OBSERVATOIRE FRANÇAIS DES DROGUES ET DES TOXICOMANIES

2004 NATIONAL REPORT TO THE EMCDDA
by the Reitox National Focal Point

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

REITOX

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INTRODUCTORY NOTE:

Starting with this edition, the way in which the information contained in the report is presented will be changed. The change to the structure was developed jointly by the national focal points and the European Monitoring Centre for Drugs and Drug Addictions (EMCDDA) in 2002-2003.

So the current report is attached and will gradually be supplemented by other tools:

- the standard tables. Some tables will be added to those already existing (21 in 2003) and others will be added to these. The total number of tables at the end of the process of change (2006) will be 25.
- structured questionnaires. The objective of these is to record qualitative information. They will be introduced progressively until 2006, when the total number is expected to be 11.

The report, standard tables and questionnaires are independent of each other but complement each other (see appendix 15.1).

Part A of the report gives information only on new developments which occurred between 2003 and the start of 2004 (up to July 2004 for the "national policy and context" part). An introductory paragraph in each section ("general context") summarises the general context and principal characteristics of the section and also provides the framework within which the new information on the drug situation in France is recorded.

Part B, as in previous national reports, contains three articles, each around ten pages long, providing further information on a specific problem linked to illicit drugs.

The report in its entirety covers only the field of illicit drugs (except for the "national policy" and "prevention" sections, which also consider alcohol and tobacco).

SUMMARY OF CONTENTS

SUMMARY

Political context 2003-2004

The year 2003-2004 was principally marked by government validation on 29th July 2004 of the action plan against illicit drugs, tobacco and alcohol (2004-2008). Publication of the plan marked the end of the process of reform of the law of 1970, a political objective made public some months previously.

The main action strategies in the five-year plan are: prevention (relaying on parents and schools), diversification of services and treatments to ensure more appropriate registrations for care, re-establishment of the scope of the law (implementation of the Evin law, intensification of the fight against trafficking etc.). The proclaimed objectives were accompanied by quantifiable indicators to facilitate evaluation.

The new five-year public health plan, adopted a few days after validation of the 2004-2008 action plan, included for the first time a policy to reduce risks linked to drug use within French legislation, defining it as falling within the responsibilities of the State. The public health plan defined quantified objectives to be achieved by the end of the scheduled five years.

2003 – Key figures

Between the ages of 12 and 18, cannabis is by far the most often tried illicit substance. Regular cannabis use (at least 10 times in the last 30 days) is as frequent as regular use of alcohol among young people aged 17 (12.6% for alcohol and 12.3% for cannabis).

11,200 to 16,900 people were undergoing methadone substitution; 71,800 to 84,500 were receiving HDB (Subutex®) but only 52,000 were actually involved in a treatment process.

Law enforcement authorities recorded 89 deaths due to overdose during the year (continuous downward trend for 10 years).

142 new cases of AIDS were diagnosed and 118 deaths from AIDS recorded among injecting drug users.

Among those attending low threshold facilities who had injected in the previous month, 10% stated they were HIV positive, 58% positive for HVC and 9% for HBV.

The police made 108,141 arrests for drug law offences (84% of which were for narcotic use).

There were 76,124 seizures of illicit narcotics in France during the year, 89% of which were cannabis.

Cannabis resin is sold on average for € 6 per gramme. The selling price of heroin appears to be falling (€ 65 per gramme for white heroin, € 40 per gramme for brown heroin). Three fifths of ecstasy tablets are sold at € 10.

Use

The latest French ESPAD survey (European School survey Project on Alcohol and other Drugs) highlights the changes in use among school children aged from 12 to 18 over the last 10 years (Choquet *et al.*, 2004). Experimentation and repeated use of cannabis have at least doubled among girls, as they have among boys, since 1993. Apart from inhalants and hallucinogenic mushrooms, experimentation levels for illicit substances other than cannabis are very low.

The ESCAPAD 2002 survey (Enquête sur la santé et les consommations lors de l'appel de préparation à la défense – Survey on health and consumption on call-up and preparation for defence day) among young people aged from 17-19 questioned during the call-up and preparation for defence day showed that cannabis remains easily the most frequently-tried illicit psychoactive substance: more than half the 17-19 year-olds stated they had already smoked it (F. Beck and Legleye, 2003b). Experimentation levels for most of the other illicit drugs are still low but are increasing slightly: this is particularly the case with inhaled products, hallucinogenic mushrooms, poppers, ecstasy and amphetamines.

Another remarkable fact highlighted by this survey was that regular use of cannabis among the young people questioned was as frequent as that for alcohol.

Recent trends

The fact that the populations attending the low threshold facilities are becoming younger has been observed for around 2 years by the TREND information system (Bello *et al.*, 2004; Bello *et al.*, 2003). These young users, generally more vulnerable than older ones, can be divided into 3 main groups: users very closely involved with the techno culture, users with social problems who are poorly integrated socially and people who are recent immigrants (particularly from eastern Europe). The young people from the first two groups move on the edges of the "urban scene"[1] and the "party scene"[2] which results in a certain decompartmentalisation of practices and use.

A decrease in injection practices was recorded at all TREND sites and this trend is confirmed by observations each year: the proportion of those who had injected in the past month in the low threshold facilities decreased from 54% in 2001 to 44% in 2002 and 37% in 2003. At the same time, other data gathered show a growth in sniffing as a method of administering numerous products (particularly cocaine hydrochloride).

The availability of cocaine, which was already increasing the previous year, still seemed to be growing in 2003. There was also more evidence of two other products in the two scenes studied: ecstasy, a product which is well-perceived by users and is becoming more widely-used in the urban scene, and natural hallucinogenic products, particularly because they are well-perceived and can be accessed without going through traffickers (by picking them, growing them at home or purchasing over the internet).

Health, social and criminal indicators

Among the substances which are the reason for patients registering for treatment in the specialised centres for drug addicts, opiates are still in the majority (57%), but the proportion they account for has decreased since the beginning of this decade in favour of cannabis (28%) and stimulants (10%).

The organisation of the consensus conference on substitution treatments provided an opportunity to take stock of the situation in France and in particular to produce a new estimate of the number of people receiving a treatment. In 2003, between 63,000 and 69,000 people began a treatment process (of which 75 to 82% used Subutex®) (A. Cadet-Taïrou *et al.*, 2004) which is slightly less than half the estimated number of opiate consumers (150,000 to 180,000).

All available indicators on deaths linked to drug use, together with a recent survey of the mortality among arrested users (Lopez *et al.*, 2004a; Lopez *et al.*, 2004b), give the same results, confirming a drop in mortality and, more especially, in overdoses linked to opiate use, since the mid-90's. This decrease coincides with the introduction of substitution treatments and the harm reduction policy in France.

As the trend observed in 2002 continues, criminal indicators (arrests, imprisonment) and seizures are still increasing.

Summary of selected issues

[1] The urban scene is defined as the places in a town where active users of drugs may be seen.

[2] The party scene refers to techno music events, particularly those relating to the techno culture: clubs, teknivals, free parties, private parties.

Buprenorphine, treatment, misuse and prescription practices (by Agnès Cadet-Taïrou, Pierre-Yves Bello, OFDT, and Serge Escots, association Graphiti): high dose buprenorphine (HDB) is the principal substitution treatment used in France. Almost eight years after it came onto the market, the situation with regard to the introduction of this substitution medicine is quite mixed. The treatment enables people who are dependent on opiates to have better access to treatment and to improve their social situation, but there is widespread and growing trafficking in this product, it is frequently injected and its use in drug-taking, not for substitution, seems to be growing.

Alternatives to imprisonment (by Ivana Obradovic, OFDT): there are many alternatives to imprisonment available in France (substitution orders, community service, personalised sentences, electronic monitoring etc.). Although public discussion inclines towards these alternative measures, the number of these measures used in sentencing for offences against the drug laws fell by almost 25% between 1996 and 2001. The reason for this may lie in the difficulty of implementing these penalties (particularly in relation to collaboration between the legal and welfare and health systems).

Public nuisances related to drug use (by Dominique Lopez, OFDT): it is difficult to find information on public nuisances linked to drug use. Some cases of NIMBY ("not in my back yard") syndrome and situations where social mediation has been required have been identified but they remain sporadic (or very localised).

PART A: NEW DEVELOPMENTS AND TRENDS

1. National policy and context

National policy: general context

Legal framework: The law of 31st December 1970 constitutes the legal framework for the French policy on the fight against drugs. It sets 3 principal objectives for public action:

- severe repression of trafficking;
- to establish the principle of prohibiting the use of drugs while at the same time offering treatment as an alternative to suppressing drug use;
- to guarantee free care and anonymity to users who wish to be treated.

The list of products covered by the 1970 law (order of 22nd February 1990 establishing the list of substances classified as drugs) is growing and incorporating new substances recognised as dangerous by order of the Minister of Health, at the proposal of the Director General of the French Health Products Safety Agency (AFSSAPS)[3].

Institutional framework: The interministerial mission to fight against drugs and drug addiction (MILDT) is the authority in charge of preparing the report of the Permanent Interministerial Committee on the fight against drugs and drug addiction and coordinating and implementing decisions which it takes.

The current Chairman of the MILDT, Didier Jayle, was appointed in October 2002.

Budget and public expenditure: The main expenditure in terms of the fight against drugs is covered by credits from the Ministry of Health and Welfare and from the MILDT.

Social and cultural context: Three quarters of French people do not believe it is possible to have a "world without drugs" (F. Beck *et al.*, 2003). The great majority of the population believe in the existing measures of the policy for risk reduction (treatment with substitution products, free distribution of syringes) and, overall, continue to support prohibitive measures in relation to drugs (against authorisation under certain conditions of cannabis or heroin use, against free sale of cannabis, (F. Beck *et al.*, 2003)). Where use of illicit drugs is envisaged for therapeutic purposes under medical supervision, 50% declared themselves in favour of providing heroin and 75% for medical prescription of cannabis to some seriously-ill patients.

In 2002, there were more people in favour of free sale of cannabis than in 1999 but they were still in a minority (24% declared themselves in agreement with this proposal against 17% in 1999).

1.1 Legal framework

Considerations on the law of 1970

An interministerial study of possible review of the law of 1970 was carried out in the middle of 2003 by the MILDT in order to offer scenarios for possible reform (see national report for last year, (OFDT, 2003, p. 4). In 2003 and 2004, the government made announcements on several occasions about modernising the law and the MILDT drew up a working document. At the end of July 2004, the Prime Minister finally opted to abandon the project to review the law. The arguments advanced by the government were that not only would reform *"come up*

[3] Appendices I and II to the list of products classified as drugs correspond to tables I and IV in the 1961 International Convention on Drugs. Appendix III includes the substances in Tables I and II and some substances in tables III and IV of the 1971 International Convention on Psychotropic Drugs. Appendix IV contains psychoactive products not classified internationally and some precursors.

against several legal obstacles" but also that to replace prison with fines could *"be interpreted as a sign that drugs are not very dangerous, which could lead to a new increase in use and use at an earlier age"* (MILDT, 2004, p. 43).

A private member's bill "concerning the fight against drug addiction, prevention and suppression of illicit use and trafficking in poisonous substances" was submitted simultaneously to the National Assembly and to the Senate in June 2004 at the initiative of more than 200 member of parliament (MP's) and senators from the UMP (Union pour un mouvement populaire (Union for a Popular Movement), France's major right-wing party). Basing its argument on the fact that the law of 1970 is *"obsolete"*, the aim of the bill was to *"reaffirm prohibition"*. The bill provides for the removal of a prison sentence for simple drug use but introduces a progressive scale of penalties. In addition to a 5th category fine (a fine of up to € 1,500), users could be faced with confiscation of their mobile phones or vehicles.

Five-year public health plan

The five-year public health policy plan 2004-2008 had its first reading in the National Assembly on 21st May 2003. It was adopted at the beginning of August 2004 after several successive readings in the two assemblies (law no. 2004-2008 of 9th August 2004 relating to public health policy, NOR: SANX0300055L).

The plan defines the quantifiable objectives of public health policy to be achieved at the end of the five years (Table 1).

Article 12 of the law incorporates the policy on harm reduction for drug users into the public health regulations, bringing it within the jurisdiction of the State. It is officially defined as intended to *"prevent transmission of infections, death from overdose by intravenous injection of drugs and social and psychological damage linked to drug addiction by substances classified as drugs"*.

Adaptation of the law to changes in crime

The law of 9th March 2004 adapting the law to changes in crime (law no. 2004-204, NOR: JUSX0300028L) introduced into criminal law two new types of offence committed by organised gangs, including trafficking in narcotics, classified in the category of crimes and offences committed in organised gangs (such as procuring).

This law also extended to other offences procedures which already existed in regard to trafficking, thus enabling enforcement of the penalty of confiscation in cases of supplying and offering narcotics, and created the possibility of exemption from the penalty for reformed traffickers.

Amendments to the list of products classified as narcotics

During 2003, using data collected under the National Poison/Substance Identification System (SINTES, OFDT), 4 products were added to appendix IV of the list of substances classified as narcotics. These were 2-CT-2 (order of 13/10/2003), 2-CT-7 (order of 13/10/2003), Tiletamine and its salts, but not injectable preparations of Tiletamine (order of 31/07/2003) and TMA-2 (order of 13/10/2003).

Table 1: Objectives set by the public health law concerning alcohol, tobacco and illicit drugs, 2004-2008

Objective	Previous objective	Indicator
	Alcohol	
To decrease the average annual use of alcohol per inhabitant by 20% ; from 10.7 litres/year/inhabitant in 1999 to 8.5 litre/year/inhabitant by 2008		Annual alcohol use per inhabitant
To reduce prevalence of at risk or harmful use of alcohol and to prevent the onset of dependence	To estimate the prevalence of at risk or harmful use (between 2 and 3 million people according to data currently available) and the incidence of this becoming dependence (unknown)	- Average age for alcohol initiation. - Prevalence of repeated binge drinking behaviour - Proportion of pregnant women who consume alcohol during their pregnancy
	Tobacco	
To reduce the prevalence of tobacco smoking (daily smokers) from 33 to 25% of men and from 26 to 20% of women by 2008 (targeting in particular young people and social categories where there is high prevalence)		- Average age for initiation to tobacco. - Prevalence of smokers (daily smokers) by sex, age group and socio-professional category. - Prevalence of tobacco smoking during pregnancy.
To reduce passive smoking in schools (total disappearance), recreational premises and the working environment.	The objective for passive smoking is to quantify it for places other than schools. The measurement system must be created or identified.	- Proportion of recreational settings (restaurants, discotheques etc.) where use of tobacco is actually prohibited or which limit tobacco use to reserved areas which are appropriately ventilated. - Proportion of workplaces where use of tobacco is prohibited or which limit the use of tobacco to reserved areas which are appropriately ventilated
	Infectious diseases	
HIV-AIDS infection: to reduce the incidence of AIDS cases to 2.4 per 100,000 in 2008 (currently 3.0 per 100,000)		Incidence of AIDS cases
Hepatitis: to reduce deaths attributable to chronic hepatitis by 30%: to reduce the number of patients with chronic hepatitis from 10-20% to 7-14% by 2008		Deaths attributable to chronic hepatitis (cirrhosis and its complications)
	Neuropsychiatric diseases	
Drug addiction: dependence on opiates and multiple addiction: to maintain the drop in the incidence of HIV seroconversions among drug users and to initiate a drop in the incidence of HVC		- Incidence of HIV from obligatory declarations of seropositivity introduced since 2003. - Biological prevalence of HVC in surveys of drug user populations: first COQUELICOT survey in 2004
Drug addiction: dependence on opiates and multiple addiction: to continue the improvement in treatment of opiate-dependent users and polydrug users	To estimate the retention rate for substitution treatment	- Retention rate for substitution treatment

Source: Law no. 2004-806 of 9th August relating to public health policy, Légifrance.

Consequence of the restriction on marketing Rohypnol®

The order of 1st February 2001 (MESP0120352A/MESP0120353A/MESP0120354A) restricted the marketing authorisation (MA) for flunitrazepam (Rohypnol®)[4].

A qualitative study examined diverted use of Rohypnol® among users who were faced with the restriction of the marketing authorisation and the strategies which they developed for dealing with this new accessibility problem (Reynaud-Maurupt and Reynaud, 2003). Following the order of February 2001, although a reduction was seen in use of Rohypnol®, the product was mainly replaced by other benzodiazepines which are more easily accessible. The MA restriction also had the direct effect of increasing sales of flunitrazepam on the black market (diversion strategies for obtaining it) together with its price. If the order is *"a success in terms of reduction in use, it is a failure, or almost a failure, in terms of reduction in use of all benzodiazepines and a partial success in terms of health benefits"* (Reynaud-Maurupt and Reynaud, 2003, p. 28).

1.2 Institutional framework, strategies and policies

The new five-year plan of action against illicit drugs, tobacco and alcohol (2004-2008) was validated by the government on 29th July 2004.

The proposed plan sets several priority objectives (MILDT, 2004)) :

- to prevent or delay experimentation with psychoactive substances by prevention among young people, closely involving parents and schools;
- to control tobacco use (this is part of the ongoing aim of the President to combat cancer) ;
- "to tackle […] nuisances linked to alcohol";
- to reduce social inequalities with regard to drugs.

In regard to prevention, the policy tackles cannabis in particular, relying on three forms of intervention: a widespread campaign of information and communication, systematic prevention in the educational environment and the introduction of a new system of appointments with specialist doctors (within the existing facilities) appropriate to young users, their parents and families.

Prevention concerning tobacco, alcohol or even cannabis will also be by better enforcement of current laws: to limit tobacco use in public places (the law known as the Evin law), to separate driving a vehicle and using psychoactive substances (driving under the influence of alcohol – article R.234-1 of the traffic regulations permitting a maximum level of alcohol in the blood of 0.5 g/l – and law no. 2003-87 of 3rd February 2003 relating to driving under the influence of substances or plants classified as narcotics).

In regard to treatment, the plan recommends optimisation and diversification of the treatments available. Development of the treatments available relies on planning at regional level, the introduction of Centres for Treatment, Assistance and Prevention of Addiction (CSAPA, medical welfare establishments created by the law renewing welfare action[5]), improvement of coordination of treatments via the networks, intensifying training for general practitioners (GP). Diversification of the treatments available relies on two main principles:

- developing programmes without substitution, particularly therapeutic communities;
- consolidating the existing system by continuing risk reduction programmes, introducing protocols encouraging supply of methadone by GP's and diversifying the development of formulations of substitution drugs.

[4] Medical prescription of the drug is restricted to hospitals and to supply by a local pharmacist on legally-controlled prescriptions for a limited period (7 days, renewable once only).

[5] Law of 2nd January 2002 renewing welfare and medical-welfare action (NOR: MESX0000158L).

The five-year plan also provides for *"experimenting with innovative treatment methods to deal with the crack problem in the Paris region and in the French departments in America"* (MILDT, 2004, p.31) using all types of intervention.

The following strategies are intended to improve treatment of users in prison:

- strengthening the partnership between prisons and the specialised sector;
- developing the partnership with the accommodation sector;
- improving substitution treatments;
- increasing accessibility of nicotine substitutes;
- implementation of risk reduction measures recommended following the report on risk reduction in the prison environment (Stankoff and Dherot, 2000) ;
- training for those working in the prison environment;
- developing monitoring tools in order to have greater knowledge of the needs of prisoners and the rate at which these needs are met.

The plan also provides for strengthening action outside France in the fight against drugs.

The objectives of the plan will be evaluated on the basis of a set of indicators available through the information systems already in place. As to new programmes, they will be evaluated as to their processes or results.

To finance all these actions, the MILDT will have 500 million Euros (M€) over 5 years. As the annual MILDT budget is around 38 M€ per year, the remaining 310 M€ will be financed by special contributions from ministries (health, interior, justice, national education etc.) according to their involvement in the actions set up in the plan.

At the end of June 2004, the Minister of the Interior set the fight against drug trafficking as one of the six priority areas for the fight against social insecurity. He announced the creation of an interministerial committee for the fight against drugs (CILAD), the intensification of searches on various means of transport (planes, trains and cars), more specific assignment of regional intervention groups (GIR) to fight the underground economy and more systematic use of "seizures of assets" as a tool to fight money laundering. At the same time, the Minister asked for indicators of concrete results to be introduced.

1.3 Budget and public expenditure

The special credits from the Ministry of Health and Welfare for major expenses for the fight against drugs were, until 2003, divided between heading 47-15 ("programmes and systems to fight addictive practices" linked with the General Health department), 47-16 ("interministerial actions to fight drug addiction" connected with the MILDT) and 47-18 ("the fight against AIDS and infectious diseases").

When the budget was voted on in 2003, headings 47-15 and 47-18 were deleted and different items relating to them were added under heading 47-11 ("public health programme, systems for prevention and health promotion").

In addition to these classification changes, the law on social security funding (law no. 2002-1487 of 20th December 2002) transferred the responsibility for meeting expenditure from the specialised centres for drug addicts (CSST) run by the State to the bodies which managed health insurance. The former article 10 under heading 47-15, now article 40 under heading 47-11, no longer needs to be quoted (Table 2).

Table 2: Special credits linked to expenditure for the fight against drugs voted in the finance act and implemented, 2002-2003

Special credits voted in the original finance act	2002	2003
Heading 47-16: interministerial actions to fight drug addiction	45.58	40.05
Budget implemented		
47-16 article 10 (credits transferred to ministries)	5.69	6.39
47-16 article 20 (decentralised intervention credits)	14.15	15.11
47-16 article 30 (prevention prog. decentralised credits, CDO, CIRDD)	21.47	16.01
Total(1)	41.31	37.51

(1) the difference between the credits allocated and the budget implemented is mainly due to budgets being frozen during the year

Sources: MILDT; Treasury special accounts (the "green accounts"), Ministry for the Economy, Finances and Industry

1.4 Social and cultural context

Media

During the year 2003-2004, there was a great deal in the French media about the debate on the public policy on how drugs information is treated; in addition to the drawing up of the new government plan by the MILDT, media attention was drawn in particular to the possibility of reform of the law of 1970 and the introduction of a system of fines to repress drug use.

This possibility was raised during the summer of 2003 and was closely followed by the press when the MILDT delivered its report on amendment of the law of 1970 on narcotics to the Prime Minister on 15th September 2003 and when the latter made televised statements (on channel M6 on 21st September 2003) in favour of reform of this law. The media also very soon reported that conflict was becoming evident between supporters of firm action and those with more flexible attitudes. At the beginning of 2004 they then announced the tabling (Agence France Presse – AFP- 23/01/04), followed by the actual submission of a bill by some members of the parliamentary majority (AFP, 17/06/04). Statements by the new Ministers for Health (radio RMC, 25/05/05) and the Interior (AFP, 24/06/04) after the change of government in the spring of 2004 were also widely reported.

This attention continued to 29th July 2004, when the adoption of a new government plan for 2004-2008 to fight illicit drugs, tobacco and alcohol was announced. The plan had been drawn up by the MILDT, based on the existing legislation.

This long period before the final arbitration was an opportunity for many to take a stand in the debate, either for greater liberalisation or, conversely, for even greater firmness, and this was widely covered in the newspapers. They were sometimes also critical of the slowness of the process; for instance, the daily *Libération,* condemning the government's procrastination, went so far on 10th March 2004 as to post on its web site a preliminary version of the five-year plan. A further sign that a solution was expected was that the French reference newspaper, *Le Monde*, gave its article on the subject lead status in its edition of 30th July, returning to this theme ten days later in an analysis column (Le Monde, 10/8/04).

Logically, in view of the widespread use of cannabis compared to other illicit substances and the priority given to this product by the MILDT, the possibility of reform of the law was, during this period, very much focused on this product. For instance, the headline in *France Soir* on 1st June 2004 was "Stop à l'hypocrisie" ("No more hypocrisy").

Although the rather high level of cannabis use in France compared to other European countries, particularly among young people, was widely commented on, two events contributed to further intensifying media interest in the spring of 2004. The first was in April: the publication, widely covered in numerous articles in the national press, including the

leading one in Le Parisien on 14/04/04, and in local press, of the results of the French section of the ESPAD survey; the second was the opening in May of an exhibition, "The scientists' view of cannabis", at the Cité des Sciences et de l'industrie (City of Science and Industry), a joint effort with MILDT and INSERM. On that occasion the link between cannabis and schizophrenia was again a matter of controversy, which led to the initiation of the collective expert examination of cannabis by INSERM.

The media retained its interest in other products to a lesser degree during this period. Although little mention was made of the error committed when a link was suggested between ecstasy use and Parkinson's disease, the newspapers and television kept returning to the subject of cocaine and the growth in its use; elsewhere the attention of various journalists (particularly Le Monde, 18 – 19 April 2004) turned to the information relating to a possible change of image for heroin and new method of use. Finally, throughout this period the press reported information concerning Subutex® and its misuse, most notably on the occasion of the consensus conference on substitution in June 2004 where substitution treatments were assessed.

At international level, the media mostly followed up the changes in opium-growing in Afghanistan and the reconstruction of that country.

In regard to cannabis, they covered its downgrading within the tranquilliser classification in the United Kingdom and the authorisation of its prescription for therapeutic use in the Netherlands. Another section of the Dutch policy was widely reported following an article in the weekly *Le Point* (22 April 2004): the decision, after the introduction of an automatic search policy at Amsterdam airport, not to arrest smugglers in possession of less than 3 kilos of cocaine.

2. Drug use in the population

Drug use in the population: general context

Drug use is generally classified on four levels which relate to the extent of use; these levels have been established on the basis of indicators used internationally:

- experimentation: having used the product at least once;
- occasional use: use at least once a year;
- regular use: use at least 10 times in the last 30 days;
- daily use: use every day.

In some cases, recent use (use at least once in the last 30 days) is also used.

Drug use among the general population: there are several surveys in France which collect data on this subject:

- for the adult population: the Health Barometer (Institut national de prévention et d'éducation pour la santé –INPES- National Institute for Health Education and Prevention), survey every four years); survey on Representations, Opinions and Perceptions regarding Psychotropic Drugs (EROPP) carried out every 3 years by OFDT) [*Standard table no. 1*].
- for the school population: European School survey project on alcohol and other drugs (ESPAD) carried out every 4 years (INSERM-OFDT) [*Standard table no. 2*].
- for young people: annual survey on health and consumption on call-up and preparation for defence day (ESCAPAD) carried out by the OFDT among young people aged from 17 to 19. This survey in particular is an opportunity to question young people who have left school early.

Cannabis is the illicit substance most used in France and its use has increased significantly over the last 10 years. In 2002, 2 out of 5 adults had already experimented with cannabis and fewer than 1 out of 10 used it occasionally or regularly (F. Beck *et al.*, 2003). Declared experimentation with drugs other than cannabis remains marginal (9.5 million cannabis experimenters, 850,000 for cocaine, 350,000 for ecstasy and 300,000 for heroin (F. Beck and Legleye, 2003c)). However, the slight increase in levels of experimentation among the 18-44 year-olds for cocaine (3.3% compared to 1.6%), hallucinogens (3.0% compared to 2.4%), ecstasy or amphetamines (2.5% compared to 1.2%) between 1995 and 2002 demonstrate that use of these products is spreading. The level of experimentation with heroin itself has been stable for around ten years (F. Beck and Legleye, 2003c).

Whatever the product considered, men living in large cities are more likely to experiment (François Beck *et al.*, 2002). Experimenters with illicit drugs are frequently unemployed or living with poor material resources, with the notable exception of experimenters with cannabis, who are better integrated socially.

At the age of 17, after tobacco, alcohol and cannabis (54.6% of boys and 45.7% of girls) and psychotropic medicines, the products most experimented with are inhalants (5.2%), hallucinogenic mushrooms (4.2%), poppers (4.0%), ecstasy (3.9%) and, to a lesser extent, amphetamines (2.0%), cocaine (1.6%) and LSD (1.3%) (according to ESCAPAD 2002, (F. Beck and Legleye, 2003b)).

Drug use among specific groups: the latest investigations carried out among people working as prostitutes (men and transsexuals, women) show that recent use of illicit drugs, excluding cannabis, involves a minority (Da Silva, 2003; Cagliero and Lagrange, 2003). However it appears to be more frequent among men and transsexuals (recent use of poppers 13%, 11% for ecstasy, 7% for cocaine, 2% for heroin) than among women (recent use of heroin 5%).

Among the homeless the data is patchy, but it is known that all products are available and are used. Users living on the street *"have addiction practices which are noticeably different from those of addicts who are better socially integrated: when you have no money or plans, you use what you can get on the day [....]"* (Solal and Schneider, 1996, p.1857). Estimates of the prevalence of use of illicit drugs in the last few months vary from 10% to 21% or even 30% depending on age, income level, the cause of their being on the street and the aid facilities

attended (Kovess and Mangin Lazarus, 1997; Observatoire du Samu social de Paris, 1999; Amosse *et al.*, 2001). The most-used drugs, apart from alcohol and tobacco, are cannabis and cocaine.

Although collection of epidemiological data on drug addicts among professionals is hindered by obstacles of various types (ethical, technical, financial, time, regulatory, cultural, practical), some assessment information is available. In 1995, a study of anonymous urine samples given by 1,976 employees from the Nord Pas de Calais found that 17.5% of workers used at least one psychoactive substance and in jobs relating to safety and security the figure was 40% of workers (B. Fontaine, 2002b). For the majority of users in the professions, use is hidden from their professional circle; work time and use time are as far as possible kept separate (A. Fontaine, 2002a).

Attitudes to drugs and drug users: the tool used to evaluate the attitudes of French people to drugs and drug users is the EROPP survey. This survey helps to measure the level of information there is about drugs, substances known as drugs, and the estimated degree of danger of the products. The study also looks at the representations of drug addiction in public opinion.

In 2002, 61% of French people stated that they felt they were well-informed about drugs, which was slightly more than in 1999. In response to the question: *"What are the main drugs you are aware of and do you know their names?"*, the French cited on average 3.8 products. The product the most often cited was cannabis (82%), followed by cocaine (60%), heroin (48%) then ecstasy (37%).

The product considered most dangerous by French people is heroin, well ahead of ecstasy and cocaine, alcohol and tobacco and finally cannabis (only 2% of those questioned felt that cannabis is the most dangerous product). This classification does not vary much with age, sex or socio-professional category. The perceived danger of cannabis varies with age and sex and, particularly, depending on familiarity with the product.

2.1 Drug use in the general population

NO NEW INFORMATION AVAILABLE

2.2 Drug use among young people and school children

School children

In 2003 the ESPAD exercise questioned a sample of school pupils aged from 12 to 18 who attended almost 400 schools (Choquet *et al.*, 2004). This new survey notably put into perspective the data collected over a 10-year period (1993-2003).

Experimentation with cannabis increases strongly with age but still remains lower than that with alcohol and tobacco and is characterised by a strong boy/girl differentiation from the age of 13, a gap which then remains quite marked.

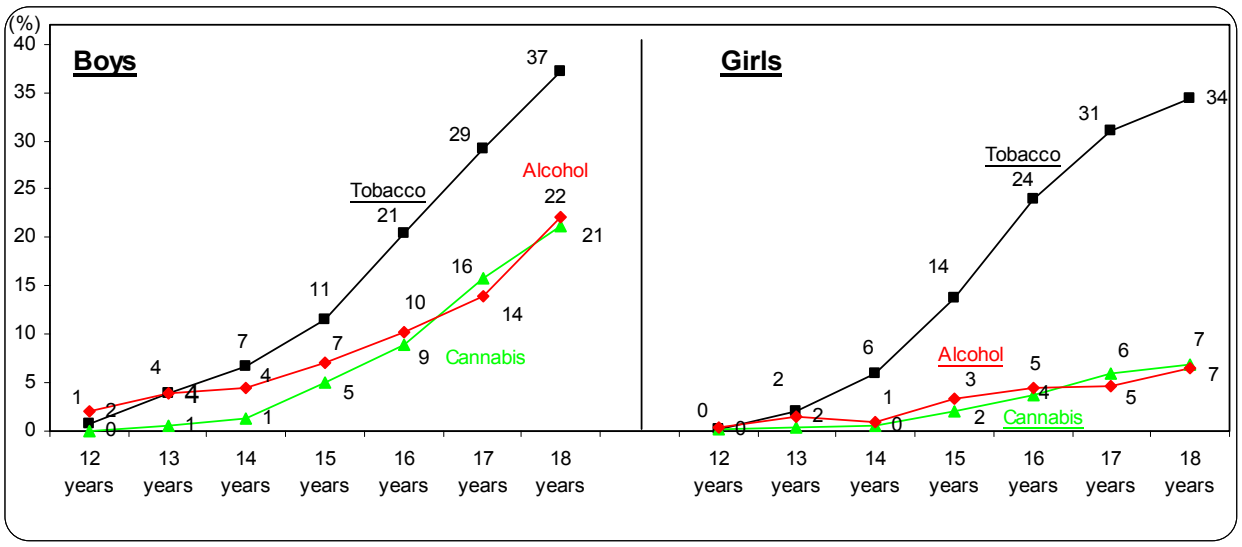
Regular use of cannabis remains exceptional before the age of 15 (1% of pupils); from the age of 16 its level is much the same as for regular use of alcohol (Graph 1). At the age of 18 there are 3 times more boys who regularly use cannabis than girls (21% compared with 7%).

