 1999, 5.4% in 2001 and 6.6% in 2004, with the majority of the treatments being based on high-dose buprenorphine (78% in 2004 vs. 22% of methadone-based treatments). The percentage of people interrupting their substitution treatments upon arrival in prison has fallen, dropping from 19% in 1999 to 5.5% in 2001. A survey in 2007, concerning the first prescription of methadone carried out within the penal environment among others, confirms the improvements in access to substitution treatments since the introduction of the 2002 circular and also demonstrates a gradual rebalancing of substitution treatments in favour of methadone (35% of opioid substitution treatments).

Furthermore, it has also been demonstrated that the number of people jailed (or re-jailed) is lower among those having undertaken substitution treatment before or during their time in prison (Levasseur et al., 2002; Rotily et al., 2000).

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

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

The Ministry of Justice circular of June 17, 1999 (NOR: JUSA9900148C) called for Prosecutors of the Republic to favour fighting local trafficking over simple drug use when dealing with arrested users. These guidelines were reaffirmed by the Ministry of Justice circular of April 8, 2005 (NOR: JUS D 05-300061 C). This recommends tailored and diversified penal responses in the fight against

substance use, as well as a crackdown policy on addictions and on individuals who promote narcotics or alcohol use under the cover of licit activities.

Social studies and personality studies (on arrested individuals) should allow the sentence to be tailored to the individual, and the most appropriate measure chosen. The diversification of penal responses is highlighted: court-ordered treatment, conditional discharge with a drug treatment referral, and discharge subject to alternative measures; socio-educational court monitoring with compulsory treatment, conditional discharge for pre-sentence penalties. The law dated March 5, 2007 concerning the prevention of delinquency (NOR: INTX0600091L) also includes an obligation (in addition to the main sentence or punishment) to complete an awareness-building course dealing with the dangers of narcotics use, the cost being borne by the offender (decree number 2007-1388 of September 26, 2007, issued in application of law number 2007-297 of March 5, 2007 NOR: JUSD0755654D).

The administration of "prison-alternative" sentences is the task of the Penitentiary Service for Reintegration and Probation (*Service pénitentiaire d'insertion et de probation* or SPIP). At a local level, working under the supervision of the sentencing judge, the SPIP identifies the social, medical and other organisations which would enable court-ordered rehabilitation to take place.

On the subject of court-ordered treatment, which is an excellent and highly appropriate alternative measure for individuals under arrest who have an addiction problem, the national trend is towards stagnation, in spite of numerous circulars attempting to re-launch it. (in particular the Guigou circular of June 17, 1999). The law of March 5, 2007, applied by means of decree number 2008-364 of April 16, 2008 (NOR: SJSP0769782D), has extended the court-ordered treatment scheme, which can now be ordered not only as an alternative to criminal proceedings, but also as part of a penal sentence. Furthermore, the law has introduced the notion of a "relay doctor", given the task of implementing the court-ordered treatment and monitoring its performance

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

9.1 Social integration

A survey carried out in 2007 by the OFDT (Obradovic & Canarelli, 2008) aimed at assessing the impact of circular number 2002/57 of January 30, 2002 concerning the first prescription of methadone by doctors practising in health care establishments (both hospitals and penal establishments), has made it possible to demonstrate that access to methadone has increased in both areas. Within the penal environment[29], a survey has shown that more than a third of opiate-dependent patients seen by the UCSAs (physical treatment units attached to the hospitals based in each penal establishment) or the SMPRs (regional psychiatric treatment services operating in detention centres) as part of a substitution treatment are able to receive methadone-based substitutes (35%). In other words, the proportion of methadone as a percentage of all substitution treatments has significantly increased as this was previously assessed at 22% in 2004, for the same sample group of establishments

[29] The results from hospitals are shown in chapter 5.3

interviewed (the DGS/DHOS 2004 survey). A weighted estimate has made it possible to establish that patients receiving methadone account for approximately 40% of the opioid-dependent prison population.

Among the difficulties most often encountered when prescribing methadone, the most frequent concerns the difficulty in identifying the patient's release date, where we take account of early release (40%). The second constraint where first prescription is concerned is related to the short time prisoners remain in detention, particularly in remand centres, which does not make it possible to monitor the detainee patients over the long-term. Additionally, almost a quarter of professionals replying to the survey (24%) stated a preference for HDB when it comes to treating opioid-dependent prisoners. Furthermore, 22% of establishments mentioned difficulties in finding a follow-up organisation to take over the prisoners' treatment at the time of release, and a similar number of professionals mentioned a lack of staff (20%) which has a negative impact on the organisation of methadone distribution. However, it must be mentioned that several penal establishments (even if few in number) continue to mention reticence on the part of doctors concerning the prescription of opiates substitution treatments in penal establishments, and more than a quarter stated that they had issued no prescriptions for methadone during the six month period concerned in 2006.

9.2 The prevention of drug-related crime and offences

In application of the law dated March 5, 2007 concerning the prevention of delinquency (NOR: INTX0600091L), as an additional punishment the judge may order an offender to attend an awareness-building course concerning the dangers of narcotics use, the cost of which is borne by the offender in question (as per the conditions specified in decree number 2007-1388 of September 26, 2007, in application of the law number 2007-297 of March 5, 2007, NOR: JUSD0755654D). These group courses, which were launched from January 2008 onwards via associations operating in the drug addiction field, are intended among other things to inform offenders of the effects of narcotics use upon their health, of the law in this field and the consequences of any infractions committed, combined with an explanation of the social aspects of drug use (risks to oneself and to others, trafficking, violence, etc). An assessment of these courses is planned for the first quarter of 2009.

As part of the fight against narcotics use by drivers, (and following the law dated February 3, 2003 which introduces a new crime of driving under the influence of cannabis, cocaine, amphetamines or opioids), on June 18, 2007 the Ministry of the Interior launched a test campaign for the approval of saliva kits, with the aim being *"to verify the effectiveness and reliability of the various saliva kits proposed by the manufacturers and to boost awareness among the public"*[30]. These kits are intended to detect the presence of substances such as cannabis, cocaine, ecstasy, amphetamines and opioids. The planned trial dates spanned the period from June 15 to September 15, 2007, with a target of 30,000 tests to be carried out in Paris, Lyon, Marseille, Bordeaux, Toulouse, Strasbourg, Rennes, Montpellier and Lille as well as in the Pays de la Loire, Centre and Lorraine regions. Three kits were tested, with the final selection plans for Autumn 2007. If the results are approved, the Ministry of the Interior hopes to be able to extend their use nationally and to reach a target of 100,000 tests carried out in 2008.

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

In April 2007, a new tool was prepared working jointly with the French Federation of Insurance Companies (FFSA) and approved by the MILDT[31]. This comprises an educational kit provided to teachers to help them generate a debate in the classroom, and an interactive area aimed at young people and parents. The kit contains a CD-ROM, a DVD and a guidebook for the teacher. It is circulated free of charge by the association's local committees. It includes eyewitness accounts from young people involved in accidents, interviews with experts, reports and explanatory diagrams.

As a reminder, the ROSITA report (*ROadSIde Testing Assessment*) submitted to the European Commission in 2006 questioned the clinical validity of saliva tests with regard to cannabis detection. The THC present in urine and blood was detected in less than half of the tests (46%).

[31] Available on the website www.preventionroutiere.asso.fr

10. Market and supply

Overview

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

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

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

- Data from repressive bodies (the police, customs and the gendarmerie) is supplied by the Statistical Information and Research Tool for Drug-Related Offences (*Outil Statistique d'Information et de Recherche sur les Infractions sur les stupéfiants* or OSIRIS) managed by the OCRTIS. This provides the number as well as the quantities seized on French territory. Seizures recorded by repressive bodies are only a partial indicator of the supply of illicit drugs, because they are directly linked to the activity of the services concerned, and because chance plays a not insignificant role in their annual variation. It is therefore indispensable to study developments over long periods.

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

Availability and supply:

- Cannabis (both resin and leaf) is the most widely available illegal product in France. For several years now the leaf variety has been particularly popular. This phenomenon can be explained by the current fascination for all products seen as "natural". It also bears witness to the increase in the home growing of cannabis, which is believed to concern some 200,000 people (estimation of the number of people having grown cannabis at least once, based on the ESCAPAD 2005 and Health Barometer surveys - please see Cannabis Données Essentielles (*Cannabis Key Data*[32]).

- The availability of cocaine is constantly increasing in France, with this drug now finding its way to extremely varied sections of society. This phenomenon has been aided over the last decade or so by constant falls in the price per gram of cocaine, which is today around €60. On the other hand, cocaine hydrochloride in its basic form, crack, remains confined to a very specific and highly marginalised section of the user population living in the Paris region. Base cocaine hydrochloride, known as "free base" is used by a section of the population found in the free party and "rave" environments.

- After cannabis, ecstasy is the second most popular illegal substance in both the commercial and alternative festive environments. For several years now, it has been noted that a small percentage of users have developed a liking for a powdered form of this drug, tiring of the tablet form.

- Heroin is a product which is today not particularly available or visible. This situation was further accentuated by the disappearance of open-concert venues,

[32] http://www.ofdt.fr/BDD/publications/docs/cdecomp.pdf

and the tendency for minor dealers to turn their attention to cocaine instead, which is more profitable. However, the situation is possibly in the process of changing. Indeed, it appears that the availability of heroin is on the rise both in the urban and festive environments, and that its use is today spreading to new audiences.

