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

ENGLISH VERSION

REITOX

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Summary

While no new information is available to describe trends in the adult population, specific surveys shows that among the young people aged 16 years old, there are large reductions in the spread of tobacco and cannabis use and a stabilisation or even a fall in alcohol drunkenness, while among the young people aged 17 and 18 years old, there is a fall in regular alcohol use and a modest increase in the number of cases in which 5 glasses of alcohol were drunk on a single occasion. Average ages for experimenting with tobacco and cannabis have risen for the first time in eight years.

The final results of a new study carried in 2005-2006¹ gives a central estimation of 230,000 (estimate range between 210,000 and 250,000) problem drug users in France in 2006, of which half involved in opiate substitution treatment. A study conducted by the OFDT in 2009 gives an estimation of 120,000 people who have used opiate substitution drugs in the first half of 2007.

In terms of offences, crime and sentencing, we note that the figure of arrests by the police, gendarmerie and customs for drug related offences continues to rise, as do the figures of sentencing, and of France's prison population.

In terms of trends, the availability of heroin and cocaine continues to rise, while the loss of interest in ecstasy, amphetamines and other synthetic drugs is confirmed. Seizures have increased, the rise being mainly due to seizures of crack cocaine, and secondarily to cannabis resin.

In terms of public policies, the recent public authorities' policy has gone in line with the plan adopted in 2006, the addiction treatment and prevention plan for 2007-2011 (which only concerns treatment and prevention). In 2008, a governmental plan to fight drugs and drug addiction was drawn up for the years 2008-2011. The first measures to implement that plan have been decided.

A Justice circular dated 9 May 2008², has stated once more that all persons using relatively small amounts of illegal drugs may be sentenced to penalties. If not sentenced, adults or minors caught possessing marijuana have to complete a drug awareness course at their own expense, with costs not exceeding 450 Euros.

The MILDT and the Directorate-General of Labour have decided to develop a concerted and determined policy in collaboration with employers, trade unions and the various associations involved, aimed at significantly reducing the use of alcohol, psychotropic substances or narcotics by the various participants in the world of work.

The Ministry of Education has introduced a compulsory programme for the prevention of addictive practices, from the fifth year of primary school through to university. A national plan to combat hepatitis B and C (2009-2012) was launched in February 2009.

France has introduced new drug testing procedures on roads since the summer of 2008: oral fluid testing devices for the on-site screening of drivers suspected of having taken drugs have been authorized since 2005, but they have only been actually used since 2008.

The reform of hospitals has been prepared during 2008 and voted in 2009, although the implementation decrees have not been published yet.

Chapter 1: A circular (may 2008) has stated once more that all persons using even relatively small amounts of illegal drugs may be sentenced with penalties. April 16, 2008 decree states that drug treatment and screening orders must now be delivered within a 6-month period, and can be

¹ The New Multicentric OFDT Study (NEMO) carried in 2005 and 2006 in order to produce local estimates prevalence of the problem use of opiates, cocaine, other stimulants and hallucinogens in six French urban areas (Lyons, Marseille, Metz, Rennes and Toulouse) and in an overseas department (Martinique).

² Circulaire CRIM 08-11/G4-09.05.2008 relative à la lutte contre la toxicomanie et les dépendances (NOR JUS D0811637C).

renewed three times. A circular of February 2008 establishes the centres de soins, d'accompagnement et de prévention en addictologie (Addictology Treatment, support and Prevention Centres, CSAPAs) to replace the centres spécialisés de soins aux toxicomanes (Specialised Centres for Drug Addicts, CSSTs) and the centres de cure ambulatoire en alcoologie (Outpatient Alcoholism Treatment Centres, CCAAs). An interministerial circular of February 2008 give details on the extension of clinics for young drug users, extending regional coverage of therapeutic communities, improving the content and continuity of the treatment provided to drug users in penal environment.

Chapter 2: There is no new available information on trends in drug use among the adult population. But surveys have shown (among the youth aged 16 years old) large reductions in the spread of tobacco and cannabis use, and also a stabilisation or even a fall in alcohol drunkenness. Among the young people aged 17 and 18 years old, there is a fall in regular alcohol use, a modest increase in the number of cases in which 5 glasses of alcohol were drunk on a single occasion, and the increase in the spread of cocaine, amphetamines, crack, heroin and GHB, although the use of these products remains marginal. Average ages for experimenting with tobacco and cannabis have risen for the first time in eight years.

Chapter 3: Concerning selective prevention, for the first time ever, people from French Overseas Departments and Territories, on the one hand, and foreign residents on the other, will constitute the specific target public of media campaigns. The minimum age for the purchase of alcohol has been raised from 16 to 18 and binge drinking is on the spot. An interministerial circular published by the end of 2008 aims at consolidating the network for counselling and support for parents (REAAP), created in 1999 in order to boost the parents skills and responsibility to prevent drug use.

Chapter 4: The final results of the NEMO study allows to give an estimate range between 210 000 and 250 000 of problem drug users in France in 2006 (a central estimation of 230,000), of which half involved in opiate substitution treatment. It is estimated that 120 000 people have used opiate substitution drugs in the first half of 2007.

Chapter 5: It is possible to estimate the number of people who sought help in the outpatient CSSTs in 2007 for their problems with illegal drugs at approximately 90,000. The number of people accommodated in residential treatment centres appears to be very low (fewer than 2,000). In those CSSTs located in penal establishments, the number of people welcomed for problems with illegal drugs is 4,700. In 2008, 140 outpatient CSSTs participated in RECAP, equivalent to 65 % of all outpatient treatment centres. Around 41,000 patients started a new episode of treatment in one of these centres during the year. Those persons receiving treatment for the first time in their life accounted for 29 % of all new patients seen. The proportion of first-time treatment patients with opiates as the main drug was much lower than for all patients (33% vs 41%). Injecting was much less frequent in this group than among all treatment patients taken as a whole (13% vs 26%).

Continuing increase in the average age for all patients beginning a new course of treatment, and for patients having never before been treated, has been noticed. This ageing effect appears to be related to a reduction in the percentage of 15- to 24-year-olds, and particularly the 15-19 age group, coupled with an increase in the number of people aged 40 and over.

With regard to the main drugs involved there was a very slight increase in the percentage of cocaine and crack, which rose from 5.7% in 2005 to 7% in 2008. The percentage for heroin fluctuated around 32% and that for cannabis around 40%. With regard to patterns of use, the data for the years 2006 to 2008 show a slight reduction in injection in the "other opiates" category (43% of injectors in 2006 compared to 40% in 2008).

Chapter 6: Although the number of new aids cases among intravenous drug users has been continuously falling since the mid-1990s, the prevalence of HIV among patients having already injected and of known serology is almost 8% and that of hepatitis C is 51%. The number of drug-related deaths has continued its upward trend since 2003. It may be explained by the wider availability of heroin and cocaine which prices have fallen considerably in recent years, by the misuse of substitution treatment and, in terms of demands, by the appearance of new users associated with the party scene.

Chapter 9: The increase of arrests has been of 31% between 2007 and 2008, the vast majority of which are arrest for “One off” use of narcotics (85%). Sentencing has also increased notably between 2006 and 2007 (32% increase). France’s prison population continued to rise: on 31st December, 2006, among the 41,920 detainees sentenced, 5,751 detainees had been sentenced for a drug-related offence as their main offence, accounting for 14% of the prison population.

Oral fluid testing devices for the on-site screening of drivers suspected of having taken drugs have been introduced in the summer 2008. The Ministry of Justice set up a monitoring system to assess the implementation of the courses over the first year, during the last three trimesters of 2008 and the first trimester of 2009. A survey carried out in 2007 showed an increase in access to methadone in prisons.

Selected issue, chapter 11: Today, it can be said that the cannabis market in France is a market reaching maturity. Apart from the high level of demand being met, a number of factors point to the fact that cannabis, or more precisely the market for THC, has made the transition from a monopolistic market to a competitive market, benefitting from technical innovations, and experiencing price variations and the differentiation of products based on their quality.

Selected issue, chapter 12: The drug issue appeared in France at the end of the 1960s, and was seen as a problem essentially affecting young people at the time. Data available for the period 1993-2007 reveal a marked trend in the ageing of drug users seeking help in the specialised centres, the proportion of those aged 40 or over increasing from less than 4% to over 21%. Drug use, initially a symptom of troubled youth, progressively became a sign of the social crisis which affected France at the end of the 1970s and in the 1980s. The image, albeit very patchy, which emerges from the information available in the TDI on users aged 40 or over in contact with the care system is one of a population mainly with problem opiate and cocaine use.

Part A: New developments and trends

1. Drug policy: legislation, strategies and economic analysis

1.1. Introduction

National policy: background information

The legal framework

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

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

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

The list of substances covered by the 1970 law (order dated February 22, 1990 establishing the list of substances considered as narcotics) is constantly evolving and regularly includes the addition of new substances recognised as posing a danger by order of the Ministry of Health, following proposals from the general director of the French Health Products Safety Agency (Agence française de sécurité sanitaire des produits de santé, AFSSAPS)³.

For a brief presentation of the penal aspects of drug use in France, please refer to the article by Marie-danielle BARRE (Barré 2008).

National action plan, strategy, evaluation and coordination

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

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

Economic analysis: budget, public expenditure and social costs

The main expenditure in the fight against drugs concerns the credits from the Ministry of Health and Social Protection and those from the MILDT. The costs for the specialised care centres for drug addicts are paid by the national social security insurance.

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

Public expenditure for all drugs considered together stood at 1,159.12 million Euros for the year 2003. Most expenditure concerned illegal drugs (approximately 80%), with the lowest proportion being devoted to tobacco (less than 5%). Finally, the percentage of expenditure devoted to the fight against legal and illegal drugs was 0.33% of total public spending in 2003. The social cost of alcohol, tobacco and illegal drugs accounted respectively for 2.37%, 3.05% and 0.18% of GDP in 2000 (KOPP and FENOGLIO 2006).

1.2. Legal framework

1.2.1. Laws, regulations, directives or guidelines in the field of drug issues (demand and supply)

The Prevention of Delinquency law of March 5, 2007 (NOR: INTX0600091L) focused on the treatment of delinquency among minors. It also included new measures concerning the penal response given to drug offenders, such as drug awareness training courses⁴. As stated once more in the Justice Circular dated 9 May 2008⁵, all persons using relatively small amounts of illegal drugs may be sentenced to penalties. If not sentenced, adults or minors caught possessing marijuana have to complete a drug awareness course at their own expense, with costs not exceeding 450 Euros. The MILDT has produced a 22-page guide to help professionals implement the drug awareness drug training courses (<http://mildt.systaliu.org/article6147.html>). This guide has been sent to the "MILDT project managers" and the CIRDD managers.

In addition to this extension of the range of possible alternatives to prosecution for drug offenders, the implementation conditions for drug treatment orders ["injonctions thérapeutiques"] and screening have been modified by the April 16, 2008 decree⁶. Drug treatment and screening orders must now be delivered within a 6-month period. They can be renewed three times.

1.2.2. Laws implementation

In February 2008, a circular from the Ministry of Health established the Centres for Treatment, Assistance and Prevention of Addiction (centres de soins, d'accompagnement et de prévention en addictologie or CSAPAs) which replace the Specialised Centres for Drug Addicts (CSSTs) and the Outpatient Alcoholism Treatment Centres (CCAAs)⁷. This circular described the process for converting the CSSTs and the CCAAs into CSAPAs, explaining the role of these new establishments and defining the regional medico-social addictology treatment system. One of its appendices described the "clinics for young users", the role of which has been modified. A decree of January 24, 2008⁸ further clarified the operating and financing conditions for these centres for treatment, assistance and prevention of addiction.

The provision of health and social care

A joint circular from the MILDT/Ministry of Health and Sport⁹ explains the methods for the implementation of the measures concerning treatment, social integration and harm reduction

⁴ DÉCRET N° 2007-1388 DU 26 SEPTEMBRE 2007 PRIS POUR L'APPLICATION DE LA LOI NO 2007-297 DU 5 MARS 2007 RELATIVE À LA PRÉVENTION DE LA DÉLINQUANCE ET MODIFIANT LE CODE PÉNAL ET LE CODE DE PROCÉDURE PÉNALE.

⁵ Circulaire CRIM 08-11/G4-09.05.2008 relative à la lutte contre la toxicomanie et les dépendances (NOR JUS D0811637C).

⁶ Décret n° 2008-364 du 16 avril 2008 relatif au suivi des mesures d'injonction thérapeutique et aux médecins relais (NOR : SJSP0769782D).

⁷ Circulaire n°DGS/MC2/2008/79 du 28 février 2008 relative à la mise en place des centres de soins, d'accompagnement et de prévention en addictologie et à la mise en place des schémas régionaux médico-sociaux d'addictologie

⁸ Décret n° 2008-87 du 24 janvier 2008 relatif au fonctionnement et au financement des centres de soins, d'accompagnement et de prévention en addictologie (NOR: SJSP0763284D).

⁹ Circulaire interministérielle n°dgs/mc2/mildt/2009/63 du 23 février 2009 relative à l'appel à projet pour la mise en oeuvre des mesures relatives aux soins, à l'insertion sociale et à la réduction des risques du plan gouvernemental de lutte contre

mentioned in the government's addiction care and prevention plan 2008-2011, covering medico-social measures in the addictology field (CSAPAs, CSSTs, CCAAs¹⁰, -, Reception and Harm Reduction Support Centres for Drug Users – CAARUDs, and Therapeutic Communities). The circular states that these measures will be introduced via various calls for projects, in order to be able to select operators for the following activities:

- Creating new clinics for young users (consultations jeunes consommateurs or CJsCs), providing suitable regional coverage, including in rural areas.
- Experimenting with advanced consultations via the CSAPAs in centres welcoming young people, with the aim of developing networking and knowledge transmission.
- Extending the regional coverage of the therapeutic communities with the opening of new therapeutic communities.
- Improving the content and continuity of the treatment provided to drug users in penal environments, particularly through the creation of short, fast access reception programmes for those leaving prison, in existing social and medico-social establishments with accommodation provided, working closely with the hospital in the area in which the prison is located. This involves the creation of collective accommodation units with around 10 places each, which will provide an immediate reception centre for detainees leaving the prison system, with no gaps between the date on which the ex-prisoner leaves prison and the date on which he is welcomed in the centre, allowing for the provision of support and the creation of medico-social and integration networks.
- Experimenting with a specific reception scheme for women in the outpatient CSAPAs and in the CAARUDs. This involves setting aside certain hours of the day in the CSAPAs or the CAARUDs for women, or the provision of dedicated premises allowing specific women-only reception services with suitable reception measures, in order to enable female addicts to have access to treatment, to improve their overall psychological condition and to reduce the risks related to the use of psychoactive substances, in addition to facilitating the monitoring of pregnancies, etc.
- Providing a CSAPA with a mobile team with the aim of improving the manner in which mothers and their children are welcomed and treated in the various health and social facilities.

The treatment of minors in detention facilities

An interministerial circular¹¹ recommended that the doctors in charge of the UCSAs (outpatient treatment/consultation units) and psychiatrists draw up a common treatment programme adapted to minors held in detention facilities. In doing so, they were asked to "identify abusive usage patterns and addictive behaviour" as the interministerial memo of August 9, 2001 had already recommended.

The fight against "drug precursors"

An order issued in late 2008¹² regarding the application of article 18 of law number 2008-650 of July 3, 2008 concerning the fight against the trafficking of doping agents allows the government to take the necessary measures needed to make the legislation applicable to chemical drug precursors more effective, and to adapt this to European law. This includes organising the control of precursors which may be misused to illegally produce narcotic or psychotropic substances; implementing measures aimed at enabling companies to cooperate with the public authorities by informing them

les drogues et les toxicomanies 2008- 2011 concernant le dispositif médico-social en addictologie (NOR : SASP0930143C).

¹⁰ Circulaire n°DGS/MC2/2008/79 du 28 février 2008 relative à la mise en place des centres de soins, d'accompagnement et de prévention en addictologie et à la mise en place des schémas régionaux médico-sociaux d'addictologie

¹¹ Circulaire interministérielle n° DGS/DHOS/DAP/DPJJ/MC1/2008/158 du 13 mai 2008.

¹² Ordonnance n° 2008-1340 du 18 décembre 2008 relative au contrôle de la fabrication et du commerce des précurseurs de drogues (NOR: ECEZ0821796R).

of any suspicions regarding any unusual or suspect orders received; enabling law enforcement units to carry out investigations based on this information with a view to intercepting any individuals seeking to obtain precursors with the aim of producing drugs; giving the relevant departments of the Ministry of the Economy, Industry and Employment the legal powers they require in order to carry out checks in companies or during the distribution process for precursors, and finally, punishing any failings vis-à-vis the obligations provided for under European law and national legislation¹³.

Parental Support Networks (Réseaux d'écoute, d'appui et d'accompagnement des parents - REAAPs)

One of the themes of the 2008-2011 addiction care and prevention plan involves "boosting parental responsibility" and supporting parents in their role as educators when dealing with young drug users. Following the family conference of June 28, 1998, an initial circular was drawn up in 2006 concerning the creation of Parental Support Networks (REAAPs - Réseaux d'Ecoute, d'Appui et d'Accompagnement des Parents)¹⁴. The purpose of the network is to encourage co-ordinated action, the sharing of know-how and experience, and the emergence of new projects aimed at parents). It is based on local initiatives, often carried out by associations or local authorities. In 2008, a new circular was issued to encourage the expansion of this scheme¹⁵. It reiterated the main principles behind the REAAPs and their key areas of involvement: "the REAAPs have a general prevention and support role vis-à-vis the parents of children up to the age of 18. The actions carried out as a network are aimed at supporting the abilities of parents through dialogue and discussion, particularly during key stages of their children's development, at times when parental authority may be tested to the full". The circular also stressed the need for organisation at both a regional and national level. Finally, it stipulated the terms for the financing of parental support activities by the DDASS (Departmental directorate of health and social affairs).

Changes to the list of products classified as narcotics

In 2009, the Ministry of Health and Sport scheduled a range of cannabinoid substances as narcotics (JWH-018, CP 47,497, and their equivalents: C6, C8 and C9, and HU-210), sold under the name of "spice"¹⁶. This decision was made following a proposal from the French Health Products Safety Agency (AFSSAPS) after the issuing of an opinion by the National Commission on Narcotics and Psychotropic Substances (Commission nationale des stupéfiants et des psychotropes). This decision was taken following several reports of plant mixtures being used as cannabis substitutes and sold as incense on several websites, under the names "Gorilla", "Spice" and "Sence".

The fight against doping

The Central Office for the Fight against Environmental and Public Health Infringements (Office central de lutte contre les atteintes à l'environnement et à la santé publique), which was created in 2004 was given a new mission in 2009 in order to combat doping¹⁷. It has authority in the anti-doping field when the substances used are not included among those listed as narcotics by order of the health ministry.

¹³ Report to the French President concerning order number 2008-1340 of December 18, 2008 regarding the control of the production and sale of drug precursors (NOR: ECEZ0821796P).

¹⁴ Circulaire DIF/DAS/DIV/DPM n° 99-153 du 9 mars 1999 relative aux réseaux d'écoute, d'appui et d'accompagnement des parents (NOR : MESA9930091C).

¹⁵ Circulaire interministérielle n°DIF/DGAS/2B/DAIC/DGESCO/DIV/2008/361 du 11 décembre 2008 relative aux Réseaux d'Ecoute, d'Appui et d'Accompagnement des Parents (REAAP).

¹⁶ Arrêté du Ministère de la Santé et des Sports du 24 février 2009 modifiant l'arrêté du 22 février 1990 fixant la liste des substances classées comme stupéfiants, **publié au Journal officiel du 27 février 2009**.

¹⁷ Décret n°2009-459 du 22 avril 2009 modifiant le décret n°2004-612 du 24 juin 2004 portant création d'un Office central de lutte contre les atteintes à l'environnement et à la santé publique.

Additionally, a law has been voted concerning the fight against the trafficking of doping agents¹⁸. It seeks to improve the effectiveness of anti-doping measures, firstly by boosting health protection measures for sportspeople and, secondly, by clarifying the responsibilities and liability of the various international and national bodies handling the fight against doping. It takes full account of the recent changes occurring internationally, and particularly the creation of the World Anti-Doping Agency, the recognition of the World Anti-Doping Code by all international federations and the signing of the Copenhagen declaration by 184 states.

1.3. National action plan, strategy, evaluation and coordination

1.3.1. National action plan and/or strategy

The MILDT's 2008 annual performance statement reflects the main objectives of the national anti-drug policy as described in the 2008-2011 government plan (please see NR 2007). It reiterated that the goals are:

- The construction of a structured drug prevention policy based on the objectives of the government plan (for example, the introduction by the Ministry of Education of a compulsory programme for the prevention of addictive practices, from the fifth year of primary school through to university).
- Where health and social care is concerned, the consolidation of harm reduction activities now enshrined in law and a search for new forms of treatment other than substitution.
- Observance of the law (with the underlying goal of harmonising penal practices, in order to provide a systematic, graduated and adapted legal response, particularly for minors).
- Boosting the fight against trafficking (for example, by reorganising the specialised departments of the national mission for the control of chemical precursors, the gendarmerie, the police or the customs department, and increasing the MILDT's drug support funds in order to better equip the units with modern anti-trafficking resources).
- A transnational approach to the fight against drugs.

A national plan to combat hepatitis B and C (2009-2012) was launched in February 2009. This includes a programme in the field of illegal drugs, and particularly opioids. Some 500,000 adults in France suffer from hepatitis B or C (280,000 and 221,000 respectively in 2004) and these two viruses cause approximately 4,000 deaths a year according to the General Health Department (Direction générale de la santé - DGS). The 2009-2012 hepatitis plan commits a sum of €4 million per year for 4 years, and seeks to "reduce morbidity and mortality levels related to chronic viral hepatitis B and C, through a combination of improved prevention and easier access to screening while improving access to effective treatment and financing". This is based on five key areas: prevention, screening, treatment, the detainee population and a fifth, more forward-looking theme combining monitoring, research and assessment. The allocated budget is considered insufficient by the harm reduction associations, the latter stressing that "this is not even equivalent to the cost of 500 hepatitis C treatments a year"¹⁹. The key objectives of this plan include a greater role for screening and, in particular, a 100% refund of screening costs for hepatitis B (compared to the current level of 65%). The aim is to increase the number of people with serological markers aware of their infection from 57% to 80% for hepatitis C and from 45% to 65% for hepatitis B.

Finally, during the French presidency of the European Union between July 1 and December 31, 2008, a new anti-drug action plan (2009-2012) was adopted.

1.3.2. Implementation and evaluation of national action plan and/or strategy

¹⁸ Loi n°2008-650 du 3 juillet 2008 relative à la lutte contre le trafic de produits dopants.

¹⁹ Source: <http://a-f-r.org/plume/La-RdR-en-France/Le-plan-Hepatitis>

No new information available.

1.3.3. Other drug policy developments

During the six-month French presidency a number of events were held in France in which the MILDT was involved by organising three major events in Paris:

- A meeting of the "Drug coordinators" of the EU member states on October 22, 2008, which brought together the MILDT president and his 26 European counterparts to exchange views and to better coordinate their activities. A debate on the link between alcohol and drug addiction was proposed by France, in addition to a debate on communication methods vis-à-vis the general public concerning the question of illegal drugs;
- A colloquium on "Drug money, the underground economy and the seizure of criminal assets in Europe" organised by the MILDT on November 21, 2008;
- A European colloquium: "How can we better treat drug addiction? New scientific and clinical challenges for Europe" organised on December 9 and 10, 2008 at the Sorbonne.