Since 1993, experimentation and repeated use[6] of cannabis have at least doubled, both among girls and among boys and whatever the age range considered (12-13; 14-15; 16-17 years). In 1993, repeated use of cannabis among boys aged 14-15 was 1.7% but ten years later it reached 5.8%; for boys aged 16-17 the prevalence went from 7% to 21% over the same period, and among girls of the same age, 4% had repeated use in 1993 compared to 11% in 2003.

[6] The idea of repeated use (at least 10 uses throughout the year) which was used here to enable comparison with the 1993 survey (health and adolescent behaviour, n=12,397, INSERM unit 472, Choquet, M. and Ledoux, S. (1994) Adolescents, enquête nationale, INSERM, Paris.).

Illicit substances other than cannabis are little used. The levels of experimentation throughout life are in general very low: the percentages are still less than 5%, except for inhalants (glue, solvents) and hallucinogenic mushrooms among boys aged 16-17. This use increases relatively little with age.

Graph 1: Regular use of tobacco, alcohol and cannabis by age and sex, 2003



Sources: ESPAD 2003 – INSERM- OFDT - MJENR

Young people aged 17 to 19

The ESCAPAD survey carried out in 2002 was on a sample of 16,552 young people questioned on national call-up and preparation for defence day (JAPD) (F. Beck and Legleye, 2003a).

The results obtained in 2002, compared with those for 2000 and 2001, confirm that cannabis remains the most-used illicit substance (at the age of 17-19, 5 out of 10 girls and 6 out of 10 boys had experimented with it, Table 3). Experimentation with it is more frequent towards the age of 15-16, on average: at 18 the boys state they smoked cannabis for the first time at around 15.2 years of age, the girls around 15.4 years of age.

Table 3: Experimentation and recent use of psychoactive substances at the age of 17-19 in 2003 (%)

	Lifetime (experimentation)			Over the last 30 days (recent use)		
	girls	boys	total	girls	boys	total
Cannabis	48.9	58.3	53.7	27.1	42.1	34.8
Hallucinogenic Mushrooms	2.6	6.7	4.7	0.5	1.8	1.2
Poppers	4.1	6.4	5.2	1.0	1.3	1.1
Inhalants	4.6	6.9	5.8	0.6	1.0	0.8
Ecstasy	3.3	6.0	4.7	1.5	2.5	2.0
Amphetamines	1.6	2.9	2.3	0.7	1.1	0.9
LSD	1.0	2.1	1.6	0.3	0.6	0.4
Crack	0.4	1.0	0.7	0.1	0.2	0.2
Cocaine	1.4	2.7	2.0	0.6	0.9	0.7
Heroin	0.6	1.4	1.0	0.3	0.3	0.3

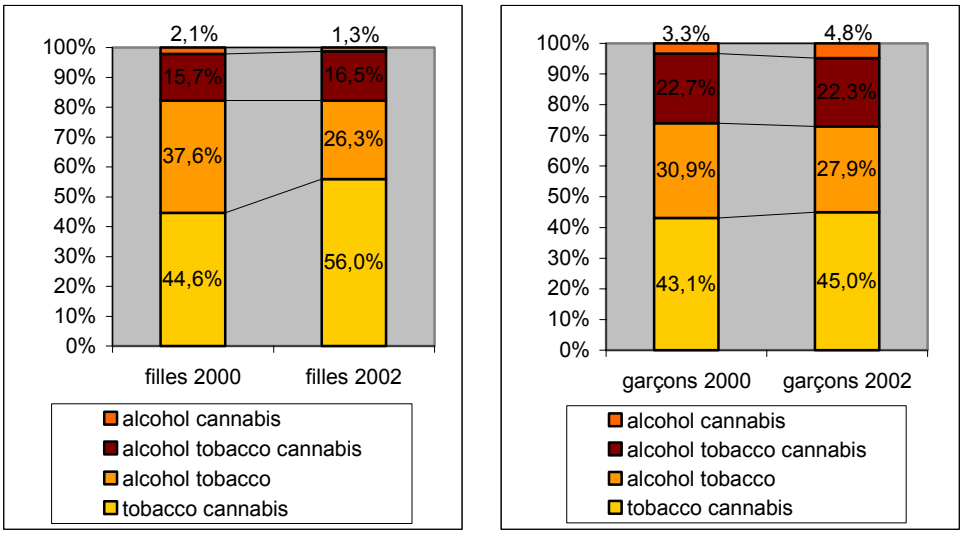
Source: ESCAPAD 2002 (F. Beck and Legleye, 2003a)

A new fact in 2002 was that regular use of cannabis was as frequent as that of alcohol. Among regular cannabis users, 97% stated they had already used the product before midday and 90% that they had already used it alone.

Levels of experimentation with other illicit drugs are still low but seem to be increasing slightly for some products: glue and solvents, hallucinogenic mushrooms, poppers, ecstasy. These substances are specific to young people. Experimentation with amphetamines is also rising but more slowly than for the products quoted above.

Polydrug use appears, like cannabis, to have increased slightly between 2000 and 2003, mainly among boys (21.5% of regular polydrug users of at least 2 products from alcohol, tobacco and cannabis, compared to 8.2% for girls). Over the last 2 years the structure of polydrug use has changed because of the increasing prevalence of regular use of cannabis (Graph 2): total use of alcohol and tobacco has decreased in favour of use involving cannabis, particularly those involving tobacco and cannabis.

Graph 2: Changes in the structure of regular polydrug use of alcohol, tobacco and cannabis at the age of 17 between 2000 and 2002



Source: ESCAPAD 2000-2002, OFDT.

The most recent surveys carried out among young people highlight similar trends (F. Beck and Legleye, 2003b; Choquet *et al.*, 2004). Experimentation with cannabis has increased in all age ranges, including the youngest. However, the first results from the ESCAPAD 2003 survey (F. Beck *et al.*, 2004) for the first time show signs of a slowdown in levels of experimentation with cannabis among boys (54.6% in 2002 compared to 53.3% in 2003). Among other illicit drugs, levels of experimentation remain low, although we note a slight increase in the prevalence of mushrooms, poppers, inhalants and ecstasy among those aged 17-18. Apart from psychotropic medicines and tobacco, boys are more often experimenters and users than girls.

There is a great variety of uses and contexts of use (party, recreational, stress management etc.). Young people often mention the transitory nature of their behaviour; the 17-19 year-olds, for example, most often expect to give up their use when they become adults (F. Beck and Legleye, 2003b).

There are few young people who have never used tobacco, alcohol or cannabis; between the ages of 12 and 18, 12% of boys and 15% of girls. At the age of 18, only 14% had not used any of these 3 products over the previous 30 days (F. Beck and Legleye, 2003b).

2.3 Drug use among specific groups

It is particularly difficult in France to takle the link between migration and addiction, both for political reasons (fear of stigmatisation) and epidemiological reasons. Nevertheless, a documentary review was carried out in 2003 and there is also some information available from surveys.

In a survey carried out among 590 adults who attended free treatment centres, alcoholism and drug addiction disorders were observed more frequently among French than among foreign patients (Collet *et al.*, 2003).

The majority of people without resources or those who are socially excluded who move into one of the centres of the organisation Médecins de Monde (MDM) to receive treatment (outside the specific programmes for drug users) are of foreign nationality (85%). The French declare more often than the foreigners that they are dependent on alcohol, tobacco, cannabis or other illicit products (Table 4). This difference was observed in 2000 and confirmed in the 2 years following (Drouot and Simmonot, 2003; Drouot and Simmonot, 2002; Cayla *et al.*, 2004) and also in another survey (De la Blanchardière *et al.*, 2004).

Table 4: Proportion of patients at an MDM centre declaring dependence on a substance, 2002-2003

Year	Substances	Nationality	
		French	Foreign
2002	alcohol	22.7***	8.1
	cannabis	20.8***	1.6
	other products (excluding tobacco and medicines)	11.7***	0.8
2003	alcohol	25.9***	8.4
	cannabis	20***	2.4
	other products (excluding tobacco and medicines)	10.2***	1

Interpretation: 22.7% of patients of French nationality who responded to the question "do you have a problem of repeated abuse or addiction to ...." declared that they had abusive use of alcohol; 8.1% of the patients of foreign nationality declared alcohol dependence

*** significant difference between the 2 nationalities, p<0.001

Source: Observatoire de l'accès aux soins de la mission France (Monitoring centre for access to treatment, French Mission) 2003, MDM.

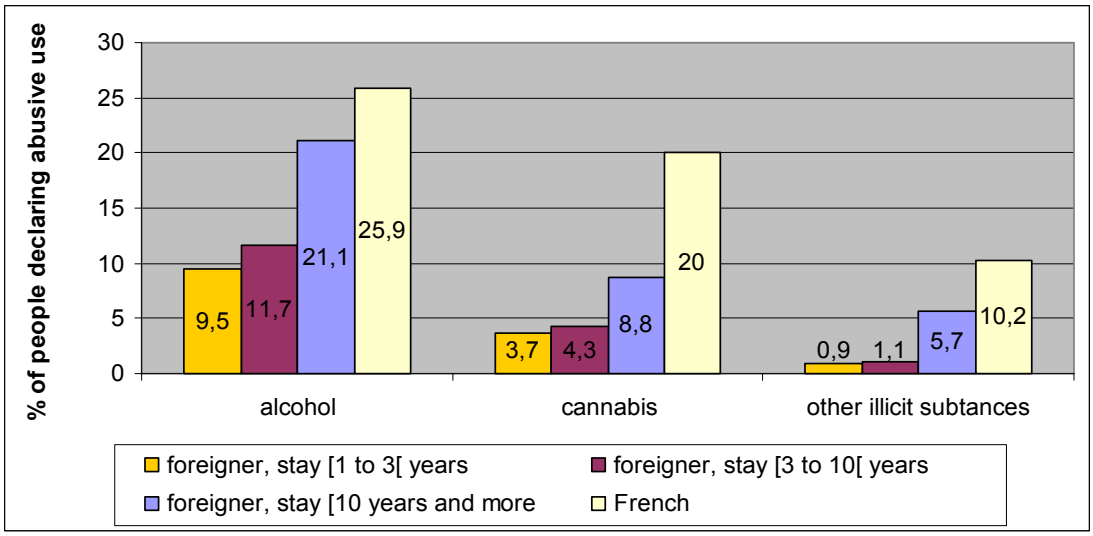
It has also been noted that abusive uses among foreign patients change depending on the length of their stay in France: the longer they stay in France, the closer their use of psychoactive substances comes to that of people of French nationality. This change in at-risk behaviours of people of foreign nationality could *"be interpreted in terms of a progressive acquisition over time of the life habits of the country where they live"* (Cayla *et al.*, 2004, p.44). Be that as it may, there are similarities for alcohol (Graph 3), but the levels of abusive use of cannabis and other illicit products by foreigners remain below the levels for French people, even after a stay of more than 10 years in the territory.

The results given previously are not inconsistent with the conclusion of C. Junt in his article "Immigration and drug addiction" (2004): *"it appears from most research that there do not*

seem to be more problems of drug addiction and dependence among migrants than in the general population"[7].

Migrant populations, because of the paths they take in their lives in exile, are faced with specific psychological and health difficulties which need to be identified and treated. Migrants, often in more or less unstable situations, are more vulnerable to health risks and possible dependence problems. In some low threshold facilities, almost 40% of crack users taken in are migrants (Toussirt, 2004). It would seem to be essential to do more in-depth research on this very specific population in order to find out more about use prevalence and its relation to the products and then to adapt treatment methods.

Graph 3: Declared abusive use when attending an MDM centre according to nationality and duration of stay in France, 2003



Source : Observatoire de l'accès aux soins de la mission France, MDM.

2.4 Attitudes to drugs and users

NO NEW INFORMATION AVAILABLE

[7] Most of the work carried out in France concerns 2nd generation migrants, often from the Maghreb - Ait Menguellet, A. (1988), Toxicomanie et immigration, In *Congrès de psychiatrie et de neurologie de langue française, 86ème session*Masson, Chambéry (France), Curtet, F. and Le poulichet, S. (1985) La toxicomanie des maghrébins, *Interventions*, (5), 16-18, Gauthier, B. and Peireira-esterela, A. (1995) La famille immigrée maghrébine confrontée à la toxicomanie, *Interventions*, (48), 20-23, Toufik, A. (1997) Pratiques et mobilité des suagers de drogues : de la dynamique du risque à celle de la prévention, *Le journal du sida*, (92-93), 31-36. And nomadic populations: Missaoui, L. and Tarrius, A. (1999) Héroïne et cocaïne de Barcelone à Perpignan : des économies souterraines ethniques de survie à la généralisation des trafics transfrontaliers de proximité, OFDT, Paris.

3. Prevention

Note to the reader: Because there is no information system it was necessary to set up a multi-institution working group to update the information relating to prevention.

Prevention: general context

Legislative framework:

The legal framework set by the law of 31 December 1970 does not cover the field of prevention. This field has, in fact, rarely been tackled by the French legislative and regulatory system. As such the "Evin" law of 10 January 1991[8] – regulating the use of alcohol and tobacco in public places and also propaganda and advertising for these products – together with the circulars from the Ministry for Education on the health of schoolchildren (between 1990 and 2003) are exceptions to this. Before legal psychoactive substances were included with drugs problems (which happened in 1999), the laws governing education dealt with prevention of drugs as one aspect of a more global approach to preventing risk behaviours.

Institutional and administrative framework for prevention of drug addiction:

Although prevention of drugs has mostly been dealt with by the community sector, it has always been included as a principle of common law of public service, which focuses on the rights of the citizen and is intended to extend the rights and services provided by the State. Within this system, responsibility for particular populations or problems is assumed by general services, which must be able to offer specific, even individualised responses. In addition to the ethical justification for this, based on equality of treatment and the fight against discrimination, there is a practical argument which reinforces the option underlying the common law: the concentration of services reserved for specific groups could limit identification of other vulnerable groups which do not correspond to pre-determined selection criteria, thereby compromising their accessibility to services and aid.

However, if the response by the authorities is to be effective, priority populations must be identified and the various components (social, educational and security) of the “psychoactive substances” phenomenon must be combined and dealt with together on a local intervention basis (local decision-making and workers)[9]. The identification of priority groups and the concentration of additional means for them are via territorial coordinated systems specific to the fight against drugs or dedicated to health in general (PRS), to the fight against social exclusion (PRAPS) or to urban policy (e.g.: CLS, CEL)[10]. They may also rely on territorial zoning based on socio-economic indicators and linked either to the quality of the housing (in ZUS) or to the educational system (number of pupils falling behind at school and rate of school maintenance allowance) within the ZEP[11]. The policy of targeting according to geographical guidelines is almost the only form of "positive discrimination" applied in France. It means that different types of social reality can be treated in an operational way without resorting to cultural distinctions which are not de facto permitted in French society because of their potentially discriminatory nature. Field workers working in and/or with the community ensure that the messages and methods of communication are appropriate for their particular targets.

Core principles:

[8] Law no. 91-32 of 10 January 1991 relating to the fight against smoking and alcoholism, *OJ* of 12 January 1991, p. 4148 (NOR: SPSX9000097L)

[9] This approach, known as the "front-line strategy", corresponds in practice to the subsidiarity principle, one of the organisational principles of public action in France, according to which decisions on prevention actions must be taken at the lowest possible level.

[10] PRS: Regional health programmes; PRAPS: Regional programmes for access to preventive measures and health care for people in vulnerable situations (one in each region in accordance with law no. 98-657 of 29 July 1998 relating to the fight against exclusions, article 71); CLS: Local security contracts; CEL: Local educational contracts.

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

Since the 1999-2002 government plan came into force in 1999, the fight against drugs has widened its scope to include all psychoactive substances, illicit or not. The new government plan for 2004-2008 reaffirms this widening of the scope of the anti-drugs policy. In regard to prevention, this global approach is expressed in two principles:

- early intervention among young people in order to delay the age when use begins;
- incorporation of prevention of drug abuse in addition to the traditional objective of prevention of use.

Central and local political coordination:

More than any other field, prevention of drug addiction covers many sectors. Setting up a coherent national prevention plan involves working with a range of public and private actors, most of whom have a great degree of autonomy. The role of the MILDT is to ensure that public action in this field results from a common strategy and is not simply the juxtaposition of individual strategies. National guidelines are defined via a government plan supported by the MILDT. In regard to school prevention, guidelines are also reflected in the regulations and programming for education.

Each ministry involved has a department whose function is to coordinate central and decentralised prevention objectives[12]. These departments are the contact points at the ministries for the MILDT for prevention matters. The interpretation of national directions at local level therefore relies on decentralised State services and the coordination systems which they run. However, the drugs policy is given special resources, in particular the network of "drugs and drug addiction" project leaders (CPDD) coordinated by the MILDT. In each department (county) a project leader, i.e. an official of the prefecture or the decentralised services, is appointed by the Prefect to coordinate local policy in this field. The CPDD has two main resources with which to do this: firstly, credits dedicated to prevention of drug addiction and training for professionals, and secondly, a steering committee for the fight against drugs and prevention of drug addiction. This latter committee, chaired by the Prefect and organised with the assistance of the CPDD, brings together the State services concerned and has to work in partnership with the courts, local authorities[13] and key associations in order to coordinate the objectives of the public and private actors and to set funding. In particular, it validates a departmental programme for prevention of drug addiction. At local level, a network of key people (including the CPDD's) ensures that the objectives of the policy to fight against adddiction and those of the related political programmes are integrated. These key people are the contacts within their own organisation who participate in crossover systems for coordination. At local level, organisations concerned by crossover systems for coordination in the field of drugs or in related ones are often represented by the same contacts-persons. This network of key people having a cross-sector vision also facilitates the coherence of the objectives of the drug policies and those of the related political programmes.

In the Ministry for Education, the School Education Office (DESCO) is responsible for coordination and evaluation of the health promotion policy for school children. DESCO leads the network of advisers (doctors and nurses) from the decentralised services (education offices and school inspectorates) which are involved in drawing up and implementing regional or departmental systems relating to health, social exclusion and prevention among school children[14]. In addition, the framework partnership agreement for public health between the Ministries for Education and Health defines the priority objectives and collaborative actions in the various fields relating to health, especially use of psychoactive products and tobacco.

In state-run secondary schools, the implementation of a prevention strategy is still the prerogative of the school heads, but is strongly backed by the ministry and its external departments. This strategy is carried out according to local initiatives of the administrative and teaching teams, described in the annual "institutional in-house plan" (*projet d'établissement)*

[12] For example: the school education Office or DESCO (national education), the Addictive Practices Bureau (health and welfare), the Mission for the Fight against Drugs or MILAD (Ministry of the Interior), etc.

[13] Departmental (sub-regional) or regional decentralised authorities which are autonomous and have peculiar powers in, for example, the fields of health, social assistance for children or child protection.

[14] Private schools under contract to the Ministry for Education, of which there were 3,530 in 2003/2004, are subject to the same operational rules as those in the public sector in regard to their staff and compliance with the national programme.

according to priorities defined by both the "*académie*" et "*départemental*" education authorities[15]. Since 1998, Health and Citizenship Education Committees (CESC) which were set up as "social environment committees" in 1990, have been the bodies which coordinate prevention in schools. They are present today in the majority of secondary schools. They are chaired by the head of the school and bring together the educational community and workers involved in local community life (associations, institutions etc.), creating a link between the school and its environment.

Coordination and professional networks:

Professionals working in the field of drug prevention have several support organisations, including the CIRDD's (see next section) and the National Institute for Prevention and Health Education (INPES). INPES comes under the Ministry for Health and Welfare and its role is:

- the expertise and advice regarding prevention and health promotion;
- the development of health education and therapeutic education;
- the implementation of national programmes for prevention and health education.

In order to be represented at local authority proceedings and to promote the exchange of experiences as well as the sharing of the professional guiding principles, the NGOs dealing with the problematic of drugs have formed themselves into several large organisations:

- the National Federation of Health Education Committees (FNES, created in 2002, www.fnes.info);
- the National Association for the Prevention of Alcoholism and Addiction (ANPAA, the founding organisation created in 1872, www.anpaa.asso.fr);
- the National Association of Drug Addiction Workers, (ANIT, created in 1980, www.anit.asso.fr);
- the French Federation of Addictology (FFA, created in 2000, www.addictologie.org);
- the network of Regional Information and AIDS Prevention Centres or CRIPS, (www.lecrips.net/reseau.htm) and in particular the first centre, created in 1988, the CRIPS of Ile-de-France (the Paris region), which, among other things, organises operations at national level.

All these associations run training courses, conferences, workshops and documenting networks related to prevention of use of psychoactive substances.

Some information on the French prevention system:

The majority of actions to prevent drug addiction in France take place in schools and largely involve the educational community, both in coordinating and in carrying out the actions. The approaches of prevention which might be classified as "selective" or "indicated", if we use the nomenclature recently adopted by the EMCDDA, are mainly done by NGOs. They all suffer from poor visibility outside local professional networks. The general perception is that of a prevention of many different forms, with vague outlines. In spite of institutional or community initiatives to professionalize prevention practices, to promote deontological guidelines, or even to share knowledge among the various professional bodies, no particular model stands out for the professional or institutional networks (apart from the fact that their approach covers both the legal and illegal nature of use).

The many services and programming systems, linked or potentially linked to prevention of drug addiction, represent various potential sources of funding. Although this variety gives the subsidised organisations a certain margin for manoeuvre, reconciling the individual systems which monitor the use of the credits is a burden on the budgetary management of these organisations.

As has already been emphasised, there are many actors involved in prevention. In the public sector, in addition to educational personnel, the services responsible for implementing the law are often involved. Indeed, personnel who have undergone training in this field – i.e. the anti-drug inter-link trainers (FRAD), officers in the *gendarmerie*, and anti-drug trainers (PFAD) from the police force – will, on request, visit schools or other organisations for young people or adults

[15] The "*académies"* (the educational district authority) administers at regional level the educational policy defined by the government.

(professionals or parents) to talk about drug use and the legislative and penal framework relating to narcotics.
De facto, the community sector is a considerable presence in the field of prevention of drug addiction, both inside and outside schools. The preventive actions carried out in the information and reception facilities dedicated to young people in local communities, but also in sport, cultural or recreational settings (night clubs, bars) or in the party scenes (techno or other) are mostly carried out with financial input from the services responsible for health, welfare, urban policy[16], for youth and culture. Locally, these initiatives are principally taken by associations or by local authority or departmental services.

Some decentralised local authorities, often in metropolitan areas, are particularly involved in the field, because of their responsibility for child welfare and child protection, among other reasons.

The state health insurance organisations or mutual insurance companies also initiate or fund numerous actions.

Finally, psychoactive substances are often tackled through preventive measures linked to social exclusion, AIDS or delinquency but most part of these actions can not be characterised and counted.

It is important to mention some ongoing national preventive or support measures, dedicated directly or not to the problems of drug addiction:

the national "Drugs, alcohol and tobacco information service" telephone helpline (DATIS);

- the travelling campaign of information and prevention of addiction run by the Mission for the Fight against Drugs (MILAD, Ministry of the Interior), which visits many schools and the French coasts during the summer;

- the Youth Counselling Centres (PAEJ), which focus on counselling, raising awareness, guidance and mediation for young people in risk situations (insecurity, on the streets) and for their families, as part of the fight against social exclusion;

- the web site www.drogues.gouv.fr, a government site giving information about psychoactive substances;

- the Resources Centres for Information on Drugs and Drug Addiction (CIRDD), created in 2000 at regional level or below, which provide technical support to the CPDD's and can give assistance and advice to local workers involved in the fight against drugs in preparing projects, particularly those relating to prevention;

- "Toxibase", the information network about drug addiction, which has a menu item "new prevention tools" on the French-language tools relating to various themes such as: primary prevention, alcohol, tobacco, risk-reduction, other addictions, doping, health education, suicide, drug addictions and illicit drugs, medicines;

- the Commission for validation of prevention tools, created in 2000 and coordinated by the MILDT (www.drogues.gouv.fr). This is composed of representatives of institutions, experts and field workers. It evaluates prevention media freely submitted to it, in order to encourage reliability and consistency in the prevention messages given out by the different workers in the field.

Monitoring of prevention today:

Prevention suffers generally from lack of visibility and confusion about how it is organised. This is accentuated by the great number of operators and sources of funds and the fragmentation of the individual information systems which they use. There are many factors which lead to harmful practices in drug use and this needs to be tackled on a wider basis, looking at social phenomena which have been of concern to politicians since the end of the 1990's: risk behaviours, exclusion and delinquency. For instance, a large part of prevention of drug addiction is based on crossover systems (mentioned previously) and because of this it is difficult

[16] Since the 1980's, the French government has been working to fight deterioration, and exclusion of the inhabitants, of districts generally located on the periphery of large cities. The actions undertaken have been grouped under the name "policy of Urban affairs" (“politique de la ville”): today they run local projects including economic, social and urban development and prevention of delinquency in 750 districts, known as sensitive urban zones, with 5 million residents.

to identify. There are also obvious difficulties in identifying prevention actions through the granting of credits: data may be counted more than once and besides we do not know what is the proportion of the actions subsidised compared to those for the whole of France.

Today, the absence of a centralised information system on prevention is hindering any attempt to produce a national picture of the organisation of prevention in France. This situation explains the predominance of support systems and services in the description of national strategies in this report.

3.1 New developments relating to prevention

Over the period 2003-2004, the definition and organisation of prevention of drug addiction had a high profile in policy and programming, particularly after the adoption of four framework documents:

- the 2003-2008 cancer plan, which in 2003 put tobacco very high on the list of priorities for health concern;
- the five-year programme for prevention and education drawn up by the Ministry for Education (recorded in a circular in December 2003);
- the government plan to fight against illicit drugs, tobacco and alcohol (adopted in July 2004), in which the prevention strategy is mainly focused on cannabis, tobacco, alcohol and risk behaviours, schools and the educational role of parents;
- the law of 9 August 2004 setting out the public health policy with quantified objectives (together with the previous objectives) on abusive use of alcohol, smoking in general and passive smoking in schools (total disappearance), recreational settings and the professional environment;

All these laws lay down quantified objectives, which is quite a new approach for the organisation of public action in France. However, since these provisions are quite recent and there are gaps in the information system, already mentioned in the general text box, there is no information available at national level on the actions taken and progress made. The information reported here concerns lines of action which should be put into practice over the period 2004-2008. In addition, since the ideas of "universal prevention", "selective prevention" and "indicated prevention" are not in current use in France, none of the reference laws indicates this distinction: they formulate common strategies for the general population and priority groups.

The reference laws previously quoted for 2004-2008 centralise the fight against smoking and cannabis use. The government plan of action against illicit drugs, alcohol and tobacco (2004-2008) provides for three main lines of action to *"crush the spread of cannabis"*: campaigns of information and communication, a structured programme in schools (see section 3.2) and finally special counselling consultations on cannabis for young users and their parents (see section 3.3). The other prevention actions target synthetic drugs (see in particular section 3.2, selective prevention), alcohol and tobacco.

3.2 New developments relating to universal prevention

See also the structured questionnaire n°23: universal school-based prevention

National policy for schools

In December 2003, the Ministry responsible for Education adopted a five-year plan for prevention and education for the period 2004 to 2008[17] according to which prevention of risk and addictive behaviours must be incorporated into the school curriculum from primary school, throughout school life and particularly at secondary school level. In order to

[17] Circular no. 2003-210 of 11 December 2003; NOR: MENE0302706C.

discourage initiation to psychoactive substances and reduce health and social risks in young users, the following methods are to be implemented:

- reminders about the law (on narcotics and regulation of smoking in public places) and the disciplinary and judicial penalties which can be incurred.
- regular information on the dangers of psychoactive substances and polydrug use ;
- information and raising of awareness of school staff and parents at the start of the school year about the effects of the products and their effects on adolescent development;
- development of aid for young regular users to guide them towards the specialised services.

Specific measures involving school nurses have also been taken to assist in the fight against smoking, including guidance towards services which help with withdrawal and selective supply (in exceptional cases) of nicotine substitutes. These measures were reinforced by the provisions in the framework agreement on partnership in public health signed by the Ministries of Education and Health for the 2003-2004 school year. In fact, the latter had as one of its priority objectives the fight against smoking and experimental facilities for children and adolescents with emotional problems.

The principal objective of the 2004-2008 government plan in regard to prevention in schools was to create conditions for effective prevention which would be suitable for all school levels. For instance, the plan reaffirmed the importance of coherent programming of preventive education on alcohol, tobacco, cannabis and synthetic drugs, suitable for every school level, from the end of primary school to the end of secondary schooling, with satisfactory rates of cover and quality. It also supported the emphasis placed on the intense fight against smoking in schools (with the objective of smoking-free schools) and the development of aid and guidance for young users.

From an organisational point of view, the circular setting up the five-year programme for prevention and education and the government plan urged all public teaching institutions to set up their own CESC (three quarters already had one).

Finally, article 312-18 of the new law setting the programme for the public health policy (Law no. 2004-806 of 9 August 2004, NOR: SANX0300055L) stated that *"information should be given on the consequences of drug use on health, particularly in relation to the neuropsychic and behavioural effects of cannabis, in secondary schools, in at least one annual session, in groups of the same age (....)".* This obligation is in support of the programme measures previously mentioned, since it is not felt to be sufficient on its own.

Quality assurance

As part of the health education programme to continue throughout compulsory schooling, an experimental health education programme was set up by DESCO, MILDT and INPES during the autumn of 2004. It will be introduced in five educational districts when the 2005 school year begins, in order to test a methodology for intervention and evaluation in the transitional periods CM2-6ème and 3ème-2nde[18]. It will be in general use in September 2006.

Since 2001, Regional Health Education Schemes (SREPS) must ensure better integration of national and regional policies, organisation of services and distribution of supply, and must reinforce or set up centres of skills in this field. During the summer of 2004, INPES invited tenders for a support project for setting up SREPS.

Support projects must contribute to training in health education, regardless of the origin of the workers and/or improvement in the quality of actions by:

[18] That is, respectively, at the 6th-7th grades and 9th-10th, corresponding to the time when children change schools .

- advice on methods, including evaluation and support for health education actions;
- documentation and supply of teaching tools needed to implement health education actions.

Some figures on prevention actions

Because of their very hierarchical structure, the gendarmerie and the police force are easily able to provide quantified information on their prevention operations. For instance, in 2003, 575 FRAD's (Gendarmerie) spoke to around 390,000 people at conferences, discussions and exhibitions. This was in a variety of venues: schools, training centres, government offices, communities, clubs, associations, businesses, training courses for adults or professionals who need to be aware of the problems related to drugs, working groups working on a prevention project. During 2002, the 250 public safety PFAD's met 160,000 people (a majority of whom were school children) and the 4 officials of the MILAD working on the lorry which acted as podium for the travelling campaign for drugs prevention met 53,000. Finally, the specialised services from police headquarters (30 police officers from the community police and Criminal Investigation Department) met 28,000 people, i.e. a total of around 240,000. Of all the people whom the police met as part of the prevention actions, the percentage of young people, mostly school children, was more than 75%. In regard to adults, these were mostly members of the school system, welfare and health workers and parents of school children.

In 2002, 39,000 young people attended a PAEJ (youth reception and counselling centre). Half of the young people attending for the first time received information teaching them about the danger of psychoactive substances (primary prevention). The other situations encountered were linked to risk situations and those where there was family and social breakdown.

In 2003, more than 800,000 calls were handled by the DATIS telephone helpline, of which 15% were genuine calls, i.e. identified by the service as real questions. During these calls, legal products were cited in 53% of cases. Among the illicit products (cited in 47% of the calls), cannabis was the product most frequently dealt with during the exchanges (26% of all genuine calls, with an equivalent percentage for alcohol), far ahead of heroin or cocaine (around 5% of genuine calls).

According to a recent National Federation of Health Education Committees survey of the 111 CODES'S and CRES's in its network, some major trends are developing in regard to prevention actions linked to drugs. Among the 247 actions on which data was collected, half dealt exclusively with alcohol and/or tobacco. The other half was composed mainly of crossover actions involving all legal or illicit psychoactive substances. The actions for illicit drugs alone were marginal. Almost 45% of operations carried out as part of these actions were dedicated to aid to professionals (training, advice on methods), 29% were for information, reception and listening etc. among the publics targeted. Finally, 25% concerned the design of tools. Three quarters of the actions had an evaluation document.