- The availability and accessibility of high dose buprenorphine (Subutex®) remains high on the urban black market despite strict rules concerning the issuing of this drug being adopted by the public authorities.

- The use of natural hallucinogens and particularly hallucinogenic mushrooms is increasing, due among other things to the upsurge in "home growing" and the availability of these drugs via the Internet.

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

The following trends, per drug, have been observed.

- The largest number of seizures concern cannabis and particularly cannabis resin. The quantities seized increased from 2002 onwards, and have been declining again since 2005;

- Since the late 1980s, we have witnessed significant growth in cocaine and crack seizures, a trend which has continued up to the present day;

- Following an increase in the quantities of heroin seized during the 1980s and up until 1994, the subsequent downward trend now appears to be in the process of being reversed since 2002;

- Since the early 1990s, ecstasy seizures have risen sharply in terms of both numbers and quantities, while the increase in amphetamine seizures has been rather more moderate;

- The quantity and number of LSD seizures fell between 1990-2006, following peaks in 1992, 1993, 2003 and 2004.

For details of the quantities seized and the number of seizures carried out over the last four years, please refer to Standard table no. 13.

Price and purity: information concerning the price and purity of psychoactive drugs has been available in France since the year 2000.

Standard table no.14 shows the purity of the drugs over the last three years. The composition and prices of the main illicit drugs are shown in standard tables nos. 15 and 16.

- Cannabis

Since 2002, cannabis leaf has been sold at under €5 per gram. In 2005, the price increased slightly compared to previous years (€6.4) with users tending to favour higher quality products. More than 80% of the samples analysed in 2005 contained less than 15% tetrahydrocannabinol (THC). The THC content is extremely variable. It was higher in those samples believed to originate from the Netherlands.

The price of resin has remained stable at around €5 per gram for several years now. More than 90% of the samples contain less than 15% of THC (2005).

- Opiates

The average price of brown heroin in mainland France revealed by the surveys carried out involving low threshold structures was approximately €40 per gram in 2006. The level of purity is most often between 0 and 20%.

The median price of an 8 mg Subutex® (HDB) tablet on the black market fell from €6 to €3 between 2000 and 2002. After rising up to €5 in 2005, in 2006 it would appear that the median price per 8 mg tablet was €3.

- Cocaine

The price of cocaine hydrochloride and cocaine in base form (crack) varies according to the sites and the social areas in which observation takes place. In mainland France, in 2006 the average price per gram of cocaine hydrochloride was €58.5 (as in 2005), one of the lowest levels seen in seven years. The purity level of the cocaine seized is often between 60 and 100%. The products most often used to cut the cocaine are lidocaine, phenacetine and procaine.

- Ecstasy

The average price of an ecstasy tablet is around €5 each. However, the price per tablet can fall well below this level if purchased in bulk. In 2003, among the tablets collected by SINTES, 89% contained MDMA and 93 % at least one metamphetamine. The average is 54 mg of MDMA per tablet (vs. 56 mg in 2002, 63 mg in 2001 and 74 mg in 2000) almost 4% of the tablets were heavily dosed (>100 mg). The dosage of the powders and gels containing MDMA is on average double that of the tablets (51% MDMA for the powders (33 doses); 53% for the gels (34 doses) and 24% for the tablets).

10.1 Availability and supply

The following information is derived from the drug trend monitoring carried out by the TREND scheme during 2007.

Heroin

In France, heroin circulates in two chemical forms: hydrochloride (white) and base (brown). These two heroin types are not available to the same extent. The first is extremely rare, and appears to be limited to a number of restricted circles such as the Chinese community in the Paris region, while the second is far more widely available.

Since 2006, we appear to be witnessing a far higher level of brown heroin availability, whether in the urban or festive environments. In 2007, this trend continued. Virtually all of the sites covered by the TREND scheme reported a rise in availability and the presence of younger users in both environments. In Marseilles, (a site which up until this year seemed to be relatively spared by this phenomenon), the availability of this product is now increasing, particularly in the alternative festive environments. It also appears that we are seeing a reorganisation of the supply chain on numerous sites, leading to this product becoming more accessible. The street selling of heroin is increasingly visible and appears to be carried out by dealer networks which up until now had limited themselves to selling cannabis resin.

High-dose buprenorphine

High-dose buprenorphine is a morphinic agonist-antagonist prescribed as part of a heroin substitution treatment.

HDB is available in pharmacies in three forms: the form marketed since 1996 under the brand name Subutex® by the laboratory Schering-Plough, and two generic forms, produced by the company Arrow and available in pharmacies since March 2006, and by the company Merck (2007). Where use is concerned, it appears that Subutex® remains by far the dominant form among users, whether as part of a therapeutic treatment package or otherwise. Users consider that the generic tablet is difficult to crumble due to its hardness and small size, making injection difficult, and that the generic variety also produces less powerful effects.

In 2007, as in previous years, despite the measures taken by the public authorities (particularly since 2005) to more tightly manage its prescription, HDB in its Subutex® form remains widely available on the black market in urban areas. Although the misuse of this product mainly concerns highly marginalised users visiting so-called "front line" centres, for two years now we have been seeing new, better socially integrated user groups appearing at a number of sites, who may consume Subutex® in order to regulate their absorption of a stimulant to help them "come down", or on a more daily basis for "recreational" purposes.

Cocaine

Cocaine is available in two forms: hydrochloride (a white powder obtained from coca leaves) which is intended to be snorted (absorption via the nasal passage) or injected (intravenous use); and base or free base (rocks or cakes) intended to be smoked (absorption via the lungs).

The availability of cocaine in its hydrochloride form has constantly increased over the last decade. The year 2007 was no exception. The use of this drug concerns extremely diverse sections of the French population, and it can be found in both the urban and festive environments. The most striking phenomenon lies in the growth of cocaine use and trafficking in the poorest inner-city areas of the main urban centres.

Cocaine in its base or free base form appears to be confined to specific areas. This is the case with crack, which is only available in northern Paris and to a lesser extent in the *département* around Seine-Saint-Denis, where it is used by an extremely marginalised section of the population. In 2007, the Paris site reported changes in the supply of crack. While this had previously been the exclusive domain of African dealers, it appeared that cannabis dealing networks were now beginning to sell crack and cocaine, which were seen as more lucrative. This new situation is believed to have had an impact on supply, which is extended to encompass new markets, including users who are better integrated socially, and youngsters from the "counterculture".

For its part, free-base does not appear to be consumed other than by users visiting alternative techno events, even though its geographical coverage zone is larger than that for crack.

Ecstasy, amphetamines and other synthetic drugs

Ecstasy is chiefly available in three forms: tablets (often featuring a logo), gel and powder. It is also sometimes found in so-called "liquid" or "crystal" forms, but these are extremely rare. For several years now, observers operating within the TREND scheme have reported the declining popularity of the "tablet" and "gel" forms. This trend appears to be continuing, encouraging the growth of the powdered form, which is distributed under the name "MDMA". The powder is increasingly available and finding its way into the hands of ever more diverse user groups. Users feel that the quality of MDMA is higher than that of the powders, and its appearance is also similar to cocaine which enjoys a very positive image.

Amphetamines, and in particular speed, are also frequently found in the festive environment, where they compete well with cocaine thanks to their similar effects and low price.

Hallucinogens

LSD is available in France in three forms: the so-called "blotter" form (which consists of absorbent paper soaked in the drug), the liquid "drops" form (the drug is added to a sugar cube or diluted in a glass of alcohol) and the microdot form.

In 2007, availability appeared to be particularly high among the rave and free party crowd, confirming the trend already observed for three years now pointing to this product making a comeback. This is also borne out by seizures carried out by the police, customs and gendarmerie, which are 134% higher than in 2006.

10.2 Seizures

In 2007, the number of seizures totalled 94,431 ((OCRTIS, 2008)), compared to 78,287 in 2006, an increase of 21%. The volumes of narcotics seized significantly fell, with this fall concerning all categories of narcotic substances, although the reduction varied in scale according to the products concerned. A product by product analysis of the 2007 figures reveals the following highlights:

- A significant reduction in the quantities of cannabis seized (-48% compared to 2006). The decline in cannabis seizures chiefly concerned resin, for which the fall was almost 50%.
- The volumes of crack seized fell by 20%, from 8.7 kg to 7 kg in 2007.
- The quantities of ecstasy seized fell slightly, (-9%) compared to 2006 with almost 1,360,000 doses. Cocaine seizures in 2006 totalled 10,166 kg, falling by 35%, with 6,579 kg seized in 2007.
- Heroin seizures exceeded one tonne for the second consecutive year, totalling 1,036 kg. The quantities were already increasing since 2002, but as for all products the changes in quantities appear to be less striking as they are more closely tied to special "one-off" seizures.

Table 10.1. Number of seizures and quantities seized of the main illicit drugs in France, 2006-2007.