1.3.4. Coordination arrangements

No new information available.

1.4. Economic analysis

No new information available.

1.4.1. Public expenditure

No new information available.

1.4.2. Budget

No new information available.

1.4.3. Social costs

No new information available.

2. Drug use in the general population and specific targeted-groups

2.1. Introduction

Drug use: the general context

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

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

Drug use among the general population

France has several surveys intended to identify this use:

- For the adult population: the Baromètre santé (the "Health Barometer" from the National Institute for Prevention and Health Education – INPES), a survey carried every four years; Enquête sur les représentations, opinions et perceptions relatives aux psychotropes. (Survey of representations, opinions and perceptions regarding psychotropic drugs, EROPP) carried out every three years by the OFDT [Standard table n° 1].
- For the school population: European School Survey Project on Alcohol and other Drugs (ESPAD) carried out every four years (INSERM-OFTD) [Standard table n° 2]. The Health Behaviour in School-aged Children (HBSC) provides data on drug use among schoolchildren aged 11, 13 and 15 years old.
- For youths: the Survey on Health and Use on Call-up and Preparation for Defence Day (ESCAPAD) carried out by the OFDT involving young people aged 17 to 18 years old. Among other things the survey makes it possible to question young people who left the educational system early [Standard table n° 30].

Cannabis is the most frequently consumed illegal product in France and its use has significantly increased over the last 10 years. In 2005, three adults out of 10 in the 15-64 age group had already experimented with cannabis, with fewer than one in 10 using it on an occasional or regular basis.

Cannabis use concerns all sections of society even if a number of trends can be observed. Cannabis use tends to be slightly higher among pupils and students, single people, the unemployed and - among the employed - in the intermediate professions, and far less among workers. However, differences between the various socio-professional categories are not particularly great when considered overall.

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

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

experimenting with cannabis who tend to be better integrated socially (job stable housing, etc.).

At 17 years of age, after tobacco, alcohol and cannabis (46.3% among boys and 37.9% among girls) and psychotropic medicines, the products most frequently experimented with are: poppers (13.7%), inhalation products (5.5%), hallucinogenic mushrooms (3.5%), cocaine (3.3%) and, to a lesser extent, ecstasy (2.9%), amphetamines (2.7%), LSD (1.2%) and heroin (1.1%), (Legleye, Spilka et al. 2009). According to the last school (Legleye, Spilka et al. 2008) and adolescent surveys (Legleye, Spilka et al. 2009), cannabis use is thus declining among adolescents.

Drug use among specific groups

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

Among the homeless population, the data tends to be patchy. We know however that all the substances are available and consumed. Users living on the street "have intoxication practices which are significantly different from those of less marginalised addicts. Due to a lack of money or ideas for sources, they tend to consume whatever they come across on a day-to-day basis [...]" (Solal and Schneider 1996). Estimates of the prevalence of the use of illicit drugs during the last few months vary from 10% to 21% or even 30% according to the age, income level, cause of vagrancy or help centres visited, (Observatoire du Samu social de Paris 1999; Amosse, Doussin et al. 2001; Bernal, Haro et al. 2007). Apart from tobacco and alcohol, cannabis and cocaine are the most frequently consumed drugs.

A recent study into alcohol use among the homeless population offers an insight into the levels of alcoholism experienced among the different categories of person using the various accommodation and warm food distribution services. It highlighted the diversity of use practices among this population group, according to the type of accommodation and resources available, and the age, sex and nationality of the respondents. The great diversity of social situations encountered corresponds to a wide variety of behaviour patterns where alcohol is concerned (BECK, LEGLEYE et al. 2006).

In the "techno/party" dance events, a quantitative study (known as the "TREND Electronic Music Survey") involving an ethnographically structured sample of 1,496 people was held in 2004 and 2005 in five French sites. It made it possible to measure the prevalence of drug use among 4 sub-groups²⁰ found in this environment, but also to study their practices and representations. It sheds light on the frequency of cocaine use (35% during the last 30 days) and that of ecstasy (32 %) in addition to the daily use of cannabis (40%). The use of cocaine or ecstasy more than once a week concerns 18% of those persons encountered in the "techno/party" environment and 26% in the "alternative" environment. The number of people experimenting with heroin is higher than expected: 23 % among the whole population group surveyed and 41% in "alternative" circles (REYNAUD-MAURUPT, CHAKER et al. 2007).

Although epidemiological knowledge of drug addictions in professional environments is naturally hindered by a range of obstacles (whether ethical, technical, financial, time-

²⁰ This concerns the "alternative" group (rave and free parties); the Urban group (music bars) comprising people who are better integrated socially and which contains a higher percentage of students, the Clubbing group, (night clubs dedicated to electronic music), mostly comprised of a hedonistic population group devoting a major budget to going out and clothing, and the Select group (clubs practising admission by recommendation or bars requiring "suitable clothing") attracting a "chic and trendy" clientele with a higher standard of living than the other groups..

related, regulatory, cultural or practical), a certain amount of information is available to enable us to assess such use. In 1995, an exploratory study focusing on anonymous urine samples from 1,976 employees in the Nord-Pas-de-Calais revealed that 17.5% of staff were consuming at least one psychoactive substance, including up to 40% of staff in safety and security posts, (Fontaine 2006). For most users well integrated within their professional environment, their drug use is hidden from their work colleagues and, as far as possible, the drugs are consumed outside working hours, (FONTAINE 2002).

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

Attitudes to drugs and drug users

The tool used to assess the attitude of the French population to drugs and drug users is the Survey on Representations, Opinions and Perceptions Regarding Psychotropic Drugs (EROPP). This survey makes it possible to measure the perceived level of information concerning drugs, substances known and recognised as being drugs, and the estimated danger levels of the substances. The survey also studies public opinions as to the manner in which drug addicts are represented.

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

The product considered most dangerous by the French population is heroin, followed far behind by ecstasy and cocaine, alcohol and tobacco and, finally, cannabis (only 2% of those interviewed considered cannabis to be the most dangerous substance). This ranking varies very little according to the age, sex or socio-professional category of the respondent. The perceived danger level of cannabis varies with age and sex, and more particularly according to the respondent's proximity to the product (Legleye, Spilka et al. 2008). The next survey is expected in the beginning of 2010

The vast majority of the population supports the existing measures provided under the harm reduction policy (substitution treatment, the free distribution of syringes, etc.) and generally remains committed to prohibitive anti-drugs measures (opposing the authorisation for cannabis or heroin use under certain conditions, and opposed to the unrestricted sale of cannabis (Legleye et al. (2008). When the use of illicit drugs is envisaged for therapeutic purposes and under medical control, half of the population states that they would be favourable to the issuing of heroin and three-quarters agree to the medical prescription of cannabis on medical grounds for certain major illnesses.

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

2.2. Drug use in the general population (based on probabilistic sample)

No new information available.

2.3. Drug use in the school and youth population (based on probabilistic samples)

No new information available.

Illegal and misused drugs.

With the exception of cannabis, experimentation with illegal or misused drugs remains rare (table 2.1). The most common products are solvents and inhalants accounting for 5% of experimenters, followed by cocaine or crack (2.7%), amphetamines, "medicines for getting high" (as they are referred to in the questionnaire) all hovering around the 2% mark, and lastly heroin and LSD, which

are both below the 1% level. The residual category of "other products" is mentioned by 7.5% of young people although their content remains unknown. In particular, as already mentioned, the nature of these products is not known, (i.e. – whether they are psychotropic, illegal or overlapping with other product categories, and particularly with cannabis, which is known by a range of different names locally, according to its nature, its source and its quality).

Table 2-1: The use of illegal or misused products at the age of 15, over the last 12 months (%)

	Boys	Girls	Sex ratio	All
Inhalation products	5	5	0.9 ns	5
Cocaine & crack	3	3	1.1 ns	3
Amphetamines	3	2	1.5 ns	2
Medicines for getting high	1	3.1	0.3***	2
Ecstasy	1	1	1.6 ns	1
Heroin	1	1	1.3 ns	1
LSD	1	1	0.8 ns	1

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

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

Table 2-2: Tobacco, alcohol and cannabis use at 16 in 2007 (% and sex ratio)

	Boys (%)	Girls (%)	Sex ratio	Together (%)
Tobacco				
Experimentation (≥1 usage / life)	58	61	0,9 ns	60
Non daily use	11	15	0,7 **	13
Daily use	18	16	1,1 ns	17
Intensive use (≥10 cig./day)	5	4,6	1,1 ns	4,8
Alcohol and drunkenness				
Experimentation (≥1 usage / life), alcohol	89	88	1,0 ns	88
Alcohol ≥1 usage / year	82	81	1,0 ns	81
Monthly usage (≥1 usage / month)	66	62	1,1*	64
Regular use (10+/month) alcohol	18	9	2,1 ***	13
Experimentation (≥1 / life) drunkenness	47	45	1,1 ns	46
Ivresse ≥1 / année	37	35	1,1 ns	36
Regular use (10+/year)	4,2	2,7	1,6 *	3,5
5 + drinks /single occasion during month	44	34	1,3 ***	39
Cannabis				
Experimentation (≥1 usage / life)	35	27	1,3 ***	31
≥1 usage / year	28	21	1,3 ***	24
Monthly usage (≥1 usage / month)	18	12	1,5 ***	15
Regular use (10+/month)	5,0	2,0	2,5 ***	3,5

Ns, *, **, *** : p-value for Chi² test for comparison between genders sexes : 0.05, 0.01 et 0.001.

Source: ESPAD 2007 OFDT-INSERM

Table 2-3: 2005-2008 evolutions of levels of psychoactive drugs use by gender (% and sex ratio)

	Garçons 2008	Filles 2008	Sex ratio	Ensemble 2008	Ensemble 2005	Évolution1 (05/08)	Évolution2 (05/08)
Tobacco : experimentation	70,5	71,0	1,0 ns	70,7	72,2	-2%	-1,5
Non daily use	11,6	11,5	1,0 ns	11,5	8,1	43%	3,5
Use during last month	41,5	39,4	1,1***	40,5	41,1	-2%	-0,6
Daily use	29,9	27,9	1,1***	28,9	33,0	-12%	-4,1
Intensive use (> 10 cig. per day)	9,1	6,2	1,5***	7,7	10,1	-24%	-2,4
Alcohol : experimentation	93,5	91,7	1,0***	92,6	92,3	0,4%	0,3
Month	80,5	74,2	1,1***	77,4	78,7	-2%	-1,3
Regular use (≥10 uses during month)	13,6	4,0	3,4***	8,9	12,0	-26%	-3,2
Daily use during month	1,3	0,2	5,4***	0,8	1,2	-39%	-0,5
Drunkenness: experimentation	65,1	54,3	1,2***	59,8	56,6	6%	3,2
≥1 during year	56,6	44,1	1,3***	50,5	49,3	2%	1,2
≥3 during year	32,0	18,9	1,7***	25,6	26,0	-2%	-0,4
≥10 during year (regular)	12,4	4,6	2,7***	8,6	9,7	-11%	-1,1
5 + drinks in a single occasion during month							
≥1	57,1	39,9	1,4***	48,7	45,8	6%	2,9
≥3	27,7	11,3	2,5***	19,7	17,9	10%	1,8
≥10	3,8	0,9	4,2***	2,4	2,2	8%	0,2
Cannabis : experimentation	46,3	37,9	1,2***	42,2	49,4	-15%	-7,2
≥1 use During year	40,5	31,1	1,3***	35,9	41,3	-13%	-5,4
≥1 use during month	29,5	19,8	1,5***	24,7	27,9	-12%	-3,2
≥10 uses during month (regular)	10,7	3,9	2,7***	7,3	10,8	-32%	-3,4
≥30 or daily use	4,8	1,7	2,9***	3,2	5,2	-37%	-1,9
Lifetime use of :							
Tranquillisers ³	13,9	23,1	0,6***	18,4	nd	nd	nd
Sleeping pills ³	12,1	17,1	0,7***	14,6	nd	nd	nd
Antidepressants ³	4,8	9,6	0,5***	7,2	nd	nd	nd
Lifetime use of:							
Poppers	15,2	12,2	1,2***	13,7	5,5	148%	8,19
Inhalants	6,2	4,7	1,3***	5,5	3,6	54%	1,90
Hallucinogenic mushrooms	4,9	2,2	2,3***	3,5	3,7	-4%	-0,14
Cocaine	4,0	2,4	1,7***	3,3	2,5	29%	0,74
Ecstasy	3,6	2,1	1,7***	2,9	3,5	-18%	-0,63
Amphetamines	3,5	1,9	1,9***	2,7	2,2	24%	0,52
LSD	1,6	0,8	2,1***	1,2	1,1	10%	0,11
Heroin	1,4	0,8	1,9***	1,1	0,7	56%	0,39
Crack	1,3	0,7	1,7***	1,0	0,7	44%	0,31
Ketamine	0,8	0,4	2,1***	0,6	0,4	28%	0,12
Subutex®	0,8	0,3	2,5***	0,5	0,5	2%	0,01
GHB	0,5	0,3	1,6**	0,4	0,3	63%	0,17

Ns, *, **, *** : p-value for Chi² test for comparison between genders sexes : 0.05, 0.01 et 0.001.

Significant increases (p<0.05) are in bold types. Significant decreases are in blue.

1 : Relative change computed with exact figures.

2 : Changes computed with exact figures.

3 : New questions in 2008.

These last figures confirm many results from HBSC and ESPAD despite some methodological differences between the different surveys: large reductions in the diffusion of tobacco and cannabis use, a stabilisation or even a fall in alcohol drunkenness. ESCAPAD also highlights a fall in regular alcohol use. Nevertheless, it shows a modest increase in the number of cases in which 5 glasses of alcohol were drunk on a single occasion. Average ages for experimenting with tobacco and cannabis have risen for the first time in eight years, a sign that probably indicates a change in behaviour with regard to the first-time use of these substances.

There are still, however, a few worrying points such as the increase in the diffusion of cocaine, amphetamines, crack, heroin and GHB, although this behaviour remains marginal: experimenting with GHB is only reported by 0.4% of 17-year-olds, crack and heroin by 1.1% and amphetamines and cocaine by 2.2% and 3.3% respectively. Therefore, it would seem that there is renewed interest in stimulants in some fringe groups in the adolescent population, although ecstasy appears to have somewhat fallen out of fashion. Finally, experimenting with inhalation products and poppers is increasing markedly, although their use seems to be given up faster than for the other substances.

Attitudes to drugs and drug users

EROPP survey. No new information available.

2.4. Drug use among targeted groups/settings at national and local level

No new information available.

3. Prevention

3.1. Introduction

General context

General principles and characteristics of prevention activities

Since 1999, the scope of the fight against drug addiction has been widened to include supply and demand for legal psychoactive substances such as alcohol, tobacco and psychotropic substances, but also doping substances. The strategy is twofold and involves, firstly, early intervention among young people in order to delay, for as long as possible, the age at which they begin using these products, and secondly, an intervention method which seeks not only to prevent use but also limit abuse. In school settings, the prevention of addictive behaviours falls within the remit of health education.

These principles are included in the various government action plans or ministerial and interministerial programmes.

Drug prevention has always been considered to be a logical extension of the basic duties and services guaranteed by the state or delegated to associations, based on the notion of local service provision (for both decision-making and direct intervention activities). Consequently, most addiction prevention work concerns "universal prevention" and is carried out in educational environments, with the participation of almost the entire educational community as concerns both the coordination and implementation of the actions undertaken. This approach is also used in professional environments, where it is managed by occupational health departments and (in companies with over 50 employees) by the CHSCTs (committees with responsibility for occupational health, safety and working conditions). "Selective" or "indicated" prevention is chiefly handled by specialised associations.

The Ministry of Education and the MILDT distribute and update a practical guide to intervention in educational environments. This guide was first published in 2005. Moreover, thanks to the various initiatives developed since 1999 to boost professionalization in this field and to harmonise prevention actions, a few essential ideas have been communicated to prevention players: for example, it is now a well-known fact that mere information about drug-related risks is not in itself sufficient to change users' behaviours as it is also relevant to develop the preventive role of parents, interactive approaches or psychosocial skills. Nevertheless, even if these intervention principles are known, most actors still have difficulty putting them into practice.

The legal framework

In its universal educational aspect, drug prevention is not well covered in French legislation. The 2004 Public Health Law, integrated in the Education Code, lays down, as a minimal objective, one annual session per uniform age group to inform participants about "the consequences of drug use on health, regarding in particular the neuropsychological and behavioural effects of cannabis in primary and secondary schools (...)"²¹. The national guidelines for this aspect of drug prevention are confirmed in various statutory texts. In particular, since 1990, the Ministry of Education approaches the question through circulars on the wider issue of risk behaviour prevention.

Indeed, the legislative system is more focused on limiting the accessibility of substances and the judicial responses to illicit uses, like the awareness-building courses on the

²¹ Loi de programmation de la politique de santé publique n°2004-806 du 9 août 2004, NOR : SANX0300055L.

dangers of narcotics for arrested drug users²². The first courses took place in 2008. The 2008-2011 government plan aims at systemizing judicial responses involving such courses. Laws on public use, advertising or accessibility conditions for alcohol and tobacco were voted a long time ago²³. A decree published in November 2006 extended the ban on smoking in public areas (the Evin law) to all areas open to the general public, including workplaces (effective 1st February, 2007) and, since February 2008, recreational facilities and restaurants.

Political coordination at a central and local level

The task of initiating and coordinating drug prevention policies is handled by the MILDT through its multi-year government plans. The ongoing one was approved in July 2008 for the 2008-2011 period. Each plan acts as a complement to the others, as with national programme against cancer during 2003-2008, the 2003-2008 five-year prevention and education plan from the Ministry of Education (general issues on pupils' health)²⁴, the current 2007-2011 plan for care and prevention regarding addictions from the Ministry of Health or the 2005-2009 plan for occupational medicine.

The implementation of national guidelines at a local level is delegated to the state's decentralised authorities and institutions but also to "Drug and Drug Addiction Project managers" (known as chefs de projet "drogues et dépendances") appointed among the staff of each préfecture, who are the MILDT's direct local representatives. Each project manager defines and organises the prevention policy in the département. To do so, he is given funds specifically assigned to drug prevention and the training of professionals.

At the same time, regional and multi-sector coordination schemes – concerning health or the fight against social exclusion, security or the urban police – also allow for the allocation of public funds. Additionally, the identification of priority areas requiring intervention (drawn up on the basis of socio-economic indicators, the quality of housing or educational data) makes it possible to concentrate additional resources on disadvantaged sections of society.

In the secondary school environment, each school principal, in collaboration with the head of the "health and citizenship educational committee" (CESC) he chairs, annually draws up preventive actions to be implemented among his school's pupils. School principals receive recommendations from their local education authority according to the ministerial guidelines laid down. Nevertheless, secondary schools benefit from a certain degree of autonomy in this area, and this is also the case for agricultural education institutions (under the supervision of the Ministry for Agriculture and Fisheries). The CESC's involving the educational community and external key players (associations and institutions, etc.) define and coordinate prevention activities within schools ("collèges" and "lycées"). Professionals from agricultural education institutions can rely on the internal "network for health education, counselling and teenagers' development" (RESEDA), set up for providing training in and the exchange and dissemination of prevention tools as well as calls for tenders related to health education.

²² Loi no 2007-297 du 5 mars 2007 relative à la prévention de la délinquance et modifiant le code pénal et le code de procédure pénale, décret no 2007-1388 du 26 septembre 2007 pris pour l'application de la loi no 2007-297 et circulaire CRIM 08-11/G409.05.2008 relative à la lutte contre la toxicomanie et les dépendances du 9 mai 2008 (NOR JUS D0811637 C).

²³ For instance: Ordonnance n°59-107 du 7 janvier 1959 et loi n°74-631 du 5 juillet 1974 interdisant la vente d'alcool aux mineurs de moins de 16 ans, loi n°91-32 du 10 janvier 1991 (dite Loi Evin) relative à la lutte contre le tabagisme et l'alcoolisme, JO du 12 janvier 1991, p. 4148 (NOR : SPSX9000097L), Loi n°2003-715 instaurant l'interdiction de vente de tabac aux mineurs de moins de 16 ans (JO du 3 août 2003). Décret n° 2006-1386 du 15 novembre 2006 fixant les conditions d'application de l'interdiction de fumer dans les lieux affectés à un usage collectif (NOR:SANX0609703D).

²⁴ Circulaire n°2003-210- du 11 décembre 2003 ; NOR : MENE0302706C.

Schemes aimed at providing assistance to decision-makers and professionals

The INPES (the French National Institute for Prevention and Health Education) is responsible for performing assessments, developing prevention practices and implementing national programmes (particularly media campaigns).

The committee for the approval of prevention tools (coordinated by the MILDT) forwards an opinion on the quality and the relevance of the tools and resources submitted to it.

In order to be represented in public debates and to encourage dialogue among professionals, the various specialised associations are grouped together in federated organisations²⁵. These federations organise training activities, series of conferences, think tanks or documentary networks related to psychoactive substance use prevention.

At local level, the “Regional Drug and Addiction Information and Resource Centres” (Centres d’information régionaux sur la drogue et les dépendances or CIRDDs) provide technical support to project managers in the drug and dependency field and the authorities. They provide documentation and methodological advice for the drafting of projects and also have an observational role, particularly in the field of prevention.

The monitoring of prevention activities today

The ReLIONPreDIL system (“Electronic Collection of Indicators for the National Monitoring of the Temporary Prevention Actions Related to Illicit and Licit Drugs”) was experimented in 9 of the 26 French regions in 2007, under the coordination of the OFDT and at the request of the MILDT. This system is aimed at gathering simple indicators in order to identify and follow up the key characteristics of local prevention activities concerning licit and illicit drugs. Its extension to national level in 2010 is being studied. The methodological details of the survey are available at the following address: www.ofdt.fr/relion.

New policies for drug use prevention

The ongoing government plan to combat drugs and drug addiction focuses on 14 strategic lines of action in the prevention field (listed below). Two of these are based on selective prevention (lines of action 1-11 and 1-12), as they are designed for people referred by the criminal justice system or inhabitants of areas targeted by urban policies. For the first time ever, people from French Overseas Departments and Territories, on the one hand, and foreign residents on the other, will constitute the specific target public of media campaigns. To support these various lines of action, the plan proposes thirty six specific measures, combined with evaluation indicators. It also identifies the major national stakeholders.

The government plan bears witness to the government’s determination to “renew efforts to prevent the onset of illicit drug use” as well as the abuse of alcohol, by curbing their everyday acceptance. The government has reduced access to alcoholic drinks for youths by raising the minimum age for the purchase of alcohol from 16 to 18. Particular attention is given to new patterns of alcohol use among young people, particularly binge drinking. In order to consolidate the preventive role of adults, particularly parents, the plan is aimed at developing their “educator skills” (their knowledge of the phenomenon and their ability to detect drug uses as early as possible), thereby enhancing their legitimacy to act. It stresses the need to develop the French population’s abilities to make conscious choices above and beyond the need to increase their knowledge of the risks related to illicit drug use or alcohol abuse. In addition to health education, the 2008-2011 government plan also highlights the importance of reminding people of the existing legal framework of prohibitions concerning the use and supply of both licit and illicit drugs.