Budget

A large number of the universal prevention actions are carried out as a result of scattered funding other than credits assigned by the MILDT, for example funds from town contracts, PRS, PRAPS, FNPEIS for sickness insurance (National prevention and health education and information fund) and private funds (for example, mutual insurance societies). The feeling of scattering often mentioned by the associations in regard to funding of prevention is reinforced by the fact that subsidies have to be applied for every year. The funds available are considered overall to be insufficient by the professionals in the community sector. In order to estimate national expenditure on prevention, it would be necessary to be able to evaluate all these credits. The information available comes from the MILDT and the INPES and does not make it possible to distinguish which relates to universal prevention or other approaches, although the former is still the one most-funded by these organisations.

The credits provided in 2003 by the MILDT for prevention are shown in Table 5, and have been falling since 2001. The budget allocations have been combined into one sum (7.11 M€) since 2003, incorporating all the credits previously covered by Ministries (Education, Youth and Sport, Agriculture). INPES expenditure on prevention of drug addiction in 2003 was slightly more than € 100,000.

Table 5 : Prevention actions financed by MILDT credits in 2002-2003 (in thousands of Euros)

Types of action	2002	2003
Actions carried out as part of departmental prevention programmes (credits managed by "drugs and dependencies" project leaders)	6.60	7.11
Local actions under the supervision or management of:		
Education (via the CESC's)	*1.30*	*0.00*
Youth and sport	*1.30*	*0.00*
Agriculture (agricultural training)	*0.13*	*0.00*
Other decentralised services (PFAD and FRAD etc.)	*0.50*	*Not available*
Associations running networks	*1.00*	*0.94*
Total	10.83	8.05

Source: MILDT, 2003

Universal prevention aimed at families

Measures dedicated to families involve providing information on the substances, their effects, their risks, signs of abuse and the places and resources available to support parents in their preventive and educational role. This objective requires more input from social protection bodies and local prevention workers in order to reach more parents directly, especially those in families where there are problems with schooling.

The government plan also provides for the development of aid services especially for parents. Reception centres for parents are to be set up within the various facilities working in the field, especially listening posts, counselling consultations on cannabis (see next section), outpatient centres for alcohol and drug addiction (CCAA) in addition to telephone helplines. A new telephone helpline specifically for cannabis, managed by the national telephone information service for psychoactive substances (DATIS) is to be set up.

Universal prevention aimed at communities

The government 2004-2008 plan provides for the introduction of counselling consultations on cannabis, reception and support facilities which offer a family approach and support involving both parents and children. These clinics can be located within the different facilities (CSST, PAEJ, CCAA etc.) on the basis of a common specification drawn up by the MILDT and the DGS. The clinics must be easily accessible, anonymous and free of charge. The service will be provided by professionals trained in the use of evaluation tools and brief intervention in the field of addictions who are capable of identifying the appropriate social, medical or psychiatric service for the patients who require specialised treatment. This new service must be advertised in the places frequented by young people.

3.3 New developments in selective prevention

Recreational environment

In regard to the party scene, the plan recommends the presence of prevention workers at party events, but suggests that "testing" (technique for rapid identification of the components of synthetic tablets) should be abandoned, arguing that this approach *"which represented a slogan for those frequenting party events, has been called into question."* Prevention actions on the party scene must comply with a risk-reduction intervention guideline drawn up by the MILDT.

Groups at risk

The government plan identifies particular groups which will require special preventive measures:

- the children of dependent parents who must be treated in collaboration with the treatment facilities, in the light of existing experience in France and abroad;
- sportsmen and women in training without highly-qualified supervisors and in whom high use of psychoactive substances has been recorded by recent surveys;
- the population of sensitive urban zones where it should be a priority to set up listening and aid services such as the listening posts and the counselling consultations on cannabis;
- people in prison who have addictive behaviour and would benefit from annual or multi-annual health education programmes.

The counselling consultations on cannabis must have the capability to treat the most problematic users.

Families at risk

See preceding section.

3.4 Possible developments which should be monitored:

The need to set up a national information system is more and more pressing. Improvements should be made over the next few years so that this system can be set up. As part of the reform of the institutional law relating to the finance laws (LOLF) indicators must be defined in order better to identify the reality and effectiveness of the funds committed. The LOLF will require enormous investment in the information system.

4. Problem drug use

Problem drug use: general context

Prevalence and incidence estimates: An estimate was made of the national prevalence of problematic use of heroin and cocaine in the population aged 15-54, using the demographic estimation method and data from the "November" survey of 1999 (Costes, 2003). The result obtained was 4.6 per thousand [*Standard table no. 7*].

Local estimates were made in 1999 of the prevalence of use of opiates and cocaine (heroin, Skenan®, Subutex®, methadone and cocaine) concurrently in five French cities, using the capture-recapture method: the estimates varied from 15.3 per thousand people aged 15 to 59 in Nice to 6.5 per thousand people aged 15 to 59 in Toulouse (Chevallier, 2001), [*Standard table no. 8*].

The number of problem opiate or cocaine users was estimated to be between 150,000 and 180,000 in 1999.

There are currently several French-language tools allowing evaluation of abuse or harmful use of cannabis among adolescents or young adults. These are two tests translated from English and one specific test for cannabis devised by OFDT: CAST (Cannabis Abuse Screening Test).

Until there is a European definition, the definition of problematic use of cannabis selected for use in France is as follows: "use likely to cause significant health and social damage to oneself or others".

France does not yet have a system for recording requests for treatment in accordance with the European protocol (TDI – [*TDI; Standard tables nos. 3 and 4*]). Until the first results of the common data collection on addictions and treatments (RECAP) are published in 2005, the information on the profile of people undergoing treatment comes from:

- the "November" survey carried out by the Directorate for research, studies and evaluation of statistics (DREES) at treatment centres in a given month

- annual activity reports from the specialised centres for drug addicts (CSST) which contain a set of questions which can be used to give a brief picture of the patients treated during the year. The latest figures available date from 2002

- the OPPIDUM survey (Observation des produits détournés de leur utilisation médicamenteuse (Monitoring of illegal psychotropic substances or those that are used for purposes other than medicinal)), on use during the past week by users treated in a range of facilities, mainly CSST's, during a given month

- the specific survey among users attending low threshold facilities (drop-in centres and syringe exchange programmes) called the "front-line" survey, carried out in the twelve sites which form the French monitoring facility for recent trends (TREND).

Profile of people undergoing treatment and attending the low threshold facilities: the people seen in the CSST's or the low threshold facilities are mainly men (around 80% of those attending). The average age of those treated in the CSST's has been rising since the end of the 1980's (this applies to people aged more than 40 but also to minors). The age of the patient varies depending on the product which is the reason for treatment: people whose treatment is linked to opiate use have an average age of 31, while those whose treatment is the result of problematic use of cannabis are around 25 years old.

Each year, around 50% of people treated in CSST's are new patients. Of these, a third attend of their own volition (around 35%), 18% following a court order and 20% are referred by health institutions. Between 1998 and 2002, an increase in the proportion referred by the courts was noted among new patients (13% in 1998 and 20% in 1002). The main products giving rise to a need for treatment were opiates. Since 1998 there has been an increase in the demand for treatment for dependence on cannabis (Delile, 2004 ; Delile, 2003 ; Palle *et al.*, 2003 ; Palle and Bernard, 2004).

Among users of the low threshold facilities, the illicit substances used most within the past month, apart from cannabis, were, in decreasing order, cocaine hydrochloride, ecstasy, heroin

and amphetamines. HDB and benzodiazepines were used by a significant number of people, but it is not possible to distinguish between therapeutic and non-therapeutic use.

From observation of different at-risk social groups in 2003 it was noted that cocaine use was spreading and involves social profiles which are increasingly diversified.

Misuse of HDB has been identified: this is facilitated by the availability of the product on urban parallel markets (also see the article on HDB in this report). Injection and sniffing of this product were highlighted among users of low threshold facilities, together with non-substitution use (primary use and primary dependence).

The practice of injection is declining while sniffing seems to be on the increase (Bello *et al.*, 2003 ; Palle *et al.*, 2003).

Among those who had injected during the past month, it was found in 2003 that almost 25% of injectors had shared their equipment. Three quarters of sniffers had shared their product and 43% their straws (Bello *et al.*, 2003).

New developments in relation to use are reported in *Standard table no. 17*.

4.1 Prevalence and incidence estimates

Problematic use of opiates

NO NEW INFORMATION AVAILABLE

Problematic use of cannabis

The ESCAPAD 2002 questionnaire included an experimental module of questions intended to contribute to a future estimate of the number of people affected by problematic use of cannabis, together with a description of their characteristics and the methods and contexts of this use (CAST questionnaire – Cannabis Abuse Screening Test).

CAST is still being tested as part of a survey carried out in partnership with department of psychiatry at Paul Brousse hospital in Villejuif, and is distinguished by the fact that it contains only factual questions about cannabis use and problems encountered following use. The questions are given below (F. Beck and Legleye, 2003a, p.107): Have you ever:

- smoked cannabis before midday?
- smoked cannabis when you were alone?
- had memory problems when you smoke cannabis?
- have friends or family members tell you that you should cut down on your cannabis use?
- tried to reduce your cannabis use without success?
- had problems because of your cannabis use (quarrels, fights, accidents, poor results at school)? What problems?

The results were first used during the last ESCAPAD exercise (F. Beck and Legleye, 2003a). There were more boys than girls who had, during their lives, experienced one of the situations described in the CAST. In particular, almost all daily cannabis users stated that they had at some time used it before midday or when alone. Among young people who had already used cannabis, around a third stated that they had already had, although generally rarely, memory problems during episodes of use. Reproaches from family and friends, unsuccessful attempts to stop use and other problems attributable to use were much more rare. Among the latter, the problems most frequently encountered during episodes of use were poor results at school (31% of boys, 34% of girls), quarrels with friends, fights (for the boys), illness or "bad trips" for the girls (13%).

Table 6: Prevalence (%) during life-time of CAST events according to level of cannabis use at age 17-19, 2002

	Experimentation[1]	Occasional use[2]	Repeated use[3]	Regular use[4]	Daily use[5]
	N=950	N=3,800	N=1,500	N=2,350	N=1,000
Use before midday	25.7	38.0	81.3	97.0	99.6
Use when alone	10.1	17.8	54.5	89.6	97.1
Memory problems	9.0	14.6	33.7	59.1	69.3
Reproaches from family and friends	4.2	5.3	17.2	45.8	56.1
Unsuccessful attempt at stopping	5.0	8.5	11.3	21.4	26.3
Other problems (quarrels etc.)	7.5	8.2	19.5	40.8	50.1
Prevalence of use (age 17-19)	***6.3***	***23.6***	***9.2***	***8.4***	***6.3***

(1) used at some time but not during the past year; (2) used between 1 and 10 times during the year; (3) used up to 10 times during the year and 10 times during the month; (4) used between 10 and 29 times during the month; (5) used daily during the last 30 days.

This table shows the prevalences by level of use, not adjusted by sex: there are more boys as the frequency of use studied increases.

Source: ESCAPAD 2002, OFDT.

4.2 Profile of clients in treatment (characteristics, method of use)

A narrow majority (52%) of patients attending CSST's in 2003 were aged 30 or more and 14% were 40 or over; 28% of patients were less than 25 and 5% were minors. The new patients are appreciably younger: 42% 30 years old and above and 38% less than 25 years old.

The patients at the CSST's have quite low socio-economic levels: although 70% of them have fixed accommodation, 22% have temporary accommodation and 7% are homeless (whether former or new patients). Only 35% of them receive income from their work, the others live on minimum income (RMI), unemployment benefit (ASSEDIC) or adult disability allowance (AAH). Now that universal health cover (CMU) has been introduced, 96% of patients have welfare cover.

In the continuing trend observed since the start of this decade in 2000, the proportion of opiates among the products which are the reason for treatment is falling to be replaced by cannabis and stimulants (cocaine, crack, ecstasy) (Table 7).

Around 40% of patients monitored by the CSST's (former and new patients) are multiple drug users. Intravenous use is falling among the patients being monitored, with the 30% of patients who had never injected becoming 50% in 2002; among new patients accepted for treatment in 2002, 60% had never injected.

Table 7: Distribution (%) of patients according to the substances leading to registration for treatment, new patients, 1998-2002

	1998	1999	2000	2001	2002
	16,682 patients	*10,225 patients*	*15,268 patients*	*14,542 patients*	*21,158 patients*
Heroin	44.9	39.7	39.0	40.8	39.0
Cocaine	6.2	6.6	6.4	7.5	7.4
incl. Crack	*2.0*	*1.7*	*1.5*	*2.7*	*2.7*
LSD and other hallucinogens	1.1	1.0	1.7	1.3	0.7
Cannabis and derivatives	26.5	29.7	30.8	33.0	35.8
Amphetamines	2.5	1.6	2.7	2.9	2.9
incl. Ecstasy	*1.0*	*0.9*	*1.7*	*1.6*	*1.7*
Solvents	0.1	0.1	0.3	0.2	0.1
Codeine derivatives	3.4	2.4	2.2	1.7	1.4
HDB and methadone	10.1	13.9	12.3	8.9	9.0
Non-opiate psychotropic medicines	5.3	5.1	4.6	3.7	3.8
Total products	100.0	100.0	100.0	100.0	100.0

Note: the data in this table have been calculated retaining only facilities where the sum of the products was almost equal to the active file so that no account is taken of responses for which information about several products was given for a single patient.

Source: use of data from CSST, DGS/OFDT standard activity reports (Palle and Bernard, 2004)

4.3 Principal characteristics and method of use obtained from sources other than treatment.

In 2003, 89% of users of low threshold facilities had used cannabis during the past month and two thirds were smoking it daily (Bello *et al.*, 2004). Cocaine in any form remained, after cannabis, the most-used substance at some time or during the past month. In the past month HDB, then cocaine hydrochloride and ecstasy were the most-used products (Table 8).

In 2003, use of cocaine in its basic form seemed to stabilise (Bello *et al.*, 2004). This could be explained by the difficulties in monitoring it because of the growing scarcity of techno party events and by increasing awareness on the part of some users of the difficulties of managing this product due to the high risk of dependency. On the other hand, cocaine in its powder form (cocaine hydrochloride) continued to spread in a variety of social groups in mainland France. In regard to this latter substance, there is a split between users in the techno party scene[19] who almost exclusively practice sniffing and users in the street in the urban scene[20] who, although they sniff, also practise injection.

Continuing the trends from the start of the millennium, primary use[21] of HDB is seen at all sites in the TREND facility. Primary use of HDB is generally among the young and those in very vulnerable situations but one also encounters profiles of people in prison or from eastern countries, people who belong to the party scene or even young people using Subutex® to control their crack use. A survey of non-substitution use of HDB in France was published recently (Escots and Fahet, 2003).

[19] The party scene means party events, especially from the techno culture: clubs, teknivals, free-parties, private parties etc)

[20] The urban scene is defined as the places in a town where active users of drugs may be seen

[21] Defined as the first use of a substance. In the case of HDB, the user uses Subutex® without having previously used another opiate.

Ecstasy, a product very often seen within the techno party scene, is seen more and more in other social environments and in particular among users on the street in the urban scene. Tablets are swallowed, MDMA powder can also be sniffed; cases of injection have been recorded in the urban scene.

In comparison to the trends reported last year (Bello *et al.*, 2003), it seems that hallucinogenic products are being used more and more among the youngest users. Use at least 10 times in a life-time of LSD, hallucinogenic mushrooms and ketamine went respectively from 34%, 23% and 15% in 2002 to 40%, 40% and 26%[22] (Table 8). Recent use of amphetamine also seems to be increasing (party scene and the hardcore techno movement).

Table 8: Frequency (%) of use, during their lives and during the past month, among users of low threshold facilities in 2003 (n=1082)

	Use		Frequency of use (1)		
	At least 10 times during their lives	In the past 30 days	Daily	Weekly	Monthly
Heroin	69	25	20	41	39
HDB(2)	62	41	79	16	5
Codeine	36	5	25	41	34
Methadone	27	17	85	6	10
Rachacha	26	5	9	22	69
Morphine sulphates	21	7	58	21	21
Cocaine/crack	79	48	---	---	---
Cocaine hydrochloride	---	35	7	48	44
Crack/Free-base	---	18	39	37	25
Ecstasy	60	32	8	52	40
Amphetamine	46	20	8	36	56
LSD	40	11	2	35	63
Hallucinogenic mushrooms	40	14	1	33	66
Ketamine	26	10	3	20	77

(1) Among people who had used it in the past 30 days

(2) High dose buprenorphine

Source: 2003 "front-line" survey, TREND/OFDT (Bello et al., 2004)

The purpose of a survey carried out in 2002 by Reynaud-Maurupt, C. and Akoka, S. (2004) was to provide information on diverted use of ketamine and the sociological profiles of users. Two standard social profiles emerged, both frequenting the techno party scene to different degrees:

- man, young, not highly-educated, living in insecure conditions or at least with low resources. He most often used psychoactive substances (without even counting alcohol and cannabis) several times a week or daily
- man or woman, whose drug use was regular but "controlled" (maximum every weekend), or several times a week. This person perceived himself or herself to be in better health than the people in the first profile.

[22] But these changes are also due to changes in the population attending low threshold facilities (notably more people coming from the party scene).

Before the first use of ketamine, the people encountered had generally already experimented with several psychoactive substances. They all had in common significant polydrug use practices, as a minimum in a party scene, or more rarely as part of a daily use activity. Generally, the first use of ketamine was in a group in a party scene. Repetition of ketamine use was more likely to involve men, people who were not highly educated or with a low level of education, and individuals in a vulnerable situation. Use was on private premises but could also occur at party events (free parties, teknivals). Abusive or daily use was recorded, associated with other psychoactive products.

The product is used *"for recreational or mystical purposes, but also for stimulation, for its calming effect or to deal with pain; to 'escape' or 'fit in', or to ease distress. It can also be used as a secondary product: to come down from another product, intensify its effects or support withdrawal from it"* (Reynaud-Maurupt and Akoka, 2004, p.118).

Of those questioned during the 2003 "front-line" survey, a majority (62%) had practised injection at some time. Nevertheless, recent injection continued to decrease, as in the results for 2002 (Bello *et al.*, 2004): only a third of people questioned (37%) had injected during the past month (and only 28% among users aged less than 25). Observations in the field provide differing information: some sites report a lessening of injection practices and others record that the quite young populations are more attracted by injection.

Although practices of sharing equipment and product have grown in frequency, they remain particularly common among sniffing enthusiasts and also among those who inject.

Table 9: Frequency (%) of equipment sharing practices in the past month among those participating in the TREND 2003 "front-line" survey (n=1082)

	Sharing equipment in the past month		
	Never	1 to 5 times	More than 5 times
Recent injectors			
Products	52	30	18
Spoon	66	24	10
Cotton	71	22	7
Rinsing water	75	17	8
Syringe	89	7	4
Recent sniffers			
Straw	55	27	18
Products	26	34	40

Source: TREND/OFDT (Bello et al., 2004)

5. Drug related Treatment

Drug related Treatment: general context

In regard to treatment, the aim of the authorities' strategy is to offer a varied range of treatments and services in order to offer each person the most appropriate response for his or her way of life and to attempt to improve the quality of treatment. Three systems are used in the treatment of users of illicit drugs: the system for specialised treatment of addiction (medical-welfare establishments), the general practice treatment system (hospitals and general practitioners) and the risk-reduction system.

1. The specialised system

Since the beginning of the 1970's, the responsibility for addictions to illicit drugs has rested with the specialist facilities. These facilities were developed after the adoption of the 1970 law, which included provisions guaranteeing anonymous treatment, free of charge, to all users of illicit drugs who wanted to be treated. Almost all French departments today have a specialised centre for drug addicts (CSST).

These facilities were originally financed by the State and since 1st January 2003 have been funded by national insurance as medical and welfare establishments. Their mission is to provide, jointly, medical, social and educational treatment which includes assistance with social integration or re-integration.

There are three types of CSST:

- outpatient treatment centres (201 in 2003)
- inpatient treatment centres providing group accommodation (42 in 2003)
- treatment centres in prisons (16 in 2003)

The outpatient CSST's meet the needs of patients who want withdrawal while remaining outpatients. They can also organise withdrawal in a hospital environment and assist patients who wish to use this method. In regard to substitution, since 1993/1994 and until recently (2002), the CSST's were the only facilities in which a patient could begin methadone treatment. Prescription of this could then be passed over to a general practitioner. The patients can also be prescribed HDB by a CSST but in this case it is not only the CSST's which can initiate treatment. The patients may also ask the facility for support, psycho-therapeutic assistance and assistance with social reintegration.

2. The general practice system

The development of the specialised treatment system does not meet all the treatment needs of users of illicit drugs. During the 1990's the accent was on improving care of patients with addiction problems within the general practice treatment system (hospitals and general practitioners).

2.1 The hospitals

Within the hospitals (health institutions), treatment of addictions is based on liaison and addiction treatment teams, the town-hospital networks and the provision of hospital beds for withdrawal cases and the performance of medical, psychological and welfare assessments.

The liaison and addiction treatment teams were created by the circular of 3rd April 1996 and are composed in principle of three people, one of whom is a hospital doctor. Their mission is to train and assist the hospital nursing teams, to draw up treatment protocols and to treat in-patients and emergency cases. These teams must also develop links with the treatment system to enable medical, psychological and welfare follow-up of the patients. Their actions within the institution include prevention, information and increasing awareness. In 2003 around a hundred health institutions had active liaison teams. A large part of the activity of these teams is, however, dedicated to the problem of addiction to alcohol and tobacco.

The town-hospital networks were also created by the circular of 3rd April 1996. In 1998 there were 67 networks, spread throughout the territory. They are financed jointly by sickness insurance credits and State credits.

Finally, it should be noted that since 2002, any doctor practising in a health institution has been authorised to prescribe methadone.

2.2 General practitioners

General practitioners in France today play a central role in the prescription of opiate-substitution treatments. They have been able since 1996 to prescribe HDB to opiate-dependent patients. They may also prescribe methadone after initiation of treatment by a CSST.

General practitioners are also the first to be able to treat patients who are beginning to use illicit drugs. The authorities are therefore arranging to introduce training for general practitioners on the identification of use and the most appropriate treatment methods.

3. Risk-reduction system (see box 7, "response to health problems")

The [*Standard Table no.21*] gives information on the different treatments used in France and their availability.

Treatment based on opiate-substitution is relatively recent in France (1996) and was introduced to deal with the epidemic linked to HIV.

In 1995, methadone substitution treatments were introduced, governed by strict prescription rules. At the beginning of treatment the product had to be delivered daily under medical supervision and urine analyses were carried to check that the treatment is proceeding properly.

Acknowledging that access to substitution treatments in specialised centres is insufficient to meet requirements, a parallel treatment based on HDB was instigated in 1996. The methods for beginning treatment and for prescription were more flexible than those for methadone: prescription was authorised by any doctor, without special conditions of practice and the maximum prescription is for 28 days, split into dispensing every 7 days, unless expressly stated otherwise. The number of patients receiving Subutex® is rising rapidly and is between 71,800 and 84,500, although the number of patients on HDB actually undergoing a treatment process did not exceed 52,000 at the end of 2002.

In parallel to the beneficial effects noted since the introduction of substitution treatments (positive impact in regard to health and social reintegration), undesirable consequences, almost exclusively reported for HDB, have also been observed. Misuse is mainly linked to the flexible framework for prescribing the product: misuse involves injection of HDB, also in patients under medical supervision, a use which does not comply with medical protocol (non-substitution use) and use in association with other products (benzodiazepines, alcohol etc.)

5.1 System

NO NEW INFORMATION AVAILABLE

5.2 "Drug free treatment"

The concept of "Drug free treatment" is not really used in France and it is difficult to link it to a type of institution or treatment.

The new 2004-2008 five-year plan recommends the development of programmes which do not include substitution and in particular of therapeutic communities. The development of these communities is to be led jointly by the MILDT and the Ministry for Health. The principle adopted is that the communities have an average capacity of 30 places and are based on an ethical and professional treatment code (rate and type of supervision, occupational and therapeutic activities to be promoted, criteria for monitoring and evaluation etc.) on which they operate.

5.3 Medically assisted treatments (withdrawal, substitution)

Withdrawal

With the development of substitution treatments, withdrawals became less frequent during the 1990's. Half of the CSST's did not declare any withdrawals in 2002. During that year, the number of patients who had undergone withdrawal as outpatients at CSST's was around 2,200. It seems, however, that the number of patients undergoing withdrawal as outpatients has been increasing since 1999. The number of withdrawals with hospitalisation, full or partial, is not known.

Table 10: Average number of patients who have undergone withdrawal, by facility, 1998-2002

	1998	1999	2000	2001	2002
Average number of patients who have undergone withdrawal as an outpatient with the CSST (by facility)	6.8	5.7	6.2	8.4	10.6
Average number of patients who have undergone withdrawal by gradually-decreasing dose in substitution treatment	5.7	4.6	5.9	7.0	11.1

Interpretation of table: on average by CSST, 10.6 patients underwent withdrawal as outpatients with the CSST in 2002
The calculation excludes the facilities which supervised more than 150 withdrawals or which did not respond to questions on the activity.

Source: use of data from CSST, DGS/OFDT standard activity reports (Palle and Bernard, 2004)

Substitution

The latest estimates of the number of people undergoing substitution treatment are as follows:

- in 2003, the estimated number of people undergoing a treatment process was between 63,000 and 69,000 (A. Cadet-Taïrou *et al.*, 2004) which is less than half the estimated number of opiate users in France
- in 2002 between 71,800 and 84,500 people received Subutex®. *"Of these, a maximum of 52,000 had been undergoing treatment for at least 6 months, at least 22,000 were beginning treatment or were 'irregular substitution users' and 6% (5,000 people) had a significant 'trafficking' operation* (A. Cadet-Taïrou *et al.*, 2004).
- the number of people substituting methadone was estimated, using sales data, at between 11,200 and 16,900 in 2003 (SIAMOIS/OFDT).

Patients monitored at CSST's

Since 1998, the number of patients who have had methadone or HDB prescribed at a CSST as an outpatient has greatly increased. The increase is particular high for methadone. Since 2001, methadone has been prescribed in CSST's to more patients than HDB. A slowdown has been observed, however, in the increase in the number of patients substituting HDB.

Extrapolating the data in Table 11 to all CSST's for outpatients, the total number of patients who had a prescription for substitution treatment from a CSST in 2002 may be estimated at around 28,000 (15,000 for methadone and 13,000 for HDB).

Practices in general practice

The processing of data from the Caisse primaire d'assurance maladie (CPAM) (National health insurance department) on reimbursements made by social security has highlighted trends in use of substitution medicines for opiate-dependence over the period 2001-2002 and then 1999-2002 for medicines obtained in general practice (in some French cities – 13 different sites) (A. Cadet-Taïrou and Cholley, 2004).

Table 11: Average number of patients by facility with a prescription for substitution treatment, 1998-2002

	1998	1999	2000	2001	2002
Average number of patients by facility with methadone substitution treatment	35.1	46.9	50.0	59.3	69.1
Average number of patients by facility with HDB substitution treatment	41.4	48.5	50.4	51.9	57.2
Average number of patients by facility with other substitution treatment (1)	2.9	2.5	3.4	1.9	1.7

(1) Principally morphine sulphate

Source: use of data from CSST, DGS/OFDT standard activity reports (Palle and Bernard, 2004)

Over the period studied it was observed that the number of patients on HDB remained the same (a slowdown, even a decrease, in French sites where the practice of substitution is already no longer used) and that there was an increase in the practice of prescribing methadone in general practice, although it differed from city to city. It was found that the proportion of patients treated with methadone was linked to the length of time and rate at which prescription of substitution treatment had been in use.

Among doctors, the use of HDB substitution is on the increase although methadone is still prescribed by only a minority of practitioners. Over all the sites studied, 35% of general practitioners prescribed an HDB substitution treatment during the second half of 2002. However, the practice of prescribing HDB, as for methadone, is often concentrated within a small number of doctors: 20% of doctors who most often prescribed HDB made 73% of registrations for treatment and 20% of doctors who most often prescribed methadone made 90% of registrations for treatment.

The average "standard dose" received by a patient substituting with Subutex® is 9.6 mg (recommended maximum 16 mg/day). It is 98.4 mg for a patient on methadone (recommended maximum 100 mg/day) but doses of methadone received by patients are much less varied than doses of HDB.

Benzodiazepines and related substances are widely prescribed, in addition, to patients undergoing substitution treatment (47% of patients on HDB and 49% of patients on methadone).

For diversion of substitution treatment and more particularly of Subutex®, see the article "Buprenorphine, treatment, misuse and prescription practice", section 4 "problem drug use" and section 10 "drug markets".

Consensus conference

A consensus conference[23] on substitution treatments, *"treatment strategies for people who are opiate-dependent: the role of substitution treatment"* was organised at the end of June 2004. The information given at this event made it possible to assess the situation in regard to substitution in France.

The recommendations of the conference were published at the beginning of September 2004[24]. According to the panel, substitution has clearly had a positive impact (number of

[23] A Consensus Conference is a method of drawing up medical and professional recommendations for defining an agreed position regarding a controversy which relates to a medical procedure, with the aim of improving quality of treatment.

[24] For further details, in French, see : http://www.anaes.fr/ANAES/anaesparametrage.nsf/Page?ReadForm&Section=/anaes/anaesparametrage.nsf/accueilagenda?readform&Defaut=y&

persons substituting, reduction of health and welfare risks) but some matters still require improvement:

- access to treatment varies according to geographical area;
- poor access to treatment for people in vulnerable situations;
- improper use of medicines for opiate substitution (injecting and sniffing HDB, HDB primary dependence, death due to methadone overdose);
- supporting or intensifying parallel use;
- little impact on infection by hepatitis C virus;
- continuing stigmatisation of dependence and psychological suffering.

Proposals were made for adapting and improving the current treatment system and the prescription framework (primary prescription of methadone by GP's, for example). Recommendations were drawn up for the initiation, adaptation and stabilisation of treatments with one or other of the medicines (treatment methods, dosage etc.). The jury also gave concrete proposals for improving professional practices.

6. Health correlates and consequences

Health correlates and consequences: general context

Drug-related deaths:

The information system available in France relies on several systems, each of which covers some of the causes of death related to drug use. These are deaths:

- due to overdose when the deceased is the object of a court procedure (OCRTIS – Central Office for the Repression of Drug-related Offences) [*Standard Tables nos. 5 and 6*]. This source of statistics covers only deaths brought to the attention of the police forces or national gendarmerie and does not include deaths by overdose of French nationals recorded abroad and deaths which occur in hospital.

Since 1995, the number of deaths due to overdose recorded by the authorities has been continuously declining (-79% between 1995 and 2002). This trend is most likely due to the combined effects of the introduction of substitution treatments, the existence of harm reduction facilities and systems and changes in the products used and users' methods of use. The majority of deaths due to overdose recorded by the authorities are linked to heroin but for two years now cocaine and medicines (including Subutex® and methadone) have occupied a more and more prominent position.

- due to drug dependency (CepiDc-INSERM) [*Standard Table no. 5*]. This category includes all deaths for which the death certificate mentions drug dependence. For reasons connected with the information system, it does not give a reliable record of overdoses, which are often put in the category of deaths from ill-defined causes. The number of deaths due to drug dependency decline continuously between 1995 and 2000.

- with traces in the blood of psychotropic substances: DRAMES (Décès en relation avec l'abus de médicaments et de substances (Death involving abuse of medicines and substances) – AFSSAPS (French Health Products Safety Agency)) records cases where the deceased was the object of a court order, which means that deaths not declared to OCRTIS or INSERM can then be identified. Although it is still very limited in space and is in the process of being installed, this system demonstrates the non-exhaustive nature of the two preceding systems.

- linked to AIDS in intravenous drug users (InVS). The number of deaths due to AIDS in intravenous drug users, which was falling between 1994 and 1999, has now stabilised.

Since there has been no survey of a cohort which meets the criteria (recruitment of users in treatment centres) set by the EMCDDA (European Monitoring Centre for Drugs and Drug Addictions), the OFDT carried out a cohort survey of people arrested for narcotics use and some of the results of this are given below.

Drug-related morbidity

1. Infectious diseases represent the largest proportion of the observed morbidity. The estimated prevalences among drug users rely on:

- declared prevalences of HIV, HBV and HCV: the "November" survey of patients attending CSST's (Tellier, 2001) and the survey of users of low threshold facilities (Bello *et al.*, 2003 ; Bello *et al.*, 2004) [Standard Table no. *9]*

Declared prevalences of HIV, HCV and HBV vary depending on the survey and the methods of use adopted by the users (injection, sniffing). There is a lack of screening of the youngest people and those who do not inject. Declared HIV positivity among people who had injected at some time is around 14%, compared to around 4% among people who had never injected. For HCV, the declared prevalence among people who had injected at some time is 55%.

– biological prevalences of HIV and HCV in users in Marseilles: Coquelicot survey (Emmanuelli *et al.*, 2003). This survey, which was intended to be developed into a national information, highlights the gap existing between declared prevalence and measured prevalence of hepatitis C, particularly among young people.