	2006		2007		Change (%)	
	Nb	Qty	Nb	Qty	Nb	Qty
Cannabis (kg)	68,049	71,762	--	37,282	--	-48%
Resin	57,848	67,892	--	34,183	--	-50%
Leaf	10,205	3,774	--	3,048	--	-19%
Heroin (kg)	3,212	1,052	--	1,036	--	-1%
Cocaine (kg)	3,135	10,166	--	6,579	--	-35%
Crack (kg)	442	9	--	7	--	-23%
Amphetamines (kg)		78	--	307	--	294%
Ecstasy (doses)	924	1,488,919	--	1,359,912	--	-9%
Hall. mushrooms. (kg)	120	15	--	23	--	53%
Total	78,287	--	94 431	--	20.6%	--

Source: FNAILS, OCRTIS 2006.

The origin and destination of the main products seized in France:

In its summary the OCRTIS points out that:

- Cannabis is the leading narcotic product where trafficking is concerned. The major fall in cannabis seizures (-48%) can be explained by the fact that other channels are now being used to import resin into Europe, in addition to alternative transportation methods (sailing boats, containers, fast motorboats, etc).
- Cocaine seizures mainly concern the airborne and maritime channels. Imported from the countries bordering the coca producing nations or brought into France indirectly via Spain, Portugal or the Netherlands, the cocaine seized in France is intended for the markets of the neighbouring European countries.
- The increase in heroin seizures can be explained by an increase in seizures during transit. Only 34% of the total seized was intended for the French market. The final destination of the heroin seized in transit is usually the United Kingdom (54%), followed by Spain (5%) and Italy (3%). Originating from Afghanistan and brought in via the Balkan route, the heroin consumed in France comes mainly from the Netherlands.
- Following the sharp fall in ecstasy seizures in 2005, seizure levels are stabilising once again. A major portion of the seizures concerns loads intercepted during transit, on their way to the United Kingdom, Italy, Portugal or Spain.

Table 10.2. Number of seizures and quantities seized of the main illicit drugs in France, 2004-2007.

	2004		2005		2006		2007	
	Nb[1]	Qty[2]	Nb[1]	Qty[2]	Nb[1]	Qty[2]	Nb[1]	Qty[2]
Cannabis (kg) [3]	75,770	107,748	73,986	86 603	68,049	71,762	--	37,282
Resin	63,701	103,705	62,396	83 471	57,848	67,892	--	34,183
Leaf	10,205	3,932	10,202	3 062	10,205	3,774	--	3,048
Plants	1,492	81	1,141	54	--	36	--	37
Oil	26	3	15	2	25	2	--	0
Seeds	346	26	232	14	--	58	--	52
Heroin (kg)	2,828	558	3,242	749	3,212	1,052	--	1,036
Cocaine (kg)	3,175	4,484	3,278	5 186	3,135	10,166	--	6,579
Crack (kg)	761	18	687	11	442	9	--	7
Amphetamines (kg)	252	76	317	111	233	78	--	307
Methamphetamines (kg)	0	0			2		--	0,15
Ecstasy (doses)	2,135	1,893,226	1,620	833 648	924	1,488,919	--	1,359,912
LSD (doses)	101	19,374	99	6 323	78	5,589	--	13,107
All products	85,810		83,932		78,287		94,431	

(1) Number of seizures carried out during the year.
(2) Quantities seized during the year.

Source: FNAILS, OCRTIS 2006.

10.3 Prices and purity

Cannabis

In 2007, the average price of cannabis leaf stood at around €7 per gram as in 2006. It appeared that users were paying great attention to the quality of the product and that this selectivity was bringing about a slight increase in market prices. The average price per gram of cannabis resin stood at €6 per gram which is slightly up compared to previous years.

The average THC content of cannabis leaf is 8% (flowering tops) although this level is highly variable (ranging from 6% to 22%). Leaf cut with glass microbeads has been found in several regions. The mass of the microbeads accounts for approximately 30% of the mass for the sample. These are very similar to silica microparticles and a number of these microbeads (though very few) may even have a diameter of less than 5 µ.

The average price per gram of cannabis resin is very much in line with that seen in previous years at €5 per gram and may even fall to 4 or 3 euros when buying in bulk. The average price per gram of cannabis leaf has increased slightly compared to previous years (€6.4) with users now tending to be more selective where quality is concerned.

The average THC content in cannabis resin is 11% which is slightly up compared to 2006 (to be confirmed in 2008).

Heroin

According to the data collected as part of the TREND scheme, the average price per gram of average quality brown heroin sold on the street or intended for users in the urban environment varies between 50 and 60. This is significantly more expensive than in previous years. According to the "heroin watch" scheme run by the SINTES programme, the average

price of heroin in its base form is €42 per gram, which has remained virtually unchanged since 2006.

Altogether, 94% of heroin circulates in its base form (i.e. "brown" heroin).

The average heroin content in the powders consumed by drug users is 7.6% (ranging from 0 to 60%). The trend is slightly up since 2003. The cutting product used in most heroin powders is a mixture of caffeine and paracetamol. The average caffeine content is 21% while the average paracetamol content stands at 42%.

High-dose buprenorphine

In 2007, despite the launch of generic products on the market, the form marketed under the brand name Subutex® continues to enjoy a virtual monopoly of the black market in major urban areas. An 8 mg Subutex® tablet sells for an average of €5.

Cocaine

In 2007, the average price per gram of cocaine was €60. This price has remained stable compared to previous years.

As has been the case for several years now, the cocaine content is between 10 and 30%. The most commonly used psychoactive cutting products are phenacetine (35%), diltiazem (30%), caffeine (20%), hydroxyzine (17%), levamisole (12%), lidocaine (11%) and procaine (5%). Apart from lidocaine, all of these products are now being encountered on a more frequent basis.

Amphetamines

The price of the most widely distributed form of amphetamine (speed, in powder form) is around €15.

Ecstasy

The generic term "ecstasy" actually covers three different varieties of the same active ingredient (tablets, gels and powders).

- In 2007, ecstasy tablets were trading at a price of around €5 each. This price can nevertheless be deceptive as more and more users now have a tendency to buy their tablets "in bulk", which tends to lower the unit price to almost €2.
- The price of the gel is around €10.
- The price of so-called "MDMA" has reached the same levels as the price per gram for cocaine, i.e. €60.

PART B. SPECIAL FEATURE

11. Sentencing Statistics.

11.1. Options available in France

Personal possession or use

In the French justice system, drug use and drug possession are considered crimes, leading to a maximum of one year's imprisonment and a fine of €3,750. These two offences are also accompanied by offences concerning preparation for drug use, including for example incitation to use drugs or the glorification of narcotics, subject to a maximum sentence of 5 years' imprisonment and a fine of €75,000. If the incitation to use drugs is directed at a minor, the penalties can rise to 5 years' imprisonment and a fine of €100,000.

Although the applicable law concerning the repression of drug use is the law dated December 31, 1970, the circular from the Ministry of Justice dated April 8, 2005 regarding the fight against drug addiction and dependency recommends that criminal proceedings should be systematically initiated for any use of narcotics in order to "avoid drug use becoming commonplace". However, the text recommends that, as a priority, the courts should refer arrestees to the specialised treatment centres. Consequently, cases brought before the criminal courts and sentences involving imprisonment should remain exceptional. This circular therefore recommends a graduated range of sentencing solutions according to the drug use concerned, including: dismissal of the case with a caution for adults with no previous criminal history and possessing only "very low quantities of narcotics", dismissal with referral to the various health or social organisations for "occasional or regular" users of cannabis, and court-ordered treatment "involving strict medical supervision, for users of hard drugs or poly-drug users". Criminal proceedings before the criminal courts are reserved for "repeat offenders and users refusing to accept alternatives".

This circular also requires strict enforcement concerning the offence of incitation to use drugs. Among others, it particularly targets hemp shops selling cannabis seeds, and clothing featuring cannabis leaves, etc which are seen as contributing to making narcotic use commonplace.

The arsenal of repressive measures has been further bolstered by the delinquency prevention law of March 5, 2007 (and its application decree 2007-1388 of September 26, 2007) which further extends the range of penal sanctions available for the use or the incitation to use narcotics. The aim of this law is to hammer home the message that drug use is illegal, through a combination of more credible penalties and better adapted solutions. Additionally, the law introduces tougher penalties for offences involving minors or carried out in schools, drug use by a police officer or a member of transport staff when performing his duties, and for violence committed under the influence of narcotics or alcohol. It also provides the possibility for the Attorney General to order attendance at an "awareness building course" on the use of cannabis and other illicit drugs. Its purpose is to make the offender aware of the harmful consequences for human health and society of the use of such products. Based on the courses proposed in the road safety field, the course must be completed within the six months following sentencing, and paid for by the offender. The cost may not exceed the maximum fine applicable for class three offences (€450).

Finally, the law of March 5, 2007 extends the use of the simplified Penal Order procedure to cover the simple use of narcotics. Up until this point, the use of such a procedure was only

applicable in the road safety field. This is a fast-track procedure making it possible for the court to grant a judge the power to decide on the penalties to be applied without debate. This procedure makes it possible to avoid the long lead times usually occurring between infractions and sentencing.

Table 11.1. Criminal offences and the resulting legal sanctions concerning the possession and use of narcotics in France.