²⁵ FNES : Fédération nationale des comités d’éducation pour la santé (www.fnes.info) ; ANPAA : Association nationale de prévention en alcoologie et addictologie (fondée en 1872, www.anpaa.asso.fr) ; ANIT : Association nationale des intervenants en toxicomanie, (www.anit.asso.fr) ; FFA : Fédération française d’addictologie (www.addictologie.org) ; CRIPS : Centres régionaux d’information et de prévention du sida, (www.lecrips.net/reseau.htm).

Objectives of Part 1 - "Preventing, communicating, informing" from the 2008-2011 government Plan to combat drugs and drug addiction.

1-1. Preventing drug use

1-2. Reminding people of the legal and statutory framework which regulates the use of illicit drugs and alcohol

1-3. Re-legitimising adults as key players of prevention

1-4. Preventing the massive use of alcohol among young people and modifying people's representations of alcohol

1-5. Implementing a prevention policy suited to higher education institutions and "grandes écoles"

1-6. Developing a prevention policy within primary and secondary schools, by giving the school community access to the necessary tools and resources

1-7. Training school and university professionals in drug prevention so as to circulate representations among the various players

1-8. Reducing addictive behaviours in sports and educational leisure facilities

1-9. Reducing occupational accidents, absenteeism and risks related to the use of alcohol, psychotropic medicines or narcotics

1-10. Reducing doping practices in amateur or recreational sports environments

1-11. Preventing subsequent drug- and trafficking-related offences among users referred by the criminal justice system

1-12. Preventing drug- and trafficking-related criminality in areas targeted by the urban police

1-13. Designing information campaigns suited to the socio-cultural context of the French overseas departments

1-14. Informing foreign residents who come to stay in France of the legislation in force with regard to drugs

The government plan having been adopted in July 2008, the year 2008 has been a period of transition between the political time necessary for redefining national aims and the time needed to implement them.

3.2. Universal prevention

In France, universal prevention remains the predominant approach to prevent the use of legal or illicit drugs. It mainly takes place in school environments.

Several projects were initiated during the second half of 2008.

The MILDT set up the scientific council for the 2009 conventions²⁶ on parents' skills as drug prevention educators for their children.

In 2008, the MILDT began preparing a study visit (in Paris), scheduled for 2009, so that school executives from 15 EU Members States could talk about drug prevention policies.

3.2.1. School

In 2008, the Ministry of Education asked schools to organise "prevention sessions" so as to generalise prevention actions from the end of primary to the end of second schooling. The Ministry participated in an interministerial workgroup (with impetus given by the Minister of Health and

²⁶ An ad hoc meeting gathering institutions and experts in charge of thoroughly studying a given subject.

Sports) to define national guidelines for training people in the prevention of doping behaviours in sporting activities, including in schools.

The updating of the prevention guide co-published by the MILDT and the Ministry of Education began in 2008 (cf. boxed text above, section entitled "General principles and characteristics of prevention activities").

3.2.2. Family

The strengthening of parents' involvement in drug prevention matters is one of the first steps undertaken by public authorities during the second half of 2008. An interministerial circular published by the end of 2008 aims at consolidating the network for counselling and support for parents (REAAP, created in 1999). This system was created to reinforce parents' skills in relation to various issues such as health, "teenage crises", sexuality, conflict management and risk behaviours²⁷.

3.2.3. Community

No new information available.

3.2.4. Universal prevention aimed at those in the professional field

All the measures put forward in the government plan are aimed at the general population, but also at the world of work, with a particular emphasis on the following points:

- Clarifying the public messages informing people of what is allowed and what is not, in order to boost individual responsibility and also (in the world of work) to more clearly specify individual and collective responsibilities (each is dependent upon the other) ;
- Carrying out identification and treatment activities in the world of work, in cooperation with all participants and partners;
- Organising studies aimed at obtaining a greater in-depth knowledge of the phenomenon (a competitive tender programme was launched by the MILDT, the INSERM and the InCA²⁸ in order to generate research, action and assessments covering the priority themes including drug use and addictive behaviour in professional environments, potential correlations between the use of illegal substances, alcohol and occupational accidents and, finally, the specific nature of psychotropic treatments classified as level 2.

This policy measure - included in the 2008-2011 plan - incorporates a guideline already featured in the previous plan, developed by the "addictive behaviour in professional environments" committee (while reinforcing it and putting it on a more concrete footing). The latter submitted a report to the Prime Minister and the Minister for Labour in January 2007.

The measures contained in the plan adopted in July 2008 are based on this report but also on existing data, which it seeks to extend and confirm (between 15 and 20% of accidents and cases of absenteeism are believed to be related to the use of psychoactive substances), particularly those put forward by the INRS (National Research and Safety Institute for the Prevention of Occupational Accidents and Diseases):

- The occasional or repeated use of alcohol, cannabis or medicines can endanger the health and safety of employees and can even be the cause of occupational accidents (even though the causes may be linked to a variety of factors);
- The resulting problems are of great concern to all companies;

²⁷ Circulaire DIF/DGAS/2B/DAIC/DGESCO/DIV/2008/361 du 11 décembre 2008 relative aux réseaux d'écoute, d'appui et d'accompagnement des parents, REAAP.

²⁸ INSERM: National Institute for Health and Medical Research; InCA: National Cancer Institute.

- Use concerns all business fields and all employees, regardless of their hierarchical status;
- Employees' use patterns are generally already established before they arrive in a professional environment (habits developed in their private environment), although certain "efficiency at any cost" organisational measures can also explain this phenomenon.

Consequently, the MILDT and the Directorate-General of Labour have decided to develop a concerted and determined policy in collaboration with employers, trade unions and the various associations involved, aimed at significantly reducing the use of alcohol, psychotropic substances or narcotics by the various participants in the world of work. In order to encourage occupational health and to reduce the number of occupational accidents related to such uses, the goal is not to offer "one size fits all", off-the-shelf solutions, but rather to provide a legal and financial framework, making it easier to find solutions.

In order to be in a position to put forward concrete measures, the public authorities will be organising an extensive debate in 2009 and 2010 with the aim of organising ad hoc conventions during the same year.

3.3. Selective prevention in at-risks groups and settings

3.3.1. At-risk groups

The Law of 5 March 2007 instituted a new judicial measure: awareness-building courses on the dangers of narcotics. Any person arrested for drug use, even minors, may be required to follow such courses as an alternative to legal proceedings, as a "penal arrangement"²⁹ or in addition to any other sentence issued (please also see section "Prevention of offences and drug-related criminality"). This new response aims at preventing recidivism. It is for this reason that, in addition to pecuniary sanctions, educational measures are also proposed. These courses aim at making drug users fully aware of the harmful consequences of illicit drug use, from a health, judicial and societal standpoint. The courses are generally provided by specialised associations, duly authorized by the State Prosecutor, for a planned duration of 2 days. They will be subject to a national assessment.

The government plan will endeavour to develop particular measures to prevent recidivism (as concerns use or trafficking) by people referred by the criminal justice system and other measures to strengthen drug prevention actions in problem (underprivileged) areas.

The most vulnerable individuals encountered by the criminal justice system (minors and adults alike) are those least likely to benefit from awareness-building and prevention activities. The goal is therefore to provide innovative working tools to professionals dealing with these individuals and to give the target groups a better chance of re-integrating society and assuming personal responsibility.

With regard to populations living in districts identified by the urban policy, the government wishes to design strategies to improve the coordination between decision-makers and the various players and to support local decision-makers to fight the problem in their areas (line of action 1-12).

3.3.2. At-risk families

No new information available.

3.3.3. Recreational settings (incl. Reduction of drug and alcohol related harm)

No new information available.

3.4. Indicated prevention

²⁹ A procedure which makes it possible for the Attorney General to propose one or several measures to a person who has admitted to having committed an offence punishable by a prison sentence of 5 years or less.

Since February 2005, many "cannabis outpatient clinics" (280 throughout France in 2008), anonymous and free of charge, have provided help to young people in difficulty as a result of their use of cannabis or other drugs and their families (see French national reports for 2006 and 2007).

3.5. National and local media campaigns

The last media campaigns on illicit drugs took place in 2005 and 2006 ("Cannabis is a reality" and the first national prevention campaign against cannabis use while driving). However the Government Plan 2008-2011 announced "long term information campaigns on the health and legal consequences of consumptions". The first actions are scheduled for the end of 2009 (October and November). The plan also mentioned that to increase awareness on drugs it is essential to focus on audiovisual media. Therefore, the MILDT stressed the need to collaborate with the "Conseil supérieur de l'audiovisuel" (CSA) on these issues. Besides this, the independent authority to protect audiovisual communication freedom adopted in June 2008 a deliberation "relating to the on air display of tobacco, alcoholic beverages and illicit drugs (délibération relative à l'exposition de produits du tabac, de boissons alcooliques et de drogues illicites à l'antenne)" ³⁰.

As far as media are concerned, drug issues are as always a source of interest for them.

During the period 2008-2009, the "drug" issues which have captured the attention of the media and public debate are those dealing with young people and cocaine.

"Dès 15 ans ils sont accros à la cocaïne" (which could be roughly translated as: Already hooked on cocaine at 15 years old), such was the title given to the double-page spread in the newspaper *Le Parisien* on January 27, 2009 dedicated to the subject. It reproduced data from the EMCDDA annual report. "La cocaïne en très forte hausse" (Cocaine use rising significantly), reports *Le Journal du dimanche* on May 17, 2009, echoing the interest generated at that time by French tennis player Richard Gasquet being tested positive for cocaine. Indeed, the issue was taken up by both the sports and general press. In June, the high school magazine *Phosphore* warned its young readers: "Alerte à la cocaïne" (Beware of cocaine).

Le Monde also featured a front-page headline on June 12, 2009 on the subject of cocaine and young people when the results of the ESCAPAD survey conducted among young 17-year-olds were made public: "La cocaïne est en hausse chez les jeunes" (cocaine on the rise among young people), whereas inside, the newspaper used the title "Les liaisons dangereuses des jeunes avec la cocaïne" (The wreaking relationships young people have with cocaine). As for the AFP (*Agence France presse*), it announced the results of the same survey with the title "Jeunes: tabac, cannabis, alcool en baisse, cocaïne en hausse" (Young people: smoking, cannabis and alcohol use declining, but cocaine on the increase) - AFP of June 10, 2009.

Finally, in addition to this information about cocaine, on July 19, 2009 *Le Monde* dedicated a full page to the development of crack around Paris "L'usage du crack se banalise en Ile-de-France" (Use of crack becoming routine in Ile-de-France).

The cocaine "craze" has not prevented newspapers from continuing, very regularly, to talk about cannabis use. This was particularly true when the initial results of the ESPAD survey were released for France, providing data for three substances - alcohol, tobacco and cannabis. The relative decline of illicit substances was highlighted by *Le Monde* on February 3, 2009: "A 16 ans les jeunes préfèrent trinquer plutôt que fumer" (At 16, young people prefer to drink rather than smoke) and *Libération* on February 3, 2009: "Plus d'alcool mais moins de joints pour les ados" (More alcohol but fewer joints for adolescents). At the end of July 2009, a survey on the clinics for young users, particularly cannabis users, also attracted the media's attention: "Bilan positif pour les consultations cannabis" (Positive assessment results for cannabis clinics), is the title of *le Figaro* on July 23, 2009.

³⁰ Délibération n°2008-51 17 juin 2008, <http://www.csa.fr/rapport2008/donnees/summary/dates.htm#6>

Alongside these articles, which stressed the fall in use or addiction treatment, the dangers of the substance are regularly reviewed. In September 2008, after a boating accident on the Seine in Paris, in which two people died, the pilot tested positive for the substance and the story was extensively covered in both the written and audiovisual media. This was also an opportunity for *le Figaro* on September 24 to publish an article on the subject entitled: “Le cannabis mieux dépisté dans les métiers à haut risque” (Better screening for cannabis in high-risk jobs). For its part, the woman’s magazine *Elle* on October 6, 2008 stated, “Non, le cannabis n’est pas une drogue douce” (No, cannabis is not a soft drug), underlining also that dangers of cannabis have since a long time been underestimated.

Again, in terms of risks, we see renewed interest in GHB and particularly GBL. Whilst GHB and its effects (the rape drug) had intermittently been described by the media in previous years, GBL (an industrial solvent and precursor of GHB) appeared in several articles during the period, particularly at the start of 2009. The media were interested in the results of using this substance, which is relatively easily accessible, since it is not listed as a narcotic. Following the example of the local press, which described cases of coma in young users following various party poisonings, particularly in the south of France (*Midi libre* on February 22, 2009 and then April 13, 2009), the national media tackled the issue (including the health magazine on the television channel France 5 on February 24 or France Info information radio on April 13). *Le Journal du dimanche* interviewed the President of MILDT Etienne Apaïre about the subject on April 19, 2009. Finally, *Le Monde* examined “Une drogue qui fait des ravages dans les soirées” (A dangerous party drug) on May 13, 2009.

But as soon as newspapers begin focussing on the perils of drug use, it is clearly and logically heroin which attracts the most media attention. From the summer of 2008, public opinion was mobilised with the issuing of a press release co-signed by the General Health Department (DGS-Health ministry), Afssaps, InVS, MILDT and OFDT. Many newspaper articles addressed the subject, including an article in *Le Monde* on August 27, 2008, which expressed concern: “More young people hooked on heroin”.

In September and October 2008, the subject then again came onto the agenda after a death and the confirmed circulation of a high-potency heroin. Finally, in January 2009, a series of non fatal overdoses was widely commented on over several days and resulted in the release of various warnings: “15 cases of overdose reported in the north of Ile-de-France” was a joint announcement made by the General Health Department and the National Health Watch Institute on January 20, 2009. Two new releases co-signed by the MILDT, OFDT and Afssaps came out on January 22 and 23, this time mentioning 44 non fatal overdoses. AFP, which was closely following the story, released a dispatch on January 23 entitled: “La récente série d’overdoses, signe alarmant du retour de l’héroïne en France” (The recent series of overdoses, an alarming sign of the return of heroin in France).

Another question provided the media with an opportunity to broaden an often very “Francocentric” vision: substances sold on the internet and, particularly, cannabinoid mixtures such as Spice. *Le Parisien* examined the phenomenon in October 2008 with the title: “Internet, nouveau supermarché des drogues douces” (Internet becomes the new supermarket for soft drugs). On February 5, 2009, the weekly *L’Express* presented “Spice”, then still authorised in France, as “the lifting grass”. A few weeks later, on February 27, the General Health Department and the French Health Products Safety Agency announced the classification as narcotics of the cannabinoid substances contained in Spice. On March 10, 2009, *Le Monde* brought the issue to the fore once more, making reference to the EMCDDA: “Le commerce en ligne complique les stratégies anti drogue en Europe”(Online marketing complicates anti-drug strategies in Europe).

4. Problem drug use

4.1. Introduction

Problem use: general context

A set of studies and work has been conducted in recent years to establish a new estimate of the number of problematic drug users in France. Several estimation methods have been used in France in order to produce a national estimate of the prevalence of problem heroin and cocaine use in 1999 (Costes, 2007).

In 2005 and 2006, the New Multicentric OFDT Study (NEMO) was carried out in order to produce local estimates of the prevalence of the problem use of opiates, cocaine, other stimulants and hallucinogens in six French urban areas (Lille, Lyons, Marseille, Metz, Rennes and Toulouse) and in an overseas département (Martinique). This work provides a new estimate for France for 2006, following the estimates previously produced in 1995 and 1999 [1-3]. It also provides an estimate of the number of regular heroin and intravenous drug users. Complete results and methodological details are presented in the referenced report [4].

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

In 2006, a specific survey (PRELUD) was carried out among drug users attending low threshold structures (Drop-in centres and syringe exchange programmes). Carried out in nine urban areas (Bordeaux, Dijon, Lyons, Lille, Marseille, Metz, Paris, Rennes and Toulouse), this survey followed on from the so-called "front line" survey carried out up until 2003 on the 12 sites included in the Emerging TRENDS project (TREND). It makes it possible to accurately describe the profiles of users attending low threshold facilities. The 2006 data was compared to the 2003 data for these nine sites.

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

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

Additionally, since 1999 France has operated a scheme for identifying and monitoring emerging trends related to illegal or misused psychotropic substances (TREND project).

The observations from this project are focused on population groups with a high prevalence of use. It is chiefly based on qualitative (mainly ethnographic) and quantitative information gathering tools deployed by a network of seven local coordination groups (in Bordeaux, Lille, Lyons, Marseille, Metz, Paris, Rennes and Toulouse) run by the OFDT. All of this data is analysed by the local coordinating groups and compared nationally among them, as well as being compared to other available data sources.

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

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

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

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

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

4.2. Prevalence and incidence estimates of PDU

4.2.1. Indirect estimates of problem drug users

Local estimations: Capture-recapture method

Six "three-sample capture/recapture analyses" were carried out in 2005-2006 in order to estimate the number of problem drug users in Lille, Lyon, Marseille, Metz, Rennes and Toulouse (NEMO study) (Vaissade and Legleye 2009).

Data sources for problem drug users were identified and the data were collected from these sources over a six-month period between 2005 and 2006. These sources notably included the drug treatment centres, general practitioners, hospital units (infectious diseases, accident and

emergency departments), low-threshold reception facilities (CAARUD), social services and law enforcement sources such as drug squads, the justice system, treatment units in prison and data held by the Central Office for the Repression of Narcotics Trafficking (OCRTIS). Data collection in prison was delayed for two months, compared to other data sources, in order to allow problem drug users entering prison during the last two months of the survey to be “captured” by other data sources. For each study (each town), the different data sources were grouped into three samples using a statistical criteria (an odds ratio between two data sources greater than one, suggesting possible linkage between both sources, leading to both data sources being combined) and a field criterion (when two data sources are locally known to be related).

Subjects were included in the study if they had resided for more than three months in one of the six cities, if they declared having used at least one illegal drug over the last 30 days (cannabis excluded): opiates, cocaine/crack, other stimulants and/or hallucinogens, and if they were 15-64 years old.

The results obtained in the six cities are the following:

Table 4-1: Estimates of problematic drug users (PDU) in 6 French cities and prevalence rates among the 15-64 year-old population, 2005-2006

Estimates of problematic drug users (PDU) in 6 french cities and prevalence rates among the 15-64 year-old population, 2005-06.							
	PDU estimates	confidence interval*		15-64 years old population	prevalence rate (p 1000)	confidence interval	
Lille	7 900	6 300	10 200	728 173	10.8	8.6	14.0
Lyon	8 400	6 300	11 800	788 893	10.7	8.0	15.0
Marseille	5 600	4 200	7 700	543 206	10.2	7.7	14.2
Metz	2 300	1 700	3 200	212 632	10.8	8.0	15.0
Rennes	1 500	1 100	2 300	196 389	7.6	5.6	11.7
Toulouse	5 400	4 300	6 900	534 132	10.1	8.0	12.9
estimates rounded to the nearest hundred ; population : INSEE, census 1999							
* Cormack method (Ref : Cormack, R.M., Interval Estimation for Mark-Recapture Studies of Closed Populations. Biometrics, 1992. 48: p. 567-576.)							
Source : Nemo, OFDT							

National estimates: EMCDDA protocol

Problem drug use has been defined, according to the EMCDDA definition, as intravenous or regular use of opiates, cocaine or amphetamines during the previous year in the 15-64 age group.

The following results are obtained from the three methods:

Table 4-2: National estimates with the EMCDDA protocol

method	average estimate	CI-	CI+
treatment data multiplier	272 000	209 000	367 000
police multiplier	187 000	144 000	253 000
multivariate	264 000	189 000	338 000
rate / 1000 hab. 15-64 years			
treatment data multiplier	7,0	5,4	9,5
police multiplier	4,8	3,7	6,5
multivariate	6,8	4,9	8,7
source : OFDT			

The results obtained from the “multiplier-treatments” and “multivariate” methods converge. The third method shows markedly lower prevalences. Taking account of the three confidence intervals, the

estimate range is found to be extremely wide, from 3.7 to 9.5 per 1,000 inhabitants between 15 and 64 years old.

Consideration alongside framework data on illegal drug use

The low prevalence of opiate, cocaine or amphetamine use very considerably limits the potential relevance of general population surveys to estimate this phenomenon. General population surveys provide us with estimates of the number of people who have used these substances at least once in their life (experimenters) or at least once in the previous year. We do not have estimates of the number of regular users of these substances (at least ten times over the previous month), as this behaviour is too rare to be measured in this type of survey. The following estimates were produced from the most recent general population surveys conducted in 2005 (BECK, LEGLEYE et al. 2006).

Table 4-3: Estimates of cocaine and heroin life time and last year users, 2005

	Life time users	Last year users
Cocaine	1 100 000	250 000
Heroin	360 000	

Sources : ESCAPAD 2003, OFDT ; ESPAD 2003, INSERM/OFTD/MJENR ; Baromètre santé 2005, INPES, exploitation OFDT

In view of these findings, we could have expected the estimates of the number of problem drug users to be less than those provided by the three methods used. This difference is partly explained by loss of social integration amongst problem drug users, as this particular population is not well covered by general population surveys.

Limitations inherent to each of the methods

The first “Multiplier method using treatment data” is based on sales data for the two medical drugs used for substitution treatment, which enable estimates to be made of the number of drug users taking these treatments. In view of the extensive availability of this type of treatment in France, these data represent an excellent base for application of this method. Substitution treatments theoretically only cover part of the target group, opiate users, although in practice there is considerable overlap between the uses of the different substances. These estimates, however, may be subject to some sources of bias, particularly misuse of the treatments or their diversion onto the black market. These sources of bias could lead to an overestimation of the population being treated, as misused medicines are not taken by “users receiving treatment”. Nevertheless, the substances are still taken by drug users. The method, therefore, is still robust if this relatively well documented phenomenon (Cadet-Taïrou, Costes et al. 2004; COSTES, CADET-TAIROU et al. 2004; Escots and Fahet 2004) is consistent over all the French départements. This is not necessarily the case, as it is known that this misuse or diversion of treatment is concentrated in a few regions (CADET-TAIROU and CHOLLEY 2004) (Paris region, Alsace, Languedoc) which do not include any NEMO study sites. There is therefore a risk that the numerator in the equation used in this method is over-estimated and therefore that the final result is also overestimated.

The second “Police multiplier” method is based on an “arrests by the police for heroin or cocaine use” indicator which is relatively non-specific: it is an indirect indicator of drug use but also one of the extents of police activity in the field. This second factor is not necessarily consistent between départements. Another possible source of bias for this indicator is that the target it measures is slightly different from the definition of the target group (intravenous drug user or regular user of opiates, cocaine or amphetamine in the previous year for the 15-64 age group), as the offence does not distinguish between extent of use. An occasional user can be arrested and the police statistics do not distinguish between the types of use.