- Estimates of the incidence of AIDS cases and HIV infection. Cases of AIDS have been notified (InVS) since the start of the 1980's and notification has been compulsory since 1986. A new, anonymous system of declaration was introduced in 2003 by the circular from the Directorate General for Health (DGS) (no. 2003/60 of 10 February 2003), which makes

declaration of HIV infection compulsory. This system is combined with virological monitoring of HIV.

The number of new cases of AIDS linked to injectable drugs has been falling constantly since 1994 (1,377 in 1994 compared to 196 in 2002), as has the proportion of declared cases of AIDS (36% in 1991, 19% in 1997 and 12% in 2002). The number of cases of AIDS diagnosed in injecting drug users shows a similar pattern whatever the sex, with the number of cases among men still higher than those among women (around 3 men for every woman).

2. Psychiatric co-morbidity: the few works existing in France do not allow us to draw sound conclusions on the prevalences of different psychiatric pathologies among drug users (Wieviorka, 2003).

3. Other drug-related pathologies: no systematic data has been collected about the other pathologies which might accompany, or result from, drug use (other infectious complications, cardiovascular complications, traumas etc.). The survey carried out by the TREND facility of users of low threshold facilities provides information on their perception of the state of health and the appearance of certain pathologies (Bello *et al.*, 2003 ; Bello *et al.*, 2004). Pathological manifestations occur more frequently among people in the most vulnerable situations. A third of the people surveyed declared that they felt themselves to be in a poor or very bad state of physical health. Almost 70% declared they had suffered fatigue in the past month, 44% loss of weight, 4% had overdosed, 2% had had jaundice. The frequency of declared complications linked to injection was also estimated.

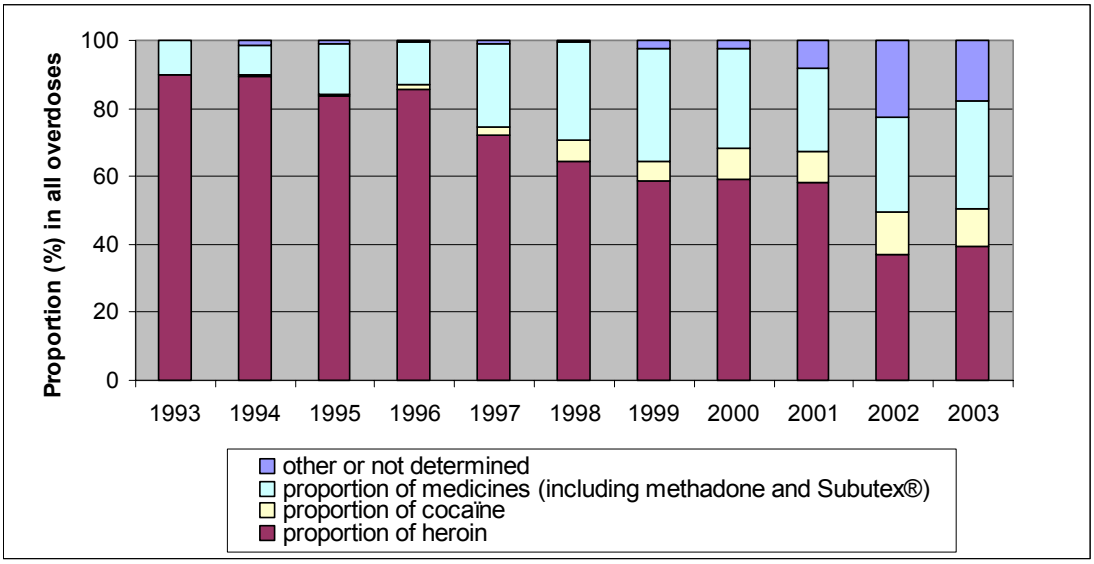
6.1 Drug-related deaths

Deaths due to overdose (OCRTIS)

In 2003, 89 deaths due to overdose were identified by the law enforcement authorities. This figure is lower than that for 2002 (97 deaths).

Of these deaths, 35 were due to heroin (in 11, heroin was associated with other products), 10 were due to cocaine (with only one death where cocaine was associated with another substance, a medicine).

Graph 4: Changes in the proportion of certain psychoactive substances in all overdose deaths recorded by law enforcement authorities, 1993-2003



Source: OCRTIS, processed by OFDT.

There were 28 deaths due to overdoses of medicines: 8 linked to Subutex® (on its own and in association), 8 linked to methadone (on its own and in association), 8 linked to various medicines (on their own or in association) and in 6 cases it was not possible to identify the medicine.

Although in 2002, only 2 deaths were connected with ecstasy use, the 2003 figure (8 cases) was similar to that for 2001. One death due to overdose linked to use of amphetamines was also notified.

In 4 cases, OCRTIS stated that cannabis was present in association with alcohol and/or medicines.

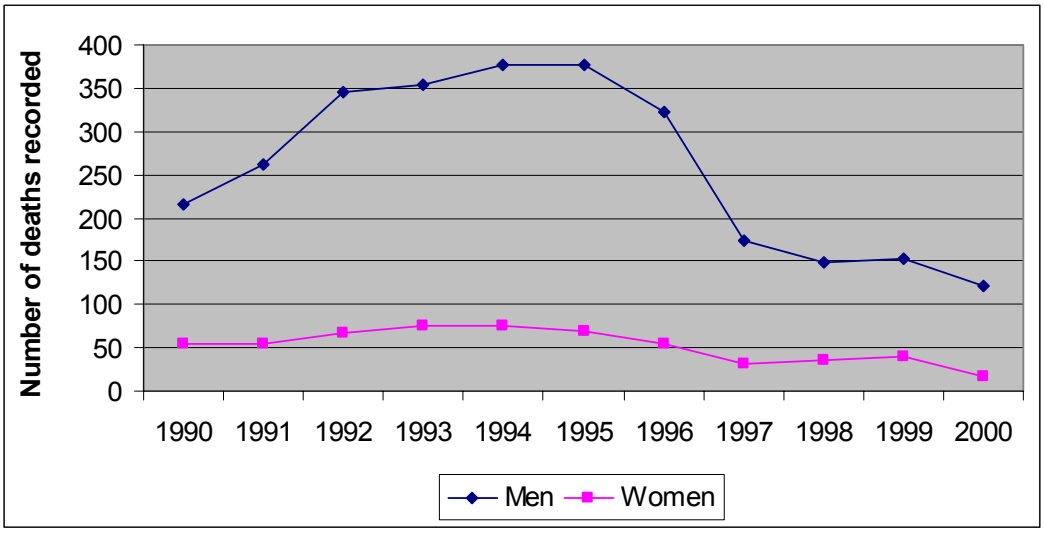
Finally, there were 3 cases where the substances which caused the deaths were not identified.

Continuing the trends observed since the beginning of the 1990's, the proportion of deaths in which heroin was implicated is decreasing, while those linked to cocaine or medicines are increasing.

National register of causes of death (INSERM)

Deaths linked to the use of psychoactive substances taken from the national register of causes of death have been coded using the International classification of diseases no. 10 (CIM10) since 2000 (previously coded using CIM9) and 2000 is currently the latest year available. The mortality indicator established by the EMCCDA means that the series can be continued over time (particularly when moving from one coding to another, as in France) and is the indicator used below[25].

Graph 5: Changes in drug-related deaths according to the definition adopted by the EMCDDA, by sex, in France from 1990 to 2000



Source: INSERM, Cépi-DC.

138 deaths linked to the use of illicit psychoactive substances were recorded in 2000 by INSERM (121 men and 17 women). For men, the deaths were concentrated between the ages of 30-39 while for women they were between 15 and 34.

[25] For further details please see: http://www.emcdda.eu.int/?nnodeid=1419. The indicator presented is selection B in the protocol drawn up for the national registers of deaths: it corresponds to the selection of certain causes of death related to use of psychoactive substances (Drug related deaths – DRD) coded with CIM9 or with CIM10.

Deaths due to AIDS in intravenous drug users (UDVI)

Since 1998, the proportion of intravenous drug users in all the people who die from AIDS has been relatively stable, between 20 and 27%.

Table 12: Deaths due to AIDS in injecting drug users, 1998-2003

	1998	1999	2000	2001	2002(1)	2003(1)
Number of deaths in intravenous drug users	204	195	135	119	181	118
All deaths due to AIDS	769	707	618	581	669	493
Proportion of intravenous drug users (%)	26.5%	27.6%	21.8%	20.5%	27.1%	23.9%

(1) adjusted data

Source: AIDS monitoring system, InVS.

Traces in the blood of psychotropic substances (DRAMES)

In the 2003 study, 64 cases of death linked to abusive use of substances or drug dependence were recorded by the Forensic science laboratories participating in the collection of data.

In 73% of cases, the deceased had a previous history of abuse or drug dependency; they were men in 52% of cases, with an average age of 31 (for women, the average age at death was 35).

Table 13: Cases of death related to abusive use of substances or to drug dependence, according to the substance involve in death, 1998-2003

	1998	2000	2002	2003(3)
Number of cases recorded	123	154	131	64
Narcotics (% in all cases)	78%	66%	69%	72%
Illicit opiates (heroin)	76	80	54	31
Cocaine	28	25	21	15
Stimulants(1)	1	4	4	4
Legal opiates(2)	0	7	16	1
Substitution treatment for opiate dependence (% in all cases)	22%	31%	31%	28%
HDB	16	25	23	8
Methadone	9	23	17	9
HDB + methadone	2	5	0	1

(1) may be : MDMA-MDA, amphetamine.

(2) may be : codeine, morphine, pholcodine, fentanyl, alfentanyl, propoxyphene, dextromoramide

(3) The laboratories in Strasbourg and Lille did not send any cases in 2003 (for example in 2000, they had sent 40 out of 154 deaths). This may certainly explain in part the fall in the number of cases recorded. But it is difficult to put forward an explanation since DRAMES is not an exhaustive source of data

Source: DRAMES, AFSSAPS

Survey on mortality of people arrested

A survey on mortality of people arrested for drug use was carried out by the OFDT (Lopez *et al.*, 2004b; Lopez *et al.*, 2004a). Part of the national file on offenders against the narcotics laws (FNAILS – File on police questioning for the use of narcotics) held by OCRTIS was merged with the national register of persons (RNIPP) to determine, on a given date (2002), the vital status of persons, and with the national register of causes of death (CepiDC-

INSERM) to find the causes of death of those who had died. The file thus compiled held more than 42,000 records of people born in France who had been arrested in 1992, 1993, 1996 and 1997 for simple use or use and trafficking of heroin, cocaine, crack, ecstasy or cannabis.

The values of the standardised mortality ratios (SMR[26]) show that men arrested for use of heroin/cocaine/crack have, overall, a risk of death 5 times higher than that for all French men; this risk is 9.5 times higher for women.

The information available indicates that the mortality rate of those arrested in connection with heroin/cocaine/crack is lower than that for drug addicts or users at treatment centres (Bargagli *et al.*, 2001; EMCDDA, 2002; Warner-Smith *et al.*, 2001 ; Quaglio *et al.*, 2001). In the same way, the SMR's calculated only for people arrested for use of heroin (respectively 5.3 [4.9; 5.6] for men and 9.7 [8.0; 11.6] for women) indicate an excessively high death rate in comparison to the general population which is lower than those which may be given in surveys of problematic users (Bargagli *et al.*, 2001; EMCDDA, 2002).

The survey showed a significant fall in deaths among people arrested for heroin/cocaine/crack between the two inclusion periods (1992/93 and 1996/97), as the mortality rates calculated over the 4 years following arrest went from 10.3 to 6.2 per thousand person years (PA[27]); p=0.01, Graph 6). This drop coincided with the introduction of the antiviral triple therapies, the development of a risk-reduction policy in France and the wider-availability of opiate substitution treatments. These changes were similar to those for deaths due to overdose and to AIDS generally used as indicators of mortality linked to the use of illicit drugs (OCRTIS, InVS, INSERM).

The data on the causes of death provide additional explanatory information. This drop in deaths among people arrested is in fact mainly linked to the fall in the crude mortality rates due to AIDS and to overdose, respectively divided by 6 and 4 between the middle and end of the 1990's. For deaths due to trauma injuries and poisoning, the rates fluctuate more but also tend to drop, although more modestly. Deaths classified as from unknown causes, some of which may be deaths due to overdoses, are also decreasing.

Survey on prison leavers

According to estimates, 40 to 60% of drug users had had at least one spell in prison in their lives (Cavailler *et al.*, 1997 ; Rotily *et al.*, 1994). As part of the evaluation of the UPS's (care units for prison leavers) the mortality rates were calculated for prisoners for the year following their release (Prudhomme *et al.*, 2003). The survey carried out among prisoners released during 1997 (1,439 prison leavers but information on the vital status of only 1,245) shows only 21 deaths which occurred among men in the 12 months following their release (crude mortality rate of 1.8% [1.1; 2.7]). Violent deaths and overdoses (drug dependence) were the most frequent causes of death (respectively 19% and 24% of all causes of death).

The mortality rate for prison leavers was compared to that for the general French population and that for workers. Taking all ages and causes together, an excessive death rate was observed among ex-prisoners compared to the general population (SMR = 321.3 [199; 491]) and workers. Significantly higher SMR's were observed for deaths due to drug dependency

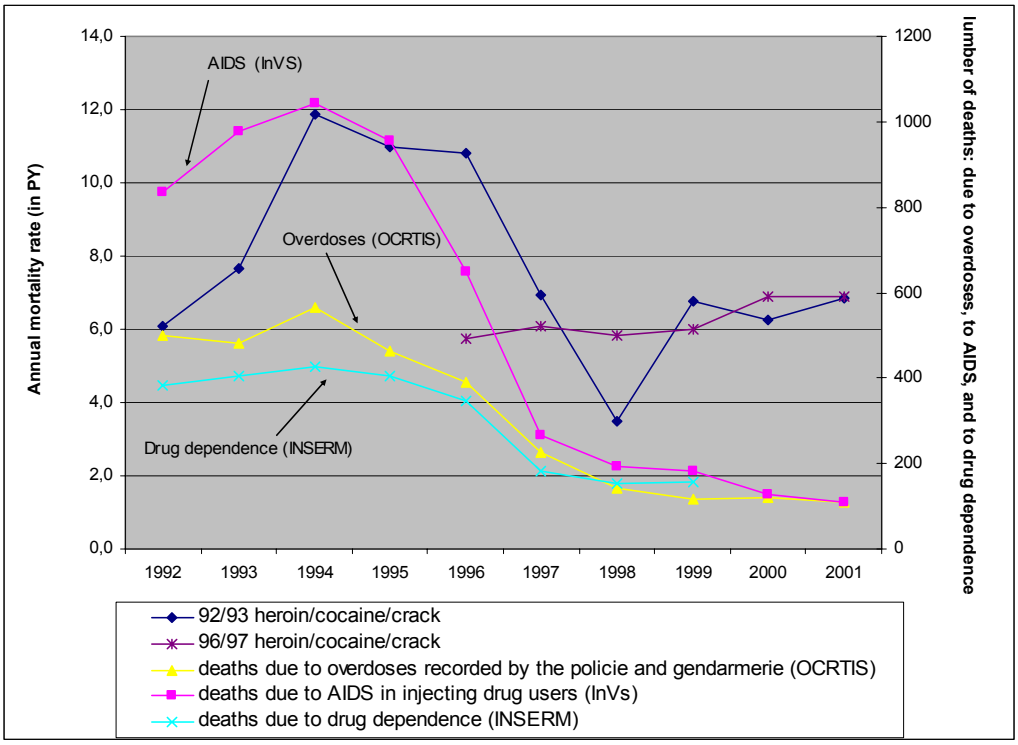
[26] The SMR was calculated by comparing the mortality rate observed in people arrested with the expected mortality rate for this population. The latter rate was obtained by applying to the cohorts surveyed the specific mortality rate by age band and sex observed in the whole of the French population in 1997. An SMR greater than 1 means that the mortality rate of the cohort surveyed is higher than the expected mortality rate and in this case we may talk of an excessively high mortality rate compared to the reference population.

[27] The populations for which mortality rates are being compared were included in this survey on different dates (1992, 1993, 1996, 1997). This calculation only makes sense if it is carried out for the same period. It is therefore necessary in this type of survey to reason in terms of person years (the years examined, counted as person years, are the same: 10 person years (PA) = 1 person monitored for 10 years or 10 people monitored for 1 year).

(overdose) and also for violent deaths (excluding suicide in those aged 35-54), diseases of the circulatory system (15-34 years) and cirrhoses (35-54 years).

No overdose was, however, observed in the two weeks following leaving prison, a time in which it has been demonstrated that the risk of death due to overdose is at its highest.

Graph 6: Changes in the mortality rate of people arrested for heroin, cocaine or crack use, 1992-2001



Graph on two axes putting into perspective the annual mortality rates in the cohort of people arrested for use of heroin/cocaine/crack (left-hand axis) and the principal indicators for death in drugs users (right-hand side – deaths due to overdoses, AIDS and drug dependency).

Source : cohorts of people arrested for narcotics use, OFDT (OCRTIS, INSEE and INSERM data); overdoses file (OCRTIS), deaths due to AIDS (InVS), deaths due to drug dependency (CépiDc- INSERM).

6.2 Drug-related infectious diseases

Monitoring system for HIV infection

By 30 September 2003, 1,843 notifications of newly-diagnosed cases of HIV infection had been registered. It was possible to analyse 1,301 of these notifications (InVS and National Reference Centre for HIV, 2004).

Infection from injectable drug use is not very frequent and represents only 3% of newly-diagnosed cases of HIV infections (5% if we exclude unknowns) although heterosexual relations were involved in more than half (53%).

According to the InVS, *"the fall in the number of new cases of AIDS among drug users and the small proportion of them in newly-diagnosed cases (3%) confirms the reduction in transmission of HIV in this population"* (Table 14).

A large proportion of drug users discovered that they were HIV-positive before they reached the stage of AIDS (86% compared to 60% of homosexuals and 40% of heterosexuals).

Table 14: New AIDS cases in injecting drug users, 1998-2003

	1998	1999	2000	2001	2002(1)	2003(1)
Number of new cases among injecting drug users	353	302	244	253	197	142
All new AIDS cases	1,936	1,820	1,712	1,641	1,539	934
Proportion of injecting drug users (%)	18.2	16.6	14.3	15.4	12.8	15.2

(1) adjusted data

Source: AIDS monitoring system, InVS.

Reasons for hospitalisation and mortality in a cohort of subjects infected by HIV by intravenous injection of drugs

The causes of hospitalisation and death, together with the way these have changed over time, were studied in a cohort of 467 subjects infected with HIV through injecting drugs intravenously (Marimoutou *et al.*, 2003). People were included regardless of whether or not they were continuing to inject drugs.

The crude mortality rate was 19 per thousand person years [12; 29] i.e. a probability of survival at 1 year after inclusion in the cohort of 98%, and 97.7% at 2 years. Compared to the general population in the Provence Alpes Côte d'Azur (PACA) region, the mortality rate for infected patients was 13 times that of 25-34 year-olds and 10 times that of 35-44 year-olds.

The incidence of hospitalisations remained stable from the 6th month of monitoring. The patients hospitalised over the period were at a more advanced stage of HIV infection when they were included, and were even more frequently active drug users on inclusion. *"The reasons for hospitalisation and deaths are rarely linked to the progression of HIV infection: the subjects have more problems linked to drug use and the living conditions associated with this than problems linked to HIV infection: voluntary intoxication or detoxification treatments, liver problems (90% of patients are also infected by the hepatitis C virus, 80% by the hepatitis B virus), psychiatric problems, traumas and accidents are very frequent."*

The survey concluded that particular attention must be paid to screening and monitoring the various co-morbidities of these patients, and in particular HBV and HCV infections and psychiatric manifestations.

Prevalence of HIV, HCV and HBV among problematic users

In the TREND “2003 front-line" survey, the rates of positivity among people who stated that they knew their serology results (77% of users surveyed for HIV, 70% for HCV and 64% for HBV) showed an overall rate of 11% for HIV (10% in 2002), 43% for HCV (49% in 2002) and 7% for HBV (14% in 2002) (Bello *et al.*, 2004).

Among recent injectors, HIV still affected at least one person in ten (10%) and hepatitis C at least six people out of ten (58%). The Coquelicot survey showed that patients are very aware of their serological status for HIV, but also showed that the declared prevalences underestimated the reality for HCV: 51% declared a positive serology for HCV although biological investigation revealed this to be 73%. The gap is largest in those aged under 30 (24.2% compared to 46.4%).

In the absence of systematic biological investigations, the situation of drug users in relation to hepatitis B (vaccinated, cured, carriers of acute or chronic hepatitis, or never having had contact with the virus) remains very imprecise.

Table 15: Rate of declared positivity for the last known serology for HIV and HCV according to methods of use among participants in the TREND 2003 "front-line" survey

	Injectors/life	Injectors/month	Sniffers month	Exclusive sniffers(1)	Total
HIV positivity	77 (14%)	35 (10%)	22 (8%)	4 (2%)	86 (11%)
HCV positivity	301 (55%)	191 (58%)	86 (34%)	7 (5%)	310 (43%)

(1) people who had never injected and only practised sniffing

Source: TREND/OFDT data and processing

6.3 Psychiatric co-morbidities

NO NEW INFORMATION AVAILABLE

6.4 Other co-morbidities linked to drug use

The frequency of pathological phenomena directly linked to injection, declared by users of low threshold facilities in 2003, seems to have increased in the case of injection of Subutex® (Bello *et al.*, 2004).

Table 16: Frequencies and odds ratio (OR) of problems linked to injection among those who had injected in the past month according to whether or not they had injected HDB – TREND 2003 "front-line" survey

	Injectors of HDB	Injectors of other product/s	OR and confidence interval at 95 %	
Abscess	31%	19%	1.9	[1.2 – 3.1]
Injection difficulties	68%	55%	1.7	[1.1 –2.-6]
Blocked vein, thrombosis, phlebitis	42%	30%	1.7	[1.1 – 2.5]
Swollen hands or forearms	44%	26%	2.3	[1.5 – 3.5]
Febrile episode (high temperature)	27%	22%	1.4	[0.9 – 2.1]
Haematoma	44%	36%	1.4	[0.9 – 2.1]

Source: TREND/OFDT data and processing

7. Responses to health correlates and consequences

Responses to health correlates and consequences: general context

Prevention of drug-related deaths: France does not have a national policy or specific interventions to reduce overdoses. Access to substitution treatments, together with the risk-reduction system are, in practice, indirect means of preventing deaths linked to opiate use.

Prevention and treatment of drug-related infectious diseases:

The risk-reduction policy is defined as all the measures implemented to prevent infection by the AIDS and hepatitis viruses and also the problems and complications resulting from drug use and the search for drugs. It principally involves preventing the health complications linked to intravenous injection and injection of products made in poor hygiene conditions (abscess, overdoses, septicaemia).

In France, the system relies on prevention actions which aim to facilitate access to sterile injection equipment and to spread publicity about prevention, together with access to screening among the high-risk population.

The actions are mostly developed by associations external to the specialised system with support from the State or local communities.

The system is based on the following complementary actions:

- free sale of syringes in pharmacies (sold without prescription since 1987);
- dispensing machines delivering Stéribox® injection kits (225 in total in 2002) or collecting used syringes (153 in 2002) ;
- community needle and syringe programmes (NSP): 118 in 2001;
- drop-in centres or contact centres for drug users (40 in 2001);

Overall, the risk-reduction system covers the greater part of French territory (87 departments covered).

Screening is, theoretically, facilitated by the existence of screening centres which are anonymous and free of charge (CDAG), of which there are 386 outside prisons and 109 in prisons (in 2002). There is a plan to control hepatitis B and C (2002-2005), the principal objectives of which are: to reduce transmissions, to improve screening, the treatment system and access to treatment, to intensify clinical research, monitoring and evaluation. Prevention of infections through sniffing is controversial in France, but several associations are involved with it, although with little support from the State.

Structured questionnaire no. 23 [*harm reduction measures to prevent infectious diseases among drug users*] provides an overall view of the political strategies selected, the interventions which result from them and which are effectively introduced in France.

The places where syringes are available, together with the estimate of the quantities distributed, are given in Standard Table no. 10.

Interventions linked to psychiatric co-morbidities: there is strictly-speaking no service specialising in the treatment of drug users presenting associated psychiatric pathologies; some psychiatric hospitals have, over the last few years, developed a system for treating drug addicts but they are still rare. Three different circulars issued since 1998 by the Directorate General for Health (DGS) have had the same objective of improving treatment and have recommended increased cooperation between the services involved (CSST, hospital psychiatric service etc.) but collaboration remains sporadic (Wieviorka, 2003).

7.1 Prevention of drug-related deaths

NO NEW INFORMATION AVAILABLE

7.2 Prevention and treatment of drug-related infectious diseases

Planned new provisions

The 2004-2008 five-year plan to fight illicit drugs makes provision for consolidating and adapting the risk-reduction system to deal in particular with new forms of vulnerability among users and with the increasingly high level of prevalence of HCV. A *"guideline"* will be drawn up for the low threshold facilities in order to *"define the framework of their operations in the field and to clarify their position in relation to repression"* (MILDT, 2004, p.36).

Availability of syringes

Although between 1995 and 1999 there was increasing access for drug users to syringes (pharmacy, in the community via the syringe exchange programme), there seems since 2000 to have been a decline in the use of the "BD 1 ml" syringes made by Becton-Dickinson. It is not possible however to quantify this decline precisely and it could be significantly lower than the drop of one third in sales from pharmacies between 1999 and 2001. In fact, it is always possible that there were errors in estimating the number of 1 ml syringes sold to injecting drug users, since diabetics also buy this type. At the same time, the number of syringes distributed in the community sector (NSP) doubled, but this could not entirely have accounted for the drop in pharmacy sales.

Sales of Stéribox®, after rising between 1996 and 1999, have recently seemed to stabilise at around 5,3000,000

Becton-Dickinson has observed a notable increase in the use of 0.5 ml syringes since 2000. Of the two millions of syringes of this type sold annually, half are probably to drug users (Emmanuelli, 2003).

Table 17: Changes in sales and distribution of syringes (in thousands) 1998-2003

	1998	1999	2000	2001	2002	2003
Steribox® (syringes)	5,440	5,759	5,262	5,304	5,207	5,300
Steribox® (annual change)	*17.9%*	*5.9%*	*-8.6%*	*0.8%*	*-1.8%*	*1,8%*
Steribox® (change 1996-2003)						*3.,3%*
BD syringes (total volume) (1)	7,151	8,627	6,466	3,808	2,684	3,001
Syringes: other brands	1,788	2,157	1,367	702	537	620
NSP syringes (2)	1,500	1,500	1,500	3,000	3,000	3,000
Total syringes for injecting drug users	15,880	18,043	14,595	12,814	11,428	11,921
Syringes for injecting drug users (annual change)	*2.7%*	*13.6%*	*-1.,1%*	*-1.,2%*	*-1.,8%*	*4,3%*
Syringes for injecting drug users (change 1996-2003)						*-1.,4%*

(1) All Becton-Dickinson syringes sold in pharmacies to drug users (1 ml in batches of 30 syringes, 2 ml in batches of 20, 1 ml per unit, 0.5 ml per unit). This estimate is from the company itself.

(2) To 2000, estimate of the volume of syringes distributed at the same time by the community sector. 1996 estimate made as part of the NSP survey "Social characteristics, use and risks in drug users attending NSP's in France" (Emmanuelli *et al.*, 1999). Estimates after 2000 were made by the DGS.

Source: SIAMOIS, InVs; DGS.

Whatever its extent, this drop in use of syringes by drug users could be compared with the drop in the practice of injection observed over the last few years among users of low threshold facilities (Bello *et al.*, 2004; Bello *et al.*, 2003) and in those attending the specialised treatment centres (Palle and Bernard, 2004; Palle *et al.*, 2003). Sniffing is tending to replace injection, particularly among the youngest users.

7.3 Interventions related to psychiatric co-morbidities

NO NEW INFORMATION AVAILABLE

7.4 Interventions related to other health correlates and consequences

NO NEW INFORMATION AVAILABLE

8. Social correlates and consequences

Social correlates and consequences: general context

Social exclusion: the social and economic situation of drug users may be deduced from the socio-economic characteristics recorded as they pass through the reception centres (CSST's or low threshold facilities). Their level of vulnerability varies depending on the type of facility attended. The users who come to low threshold facilities exhibit greater social exclusion than those encountered in the CSST's: more unemployed people (50% of patients at low threshold facilities live on welfare assistance, compared to around 30% at the CSST's), more insecure accommodation situation (40% at low threshold facilities compared to 30% at CSST's), more single people and fewer parents with dependent children.

Looking overall at the careers, way of life and risk ratio of users (in particular of heroin) enables us to understand the processes of insecurity at work (economic and social instability, lack of schooling, lessening of responsibilities) associated with the onset of drug addiction problems in the life of the individual. For Bouhnik and Touzé (1996), instability of living conditions of users associated with repression and repeated imprisonment contribute to the growth of at-risk behaviours. According to Jamoulle (2001), the users must deal with several forms of insecurity: economic, social and civic, health and psychological.

Among the homeless, drug addiction generally comes before the individual's social exclusion (Dabit and Ducrot, 1999; Declerck and Henry, 1996; La Rosa, 1998). On the other hand, exclusion engenders a sharp feeling of loss of social position which is likely to push an individual towards addiction since they have not deliberately chosen marginality. But the substances can also be a way of enduring the violence generated by life on the street: *"the use of psychoactive products appears to be a means of enduring difficulties and this use is itself the cause of additional difficulties because it leads to premature insecurity"* (Joubert, 2003).

Drug-related offences and crime: according to the current laws on narcotics use in France, any person who uses and/or deals in these substances lays himself or herself open to criminal sanctions which could even mean imprisonment. The user may, for example, be arrested, which may or may not be followed by sentencing, and possibly imprisonment.

Crime data on offences against the narcotics laws (ILS) offer the advantage that they are properly kept, historic and easily accessible. On the other hand, they do not give a complete picture of how offences are dealt with, particularly in regard to details of alternatives to prosecution (between arrest and possible sentencing).

Arrests for ILS are classified in two major categories: simple use and trafficking (broken down into use and trafficking, local trafficking and international trafficking) [*Standard Table no. 11*].

Sentences recorded in the national police records (CNJ) register judgements made against users who have come before the court. A sentence may cover several offences but, conventionally, sentences are shown as for the principal offence. The statistical categories used are as follows: illicit use of narcotics, assisting drug use, possession/procuring, manufacture/use/carrying, supplying, import/export and other offences against the narcotics laws.

Since 2003, driving under the influence of substances or plants classified as narcotics has been an offence (law no. 2003-87 of 3 February 2003, NOR: JUSX0205970L). The offence is liable to 2 years' imprisonment and a € 5,000 fine for single use of narcotics and the penalty is greater when use of alcohol at the same time has been noted. Screening is compulsory for all drivers involved in a fatal accident and is automatic if there is suspected use in the case of personal injury accidents. Random checks may also be carried out.

Drug use in prison [*Standard Table no. 12*]: A survey carried out in 1997 showed that 32% of those entering prison declared prolonged and regular use of drugs (illicit drugs and medicines diverted from their normal use) during the year preceding imprisonment (Mouquet *et al.*, 1999); in the general population, regular users of illicit drugs represented 15% of those aged 18 to 25 and 4% of those aged 26 to 44 (François Beck *et al.*, 2002). These data clearly show that drug users are over-represented in comparison to the general population.

The existing studies show that all products smoked, sniffed, injected or swallowed before imprisonment are still used, but to a lesser extent, during imprisonment (Rotily, 2000). In addition, more accessible use, such as use of medicines, have developed within the prison environment. Generally speaking, there is a changeover from use of illicit, rare drugs towards medicines (Stankoff and Dherot, 2000).

These uses of narcotics, whether begun or continued in prison, have grave effects on the state of health of those involved: serious abscesses, risk of accidents where medicines are associated with other products, severe withdrawal symptoms of greater duration, appearance or intensification of psychological or psychiatric pathologies. In addition, prisoners constitute a population which, from the point of view of the health and social consequences of drug use, has increased risk factors. The low level of access to treatment for this population and, more fundamentally, the situations of insecurity and exclusion which they have often been faced with before imprisonment (absence of a fixed home or of welfare assistance) are all factors in the prevalence of at-risk use among those entering prison.

Injection seems to be widely-practised within this vulnerable population, although the number of intravenous drug users seems to be decreasing: 6.2% of prison entrants declare that they had used drugs intravenously in the course of the year preceding imprisonment (Mouquet *et al.*, 1999). According to the surveys, 60 to 80% of these stop injecting when they enter prison. However, those who continue, even if they reduce the frequency of their injections, tend to present higher risks of infection (since they inject a lot, they are more often infected), so that the risks of infection are great if there is sharing of equipment, unprotected sex or tattooing.