Offence categories	Penalty (maximum sentences)	Reference text
- The illegal use of narcotics	1 year's imprisonment and a fine of €3,750	Public health code L.3421-1
- Narcotics use observed in an area open to or frequented by the public (hotel, furnished house, boarding house, bar, restaurant, club, dance hall or performance venue	Closure by order of the local authority or courts + confiscation of the product concerned by the offence	Public health code L.3421-3, L.3422-1 Code of criminal procedure, art.706-33 Penal code, art. 222-49
- Incitement to use narcotics or positive presentation of such infringements - Incitement to contravene the narcotics laws	5 years' imprisonment and a fine of €75,000	Public health code, L.3421-4
- Proposal or transfer of narcotics to a person for his personal use	5 years' imprisonment and a fine of €75,000	Penal code, art. 222-39 1st paragraph
- Proposal or transfer of narcotics to minors or on educational or administrative premises	10 years' imprisonment	Penal code, art. 222-39 2nd paragraph
- Inciting a minor to use narcotics	5 years' imprisonment and a fine of €100,000	Penal code, art. 227-18 1st paragraph
- *Aggravating circumstances:* a minor under the age of 15 or offences committed in or near an educational establishment	7 years' imprisonment and a fine of €150,000	Penal code, art. 227-18 2nd paragraph

N.B.: Attempts to commit the offences mentioned in articles 222-36 to 222-39 are punishable by the same range of penalties (art.222-40 of the Penal code).

Production, dealing or trafficking

Concerning the repression of drug trafficking, the range of sentences is particularly severe in France when compared to other countries of the European Union. The applicable legal framework (which is based on the law dated December 31, 1970 and extended by means of numerous application circulars from the Ministry of Justice), includes a range of penalties clearly aimed at deterring would-be offenders. As an example, it authorises the use of special measures to foil presumed drug traffickers (with extended custody for up to 4 days, and the use of night searches). Additionally, since the late 1990s, around twenty new laws have further reinforced this arsenal of repressive measures, in order to combat local or international drug trafficking. Accordingly, stricter sentences have been introduced for certain categories of narcotics trafficking which can lead to life imprisonment and fines of €7.5 million. New categories of offence have also been created, including the proposal and transfer of drugs for personal use, introduced with the aim of providing a specific response to offences committed by "user-resellers", or laundering, which can be categorised as a criminal offence.

When we consider the policing and legal resources made available to fight drug trafficking, the range of available instruments and measures has been bolstered. Following the

introduction of the law dated January 17, 1986, arrested user-resellers can be sent for immediate trial with no waiting time. The legal measures aimed at fighting laundering activities make it possible to launch action against traffickers based on their outward appearance of wealth. The fact that a person is unable to demonstrate a legal income matching his/her lifestyle while maintaining ongoing contact or dealings with a narcotics user or trafficker is punishable under the law of May 13, 1996 as "drug procurement". Finally, a number of new features have been introduced within the Penal Code to make it easier to identify all levels of drug trafficking networks. The law of March 9, 2004 also provides the possibility of dismissing charges for "penitents" who have helped bring an end to an offence and possibly identified other guilty parties by informing the administrative or legal authorities of drug trafficking activities. The law has also extended the special procedural characteristics related to the fight against drug trafficking, by adding the newly introduced right to carry out infiltration activities to the possibility of holding prisoners in custody for four days or of carrying out night searches (art. 706-82 of the Code of Criminal Procedure).

Additionally, where drug trafficking is concerned, two types of aggravating factors are taken into consideration: a) when the offences are committed on administrative premises or b) when they involve minors or are carried out in or near educational premises. These tougher sentences when minors are involved are enshrined in the delinquency prevention law of March 5, 2007, which introduces sentences of up to 10 years' imprisonment and a fine of €300,000 for "direct incitation to carry, possess, propose or transfer narcotics when directed at a minor or when perpetrated in educational establishments".

Criminal offences and the corresponding penalties for drug trafficking in France.

Table 11.2. List of offences.

- The transportation, possession, proposal transfer, acquisition or illegal use of narcotics - Facilitating drug use	10 years' imprisonment and a fine of €7,500,000	Penal code, art. 222-37 §.1, §.2
- The illegal importation or exportation of narcotics	10 years' imprisonment and a fine of €7,500,000	Penal code, art. 222-36, 1st paragraph
- Inciting a minor to participate in drug trafficking (transportation, proposal and transfer)	7 years' imprisonment and a fine of €150,000	Penal code, art. 227-18-1 1st paragraph
- Aggravating factors: a minor under the age of 15 or offences committed within or near an educational establishment	10 years' imprisonment and a fine of €300,000	Penal code, art. 227-18-1 2nd paragraph
- A failure to provide proof of legitimate income corresponding to the individual's lifestyle while at the same time maintaining regular contact or dealings with a person carrying out illegal activities in the narcotics field, or several persons involved in the use of narcotics.	5 years' imprisonment and a fine of €75,000	Penal code, art. 321-6
- Aggravating factor: (if the person concerned is a minor)	10 years' imprisonment and a fine of €75,000	Penal code, art. 222-39-1, 2nd paragraph
- Simple money-laundering	5 years' imprisonment and a fine of €375,000	Penal code, art. 324-1
- Aggravated laundering activities carried out on a regular basis or using means and resources related to a professional activity,	10 years' imprisonment and a fine of €750 000	Penal code, art. 324-2

or committed as an organised group.

Table 11.3. List of offences (cont.).

- The illegal production or manufacturing of narcotics	20 years' imprisonment and a fine of €7,500,000	Penal code, art. 222-35 1st paragraph
- Aggravating factor: if the offences are committed by an organised group	Prison sentence increased to 30 years	Penal code, art. 222-35 2nd paragraph
- The illegal importation or exportation of narcotics as an organised group	30 years' imprisonment and a fine of €7,500,000	Penal code, art. 222-36 2nd paragraph
- The management or organisation of any group intended to produce, manufacture, import, export, transport, possess, propose, transfer, acquire or illegally employ narcotics.	Life imprisonment and a fine of €7,500,000	Penal code, art. 222-34
- The laundering of money derived from crimes mentioned in the above-mentioned article (222-34, 222-35, 222-36 2nd paragraph)	From 20 years' imprisonment to life imprisonment and a fine of €7,500,000	Penal code, art. 222-38 2nd paragraph

N.B.: Even the attempted perpetration of the offences described in articles 222-36 to 222-39 is punishable by the same penalties (art.222-40 of the Penal Code).

Drug and driving

The law of June 18, 1999 (and its application decree) introduced automatic drug tests for all drivers involved in a fatal road accident, the application requirements for which were stipulated in the law dated February 3, 2003 (and its application decree) concerning the recording of motoring offences carried out under the influence of narcotics. Any driver whose blood test reveals the presence of narcotics faces a sentence of two years' imprisonment and a fine of €4,500. The penalties may be increased to 3 years' imprisonment and a fine of €9,000 if alcohol has also been consumed.

Screening is compulsory for all drivers involved in a fatal accident, and systematic if use is suspected, in all accidents where physical harm is done. Tests may also be carried out on a targeted basis when the driver is suspected of having used drugs, (i.e. when he shows the outward signs of drug use such as sweating, red eyes and incoherent speech, etc). Drivers may also be subjected to testing when they are involved in any road traffic accident or any infraction of the Highway Code, or whenever there are reasonable grounds for presuming that drugs may have been consumed (art. L235-2 of the Highway Code).

The only drug tests used up until 2008 were urine tests which required special equipment. Since August 2008, police drug screening operations are now carried out using saliva tests, the widespread deployment of which in the road safety field was authorised via an order from the Ministry of Health[33], as a modification to the Highway Code. The drivers undergoing testing must provide the security forces with a sample of their saliva taken using a testing stick, and mixed with a chemical substance. After approximately eight minutes, this sample shows whether or not the person has consumed narcotics (cocaine, heroin, cannabis, amphetamines or ecstasy). In the event of a positive test result, blood tests are then carried

[33] Decree dated July 24, 2008 modifying the decree dated September 5, 2001 establishing the terms for drug tests, analyses and examinations via decree no. 2001-751 of August 27, 2001 covering drug tests carried out on drivers involved in a fatal road traffic accident, modifying decree no. 2001-251 of March 22, 2001 regarding the regulatory part of the Highway Code (Decrees in the Council of State) and modifying the Highway Code.

out to confirm the result. The quantities and types of drug detected generally form part of the criteria taken into account by the courts, which may issue a fine of up to €4,500, two years' imprisonment and a driving licence suspension of three years.

Where minors are concerned, the circular dated April 8, 2005 recommends referral to one of the health or social bodies rather than the dismissing of the case and issuing a caution as was previously the norm. This previous solution was seen as unhelpful as it encouraged a feeling of impunity among young drug users. This referral to the health services may also be backed up by referral to the child courts if it is considered that the youngster's drug use is part of a more complex problem or is particularly dangerous in nature.

Table 11.4. Criminal offences and the corresponding penalties for driving after taking drugs in France.

	Sentence (maximum sentence)	Reference text
- The offence of driving after taking drugs	2 years' imprisonment and a fine of €4,500	Highway Code, art. L 235-1, L 235-2, L 235-3
Aggravating factors:		
- The use of narcotics in cases of manslaughter	5 years' imprisonment and a fine of €75,000	Penal code, art. 221-6-1
- Trespass to the person	5 years' imprisonment and a fine of €75,000	Penal code, art. 222-19-1 and 222-20-1

11.2. Data sources and origins

Currently, the French statistical system exhaustively covers all stages of the judicial system (from the arrest through to the enforcement of the sentences) although the level of detail may vary at each stage.

Description of the systems used (data availability lead times, units, the processing of multiple offences, multiple penalties, variables, etc).