The third “multivariate indicator method” has the advantage of linking different data sources for which known prevalence estimates for 6 départements are extrapolated to the other 90 départements. Nevertheless, each of the four indicators used has its own limitations. Those relating to the number of people receiving substitution treatment and the number of arrests have already

been described above. The “treatment data” come from an administrative source (activity report submitted to the statutory authorities). The reliability of declaration data on new patient intakes is debateable. In addition, intra and inter-centre double counts cannot be excluded. Stéribox® sales are an indicator of both the magnitude of intravenous drug use, which only corresponds to part of the definition of problem drug use, and the coverage of harm reduction practices, which may vary across France.

Finally, it must not be forgotten that these three methods are all based on local estimates obtained from the NEMO study: the first two methods used local estimates in order to estimate the proportion of the population hidden from the information source used, and the last method uses departmental estimates as anchor points for extrapolating data. There are inherent difficulties in using the “capture/recapture” method in drug addiction as it uses theoretical hypotheses which have not been completely confirmed in practice. The capture-recapture technique relies on the hypothesis that each person belonging to the target group (the subject of the estimate) has the same probability of being captured by the different information sources (the hypothesis that the population is homogenous) and on the hypothesis that the sources are independent, i.e. that being recorded in one system does not change the probability of being recorded in all the other systems. In reality, regular illegal drug users are not homogenous: some “manage” their use and are very unlikely to be “identified” either by the health and social system or by the legal system, particularly for cocaine use. There are also possible links between being “captured” by several sources. A user who has been arrested may be prosecuted or even imprisoned, making it impossible for him/her to be identified by a CSAPA or CAARUD during this period. The use of log-linear analysis with three data sources, however, makes it possible to get away from the hypothesis that the sources are mutually independent and according to the log-linear methods used, it appears unlikely that there is any interaction between the three sources. Finally, beyond these limitations on the bases of the hypotheses underpinning the method, the magnitude of the confidence intervals surrounding the NEMO estimates due to the small numbers of triplicates must be emphasised.

Comparison with previous estimates

The first methodologically documented estimates of problem drug use prevalence in France date from the middle of the 1990s. A demographic method used in 1995 based on 1993 data produced an estimate of at least 160,000 heroin addicts (COSTES 1995). A few years later, the first application of the European protocol, which was under construction, to the situation in France produced an estimate of 146-172,000 problem opiate users in France in 1995 (Observatoire français des drogues et des toxicomanies (OFDT) 1999).

It was during the same period that the capture/recapture method was first used in France for drug addiction (in the Toulouse metropolitan area) (BELLO 1998). The European protocol was applied a second time at the beginning of this century, when the capture/recapture method was extended to several towns (CHEVALLIER 2001). The new estimate based on 1999 data was similar to the previous one: 146-180,000 problem opiate or cocaine users (Observatoire français des drogues et des toxicomanies (OFDT) 2002).

The raw figures, which increased from 160,000 in 1993 to 230,000 in 2006 suggest a marked increase in the phenomenon. This impression is misleading for at least two reasons. Firstly, the methods and, in particular, the subject of the estimate, have changed. The context has moved from the concept of “heroin addicts” (1993) to “problem opiate users” (1995) and then to the definition “problem opiate or cocaine users” (1999) and finally to “intravenous drug users or regular users of opiates, cocaine or amphetamines” (2006). The scope of the estimate has therefore broadened over time.

The second reason is the magnitude of the confidence intervals around the central estimates. It can be seen from the confidence intervals obtained from the capture/recapture method – which lies at the heart of all of the methods used – that the national estimate calculated for 2005-06 ranged from 144,000 to 367,000. For these reasons, it is difficult to conclude that there has been a clear increase in the estimates.

We can only highlight that there may have been an increase in the number of problem drug users. Other information sources also indicate, firstly, “ageing of the population concerned”, with reduced

mortality rates since the increase in substitution treatments at the end of the 1990s, and secondly, a degree of “population renewal” because of the spread of stimulants, the emergence of new opiate users and changes in the party scene, etc.

Finally, we should re-examine the theoretical definition produced by the EMCDDA. A problem drug user is defined as an intravenous drug user or regular user of opiates, cocaine, or amphetamines during the previous year in the 15-64 age group. To a greater or lesser extent, all of the methods proposed assume that the user can come into contact with one of the information sources used (arrest, treatment, health problems, death, etc.). These sources can extrapolate by estimating the number of people who have not yet come into contact with them but will do so in the future, but not the number of those “who will never come into contact with them”. It is therefore extremely likely that our estimate does not cover all “regular opiate, cocaine or amphetamine users) because of the inability (of these methods) to detect “controlled” uses of the substance in a better socially integrated population.

Estimation of the number of regular heroin users

It would be useful to try to apply the European protocol in order to obtain an estimate of the number of heroin users in France. It is known that the magnitude of this behaviour in the French population cannot be obtained from data produced by general population surveys. This is firstly due to the fact that the prevalence of the phenomenon is below the limit which can be identified by these surveys, and secondly, to frequent loss of social integration of the population concerned.

Unfortunately, it is also impossible to apply the different methods of the European protocol described above to the limited field of heroin users. The breakdown by substance, which is available for some information sources, is not present in all of the sources these methods use. Therefore, if we wish to estimate the number of “problem heroin users” within the meaning of the EMCDDA definition, a figure which can be approximated to the number of “regular heroin users”, the only solution is to search for the proportion of heroin users in the different drug user surveys and use this proportion to estimate the number of “problem drug users”.

A mean estimate can be produced from these different available health data: 32% of problem drug users³¹ are heroin users (use during the previous month).

It can therefore be estimated that approximately one third of problem drug users are active heroin users. To this third can be added a considerable proportion of people who were former heroin users, and who are now abstinent, either because they are receiving treatment (particularly substitution) or because they have moved on to other substances, and who may subsequently, either occasionally or regularly, take heroin again. This 32% figure can therefore be considered to be a minimalist estimate.

Estimation of the number of intravenous drug users

It would also be interesting to try to use the European protocol to obtain an estimation of the number of intravenous drug users in France. For the same reasons as above, this can neither be obtained from the general population survey data nor by directly applying the European protocol.

Here again the only solution is to look for the proportion of intravenous users in the different drug user surveys and apply this proportion to estimate the number of “problem drug users”.

The different health data available provide a mean estimate of 63% injecting at least once during their life and 35% injecting within the previous month.

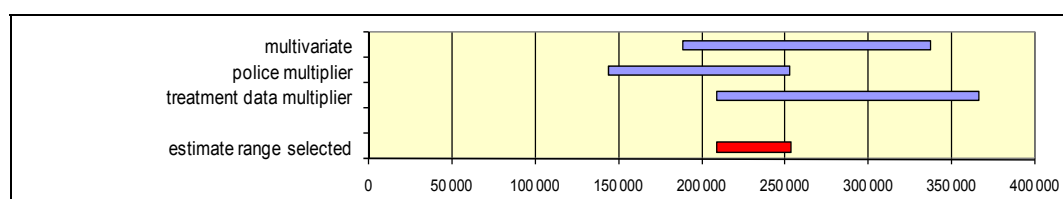
Results summary

The aim of this work was to produce a new estimate of problem drug users in France, together with the corresponding prevalence rate. There is great temptation to emphasise the wide range of results obtained and produce a wide estimate range. This however risks reducing the visibility and

³¹ In view of the sources and data used, the range of substances can be considered to exclude cannabis.

understanding of the result. The role of the expert is to offer a single estimate (or narrow estimate range) which in his/her opinion is probably closest to the actual situation.

Graph 4-1: Narrow estimate of problem drug users, summary



In view of the inherent limitations of each of the methods used and described above, there is no “best method”. The values common to the confidence intervals for the three methods are therefore offered as the most likely estimation range, between 210 000 and 250 000 problem drug users in France en 2006 of which half involved in opiate substitution treatment. Indeed, it is estimated that 120 000 people have used opiate substitution drugs in the first half of 2007 (Observatoire français des drogues et des toxicomanies (OFDT) 2009).

Table 4-4: Problem drug prevalence estimates in France, 2006

Problem drug use prevalence estimates in France, 2006	
estimate range selected	210 000 - 250 000
rate/ 1000 hab. 15-64 years	5,4 - 6,4
central estimation	230 000
rate/ 1000 hab. 15-64 years	5,9
including	
- last month heroine users	74 000
rate/ 1000 hab. 15-64 years	1,9
- life time injecting users	145 000
rate/ 1000 hab. 15-64 years	3,7
- last month injecting users	81 000
rate/ 1000 hab. 15-64 years	2,1
Source : OFDT,2008	

4.2.2. Estimates of incidence of problem drug use

No new information available.

4.3. Data on PDUs from non-treatment sources

No new information available.

4.4. Intensive, frequent, long-term and other problematic forms of use

No new information available.

5. Drug-related treatment: treatment demand and treatment availability

5.1. Introduction

Treatment policies targeting users of illegal drugs have been characterised by several key periods in France. Prior to the 1970s, illegal drug users were treated in psychiatric hospitals. The adoption of a law in 1970 which made it possible for any drug user to obtain free, anonymous treatment aimed at bringing about abstinence, encouraged the development of specialised outpatient treatment centres or residential centres, with the latter being intended to accommodate drug users after withdrawal. On the one hand, the psychiatric institutions did not wish to specifically welcome drug users, who were coming forward in ever greater numbers, while on the other hand several associations showed themselves extremely willing to play their part in treating these patients. Despite this, the two treatment systems continued to exist in parallel, with the latter gaining importance in relation to the former.

The second major highlight in the history of drug treatment policies was brought about as a result of the AIDS epidemic. Lagging behind in comparison to other countries, the French public authorities belatedly turned to substitution and harm reduction treatments in the early 1990s. The decision taken in France to embark upon a rapid and massive roll-out of high-dose buprenorphine substitution treatments resulted in general practitioners playing a much greater role in the treatment of opiate users. At the same time, the rapid spread of the AIDS epidemic and the adoption of the resulting harm reduction policy introduced as a direct result raised the question of access by drug users to hospitals, (not psychiatric hospitals this time, but rather general hospitals) in order to obtain treatments for both their somatic and addiction problems. In the same manner as for anti-alcohol treatments, liaison teams for drug users were set up both in order to encourage treatment by the hospitals' somatic departments and also to avoid having users welcomed for somatic problems leave hospital before a diagnosis and addiction treatment package had been proposed to them. This process of integrating addictology within the hospital environment was carried through to completion with the adoption in 2007 of a plan by the Ministry of Health which will be described in more detail in the following section.

As in most developed countries, the treatment policy for drug use in France is organised around specialised treatment and harm reduction programmes, private GPs, and hospitals. Over and above poster campaigns and publicity initiatives, in practice these policies are based on a relatively stable combination of the various sectors and tools available.

5.2. General description, availability and quality assurance: strategy/policy

For the period currently underway, the public authorities' policy in the drug treatment field has been described in two plans adopted in 2006 and 2008. The first, the addiction treatment and prevention plan for 2007-2011 (which only concerns treatment and prevention) was drawn up by the health ministry at the request of the President of the Republic. The second, the 2008-2011 governmental plan to fight drugs and drug addiction mentioned in a previous report was drawn up by the President of the MILDT, Etienne Appaire. This second plan, which covers treatment as well as prevention and repression, includes the objectives of the previous plan while setting a number of specific new objectives.

The drug treatment and prevention plan for 2007-2011 (MINISTERE DE LA SANTE ET DES SOLIDARITES 2006) restates the need to implement a policy targeting all forms of addictive behaviour, whether this concerns the use of illegal substances, alcohol or tobacco, or drug-free forms of addiction such as gambling and gaming. This plan chiefly focuses on boosting the resources available to the hospital system to treat addictions. It provides for the creation of addictology clinics or addictology liaison teams in all hospitals with an emergency department. These clinics or liaison teams should make it possible to bring together all existing tobacco, alcohol

or drug consultations in the same place and the same department. For those patients requiring more specific treatment or hospitalisation, addictology departments offering simple or complex withdrawal treatments should be created by 2011. Moreover, there is a plan to include, in each university hospital (a total of 26 establishments), an addictology section, serving as both an emergency addictology department and a regional reference, training and research centre.

This plan also incorporates a number of objectives already under discussion such as merging the specialised drug treatment and alcohol treatment schemes into CSAPAs, boosting therapeutic accommodation capacities for illegal drug users through the creation of several therapeutic communities in addition to roping in general practitioners by strengthening the addictology health networks. The 2007-2011 plan also states that it is necessary to create precise standards and benchmarks for the patient treatment strategy, before, during and after the treatment.

All of these objectives are detailed in the 2008-2011 governmental plan to fight drugs and drug addiction (MILDT 2008) which nevertheless more specifically emphasises a number of these objectives and proposes several new ones. The objectives proposed by the MILDT are described below:

- Improving the skills of professionals in the individual targeted prevention and treatment fields thanks to various training programs.
- Improving the socio-sanitary care received by young users of psychoactive substances by increasing the number of clinics for young users and their availability in the form of prior consultations at "general purpose" locations welcoming young people.
- The creation of new therapeutic communities, (centres in which the goal of abstinence must be clearly stated).
- The development of new methods for treating cocaine users.
- Improvements to the provision and continuity of treatments provided to drug and alcohol users in penal environments.
- Protecting the health of unborn children and their mothers, and taking full account of the specific characteristics of female drug and alcohol users.
- The reduction of health risks related to drug use.
- The reduction in morbidity and mortality linked to hepatitis C among drug users.
- Improvements to the social integration and reintegration of addicts.

5.3. General description, availability and quality assurance: treatment systems

Two schemes contribute to treating illicit drug users: the specialised addictology treatment scheme (provided through medical/social establishments) and the general healthcare system (hospitals and GPs).

5.3.1. Organisation and quality assurance

The specialised scheme

These centres were created following the adoption of the 1970 law which included a number of measures guaranteeing free and anonymous treatment for all illicit drug users wishing to receive treatment. Virtually all of the French "départements" today have at least one Specialised Drug Treatment Centre (CSST).

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

Three types of CSST can be distinguished:

- Outpatient treatment centres (numbering 216 in 2007);

- Inpatient treatment centres including therapeutic communities (numbering 40 in 2007). More precisely, these centres are rehabilitation centres for patients after detoxification or following substitution treatment. Residential detoxification is carried on in general hospitals.
- Treatment centres in penal establishments (numbering 16 in 2007). These centres may be compared to outpatient centres, located inside the prison, and only treating people who are presently in jail. Drug-free quarters in prison do not exist in France.

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

In France, the concept of "Drug-free treatment" is not really used and it is difficult to equate this to a given type of institutional treatment. However, a very limited number of "therapeutic communities", which are supposed to offer drug-free treatment, have been recently created. An evaluation study of these new centres is currently underway. The results of this study are not yet available.

In the course of 2009, all CSSTs will have to get a new administrative agreement as CSAPA for a three-year period. A circular³² dated February 28, 2008 describes the CSAPAs' missions. These missions are roughly identical to those which were previously handled by the CSSTs. The CSAPAs are responsible for welcoming, providing information and guidance to and conducting medical, psychological and social assessments for all persons suffering from addiction problems regardless of the substance (including "drug-free" addictions) who come to them for assistance. The CSAPA consequently has a medical, psychological, socio-educational and harm reduction role and may specialize in either illegal drugs or alcohol.

Treatment via the general healthcare system

The development of the specialised treatment system makes it impossible to meet all of the treatment needs of illicit drug users. Since the 1990s, the focus has been placed on improving the reception of patients suffering from addiction problems by the general healthcare system (hospitals and general practitioners).

A- Hospitals

As mentioned in the section dealing with treatment policy, the addiction prevention and treatment plan has provided for the creation of a new addictology treatment organisation within hospital environments. The administrative circulars of May 16, 2007 and September 26, 2008³³ provide precise details of the organisation to be set up within the hospital system. Addictology treatment within hospitals is organised into an addictology treatment system comprised of a number of components. The goal is to enable each person suffering from addictive behaviour to have access to comprehensive, progressive and locally available treatment and, if necessary, to a specialized technical centre. This system includes three distinct levels.

Level 1 hospitals have the task of carrying out simple residential withdrawal courses, liaison activities and consultations. Created by the circular dated April 3, 1996, the liaison and addictology treatment teams, which usually comprise three people including one hospital doctor, have the task of training and assisting teams of care staff in hospitals, drawing up therapeutic protocols, and working with hospitalised and emergency patients. They carry out prevention, information and

³² Circulaire n°DGS/MC2/2008/79 du 28 février 2008 relative à la mise en place des centres de soins, d'accompagnement et de prévention en addictologie et à la mise en place des schémas régionaux médico-sociaux d'addictologie. NOR : SJSP0830130C.

³³ Circulaire n°DHOS/O2/2008/299 du 26 septembre 2008 relative à la filière hospitalière de soins en addictologie. NOR : SJSH0830983C.

awareness-building activities within the care establishment. Patients can also be received for outpatient treatment via the addictology clinics.

The level 2 hospitals offer the same services as the level 1 hospitals, with the addition of the possibility to provide complex residential treatment courses either involving hospitalisation or day care.

Level 3 hospitals handle the activities of the level 2 hospitals in addition to education, training, research and regional coordination activities.

The circular dated September 26, 2008 also states that the hospital addictology treatment systems must be organised in coordination with the specialised CSAPA and CAARUD schemes, the general practitioners and the health networks.

B-General practitioners

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

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

5.3.2. Availability and diversification of treatment

Medical treatments (substitution, withdrawal).

Withdrawal treatments used or monitored by staff in Specialised Drug Treatment Centres (CSSTs).

In 2006, an average of approximately 17 patients per centre underwent outpatient withdrawal treatment via an outpatient CSST (table 5.1) and almost 13 patients undertook withdrawal treatments in hospital with the support of a centre. The data shown in table 5.1 reveals a major increase in the number of withdrawal treatments undertaken between 2003 and 2004. However, this change is almost certainly linked to changes in the wording of the questions following the adoption of a new report in 2004. Nevertheless, the trend is clearly an upward one and this has been the case since the 1990s. This change needs to be put in perspective, as the total number of people welcomed by the specialist centres has also increased sharply since the late 1990s.

Table 5-1: Average number of patients undergoing a withdrawal treatment per outpatient CSST, 1998-2006

	1998	1999	2000	2001	2002	2003	2004	2005	2006
Average number of patients per CSST having undertaken outpatient withdrawal treatments provided by the CSST.	6.8	5.7	6.2	8.4	10.6	11.0	16.8	16.1	17.5
Average number of patients per CSST having undertaken a withdrawal treatment in hospital, with the support of the CSST (per centre)	N.Av	N.Av	N.Av	N.Av	N.Av	N.Av	10.3	13.2	12.8

Source: Processing of the standard activity reports from the outpatient CSSTs 2006, DGS/OFDT.

Guide to the table: on average, 6.8 patients per CSST undertook an outpatient withdrawal treatment provided by the CSST in 1998. Note: the calculations were made by excluding those centres issuing more than 150 withdrawal treatments or who failed to answer the questions concerning their activity. The total number of patients having undertaken withdrawal treatments is calculated by extrapolating the average number of withdrawals to all CSSTs with a new "withdrawal treatment" patient intake of fewer than 150 patients. To this figure is added the total for those centres excluded from the previous calculations due to the size of their intakes of new patients undertaking withdrawal treatments.

According to the data supplied by the CSSTs, the number of patients having undertaken a withdrawal treatment in 2006 can be estimated at somewhere between 8,000 and 9,000. However, these numbers also include alcohol dependant patients treated within CSSTs.

Substitution treatments for patients attending front-line structures

At the time of the 2006 Prelud survey, 60% of users stated that they were receiving a medically prescribed substitution treatment. In just under two-thirds of these cases, HDB was used (62.2%), while a third received methadone (32.4%). Finally, a minority (4%) received a treatment based on morphine sulphate.

On average, users receiving a substitution product tend to be older than those not receiving a treatment of this kind. While the average age of the latter stands at 32.1 years old, this rises to 33.6 years old for users receiving an HDB substitution treatment, 34.7 years old for those receiving methadone and 35.2 years old for those receiving morphine sulphate.

In 79.4% of cases for morphine sulphate, 59.0% for HDB but only 16.4% for methadone, the substitute drug was also mentioned among those substances used for extra-therapeutic purposes. Thus, among drug users receiving morphine sulphate and HDB, it would appear that it is the prescribed drug itself which is most often mentioned as the substance causing the most problems by contributors (66.2% and 42.2% respectively). Indeed, among the active drug users interviewed via the CAARUDs, a majority use injection as the preferred administration method, while sniffing or smoking is less common. On the other hand, among those receiving methadone, this drug is mentioned as problematic in only a small number of cases (9.5%), being outpaced by heroin (24.3%) and cocaine/crack (19.5%). Unlike the other two substitute drugs, methadone (when used outside the scope of a therapeutic programme) is almost exclusively used orally (96.5%) (TOUFIK, CADET-TAIROU et al. 2008).

The issuing of substitution treatments

Two drugs are used for the purpose of opiate substitution treatment: methadone, the prescription of which may only be initiated in CSSTs and healthcare establishments, and High Dose Buprenorphine (HDB) or Subutex®, which can be prescribed immediately by any doctor. After being introduced onto the market in 1996, HDB quickly became the leading treatment for opiate dependency in France, in volume terms. We should also point out that since 2006 Subutex® is no longer the only product available, as generic specialities have also become available on the market (HDB Arrow® in 2006 and HDB Merck® in 2007³⁴).

Recent data from the Caisse nationale de l'assurance maladie (national health insurance organisation for salaried employees) reveal that 119,819 people received refunds for opiate substitution treatments during the first half of 2007 with a clear predominance of HDB (a factor specific to France), which accounted for 80% of the total. By late 2007, the level of market penetration for generic products stood at between 15 and 20% of HDB refunds.

However, methadone's share continues to rise and it must be remembered that easier access to this drug is one of the recommendations from the Consensus Conference on substitution treatments held in June 2004. Data from the health insurance system also show that refunds for HDB treatments rose by 24.3% while those for methadone increased by 155% in 4 years.