Finally, prisoners seem to be more affected by infectious diseases than those in the general population. The most recent data can be used to estimate that the prevalence of HIV in the prison environment is 3 to 4 times greater than outside prison and that of HCV 4 to 5 times greater. However the prevalence of HIV inside as well as outside prison has declined, although that of hepatitis C is growing considerably.

Social cost of drugs: the latest estimate available dates from 2000 and is based on 1995 figures (Kopp and Fenoglio, 2000). Excluding the cost of use and considering only illicit drugs, this cost is 2,0352 million Euros, which is equivalent to 0.16% of the national GDP.

The social cost of drugs is spread between: losses of income and production (45.7%), expenditure by the public authorities (36.3%) and expenditure on health (11.4%); mainly the cost resulting from treatment of AIDS and the costs relating to Subutex®), losses of compulsory insurance contributions and other costs borne by private agents.

8.1 Social exclusion

NO NEW INFORMATION AVAILABLE

8.2 Drug-related offences and crime

Direct offences associated with narcotics use

Arrests

In 2003, the police, gendarmes and customs made 108,141 arrests for offences against the narcotics law, i.e. 12% more than in 2002. All categories of arrest increased in comparison to the previous year, and in particular arrests for international trafficking (+26.5% between 2002 and 2003) (Graph 7).

Use of drugs is still the main reason for arrest: 100,219 arrests, i.e. 84% of arrests for offences against the narcotics law in 2003, a proportion equivalent to that for the three previous years.

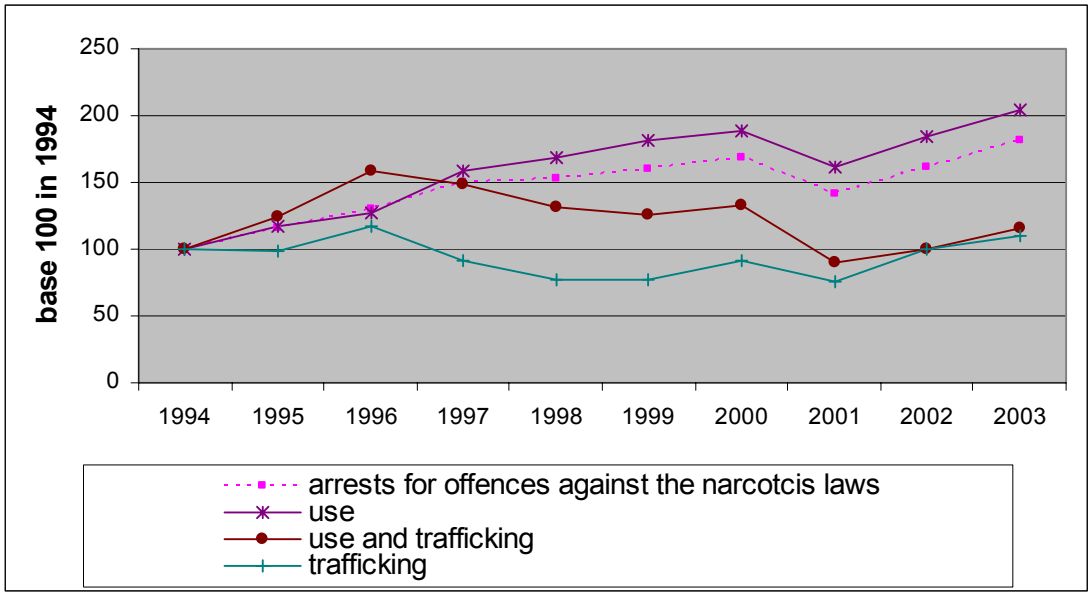
9,589 arrests for use and trafficking were recorded: this is the second reason for arrest which has remained in the same proportion in all arrests since 2001. The arrests for trafficking break down as: 1,299 arrests for international trafficking and 6,623 for local trafficking (i.e. 7.3% of all arrests for offences against the narcotics laws). While the majority of arrests

involve cannabis, the prominence of this product is less marked in arrests for use and trafficking and for trafficking (Table 18).

In regard to the products, the notable changes in 2003 compared to the previous year are as follows:

- increase in arrests for use and trafficking and for trafficking of cocaine and crack;
- increase in arrests for use of amphetamines (176 compared to 95 in 2002);
- increase in arrests for use of hallucinogenic mushrooms.

Graph 7: Changes in categories of arrest, 1994-2003



Interpretation: the changes in the categories of arrest are shown here taking 1994 as the reference year (base 100); annual changes in the categories of arrest are therefore calculated on the basis of an index of 100 in 1994: a figure below 100 indicates a drop in comparison to the reference year while a figure above 100 indicates a rise.

Source: FNAILS, OCRTIS.

Table 18: Arrests for drug law offences, by substance, 2003

	Use	%	Use & trafficking	%	Trafficking	%	Total
Cannabis	82.143	*9..6*	7,617	*79.4*	4,508	*56.9*	94,268
Heroin	3.258	*3.6*	778	*8.1*	966	*12.2*	5,002
Cocaine	2.104	*2.3*	464	*4.8*	1,570	*19.8*	4,138
Crack	897	*1.0*	164	*1.7*	373	*4.7*	897
Ecstasy	.548	*1.7*	414	*4.3*	384	*4.8*	2,346
Medicines (1)	197	*0.2*	79	*0.8*	39	*0.5*	197
Others	483	*0.5*	73	*0.8*	82	*1.0*	483
Total	90,630	*100.0*	9,589	*100.0*	7,922	*100.0*	108,141

(1) methadone, Subutex®, others

Source: FNAILS, OCRTIS

Sentencing

In 2002, 21,629 sentences were passed for offences against the narcotics laws (ILS) where this was the main offence (but in total, an offence against the narcotics laws appeared in 25,662 sentences).

After the drop in 2001 observed for all crime data (arrests and imprisonments), the number of sentences for offences against the narcotics laws increased again although it has still not reached the level of 2000 (22,831 sentences in 2000).

The principal explanation which can be suggested for this increase in sentences for offences against the narcotics laws while the overall number of sentences for offences has fallen is the amnesty of July 2002. The presidential amnesty, in fact, concerned the least serious acts and it might be supposed that some of the sentences given in 2002 for use were repealed while all acts relating to trading, whether they related to use and resale or to trafficking, were excluded from this.

Table 19: Sentences for drug law offences (as the main offence) according to the nature of the offence, 2001-2002

	2001 (revised)	2002 (provisional)	Distribution in 2002 (%)	*Change from 2001-2002 (%)*
All offences	41, 289	38, 741		*-7.1*
All offences against the narcotics laws	21,203	21,629	100.0	*2.0*
illicit use of narcotics	5,689	4,658	21.5	*-18.1*
possession, procuring	8,293	8,877	41.0	*7.0*
supplying	2,357	2,225	10.3	*-5.6*
trading, use, carrying	3,377	4,257	19.7	*26.1*
trafficking (export - import)	1,373	1,509	7.0	*9.9*
assisting drug use	52	53	0.2	*1.9*
other offences against the narcotics laws (1)	62	50	0.2	*-19.4*

(1) Including 16 sentences for laundering and 16 for non-justification of resources by a person associated with someone involved in an illicit activity regarding narcotics

The figures are revised from one year to the next and remain provisional for the current year (hence discrepancies with the information requested from the statistics department at the Ministry)

Source: National police records (SDSED – Ministry of Justice).

Three quarters of sentences for offences against the narcotics laws are punished by imprisonment (16,406), half of them being given a total suspended sentence (the others including at least part of the sentence as imprisonment, i.e. actual detention). Logically, the more serious the offence is deemed to be, the more likely it is to require a prison sentence. For instance, 94% of sentences for import-export resulted in a prison sentence compared to 75% for cases of possession and procurement and 58% for cases of simple use of narcotics.

The average duration of the prison sentence given (but the whole sentence may not be served) is long for the most serious offences (except for supplying): 6.2 months on average for use against 31.3 months for import-export of narcotics.

Imprisonments

At 31 December 2003 there were 5,197 people in prison for an offence against the narcotics laws as their main offence. That is 26% more than in 2002. For the second consecutive year, the number of people sent to prison for offences against the narcotics laws rose, although this figure had been falling since 1995. The rise in 2002 was more modest (+5%).

The new version of the national register of prisoners came into force in 2003. The 2003 figures are not therefore comparable to those for previous years. In 2003, 13,142 people were imprisoned for an offence against the narcotics laws, either alone or in association, out of a total of almost 90,000 people sent to prison. The most-often selected offence was possession of narcotics (present in 9,282 cases of imprisonment, i.e. 70% of those for offences against the narcotics laws), followed by use of narcotics (selected for 1,977 people imprisoned in the course of the year, i.e. 15% of cases of imprisonment for offences against the narcotics laws).

Other offences

Offences on the road

The first figures for the number of offences of "driving under the influence of substances or plants classified as narcotics" are partial, since the checks were not actually introduced until the second half of 2003 and only police figures are involved here.

Out of all the 2,138 checks made for any reason (accident, offence, suspicion of narcotics use), 344 were found to be positive for narcotics (i.e. 16%). In the case of accidents or offences (2079 checks), the tests were positive in 15.3% of cases. In the case of suspicion of narcotics use (59 checks), this proportion was 44.1%.

8.3 Use in prison

NO NEW INFORMATION AVAILABLE

8.4 Social cost

Kopp and Fenoglio (2004) have identified all the costs and economic benefits of illicit drugs in France (Table 20). Public savings plus the economic weight of the drugs were 1,385 million Euros (M€) the major part (99 %) of which was generated by the traffickers' turnover (private sphere). Compared to wealth created at national level, the amount of 1,385 million Euros represents 0.11% of the GDP.

Table 20: Public savings and the economic weight generated by illicit drugs (in millions of Euros), 1997

	weight	proportion(%)
public sphere	**12.56**	0.91
incl.: pensions not paid	*9.38*	*0.68*
general medical practice	*1.26*	*0.09*
hospital treatment	*1.91*	*0.14*
taxation	*0.0*	*0.0*
private sphere	**1,372.04**	99.09
including traffickers	**1,372.04**	99.09
incl.: cannabis	*670.78*	*48.45*
heroin	*701.27*	*50.65*
cocaine	*na*	
synthetic products	*na*	
balance of trade	*na*	
Total	1,384.60	100

Sources: Kopp and Fenoglio (Kopp and Fenoglio, 2004). Reference year 1997.

9. Responses to social correlates and consequences

Responses to social correlates and consequences: general context

Social integration: the harm reduction policy aims to reduce not only the health problems but also the social problems which are a feature of the drug user's career: isolation, living on the street, emotional, family and professional breakdown. Among the harm reduction facilities are the drop-in centres, which are places of contact for users and sleep-in centres, which offer emergency night accommodation for drug users in very vulnerable situations (4 in 2002). There are front-line teams whose purpose is to improve the treatment of drug users and also to be local mediators (4 in 2001). The drug users can also attend facilities which belong to the system for fighting exclusion: emergency sleeping accommodation, accommodation and rehabilitation centres (CHRS), day reception centres and mobile assistance teams.

Within the different facilities, social workers and special education teachers work with users to facilitate their rehabilitation.

One of the objectives set by the substitution treatments, in addition to bringing dependent users to the treatment system, is to help with their social rehabilitation. Several surveys have shown the positive benefit after 6 months to 2 years of treatment of the individual: an improvement in registrations with the authorities, better professional involvement, improvement in housing conditions (Bilal *et al.*, 2003; Batel *et al.*, 2001; AIDES, 2002; Duburcq *et al.*, 2000 ; J. Reynaud *et al.*, 1997 ; Fhima *et al.*, 2001a; Lavignasse *et al.*, 2002).

Some surveys have also shown that the treatments distance users from crime and offending whatever the socio-demographic and economic characteristics of these users may be (Facy, 1999; Calderon *et al.*, 2001; Henrion, 1995).

Assistance to drug users in prison:

- prevention of infectious diseases: all prisoners, on their arrival at the prison, are offered a medical consultation in the outpatient consultation and treatment units (UCSA) with, in particular, screening for tuberculosis, voluntary, confidential screening for HIV infection and, more recently, hepatitis C, together with a vaccination against hepatitis B. The regional medico-psychological service teams (SMPR) are responsible for psychiatric treatment in 26 prisons (generally large) while the UCSA's are responsible for somatic treatment.

However, a report produced for the Ministry of Justice on reduction of risk of transmission of HIV and viral hepatitis in the prison environment says that *"actions for prevention of HIV infection, AIDS and hepatitis are not effective in all institutions"* (Rotily, 2000, p. 46). In the opinion of the author, three strategies in the risk-reduction policy need to be improved: informing and educating prisoners, the offer of screening (HIV, HCV) and vaccinations, and reduction of overpopulation and promiscuity in the prison environment.

- risk-reduction: injection equipment is not provided in prisons in France. It contravenes article D-273 of the criminal code of procedure which states that prisoners may not keep for their use any object, medicine or substance which may enable or facilitate a suicide, aggression or escape. A circular from the prison authorities in 1996 provided for free, regular distribution of bleach to prisoners.

There is no law which explicitly prohibits the practice of tattooing. In the same way the rules state that condoms must be provided, mainly in the UCSA's in prisons.

- registration for treatment and treatment of dependencies: of the 186 prisons in France, few are developing a specific system of treatment for drug addicts. There are drug addiction units in 16 remand prisons; Care Units for prison leavers (UPS) were set up in 7 prisons as an experiment in 1997 (2 closed in 2003); outpatient alcoholism treatment centres (CCAA) have been opened in only 3 prisons. There are 102 prison services for integration and probation (SPIP) which assist with social monitoring of prisoners and their integration on leaving prison; they arrange for social rehabilitation of drug addicts (some of whom have begun treatment while in prison) by directing them towards public or community partners.

The prescription of substitution medicines is theoretically possible in prison under the same conditions as outside, in order to initiate or continue treatment with methadone or Subutex®. All

prisons must, when a prisoner enters the establishment, offer substitution treatment or a withdrawal method to those who express a need for it (circular DGS/DH/DAP of 5 December 1996). The Ministry of Health has carried out three successive surveys on substitution treatments (March 1998, November 1999 and December 2001) which seem to show that access to substitution treatments for prisoners who are heroin addicts is still, in spite of real progress, less easy than it is outside prison: the proportion of drug users given a substitution treatment in prison was 18% in 2001 (6% in 1998). The rate of interruption of substitution treatments on entering prison has fallen appreciably, from 19% in 1999 to 5.5% in 2001.

It has been demonstrated that the number of imprisonments (or reimprisonments) is lower among people who benefited, before or during imprisonment, from substitution treatment (Rotily *et al.*, 2000 ; Levasseur *et al.*, 2002).

Alternatives to prosecution and substitution orders

The priority given to the medico-welfare sector in the fight against drugs assumes that policies are encouraging alternative legal responses: intervention by the courts in regard to narcotics has therefore become more liberal for users over the last decade. In 1993 the policy of using treatment orders was re-launched and relations between the judges and the medico-welfare system were strengthened by introducing Departmental agreements on objectives in health and justice (CDO).

The legal responses possible were diversified by the circular of 17 June 1999 (NOR: JUSA9900148C) in which the Minister of Justice asked Public Prosecutors, when dealing in the courts with users who had been arrested, to concentrate more on the fight against local trafficking rather than the fight against simple use. Social and personality surveys (of the individuals arrested) were to be used to enable the sentence to be personalised and an appropriate measure selected. The diversification of responses to crime was higlighted: treatment orders, discontinuation of proceedings with referral and conditional discontinuation of proceedings, for alternative measures; socio-educational legal controls with compulsory treatment and probation for presentencing measures.

The prison service for integration and probation (SPIP) is responsible for monitoring sentences which were alternatives to imprisonment. The SPIP identified, at local level, and under the supervision of the Judge responsible for the execution of sentences (JAP), the social, medical or other facilities which would enable the compulsory treatment orders to be implemented.

In regard to treatment orders, an alternative measure particularly applicable to people arrested who had a dependency problem, the national trend is rather towards stagnation, in spite of numerous efforts to relaunch it through circulars (Guigou circular of 17 June 1999 in particular).

At a later stage in the criminal process, offenders against the narcotics law may benefit from a substitute sentence order instead of imprisonment or a fine: the substitute sentence may take the form of community service, a day-fine or other measure. National data are patchy in regard to this, in the sense that they do not make it possible to distinguish the proportion of these measures applied to simple users, for example. In addition, monitoring of these measures is implemented by individual establishments but there is no national summary of changes observed in the implementation of these measures.

9.1 Social integration

NO NEW INFORMATION AVAILABLE

9.2 Prevention of drug-related offences and crimes

Assistance to drug users in prison

Substitution treatments

The latest survey, carried out in 2003 by the Ministry for Health, on substitution treatments in prison showed that the number of prisoners with access to an opiate-substitution treatment has increased significantly since 1999 (+55% between 1999 and 2001, + 49% between 2001 and 2003).

80% of prisoners undergoing substitution treatment received Subutex® but the number of prisoners on methadone grew significantly between 2001 and 2003.

Table 21: Prisoners receiving a substitution treatment, 1999-2003

	1999	2001	2003(1)
Total number of prisons	168	168	163
Number of establishments where no prisoners are receiving substitution	43	21	6
Prisoners on Subutex®	1,375	2,182	3,023
Prisoners on methadone	270	366	768
Total	1,645	2,548	3,791
Proportion of prisoners in the prison population receiving substitution	*3.3 %*	*5.5 %*	----

(1) in 2003, one prison closed and during 2003, 4 prisons did not respond to the questionnaire, which explains the difference in numbers between 1999/2001 and 2003

Source: survey on substitution treatments in prison, DGS.

Organisation of treatment

A recent report on the organisation of treatment for prisoners receiving substitution treatment or presenting with opiate dependence draws attention to significant gaps in the health treatment offered to prisoners (Michel and Maguet, avril 2003). The report was based on a survey of various prisons, prison personnel and prisoners, and stated that *"improving the organisation of treatment for prisoners receiving substitution treatment is only one aspect of the prison health system, which must be looked at in its entirety,"* and that *"the substitution policy for prisons can not be treated as a separate matter from the overall penal policy."*

The main recommendation made by the experts was that substitution treatment must be considered as an integral part of an overall treatment plan centred on the patient. It was found, in fact, that even though all the prisons surveyed permit prisoners to continue a pre-existing treatment, the actual provision of this treatment is often limited to supply of the product.

Among the other recommendations in the report, it suggested that:

- initiation of treatments and prescription methods must be on the same basis as these practices outside prison;
- the methods of supply must be decided according to the products (methadone or Subutex®) and types of establishment;
- co-prescriptions of psychotropic drugs, and in particular the benzodiazepines, must be limited;
- as far as possible the treatment must be confidential;
- training must be given to prison and health personnel;
- prevention must be promoted among prisoners.

Alternatives to prosecution

In 2002, 4,068 treatment orders which had run their course and had been successful gave rise to discontinuation of proceedings (figure equal to that for 2001).

Substitute sentences

A substitute sentence was given in 1,642 sentences in 2002 for an offence against the narcotics laws as the main offence, i.e. in 8% of cases. The more serious the offence, the less this type of sentence is used (12% of sentences for use of narcotics received a

substitute sentence compared to 3% for cases of import-export). This proportion is 14% in cases of sentencing for use alone.

The use of substitute sentences for offences against the narcotics laws is relatively rare (11.6% of sentences for offences). The sentences are most often day-fines (65% of substitute sentences for offences against the narcotics laws) or community service orders (31%). Compulsory care measures and discharge without sentencing are rare.

10. Drug markets

Drug markets: general context

The TREND information system focuses on 2 areas. The urban scene is defined as the places in a town where active drug users may be seen (squats, in the street etc.). The party scene means party events, especially those from the techno culture: clubs, 'teknivals', 'free parties' and private parties.

Availability and supply: information on changes in minor trafficking (on the urban and party scenes) and accessibility and availability of products is gathered thanks to the TREND observation sites.

- Cannabis is the most easily-available and accessible illicit product in France.

- Heroin is a product which is not readily available and not very visible. This situation has become more marked with the disappearance of the open drug scene and the fact that small-scale traffickers have moved into selling cocaine, which is more profitable.

- Cocaine in its base form is available both in the techno party scene and the urban scene; crack is mainly available in Guyana, in the Antilles and in inner urban Paris.

- Since the beginning of 2000 HDB (Subutex®) has become more available on the parallel market.

Within the urban scene, trafficking since 2002 has tended to move to less visible premises and areas.

In the techno party scene, new regulations governing the organisation of events which were introduced at the beginning of 2002 have made unauthorised free party events rarer and there are more commercial techno parties. This has contributed to a certain movement of trafficking towards the urban environment: clubs and discos, private premises (private parties) and across the borders (Spain, Belgium).

Seizures: France is a transit country for substances intended for the Netherlands, Belgium, the United Kingdom, Italy and beyond and it is therefore difficult in France to separate the quantities of drugs intended for the domestic market from those which are just passing through. Trafficking in France therefore needs to be tackled according to the products since the country where they were procured and the country which is their destination vary depending on the substance in question.

Seizures recorded by the authorities (police, customs, gendarmes) in France are only a partial indicator of the illicit drugs available, because they are directly linked to the activity of the services concerned and because chance plays a significant role in the annual variations in the figures. Changes must therefore be studied over long periods.

The number and quantities seized on French territory are taken from the file on police questioning for the use of narcotics (FNAILS) managed by OCRTIS. The trends observed for each product are as follows:

- since the end of the 1980's, there has been a considerable increase in the number of seizures and quantities seized of cocaine and crack and this continued in the 1990's and the 2000's.

- after an increase in the quantities of heroin seized in the 1980's and up to 1994, the trend is now downwards.

- since the beginning of the 1990's, the number of seizures and quantities seized of ecstasy have increased considerably although the increase in seizures of amphetamines was more moderate.

- the quantities seized and number of seizures of LSD dropped over the period 1990-2002 after peaking in 1992 and 1993.

For the quantities seized and the number of seizures carried out over the past four years, see *Standard Table no. 13*.

Price, purity: information on the prices and purity of psychoactive substances has been available in France since 2000, from the OFDT monitoring system, TREND.

Standard Table no.14 gives information on the purity of products over the last three years. *Standard Tables nos. 15 and 16* give the composition of products and the prices of the principal illicit products.

Marijuana was sold in 2002 at less than € 5 per gramme, and two thirds of samples analysed contained less than 5% tetrahydrocannabinol (THC). Cannabis resin, around € 7 per gramme on the market, contained between 5 and 10% THC (42% of the samples analysed) or 10 to 15% (28% of samples analysed).

The average price for brown heroin in mainland France seems to have been falling since 2001 but there are considerable local discrepancies. The purity rate is mainly between 0 and 20%. The average price of an 8 mg Subutex® (HDB) table on the black market has been € 3 since 2002 although it was € 6 in 2000.

The prices of cocaine hydrochloride and free-base (crack) vary depending on the sites and social scenes where they are observed. In mainland France, the average price of a gramme of cocaine hydrochloride is € 63 and this seems to have been stable for 4 years. The purity rate of the cocaine seized is most often between 60 and 100%. The most-often used products for cutting are lidocaine, phenacetine and procaine.

Rounded prices remain the rule for ecstasy tablets with three-fifths of the tablets sold at € 10 each. Batch purchasing seems to be becoming more common. The tablet price then easily falls below € 5 or € 3. In 2003, of the tablets collected by SINTES, 89% contained MDMA and 93% contained at least one metamphetamine. The average was 54 mg of MDMA per tablet (compared to 56 mg in 2002, 63 mg in 2001 and 74 mg in 2000). Almost 4% of the tablets were high-dose (>100 mg). Dosage in powders and capsules containing MDMA was on average double that of tablets (51% MDMA in powders (33 doses); 53% in capsules (34 doses) and 24% in tablets).

10.1 Availability and procurement

2003 continued in the same way as the previous year, with strong police activity around the places frequented by users on the street and around commercial party establishments (clubs, discos etc.) (Bello *et al.*, 2004).

Cannabis: availability of marijuana seems to be on the rise because many users now grow hemp themselves (home-cultivation).

Heroin: the availability and accessibility of this product remain marginal but seem to be growing in the 'underground party scene'. In the urban scene, the situation varies depending on the sites surveyed.

Cocaine: the powder form of cocaine has become more available compared to 2002 in the two scenes monitored by TREND.

Ecstasy: the product is freely available in 'teknivals', commercial party events and clubs and discos.

Hallucinogenic mushrooms: an upsurge was noted in 2003 in purchases over the Internet of varieties of mushrooms considered to contain higher doses of the active substance (Hawaiian and Mexican varieties, around € 10 per gramme) and home-cultivation through the purchase of ready-to-use kits and spores.

LSD: although this seemed in 2002 to have disappeared in France, LSD has re-appeared at 'teknival' party events, commercial parties and 'free parties'.

10.2 Seizures

The number of seizures carried out per year has been rising constantly since 1998 (+60% between 1998 and 2003), as have the volumes seized (Central office for the repression of narcotics trafficking, 2004).

Table 22: Number of seizures and quantities seized of the principal illicit drugs, 2001-2003

	2001		2002		2003	
	No.(1)	Qty.(2)	No.(1)	Qty.(2)	No.(1)	Qty.(2)
Cannabis (kg)	46,666	62,174	57,794	57,115	67,443	82,515
Heroin (kg)	2,650	351	2,633	476	2,560	545
Cocaine (kg)	1,650	2,096	2,048	3,651	2,636	4,172
Ecstasy (tablets)	1,589	1,503,773	1,782	2,156,937	1,864	2,211,727
Amphetamines (kg)	111	57	149	152	181	275
	No.(1)		No.(1)		No.(1)	
All products	53,534		65,907		76,124	
Changes base 100 in 1998	112.4		138.3		159.8	

(1) number of seizures made in the course of the year

(2) quantities seized in the course of the year

Source: FNAILS, OCRTIS

Seizures of cannabis, heroin, cocaine, crack, ecstasy and amphetamines rose overall in 2003 compared to 2002. Seizures of metamphetamines, LSD and Khat were more marginal and the numbers fell.

Seizures of cannabis resin increased considerably (58 tonnes in 2002 to 78 tonnes in 2003) while seizures of marijuana fell and those of oil remained marginal.

Cannabis enters France in two main ways: by sea (40 to 50% of seizures) and by air, through smugglers carrying it in their bodies or luggage. The seizures made in France are in the minority compared to those made in Spain (46 tonnes in 2003).

The 545 kg of heroin seized in 2003 represented the largest volume seized over the previous five years. The quantities seized came principally from the Netherlands and were destined for France, the United Kingdom and Spain. A large seizure of 67 kg made in March 2003 in the Loiret raised the figures for heroin seizures to a high level. It should be pointed out that the majority of seizures are of quantities below 5 grammes.

The volume of seizures of ecstasy is still rising in comparison to last year. The majority of ecstasy and amphetamines seized come from the Netherlands. 65% of seizures made are of small quantities (1 to 20 tablets) but nevertheless 31 seizures of above 10,000 doses were recorded (i.e. 1.7% of seizures).

10.3 Price, purity

Cannabis: the average price of the resin reached € 6 per gramme in 2003 (a drop in comparison to 2002) within a range of € 3 to € 7.5. The average price of marijuana remained stable in comparison to previous years at around € 5 per gramme, but it may triple depending on the alleged quantities.

Analysis carried out in 2003 at customs' laboratories of seizures of cannabis resin (around 650 samples analysed) showed that the proportion of samples with less than 5% dose of THC has dropped since 2001 and there are now more samples with a dose between 5 and 10% and in particular samples with more than 10% dose of THC. These resins with more than 10% THC represented 40% in 2003, compared to only 27% of resins in 2001. Concentrations in resins varied from 0.4% to 40% with an average of 10%; that in marijuana varied from 0.3% to 22% with an average of 4%. According to analyses carried out by the police services (on 465 resins), the majority of samples (43% of the samples analysed) had a dose of 5 to 10% THC, or 10 to 15% THC (35% of samples analysed).

Heroin: the average prices in mainland France seem to be falling both for white heroin (€ 65 per gramme) and brown heroin (€ 40 per gramme). There is considerable variation in prices

depending on the site. The proportion of samples seized which contain more than 20% of heroin is increasing (57% with 0 to 20% dose of heroin, 28% with 20 to 50% dose and 15% with 50 to 100% dose of heroin).

Crack: in Guyana the price varies from € 3 to € 5 per dose (*"caillou" (rock)*), in Martinique the average price is € 10 per dose and in Paris a dose costs between € 15 and € 30 and between €20 and € 30 for a *"galette" (slab)* (2 or 3 doses).

Ecstasy: the tablets collected in 2003 from users contained MDMA (89% of tablets), amphetamine (9% of tablets) and at least one metamphetamine (93% of tablets). In 2003, the average was 54 mg of MDMA per tablet (compared to 56 mg in 2002, 63 mg in 2001 and 74 mg in 2000); this corresponds on average to a concentration of 24%. Almost 4% of the tablets collected contained more than 100 mg of MDMA (a high dose), which is a slight increase compared to the three previous years.

Powders containing MDMA have a greater concentration of the active substance than the tablets, with on average 51% MDMA (giving 33 doses); the same applies to capsules (53% on average, giving 34 doses). This is double the average dose of tablets.

The average price of a single tablet had fallen slightly compared to 2002 (€ 9.7). Rounded prices remained the rule with three-fifths of ecstasy tablets sold for € 10 (compared to almost half in 2002), a sixth sold for € 15 and 1 in 8 sold for € 5. The price of tablets when they are bought in batches soon drops below € 5 or € 3. The average price also varies according to the place of sale: it costs more in discos or in bars than on the street or at ‘teknivals’.

PART B: SELECTED ISSUES

11. Buprenorphine, treatment, misuse and prescription practices

During the 1970's, the policy for fighting drug addiction did not consider any therapeutic objective other than withdrawal. As the HIV/AIDS epidemic among injecting drug users grew during the 80's, risk reduction methods (free sale of syringes in 1987, development of syringe exchange programmes) were progressively developed. Substitution treatments for opiates have only developed in any significant way in France since 1996 and are mostly based on prescription of high dose buprenorphine (HDB) and, to a lesser extent, of methadone.

Since 1993, methadone treatments have lost their experimental status, but are still governed by strict prescription rules: they can only be initiated by doctors practising in a specialised centre for drug addicts[28] (CSST). Referral to a general practitioner can only be done once the patient is stabilised (Ministère des Affaires Sociales de la Santé et de la Ville, 1995). At the start of treatment, the product must be dispensed daily under medical supervision, with urinary analyses carried out to check progress of the treatment. The prescription may then be given for a period of 14 days, dispensed in two 7-day lots[29]. Conditions for access to "methadone" programmes and remaining within these programmes are more or less strict, depending on the centre. They can sometimes be very selective.

Because of the conditions for access, the fact that there are too few places and that the centres are unequally distributed over the national territory, the availability of treatment has clearly been insufficient in comparison with needs. In addition, some professionals who are rather set on the psychotherapeutic approach to dependence seemed reluctant to use medication treatments for opiate dependence.

So, an additional therapeutic treatment was introduced in France at the beginning of 1996 which was based on high dose buprenorphine with an initial prescription which could be given by any doctor. The choice of HDB by the health authorities was based partly on previous experience of activist doctors who used an analgesic form of buprenorphine (Temgesic®) for substitution in opiate-dependent people and partly on the absence of risk of overdose[30] (contrary to methadone) where HDB is used without any other psychotropic molecule.

Prescription framework

The legislation (Ministère des Affaires Sociales de la Santé et de la Ville, 1995) states that the prescription is part of an overall treatment, both psychological and social, but does not set out the treatment procedures. In the same way, working in a network of specialised centres, doctors and local pharmacists is recommended but is not obligatory. The prescription procedures stated in the MA (marketing authorisation) are also more flexible than those for methadone: prescription is based on a legally-controlled prescription for a maximum period of 28 days, dispensed in 7-day lots unless expressly stated otherwise by the doctor[31]. It is specified that treatment is reserved for voluntary patients aged over 15. The only criterion for selection of patients is the existence of a confirmed drug dependency on opiates.

[28] And since 2002 by doctors in health institutions.

[29] Order of 8th February 2000, relating to split dispensing of methadone-based medicines.

[30] High dose buprenorphine is a morphinic agonist-antagonist. The partial agonist action limits the depressive effects, particularly the cardio-respiratory effects.

[31] Order of 20th September 1999 relating to split dispensing of certain buprenorphine-based medicines.

In the years following the marketing authorisation for HDB, considerable effort has gone into training doctors. The training is mainly provided by the producing laboratory using documents written by professionals in the sector. Training is also given within the networks and within continuous training organisations supported by public subsidies. Finally, university training about drug addiction now incorporates these new treatment options.

The practice of prescribing HDB is fairly widespread among GPs, who are the principal prescribers. Office-based doctors prescribed 93.2% of the HDB dispensed in 2002 (Assurance Maladie (Health Insurance), 2003).