Arrests for drug-related offences: the OSIRIS database (Statistical Information and Research Tool for Drug-related Offences (*Outil Statistique d'Information et de Recherche sur les Infractions sur les stupéfiants*))
All drug offence cases initiated by the police and gendarmerie in France (including the overseas *départements*) are recorded in the OSIRIS database (ex FNAILS) maintained centrally by the Central Office for the Repression of Drug-Related Offences (OCRTIS, 2007). The recording process is virtually exhaustive, with the exception of those offences recorded by the Customs Department for which no report was issued (in most cases, this concerns very small quantities of drugs, resulting in other action by the Customs Department. Otherwise, the case is referred to the police).

OSIRIS contains information concerning the arrests (categorised as simple drug use, use-selling, local trafficking and international trafficking), the persons arrested (age, gender, socio-professional category and nationality) and seizures.

The product mentioned is the "dominant drug" i.e. that which is usually consumed by the user or stored in the highest quantities by the dealer. When this rule cannot be applied, it is the "hardest" drug which is entered[34].

Following the arrest (intervention), the cases are handled by the public prosecutor's office which decides whether or not to take legal action (prosecution). The statistics related to this stage, which are derived from the activities of the "public prosecution managers", are not particularly detailed (please see below), the planned computerisation of the public prosecution system looks highly promising when it comes to improving our knowledge of the processing activities carried out at this stage by the public prosecutor's office.

Cases processed by the public prosecutor's office: the public prosecution managers

The public prosecution managers list the number of cases (and not the number of people) processed each year by the public prosecutor's offices of the courts of first instance. This statistic provides information concerning the total number of cases presented to the public prosecutor's offices (5th degree misdemeanours, offences and crimes), and the proposed action (legal proceedings, penal agreements, alternative proceedings or dismissal of the case, etc).

At a national level, this data is not detailed on an offence-by-offence basis, which means that it is impossible to know how many narcotics cases are dealt with at this stage of the criminal action procedure. This loss of information is considerable when we bear in mind that for 5 million cases dealt with by the public prosecutor's office in France, only a little over 1 million are referred for criminal proceedings (with the others being dismissed).

Additionally, among these one million cases, approximately 600,000 result in prosecutions before the court (please see "*Use of the national criminal record*") while 400,000 are the subject of alternative measures other than court action with no possibility for us, once again, to match these measures to the specific offences concerned. Consequently, the alternatives to court action proposed to drugs offenders are not detailed (either by type of offence or type of measures taken). Only court-ordered treatment appears clearly within the system and may be linked to specific drug users, (please see 11.2.c).

The computerisation of the data centralisation process for the courts (the Infocentre project) which has already been carried out in a number of regions, will provide detailed information for each offence, for all cases processed, as well as for the alternative measures used.

The Ministry of Justice's "Infocentre" project

This planned computerisation of the activity data from the public prosecutor's office is currently being trialled and should be extended more widely around 2009-2010. The initial detailed data is being supplied by seven courts from the Paris area (which process approximately 25% of all criminal cases in France). This data, which has not been published, makes it possible for us to learn the outcome of narcotics cases, detailed on an offence-by-offence basis, (please see 11.3).

Sentencing: the use of the national criminal record

Sentencing information has been obtained since 1984 thanks to the use of the national criminal record. This use of the criminal record for statistical purposes is carried out by the Ministry of Justice's statistical department. The database contains information from 1984 onwards. The data is exhaustive, and covers the whole of the country. For each sentence issued by the judges, the data from the Ministry of Justice describes the various offences for which penalties were issued, the type of proceedings, the nature of the sentence, the length

[34] For a more detailed decription, please refer to the OFDT's directory of statistical sources at: http://www.ofdt.fr/ofdtdev/live/donneesnat/sources.html

of the sentence or the total fine involved and the characteristics of the individuals sentenced (age, gender and nationality).

As the ruling issued against an offender may be based on several offences, it is important to consider the concept of the main offence which is generally the most serious of the offences committed (it may be the case that the offences are listed in the order in which they are shown in the police report although a consistency check is carried out according to the total sentence imposed). This is the notion most frequently used in the Ministry of Justice's statistics. Other accounting units make it possible to carry out a more detailed analysis. As an example (for the use of narcotics), sentences for drug use as part of a combined offence (in order to examine the most common combinations and the corresponding sentences) or those for drug use as the sole offence.

Sentences should not be confused with the persons being sentenced. A person sentenced twice during the year will be counted twice in the sentencing statistics.

The classification used at this stage of the legal process is based on the NATINF code, used for all offences under the Penal Code. The statistics published for drug offences are classified in six different categories: illegal use, possession-acquisition, trafficking (importation-exportation), production-dealing-trafficking, offer-transfer, assistance to others and other offences (including laundering, and a failure to provide proof of income, etc).

As French legislation does not make it possible to distinguish between sentences according to the product concerned, the sentencing statistics do not mention the product involved in the drug-related offences for which sentences are handed down. These details are only available at the policing stage.[35].

The data concerning the enforcement of custodial sentences is also provided here for information purposes.

The enforcement of custodial sentences: the national register of detainees and quarterly prison population statistics

Since 1993, the sentence enforcement statistics have been established based on the national register of detainees. This database makes it possible to identify prisoner flows for the year, (i.e. the number of people entering and leaving penal establishments between January 1 and December 31 each year), for each offence. The difference between the entry and exit data makes it possible to calculate the number of people present in the penal establishments on a given date.

A new version of the national register of detainees has been in force since 2003. Unlike the previous version, for each prison sentence issued it takes account of all of the offences resulting in the sentence, whereas previously only the main offence was recorded. However, in its current form, this application does not make it possible to identify the ranking and total number of alleged offences. The data from 2003 is consequently of less interest for the time being. The number of incarcerations for narcotics use as the main offence or sole offence is not yet known.

Furthermore, the categorisation of the offences is more detailed. Drug offences are now broken down into use, transfer, possession, trafficking, assisted use, incitation to use and unspecified drug-related offences, compared to 4 categories used previously (use, transfer, trafficking, other drug-related offences). The transfer of data from the former "trafficking" category to the "possession" category has been reported. Since 2003, when the use of

[35] For a more detailed description please refer to the OFDT's directory of statistical sources: http://www.ofdt.fr/ofdtdev/live/donneesnat/sources.html

statistics from the national register of detainees ended, the available data concerning incarceration for drugs offences has been obtained using the quarterly statistical report from the headquarters of the Penal Administration, which describes the detainees present in the country's penal establishments on the first day of each quarter. The data is not particularly detailed on an offence-by-offence basis. Only a blanket category makes it possible to identify those persons with drug offences as their main offence.

The case of traffic offences

Where legal proceedings, sentences and incarceration are concerned, the legal processing of drug-related traffic offences is recorded by the statistical system described above (the public prosecution managers or infocentre, the national criminal record, the national register of detainees, etc). The categories are the same as those used when dealing with drunk drivers ((MIAT et al., 2006)):

- Driving after taking drugs
- Refusal to submit to testing
- Unintentional violence (homicide or injury) caused by a driver having used narcotics

At the policing stage, offences related to driving after taking drugs are included in a specific statistic concerning checks and offences related to the Highway Code (the Road traffic and Road Safety Sub-Department - Ministry of the Interior and Regional Planning).

Since 2004, this document has included statistics concerning the checks carried out by the police and gendarmerie, and data concerning offences (infractions and misdemeanours) under the Highway Code recorded by the same departments. This data is supplied to the ministry each month and is published nationally.

The data is detailed for offences related to speeding, driving without a license, drunk driving and (since 2004) drug use (the data from 2003 being only partial).

Where narcotics use is concerned, the number of drug tests and positive test results is given, according to the circumstances justifying the drug test (accidents involving death, bodily injury or property damage, offences, suspected drug use without accidents or infractions, etc). The percentage of positive test results must be interpreted with caution since, in view of the particularly high levels of positive results, it is likely that the drug tests and searches were not carried out on a random basis, but instead targeted those drivers most likely to have taken drugs.

The annual total for the various drug offences is also shown, including driving a vehicle and having taken illegal substances or herbs listed as narcotics, driving a vehicle under the influence of both drugs and alcohol, and the refusal by the driver of the vehicle to undergo analyses or examinations with the aim of establishing whether or not he has driven the vehicle after taking drugs.

All of the data concerning road traffic offences is examined and published each year by the *Observatoire national interministériel de la sécurité routière* in "La sécurité routière en France" (*Road safety in France*).

Links between the systems

Links between the various statistical systems are not in place in the following areas 1/ nomenclature, 2/ accounting units, 3/ data transmission lead times and 4/ product-specific information.

Differences in nomenclature

For classification purposes at the policing level, the categories specific to the OCRTIS are used, which are either based on police procedures or which re-categorise the offences following a reading of the paper version of the procedure. In either case, this classification is not that used by the Penal Code (which is used for sentencing and incarceration). Matching the categorisation used by the police statistics to the statistics used by the Ministry of Justice is no simple matter and a precise match can only be made for cases of drug use alone or for all trafficking offences taken together.

Differences in accounting units

Arrests for drug offences concern one person and one person alone, even if a person arrested several times in the same year is included in the statistics separately on each occasion. This accounting unit is found again where sentencing is concerned (one person sentenced per ruling) even if at this stage the sentence may concern several offences or several penalties. On the other hand, where the public prosecutor's office is concerned, the accounting unit concerned is that of "cases", with it being possible for several people to be covered by the same "case".