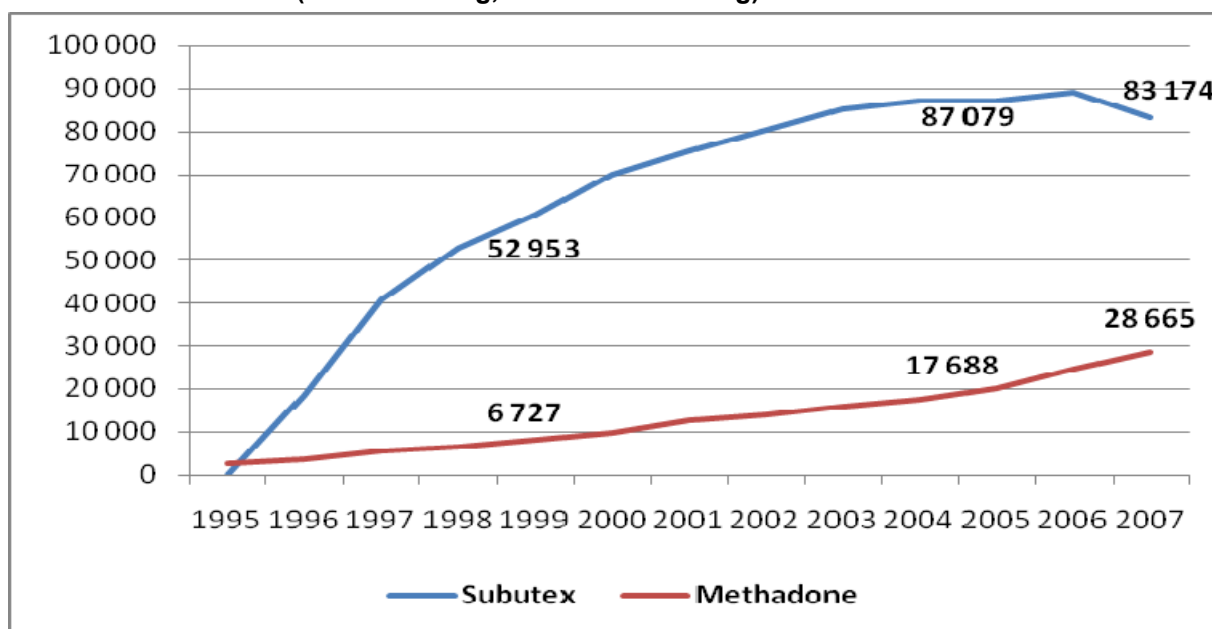
Graph 5.1 below presents an estimate of the number of patients treated in France using HDB and methadone. This data is derived from the sales figures for these two substitute drugs, supplied by the GERS³⁵ based on the assumption that the average dose prescribed over a year is 8 mg per day for Subutex® and 60 mg per day for methadone. The quantities of Subutex® sold therefore represent a theoretical equivalent of 83,174 patients having received a daily dose of 8 mg throughout 2007. For methadone, a similar calculation gives us a theoretical total of 28,665 patients. These are theoretical patients, as treatment compliance is not always so good for real patients and the latter do not all undergo treatment programmes between 1 January and 31 December. During a given year, some may be ending their treatment while others may only be starting. The number of people having received at least one prescription for a substitution treatment will therefore logically be higher than the number of theoretical patients.

³⁴ HDB Merck became HDB Mylan® in 2008

³⁵ Groupement pour l'élaboration et la réalisation de statistiques (*Group for the Production and Elaboration of Statistics*)

We should also point out that these data do not take account of the generic versions of HDB introduced in 2006 ("offsetting" the effective reduction in the number of patients receiving Subutex® in 2007, as shown in the graph) and that for methadone, the data is based on refund data for both general practitioner consultations and hospital care.

Graph 5-1: Opiate substitution treatments, an estimate of the number of people receiving an opiate substitution treatment (Subutex® 8mg, Methadone® 60 mg)



Source: GERS/SIAMOIS/InVS

It should, however, be borne in mind that prescribed HDB is sometimes misused and that the substance is not always used within the scope of a therapeutic programme. However, the level of such misuse has fallen since the introduction of a drug control plan for opiate substitution treatments by the health insurance system, as one of the major indicators revealing the misuse of HDB (an average daily dose exceeding 32 mg/day³⁶) was slashed by two-thirds between 2002 and 2007. Six percent of subjects received more than 32 mg/day of HDB at the time, compared to 2% of subjects in 2006 and 1.6% the following year, according to a recent study (Canarelli T. and Coquelin A. 2009). This study, just like the previous one in 2002, also revealed that two-thirds of patients having received refunds for opiate substitution treatments in 2006 and 2007 are undergoing regular treatments and are therefore presumably enrolled in a therapeutic programme. For their part, the other recipients of such treatments are not necessarily receiving the drugs outside the scope of a treatment programme.

Substitution treatments in hospitals

The survey carried out in 2007 by the OFDT (OBRADOVIC and CANARELLI 2008) aimed at assessing the impact of circular no.2002/57 of 30 January 2002 regarding the first prescription of methadone by doctors in health establishments (hospitals and prison treatment centres) made it possible to demonstrate that access to methadone had increased on both fronts.

The part of the survey carried out in hospitals highlighted the major role played by general practitioners in providing dependent opiate users with specialised treatments, both "upstream" (by referring patients to hospitals to initiate a course of treatment), and "downstream" (by dealing with patients following discharge from hospital). The survey also underlines the importance of ensuring

³⁶ The maintenance dosage for HDB is 8mg/day with a maximum dose of 16 mg/day. An average daily dose in excess of 32 mg/day points to suspected misuse of HDB (trafficking and/or dealing).

"seamless" operation between the various partners in the treatment scheme, in order to avoid any gaps or breaks in the substitution treatment when the patient leaves hospital.

Substitution treatments in prison treatment centres

Please see 9.6.1

5.4. Access to treatment: characteristics of treated clients (TDI data included)

5.4.1. Total number of treated clients

In France, only those people welcomed in the CSSTs are included in data collection compatible with the TDI protocol. Furthermore, this collection is not exhaustive as in 2008; around a third of the CSSTs supplied no data at all. To this should be added the fact that the TDI data only concerns those persons beginning or resuming a course of treatment. We must therefore use other sources to quantitatively assess the total number of people coming forward to seek help from professionals for their illegal drug use problems.

We currently possess fairly precise data concerning the number of people treated via the specialised schemes. Each year, the CSSTs must supply the administrative authorities with an activity report, which includes a selection of data concerning the drug users seen during the year gone by. The response rate for these reports is 90% each year and almost 100% over a two-year period. Based on these activity reports, it is possible to estimate the number of people who sought help in the outpatient CSSTs in 2007 for their problems with illegal drugs at approximately 90,000. This number includes double entries which, however, should not account for more than 5% of the overall total. In relation to the outpatient CSSTs, the number of people accommodated in residential treatment centres appears to be very low, at slightly fewer than 2,000 people, some of whom have already been counted among those people visiting the outpatient CSSTs. Indeed, many of the patients accommodated in the residential centres are referred by the outpatient CSSTs. In those CSSTs located in penal establishments, the number of people welcomed for problems with illegal drugs can be assessed at 4,700.

Regarding general practitioners, the only national data available concerns those persons receiving substitution treatments. The previously mentioned data indicates that approximately 120,000 people received refunds for their substitution treatments from the Social Security system during the first half of 2007. If we assume that two-thirds of these people were still receiving treatment at the end of the year and that the total number does not vary from one 6-month period to another, this gives us a total annual number of 160,000 different people seen by a GP to obtain a substitution treatment prescription in 2007. The equivalent figure for the whole year is higher but is not known precisely. A percentage of these people are also included among those having visited a CSST in 2007.

Regarding the hospitals, we have access to national data from the PMSI³⁷ medical-economic information system concerning the number of hospitalisations for which the main diagnosis was behavioural problems related to the use of psychoactive substances excluding alcohol and tobacco (diagnoses: ICD10 F11 to F16, F18 and F19). This number of hospitalisations totalled 5,800 in 2007, including 2,200 stays exceeding 24 hours in hospital. It should be noted that this data does not include visits to the emergency department. These statistics only concern hospital stays. As the same person may have been hospitalised several times, the number of people recorded is obviously lower than the total number of stays. Double entries also exist concerning those hospitalised persons who have also sought help in the specialised centres or through visits with GPs. Other data dating back to 2005 from an activity report by the liaison teams (requested for one year only) makes it possible to assess the number of people seen in outpatient clinics (i.e. non-hospitalised) for illegal drug use problems at approximately 8,000. Once again, it is not possible to add these figures to the others, in view of the many possibilities for double entries concerning these individuals and those who are hospitalised or already counted in the other previously mentioned

³⁷ <http://stats.atih.sante.fr/mco/diagone.php>

sectors. The data concerning the hospitals is extremely fragmented. Nevertheless, we can clearly see that the number of people with an illegal drug use problem seen at a hospital (excluding the CSSTs) during a given year was, until fairly recently, quite low when compared to the total number of people welcomed in the CSSTs (no more than 10%). Governmental plans to increase addiction treatment capacity within general hospitals may lead to a rise in the number of treated persons. It must however be kept in mind that the vast majority of treatment facilities within general hospitals target the most common addictions, alcohol and tobacco.

5.4.2. Characteristics of all clients starting treatment in specialised centres

The profile of those persons receiving treatment shown in this paragraph corresponds to that of new patients having started treatment in 2008, exclusively via the outpatient treatment centres.

In 2008, 140 outpatient CSSTs participated in RECAP, equivalent to 65 % of all outpatient treatment centres. The data shown below concerns around 41,000 patients (referred to as “new patients”) who started a new episode of treatment in one of these centres during the year.

Those persons receiving treatment for the first time in their life (referred to as “first-time treatment” patients) accounted for 29 % of all new patients seen. For the other patients, these were new requests for treatment or a renewal of treatment following a break in contact with the treatment centre in excess of six months. The percentage of first-time patients among all patients should be taken with caution since information concerning the existence of previous treatments is unknown in 27 % of cases.

In the use descriptions shown below, it has to be borne in mind that in approximately 21 % of the cases there is no information on the main drug.

Socio-demographic characteristics of patients

Among the new patients, 81% were male with an average age of 29.4 years old. This mean age is actually the result of a mix of two subpopulations, cannabis users on the one hand, with a mean age of 25, and opiate and cocaine users on the other hand with a mean age of around 32. Patients seeking treatment for the first time in their lives had a slightly higher proportion of males among them (83 %) and were on average younger, with a mean age of 26. The most extensively represented age group among all treatment patients is the 20-24 age group (accounting for 23 % of patients) with the under-25s accounting for 36 % of the total. A little more than 15 % were aged over 40. In contrast, half of “first-time treatment” patients were under 25 and 8 % were aged forty or over. As will be seen further, this age difference is closely related to the higher proportion of cannabis users among “first-time treatment” patients.

Table 5-2: Breakdown of patients by age (as a %) in 2008

Age	All treatments	First treatments
< 20 y.o.	12.7	21.5
20-24 y.o.	23.3	30.1
25-29 y.o.	21.4	22.2
30-34 y.o.	14.6	11.1
35-39 y.o.	12.7	7.4
40-44 y.o.	8.4	3.7
45-49 y.o.	4.2	1.9
50 and over	2.8	2.2
Total	100.0	100.0

Source: RECAP / OFDT – 2008.

The two main sources of referral are the patient’s own initiative (35%) and the justice system or the police (31%). In the case of first-time treatments, it may be noted that this latter source of referral accounts for almost half of the patients (47%). Most of the people referred by the court or police are cannabis users. The results concerning the origin of the consultations are shown in Table 5-3.

Table 5-3: Breakdown of patients by treatment origin (as a %) in 2008

Origin of the treatment	All treatments	First-time treatments
Patient's own initiative	35.3	24.2
Family or friend	9.3	10.1
Other specialised centres for drug users	6.1	1.9
General practitioners	6.9	5.5
Hospital or other medical establishment	4.3	3.2
Social services	4.1	4.3
Police, courts or court-ordered treatment	30.8	46.8
Other	3.2	4.0

Source: RECAP / OFDT – 2008.

Patients most frequently lived with their parents or alone (37% and 28%) and most lived in stable housing (77%). Nevertheless, 20% of them stated that they lived in precarious housing conditions. Due to the higher proportion of younger people among them, first-time treatment patients were less likely to live alone and more likely to live with their parents.

Table 5-4: Breakdown of patients by living status (with whom) (as a %) in 2008

Living status (with whom)	All treatments	First-time treatments
Alone	28.0	22.6
With parents	36.7	46.3
Alone with child	2.8	1.8
With partner (alone)	12.3	11.7
With partner and child(ren)	10.9	10.0
With friends	3.1	2.4
Other	6.1	5.2

Source: RECAP / OFDT – 2008.

Regarding their socio-professional situation, economically inactive or unemployed patients accounted for a total of 43%, while just over a quarter (27%) had a regular job and 14% were still at school or students. First-time treatment patients differed from all treatment patients by a higher proportion of students and pupils and a lower proportion of economically inactive persons. Where the patients' educational profiles were concerned, 63% of people treated in the CSSTs in 2008 had reached secondary school level. A total of 5 % of users had not got past primary school level and 32 % stated that they had an educational level above the baccalauréat (A-level/High School Diploma). The distribution of educational level is not different among first-time treatment patients.

Table 5-5: Breakdown of patients by professional situation (as a %) in 2008

Professional situation	All treatments	First treatments
Regular employment	26.9	29.3
Student, secondary school pupil	13.8	19.8
Economically inactive	20.7	13.4
Unemployed	22.5	19.3
Other	16.2	18.2
Total	100.0	100.0

Source: RECAP / OFDT – 2008.

Drug use

Table 5.6 features a detailed breakdown of patients according to their declared main drug in 2008. Almost half of the patients (48%) sought help from the treatment centres in 2008 for problems related to cannabis use. A majority of them (56%) declared that they used cannabis on a daily basis. The proportion of first-time treatment patients with cannabis as the primary drug was higher than for all treatment patients - two-thirds. The distribution of frequency of use was not different in

the two groups. The share of cannabis users among patients undergoing treatment in France is partly the consequence of the large and still increasing number of arrests for cannabis use. Some arrested users are referred to treatment centres by the courts. The creation of clinics for young users, mainly dedicated to cannabis users, may seem to have played an important role in increasing the number of cannabis users in contact with treatment centres but, as will be seen later (section 5.5), data on the total number of people treated for cannabis use since the end of the nineties shows an increase that took place before the launch of the clinics for young users.

Opiates were identified as the main drug by 41% of patients. In all, 80% of them took heroin, with methadone accounting for just over 3% and other opiates (including HDB)³⁸ 16%. Among the opiate users, almost 80% used the substances on a daily basis and 10% took them regularly (i.e. several days a week). The opiates were generally sniffed (52%) or injected (24%). The proportion of first-time treatment patients with opiates as the main drug was much lower than for all patients (33% vs 41%). The distribution of frequency of use was similar in the two groups although there was a slightly higher proportion of daily use among first-time treatment patients. Injecting was much less frequent in this group than among all treatment patients taken as a whole (13% vs 26%).

Table 5-6: Breakdown (as a %) according to the main drug taken, 2008

Main drug	All treatments	First-time treatments
Heroin	32.6	21.6
Methadone	1.4	0.9
Other opiates	6.7	3.1
Cannabis (all)	47.8	65.5
Barbiturates	0.1	0.1
Benzodiazepines	1.4	0.5
Other hypnot. and tranquilizers	0.5	0.2
Cocaine	5.3	4.8
Crack	1.8	0.8
Amphetamines	0.3	0.3
MDMA and other derivatives	0.6	0.6
Other stimulants	0.0	0.0
LSD	0.2	0.2
Other hallucinogens	0.1	0.1
Volatile inhalants	0.2	0.4
Other substances (all)	1.2	1.0

Source: RECAP / OFDT – 2008.

Cocaine was the third main drug, being mentioned by more than 5% of patients. Cocaine users declared that they used it every day (37%) or frequently (26%). The cocaine was sniffed (67%) or smoked (16%) and it was also injected by a non-negligible percentage of patients (14%). Cocaine was slightly less frequently mentioned as the main drug among first-time treatment patients but the difference was not very significant. Among cocaine users seeking treatment for the first time in their lives, the percentage of persons injecting cocaine was smaller than among all cocaine treatment users (6% vs 14%) while a larger proportion sniffed this substance (79% vs 67%).

Among all patients seeking treatment in 2008, more than three-quarters (74%) stated that they had never used injection as an administration method. It is possible to divide the patients having injected into two groups: 14% of them had not used this method recently and 11% stated that they had injected during the month preceding the interview. Those who used injection during the previous month were mostly opiate users (82%): 52% were heroin addicts and 26% declared other opiates (including HDB) as their main drug. Nevertheless, a non-negligible number of people using injection as an administration method were receiving treatment for cocaine use (8%). The persons welcomed by the CSSTs for the first time in their lives tended to use intravenous administration less often than patients who had already received treatment. Thus, in 2008, 91% of first-time outpatients (all

³⁸ For methadone and HDB, this means non-therapeutic use.

products considered together) had never used injection as an administration method (vs 74% among all treatment patients).

5.5. Access to treatment: Trends of patients in treatment

TDI-compatible data concerning patients has only been available in France since 2005. Consequently, changes can only be monitored over a relatively short period.

The data shown in Table 5.7 reveals a continuing increase in the average age for all patients beginning a new course of treatment, and for patients having never before been treated. When we look at changes in the distribution by age range (Table 5.8), we see that this ageing effect appears above all to be related to a reduction in the percentage of 15- to 24-year-olds, and particularly the 15-19 age group, coupled with an increase in the number of people aged 40 and over. This sharp reduction in the percentage of 15- to 19-year-olds is also seen for "first treatment" requests with, however, a stabilisation occurring between 2007 and 2008. According to the data derived from the activity reports concerning all users seen by the CSSTs, the percentage of the under-18 age group (who are usually cannabis users) increased sharply in the early 2000s and subsequently began to decline after 2005. In order to be able to interpret these changes, we need to keep in mind that, according to the activity reports supplied by the CSSTs, the number of people seen by the centres has tended to increase from year to year. Thus, a reduction in the percentage of those under 18 does not necessarily mean that the actual number has decreased.

Table 5-7: Mean age of patients, changes over the period 2005-2008

	2005	2006	2007	2008
All treatments	28.0	28.3	29.1	29.4
First-time treatments	24.1	25.0	25.9	26.2

Source: RECAP / OFDT – 2005 - 2008.

Table 5-8: Distribution of patients by age (as a %), changes over the period 2005-2008

	2005	2006	2007	2008
<15	0.6	0.8	0.7	1.4
15-19	16.0	14.8	11.9	11.3
20-24	24.8	25.2	24.7	23.3
25-29	19.0	19.4	21.2	21.4
30-34	16.6	15.4	14.9	14.6
35-39	12.3	12.3	12.5	12.7
40-44	6.8	7.1	8.4	8.4
45-49	2.5	3.2	3.5	4.2
50-54	0.8	1.2	1.4	1.7
55-59	0.3	0.5	0.6	0.7
60-64	0.2	0.2	0.2	0.3
>=65	0.1	0.1	0.1	0.2
Total	100.0	100.0	100.0	100.0

Source: RECAP / OFDT – 2005 - 2008.

Other than the trend towards an increase in the average age of those persons welcomed by the centres, the patients' characteristics changed very little between 2005 and 2008. In line with the

reduction in the percentage of 15- to 24-year-olds, the percentage of people living with their parents also fell, from 42% to 37%, while the percentage of people living alone increased from 25% to 28%. For reasons which are similarly related to changes in the breakdown by age ranges, the percentage of pupils and students is declining, falling from 17% in 2005 to 14% in 2008, while the percentage of people with regular employment rose from 23% to 27%.

With regard to the main drugs involved, we should mention that there was a very slight increase in the percentage of cocaine and crack, which rose from 5.7% in 2005 to 7% in 2008. The percentage for heroin fluctuated around 32% and that for cannabis around 40%. With regard to patterns of use, the data for the years 2006 to 2008³⁹ show a slight reduction in injection in the "other opiates" category (43% of injectors in 2006 compared to 40% in 2008).

³⁹ The data from 2005, (the first year for the RECAP national data collection scheme) is less reliable than that of the following years for certain questions.

6. Health correlates and consequences

6.1. Introduction

Health-related consequences: general context

Deaths caused by drug use

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

- By overdose, when the death is covered by a legal procedure (OCRTIS) [standard tables 5 and 6]. The statistical source covers only those deaths notified to the police and gendarmerie, and does not cover the overdose deaths of French citizens abroad or deaths occurring in hospitals.
- The number of overdose deaths recorded by the security forces is constantly falling (-90% since 1995 with 57 cases deaths recorded in 2005). Apart from the problems of recording such deaths, the reduction in the number of overdoses in France is the result of a combination of several factors including: the introduction of substitution treatments, the existence of harm reduction structures and schemes, or changes to the substances consumed and their use methods among users. Most overdose deaths recorded by the security forces are related to heroin, although medicines (including Subutex® and methadone) have seen their share increase between 2002 and 2004 (accounting for almost a third in 2004), and despite the fact that a sharp rise in deaths caused by cocaine was recorded in 2004 (this drug accounting for a fifth of deaths). In 2005, more than half of deaths were a result of a heroin overdose. The OCRTIS has not supplied updated information since the year 2006.
- By drug dependency (CepiDc-INSERM) [Standard table no. 5]. This category concerns all deaths for which the death certificate mentioned drug dependency. For reasons related to the nature of the information circuit, it is not particularly effective at recording overdoses, which are often listed in the group "unknown cause of death". The number of deaths through drug dependency fell between 1995 and 2000 (the year in which the WHO international pharmacopoeia, 10th revision was implemented) and remained unchanged between 2000 and 2005.
- With the presence of psychotropic substances in the blood: the DRAMES scheme (Décès en relation avec l'abus de médicaments et de substances -AFSSAPS) lists those cases of death for which a legal inquiry was launched. It allows identification of cases of deaths which have not been declared to the INSERM or to the OCRTIS. Two retrospective studies were carried out for the years 1998 and 2002, in addition to a forward looking study in 2002 with 7 medico-legal toxicology laboratories volunteering to take part. Subsequently, 16 laboratories were included in 2003 and 2004. A reduction in the number of recorded deaths was noted in 2003 (64 compared to 131 in 2002), followed by a slight increase in 2004 (91 cases). With regard to the substances encountered, in line with the findings of the OCRTIS data, cocaine was found to have increased sharply in prevalence during 2004, achieving prevalence identical to that of heroin which, for its part, was declining. The role of substitution treatments concerned 38% of recorded deaths in 2004 with methadone being identified in more than three quarters of cases (Arditi and al 2006). In 2005, the DRAMES data revealed 66 cases of fatal overdoses: heroin was responsible for most deaths (23 cases), cocaine was responsible for 7 deaths (compared to 20 in 2004), but the number of cases combining heroin + cocaine is rising (11 cases compared to 2 in 2004). In line with the findings of the OCRTIS data, the percentage of deaths involving substitution treatments fell in 2005, concerning 19.6% of deaths, with methadone being identified in virtually all cases (11 cases out of 12). Data collected in 2006 confirm these trends.

- Related to AIDS among intravenous drug users (InVS). The number of AIDS deaths among intravenous drug users has been falling since 1994. Since 1999, the number of death has continuously fallen, albeit at a slower pace. The share of these deaths among all AIDS deaths has remained stable since 1998 and stands at 20% in 2007.

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

Morbidity related to drug use

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

- The declared prevalence of HIV, hepatitis B and hepatitis C: the so-called "November survey" carried out among patients visiting the CSSTs (TELLIER 2001), the survey being replaced by data derived from the RECAP scheme from 2005 onwards, in addition to the survey carried out among the users of "front line" structures (Bello, Toufik et al. 2003; Bello, Toufik et al. 2004) itself replaced by the PRELUD survey conducted in 2006 (Standard Table n° 9). Based on the RECAP data for 2007, the prevalence of HIV among patients having already injected and of known serology is almost 8% and that of hepatitis C is 51%.

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

- The biological prevalence of HIV and hepatitis C (saliva samples) among drug users of front line centres: the PRELUD survey conducted in February 2006 in five French towns and cities.

- Incidence estimations applied to cases of AIDS and HIV infection. Notification of AIDS cases (InVS) has been organised since the early 1980s and has been compulsory since 1986. A new anonymous declaration scheme was set up in 2003 via the circular from the General Health Authority (Direction générale de la santé, DGS) - (n° 2003/60 dated February 10, 2003) which also makes it compulsory to declare HIV infections. This system is combined with the virological monitoring of HIV.