On the basis of a study involving thirteen cities or districts in metropolitan France it can be estimated that in 2002, 35% of GPs prescribed treatment with high dose buprenorphine. However, there are considerable variations between one city and another (from 23% to 60%). The number of prescribing GPs continues to increase and grew by 11% between the first half of 2001 and the second half of 2002 (A. Cadet-Taïrou and Cholley, 2004).

However, prescription is frequently concentrated in a limited number of doctors. During the second half of 2002, 20% of the doctors who were the greatest prescribers of substitution treatments carried out 73% of the treatments. In 2001, only 10% of the GPs belonged to a "drug addiction" network and these doctors would, on average, monitor 32 addict patients per year, compared to 6 for non-network doctors (Coulomb *et al.*, 2002). The proportion of practitioners who have prescribed a substitution treatment for only one or two patients in 6 months is 59% of prescribers. Although prescription of substitution treatment by HDB seems to be a widespread practice, a significant proportion of doctors have little experience of these treatments. This may be linked to a lack of training since 81% of those who see fewer than 10 patients per year consider themselves to be insufficiently trained or not trained (Coulomb *et al.*, 2002).

Within this prescription framework, it is difficult to estimate the proportion of patients who receive support together with the substitution treatment. Seventy-two percent of GPs say that they offer psychological support along with treatment (Coulomb *et al.*, 2002). However, many experience difficulties in getting their patients registered for psychological or psychiatric treatment in specialist centres or at a hospital.

Treated patients

How many of them are there?

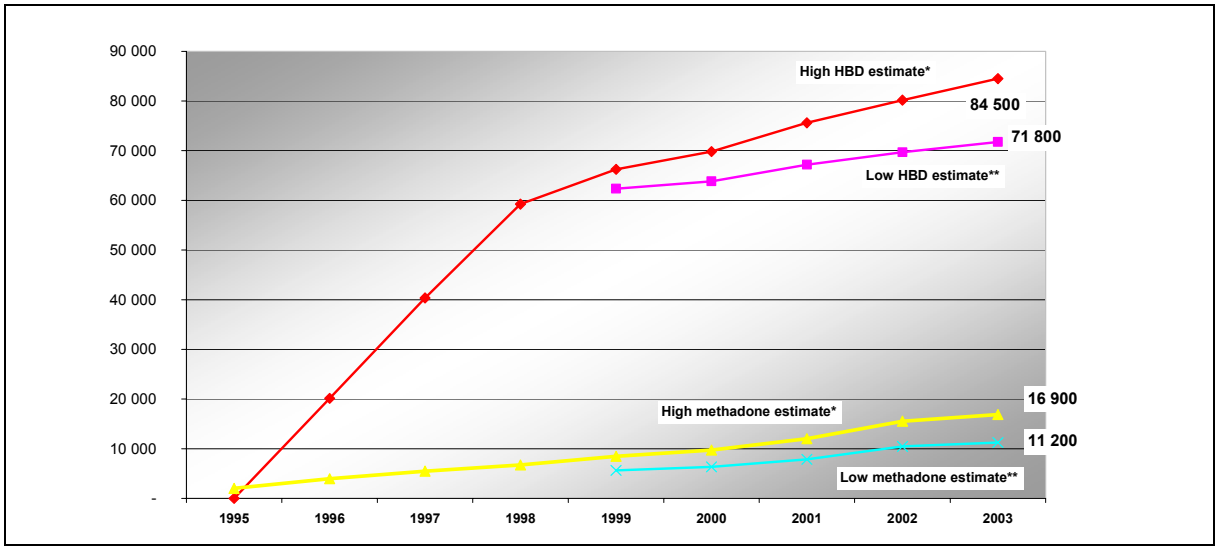
The growth in distribution of Subutex among opiate-dependent people is usually monitored by dividing sold quantities by the average estimated therapeutic doses. This theoretical number of treated patients was between **71,600 and 84,500** in 2003[32], which is slightly less than half the number of problem users of opiates in France (Graph 8). After significant growth, the trend now is towards stagnation in the number of patients receiving HDB and even towards a decrease over the areas where the practice of substitution has been widespread and long-standing (A. Cadet-Taïrou and Cholley, 2004).

However, after HDB came onto the market in 1996, it rapidly became, quantitatively, the main treatment for opiate-dependence in France. The relaxed framework adopted in France for HDB made this product highly available, whether via medical prescription or on the parallel market. In addition to patients involved in a medium or long term treatment protocol, people have been identified who receive intermittent prescriptions, once or twice in six months, or who experience multiple treatment interruptions (**at least 22,000 people** at the

[32] OFDT estimates using SIAMOIS/InVS and CNAMTS data. The high value is based on a theoretical average dose of 8 mg, the low value is based on the projection of a series of median doses dispensed to patients and observed in 13 cities.

end of 2002, according to OFDT[33] estimates). As well as these users, there are slightly less than 5000 people who consult many doctors to obtain drugs for trafficking.

Graph 8: Estimated number of users of substitution treatment



Sources: SIAMOIS InVS data and OFDT estimates

In addition to these "total or partial prescription" users there are "non-prescription" users who are difficult to quantify (Figure 1). In the TREND[34] "2003 low-treshold" survey, 24% of Subutex® users in the past month, had acquired it exclusively on the black market and 25% had acquired some of it from that source (Bello *et al.*, 2004).

So, the number of ***patients on HDB actually undergoing a treatment process*** in 2002 was not more than **52,000.** By comparison, the number of patients treated with methadone in June 2003 was almost 11,000.

Who are they?

The majority (76% to 79%) of HDB users are men. According to the sources, the average age of users is between 30 years 6 months (2003) and 34 years 5 months (2002) (A. Cadet-Taïrou and Cholley, 2004; Bello *et al.*, 2004; Claroux-Bellocq *et al.*, 2003; Thirion, 2003). The trend is for the age to increase, probably linked to a cohort effect: the patients age as they are being treated.

Significant variations can be seen in the average age of the patients, and this is partly explained by variations in the length of time for which substitution practices have been in use in the different urban agglomerations studied (A. Cadet-Taïrou and Cholley, 2004). These differences are also a reflection of age variations between population groups. Patients using buprenorphine under medical supervision are older than patients using non-protocol Subutex® with no protocol (31.7 compared to 29.2) (CEIP de Marseille, 2003).

The women are on average younger than the men (0.7 year difference between men and women for all the patients who received a Subutex® prescription (A. Cadet-Taïrou and Cholley, 2004), 1.8 years in low-threshold facilities) (Bello *et al.*, 2004). This may be linked to the fact that women begin the treatment process at an earlier stage than men.

[33] OFDT estimates using Health Insurance refund data: this data gave an estimate for the number of French people who had received refunds over 3 months (2000 projected to 2002) and was used to study the doses dispensed and the consultation habits of patients (doctor shopping, irregular prescriptions) for each half-year between 1999 and 2002, over 13 cities.

[34] The TREND network information system is concerned with users attending low-threshold facilities (syringe exchange programmes, drop-ins etc.). Many are still active users. Some use Subutex® under medical supervision (protocol) but others do not.

The patients on Subutex® are frequently in insecure situations: 56% of patients who received a prescription in the second half of 2002 had CMU (couverture maladie universelle – universal health cover[35]) compared to 7% of the French population as a whole (A. Cadet-Taïrou and Cholley, 2004; Claroux-Bellocq *et al.*, 2003). Among users of the low-threshold facilities, the youngest [aged 15 – 24] more often have no fixed address (64%) than do older users (45%) and absolutely no social security cover (17%) (Bello *et al.*, 2004).

The patients receiving methadone, who represent between 12% and 18% of patients on substitution treatment, are two years older on average and are slightly more often women than patients on Subutex® (24% compared to 21% among patients on a treatment protocol attending the specialised centres for drug addicts) (CEIP de Marseille, 2003). However, local data show that variations in sex ratios between the two populations are not constant (A. Cadet-Taïrou and Cholley, 2004). Nor do the differences in ages follow any pattern. The trend is towards homogenisation of the populations on buprenorphine and methadone (A. Cadet-Taïrou and Cholley, 2004).

The positive effects of high dose buprenorphine treatments

All the available information, although patchy, whether recorded in relation to individuals or groups, points to a positive assessment of substitution treatment strategies for opiates addicts. Some studies, mostly carried out on the second part of the 90s, provided a longitudinal individual follow-up of patients by GPs involved in the treatment of drug addicts, practising privately or in the specialised centres for drug addicts: for example, SPESUB (1996) (Duburcq *et al.*, 2000), ARES 92 (1996) (Barbier and Lert, 2001), ANISSE (2000) (Batel *et al.*, 2001). The follow-ups relate to periods from 6 months to 2 years. As with any longitudinal analysis, the evaluations only concern subjects who remained in the original treatment system, but these studies alone are able to observe the actual effects of substitution treatments in regard to individuals. Two retrospective studies supplement their results, that of Bilal (1999) (Bilal *et al.*, 2003) and the AIDES survey (2001) (AIDES, 2002), carried out from the point of view of the patients.

In terms of use, we note a progressive movement away from the drug-taking culture. The use of illicit substances is decreasing, as are injection practices. It is becoming less common to share equipment and syringes. Substitution treatment is also, for the patient, an opportunity for improved treatment, even if it does not solve everything. In particular, it provides better access to anti-retroviral treatments (Carrieri *et al.*, 1999). Finally, the positive results of HDB administered during pregnancy on the condition of the mother and child leave no room for doubt (Lejeune *et al.*, 2003). These different follow-up studies of users undergoing substitution treatment or the qualitative studies carried out among users (Milhet, 2002), provide evidence of the assistance given by substitution in the process of social reintegration. Housing conditions tend to improve, as do employment situations and access to social security cover. The fabric of relationships shifts away from the "network" linked to drug addiction. Finally patients feel better about their quality of life. In addition, undergoing substitution treatment during a period of imprisonment appears to limit the number of subsequent prison sentences (Levasseur L. et al, 2002).

In regard to public health, the most noteworthy element lies in the significant drop in deaths from overdoses, on which several sources agree (Lopez *et al.*, 2004b), although the benefit can not be attributed solely to substitution treatments. The epidemic linked to HIV, which was particularly strong among injecting drug addicts, has also slowed considerably. The decrease in frequency of injection may have contributed to this.

Attempts to compare treatment by HDB and methadone in France are hindered by the significant differences in conditions for prescribing these two substances and the treatment

[35] Coverage of health costs without payment of contributions, for people on very low incomes.

system offered. Because of this, the populations treated within one system or another are quite different so that it is not possible to compare like with like.

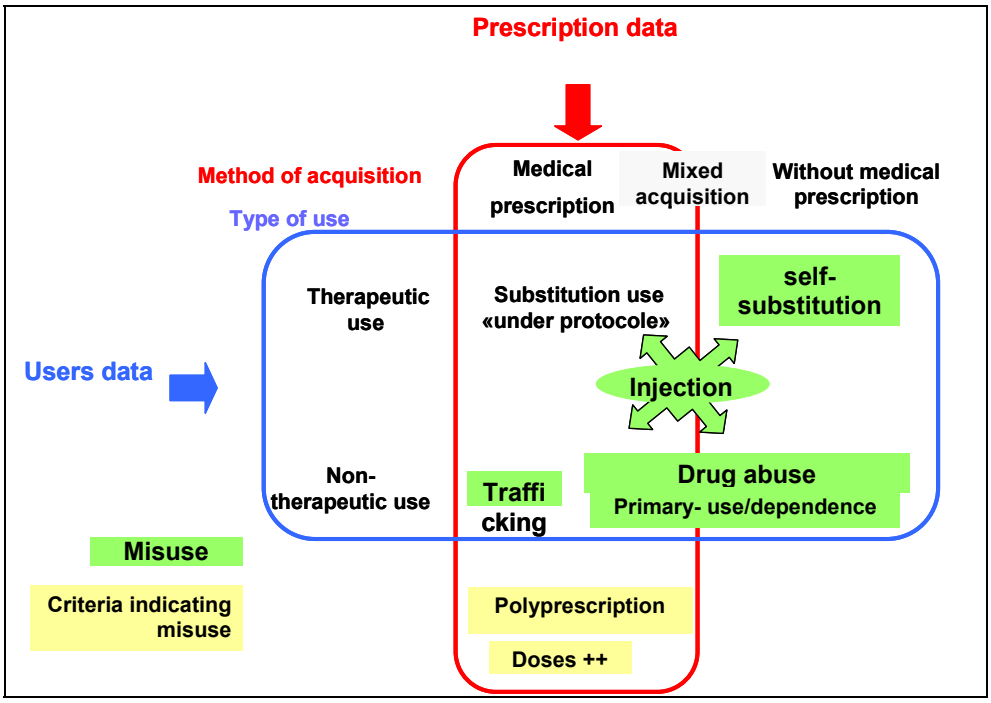
Misuse

The development of HDB treatments has led to numerous improvements in the status and living conditions of people dependent on opiates, but this has also brought undesirable consequences. Recorded misuse relates to the method of obtaining the medicine (bought in the street from a dealer) and the use made of it.

Concerning undesirable uses, a distinction must be made between:

- **"Non-protocol therapeutic use"** or **self-substitution** (by opiate-dependent patients, using Subutex® as a substitute without medical supervision)
- **"Drug abuse"**: For others, use of HDB is not for the purpose of stopping heroin use. It is a way of managing opiate use. So there is a continuum of situations between use of HDB as any other drug to control heroin use, as a breakdown product or as a maintenance product, and self-substitution.
- A **non-substitution use** (**primary use** and **primary dependence)** has been clearly highlighted for 3 or 4 years by the TREND facility. This use is not attributable to a pre-existing drug dependence: it is **a drug abuse** or with a its purpose of controling various problems.

Figure 1: Practices of Subutex® users according to use of the method of acquisition



Source : OFDT

Procurement for non-therapeutic use is from doctors and from the black market.

Moreover, whether as part of a substitution treatment or not, **buprenorphine injection** (buprenorphine is theoretically not injectable) has developed, which limits the impact of substitution treatments on injection but also leads to worrying health consequences. Finally, its use by some users as a drug, either for substitution or not, leads to **dangerous combinations,** particularly with benzodiazepines, which can entail potentially lethal overdoses.

It seems to be very difficult, even impossible, to mark a clear boundary between self-substitution use (therapeutic) and drug abuse (non-therapeutic), since both can be in play alternately. In the low-treshold facilities (2003), which most often receive users who are still following their drug abuse career, 41% of people had used Subutex® in the past month. Of these, 13% used it exclusively for drug abuse, while 34% mixed therapeutic and drug abuse. The oldest patients are most frequently undergoing a treatment procedure (Table 23).

Although it is not possible to include everyone's experience within a general picture, it seems nevertheless that some of the opiate-dependent users are gradually changing: buprenorphine is at first considered as an occasional substitute, then as a means of self-controlled maintenance, and may then be incorporated into a treatment process (Milhet, 2002). Non-protocol use of buprenorphine has preceded prescribed use for many users: 28 % of them in the AIDES survey (2001) said that they were regularly using their substitution product several months before it was prescribed for them by a doctor (AIDES, 2002).

Table 23: Frequency of reasons for use of HDB in the past month, in 2003, among participants in the "2003 low-threshold" survey by age group

	15-24 years	25-34 years	35 years and over	All
As treatment	47%	50%	66%	54%
To "get high"	20%	10%	13%	13%
Both	33%	40%	21%	34%
Total	100% (n=80)	100% (n=209)	100% (n=100)	100% (n=389)

Source: TREND/OFDT (Bello et al., 2004)

Self-substitution

Several studies confirm the existence of self-controlled substitution (Reynaud-Maurupt and Verchère, 2002; Escots and Fahet, 2003; Bello *et al.*, 2004). There are many reasons for this “street substitution”, but they seem linked in particular to social insecurity. So in 2001 the TREND facility highlighted the existence of users in very vulnerable circumstances or on the street, young people and adolescents, and people who may have begun to use HDB in prison. In 2002, the facility also noted "the existence of a very marginalised population, particularly migrants who do not have, or do not wish to have, anything to do with the treatment system" (Bello *et al.*, 2003).

The 202 users of HDB without a medical prescription encountered in the ASUD/OFDT (2000) study (Bello, 2001) mentioned first and foremost the great accessibility of the product (35%) as a reason for their use of diverted HDB. The majority of users who gave this reason stated that they did not have adequate social security cover and considered street Subutex® to be cheaper than in a pharmacy. The insufficiency of the doses prescribed by doctors compared to what they felt they needed was mentioned by 29% of users. The other reasons were the fact that they were injecting (greater number of doses needed), the need for anonymity (9%), particularly among minors or young adults still benefiting from their parents' social security and not wishing the latter to be informed of their use. Finally, 6% were intermittent users and 5% got supplies in the street because their doctor refused to prescribe it.

Other data show that this "unauthorised substitution" is done by opiate users who are still active and is accompanied by risk behaviour more frequently than it is for patients under the treatment protocol: their injection rates, including HDB (Table 25) and their use of licit and illicit products are greater (Bello *et al.*, 2003; CEIP de Marseille, 2003).

Drug abuse and non-substitution use

In drug abuse in heroin-dependent patients, HDB is considered to be a drug like other drugs and is used as an alternative to heroin when heroin can not be obtained, if the heroin available is insufficient or to control use of other substances. Procurement in these situations is largely unlawful (Table 26).

For some years now, it has seemed that HDB represented for some a vehicle for entry or relapse into drug abuse (**non-substitution use**). This phenomenon was the subject in 2002 and 2003 within the TREND network of a specific study which included a quantitative and a qualitative section (Escots and Fahet, 2003). Three use situations were found which were not the result of heroin dependence:

- the user who uses Subutex® without ever having previously used other opiates (**primary user**). In 2003 these represented 6% of users of low-threshold facilities;
- the user for whom HDB is the cause of a first drug dependency on opiates (**primary drug dependency,** 11%) ;
- the former heroin addict who, after long-term stoppage of his or her heroin dependency begins a dependency on HDB which is not continuous with his or her previous addiction (**non-consecutive use,** 10%).

All these users represent around a quarter of the HDB users encountered in the low-threshold facilities in 2002.

Table 24: Frequency of methods of obtaining HDB in the past month, in 2003, among participants in the "2003 low-threshold" survey according to intentionality of use

	As treatment	To "get high"	Both	All
Prescription only	69%	22%	35%	51%
Black market only	18%	54%	23%	24%
Both	13%	24%	42%	25%
Total	100% (n=196)	100% (n=46)	100% (n=126)	100% (n=368)

Source: TREND/OFDT (Bello et al., 2004)

Non-substitution use of HDB involved groups with quite a wide age range (from 15 to 51 years) (Escots and Fahet, 2003) and varied socio-demographic profiles. The main part of this group is composed of very vulnerable young people who are more or less living on the streets. But non-substitution use of HDB also involves older users who had not developed opiate-dependence; subjects at times not involved in any way with drug use; users of the techno party scene who regulate their use of psychostimulants or use them to get high; delinquents who are not addicts at the time of their imprisonment; very vulnerable people, living on the streets, in squats or in institutions, who include, among others, immigrants of uncertain or illegal status. In Guyana, young Creoles use it to regulate their crack use. Non-substitution use of HDB is also seen in better-integrated socio-professional groups or those on their way to that status, since the qualitative survey also covered students, trainees undergoing professional training, salaried workers from various economic sectors and craftsmen (Escots and Fahet, 2003). The user profiles vary considerably from one city to another (Escots and Fahet, 2003; Bello *et al.*, 2004).

The reasons for use of HDB in a non-substitution way fall into three major categories as shown by the research; the categories sometimes overlap within the same subject (Escots and Fahet, 2003).

- In a subject who is not opiate-dependent, to get high, like any other product, because of its effectiveness, its cost and ease of access;

- For others, HDB provides a way of operating. In terms of performance, Subutex® allows the subject to meet others, talk to them or perform activities such as busking, studying, working etc. Some users find that using HDB helps to improve their sexual relations.
- The tranquillising effect of Subutex® is a means of soothing tensions, limiting aggression and reducing anxiety.

A proportion of the users who had become dependent on HDB without ever having developed previous opiate-dependence were already problem users of other substances, particularly benzodiazepines and alcohol, but almost half of them had never used heroin or cocaine before HDB.

Non-substitution use frequently leads to drug dependency which is difficult to break, according to the evidence of users.

Finally, the method of use, as already mentioned, does not affect the method of procurement. Of "non-substitution users" of HDB, 58% obtain it only by medical prescription (Escots and Fahet, 2003) and 17% only on the black market, with the rest mixing these two sources of supply.

Subutex® is a substance which has a negative image with users who use it outside substitution treatment for heroin (Bello *et al.*, 2004). Several combined elements are the reason for this.

- High dose buprenorphine is considered as a very addictogenic substance which makes attempts at withdrawal painful and difficult;
- Buprenorphine appears to be perceived among users more and more as causing injuries occurring at the time of injection;
- The phenomenon of assimilation of Subutex® as a simple street drug (already begun in previous years) appears to be continuing, leading to growing discreditation and devaluation of its users in their own view and that of other users.

Because of this, at the same time as this movement towards the use of Subutex®, we may observe a movement in the opposite direction away from this use towards other opiates, particularly heroin.

Injection of HDB and its consequences

The use of HDB by injection involves all groups of HDB users (under medical supervision or not, substitution or not) in different proportions. The prevalence varies, for instance, with populations. The practice seems to be more important among the most desocialised users encountered in low-threshold facilities and/or the prison environment (Table 25 and Table 26) (Lert, 1999; Vidal-Trécan and Boissonnas, 2001; Stambul, 1999). It seems to be more current in subjects monitored in private medicine than in those treated in specialised drug treatment centres (22% compared to 6% in the OPPIDUM 2002 survey). Injection also seems to be more frequent when HDB is used to "get high" (Table 26).

It seems to diminish with duration of treatment and with degrees of integration into a treatment process (Courty, 2003).

However, the observations of the TREND network mention both a decrease in the practice of injection and a growth in sniffing, particularly among the youngest users. Of participants in the low-threshold survey, 64% injected HDB in 2001 and 47% in 2003. Over the same period sniffing was used by 10% of them in 2001 and 25% in 2003.

Table 25: Method of administration of substitution treatments in patients attending specialised drug treatment centres (CSST)

	Buprenorphine protocol			Buprenorphine without protocol		
	1999	2000	2002	1999	2000	2002
Oral	85%	88%	87%	39%	49%	53%
Injection	15%	14%	11%	43%	32%	27%
Sniffing	6%	6%	7%	22%	30%	29%
Inhalation			1%			6%

NB: there are several possible methods of use

Sources: OPPIDUM/CEIPs/AFSSAPS

Table 26: Frequency of methods of administration of HDB in the past month, in 2003, among participants in the "2003 low-threshold" survey by intentionality of use

	As treatment	To "get high"	Both	All
Oral	66%	33%	64%	61%
Injection	41%	50%	55%	47%
Sniffing	17%	33%	33%	25%
Total	100 % (n=205)	100 % (n=48)	100 % (n=126)	100 % (n=379)

NB there are several possible methods of use

Source: TREND/OFDT (Bello et al., 2004)

In addition to the risk of viral contamination, injection of HDB amplifies the risk of respiratory depression and overdose, particularly when it is associated with the use of benzodiazepines or alcohol (Pirnay *et al.*, 2002) and this seems especially to be linked to the use of supra-therapeutic doses.

In particular, the injection of tablets of Subutex®, which contain HDB but also various excipients, is the cause of abscesses, significant and persistent oedema of the hands and forearms (boxing glove and Popeye syndrome) deep-vein thrombosis and necrotic ulcerations of the skin. They can also cause systemic candida infections with secondary locations in the prostate, bones, joints or skin (Bello *et al.*, 2002).

The data collected from users of low-threshold facilities show that the probability of the presence of abscesses or swelling of the hands or forearms is twice as high in Subutex® injectors than in injectors who said that they had not used Subutex® in the past month (Table 27).

Table 27: Frequencies and odds ratios (OR) of problems linked to injection in injectors during the past month depending on whether or not they had injected Subutex®

	Subutex® injectors	Injectors of other substances	OR and confidence interval of 95%	
Abscess	31%	19%	1.9	[1.2 – 3.1]
Injection difficulties	68%	55%	1.7	[1.1 –2,-6]
Blocked vein, thrombosis, phlebitis	42%	30%	1.7	[1.1 – 2.5]
Swelling of hands or forearms	44%	26%	2.3	[1.5 - 3.5]
Febrile episodes	27%	22%	1.4	[0.9 – 2.1]
Haematoma	44%	36%	1.4	[0.9 – 2.1]

Source: TREND/OFDT (Bello et al., 2004)

Polydrug use in subjects on HDB

As for subjects treated with methadone, patients treated with HDB are also seen to use other psychoactive products in parallel with the treatment (Bello *et al.*, 2004; CEIP de Marseille, 2003). This use is, however, greater in users who are not under medical supervision that in those who are (Table 28).It has been noted in fact that users of low-threshold facilities who are on HDB are much more likely to use more than one drug: 53% use benzodiazepines, 48% cocaine, 32% ecstasy, 26% heroin, 25% Flunitrazepam (Rohypnol®), 23% crack, 21% amphetamines etc.

Table 28: Use of psychoactive substances by users of specialised drug treatment centres (CSST) according to whether or not they are taking part in a treatment protocol

Substances used	Methadone protocol	HDB protocol	HDB without protocol
Heroin	13%	8%	27%
Cocaine	10%	6%	19%
Alcohol dependence	20%	17%	22%
Codeine	1%	1%	0%
Benzodiazepines	22%	21%	37%
Antidepressants	9%	8%	1%
Tranquillisers	7%	7%	4%
Average number of substances	2.2	2.0	2.0 %

Sources: OPPIDUM/CEIPs/AFSSAPS

The use of illicit drugs decreases as treatment progresses (Duburcq *et al.*, 2000; Fhima *et al.*, 2001b). On the other hand, these data raise the question of alcoholisation of patients undergoing substitution treatment and the persistence of significant use of benzodiazepines. For instance, the AIDES survey (AIDES, 2002) carried out in 2001 among patients receiving substitution treatment at treatment centres or in general practice shows that 26% used benzodiazepines and 72% used alcohol. In the same way, the SPESUB survey showed that alcohol dependence originally declared by 20% of patients involved 32% of them 2 years later (Tracqui *et al.*, 1998).

Health insurance (Assurance Maladie) data confirm the existence of significant prescription of benzodiazepines with substitution treatments: in the second half of 2002, over 13 cities (A. Cadet-Taïrou and Cholley, 2004), 47% of patients who had acquired HDB received a prescription for benzodiazepines. Some patients may receive a substitution treatment and benzodiazepines by doctor shopping (since a patient may obtain different products from several different prescribers). However, combined prescriptions from a single doctor are frequent (56% of GPs in a study in the Marseilles district (Ronflé *et al.*, 2001) which showed that HDB/benzodiazepines combination is also a practice of doctors for some patients).

Deaths associated with the presence of HDB were reported by several sources (M. Reynaud *et al.*, 1998; Tracqui *et al.*, 1998; Kintz, 2001). HDB is, in almost all cases, found in association with other substances, particularly benzodiazepines. It is not at present possible to quantify the phenomenon exactly as there have been no systematic samplings. Out of 119 cases of death with presence of buprenorphine (Kintz, 2001) which occurred between 1996 and 2001 and in which it was possible to carry out toxicological analyses, other psychoactive medicines were found to be present in 113 cases (Benzodiazepines, antidepressants, tranquillisers).

The risk of death also seems to be associated particularly with intra-venous injection (Baud, 2000; M. Reynaud *et al.*, 1998; Tracqui *et al.*, 1998) and could be greater in the case of *occasional* combination of substances.

The data available, although patchy, tend however to confirm the existence of a greater risk with methadone than with Subutex® (Auriacombes *et al.*, 2001).

Doctor shopping and parallel market for HDB

In terms of value, HDB is eleventh in the list of medicines refunded in France, at 110 million Euros in 2002 (Assurance Maladie, 2003), and a considerable proportion of the refunds seem to correspond to prescriptions which are not for therapeutic use.

Doctor shopping is when a patient consults several different doctors at the same time for the purpose of obtaining a greater daily dose of medicines than prescribed by a single doctor. It can be linked, to the need felt by the patient for larger doses than prescribed by the reference doctor if he *or she considers this dose to be* too low, especially if he or she is injecting or and multiplying the doses over the day. It can also be a way of obtaining more of the substance in order to resell some of it.

There has been evidence of doctor shopping for several years from data from Assurance Maladie (Cholley and Weill, 1999; Fumeau *et al.*, 2000; Damon *et al.*, 2001; V. Pradel, 2003; Claroux-Bellocq *et al.*, 2003; A. Cadet-Taïrou and Cholley, 2004). The use of doctor shopping for trafficking purposes seems to involve between 6% and 10% of the people who receive an HDB prescription (around 5,000, assumed to be users).

This activity seems to be concentrated in some cities. A study of the 2002 data from 13 cities showed that Paris and its northern suburbs, Marseilles and Toulouse are the places where trafficking is most frequent, while other sites are practically free from it (Table 29). The use of an indicator representing the proportion of HDB potentially dispensed and diverted locally to the black market suggests that the quantities involved are far from negligible in the concerned areas (V. Pradel *et al.*, 2003; A. Cadet-Taïrou and Cholley, 2004). From 21% to 25% of the quantities sold annually in France may be diverted towards the parallel market.

Table 29: Classification of 13 cities according to three indicators showing doctor shopping and diversion activity

	Lille Rennes Metz and Dijon	Nice, Bordeaux, Lyon, Grenoble, Montpellier	Bobigny, Toulouse and Marseilles	Paris
average % of patients who had consulted at least 5 different prescribers	2%	4%	8%	11%
average % of patients receiving more than 32 mg per day	1%	3%	8%	12%
Proportion of HDB potentially diverted	7%	12%	25%	40%

Source: CNAMTS data, OFDT processing (A. Cadet-Taïrou and Cholley, 2004)

The numerous indicators attest to the existence of a parallel market and to easy accessibility. In the specialised drug treatment centres, 10% of patients on buprenorphine in 2002 obtained the treatment illegally (CEIP de Marseille, 2003). In the low-threshold facilities in 2003, 24% of users obtained their supplies exclusively on the parallel market and 25% mixed lawful (prescriptions) and unlawful supplies.

The price of the 8 mg tablet on the black market seems very modest (median price 3 Euros in 2003 (Bello *et al.*, 2004)). It varies depending on the city, from 1 Euro (Paris) to 4 Euros

(Dijon, Bordeaux), according to the intensity of the local market (the pharmacy price is 24.2 Euros for 7 tablets, i.e. around 3.5 Euros per tablet).

The changes in the different indicators over the 2000-2002 period show a significant growth in the phenomenon of diversion (A. Cadet-Taïrou and Cholley, 2004). In 2002, observations by the TREND network showed an increase in the presence of Subutex® on the parallel market, mostly in cities (Bello *et al.*, 2003). Its median price dropped by 50% between 2000 and 2003, which is evidence of the increased availability of Subutex® on the black market over the last few years. These figures led Assurance Maladie to set out a plan in April 2004 which was aimed at reducing polyprescriptions for HDB.

Conclusion: observations which lead to questions

After eight years of important development in substitution treatments in France for methadone and HDB, the current situation appears to be one of contrast.

Compared to the situation which already existed in 1996, the life of very many users has been transformed by the inrush of substitution treatments and the breaking of the vicious circle of dependence, heroin-taking, withdrawal syndrome. Breaking this circle gave both users and those treating them time to seek answers to the social, medical and psychological problems caused by use of substances. So we note with satisfaction that it has enabled opiate-dependent people to have better access to treatment and to improve their social situation, although it can not solve all the problems. For instance, in spite of the shortening of the drug abuse career and greater closeness between users and the treatment system, contamination by hepatitis C persists at a significant level.

At the same time, we note that HDB is the object of significant, increasing trafficking and is extremely available on the black market, that injection of HDB is frequent and is accompanied by injuries which are sometimes dramatic, that addictions to HDB are developing and that deaths have been described which are associated with HDB.

Because the background to its appearance was the struggle between supporters of risk reduction and some specialist workers, HDB is still passionately debated in France. Eight years later, however, we need to find an equilibrium which will enable users who need it to benefit from the positive results, while limiting the negative consequences.

The great availability of HDB on the black market is linked to the relative ease with which several prescriptions can be obtained. Limiting trafficking involves the responsibility of all the actors (patient, doctor, pharmacist, Assurance Maladie). The extent of HDB injection, sometimes by people who are part of a treatment system, poses the question of diversifying the forms of substitution on offer which, in 2004, are still exclusively provided orally. In counterpoint to the almost complete absence of misuse of methadone because of the system under which it is prescribed and its galenic form (syrup), is the role of the HDB prescription treatment system or systems in the misuse recorded.

All these points will certainly be dealt with at the national consensus conference on treatment strategies for opiate-dependent persons, to be held in June 2004.