Differences in timing and data submission lead times

Not only do the authorities concerned by each of these statistical systems not publish their data within the same lead times (i.e. one year for the police statistics and two years for the sentencing statistics), but moreover the comparison of data from the same year at the various stages of the legal system is not meaningful as an arrest made in year y may be dealt with by the justice system in year y+1 or later

Differences concerning product information

As stated above, only the policing data, (which is based on the details contained in the legal procedures), make it possible to distinguish between the various drugs involved in drug-related offences.

Legal measures specific to drugs offences: conditional discharges, alternative measures instead of legal proceedings and additional penalties.

Currently, at a national level, only court-ordered treatments (which for a long time were specifically reserved for drug users under legal supervision, although they were more recently extended to alcohol users) may be distinguished among the various social and healthcare measures offered to drug users under legal supervision. In 2005, 5,227 court-ordered treatments were issued in France. These concerned all drug users. On the other hand, French law allows for other alternatives to legal action for narcotics offenders, and particularly users (please see 11.1). A number of these measures concern social or health care (referral to health or social organisations) while others do not (including in particular the issuing of cautions). Currently, we do not know the number of drug users (or drug use cases) referred to these non-judicial alternative measures.

Generally speaking, we can currently calculate the number of measures announced (whether alternative to or additional to legal action) but it is not possible to match these to specific drug-related offences. The computerisation of the public prosecutor's offices will eventually make it possible to carry out a detailed analysis of this kind.

Another aspect which remains unknown is the outcome of these measures. For some of these, statistical reports summarising the activities of the associations given the task of monitoring alternative measures to legal proceedings make it possible to trace the number of measures received and processed, and occasionally the results of the measures concerned (whether obligations have been met, etc.).

11.3. Sentencing statistics

This section includes the latest results concerning the different stages of the criminal justice process for each of the three categories identified:

a. Drug use/personal possession
b. Production, dealing or trafficking
c. Drug driving

Nevertheless the "possession for personal use" category does not exist within the French justice system and consequently is not found other than in the policing phase. Only offences concerning "drug use" can be identified during the legal proceedings phase.

The provisional data from 2007 does not make it possible to distinguish between arrests for use and dealing and those for trafficking. Consequently, these two categories of arrests are considered together.

Drug use/personal possession

Arrests for drug use:
In 2007, 112,923 arrests for simple drug use were recorded by the Office Central pour la répression du trafic illicite des stupéfiants (OCRTIS - *Central Office for the Repression of Drug-Related Offences*. Most of these arrests concerned the use of cannabis (97,460 arrests, equivalent to 86.3% of all arrests for drug use).

This is followed (much further behind) by arrests for heroin, (6,438 arrests) and for cocaine (4,043 arrests).

Table 11.5. Arrests for simple drug use -2007.

	Use	% in column
Cannabis	97,460	86.3%
Heroin	6,438	5.7%
Cocaine	4,043	3.6%
Others (2)	2,969	2.6%
Ecstasy	751	0.7%
Crack	494	0.4%
Medicines (1)	332	0.3%
Amphetamines	294	0.3%
Mushrooms	142	0.1%
Total	112,923	100%

(1) Subutex®, methadone, skenan®, rohypnol®, others.
(2) Khat, methamphetamines, LSD, opium, morphine, solvents, others
Sources: *Les grands traits de l'usage du trafic illicite des produits stupéfiants en France (Key aspects of the illegal use of narcotic products in France)*, Annual report: 2007 – Summary; OCRTIS - 2008

Cases of drug use dealt with by the public prosecutor's offices in the Paris region
Please see tables 11.6 and 11.7 below.
Where narcotics use is concerned, most of the cases dealt with by the public prosecutor's office result in an alternative to prosecution before the courts (77%). These usually involve a caution or a court-ordered treatment.

Sentences for drug use
Totalling 16,341 sentences, drug use is chiefly punished by fines (49.3%), prison sentences (34.2%), of which 32.7% are firm or partially suspended sentences, the average length of which is 5.9 months. Lighter sentences such as alternative penalties (community service or day-fines), and educational measures or penalties account for 15.9% of all sentences for drug use.
Please see table 11.9 below.

Production, dealing, transport

Arrests for transport and use-selling
In 2007, 21,397 arrests for use-selling and trafficking were recorded by the OCRTIS, including 13,154 arrests for the use-selling and transport of cannabis, accounting for 61.5% of the total.

Cocaine and heroin are the second and third most important substances where use-selling and transport are concerned, accounting for 3,116 and 2,952 arrests respectively.

Table 11.6 Arrests for drug use/dealing and trafficking – 2007.

	Use/dealing and trafficking	% in column
Cannabis	13,154	61.5%
Cocaine	3,116	14.6%
Heroin	2,952	13.8%
Ecstasy	388	1.8%
Crack	269	1.3%
Medicines (1)	245	1.1%
Amphetamines	109	0.5%
Mushrooms	10	0.0%
Others (2)	1,154	5.4%
Total	21,397	100.0%

(1) Subutex®, methadone, skenan®, rohypnol®, others.

(2) Khat, methamphetamines, LSD, opium, morphine, solvents, others

Sources: *Les grands traits de l'usage du trafic illicite des produits stupéfiants en France (Key aspects of the illegal use of narcotic products in France)*, Annual report: – Summary; OCRTIS - 2008

Drug-related offences (other than use) dealt with by the public prosecutor's offices of the Paris region

The use of alternative measures (other than legal proceedings) is less frequent for drug trafficking than for drug use. Half of the trafficking cases result in the imposition of an alternative measure, but a third of these cases are referred to the judges for the initiation of criminal proceedings. Concerning the nature of the alternative measures used, these are more likely to be cautions than social/health measures, which are chiefly intended for "simple" drug users.

Table 11.7. Drug-related offences dealt with by the public prosecutor's offices of the Paris region in 2005.

	Drug use offences		Other drug law offences		Total	
Cases processed	11233	100%	10198	100%	21431	100%
Non valid cases	406	4%	552	5%	958	4%
Cases closed without proceedings	613	5%	555	5%	1168	5%
Alternative proceedings	8659	77%	5747	56%	14406	67%
Proceeded cases	1555	14%	3344	33%	4899	23%

Table 11.8. Alternative proceedings (alternatives to court action) issued for drug-related offences in 2005 by the public prosecutor's offices of the Paris region.

	Drug use offences		Other drug law offences		Total	
Cautions	6153	71%	4659	81%	10812	75%
Court-ordered treatment	1231	14%	144	3%	1375	10%
Referral orders	689	8%	324	6%	1013	7%
Penal agreements	333	4%	101	2%	434	3%
Other	253	3%	519	9%	772	5%
Total	**8659**	**100%**	**5747**	**100%**	**14406**	**100%**

Sentences for drug-related offences (other than drug use)

Sentences for use-selling and trafficking are chiefly divided between the possession/acquisition of narcotics (12,967 sentences), the trading, processing[36] and transportation of narcotics (7,079 sentences), and the trafficking of narcotics (importation-exportation), 1,961 sentences. Possession/acquisition chiefly results in the imposition of prison sentences (78.8%), of which 54.2% are firm or partially suspended, for an average period of 10.7 months, and by fines (9.9%). Minor trafficking (trading, transportation, and dealing in narcotics) and trafficking offences (importation/exportation) tends to receive heavier sentences. In the case of retail trafficking, 89.1% of the sentences issued are prison sentences, of which 59.1% are firm or partially suspended, for an average period of 15.1 months. Drug offences concerning trafficking (importation/exportation) are punished by prison sentences in 97.5% of cases, of which 79% are firm or partially suspended, for an average period of 26.6 months.

[36] Narcotics based processing refers to the use of narcotics in the making of other substances. This category was issued in the 1994 revision of the original law of 1970. Although considered as an official code in the Ministry of justice statistics, it does not appear as such in the police recordings.

Table 11.9. Sentences for drugs offences: main offence and type of sentence issued - 2006.

Sentence type		***Including***			***Including***					
Offence types	**All sentences**	All prison sentences.	*Detention / imprisonment (firm or part. susp.)*		Fines	**Alternative penalties**°	Comm. service	*Day-fines*	Educational measures	Dismissal of charges	Educational penalties
	Nb	Nb	*Nb*	*Average length*	Nb	Nb	*Nb*	*Nb*	Nb		Nb
Total drug offences	40,225	25,427	*13,205*	*13.0*	9,906	3,105	*1,041*	*1,741*	1,538	225	24
Use of narcotics	16,341	5,589	1,827	*5.9*	8,059	1,796	*596*	*916*	785	100	12
Possession/acquisition of narcotics	12,967	10,223	5,536	*10.7*	1,287	836	*288*	*521*	529	83	9
Drug trafficking (import/export)	1,961	1,911	1,509	*26.6*	21	25	*6*	*19*	3	1	0
Trading, processing, transport of narcotics	7,079	6,309	3,731	*15.1*	361	269	*73*	*186*	115	23	2
Proposition/transfer of narcotics	1,728	1,296	553	*8.2*	150	167	*73*	*93*	98	16	1
Assisting others in the use of narcotics	40	32	16	*3.8*	4	1	*0*	*1*	3	0	0
Other drug-related offences	109	67	33	*30.7*	24	11	*5*	*5*	5	2	0

Drug driving

Arrests:
In 2006, 20,902 drug tests were carried out by the police resulting in 6,552 drug-related misdemeanours being recorded.