The number of new AIDS cases related to injectable drugs has been constantly decreasing since 1994 (with 1,377 in 1994 compared to just 75 in 2007) as has its overall percentage of all declared AIDS cases (36% in 1991, 19% in 1997 and less than 10% ten years later). The number of new AIDS cases diagnosed among intravenous drug users shows the same trend regardless of gender, sex ratio men/women apparently changing in 2006 and 2007 (2 men for a woman versus 3 to 4 men for a woman the preceding years).

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

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

4. Driving: the law dated February 3, 2003 introduced a new offence for any driver found to have narcotics in his blood following a blood analysis. Drivers now risk two years' imprisonment and a fine of €4,500. The penalties may be increased up to 3 years' imprisonment and a fine of €9,000 if alcohol has been consumed simultaneously. The screening of the driver is now compulsory in the event of a fatal accident but may also be carried out for any road traffic accident, any infraction of the Highway Code or when there are reasonable grounds for suspecting that narcotics have been taken (OFDT 2005).

6.2. Drug related infectious diseases

6.2.1. HIV/AIDS and viral hepatitis

Following the introduction of compulsory HIV notification in March 2003, 25,388 cases of HIV infection have been declared. In 2007, the number of HIV-positive declarations was estimated at 4,789, slightly down compared to previous years (4,905 and 5,133 respectively in 2006 and 2005).

In 2007, contamination by intravenous drug use (IDU) accounted for a little less than 2% of new infections. The most frequent contamination method continues to be heterosexual intercourse (45% of cases), particularly among women (66% of cases), followed by homosexual sexual intercourse (22% of cases accounting for 36% of contaminations among men).

Table 6-1: The discovery of HIV infection in 2003-2007 broken down by contamination method (France, data from 30/06/08).

Contamination method	Women		Men		Total	
	na	%	na	%	na	%
Heterosexual intercourse	6 186	66.1	4 608	31	10 794	44.6
Homosexual intercourse	-	-	5 273	35.6	5 273	21.8
Drug injection	89	0.9	321	2.2	410	1.7
Other	83	0.9	101	0.7	184	0.7
Unknown	2 993	32	4524	30.5	7 517	31
Total	9 351	100	14 827	100	24 178	100

a: Number of provisional, non-rectified cases within the primary (la sous declaration) declaration periods

b: 142 mother-to-child transmissions, 32 homosexual drug users, 8 transfusion recipients and 2 haemophiliacs contaminated during the 1980s.

Source: the compulsory notification system for HIV infection, InVS (data from 30/06/08).

The number of new AIDS cases among intravenous drug users has been continuously falling since the mid-1990s. Although at the time they accounted for a quarter of those persons diagnosed with AIDS, in 2006 they accounted for no more than 8% in 2007.

Table 6-2: New AIDS cases among intravenous drug users (IDU), 1998-2007

	1998	1999	2000	2001	2002	2003	2004	2005*	2006*	2007*
IDU	358	312	247	259	206	174	167	122	97	75
Total new AIDS cases	1 953	1 844	1 741	1 682	1 651	1487	1387	1329	1126	893
IDU as a %	18,3	16,9	14,2	15,4	12,5	11,7	12	9,2	8,6	8,4

**: Provision, non-rectified data from 30/06/08, Source: AIDS monitoring system, InVS (Data from 30/06/08).*

The PRELUD data

No new information available.

ENa-CAARUD data

No new information available.

Données RECAP.

No new information available.

6.2.2. STIs and tuberculosis

No new information available.

6.2.3. Other infectious morbidity

No new information available.

6.2.4. Behavioural data

No new information available.

6.3. Other drug-related health correlates and consequences

6.3.1. Non-fatal overdoses and drug-related emergencies

No new available information available.

6.3.2. Other topics of interest

No new information available.

6.4. Drug-related deaths and mortality of drug users

Three information sources on illicit drug-related deaths are available in France: the General Mortality Registry File (GMR) file updated by the CépiDc from the National Institute for Health, the DRAMES file (voluntary participation), the OCRTIS file (Central Office for the Repression of Drug-related Offences) and the CépiDc file from the National Institute for Health and Medical Research (INSERM).

The following table shows drug-related deaths, as reported by the three information sources. In order to ensure consistency in comparisons, the count only begins from the year 2000 when ICD-10 was implemented in France.

Table 6-3: Drug related deaths in France from three available sources

Year	DRAME	OCRTIS	CépiDc		
			All	15-59 yrs	60 yrs and +
2000	101	119	248	224	24
2001	NA	107	274	244	30
2002	74	97	244	219	25
2003	64	89	233	212	21
2004	86	69	266	238	30
2005	68	57	303	264	39
2006	168	60	305	273	32
2007	200	96	332	281	52

NA: not available.

Source: OCRTIS, DRAME, CépiDc, various reports.

The DRAMES data cannot be compared with the other information sources as the variations in the number of deaths are due to an increasing number of laboratories participating in the record. Although this figure has stabilised since 2006, it is reasonable to assume that there was a progression in 2007, as suggested by the data provided by the other two institutions. Police data (OCRTIS) confirm the upwards trend in drug-related deaths previously recorded by the deaths register (INSERM-CépiDc): an increase of more than 9% in the number of deaths recorded by this deaths register is seen between 2006 and 2007 with a 44% increase since 2003. Another specific feature of the deaths listed in 2007: 15% of drug-related deaths involve people of 60 years old and older (compared to an average of 11.5% for all of the eight years considered). Of these 51 deaths, 7 were known drug addicts (ICD-10, F codes) and 38 people died following accidental opiate or morphine drug overdoses, generally associated with palliative treatment (X42 codes). The remainder involved suicide drug-related deaths. These 44 cases can be interpreted as “false positives”: they meet the definition of a drug-related death but the victims do not fall into the category of drug addicts or irregular drug users.

It can be seen, however, that once this correction is made, the number of drug-related deaths has continued its upward trend since 2003. There are several explanations for this: in terms of the drugs supply, there is a wider availability of substances such as heroin and cocaine – the latter benefits from a positive image with users – and whose prices have fallen considerably over recent years (see the different TREND reports and the standard table 16). To this can be added misuse of substitution treatments in general and methadone in particular. On this subject, the dispensing of so-called dry methadone was confirmed by AFSSAPS in 2007 and made available to patients during the first half of 2008. In terms of demand, we note the appearance of new users associated with the party scene. They are characterised by irregular use patterns and very little or no contact with the treatment centres. A lack of knowledge of harm reduction practices differentiates these relatively young users from their elder peers (Toufik, Cadet-Taïrou et al. 2008).

The differences between each source have been highlighted in the different national reports. Data from the general deaths register (CépiDc) are used as the reference although this itself has some limitations (for example, the results of some toxicology tests are not considered in the register and some deaths are erroneously coded in the “unknown cause” section (Lecompte, Hatton et al. 1994). A study on overlap between CépiDc and OCRTIS data for the years 2001 and 2002 estimated an under-declaration of the total number of drug-related deaths in the region of 30% and highlights the limitations imposed by medical secrecy and the legal services (COSTES, VAISSADE et al. 2009).

Almost half of the CépiDc drug-related deaths (46%) are classified into section F19: several psychoactive substances were detected without it being possible to define which one caused the death. Published results usually do not reveal which substances were detected. The DRAMES data provide further information: in addition to being an exhaustive listing of the number of drug-related deaths, their primary objective is to monitor associations of substances, with particular attention to drug uses.

Table 6-4: Substances associated with drug related deaths in France in 2007

Substances identified	2006 (n=168)	2007 (n=192)
Heroin alone	23%	29%
Heroin in association with another substance	14%	16%
Heroin present	37%	45%
Heroin and cocaine alone	8%	11%
Heroin and cocaine present	11%	14%
OST, without heroin or cocaine, or legal opiates	30%	34%
OST present	40%	42%
Methadone alone	17%	29%
HDB alone	12%	5%
Methadone present	24%	36%
HDB present	17%	7%
Legal opiates alone	8%	3%
Legal opiates present	14%	8%
Opiates alone	65%	70%
Opiates present	85%	90%
OST + legal opiates	41%	43%
OST+ legal opiates present	51%	48%
Cocaine alone	8%	9%
Cocaine present	26%	28%
MDMA present	6%	3%
Amphetamine alone	0%	0%
Amphetamines or methamphetamines present	2%	1%
Solvents, poppers alone	1%	0%
Solvents, poppers present	1%	0%

Source: AFSSAPS - DRAME.

200 deaths were subjected to toxicological analysis which led to a conclusion of drug-related death (191 deaths directly due to use and 9 indirectly) in 2007. 110 cases were deaths solely due to the use of illicit substances, 21 cases involved an association with ethanol and 37 cases an association with psychoactive medicinal specialities. Of these 191 deaths, heroin was present in 45% of cases (29% alone and 16% in association with another substance – usually cocaine). There were 66 cases of deaths by OST abuse alone, a significant rise compared to 2006 data. Ten deaths as a result of HDB, 55 due to methadone and one to OST HDB+methadone were recorded. Six other cases of death due to OST in association with an illicit substance (cocaine, heroin) or with medicine misuse (codeine, morphine) were recorded. Heroin-cocaine involved 11% of cases (n=21). THC was present in 65 cases. No deaths due to the use of MDMA, amphetamines, poppers or solvents alone were recorded.

6.4.1. Drug-induced deaths (overdose/poisonings)

No new available information.

6.4.2. Mortality and causes of deaths among drug users (mortality cohort studies)

No new available information.

6.4.3. Specific causes of mortality indirectly related to drug use

No new available information.

7. Responses to health correlates and consequences

7.1. Introduction

Responses to health problems: general context

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

The prevention and treatment of infectious illnesses related to drug use

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

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

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

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

- The unrestricted sale of syringes in pharmacies (sold without prescription since 1987); 2,645,063 Stéribox® 2 syringes kits have thus been sold in 2007.
- Vending machines selling "Stéribox®" type injection packs (with a total of 255 in 2006) or intended for the recovery of used syringes (224 by the end of 2006) disseminated over a total of 56 French départements. At the same date, all regions have at least one automat, except Corsica and Franche Comté.
- Association-run syringe exchange programmes (SEPs) of which there were 130 operational in 2006, CAARUD data (TOUFIK, CADET-TAIROU et al. 2008);
- "Reception" or contact centres for drug users (40 in 2001).

Overall, the harm reduction scheme covers most of France.

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

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

Treatment related to psychiatric comorbidities: there is no service strictly specializing in the treatment of drug users with associated psychiatric problems. A number of psychiatric hospitals have developed the ability to treat drug users over the last few years, but these nevertheless remain rare. Since 1998, three different circulars issued by the General Health Authority (DGS) have sought to improve treatment, recommending heightened

cooperation between the departments and services concerned (CSSTs, psychiatric departments in hospitals, etc.) but cooperation is currently carried out on an "as needs" basis (Wieviorka 2003).

7.2. Prevention of drug-related emergencies and reduction of drug-related deaths

No new information available.

7.3. Prevention and treatment of drug-related infectious diseases

No new information available.

7.4. Responses to other health correlates among drug users

No new information available.

8. Social correlates and social reintegration

8.1. Introduction

Social consequences: general context

Social exclusion

The social and economic situation of drug users can be understood via details of their socio-economic characteristics recorded during their visits to reception centres (CSSTs or low threshold services). Their level of precariousness varies according to the type of structures attended. Drug users attending low threshold services structures tend to be characterised by a higher level of social marginalisation than those encountered in the CSSTs including more unemployed people (with 50% of those attending the "front-line" structures living off welfare benefits compared to 30% for the CSSTs), more precarious living conditions (40% for "front-line" structures vs 30% for the CSSTs), more single people and fewer parents with dependent children, etc.

By retracing the personal history, living systems and relationship to risks of drug users (particularly heroin users), we can understand the backgrounds and marginalisation processes which contribute to the development of a drug problem during an individual's life, (including economic and social fragility, school dropout and low levels of individual solidarity). Bouhnik and Touzé (BOUHNİK, TOUZE et al. 2002) explain that the increasing precariousness of drug users' living conditions, combined with repression and repeated incarceration increase "high risk" behaviour. According to (Jamoulle 2001), drug users are confronted with several forms of precariousness, including economic, social/community, health and psychological instability.

Among the homeless, drug use generally predates the individual's desocialization (Declerck and Henry 1996; La Rosa 1998; Dabit and Ducrot 1999). On the other hand, exclusion tends to generate a strong feeling of loss of worth or status likely to push individuals towards drug use if they have not deliberately chosen to become marginalised. In the case of alcohol, the heaviest use observed among the homeless population is accompanied by the worst situations of precariousness. The proportion of people presenting a major risk of problem alcohol use appears to be far higher among the homeless population than among the general population, particularly in the most difficult social situations (Legleye, Spilka et al. 2008). However, drugs can also be a means of helping persons face up to the violence inherent in life on the street: "The use of psychoactive substances appears to be a means of enduring difficulties, although this solution itself generates further difficulties by bringing on precariousness even earlier." (JACOB, JOUBERT et al. 2000).

Responding to social problems: an overview

Besides addressing health problems, the national policy is aimed at reducing the social problems related to the high-risk lifestyle choices associated with drug use behaviours. This harm reduction approach is based on the acknowledgment that the behaviour of drug users involves certain risks. These include intravenous drug use (IVDU), unsafe sex, smoking, etc. Users should therefore receive support in order to ensure their health and well-being.

Social integration or reintegration has been a core element of the drug strategies implemented in France since 1998. The objective of the ongoing National Action Plan is to "treat drug users, support social integration and reduce drug-related harm". One of the Plan's 5 sections is devoted to this goal. In this section, the Government Plan identifies 69 measures for attaining this general objective (out of a total of 193 measures). These include creating an addictology cluster in each university hospital centre, increasing

housing capacities in specialized addiction settings, setting up a standardized system for assessing the quality of medical practices used in the field of risk reduction and extending the regional coverage of therapeutic communities. Since 2008, one new therapeutic community has been opened and two more should be set up by 2011.

"Reception centres" feature among the facilities available in France which serve as "contact points" for users. Hostels provide overnight emergency accommodation for drug users in high-risk situations. Drug users may also turn to one of the facilities set up to fight exclusion: emergency housing beds, Lodging and Social Readaptation Centres (CHRS), day reception centres and mobile aid teams. In most of these settings, social assistants and specialised educators work with users to facilitate the reintegration process.

One of the goals of substitution treatments - in addition to increasing addicts' contact with the care system - is to contribute to their social integration. Several studies have shown the benefits for users, 6 months to 2 years after starting treatment, such as better use of the administrative system, better professional integration and improvement in housing conditions (Reynaud, Reynaud-Maurupt et al. 1997 ; Duburcq, Charpak et al. 2000 ; Batel, Constant et al. 2001 ; CALDERON, SOLETTI et al. 2001; Fhima, Henrion et al. 2001 ; Lavignasse, Lowenstein et al. 2002; Bilal, Menares et al. 2003). Several studies have also pointed out that treatment keeps drug users away from crime and from committing offences, regardless of their socio-demographic and economic characteristics. (HENRION 1995; Facy 1999; CALDERON, SOLETTI et al. 2001).

Other programmes have been designed to help drug users. The Counselling Drug Clinics Programme, introduced in 2004, provides drug-related support to vulnerable groups, which generally include young people with cannabis problems, mostly referred by the criminal justice authorities. In 2008, these clinics were classified as 'Centres for Treatment, Support and Prevention in Addictology' (CSAPA)⁴⁰, after The Minister of Health announced the implementation of an 'Addiction Management Policy' in November 2006 and called for a new system providing access to treatment or help for anyone with an addiction and in need of appropriate assistance.

8.2. Social exclusion and drug users

8.2.1. Social exclusion among drug users

No new information available.

8.2.2. Drug use among socially excluded groups

No new information available.

8.3. Social reintegration

8.3.1. Housing

No new information available.

8.3.2. Education, training

No new information available.

8.3.3. Employment

⁴⁰ Circulaire n°DGS/MC2/2008/79 du 28 février 2008 relative à la mise en place des centres de soins, d'accompagnement et de prévention en addictologie et à la mise en place des schémas régionaux médico-sociaux d'addictologie (http://www.sante.gouv.fr/htm/dossiers/addictions/08_79t0.pdf)

No new information available.

9. Drug-related crime, prevention of drug related crime and prison

9.1. Introduction

Drug-related offences and criminality

The law of 31 December 1970 constitutes the current legal framework concerning French policy on drugs. Its objectives are to severely repress trafficking; to prohibit the use of narcotics yet also propose alternatives to the repression of use; to ensure free and anonymous care for users who seek treatment.

Under the terms of the laws applicable to narcotics use in France, any person who uses and/or possesses and/or deals these substances may face various penal sanctions such as imprisonment. Consequently, a mere drug user facing arrest may possibly be sentenced to a one-year imprisonment maximum penalty.

On the drug trafficking side, the law has been modified several times, mainly increasing the severity of punishment up to maximum fines of 7,5 M€ and 10 years of imprisonment. A number of laws have also been passed to create new offences. For instance, a law passed on 17 January 1986 created offences for selling or supplying drugs for personal use.

The penal data concerning drug law offences on narcotics are all the more useful as they are easily accessible and published on a regular basis, offering an interesting insight into the national judicial evolutions. On the other hand, these data do not enable us to have a complete overview of the way offences are dealt with, from the arrest stage through to sentencing and enforcement: indeed, the Home Office, Customs and Justice information systems do not record drug use, for instance, according to the same criteria and the data provided by the Home Office and the Justice government departments are currently hard to match.

Arrests for drug-related offences are listed in two major categories: “one-off” use and trafficking (itself broken down into use-dealing, local trafficking and international trafficking) [Epidemiological table number 11].

The sentences recorded in the National Police (Criminal) Records (CJN, Casier judiciaire national) provide us with information concerning the sentencing decisions issued against those individuals brought before the courts for drug-related offences. Sentences may cover several offences although they are usually presented based on the main offence. The statistical categories used are as follows: illicit narcotics use, assisting another person in the use of narcotics, possession/acquisition, production/narcotics-based processing/transport, supply and transfers, possession/acquisition, importation/exportation, and other drug-related offences.

Alternatives to legal proceedings and court-ordered drug treatment.

The French legal framework does not make a distinction between narcotics. Theoretically, an offence such as illicit possession would be prosecuted and judged in the same way regardless if the object of the offence would be cannabis, heroin or LSD. However, judicial authorities have the right to judge according to the principle of opportunity. In the absence of aggravating circumstances and in the case of small quantities for personal use only, the law foresees sanctions ‘not including deprivation of liberty’, which can be either alternatives to prosecution or alternatives to imprisonment.

Compulsory treatment for drug users as an alternative to prosecution has been made possible since the 1970 French law on narcotics (loi n°070-1320 du 31 décembre 1970 relative aux mesures sanitaires de lutte contre la toxicomanie et la répression du trafic et

de l'usage illicite de substances vénéneuses, Journal Officiel du 3 janvier 1971). Such treatment can only be ordered with the patient's consent.

In 1993, the Departmental agreements on objectives in Health and Justice (CDO) were launched to improve communication between health institutions and legal bodies and thus promote the use of health-based alternatives to court proceedings, such as court-ordered treatment and referrals to health and social structures. The Ministry of Justice circular of June 17, 1999 (NOR: JUSA9900148C) called for Prosecutors of the Republic to favour the fight against local trafficking over simple drug use when dealing with arrested users. These guidelines were reiterated in the Ministry of Justice circular of April 8, 2005 (NOR: JUS D 05-300061 C). The 1999 Directive asked prosecutors to prioritize treatment approaches for small offenders, both related to drug use or to other small crimes. Particularly concerning problematic drug users, the recommendation of the Directive is to apply to the largest extent possible therapeutic alternatives to prisons, while "the imprisonment of drug users not having committed other related offences must be the last resort".

The French criminal justice system contains an array of traditional and experimental alternatives to prosecution, most of them including quasi-compulsory or compulsory treatment. Alternatives to prosecution (mostly including QCT) include conditional discharge with a drug treatment referral, drug treatment and testing order ("injonction thérapeutique"), legal reminders (possibly associated with health care referral), reparation-oriented reactions and restorative justice. Alternatives to imprisonment (mostly including compulsory treatment) include court-ordered drug treatment within a deferred sentence, pretrial intervention, community sentence (victim-offender mediation, community service and family group conferencing) and probation. The law dated March 5, 2007 concerning the prevention of delinquency (NOR: INTX0600091L) has included an obligation for drug users (in addition to the main sentence or punishment) to complete drug awareness-courses, which maximum cost is 450 Euros (decree number 2007-1388 of September 26, 2007, issued in application of law number 2007-297 of March 5, 2007 NOR: JUSD0755654D).

The follow up of alternatives to imprisonment is ensured by the Penitentiary Service for Reintegration and Probation (Service pénitentiaire d'insertion et de probation or SPIP). At a local level, working under the supervision of the sentencing judge, the SPIP identifies the social, medical and other organisations suitable for implementing the court-ordered drug treatment proceedings.

At national level, the law of March 5, 2007, applied via decree number 2008-364 of April 16, 2008 (NOR: SJSP0769782D), has extended the 'therapeutic order' scheme, enabling it to be applied as part of a penal sentence. This law change also extended the perimeter of the 'therapeutic order' to all substances, particularly alcohol. The duration of treatment was also limited: the 'therapeutic order' is now supposed to be delivered within a 6 month period. It can be renewed 3 times. Eventually, the supervision is now supervised by a "relay doctor", ("médecin-relais"), i.e. a physician reporting to the justice authorities.

Further along in the criminal procedure, individuals who have infringed the 1970 Drug Law may benefit from an alternative to imprisonment penalty, rather than a prison sentence or a fine. These alternatives to imprisonment may take various forms: community service, 'jours-amendes' penalties (days in prison paid off by fines), or other types of penalty. The national data on this topic are fragmentary: they do not reveal the proportion of these measures applied to simple drug users, because follow-up of the drug users through the government information systems is hard to ensure. Nevertheless, the available data show that community service orders are decreasing on a national level, in spite of expert recommendations (Warsmann 2004).