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12. Alternatives to imprisonment

Policy, organisation, structures

Policy and national strategy

Never since the Liberation have French prisons been so overcrowded, with a record occupation rate of 125% in July 2003 (up to 240% in some remand centres). The public debate which began in 2000 with the publication of the statement by the senior doctor at the Prison de la Santé (Vasseur, 2000) and the reports of parliamentary select committees held as a result of it, describing prison conditions as a real *"humiliation for the Republic"* (Mermaz and Floch, 2000 ; Hyest and Cabanel, 2000), showed that there is consensus on the need to *"send fewer people to prison so that we can provide better prison conditions"* notably by developing alternatives to imprisonment for drug-dependent offenders.

Nevertheless, prison inflation has continued and progressed, in parallel with relative non-enforcement of sentences (the rate of enforcement of custodial sentences in 2003 was estimated to be only 48%[36]). Even more recently, the Warsmann report (2003) established that imprisonment should be reserved for the most serious offences, thus relaunching the debate on the meaning of penalties. So the development of alternatives to imprisonment was recommended again, three years after the recommendations of the reports issued by the Senate and the National Assembly, as one of the "87 concrete proposals" formulated by Warsmann, a member of parliament, to make non custodial sentences more credible so that the courts could more often resort to such sentences.

The expansion of these measures, known as "third way", and particularly those targeting drug-using offenders, has been promoted for around 12 years now[37].. After several parliamentary information reports published in the mid-90s which referred to the inappropriate nature of the prison system for drug addicts, the French governmental three-year action plan on drugs (1999-2001) stated that prosecution and imprisonment should be reserved *"for cases where use is the source of dangers, either for the user himself or herself, or for his or her environment"* (MILDT, 1999, p.58). A circular from the Minister of Justice (17th June 1999) accompanied this public recommendation, inviting public prosecutors dealing with drug users questioned by the police to favour control of local trafficking rather than control of simple use, and alternatives to imprisonment rather than prison sentences, which were felt to be disproportionate for such offences[38]. During the implementation period of the three-year plan, the numbers of prison penalties for drug use actually decreased, from 690 in 1998 to 395 in 2001 (for use on one occasion only) although it continued to be set as a penalty in the courts cases. The alternatives to imprisonment do not seem to have expanded proportionately (see section on implementation of interventions), although it has proved difficult to quantify how often they are used in sentencing and how often they are implemented (see section on follow-up measures). Nevertheless, the development of this type of penalty has been clearly stated as one of the main axes of the national strategy.

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[36] This rate has been issued by the prison services, provided that 89 254 imprisonment penalties were set in 1999 and 60 535 were actually enforced Timbart, O., Lumbroso, S. and Braud, V. (April 2002), Le taux d'exécution des peines d'emprisonnement ferme. Rapport final..

37 The “third way” measures generally refer to the penal measures set as alternatives to prosecution. The alternatives to prosecution do not encompass neither the alternatives to imprisonment nor the non custodial alternative sentences Tournier, P. V. (2002) Alternatives à la détention en Europe, *Questions pénales,* **XV,** (4), 1-4..

38 DACG-DAP-DPJJ circular of 17th June 1999 relating to judicial responses to drug addiction (NOR: JUSA9900148C).

The policy framework for controlling drugs in the coming years has been set in the five-year action plan issued in August 2004: it aims at *"making the justice-health cooperation link more efficient"*, notably by seeking to *"make compulsory treatment more effective"*. The action plan clearly sets a target of "adapting" the existing medical-penal system, notably by redefining the legal framework of the treatment order and the methods for implementing compulsory treatment. It should be noted, however that reflection on future trends has been part of a renewed politico-institutional context, notably because of the law known as "Perben II", which initiated an important reform of the enforcement of sentences[39]. The purpose of this law was to give further means to the Courts to *"effectively control organised crime"* and to *"improve the general functioning of the criminal courts and the prison system"*. Taking these new penal priorities into account, the government undertook a programme to build 13,200 prison places, which seems to contradict the objective of reducing the load of prison establishments[40]. Although the law mentions alternatives to imprisonment, it nevertheless sees them figures them in as part of a more restricted system (in order to improve treatment of prisoners with psychiatric problems or in the form of electronic monitoring), which tends to favour punishment over treatment.

The MILDT is the authority responsible for coordinating and monitoring the statistical follow-up of the penal measures taken in regard to drug addicts so as to refer them to treatment facilities. The aim of its multiannual action plans is to organise the cooperation between the stakeholders involved in the health and prison systems.

Legislation

The French legislative framework is distinguished by the double status it confers on the drug addict: as a user breaking the drugs laws, he or she is considered to be an offender who may be a danger to society, but also as being ill, a danger to himself or herself, and therefore needing treatment. So there is in France a common legislative framework based on the idea of compulsory treatment and which involves both the health system and the courts (article 138 of the Code of Criminal Procedure and article 132 of the Criminal Code). The 31st December 1970 law attempted to resolve this ambiguity by linking the principle of the treatment order to all stages of criminal procedure, from referral to the public prosecutor to the final judgement.

So the drug addict who attends court has the option of escaping from prosecution or imprisonment by undergoing a detoxification programme, which refer to three types of court order:

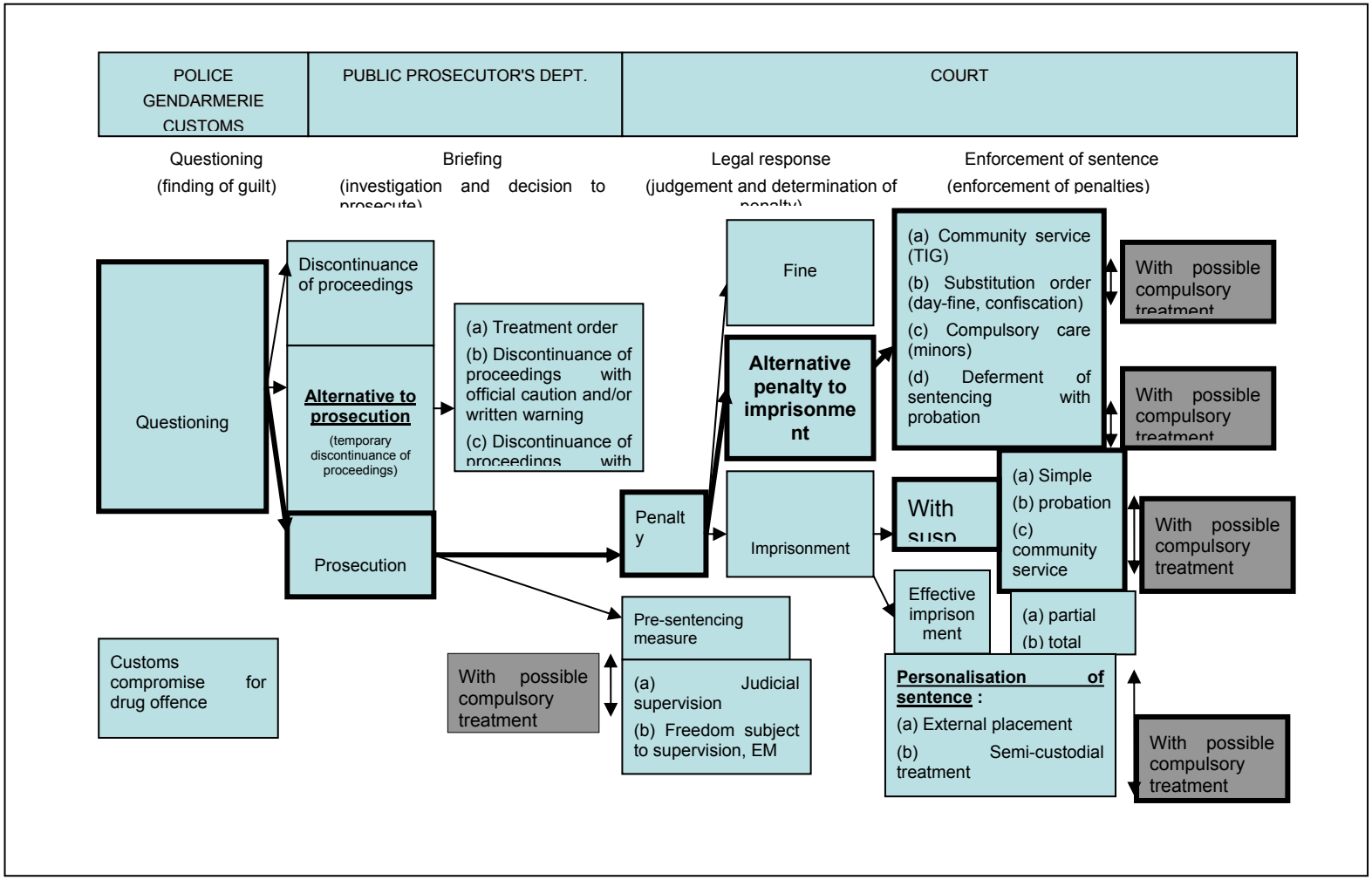
- those made by the Public Prosecutor in which treatment is imposed in exchange for abandonment of prosecution (strictly speaking, *" treatment order"*),
- those made by the investigating courts where it is required as a *temporary protective measure*,
- and those made by trial courts where it is served like a sentence (*compulsory treatment*). It is the latter method which, in the strict sense, falls within "alternatives to imprisonment" with health content.

So in France the "alternatives to imprisonment" describe all measures ordered by the trial court for medical, professional or family reasons. Properly understood, the idea of an alternative to custody therefore excludes such as alternatives to prosecution, required by the prosecuting authorities, upstream in the criminal process, together with measures for personalizing sentences aimed at reducing the duration of a sentence in progress or changing the way in which it is enforced, ordered by the judge responsible for the enforcement of sentences further in the criminal justice process (as indicated in bold type in Figure 2).

[39] Law no. 2004-204 of 9th March 2004 on adaptation of the legal system to evolutions in criminal behaviour, adopted on 11th February 2004 by Parliament (NOR: JUSX0300028L).

[40] This building programme was a result of the general law on the judiciary promulgated on 9th September 2002.

Figure 2: Career of the illicit drug user in the penal system: position of alternatives to custody or imprisonment



Judgements may consist of compulsory treatment in two main, very distinct forms: that of conditional suspension of sentence with probation, or probation (article 132-45-3 of the New Criminal Code) and that of deferment of sentencing with probation (article 132-63 of the New Criminal Code) which may be ordered within the context of personalisation of sentence. It is limited, therefore, to the alternatives to imprisonment with health content.

For instance, when an addiction problem is found in a person who is the subject of a criminal procedure for any offence whatever, compulsory treatment may be ordered by the court in the form of various measures (court supervision, deferment of sentence, probation, community service etc.). The latter measure seems particularly appropriate when the use is linked to the commission of the offence. The compulsory treatment does not then replace the penal measure but constitutes one of its conditions: it is ordered for the benefit of the person and also for reasons of public safety (to prevent a further offence).

Nevertheless, it tends to be difficult to implement this in collaboration with the welfare and health system (see section on implementation of interventions). The development of the "open drug scene" (combining all sentences which replace imprisonment) is therefore part of a will, which has been evident since the end of the 90s, to limit the use of imprisonment for short sentences and to diversify and personalise sentences according to the history, personality and situation of the convicted person.

The law **of 11th July 1975** instituted the first ***alternative sentences*** defined as community sentences that do not involve paying a fine or being locked up - e.g., a curfew order, a drug treatment and testing order, or attendance centre order.

(the day-fine, a little-used sentence which consists of paying a sum to the Treasury, the total amount of which is paid as a contribution over a certain number of days, or confiscation etc.), "substitutes for short terms of imprisonment" which may be "as much of a deterrent as prison sentences, without offering the disadvantages of these"[41]. The community sentence has also been created as a mode of enforcement of suspended sentences with probation.

In **1983**, ***community service*** (TIG) was created: instead of a custodial sentence of three months at the most, the sentenced person may do a number of hours of unpaid work in the community to make up for his or her crime. The order can vary between 40 and 240 hours; it has to be carried out within a year of the sentence. Community Punishment Orders can also be given when a young offender fails to pay a fine.

The law of 11th July 1975 was also aimed at encouraging the use of another type of measure as an alternative to imprisonment: ***personalized sentences***. Unlike the day-fine or community service, the personalised sentence is used as a method of enforcing a prison sentence in which the prisoner sentenced to a term of imprisonment is authorised by the judge to undergo that sentence outside the prison. The following forms of this should be distinguished:

- individualized sentences, according to the characteristics of the offender:

- simple suspended sentence, created in 1891;
- probation, created in 1958: the main "alternative penalty" ordered by the courts, which may take the form of a detoxification programme;
- deferment of sentence with probation, created by the 6th July 1989 law enabling the regional criminal court, after having established the guilt of the accused, to defer the sentencing order subject to the guilty person undergoing, under the supervision of the Judge responsible for the enforcement of sentences, probation (which may also incorporate compulsory treatment) for a maximum period of 12 months, at the end of which the court will decide on the sentence.

- and ***measures to personalise custodial sentences*** ordered by judges responsible for the execution of penalties and subject to a series of constraints which may be health constraints:

[41] Law no. 75-624 of 11th July 1975 amending and supplementing certain provisions of criminal law.

- conditional release under the 14th August 1885 law, which provides a period of supervision after release, appropriate to the profile of drug addicts (including, for example, health monitoring working with the family of the prisoner),

- external placement, which may be subject to health monitoring (this measure is rare for prisoners who are drug addicts),

- semi-custodial sentence which, although it imposes a strict framework, includes assistance to prisoners in social re-integration (this measure is of little benefit to prisoners who are drug addicts).

In the mid-90s, while the increase in the prison population was leading to occupation rates which were much greater than their capacities, the report by Guy-Pierre Cabanel relating to the prevention of reoffending recommended the development of alternatives to imprisonment by improving the existing facilities, notably by introducing house arrest with electronic monitoring (Cabanel, 1996). Following these recommendations, the **19th December 1997 law** provided for the ***electronic monitoring*** of people under court supervision and people sentenced to short prison terms or for whom the remainder of their sentence was not more than one year (which may relate *a priori* to drug addicts sentenced for a simple offence of use, which carries a maximum sentence of one year in prison, but which is in fact more often applied to prisoners considered to be dangerous)[42]. To encourage its wider use, the **9th September 2002 law** made it possible for a person subject to private law to operate the use of electronic monitoring of a person[43].

Even more recently, the **9th March 2004 law** adapting the legal system to evolutions in criminal behaviour , inspired by the Warsmann report (2003), listed alternatives to imprisonment as one of the relevant methods for the prevention of reoffending[44]. However, the guidelines of the law favoured a semi-custodial sentence or electronic monitoring and day-fines, rather than measures with a welfare and health content which had been explicitly indicated in the circular of 17th June 1999 to Public Prosecutors as the specific method of treatment appropriate to drug addiction.

Public debate

Since the middle of the 90s, the question of prison conditions and alternatives to imprisonment has arisen regularly in public debate, often as political changes have occurred. Successive governments have encouraged the production of parliamentary reports and scientific works, which have given rise to new laws. For instance, the first commission relating to controlling criminal reoffending set up by the Ministry of Justice and chaired by Professor Elisabeth Cartier foreshadowed the works of the "RCP" Association (Recherches, Confrontations et Projets sur les mesures et sanctions pénales – Research, comparisons and projects concerning penal measures and sanctions) supported by the office of the Minister of Justice. In 1998, RCP formulated "fifteen proposals for opening up the debate about reform of the methods of implementing custodial measures and penalties", which led to the publication of a special circular on 17th June 1999 promoting alternative measures for penal treatment of drug-dependent offenders.

In the same way, many of the conclusions of the "Farge Commission" on conditional release, set up in 2000, were expressed in the 15th June 2000 law[45]. The reports of the Senate and National Assembly on the prison situation, published on 5th June 2000, dealing in particular

[42] Law no 97-1159 of 19th December 1997 establishing electronic monitoring as a method of enforcement of custodial sentences (NOR: JUSX9601732L).

[43] Law no 2002-1138 of 9th September 2002, the general law on the judiciary (NOR: JUSX0200117L).

[44] Law no 2004-204 of 9th March 2004 adapting the legal system to changes in crime, adopted on 11th February 2004 by Parliament (NOR: JUSX0300028L).

[45] Law no. 2000-516 of 15th June 2000 reinforcing the protection of the presumption of innocence and the rights of victims (NOR: JUSX9800048L).

with the question of alternatives to imprisonment, also contributed to the debate raising the issues of the enforcement and legitimacy of penal sanctions in France. Eventually, most recently, the report of the Parliamentary commission at the Ministry of Justice under Jean-Luc Warsmann, member of parliament for the Ardennes, on "alternative penalties to imprisonment, methods of enforcement of short sentences and preparation of prisoners leaving prison" led to re-examination of the meaning of penalties and formed the basis of some of the guidelines selected for the 9th March 2004 law.

At the same time as Parliament was carrying out these investigations, information given in the media and the actions of activist policy groups and associations contributed to keeping public attention on the meaning of sentencing and renewing arguments in favour of expanding alternatives to imprisonment[46]. So for example, when it appeared at the hearing of the parliamentary commission of enquiry, the International Centre for Prison Studies produced a document bringing together the main points of the facts which it had learned from 1998 to 2000, analysing prison conditions, acts of violence indoors, health, employment, detention on remand, private life and family background, reintegration and alternatives to imprisonment (Observatoire international des prisons (OIP), 2000). This report notes in particular the insufficient use of alternatives to imprisonment: *"although alternative penalties exist in the penal code, they are insufficiently used, or are used for offences which would not always give rise to a term of imprisonment. So instead of ordering a suspended sentence, community service is used".* So the question of the place of alternatives to imprisonment in the prison policy comes up again and again in public debate whenever reports are published or particular events occur which are linked to the difficulties of treating drug addicts in current prison conditions. More specifically, the position in this debate of penal treatment of drug addicts who come before the courts fluctuates according to media attention given to questions linked to the situation of users sent to prison. So for example, when the two parliamentary reports referred to above came out in 2000 this generated questioning about the advisability of imprisoning people suffering from psychiatric problems and/or drug addicts, but, for all that, this did not result in any special parliamentary initiative.

Implementation structure

The law of 1970 and the Public Health Code provide for a large curative and medical section within the penal system. The convicted drug user is considered within this system to be an offender but also to be ill: he or she undergoes treatment under supervision of the health authorities (Bisiou and Caballero, 2000).

The option offered to drug addicts to avoid prosecution or imprisonment by undergoing a detoxification programme is implemented under two types of referral via the penal system. In the first case (alternative to prosecution, upstream of the trial), by order of the Public Prosecutor, the drug user questioned by the police and passed on to the Public Prosecutor's department may benefit from referral to the welfare and health authorities rather than prosecution; the medical option thus offered has the advantage of facilitating voluntary treatment. In the second case (compulsory treatment ordered by the trial court), the health referral is ordered by the judge: it is compulsory for the convicted person, who runs the risk of imprisonment if he or she does not comply with the penalty. In this system, a relapse by the offender is considered to be not only a "breach of contract" leading to the lifting of the conditions precedent which justify non-imprisonment, but also as an indication of relapse and therefore of probable further offence. The examining judge, the judge in a youth court and the trial court, have the power to order any person brought before the court for unlawful use of drugs to undergo a detoxification programme.

[46] We quote examples from the League of Human Rights and the Federation of Associations for Prison Actions and Justice (FARAPEJ).

Article L.3424-1 of the Public Health Code (formerly art. L.628-2) states that those questioned by the police for unlawful use of drugs, if it is established that they are undergoing medical treatment, may be ordered by the examining judge to follow a detoxification programme. The examining judge must hold an inquiry to seek proof of the offence and also the reasons for prescribing a cure, if necessary. The cure must be undertaken either in a specialised establishment, or under medical supervision, but under the supervision of the court, which is kept informed of its progress and results. This supervision is quite strict, since it applies to the drug addicts assumed to be the most dependent. In practice, a fraction of the drug addicts questioned by police who happen to have refused or abandoned a cure (treatment order) and who have been referred several times to the health authorities are placed under investigation.

In the special case of treatment orders, the examining judge may extend the cure by a period of medical and welfare surveillance, together with rehabilitation measures. On the other hand, if the drug addict complies with the treatment penalty ordered, the court dealing with the case may not pass a sentence for unlawful use.

The trial court (police court or regional criminal court in cases of offences against the drugs laws) also has the power to order various measures for treatment of drug addicts referred to them (usually in these cases this will be compulsory treatment). Article 3424-2 of the Public Health Code (formerly art. L.628-3) states that it may order persons placed under investigation for unlawful use of drugs to attend a detoxification programme, by confirming the order of the examining judge or extending its effects. This measure may be declared to be immediately effective as a protective measure. The treatment regime and methods are similar to those previously described. In particular, the trial court may order the cure as the principal measure by deciding that there are no grounds for passing the sentences provided for in article L. 3421-2 (formerly art. L.628). It may also order this cure as an alternative to imprisonment in addition to a fine or a suspended sentence. The courts may use deferment of sentencing or stay of proceedings, a period then being set for the user to undergo detoxification.

In the case of ***users who are aged under 18***, the treatment may be prescribed by the judge in the youth court in the preparatory stages of the case, or by the youth court at the time of judgement. However, in practice the courts use this only to a limited extent, favouring minors being taken into custody earlier, at the initiative of the Public Prosecutor's department. Paradoxically, the concern for medical and psychological treatment for minors has the consequence of increasing the rigour of procedures. In order to attempt to control the increase in the use of drugs (particularly cannabis) among adolescents, there are various provisions which reinforce the coercive measures (following the example of the immediate placement centres dedicated to accepting offending minors without delay in order to carry out an assessment so that they can be referred: a psychological, school, professional, family and health assessment within a period of three to four months)[47].

But health intervention for drug addicts within a judicial context has proved to be complex. The double problem of drug addiction and delinquency inherent in the subject involve a multitude of stakeholders (health, welfare and criminal workers) who have distinctly different methods of operation and who may sometimes be set in contradictory professional cultures. One of the conditions for the success of alternatives to imprisonment with a health content is therefore good collaboration, at departmental level, between court and health authorities. The particular mission of the court/health interface is to assess the situation of the person concerned, prepare the bridge to the sector which will take responsibility and to ensure periodical monitoring, in close cooperation with the social workers appointed by the court.

[47] Guideline circular relating to judicial protection of young people of 24th February 1999 (NOR: JUS F 99 500 35 C).

Since it has been acknowledged that many of the factors identified as leading to lack of success of alternatives to punishment are linked with the lack of coordination across the different sectors involved – namely justice, health and social welfare –, an institutional coordination framework was created to try and improve welfare and health referral for substance users brought before the court. That is the reason why the sub-regional conventions between health and justice services on addictive substances were promoted in 1993 to enable improvements to be made to treatment of drug users and to promote measures for prevention of use as judicial measures[48]. This was extended to all sub-regional areas (French 'départements') in 1999[49] in the form of service agreements signed between departmental authorities and treatment establishments responsible for providing treatment to those referred to them by the courts.

Interventions

Types of intervention

The variety of structures and methods used demonstrates that treatment is essentially a medical act which falls outside the authority of judges. From outpatient treatment (which does not involve hospitalisation and allows the subject to move freely in society) to treatment with methadone, through therapeutic communities and visits to a psychiatrist, the range of treatment on offer has diversified as the "risk reduction" policy has developed. Detoxification treatment remains the reference standard but "maintenance" or "low threshold" treatments exist which are not aimed at medium term withdrawal but which attempt to resocialise users and assist in their medical supervision.

Four phases of the basic treatment principles have been defined:

- ***reception and pre-treatment***, first contact of the drug addict with treatment: within the narrow framework of alternatives to imprisonment, this phase is disappearing in favour of the court order;
- ***withdrawal and treatment,*** generally carried out in hospital, involving a withdrawal phase of several days thanks to "detoxification beds", immediately or after "maintenance" with methadone, then a treatment phase after withdrawal to consolidate the detoxification;
- ***convalescence***, in an accommodation centre, with a host family, in a therapeutic apartment or a production workshop is the longest phase; the presence of a specialist doctor in drug addiction in an approved centre, capable of settling a system for assessment of the treatment, is recommended in the circular from the Ministry of Health, which organises the convalescence phase[50]. The decree of 26th February 2003 set the minimum conditions for organisation and operation of the specialised centres for drug addicts (CSST) which are responsible for ensuring medical and psychological monitoring of the drug addict and preparing him or her for reintegration[51];

[48] Interministry letter of 14th January 1993 relating to [implementation] of agreements on objectives for the control of drug addiction.

[49] Guideline for the implementation of departmental agreements on objectives for control of drug addiction, MILDT, 12th February 1999.

[50] Circular of 3rd July 1979 from the Ministry of Health, BO Min.santé (Min. of Health Official Bulletin), No.80-3 text 17892.

[51] The activities and method of operation of the CSST were originally defined by Decree no. 92-590 of 29th June 1992. This Decree was rescinded and replaced by Decree no. 2003-160 of 26th February 2003 setting the

- ***Assistance with reintegration*** completes the procedure, enabling the patient to organise his or her life away from drug addiction, particularly from a social and professional point of view.

The solutions offered by the CSST's "in the community" are developed either as "outpatient", that is, in non-residential treatment centres (201 centres of this type deal with withdrawal and psychological monitoring), or in centres with accommodation (which provide treatment after withdrawal as half-way houses, in several ways: in one of the 46 group accommodation centres, mainly in rural locations, therapeutic apartments, host families). In addition, there are 16 treatment centres within prisons in France (drug addiction units) which provide psychological support and preparation for release at remand centres.

The treatment programmes developed as alternatives to imprisonment may therefore include daily attendance as an outpatient at a hospital without appointment, hospitalisation to initiate or continue a treatment procedure, or monitoring in general practice with supply of sterilised equipment and treatment of specific pathologies (HIV, hepatitis). The CSST's may therefore treat drug addicts who have been brought before the courts at different stages of their treatment career, which allows real monitoring and the possibility of moving on from one stage to another.

In addition, other treatment methods are emerging: for example, the drug addiction operational unit at the Marmottan hospital was one of the first structures to offer selective withdrawal to polydrug addicts. So for instance, heroin addicts who are users of other products (alcohol, medicines, cocaine, crack etc.) are hospitalised and treated using a substitution treatment which will not be covered here, which is followed at the same time as withdrawal from all other products.

There is less residential treatment available overall today (fewer than 600 places), although the needs and types of populations concerned are increasing. Bearing this in mind, the five-year action plan (published August 2004) has raised the idea of diversifying and breaking new ground in the treatment offered by developing programmes without substitution, notably the therapeutic communities which will be developed over the next few years for "users with a relatively short history with the products or, on the other hand, for people with repeated treatment failure who need a longer-term and more structured treatment than outpatient monitoring". The system is not well-developed in France (50 places) because of changes of stance by the authorities in the mid-80s[52], but this treatment method advocating rehabilitation through employment and "return to nature" may be promoted as part of an experiment piloted by the MILDT and the Ministry of Health providing an average capacity of 30 places. An ethical code and a professional charter will be drawn up on the basis of French and foreign experiences to look ahead at the benefits and limits of this model (indications and contra-indications, proportion and type of supervision, occupational and therapeutic activities to be promoted, criteria for monitoring and assessment, co-ordination with care services, place of medical and psychiatric treatments etc.).

The system needs to be reinforced by opening up post-withdrawal places, as part of a new therapeutic framework, particularly through self-help groups for ex-users (for example on the Narcotics Anonymous model). Moreover, on the basis of an analysis of European practices,

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minimum conditions for organisation and operation of specialised centres for drug addicts (Official Journal no. 50 of 28th Feburary 2003)

[52] Some official reports appeared which emphasised questionable practices in this field; several of them even classified one of the associations running the therapeutic communities, "le Patriarche", as a sect (Report of the Auditor-General's Department on the system for control of drug addiction, 1998; Guyard Report on sects on behalf of the National Assembly Select Committee on the financial, property and fiscal position of sects and their economic and financial activities, report no.1687, June 1999).

the plan recently issued provides for promotion of experimentation with medical prescription and controlled delivery of opiates by injection (heroin under medical supervision), particularly for drug addicts whose treatment fails repeatedly. Two medically-supervised programmes will probably be set up, on the basis of a specification and research protocol making use of the knowledge from research carried out in other European countries (Germany, Spain and Switzerland).

Implementation

The first statement is that of the weakness of the prosecutions following an arrest. The rate of drug use offences brought to justice remains rather low. The data produced by the Public prosecutor's departments on a national basis do not allow to draw any further conclusions. Nevertheless, there are available data in the computerized courts based in the Ile-de-France region. Those make it possible to make out the detail and proportion of alternatives to custody. In these courts, the so called "third way" measures would be the most current penal response given to drug use arrestees (Infostat Justice, juillet 2004).

The second statement stresses that the treating referrals can be made by justice services even if the offender is not suspected of any drug use offence.

One can notice however that the structure of the sentences passed against simple drug users shows a relatively high rate of imprisonment in view of the measures provided for by the Criminal Code and the recommendations made to prosecutors to limit its use (almost 15% in 2001, compared to 45% for fines and 40% for alternative sentences, compulsory care measures or discharges). In addition, the actual efficiency of alternatives to imprisonment, an essential condition of their effectiveness, is not always guaranteed. Moreover, it is difficult to quantify these measures in view not only of the difficulty of isolating from the statistics all the measures relating to alternatives to imprisonment for a specific category of offence (drug use), but also the difficulties of cross-checking between the mass of statistics issued by the Ministry of Justice and those from the Ministry of Health.

Nationally, taking all offences together, alternatives to imprisonment have been gradually eroded over the last few years: in 2001, for example, the courts delivered 18,000 community service orders (TIG), which implies a drop of 25% over five years. For offences against the drug law, the drop was approximately proportional; for convictions for use, it dropped a little less markedly. In the same way, probation, which exempts the accused from prison on condition that he or she complies with certain obligations (particularly compulsory treatment if the accused is a drug addict) has also been neglected, notably because, according to the Warsmann report (2003), of "too great a delay in enforcement" and "scarcely discernible control of obligations". So there is an increasingly smaller proportion of community service orders or probation orders involving compulsory treatment given against offenders against the drugs laws.

In regard to drug users in particular, fines continue to represent more than a third of convictions: the proportion of them has even increased over the last few years. It should be pointed out that the use of "day-fines", payments of money replacing days of detention, has increased notably in the last few years, also following the philosophy of using financial penalties to the detriment of alternatives with a health content. It has increased particularly in convictions for use, among the alternative sentences passed for one instance of unlawful drug use as a single offence (Table 30).

Table 30: Drug use, changes in police questioning and judicial convictions (standard and alternative sentences) from 1998 to 2002

Year	Users questioned	Treatment orders	Total number of convictions	Number of convict-ions	Convictions with imprison-ment	%	Convictions with imprison-ment with probation (compulsory treatment)	Convict-ions with fines	Convictions with discharge	Convictions with alternative sentences (community service order, day-fine)	Convict-ions with compul-sory care measures (minors)
			drug use	***single offence of use***							
1998	74,663	4254*	6622	3452	690	20.0	632	1204	79	287	185
1999	80,037	4183*	7000	3287	577	17.6	463	1306	93	294	163
2000	83,385	3606*	6762	3397	486	14.3	453	1387	56	304	215
2001	71,667	4038*	5689	2933	395	13.5	346	1317	79	290	139
2002	81,254	4068	4803	not available							

N.B.: since 1998, court statistics have only included treatment orders actually implemented by the DDASS's (Departmental Directorates of Health and Social Affairs), i.e. when the user has made contact with the health authority (they no longer show the number of those ordered by the Public Prosecutor's Department).

Source: OCRTIS (Home Office) statistics and statistics on convictions (Ministry of Justice)

Using the limited statistical information available on the only alternatives to imprisonment ordered for offending users, we may estimate that the number of prison sentences is almost as high as that for alternatives to detention with a treatment component. This statement should be seen in the light of more reliable figures and tempered by analysis of the way in which sentences are enforced: in effect, during their "criminal career", some users who have come before the courts are given an external placement order which involves compulsory treatment, or have their sentence interrupted before it officially ends by a release on parole of a therapeutic nature etc. Moreover, among people who have committed an offence of drug use (a single offence or one combined with others) and are given a prison sentence, some do not serve it: they may in fact be convictions in absentia, and therefore not enforceable and liable to being opposed, or even convictions with imprisonment which may be converted into community service orders.

What should be emphasised, however, is that the chances of the offender's benefiting from an alternative to prison vary depending on the seriousness of the "other offences". Indeed the dispute about unlawful drug use is distinguished by a high prevalence of "multi-offences": in 2001, for example, one in five offences of use punished with a conviction comprised a single use (2,933 cases out of 13,615 convictions). Now faced with multiple convictions (4 out of 5 convictions linked to use), judges tend to have a more repressive attitude: their severity is conditioned by the nature of the other offences of which the drug user is guilty. The user who is a drug dealer (use and trafficking, carrying and/or supply) is likely to be much more severely punished than the user liable for possession and/or acquisition.