Sentencing:
In 2006, 5,207 sentences were issued for driving after taking drugs. Offences for drug driving can be broken down into four types of offence:

- 4,021 offences for driving a vehicle under the influence of drugs
- 934 offences for driving a vehicle under the influence of both drugs and alcohol
- 201 offences for injury and manslaughter caused by drivers under the influence of drugs
- 51 offences for a refusal on the part of the driver having used narcotics to submit to analyses or tests, in cases involving injury or manslaughter.

These offences are chiefly punished by means of prison sentences (49%) and fines (34.5%).

A driver found to have used drugs can be sentenced to imprisonment (42.5% of the sentences issued in 2006, of which 9.7% were firm or partially suspended), a fine (34.5% in 2006) or an alternative penalty (community service or day-fine, etc.), which in 2006 accounted for 15.8% of the sentences issued. If the driver is found to have driven the vehicle under the influence of both drugs and alcohol, he faces a heavier sentence, chiefly involving imprisonment (68.8% of sentences in 2006, of which 11.2% were firm or partially suspended).

Bodily injury or manslaughter committed by a driver having taken drugs is punished by means of prison sentences (87.6%, of which 27.8% are firm or partially suspended).

The nature of the sentence is likely be more serious according to the scale of the injuries committed, with the average length of imprisonment being 9 months in cases involving sentences for manslaughter caused by persons driving under the influence of drugs.

Table 11.10. Sentences in 2006 for drug-related driving offences (sentence based on the main offence).

Sentence type		***Including***			***Including***				
Offence types	**All sentences**	All prison sentences.	*Detention / imprisonment (firm or part. susp.)*		Fines	**Alternative penalties**°	Comm. service	*Day-fines*	Educational measures	Dismissal of charges
	Nb	Nb	*Nb*	*Average length*	Nb	Nb	*Nb*	*Nb*	Nb	Nb
All offences committed by drivers under the influence of drugs	5,207	2,556	*306*	*4.2*	1,795	823	*105*	*191*	16	17
Driving a vehicle under the influence of drugs	4,021	1,708	*165*	*3.0*	1,613	676	*86*	*145*	11	13
Driving a vehicle under the influence of drugs + alcohol	934	643	*85*	*3.6*	162	124	*16*	*41*	4	1
Bodily injury + manslaughter caused by drivers under the influence of drugs	201	176	*49*	*9.0*	11	11	*2*	*3*	1	2
Bodily injury + manslaughter caused by drivers under the influence of narcotics. *Refusal by the driver to submit to analyses or tests*	51	29	*7*	*4.7*	9	12	*1*	*2*	0	1

PART C: BIBLIOGRAPHY AND APPENDICES

12. Bibliography

Amosse, T., Doussin, A., Firdion, J.-M., Marpsat, M., & Rochereau, T. (2001). *Vie et santé des jeunes sans domicile ou en situation précaire. Enquête INED, Paris et petite couronne, février-mars 1998*. Paris: CREDES.

Arditi, J., & al, e. (2006). DRAMES, nouvel outil pour connaître les causes des décès chez les toxicomanes : bilan de cinq études. Le Courrier des addictions, 8(1), 29-31.

Barré, M. (2008). *La répression de l'usage de produits illicites. État des lieux*. Etudes et Données Pénales n°108, 80 p.: CESDIP.

Batel, P., Constant, M.-V., Jourdain, J.-J., Lavignasse, P., Lowenstein, W., Mucchielli, A., et al. (2001). *Retombées économiques et sociales d'un traitement de substitution par buprénorphine haut dosage. Résultats préliminaires après six mois de suivi*. Paris: ANISSE.

Bello, P.-Y., Toufik, A., Gandilhon, M., & Giraudon, I. (2004). *Phénomènes émergents liés aux drogues en 2003 - 5ème rapport national du dispositif TREND*. Saint-Denis: OFDT.

Bello, P.-Y., Toufik, A., Gandilhon, M., Giraudon, I., & Bonnet, N. (2003). *Phénomènes émergents liés aux drogues en 2002. 4ème rapport national du dispositif TREND*. Paris: OFDT.

Bilal, S., Menares, J., De la Selle, P., Toufik, A., & Perdrieux, Y. (2003). Impact des traitements de substitution aux opiacés sur la vie sociale, une étude en médecine de ville. Annales de Médecine Interne, 154(Hors série II), 2S6-2S14.

Cadet-Taïrou, A., Gandilhon, M., Toufik, A., & Evrard, I. (2007). *Phénomènes émergents liés aux drogues en 2005 - Septième rapport national du dispositif TREND*. Saint-Denis: OFDT.

CAGLIERO, S., & LAGRANGE, H. (2004). *La consommation de drogues dans le milieu de la prostitution féminine.* Saint-Denis: OFDT.

CALDERON, C., SOLETTI, J., GAIGI, H., GUICHARD, A., & LERT, F. (2001). *Attentes des usagers de drogue concernant les traitements de substitution : expérience, satisfaction, effets recherchés, effets redoutés*. Paris: AIDES.

Centre d'évaluation et d'information sur la phamacodépendance (CEIP) de Marseille. (2006). *OPPIDUM, résultats de l'enquête 17 (octobre 2005)*. Saint-Denis: AFSSAPS.

CHEVALLIER, E. (2001). *Estimations locales de la prévalence de l'usage d'opiacés et cocaïne en France : une étude multicentrique à Lens, Lille, Marseille, Nice et Toulouse*. Paris: OFDT.

Costes, J. M. (2007). *Cannabis, données essentielles*. Saint Denis: OFDT.

DA SILVA, L., & EVANGELISTA, L. (2004). *La consommation de drogues dans le milieu de la prostitution masculine.* Saint-Denis: OFDT.

Dabit, D., & Ducrot, S. (1999). Alcool et sans abris : une enquête du mouvement Vie Libre menée en région parisienne. Alcoologie, 21(3), 439-446.

Declerck, P., & Henry, P. (1996). Pathologie de la rue. La revue du Praticien, 46, 1844-1848.

Duburcq, A., Charpak, Y., Blin, P., & Madec, L. (2000). Suivi à 2 ans d'une cohorte de patients sous buprenorphine haut dosage. Résultat de l'étude SPESUB (suivi pharmaco-épidémiologique du Subutex® en médecine de ville). Revue d'épidémiologie et de santé publique, 48, 363-373.

Escots, S., & Fahet, G. (2003). *Usages non substitutif de la buprénorphine haut dosage, investigation menée en France, en 2002-2003*. Saint Denis: ORSMIP/OFDT.

Facy, F. (1999). *Toxicomanes et prescription de méthadone*. Paris: EDK.

Fhima, A., Henrion, R., Lowenstein, W., & Charpak, Y. (2001). Suivi à 2 ans d'une cohorte de patients dépendants aux opiacés traités par buprénorphine haut dosage, Résultats de l'étude SPESUB. Annales de Médecine Interne, 152(Suppl. au n°3), 1S26-21S36.