9.2. Drug-related crime

9.2.1. Drug law offences

Arrests for drug-related offences (OCRTIS 2009):

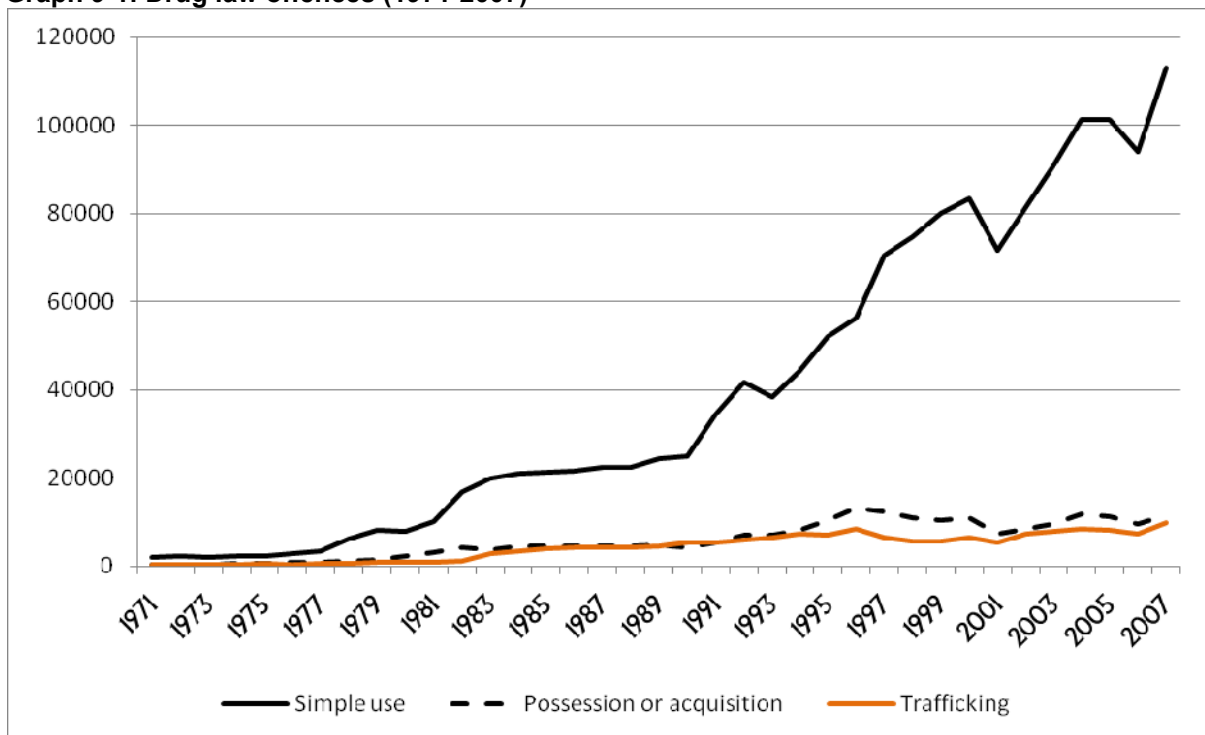
The number of drug law offences skyrocketed over the last 30 years (cf. Graph 9-1). The majority of reported drug offences in France (over 80 %) are related to drug use or possession for use. In 2007, cannabis remained the drug most often involved in drug law offences. Thus, police reports show drug offences have increased consistently since the 80's, although it is not known precisely whether this is due to increased police activity, an increase in drug use and trafficking, or better performance of the data gathering systems (or other factors that we may not even guess).

Reasons for arrest

The “one-off” (or simple) use of narcotics remains the main reason for arrest, accounting for a total of 147,927 arrests, i.e. 85% of arrests for drug-related offences in 2007, a percentage which has remained unchanged since 1998. In 2008, 17,875 arrests for use-dealing were recorded, the second leading reason for arrest, i.e. 10.2% of all arrests for drug-related offences.

Arrests for trafficking can be split up into 1,686 arrests for international trafficking and 8,265 arrests for local trafficking, accounting for 5.7% of all arrests for drug-related offences.

Graph 9-1: Drug law offences (1971-2007)



Source: FNAILS, OCRTIS

Substances involved in the drug-related offences

Cannabis remains the main substance concerned by arrests for drug-related offences, regardless of the grounds for arrest, accounting for 90% of arrests for use and 70.7% of use-dealing and trafficking cases.

Table 9-1: Arrest for drug-related offences (by substance), 2008*Source: OSIRIS, OCRTIS.*

	Use	% in the columns	Use/dealing and Trafficking	% in the columns	Total	% in the columns
Cannabis	133,160	90.0%	19,685	70.7%	152,845	87.0%
Heroin	7,827	5.3%	3,792	13.6%	11,619	6.6%
Cocaine	4,430	3.0%	3,168	11.4%	7,598	4.3%
Crack	784	0.5%	264	0.9%	1,048	0.6%
Ecstasy	619	0.4%	397	1.4%	1,016	0.6%
Medicines (1)	435	0.3%	314	1.1%	749	0.4%
Amphetamines	364	0.2%	82	0.3%	446	0.3%
Mushrooms	120	0.1%	17	0.1%	137	0.1%
Others (2)	188	0.1%	107	0.4%	295	0.2%
Total	147,927	100%	27,826	100%	175,753	100%

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

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

After cannabis, heroin and cocaine are the main substances involved in the drug-related arrests. Arrests for heroin use are more frequent than those for cocaine use (5.3% vs 3%) with a similar picture for arrests for use-dealing and trafficking. Arrests for the use-dealing/trafficking of heroin (3,792 in all) accounted for 13.6% of all arrests, while arrests for the use-dealing and trafficking of cocaine accounted for 11.4% of these arrests.

We should point out the relative importance in France of the number of arrests related to the misuse of medicines (particularly Subutex® but also unspecified substances: this concerned users unable to provide proof of a prescription), and those for hallucinogenic mushrooms.

The rise in the number of arrests (+31%) chiefly concerns cannabis, heroin, cocaine and crack:

- After falling in 2006, arrests for cannabis stood at 152,845 in 2008, setting a new record. This rise can be seen for arrests for “one-off” use (+ 36.6%) and also arrests of user-dealers and traffickers (+50%).
- The rise in the number of arrests for the use, use-dealing and trafficking of heroin which began in 2005 continued in 2008, with 23.7% more arrests. This increase was more significant for use-dealing and trafficking arrests, which rose by 28.5% than arrests for use (+ 21.6%).
- These figures appear to signal the end of the fall witnessed throughout the 1990s.
- Cocaine is also increasingly encountered during arrests. In 2008, the law enforcement services recorded a rise of 9.6% in arrests of cocaine users and 1.7% in the number of arrests of user-dealers and traffickers.
- After falling in 2006, arrests for crack rose by 16% in 2007 and by 37.4% in 2008 with a total of 1,048 arrests, chiefly concentrated in the French overseas départements and the Paris area.

Arrests for amphetamines also increased after a slight reduction in 2006, totaling 446 arrests in 2008, including 364 arrests for use and 82 for use-dealing and trafficking.

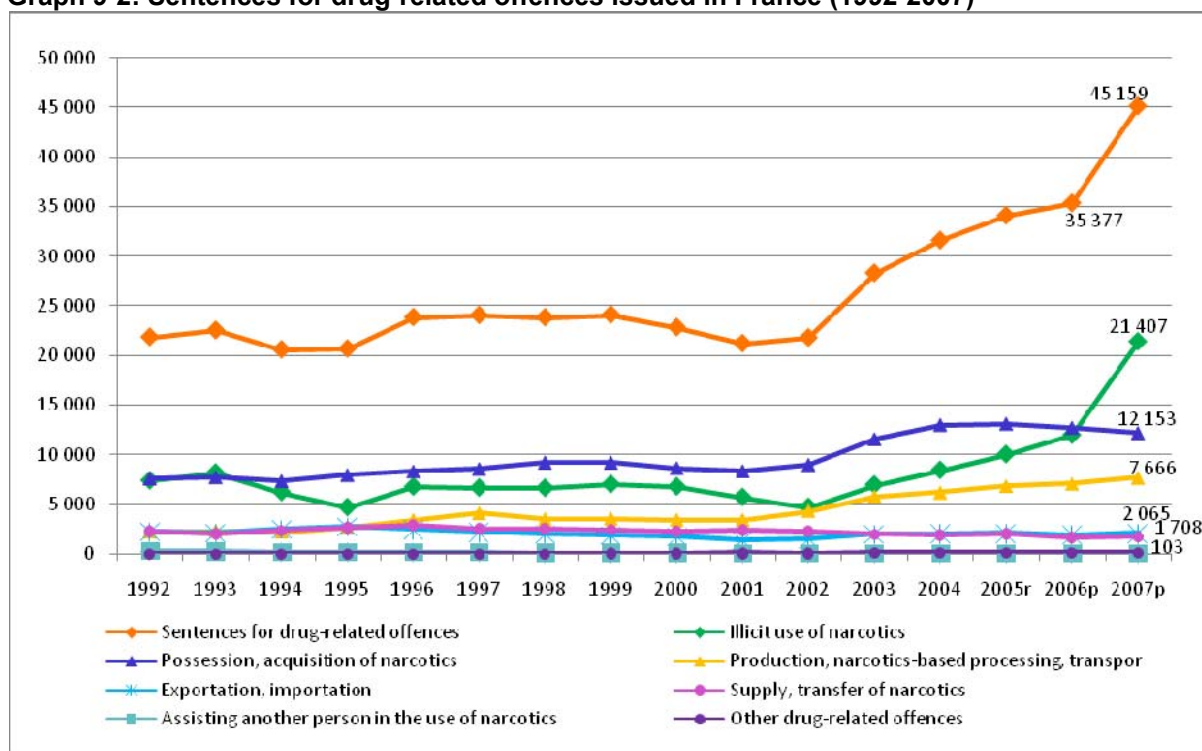
The drop in the number of arrests for ecstasy recorded since 2005 continued in 2008 (-10.8%), falling from 2,084 arrests in 2005 to 1,016 arrests in 2008.

Information from the Ministry of Justice: Sentencing.

Sentencing statistics are published with a two-year interval (Justice, 2008). The following information therefore concerns 2007 and is not officially considered as final.

A total of 45,159 sentences were issued in 2007 for cases in which a drug-related offence was listed as the main offence⁴¹, i.e. 27.6% more than in 2006.

Graph 9-2: Sentences for drug-related offences issued in France (1992-2007)



Revised 2005 data and provisional 2006 data.

Source: Data from the Statistical Yearbook of the Ministry of Justice 2008

In 2007, 21,407 sentences were issued for use (an increase of 78.7% compared to 2006). Representing 47.4% of offenses, the offense for use of narcotics becomes the first offense punishable.

- Possession, acquisition of drugs for 12,153 convictions, or 26.9% of all convictions.
- Convictions for production, narcotics-based processing and transport, amounting to 7,666 recorded an increase of 9%.
- Trafficking (import-export) was punished as the main offense in 2,065 convictions, or 4.6% of drug related offences.
- In 2007, 60% of cases in which a drug-related offence was listed as the main offence resulted in a prison sentence (imprisonment without remission or combined with a partial suspension in half of the cases), 28.9% resulted in a fine and 7.7% resulted in an alternative sentence: day-fines or community service, etc.

The dismissal of charges is rare, accounting for less than 1% of all sentences issued. Educational measures (1,214 in 2007) account for 2.7% of sentences for drug-related offences.

⁴¹ A sentence may cover several offences (a frequently encountered situation where drug-related offences are concerned). The main offence is that listed first in the criminal record, although this may not always be the most serious offence.

Information from the Ministry of Justice: incarceration.

Stock data show that by the end of the year 2006, among the 41,920 inmates, 5,751 had been sentenced for a drug-related offence recorded as the main offence, accounting for 14% of the prison population.

Flow data show that since the limitations in the use of the National Prisoner Database (FND) for statistical purposes in 2003, the data presented by the Ministry of Justice have been extracted from the quarterly statistics issued by the Prisons Department, which no longer enable prison analysts to calculate the movements of drug offenders entering prison settings.

9.2.2. Other drug-related crime

Driving after using narcotics ("Drug Driving"): Screening and sentencing in 2005-2006⁴².

A recap of the applicable legislation.

The law of June 18, 1999 and its application decree (of August 27, 2001) introduced automatic screening for narcotics for all drivers involved in a road traffic accident resulting in an immediate death, and the introduction of an epidemiological study (carried out between October 2001 and 2003) prior to a possible widescale study (the SAM study). The law of February 3, 2003 introduced a new offence aimed at punishing any driver whose blood analysis revealed the presence of narcotics. Drivers in such a situation face a 2-year prison sentence and a fine of €4,500. These punishments may be increased to 3 years' imprisonment and a fine of €9,000 if alcohol has also been consumed.

A new drug testing procedures on roads has been introduced since the summer of 2008: oral fluid testing devices for the on-site screening of drivers suspected of having taken drugs have been authorized since 2005, but they have only been actually used since 2008⁴³. Until then, the screening procedure was performed with roadside urine tests, in the presence of a physician. This procedure was considered to be too complicated and not cost-effective enough. Since 2008, drivers suspected of driving under the influence of drugs have been screened with the Drugwipe® tests - even though Rosita (RoadSide Testing Assessment) and Rosita 2⁴⁴ have both concluded that improvements should be made regarding the detection of cannabis and benzodiazepines by the Drugwipe® tests. The screening and confirmation cut-off concentrations for THC, amphetamine-type stimulant drugs, cocaine and opiates in oral fluid are 15ng/ml, 50 ng/ml, 10 ng/ml and 10 ng/ml of saliva respectively (arrêté du 24 juillet 2008: http://www.legifrance.gouv.fr/jopdf/jopdf/2008/0730/joe_20080730_0044.pdf). False positives are supposed to be minimised by a blood test performed in a medical setting whenever the saliva test (performed on the roadside) proves positive for drivers tested for cannabis, amphetamine-type stimulant drugs, cocaine and opiates.

⁴² Ministry of the Interior (...), Bilan du comportement des usagers de la route, année 2006, 77 p. (http://www.interieur.gouv.fr/rubriques/a/a7_statistiques_securite_routiere); Special extract from the National Police (Criminal) Records by the sous-direction de la statistique, des études et de la documentation (Sub-department for statistics, studies and documentation).

⁴³ Loi du 3 février 2003 relative à la conduite sous l'influence de substances ou plantes classées comme stupéfiants (<http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000235043&dateTexte=>); Loi du 12 juin 2003 renforçant la lutte contre la violence routière (<http://droit.org/jo/20030613/EQUX0200012L.html>); Comité interministériel de sécurité routière du 24 janvier 2005 - promoting the use of roadside oral fluid testing and a systematic implementation of saliva tests (http://www2.securiteroutiere.gouv.fr/IMG/pdf/DP_CISR_24-01-05.pdf); Arrêté du 24 juillet 2008 modifiant l'arrêté du 5 septembre 2001 fixant les modalités de dépistage des stupéfiants et des analyses et examens prévus par le décret n°2001-751 du 27 août 2001 relatif à la recherche de stupéfiants pratiquée sur les conducteurs impliqués dans un accident mortel de la circulation routière (NOR SJSP0817087A).

⁴⁴ As a reminder, the ROSITA reports were submitted to the European Commission in 2006. Their objective was to question the clinical validity of saliva tests with regard to cannabis detection. The THC present in urine and blood was detected in less than half of the tests (46%).

By the end of 2008, 52,000 testing kits had been distributed to police officers across France. This two-step system is still in force.

Screening (blood tests, or urine tests if it proves impossible to obtain a blood sample) is compulsory in all accidents resulting in an immediate death, or in cases involving bodily injury when the driver is suspected of having taken drugs. Screening is also authorised for any driver involved in any road traffic accident or committing certain Highway Code infractions, or when there are reasonable grounds to presume that he may have used narcotics (art. L235-2 of the Highway Code).

Screening in 2007

No new data available

Offences punished in 2007.

No new data available

Sentencing in 2007

In 2007, 6,882 sentences were issued, i.e. 32% more than in 2006. Of these sentences, 44.9% resulted in a prison sentence (of which only 15% involved partial or total imprisonment without remission). Approximately 40.5% involved a fine and 14.3% an alternative sentence (probably a driving licence confiscation).

Punishments tend to be less severe for driving under the influence of narcotics alone or for refusing to cooperate. However, they are more severe in the event of injury (8.4 sentences out of 10 result in imprisonment) and especially in the case of manslaughter, 45% of which result in imprisonment without remission, for an average duration of 9.6 months each.

Table 9-2: The sentencing of drivers for narcotic use ("drug driving") in 2007

	All sentences	Prison sentences	Fines	Alternative sentences	Educational measures	Charges dismissed
Total number of offences committed by drivers having used narcotics	6 882	3 087	2 787	986	9	13
Driving a vehicle under the influence of narcotics	5 319	2 023	2479	802	6	9
Driving a vehicle under the influence of narcotics + alcohol	1275	845	282	144	2	2
Manslaughter or unintentional injuries committed by a driver under the influence of narcotics	216	181	11	22	1	1
Refusal by the driver of a vehicle to undergo analyses or examinations	72	38	14	18	0	1

Source: Ministry of Justice – Sous-direction de la statistique, des études et de la documentation (Sub-department for statistics, studies and documentation) – special extract from the National Police (Criminal) Records

9.3. Prevention of drug-related crime

The French criminal justice system contains an array of traditional and experimental court-ordered treatment options, some of them including quasi-compulsory treatment (conditional discharge with a drug treatment referral, drug treatment order, legal reminder possibly associated with a health care referral). Compulsory treatment in itself can be used as an alternative measure to either prosecution (deferred prosecution, drug treatment and testing order ["injonction thérapeutique"]) or imprisonment (as an alternative or supplement to existing criminal justice sanctions and procedures: court-ordered treatment for drug offenders within a deferred sentence, a pre-trial intervention, a community sentence, diversion, probation).

The length of some of these treatment options has recently been limited by national law: the drug treatment and testing order ["injonction thérapeutique"] is now supposed to be delivered within a 6-month period. It can be renewed three times (loi du 5 mars 2007 sur la prévention de la délinquance, article 49; article L 3423.2 du Code de la santé publique). Further details regarding the execution of drug treatment and testing orders can be found in the legal documents available online (<http://www.legifrance.gouv.fr>): circulaire du 9 mai 2008 relative à la lutte contre la toxicomanie et les dépendances (NOR JUS D0811637 C), décret n° 2008-364 du 16 avril 2008 relatif au suivi des mesures d'injonction thérapeutique et aux médecins relais (NOR: SJSP0769782D).

The most recent examples of QCT options can be found in the counselling cannabis clinics for young users ("consultations jeunes consommateurs") which have been in operation since 2004. It has been shown that 50% of the outpatients admitted in these clinics (screening, counselling and brief intervention) were referred by the criminal justice system; the majority of outpatients were male (81% vs 19% females) and 92% used cannabis (OBRADOVIC 2009). Half of the outpatients came through the legal services route (48%), especially among males between 18 and 25: attendance at these counselling sessions was either an alternative measure to court proceedings (66%) or a mandatory care penalty (for 26% of outpatients), given that failure to seek mandatory care resulted in immediate imprisonment (<http://www.ofdt.fr/ofdtdev/live/english-tab/engpubli/tends.html>).

In addition to these different treatment options, the range of alternatives to prosecution offered to drug offenders has been extended since the law of March 5, 2007 and the April 16, 2008 decree, with new information sources including drug awareness training courses. Adults or minors caught possessing marijuana have to complete a drug awareness course which they must pay for. As outlined in Justice Circular 08/11 dated 9 May 2008⁴⁵, all people who use relatively small amounts of illegal drugs should be sentenced to penalties. The educational goal of these compulsory training courses is to inform offenders about drugs, their use and misuse and the existing drug-related policies and laws and the consequences of violating them.

The Interministerial mission for the fight against drugs and drug addiction and the Ministry of Justice have published guidelines to aid and support those responsible for developing and conducting these drug awareness courses (23-page booklet available online: <http://www.drogues.gouv.fr/IMG/pdf/guide-methodologique-danger-usages-stupefiants.pdf>). This good practice guide offers recommendations, advice and overviews on ways to implement the drug awareness programme.

The Ministry of Justice set up a monitoring system to assess the implementation of the courses over the first year, during the last three trimesters of 2008 and the first trimester of 2009. Half of the courts (45.3%) responded (n=82): the available data, based on a sample of 27,175 cases involving drug use, show that 9% of the penalties delivered by the courts included attendance at drug awareness courses (n=2,311, in 42 of the 82 responding courts) and 14% were under Drug Treatment and Testing Order (DTTOs, n=3,815, in 44 of the 82 responding courts): 95% of these penalties were delivered as alternatives to prosecution. Additionally, 395 drug awareness courses

⁴⁵ Circulaire CRIM 08-11/G4-09.05.2008 relative à la lutte contre la toxicomanie et les dépendances (NOR JUS D0811637C)

concerned drug users under 18 (17% of penalties) and 1,916 implied adult drug users (83%). As far as DTTOs are concerned, 467 of them involved minors (12%) and 3,348 adult drug users (88%).

9.4. Interventions in the criminal justice system

No new information available.

9.5. Drug use and problem drug use in prison

A study carried out in 2003 revealed that 33% of people entering prison reported regular use of illegal drugs or diverted medicines during the year preceding their incarceration, while in the general population, the regular use of illegal drugs concerned 6% of 18 to 25-year-olds in 2002, and 2% of 26 to 44-year-olds. These data clearly reveal an over-representation of drug users compared to the general population. Although the currently available data need updating, it is acknowledged that 29,8% of inmates report using cannabis in the past year, 7,7% report cocaine or crack use in the same time frame, 6,5% mention heroin use, 5,4% diverted medicine use and 4,0% report LSD, ecstasy or inhalants use in the past year (data recorded in 2003, DREES, 2005).

Studies have shown that all substances smoked, sniffed, injected or swallowed prior to incarceration continue to be used, although in lower quantities, during imprisonment (Rotily (2000). Furthermore, the use of easy-to-obtain substances, such as medicines, has increased in penal establishments. Generally, we are seeing a relative transfer of use away from illegal and rare drugs, to medicines (Stankoff and Dherot 2000).

The use of narcotics, whether initiated or continued in prison, has a major influence on the state of health of the individuals concerned, including serious abscesses and the risk of accidents when medicines are combined with other substances, severe and longer withdrawal symptoms, in addition to the occurrence of psychological or psychiatric disorders. Furthermore, detainees constitute a population group more likely to combine risk factors where the health and social consequences of drug use are concerned. The low level of access to treatment experienced by this population group, and more fundamentally, the situations of precariousness and exclusion which they often faced prior to incarceration (including the lack of a stable home or Social Security cover, etc.) help explain the prevalence of "high risk" consumption among new detainees.

The use of injection as an administration method tends to be higher among this precarious population, although the number of intravenous users appears to be diminishing: in 1997, 6.2% of new detainees stated that they had taken drugs intravenously during the year preceding their incarceration (Mouquet et al 1999). In 2003, only 2.6% of new detainees stated that they used injection as an administration method. According to surveys, between 60 and 80% of prisoners stop injecting while in prison. Those who continue injecting reduce the frequency of their injections, but they seem to be the largest injectors and are more often infected with HIV and/or hepatitis C. This means that the risks of contamination when sharing equipment, engaging in unprotected sex or adding tattoos are very high.

9.6. Responses to drug-related health issues in prisons

Even though prison conditions came under fire from several parliamentary, institutional and international reports, France's prison population continued to rise in 2008 compared to the number of places available: 13,000 inmates exceeding the official capacity were recorded at the end of the year. At 1st December 2008, official prison figures stood at 63,619 persons incarcerated for 50,631 places. Thus, after a 5.1% increase during 2007, the growth of prison overpopulation remained a lingering issue in 2008, with a new increase of 2.6% (63,619 inmates in December 2008, vs 62,009 in December 2007).

Consistent evidence stresses the difficulties inherent in offering individual health care in overpopulated prison settings, especially for drug users. This concern is endorsed in several national action plans, such as the Viral Hepatitis Strategic Plan ("Plan Hépatites 2009-2012") or the

“Second Plan national santé environnement”. In the context of the new penitentiary law project, a national Chief Inspectorate of Prisons and Other Closed Institutions (such as immigration removal centres, young offender institutions, etc.)⁴⁶, currently labelled as the “general controller of the jails”, was nominated in 2008. A team of 20 inspectors was appointed, with a budget of €3 M for the year. The responsibility of the Chief Inspectorate of prisons was to report on the general treatment of prisoners in prisons and on conditions in prisons. The first 2008 review pointed out that prisoners had to cope with restricted living space, lack of intimacy, poor sanitation, the spread of disease, unsatisfactory food, and inadequate healthcare⁴⁷ (Contrôle général des lieux de privation de liberté, 2009).