Although the method of statistical registering of these special measures of the courts has not been improved, and the treatment of users brought before the courts under this system has been the subject of a special procedure. After the court authorities have passed the sentence, actual enforcement of the measure theoretically depends on the health authorities: now the statistics from the treatment centres seem to show, if we look at the entrants or in the active patients file, that insufficient numbers of users were sent to the CSST treatment centres by the court. The departmental agreements on objectives (CDO) were designed to bring these two links in the penal chain closer together. These agreements are signed by the Prefect and the Prosecutor and are intended to apply locally, ensuring that convictions accompanied by compulsory treatment, community service orders suitable for drug addicts and measures for personalizing sentences in prison in particular, will be effective. The CDO system has granted additional financing to potential operators of the treatment system (specialised drug addiction centres, accommodation centres, legal network centres etc.) which has actually enabled a growing number of users brought before the courts to access drug treatment services for the first time, at different stages of the criminal procedure, from the pre-sentencing phase to the assistance on release from prison (6,500 in 1998, 37,500 in 2001). Nevertheless, this process to motivate the health-justice collaboration has been of little benefit to alternatives to imprisonment, since in 2001, only 11% of people treated under the system were given a community service order or a suspended sentence and deferment of sentencing with probation (which even so represents around 3,500 users)[53]. The alternatives to imprisonment have therefore been the poor relation in a system which has, overall, functioned well.

Financing

Theoretically, the general treatment of drug addicts, whether or not ordered by the court authorities, is the responsibility of the CSSTs, (specialised centres for drug addicts) and the centres for risk reduction funded by the Ministry of Health. In 2001, the number of centres attached to the health services was 263, two thirds of which were managed by [welfare] associations. They are established in 90 French departments. The amount of the annual budget allocated to them has diminished since 1999 (118 M€ in 2002 compared to 130 M€ in 1999).

[53] Source: annual MILDT statements for the years 1998, 1999, 2000 and 2001.

However, service agreements with treatment centres, entered into as part of the departmental agreements on objectives (CDO), have provided a specific addition to this ordinary financing. Financing of the CDO comes from decentralised credits provided for the centres by the Interministerial Mission for the Fight against Drugs and Drug Addiction (MILDT), at a level which increased up to 2001, from 2.5 M€ in 1998 to 4.9 M€ in 1999, 7.1 M€ in 2000 and 9.9 M€ in 2001 (incorporating the European Social Fund for these last two years). This expansion of means has resulted in a growth in the number of centres financed: 203 in 1999, 286 in 2000 and 333 in 2001.

All centres for the treatment of drug addiction, together with the CDO system itself, have been funded by the Caisse nationale d'assurance-maladie (National Health Insurance Fund) (CNAM) since 2003, as are the outpatient alcoholism treatment centres (CCAA).

Available estimates show that under the CDO, more than a third of alternatives to imprisonment with a health component are provided for by the specialised alcohol network, one third by the CSST, ahead of the accommodation and social rehabilitation centres (16%), the specialised justice network (13%) or other types of structure (Gorgeon *et al.*, 2003).

Monitoring the measures

Within the criminal system, the enforcement of custodial sentences is under the responsibility of the Public Prosecutor's Department; probation and community service orders are the responsibility of the Judge responsible for the execution of sentences (JAP), and fines are the responsibility of the tax authorities. Currently, each stage of the criminal procedure is monitored by an independent management system which does not communicate with the others.

The two possible stages of health and welfare guidance within the criminal process are on the one hand, treatment orders; on the other hand probation and community service orders. In both cases, the "bridge" towards the treatment system is supposedly guaranteed by the court departments responsible for implementation and control of compulsory treatment. However, one can observe a relative "wastage", estimated at 30%, with treatment orders (Setbon and De Calan, 2000) of users throughout all the stages which are supposed to lead them from guidance by the Public Prosecutor's Department to the DDASS services then into the designated specialised centre for drug addicts which will provide treatment for a user brought before the courts. In the case of compulsory treatment ordered after a judgement, the assistance is provided by a ***referral judge***, who follows up the case throughout its course (judge responsible for execution of sentences, youth judge, investigating judge or remand judge) and who ensures, if necessary, that the social workers appointed by the court (prison integration and probation service, judicial youth protection facility, associations for judicial review) are actually involved. Because it is supervised throughout the process, compulsory treatment does not exhibit the same weaknesses as the treatment order: it is assumed to be more efficient, although there is no accounting system which can currently assess it thoroughly.

In the absence of an integrated information system, it is not possible continuously to monitor a case from the announcement of conviction to enforcement of the sentence. In order to remedy this situation, either court investigations have to be carried out, or good use must be made of the existing statistical data, allowing for biased information which is often difficult to interpret

Specific target groups

At the time when the CDO system was relaunched in 1999, assistance to young users was established as a core target. Nevertheless, there are no treatment programmes as alternatives to imprisonment which specifically target certain categories of the population.

Specific projects

We may consider that electronic monitoring falls under the pilot projects launched in relation to alternatives to imprisonment but this system does not come under health authorities and is not intended particularly for drug addicts. It is difficult today to evaluate the implementation and effectiveness of electronic monitoring: this device was introduced in 1997 and was first tried out in October 2000 in four sites, where 20 bracelets were tested. Since the electronic monitoring experiment began, 1,384 prisoners have been fitted with the device (to 15th December 2003). On 15th December 2003, 312 were simultaneously fitted with the device. Between the 1st and 15th December 2003, 63 new electronic monitoring orders were granted. The general law on the judiciary (LOPJ[54]) expects 3,000 people to be electronically monitored by 2007.

Concerning alternatives to imprisonment with a health dimension, there are no specific projects currently in progress.

Quality assurance

Guideline document

In regard to alternatives to imprisonment targeted at offending users, no specific guideline document has been issued, apart from the circular of 17th June 1999 which fell into disuse following the change in government majority in April 2002.

Evaluation and research

In the field of alternatives to custody, there has not been any overall evaluation but a number of specific evaluation results. The most relevant study in this field is that of M.Setbon and J. de Calan dealing with drug treatment and testing order (Setbon *et al.*, 2003). This research work has proved that few drug users actually access treatment even when referred to by justice and when they do, a small amount of them benefit from an appropriate healthcare treatment.

The evaluation carried out by CESDIP in 1999 on the "compulsory treatment of drug addicts on probation" sought to explore the significance of compulsory treatment within different contexts (ILS (drug offences) or thefts, province or Paris region), from the study of three cohorts of people subject to this obligation (Simmat-Durand and Toutain, 1999). The report reached conclusions on three points: the first objective of compulsory treatment, which encourages offenders to take up treatment through a compulsory contact with the treatment system, is "a delusion" since it refers to populations who have been drug addicts for a long time and whose degraded state of health has occasioned many contacts with those involved in health care. The second objective, from the point of view of the Ministry of Justice, the prevention of reoffending, is the most difficult to evaluate, although it seems clear that the objective of avoiding imprisonment has not been achieved since half the population studied had had repeated terms in prison. Finally, the third objective, defined *a posteriori,* of controlling social exclusion, seems to be contradicted by the significant proportion within the population studied of people in a situation of prolonged exclusion from the employment market (almost 60%). In all the evaluations carried out, analyses were done without reference to well-identified indicators of success.

Apart from the specific studies relating to compulsory treatment prescribed by the court system, various works or evaluations on connected subjects in turn raise the question of their legitimacy, efficiency or effectiveness, without however developing operational indicators of

[54] Law of 9th September 2002.

success, or definitive conclusions on the chances of reoffending of a user treated within the prison system.

The effectiveness of quasi-obligatory approaches to treatment is a recurrent question, since it has not been scientifically proved. The majority of specialist psychiatrists and psychologists consider that coercion is not very favourable to success of the treatment. Moreover, the mechanisms provided for the law of 1970 are often criticised: they show that the law of 1970 is a law of justice, not of therapy, since the judge is at the centre of the system, deciding to apply the repressive measure, the therapeutic measure, or both. Many doctors stress the difficulty of creating a relationship of trust with the patient in a court-ordered context, where the patient is there because of a criminal sentence and the doctor is placed in the position of an auxiliary of the court. Some works consider that the difficulties arising from the contradiction between medical and judicial imperatives may be resolved by better cooperation between the two institutions in the field. Bearing this in mind, the CDO system was created, then evaluated and presented as an essential tool for development of the justice/health collaboration.

The evaluation of the CDO system carried out in 2002 showed that the system met the objectives assigned to it by allowing better health identification of people who come to the notice of the courts, a greater range on offer of welfare and health treatment for these people and entry to a network reinforced by court and health authorities. These improvements have particularly affected the pre-sentencing phase, although alternatives to prison have only developed slightly in favour of this system.

More generally, some researchers wonder about the actual usefulness of alternatives to imprisonment in terms of opportunity, or even reintegration[55]. Moreover, the question of the effectiveness of alternatives to imprisonment with a health dimension comes up against the obstacle of the actual question of the quality of treatment for heroin users. If the positive impact of new methods of intervention aimed at reducing all health risks in drug use may be grasped through favourable activity and epidemiological indicators (number of syringe exchange programmes and low threshold services, proportion of doctors prescribing substitution drugs, sales of syringes, volume of medicines prescribed, drop in mortality by overdose, reduction in the prevalence of HIV, retention of patients on substitution drugs in treatments, compliance by HIV-positive users with treatments for HIV infection, etc.), evaluation of the system highlights the persistent problems: a continuing high incidence of contamination by hepatitis C (HCV), still too frequent injection of Subutex® (buprenorphine), diversion of some of this to be sold on the street, unequal distribution of methadone and buprenorphine, need to improve welfare and psychiatric treatment, discontinuity of treatment when entering or leaving prison, insufficiency of solutions in the event of failure of treatment or of severe polydrug addiction. The difficulty of defining effective interventions with compulsive crack or cocaine users probably does not favour their use in a problem context which is worsened even further by legal constraint. And lastly, the report of the member of parliament Warsmann (2003) emphasised that the loss of "credibility and efficiency" of alternatives to imprisonment has led magistrates to neglect it and to use prison even more.

[55] For example, Pierre-Victor Tournier, Director of Research at the CNRS and President of the French Criminology Association, reflected in a preliminary study about "promising examples in regard to crime": "Would a person sentenced to community work (TIG) have been sentenced to imprisonment if the community work had not existed in the legislation? Would he not, in fact, have received a simple suspended sentence, or even a fine?" In the same way, for alternative measures, we may imagine, writes Tournier, "that the investigating judge would not use detention on remand if the judicial review had not existed in law." "If this is the case," he concludes, "this judicial review is not playing its role as an alternative to custody," but "is enabling the net of social control to be widened" (quoted in the review "Combat face au Sida" (The fight against AIDS), No. 35 - March 2004).

Finally, although it does not relate to research or even to evaluation strictly speaking, the recommendations in the parliamentary reports regularly called for on the question of prison conditions, enforcement of sentences etc. are a crucial source of debate and reforms. The Warsmann report referred to above, for instance, notably proposed, in order to relaunch alternatives to imprisonment, the development of a "relaunch plan" and diversification of measures for community service (TIG). It suggested calling the accused, at the time of the hearing, to the department responsible for setting up the community service (TIG) or the probation, who would immediately specify to them the obligations to which they were subject. In the case of community service orders, it pleaded for a "national relaunch programme" so that they would no longer be confined to the highways and parks sector but would be opened up to the tertiary sector and hospitals. The report also recommended ensuring an increase in probation, enforcing short sentences outside prison, in a day prison or by electronic monitoring, and controlling reoffending by reducing sudden release from prison by re-evaluating the system for personalising sentences for prisoners (declining): in 2002 in fact, only 5,056 releases on parole were granted (which is a drop of 14% in one year), which represents a historic minimum since their creation in 1885. In regard to this, the Council of Europe named France in September 2003 as one the countries with the lowest rate of use of release on parole in Europe (9% of those leaving prison). In order to avoid sudden release which is prejudicial to reintegration of prisoners, the member of parliament wanted the law to adopt "the principle of progressive enforcement of the sentence": it should be possible to serve the last three months of a sentence of from 6 months to 2 years in prison, or the last 6 months of a sentence of from 2 to 5 years, either in a day prison, on an external site or under electric monitoring.

So studies are in progress, in a fragmentary way, but they take little note, and even less in a specific way, of the health dimension of the sentence relating to offending users.

Training

The ability of the public authorities to make collaboration between health and court authorities succeed is expressed partly in the effort put into training for members of the judiciary on the one hand, and health professionals on the other hand. This point was one of the priorities proposed from 1998 to 2001 by the MILDT and may be followed up in the next five-year plan. In May 2004, a seminar organised by the Ministry of Justice (National Training School for the Judiciary, National Training School for Prison Administration, Centre of Sociological Research on law and penal institutions) entitled "Prosecute and punish without imprisonment. Alternatives to imprisonment" put the question again in terms of opportunity and applicability, but the specific problem of drug addicts in the prison environment was not mentioned.

At the same time, those involved in health were pursuing their efforts to raise awareness about the need to develop the interface with the judicial authorities. For several years, a regular training course run by the National Association of Drug Addiction Workers (ANIT) has dealt with relations between the CSST and the judicial and prison services. The various problems brought up relate to organisation of the partnership or to partnership difficulties between the different services in relation to standard criminal procedures (judicial review, probation, personalisation of sentences etc.) Actual cases, directed towards the treatment system, are presented.

The results of this training have, to date, not been evaluated.

So, although the public debate on the advisability of using alternatives to imprisonment for punishing drug users has steadily widened, although less since 2002, these recommendations seem to have had relatively little influence at this stage of observation of trends in crime. One of the issues at stake in this coupling of repression and treatment is the

public effort made in encouraging and supporting collaboration of the judicial and health authorities which began with the departmental agreements on objectives. According to the evaluation report for the three-year plan currently in effect, one of the axes of progress identified was certainly personalisation of the shorter sentences, where these relate to drug addicts, incorporating compulsory treatment, particularly for release on parole and semi-custodial sentences (Setbon *et al.*, 2003).

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Glossary

Convicted person: person detained in a prison following a definitive conviction.

Remand centre: accepts accused persons and convicted persons who have less than one year of their sentence left to serve

Community: all activities of the prison integration and probation service (SPIP) and associations for judicial review which contribute to implementing the decisions of the court which must be enforced totally or partially outside prisons. The purpose of these measures is to enable better integration of people into society. They may be taken before judgement (judicial supervision), at the time of judgement (probation) or be a method of enforcing the prison sentence (semi-custodial sentence)

Accused: person held in a prison who has not yet been judged or whose conviction is not yet definitive

Semi-custodial sentence: method of enforcing a sentence which allows a convicted person to carry on a professional activity outside prison, to follow an education or training course, or even to benefit from medical treatment. The convicted person must return to the day prison at the end of these activities

Community service (TIG): This sentence, an alternative to imprisonment, was adopted in 1983 and requires the will of the convicted person if it is to be enforced. It relates to unpaid work of a duration of 40 to 240 hours maximum for a local authority or organisation.

13. Public nuisances: definition, political trends, legal problems and intervention strategies

Definition

In relation to drug use, the concept of "public nuisances linked to drug use" is not currently used in France although it is used in other European countries (Netherlands, Belgium). So the idea is not a matter for public discussion, except on occasions and this article will examine this further. Some behaviours or actions listed in the definition adopted in the Netherlands[56] have in fact been studied or covered in the media but without a clear link being made to the idea of nuisances: lack of safety, socially-unacceptable behaviour, groups gathering in public places, damage, squats, abandoned objects linked to use … some of these are listed by Renn and Lange (1995) as being the main "nuisances relating to drug users"[57].

Measures taken

Unlike other European countries such as the Netherlands and Belgium, France has no legislation specifically aimed at controlling "public nuisances linked to drug use".

Some regulations applying to public events thus control behaviour or acts linked to drug use which may occur at these events.

After action by some prefects and mayors against events that were part of the techno movement, especially large "teknivals" involving more than 20,000 people, an amendment was tabled to the law on everyday security with the aim of regulating these gatherings. Members of Parliament rejected it in June 2001 but the bill was taken up again by the government in the autumn of 2001 and passed. Article 53 of the law on everyday security (LSQ[58]) therefore gives a legal framework for the gatherings currently known as "rave parties". The organisers of these events must now declare their plans to the prefects of the departments in which the rave parties are planned. Decree no. 2002-887 of 3 May 2002 states the procedures for this declaration (OFDT, 2003, p.57).

Since 2002, numerous observers (Bello *et al.*, 2003) have highlighted the effects of this new regulation in the urban and party contexts on: the general organisation and type of event organised; the use of psychoactive substances and trafficking, particularly its visibility.

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[56] Initially, nuisances linked to drugs were limited to petty offences committed by drug users. The idea was then extended to refer to behaviour of users which non-users perceive as disturbances of public order and which lead to a feeling of lack of safety. They therefore refer to a very wide range of deviant behaviours linked either to codified rules such as those of the criminal code, or to more or less explicit social rules. Martineau, H. and Gomart, E. (2001) Les nuisances liées aux drogues : la politique néerlandaise, *Questions pénales,* **14,** (1).

[57] The following are the nuisances generally related to drugs: used syringes abandoned in public places; drugs being used in public places in full view of passers-by; drug dealing (trafficking) in public areas; groups of users "hanging around" in public areas, particularly the entrances to apartment blocks; users begging; users offering substances to passers-by. Renn, H. and Lange, K.-J. (1995) Quartiers urbains et le milieu des drogues, une enquête comparative des nuisances dues aux scènes ouvertes de la drogue dans les grandes villes européennes, Commission Européenne.

[58] Law no. 2001-1062 of 15 November 2001/NOR: INTX0100032L

The same law on everyday security prohibits occupation of common areas in residential buildings (article 52 amending article 126-1 and 126-2 of the building and housing code[59]). But it is still too soon to know the impact of this measure on the gatherings at which it is aimed.

Within the more specific context of the fight against drugs and prevention of dependencies, the 1999-2001 three-year plan (extended to 2002) acknowledges that treatment centres and drop-ins in areas where there are marginalised drug users *"are often not welcomed by local residents who are often poorly-informed and will not put up with very marginalised addicts gathering in one place"* (MILDT, 1999) and recommends the creation of mobile neighbourhood teams in the districts where there are most problems.

Five teams have been created so far. Their objectives are firstly to improve treatment of active, marginalised users and secondly to make the risk and damage reduction policies more acceptable to residents through information and dialogue. The first mobile neighbourhood team ("Coordination 18"), created in 1999, was evaluated in 2000-2001 (detailed results below).

Results/evaluation

The various types of nuisance are not generally covered by descriptions of criminal acts and are rarely the subject of formal complaint to the authorities; police statistics are not therefore the best option for the study of this phenomenon. Moreover, nuisances generally occur within a very localised geographical area and it is not therefore possible to generalise from results observed locally. Finally, as with the feeling of lack of safety, it is likely that some categories of the population are more sensitive to this (Peretti-Watel, 2000; Lagrange, 2001; Robert and Pottier, 2001; Pottier *et al.*, 2002). It is also known that perceptions of drug users by the general population are based on *"the way in which individuals judge deviance in all its forms, and therefore the value which they attribute to the established social order which this particular deviance transgresses"* (F. Beck and Peretti-Watel, 2000).

Since it was not possible to rely on current administrative statistics (police, courts) to qualify the extent of the nuisances caused by drug use, a review of the national literature was carried out. The information gathered on the subject was patchy. The rare field surveys that exist are very localised and little reliance can be placed on a few statements and some evaluations of perceptions.

"Open drug scenes" in urban areas

Evaluation of nuisances in the Goutte d'Or district

A survey carried out in 1994 in 6 European cities (Amsterdam, Hamburg, Rotterdam, Paris, Barcelona, London) was intended to determine to what extent the population of a certain district (Goutte d'Or in the case of Paris) was exposed to "open drug scenes"[60] and to what extent this is considered to be a nuisance (Renn and Lange, 1995). Residents, traders, police and drug addicts, prostitutes and homeless people were questioned in each district.

[59] "Art. L. 126-2. – The owners or managers of residential buildings or their representatives who fulfil the obligation stated in article L. 127-1 may also, where the common areas of the building are occupied by persons who hinder access and free movement of the tenants or prevent the proper functioning of safety and security systems or prejudice the peace of the premises, call the police or gendarmerie to restore peaceful enjoyment of these premises"

[60] An "open drug scene" or "drug scene" is a place where users and dealers meet and settle in large or small groups, an area which is generally accessible and where other people can easily see them.

In this district of the 18th arrondissement of Paris, 87% of residents had noticed drug users and 73% cited these users as a general nuisance. Incidents which were considered to be the main nuisances were: first, drug use in public (94.5%), then abandonment of syringes (94%) and finally the presence of drug users in the lobbies of apartment blocks (93.3%). It was found that nuisances perceived by the residents were closely linked to the visibility of the "open scene". In the case of the Goutte d'or, the level of nuisance[61] resulting from the presence of the open scene was, however, considered relatively low (just as in Barcelona and London), which was not the case in some districts in Dutch cities.

The main limitation of this type of survey is that its results reflect a local situation at one particular time, which cannot in any way be generalised to refer to all districts with problems.

Investigations carried out at TREND sites

By means of ethnographic investigations, several TREND (recent trends and new drugs) sites were able to show the existence of "open drug scenes" although problems with local residents were not emphasised (except in only one or two districts of Paris). The visibility of cannabis (use and trafficking) was reported at numerous sites (Rennes, Toulouse, Paris, Bordeaux, Lyon, Guyana and Martinique). There is little record of open scenes for heroin, although open scenes for Subutex® are more common (Lyon, Paris, Toulouse, Bordeaux and Rennes).

The reappropriation of public space: the anti-crack community group

In 2001 an "open scene" for crack was set up in a street in the 19th arrondissement of Paris. *"In order to reconquer the public space and have the open scene broken up by the police"* (Collectif anti-crack, 2002), traders and residents united to form the anti-crack community group. After 4 demonstrations, the group achieved closure of the "scene" and since 2002 have organised street patrols by family men living in the district. Their objectives are:

- to ensure that the residents reclaim the public space in the district;
- to organise young people in the district against drugs;
- to extend the preliminary exchanges undertaken with the drug addicts;
- to close 3 crack *"dens"* into which trafficking has withdrawn and to rehouse the families living there.

Following these measures *"the public space is largely reclaimed .... there is still trafficking in the streets but it moves around, sometimes on one corner, sometimes on another ... there is still trafficking but it is on the defensive and relies on backstreet bases (crack houses) which must be destroyed"* (Collectif anti-crack, 2002). The community group was dissolved in September 2002, after the crack dens had been closed and families rehoused.

Socially-unacceptable behaviour

A survey carried out for the Paris police headquarters in 1998 questioned Parisians about the most "tolerable" socially-unacceptable behaviour[62].

Although the quality of the wording leaves much to be desired, it appears, fairly logically, that attacks on individuals are the least tolerable, followed by material damage. Abandonment of used syringes, the only nuisance directly linked to drug use about which the Parisians were questioned, was considered to be intolerable by the Parisians (10% stated it was tolerable) but there is no indication of to what extent the respondents were exposed to it.

[61] Nuisance is measured using the average of subjective impressions of unpleasant incidents reported by individuals. The average value of the statistical distribution of unpleasant incidents represents the level of nuisance in the city.

[62] Survey carried out by IFOP, January 1998. 1,004 people representative of the population of Paris, aged from 18 years upwards and cited in Roché, S. (2000) La théorie de la "vitre cassée" en France : incivilités et désordres en public, *Revue Française de Science Politique*, **50,** (3).

For purposes of comparison, soliciting and sexual exhibitionism were also classified as intolerable (10% stated that they were tolerable) but less than insults and provocations (12% stated that they were tolerable), damage to vehicles (16% stated that this was tolerable), noise (28% stated it was tolerable) and gatherings of unemployed individuals in public places or the common areas of residential buildings (44% stated that these were tolerable).

Introduction of the risk reduction policy

"Coordination 18" was set up in 1999 with the objective of ensuring social mediation between the parties concerned by nuisances linked to drug addiction (drug users, local residents, traders etc.) and the police. Between 2000 and 2001, one year after it was set up, the functioning and actions of this structure were evaluated (Fayman *et al.*, 2003). It is evident that the on-the-spot team were not sufficiently motivated in their social dialogue with local residents although it seems to be agreed that this is the best solution to bring local residents to accept the establishment of low-treshold structures in their environment.

Two years after this evaluation, Annick Lepetit (Mayor of the 18th arrondissement between 2001 and 2003, Member of Parliament for Paris since 2002) observed that the residents' attitude had changed. This was due in particular to the presence of "Coordination 18" in this district, thus confirming that dialogue and collaboration are absolutely essential elements in the risk reduction policy: *"the residents have changed: today it's the nuisances they complain about, not the presence of low-threshold structures. This hasn't happened by chance but through dialogue and information"* (Bonnin, 2002). These comments should be interpreted in the light of the events of April 2003: the residents of the district, with the support of the council of the arrondissement, opposed the establishment of a care centre for the homeless which also included a syringe exchange programme, and won their case.

The conflicts which can arise between residents and promoters of risk reduction services relate first and foremost to the right to urban space (Benech-le-roux, 2001) and are better known under the terms NIMBY[63]. According to Gibier (2002, p.37), the appearance of the NIMBY syndrome in the French population *"does not mean that the average Frenchman is 'against treatment' and therefore 'for repressive measures' […] but for a simplistic view of treatment which makes the problem disappear and makes it invisible. And that's hardly realistic"*.

The various surveys carried out among the general population on the opinions and perceptions of French people about drugs indeed show solid support for the various measures of the risk reduction policy (F. Beck and Peretti-Watel, 2000; F. Beck *et al.*, 2003). In regard to *"the law provides for the creation of treatment centres for drug addicts in collaboration with city councils, hospitals, the police and residents"* only 4.7% of those surveyed answered that they were against it, but when the establishment of a reception centre was made more real and they were asked *"and would you agree to the opening of such a centre in your district?"*, 21.5% were against it.

Information about "public nuisances" linked to drug use is rare and inadequate. However, surveys on opinions and perceptions about illicit drugs, together with some cases which have been covered in the media, have shown that the NIMBY syndrome exists here and there. The next victim survey (2005) to be carried out jointly by the National Institute for Statistics and Economic Studies (INSEE) and the National Delinquency Monitoring Board (OND) should provide new information since it is planned that the questionnaire will include

[63] NIMBY: “not in my back yard”. The idea behind the "NIMBY" syndrome is simple: "the establishment of any community facility creates nuisances for local residents close to the facility even if they gain direct advantage from it. Their natural, selfish reaction is then to oppose the project and to demand that it is established elsewhere." Jobert, A. (1998) L'aménagement en politique ou ce que le syndrome NIMBY nous dit de l'intérêt général, *Politix*, (42), 67-92.

questions about the visibility of acts linked to illicit drug or alcohol use and the degree of inconvenience caused[64].

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[64] The victim survey is a questionnaire (variable part) in addition to the fixed part of the continuous household survey (EPCVM) carried out by INSEE.

PART C: BIBLIOGRAPHY AND ANNEXES

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15. Annexes

15.1 List of standard tables and structured questionnaire relating to the different sections of the report

Section	Subject	Standard Table	Structured questionnaire
Section 1	National policy and context		
Section 2	Drug use in the population	no. 1: population survey on drug use no. 2: school survey on drug use (ESPAD)	
Section 3	Prevention		no. 22: universal school based prevention
Section 4	Problem drug use	no. 7: national prevalence estimates no. 8: local prevalence estimates no. 17: new developments in drug consumption	
Section 5	Drug-related Treatment	no. 3: characteristics of people starting treatment no .4: evolution of treatment demand Treatment demand indicator (TDI) no. 21: treatments availability	
Section 6	Health correlates and consequences	no. 5: drug-related deaths no. 6: evolution in drug-related deaths no. 18: mortality among cohorts of users no. 9: prevalence of infectious diseases (HIV, HCV. HBV)	
Section 7	Responses to health correlates and consequences	no.10: syringes exchange distribution and sale	no.23: harm reduction measures to prevent infectious diseases among drug users
Section 8	Social correlates and consequences	no. 11: arrests for drug law offences no. 12: drug use among prisoners	
Section 9	Responses to social correlates and consequences		
Section 10	Drug Markets	no. 13: quantity and number of seizures	

15.2 List of tables

15.3 List of graphs

15.4 List of figures

15.5 List of text boxes

15.6 List of acronyms

AAH	Adult disability allowance
AFP	Agence France presse
AFSSAPS	French Health Products Safety Agency
ANIT	National Association of Drug Addiction Workers
ANPAA	National Association for the prevention of alcoholism and addiction
ASSEDIC	French unemployment benefits department
ASUD	Drugs users' self-support association
BD	Becton-Dickinson
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 contracts
CepiDC	Centre for epidemiology of the medical causes of death
CESC	Health and Citizenship Educational Committees
CESDIP	Centre for sociological research on the law and penal institutions
CHRS	Accomodation and rehabilitation center for persons of no fixed abode
CILAD	Interministerial committee for the fight against drugs
CIRDD	Centres for information and resources on drugs and dependencies
CLJ	Youth recreation centres
CLS	Local security contracts
CMU	Universal health cover
CNAM	National Health Insurance fund
CNAMTS	National State Health Insurance Office for Salaried Workers
CNRS	National centre for scientific research
CPAM	French government department dealing with health insurance
CPDD	Drugs and dependencies project leaders
CREDES	see IRDES
CRIPS	network of Regional Information and AIDS Prevention centres
CSAPA	Centres for Treatment, Assistance and Prevention of Addiction
CSST	Specialised centers for drug addicts
DAP	Prison service (Ministry of Justice)
DATIS	national "Drugs, alcohol and tobacco information service" telephone helpline
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)
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 and welfare; Ministry of social affairs, labour and solidarity)
DU	drug user
EMCDDA	European monitoring center for drugs and drug addictions
ENAP	National training school for prison administration

ENM	National training school for the Judiciary
EPCVM	Continuous household survey (INSEE)
EROPP	Survey on Representations, Opinions, and Perceptions Regarding Psychotropic Drugs (OFDT)
ESCAPAD	Survey on Health and Consumption on Call-Up and Preparation for Defence Day (OFDT)
ESPAD	European School Survey Project on Alcohol and other Drugs (INSERM-OFDT-MJENR)
FARAPEJ	Federation of associations for prison action and justice
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
FNPEIS	National prevention and health education and information fund
FRAD	Anti-drug shift trainers (Gendarmerie)
GDP	Gross domestic product
GIR	Regional intervention groups
GMR	General mortality register
GP	general practitioner
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HDB	High dose buprenorphine
HIV	Human immunodeficiency virus
ICD	International classification of deseases
IDU	injecting drug users
ILS	Infringement of drug law / drug offences
INPES	National Institute for Health Education and Prevention (former CFES)
INSEE	National institute for statistics and economic studies
INSERM	National Institute for health and medical research
INVS	National health watch institute
IRDES	Institute for research and economic documentation on health (formerly CREDES)
IT	Treatment order
JAP	Judge responsible for the execution of sentences
JAPD	Day of defense preparation
LOLF	institutional law relating to the finance laws
LOPJ	General law on the judiciary
LSQ	Law on everyday security
M€	Million(s) of Euros
MA	Marketing autorisation
MDM	Médecins du Monde (non gouvernemental organisation)
MDMA	Méthylènedioxymétamphétamin
MILAD	Mission for the Fight Against Drugs (Ministry of Interior)
MILDT	Interministerial mission for the fight against drugs and drug addiction
NIMBY	not in my back yard
NSP	Needle and syringe programme (also NEP: needle exchange programme)
OCRTIS	Central Office for the Repression of Drug-related Offences
OFDT	French monitoring center for drugs and drug addiction
OND	National deliquency monitoring board

OPPIDUM	Monitoring of illegal psychotropic substances or those that are used for purposes other than medicinal (CEIP)
OR	Odd ratio
PACA	Provence-Alpes-Côte d'Azur region
PAEJ	Youth Reception and Counselling Centres
PFAD	Anti drug trainer / police officer
PRAPS	Programmes for access to preventive measures and health care for people in vulnerable situations
PRS	Regional health programmes
PY	person year
RCP	Research, comparisons and projects concerning penal measures and sanctions
RECAP	Common data collection on addictions and treatments
RMI	Minimum income
RNIPP	National register of persons (INSEE)
RRD	Risk and harm reduction
SEGPA	General and professional teaching section
SIAMOIS	System of information on the accessibility of injection equipment and substitution products (InVs)
SINTES	National poison/substance identification system (OFDT)
SMPR	Regional hospital medical/psychological services
SMR	Standardised mortality rate
SPIP	Prison service for integration and probation
SREPS	Regional Health Education Schemes
TDI	Treatment demand indicator
THC	Tetrahydrocannabinol
TIG	community service
TREND	Recent trends and new drugs (OFDT)
UCSA	Outpatient treatment/consultation unit
UMP	Union for a popular movement
UPS	Care unit for prison leavers
ZEP	Priority education zones
ZUS	Sensitive urban areas