Fontaine, A. (2006). *Double vie : les drogues et le travail*. Paris: Les Empêcheurs de penser en rond.
HENRION, R. (1995). *Rapport de la commission de réflexion sur la drogue et la toxicomanie*. Paris: Documentation française.
JACOB, E., JOUBERT, M., & TOUZE, S. (2000). *Evaluation des Points écoute jeunes et/ou parents créés à partir de la Circulaire n° 97/280 du 10 avril 1994*. Paris: OFDT.
Jauffret-Roustide, M., & al, e. (2006). Estimation de la séroprévalence du VIH et du VHC et profils des usagers de drogues en France, étude InVS-ANRS Coquelicot, 2004. BEH, 33, 244-247.
Justice, M. d. l. (2007). *Annuaire statistique de la justice. Edition 2007*. Paris: La Documentation française.
Kovess, V., & Mangin Lazarus, C. (1997). La santé mentale des sans abris à Paris : résultat d'une enquête épidémiologique. La revue française de psychiatrie et de psychologie mentale, 9, 17-23.
La Rosa, E. (1998). *Santé, précarité et exclusion*. Paris: PUF.
Lavignasse, P., Lowenstein, W., Batel, P., Constant, M. V., Jourdain, J. J., Kopp, P., et al. (2002). Economic and social effects of high-dose buprenorphine substitution therapy. Six-month results. Annales de Médecine Interne, 153(Suppl 3), 1S20-21S26.
Legleye, S., Spilka, S., Le Nézet, O., Beck, F., & Godeau, E. (2008). Tabac, alcool et cannabis durant la primo adolescence. Résultats de l'enquête HBSC 2006. Tendances, 59, 4 p.
Levasseur, L., Marzo, J.-N., Ross, N., & Blatier, C. (2002). Fréquence des réincarcérations dans une même maison d'arrêt : rôle des traitements de substitution. Etude rétrospective préliminaire. Annales de Médecine Interne, 153(Suppl 3), 1S14-11S19.
MIAT, DLPAJ, & ONISR. (2006). *Bilan du comportement des usagers de la route Année 2006*. Paris: Ministère de l'Intérieur et de l'aménagement du territoire, Direction des Libertés Publiques et des Affaires Juridiques, ONISR.
Mouquet, M.-C., & al, e. (1999). La santé des entrants en prison : un cumul de facteurs de risque. DRESS Etudes et Résultats, 4(10).
Obradovic, I., & Canarelli, T. (2008). *Initialisation de traitements par méthadone en milieu hospitalier et en milieu pénitentiaire*. Saint-Denis: OFDT.
Observatoire du Samu social de Paris. (1999). *Conduites addictives, substitution et grande exclusion, enquête sur 275 personnes*. Paris: OSS.
OCRTIS. (2007). *Usage et trafic des produits stupéfiants en France en 2006*. Paris: Ministère de l'Intérieur et de l'Aménagement du Territoire, Direction Générale de la Police Nationale, Direction Centrale de la Police Judiciaire, OCRTIS.
OCRTIS. (2008). *Les grands traits de l'usage et du trafic illicite des produits stupéfiants en France. Rapport annuel 2007 - résumé*. Nanterre: DCPJ SDLCODF OCRTIS.
OFDT. (2005). *Drogues et dépendances, données essentielles.* Paris: La Découverte.
Office central pour la répression du trafic illicite des stupéfiants (OCRTIS). (2005). *Usage et trafic des produits stupéfiants en France en 2004*. Nanterre: OCRTIS.
REYNAUD-MAURUPT, C. (2006). *Usages contemporains de plantes et champignons hallucinogènes - Une enquête qualitative exploratoire conduite en France*. St Denis: OFDT.
REYNAUD-MAURUPT, C., CHAKER, S., CLAVERIE, O., MONZEL, M., MOREAU, C., EVRARD, I., et al. (2007). *Pratiques et opinions liées aux usages des substances psychoactives dans l'espace festif "musiques électroniques"*. St Denis: OFDT.
Reynaud, J., Reynaud-Maurupt, C., & Mucchielli, A. (1997). L'impact du réseau Option Vie sur la réinsertion sociale des usagers de drogue : l'exemple d'un travail niçois. In G. Decrouy (Ed.), *L'exclusion sociale dans les Alpes-Maritimes. VIH, drogue, délinquance, précarité : enquête sur le terrain* (pp. 297-309): L'harmatthan.
Rotily, M. (2000). Stratégies de réduction des risques en milieu carcéral. Synthèse de l'étude menée par l'ORS PACA/ M. Rotily. In *Rapport de la mission santé-justice* (Vol. Annexes, pp. 35-51). Paris: Ministère de la justice.

Rotily, M., Delorme, C., Galinier, A., Escaffre, N., & Moatti, J. (2000). HIV risk behavior in prison and factors associated with reincarceration of injecting users. Presse Med, 29(28), 1549-1556.
Sansfacon, D., Bachelard, O., Lopez, D., & Valade, C. (2005). *Drogues et dommages sociaux. Etat des lieux*. Saint-Denis: OFDT.
Solal, J.-F., & Schneider, M.-C. (1996). Toxicomanies et exclusion sociale. La revue du Praticien, 46, 1854-1860.
Stankoff, S., & Dherot, J. (2000). *Rapport de la mission santé-justice sur la réduction des risques de transmission du VIH et des hépatites en milieu carcéral*. Paris: Direction de l'administration pénitentiaire, Direction générale de la santé.
TELLIER, S. (2001). *Prise en charge des toxicomanes dans les structures sanitaires et sociales, novembre 1999*. Paris: DRESS.
Warsmann, J.-L. (2004). *44 propositions pour améliorer la lutte contre la drogue*. Paris: Ministère de l'Intérieur, de la sécurité intérieure et des libertés locales.
Wieviorka, S. (2003). Comorbidités. In *Report to the EMCDDA by the Reitox National Focal Point - France, drug situation 2002* (pp. 92-101). Paris: OFDT.

13. List of tables

14. List of graphs.

15. List of abbreviations

AAH	Adult disability allowance
AFSSAPS	French Health Products Safety Agency
AMM	Marketing authorisation
ANAES	National Agency for Health Accreditation and Evaluation
ANIT	National Association of Drug Addiction Workers
ANPAA	National Association for the prevention of alcoholism and addiction
ANRS	National AIDS research agency
ASSEDIC	French unemployment benefits department
ASUD	Drug users' self-support association
BEP	Vocational diploma
BHD	High dose buprenenorphine (HDB)
CAARUD	Reception and harm reduction support centres for drug users
CAMPS	Early Medicosocial Services Centres
CAP	Vocational training certificate
CAST	Cannabis abuse screening test
CCAA	Outpatient Alcoholism Treatment Centres
CDAG	Anonymous free screening centre
CDO	Departmental agreements on objectives in Health and Justice
CEIP	Drug Dependency Information/Evaluation Centres
CEL	Local educational contract
CépiDC	Centre for epidemiology of the medical causes of death
CESC	Health and Citizenship Educational Committees
CFES	French committee for health education (now INPES)
CHRS	Accommodation & rehabilitation centre for persons of no fixed abode
CIFAD	Interministerial training center for the fight against drugs
CIM	International classification of diseases (ICD)
CIRDD	Centres for information and resources on drugs and dependencies
CJN	National police (criminal) records
CLS	Local security contracts
CNAMTS	National State Health Insurance Office for Salaried Workers
CNRS	National centre for scientific research
COM	Pacific French overseas territories
CPAM	French government department dealing with health insurance
CPDD	Drug & dependencies project leaders
CRIPS	Regional AIDS information and prevention centre
CSAPA	Addictology treatment, support and prevention centres
CSST	Specialised centers for drug addicts
DAP	Prison service (Ministry of Justice)
DAPSA	Support facility for Parenthood and Addiction Care
DATIS	National "Drugs, Alcohol and Tobacco Information Service" telephone helpline
DDASS	Direction of Health and Social Affairs at local level - for the Département
DESCO	School education Office (Ministry of youth, education and research)
DGS	General Health department (Ministry of health and Welfare)
DH	Hospitals directorate (Ministry for Health and Welfare)
DLPAJ/CSR	Directorate of civil liberties and legal affairs, sub-department for traffic and road safety (Ministry of the Interior and Regional Planning)
DOM	French overseas territories
DRAMES	Death involving abuse of medicines and substances (AFSSAPS)
DRD	Drug related Death (EMCDDA definition)
DRESS	Directorate for research, studies and evaluation of statistics (Ministry of health andwelfare; Ministry of social affairs, labour and solidarity)
DSM	Diagnostic and statistical manual of mental disorders
ENVEFF	National Survey on Violence Against Women
EROPP	Survey on Representations, Opinions, and Perceptions Regarding Psychotropic Drugs(OFDT)
ESCAPAD	Survey on Health and Use on Call-Up and Preparation for Defence Day

	(OFDT)
ESPAD	European School Survey Project on Alcohol and other Drugs (INSERM- OFDT-MJENR)
ESSAD	Specialized Home Care Unit
FFA	French federation of addictology
FNAILS	File of Police Questioning for the Use of Narcotics (OCRTIS, Ministry of Interior)
FNES	National Federation of Health Education Committees
FRAD	Anti-drug shift trainers (Gendarmerie)
GECA	Group of Studies on Pregnancy and Addictions
GIP	Public interest group
IC	Confidence range
ILS	Drug-related offences
INPES	National Institute for Health Education and Prevention (former CFES)
INRETS	National Institute for Research on Transport and Safety
INSERM	National Institute for health and medical research
INVS	National health watch institute
IST	Sexually transmitted infections
IT	Treatment order
IVG	Termination of pregnancy
JAP	Judge responsible for the execution of sentences
JAPD	Day of defense preparation
JO	Journal Officiel
LOLF	Organic Law Pertaining to Finance Laws
M€	Million(s) of Euros
MILAD	Mission for the Fight Against Drugs (Ministry of the Interior)
MILC	Interministerial mission for the fight against cancer
MILDT	Interministerial mission for the fight against drugs and drug addiction
MST	Sexually transmissible diseases
OCRTIS	Central Office for the Repression of Drug-related Offences
OEDT	European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)
OFDT	French Monitoring Centre for Drugs and Drug Addiction
OMS	World Health Organisation
OPPIDUM	Monitoring of illegal psychotropic substances or those that are used for purposes other than medicinal (CEIP)
OR	Odd ratio
PA	person-year
PAEJ	Youth reception and counselling centre
PES	Syringe exchange programme
PFAD	Anti drug trainer / police officer
PRAPS	Programmes for access to preventive measures and health care for people invulnerable situations
PRS	Regional health programmes
PRSP	Regional Public Health Programmes
RDR	Risk and harm reduction (policy)
RECAP	Common data collection on addictions and treatments
RMI	Minimum income
RSM	Standardised mortality ratio
SAM	Road Safety epidemiological survey on narcotics and fatal road accidents
SFA	French Society of Alcohology
SIAMOIS	System of information on the accessibility of injection equipment and substitutionproducts (InVs)
SINTES	National poison/substance identification system (OFDT)
SMPR	Regional hospital medical/psychological services
SPIP	Prison service for integration and probation
TDI	Treatment demand indicator
THC	Tetrahydrocannabinol
TREND	Recent trends and new drugs (OFDT)
UCSA	Outpatient treatment/consultation unit
UDC	Coordination Unit for Maternity and Risk Situations
UDVI	Intravenous (or injectable) drug users
UPS	Care unit for prison leavers