In 2008, juvenile delinquency issues were closely studied: the drug awareness training courses mentioned above are part of the specific procedures implemented for dealing with juveniles. As far as prison facilities are concerned, a joint circular from the Ministry of Health and the Ministry of Justice⁴⁸ ordered health authorities working in special juvenile detention institutions (“établissements pénitentiaires pour mineurs”) to offer more adequate services to young people and the community which they came from. One of the recommendations involved offering more accessible health services for youth and families, especially for young girls, ranging from health screening to communicable disease testing. The first step in responding to the needs of youth in the juvenile justice system should be the provision of screening and assessment: all young people should receive screening at the earliest point of contact with the juvenile justice system; young people requiring further evaluation should receive thorough assessments and subsequent care. Recommendations for treatment included psychological/pharmacological therapies and plans for social reintegration.

One objective of the 2008-2011 national action plan on drugs was to “improve care and continuity of care provided to drug and alcohol users in prison”. The Plan called for a strategy of coordinated prevention and care actions for addictions in prisons related to the guidelines already identified in the August 9, 2001 interministerial memo.

This general orientation led to specific measures:

- The setting up of hepatology sessions in prisons, including the supply of Fibroscan®;
- The dissemination of good professional practice guidelines on opiate substitution treatments,
- The study of better ways of providing information about HIV and hepatitis, and of the benefits of screening and its renewal if markers are negative.

A national call for tenders was launched, with the aim of appointing agencies to coordinate short and accessible reception programs dedicated to released prisoners, within the existing social and medical-social structures (with accommodation), in cooperation with hospitals intervening in prison facilities. Outcomes should be evaluated in the future.

9.6.1. Drug treatment (including number of prisoners receiving opioid substitution treatment)

Few of the 186 penitentiary institutions in France have developed a specific care programme for drug addicts. Addiction centres exist in 16 large correctional institutions: pilot Care Units for Prison Leavers (UPS) were opened in 7 prisons in 1997 (2 closed in 2003) and CCAAs were opened in only 3 establishments. The 102 Penitentiary Services for Reintegration and Probation (SPIP) play a

⁴⁶ Loi n°2007-1545 du 30 octobre 2007 instituant un Contrôleur général des lieux de privation de liberté (NOR: JUSX0758488L) ; Décret n° 2008-246 du 12 mars 2008 relatif au Contrôleur général des lieux de privation de liberté

<http://www.legifrance.gouv.fr/WAspad/UnTexteDeJorf?numjo=JUSX0758488L>

⁴⁷ Le Contrôleur général des lieux de privation de liberté, Rapport d'activité 2008, Paris, Dalloz, 2009, 253 p.

⁴⁸ Circulaire interministérielle n°DGS/DHOS/DAP/DPJJ/MC1/2008/158 du 13 mai 2008 relative à la prise en charge sanitaire des mineurs incarcérés (NOR : SJSP0830413C).

role in the social monitoring of all detainees and their reintegration upon release from prison; they ensure social reintegration for drug addicts (including those who began treatment in prison) by guiding them towards partner organisations in the form of government bodies or associations.

Theoretically, substitution medicines can be prescribed to prisoners in the same way as for the rest of the population in order to start or continue a programme of treatment with Subutex® (since 1996) or methadone (since the issuing of circular number 2002/57 dated January 30, 2002). All adult prisons are required to provide substitution treatments to inmates when they arrive in the establishment (under the terms of circular DGS/DH/DAP dated December 5, 1996). The Ministry of Health has carried out four successive surveys concerning substitution treatments (March 1998, November 1999, December 2001 and February 2004) which show that it is easier for heroin-addicts to obtain substitution treatments outside of prison (as opposed to when they are incarcerated), despite the fact that the percentage of the prison population receiving substitution treatments has increased: 2% in 1998, 3.3% in 1999, 5.4% in 2001 and 6.6% in 2004, with a majority of high-dose buprenorphine treatments (78% in 2004 vs 22% of methadone-based treatments). The percentage of people interrupting their substitution treatments upon arrival in prison has fallen, dropping from 19% in 1999 to 5.5% in 2001.

A survey carried out in 2007 (OBRADOVIC and CANARELLI 2008) showed an increase in access to methadone in prisons. Among the opioid-dependent prison population, 40% were patients receiving methadone maintenance treatment. Among the difficulties most often encountered when prescribing methadone, the most frequent concerns identifying the patient's release date, early release (40%) being taken into account. The second constraint as far as initial prescription is concerned is related to the short time prisoners remain in detention, particularly in remand centres, which does not make it possible to monitor the detainee patients over the long term. Additionally, almost a quarter of professionals responding to the survey (24%) stated a preference for HDB when it comes to treating opioid-dependent prisoners. Furthermore, 22% of establishments mentioned difficulties in finding a follow-up organisation to take over prisoners' treatment upon their release, and a similar number of professionals mentioned a lack of staff (20%), resulting in a negative impact on the organisation of methadone distribution. However, it must be mentioned that several penal establishments continued to cite doctors' reticence to prescribe opiate substitution treatments in penal establishments, and more than a quarter stated that they had issued no prescriptions for methadone during the six-month period concerned in 2006.

Furthermore, it has also been demonstrated that opioid-dependent patients reporting maintenance therapy when entering prison had poorer health statuses, higher levels of opioid use and longer criminal histories. Also, they were less socially integrated than the opioid-dependent patients without maintenance treatment (Marzo JN, Rotily M et al. 2009).

9.6.2. Prevention and treatment of drug-related harm

No new information available.

9.6.3. Prevention, treatment and care of infectious diseases

Infectious illnesses seem to be more rampant among prisoners than among the general population. The most recent data indicate that the prevalence of HIV in the prison population at somewhere between 3 and 4 times higher than that noted among the general population and that of hepatitis C is about 4 to 5 times higher. Just like "on the outside", however, the prevalence of HIV in prison is receding while that of hepatitis C continues to grow sharply.

There is no legal provision in France for syringe exchange and related programs. A Penitentiary Administration circular has allowed the free and systematic distribution of bleach to detainees since 1996.

No legal text explicitly prohibits tattooing. However, regulations state that condoms must be made available, especially in the hospital units (UCSA).

Prevention of infectious diseases

New arrivals are screened for substance misuse problems. Upon their arrival in prison, all detainees are offered a medical consultation provided by an outpatient consultation and treatment unit (UCSA), with tuberculosis screening, a voluntary and confidential HIV test and, more recently, screening for Hepatitis C along with Hepatitis B vaccination. Regional medico-psychological hospital services (SMPR) are responsible for psychiatric care in 26 penitentiary institutions (larger prisons in general), while the UCSA deal with physical care.

9.6.4. Prevention of overdose-risk upon prison release

No new information available.

9.7. Reintegration of drugs users after release from prison

No new information available.

10. Drug markets

10.1. Introduction

Market and supply: general context

Four sources enable continuous information to be collected about the market and psychoactive substances on offer.

- The TREND (Recent trends and new drugs) monitoring system which collects mostly qualitative information (accessibility, availability, average prices), from users and different workers in prevention, care or law enforcement. It concentrates on observations in two main fields: the urban context and the recreational scene. The former includes urban areas where active drug users can be observed (squats, street etc.), and the second includes party events particularly related to techno culture: club, teknival, free-party, private party.
- The substance monitoring system, the National Poison/Substance Identification System (SINTES), which mostly collects information about compositions, but also prices.
- Data from the law enforcement services (police, customs, gendarmerie) come from the Statistical Information and Research Tool for Drug-Related Offences (OSIRIS) managed by the Central Office for the Repression of Narcotics Trafficking (OCRTIS). This provides the number of seizures and the amounts seized on French territory. Seizures recorded by the law enforcement services are only a partial indicator of the illicit drugs on offer as they are directly related to the activity of the services concerned, and because chance plays a significant role in their annual variations. It is therefore essential to study changes over long periods.
- General population surveys on accessibility, supply and perceived availability of different illicit substances.

Availability and supply

- Cannabis (resinous and herbal cannabis) is the most widely available illicit substance in France.

Herbal cannabis has been popular over the past few years. This phenomenon can be explained by the current craze for substances thought of as “natural”. Another indicator of this is the increase in the home-growing of herbal cannabis, involving approximately 200,000 people (estimate of the population which has grown cannabis at least once from the ESCAPAD surveys 2005 and the Health Barometer– see Main Cannabis Data ⁴⁹).

- The availability of cocaine in hydrochloride form has continually increased over the last ten years. It is used by very different groups in the French population and affects both disadvantaged users and users in the recreational scene. The most striking phenomenon is the development of use and trafficking in the underprivileged suburbs of large city conurbations.
- Behind cannabis and cocaine, ecstasy is the most widely used substance in the recreational scene, whether commercial or alternative. Some users have been very interested in a variety circulating in powder form over recent years, having become bored with the tablet form.

⁴⁹ <http://www.ofdt.fr/BDD/publications/docs/cdecomp.pdf>

Ecstasy was traditionally available in three forms: tablet, usually stamped with a logo, capsule and powder. Depending on the form and the event in question, availability varies: “tablet” and “capsule” forms are very widely found in the commercial party scene, the powder form being more frequent in the alternative scene.

TREND system observers, over the last few years, have noted a loss of interest in the “tablet” and “capsule” forms in the alternative recreational scene particularly. Users mention the poor quality of tablets, which increasingly contain substances other than the stated MDMA, together with the very ‘ordinary’ nature of the tablet which no longer lets them stand out. The tablet has therefore become the “beginner’s drug”. This loss of interest has favoured the development of the powder form, which circulates under the name MDMA. Users consider MDMA to be of better quality than the tablets and like its appearance, similar to that of cocaine, which carries a very positive image. A crystal form has also appeared since 2006.

- Since the middle of the 1990s, heroin has become a relatively unavailable and low profile substance. This situation has become more pronounced with the disappearance of “open scenes” and the switchover of dealers to cocaine sales, which are more profitable. Since 2006, we have seen a wider availability of brown heroin both in city centres and in the recreational scene. This trend has been confirmed. Almost all of the TREND system sites describe increased availability and the emergence of younger users in both scenes. It also seems that we are witnessing a re-organisation of the drugs on offer which makes the substance easier to obtain. Street drug sales are appearing increasingly visible and would seem to be due to networks which, until then, were only offering cannabis resin. As the time course of events would indicate, heroin use appears to be markedly carried forward by the drugs on offer and not vice-versa: the increased seizures (drugs on offer) were followed by a progressive increase in availability, before an increase in use numbers was seen, promoted by a positive context: a distancing from the images associated with heroin use in the 80s, poly-experimentation and polydrug use practices.

-.HDB is available in pharmacies in three forms: the commercial form since 1996 under the name Subutex® from Schering-Plough and two generic forms manufactured by Arrow since March 2006 and Merck since 2007. The availability and accessibility of high dose buprenorphine (Subutex®) remain just as high on the black market in city centres, despite stricter dispensing supervision measures taken by the public authorities.

Whilst misuse has usually involved very marginalised users since 2006, its use has emerged in some sites of new populations, who are more socially integrated, and who take Subutex® either to counteract a stimulant or to manage the so-called “coming down” phase, or in a more everyday context for “relaxation” purposes.

The use of natural hallucinogens and particularly hallucinogenic mushrooms has increased particularly because of the increase in home growing and supply through the Internet, although this remains confined to a very limited fringe of the population.

For the past two to three years, we have seen a spread in the use of synthetic hallucinogens in the recreational scene (LSD, ketamine and GHB/GBL) beyond their nuclei of respective users accompanied by an increase in their availability.

Seizures

France is a transit country for substances intended particularly for the Netherlands, Belgium, United Kingdom, Italy and beyond, and where it is therefore difficult to separate the amounts of drugs intended for the internal market from those which are only passing through. The trafficking aspect in France therefore needs to be considered by substance, as the acquisition and destination countries vary for the substance in question.

The following substance-related trends are seen:

- the largest number of seizures concern cannabis, particularly cannabis resin. The amounts seized had followed a rising curve since 1980 with a strong acceleration between 2002 and 2004 and a subsequent fall for the 3 subsequent years;
- since the end of the 1980s, a large increase in cocaine and crack seizures, which is continuing;
- following an increase in the amounts of heroin seized in the 1980s, and until 1994, the trend then slowed, and appeared to reverse from 2002;
- since the beginning of the 1990s, the number and amounts of ecstasy seized have increased very greatly, whereas the rise in amphetamine seizures has been more modest;
- the amount and number of LSD seizures fell during the period 1990-2006 after peaks in 1992 and 1993 and then in 2003 and 2004.

10.2. Availability and supply

The following information comes from trend observations collected by the TREND system during the year 2008.

Heroin

In France, heroin circulates in two chemical forms: the hydrochloride (white) and the base (brown) forms. The availability of these two types of heroin differs. The white form is extremely rare and appears to be restricted to confined circles, the Chinese community in the Paris region, whereas the brown form is far more readily available.

The availability of heroin continues to increase. This increase has now spread to all urban areas for the TREND observation sites except for Marseilles. A recurrence of visible dealing and even street dealing is seen in Paris and in Lille (north of France) in some working-class peripheral districts. However, the substance is usually bought from the dealer's premises.

The substance which is most available and accessible is mediocre quality heroin, sometimes almost devoid of effect. Purer heroin can be bought at high cost in more restricted networks which are not open to everyone. Micro-networks of users with collective supplies obtained directly from Belgium, the Netherlands or even from Spain, for the more southern regions, appear to play an increasingly important role in supply, particularly for socially integrated users who adapt to the poor quality of the more accessible heroin.

The increase in local dealing is a phenomenon noted by the police services, which have seen the number of seizures of less than 5 grams increase by almost 50% between 2006 and 2008. They are also seeing the increasing impact on the French market of what they call "drug tourists", who regularly import small amounts of heroin in order to minimise criminal risks.

In the recreational scene, heroin is also seen by both observers and users to be readily available in the alternative recreational scene (rave parties, free parties or even teknivals), with regional exceptions. Conversely, availability is limited or practically absent in the commercial recreational scene (clubs) where establishment owners provide continued surveillance.

High dose buprenorphine

High dose buprenorphine is a morphine agonist/antagonist, prescribed as heroin substitution treatment.

As in previous years, and despite measures taken by the public authorities, particularly since 2005, to regulate its prescription more strictly, HDB, in the form of Subutex®, remained available on the black market in some urban centres in 2007 and 2008.

It would appear that the use of Subutex®, both in and outside of the treatment context, dominates amongst users, who see the generic tablet as being difficult to split because of its hardness and small size, thereby making injection difficult. They also criticize its less potent effects.

In 2007, the National Insurance funds implemented generalized measures directed at “deviating” users or healthcare professionals, which nonetheless varied in severity depending on the sites. Routine surveillance enabled users likely to divert HDB to the black market to be identified by ad hoc indicators.

Monitoring of volumes prescribed and dispensed by doctors or pharmacists also resulted in the issuing of notices which significantly disrupted the HDB black market in Paris in 2007, particularly with the dismantling of a black market network. Five doctors and fifteen pharmacists, together with several traffickers of medicines, were arrested between the end of March and mid-July.

In 2008, almost every site provided quantitative information showing disruptions in dealing. Above all, the national proportion of HDB reimbursement recipients who were being given doses of more than 32 mg, estimated to be 6% in 2002 (probably a slight over-estimate), fell to 2% in 2006 and then to 1.6% in 2007.

In addition, five out of the seven TREND sites reported an increase in the price of the 8 mg tablet, resulting in an average price in 2008 of 5.5 Euros, compared to a fall to 4 Euros in 2006.

Curiously, availability appears to be continuing at the same level on the black market, which appears to find ways to bypass each new obstacle (“carte vitale” social security card dealing, recruitment of drug mules sent to doctors, falsified prescriptions, etc.). Here or there, however, more difficult accessibility and a few periods of shortage were reported in 2008, or alternatively a less overt, but still equally well supplied market.

Several contextual factors are liable to cause a fall in HDB demand. An increasing proportion of treated patients turn towards methadone treatment. In addition, outside of the treatment context, users are tending to replace HDB with heroin whenever possible. Even though not quantifiable, this trend appears to be relatively likely and may contribute to the lack of a perception of shortage on the market, although the market appears nevertheless to be increasingly restricted.

Cocaine

Cocaine is available in two forms: hydrochloride (white powder obtained from the cocoa leaf) intended to be sniffed (nasal route) or even injected (intravenous route) and base or free -base (block, cake), intended to be smoked (pulmonary route).

The availability and use of cocaine are continuing to increase in France. That said, accessibility varies depending on the quality of substance bought. Obtaining what is considered to be the purest cocaine, of high quality, implies membership of specific networks, a good knowledge of the distributors and appropriate financial resources.

The structuring and increase in the local cocaine offer continues. This dual movement is occurring through incorporation of the substance into the drugs on offer from pre-existing small dealing networks or by the networks switching purely and simply to cocaine sale. In Lille, for example, it is offered by dealers selling heroin, and in Rennes, Toulouse and Marseilles by people selling cannabis. This integration/switching process has resulted in the emergence of the substance where it was previously absent, particularly in disadvantaged suburban areas. This could partly explain a recently seen phenomenon, the street sale of cocaine, a method reserved previously more for heroin and cannabis.

This finding is shared by OCRTIS in its report for the years 2007 and 2008 (Office central pour la répression du trafic illicite des stupéfiants (OCRTIS) 2007; OCRTIS (Office central pour la répression du trafic illicite de stupéfiants) 2008): “Since the middle of the 2000s, the structures and people involved have changed. A number of networks previously specialised in Moroccan cannabis resin dealing have switched to cocaine dealing, which is more profitable. New players in cocaine dealing unknown to the law enforcement services have emerged and who, depending on opportunities, have created short cocaine importation distribution networks to the French market, and in particular to some sensitive cities, from western Africa, (Senegal, Mali) or the West Indies (Dominican Republic, French Overseas Departments and Territories)”.

Cocaine sold as base or free-base appears to remain restricted to very specific areas. This applies to crack, which only circulates in the North of Paris and, to a lesser extent, in the bordering

department of Seine-Saint-Denis, in an extremely marginalised population. In Paris, changes in the crack on offer have been observed. Whereas, until recently, there was a monopoly of African dealers, it appears that the cannabis dealing networks have switched to selling crack and cocaine, which are thought of as more lucrative. This new situation would appear to have an influence on demand, with demand now coming from people who are better socially integrated and young people from counter-culture environments.

Whilst having a more extensive geographical penetration than crack, “free-base” does not really appear to be used except by users who attend alternative techno events.

Ecstasy, amphetamines and other synthetic drugs

The trends started in previous years are continuing: loss of interest in tablet and capsule forms, the availability of which has fallen. The presence of a “crystal” form is confirmed. This has a positive image with a reputation of being fairly pure.

Amphetamines, and particularly speed, remain extensively present in the recreational scene and effectively compete with cocaine through its similarity of effect and low price.

Hallucinogens

LSD is available in France in three forms: the so-called “blotting paper” form (absorbent paper impregnated by the substance); the liquid so-called “drop” form (impregnation of a sugar lump or diluted in an alcoholic drink) and the micro-dot form. Since 2005, the “gel” form has been seen. These forms circulate in very variable proportions depending on the region.

Several TREND sites have noted that the often erratic availability of the substance has improved since 2007, particularly in large parties (large raves or teknivals) especially in summer. This situation is far more apparent in Paris, and the summer of 2008 was marked by a permanent presence of LSD in parties. Figures for seizures and the detaining of users have increased since 2006 (seizures) and since 2002 (detained users), which tends to support the belief that there has been a change in the LSD market.

Although the substance is not always accessible, depending on the sites, it would seem that a constant factor is increased expression of interest and demand from a fringe population of the young generation of party experimenters. Fear of the effects, however, greatly limits the number of psychotropic fans ready to take the plunge.

Ketamine, which was very rare in France, has seen an increase in availability since 2006 in 4 of the 7 TREND system sites. It remains available mostly in the techno party scene although far more consistently. This increase in availability is linked to a spread in users towards younger partygoers particularly “young deviants” who are poorly integrated socially and whose use is considered “extreme”. A large proportion of these poorly integrated young people inject it. The first daily uses are described on one of these sites, Toulouse.

The use of GHB/GBL, which increased between 2002 and 2005 in the gay party community where, amongst other things, it was used in sexual activity, extended between 2005 and 2008 amongst the very young party users in towns in which the gay party and “gay friendly” recreational scene was shared with other partygoers. GBL, the precursor of GHB, is particularly easy to obtain on the internet or as a solvent in many commonly used preparations and the substance appears to be very accessible. The coma “epidemic” which discreetly occurred in the gay scene (particularly in Paris) in 2006 and 2007 and which had declined, emerged in 2008 but to a far lesser extent, in a younger mixed population.

10.2.1. Perceived availability of drugs, exposure, access to drugs

No new information available.

10.2.2. Drugs origin: national production versus imported

Apart from the self supply of cannabis and mushrooms by indoor home cultivation, there is no local illicit drugs production in France. TREND System has heard about tow cases of self production of methamphetamine but it seems to be very, very rare.

10.2.3. Trafficking patterns, national and international flows, routes, modi operandi and organisation of domestic drug markets

There are no real trend changes since the publication of the paper “Cocaine small-scale dealing in France”⁵⁰. This study was focusing on cocaine, but results are available for other illicit substances since networks are now involved in multi-substances traffic. The most striking evolution concern, the increase of the number of micro-networks or “user-dealer” networks, that is to say groups of users who share money to buy drugs that they get directly in Belgium, Nederland or Spain. This phenomenon is responsible for an increased geographical spread in drugs accessibility (i.e. suburban and rural areas).

10.3. Seizures

Origin and destination of the main substances seized in France

Cannabis is the first illicit drug being smuggled in 2008. Seizures of cannabis resume upward trend, with 74,529 kg seized in 2008. The same year, 2008, cannabis resin is seized in France is almost entirely Moroccan. It is sent to France via Spain. A significant proportion of cannabis seized in transit. In 2008, 65% of seizures were in transit and were intended for the Netherlands, the United Kingdom and Italy.

Cocaine seizures are predominant on the air and sea carriers. Imported from neighbouring countries producing coca or indirectly channelled into France via Spain, Portugal and the Netherlands, a large proportion of cocaine seized in France (80%) is bound for markets in neighbouring European countries.

From Afghanistan via the Balkan route, heroin consumed in France comes first and foremost via the Netherlands. The final destination of the heroin seized in transit is primarily intended for the UK market, before the Spanish, Italian and Portuguese. Sharp decrease in seizures of Ecstasy in 2008, production of ecstasy is primarily located in the Netherlands. Destination countries of ecstasy seized in France are Spain, Portugal and the United Kingdom.

The main countries of acquisition of amphetamine are the Netherlands and Poland, while Spain, Portugal and the United Kingdom are the main markets of destination of amphetamine seized in France in 2008.

10.3.1. Quantities and numbers of seizures of all illicit drugs

In 2008, the number of seizures reached 112,402, against 94,431 in 2007, an increase of 19%, while volumes seized showed a significant increase (100%) and regain their 2006 level. This increase affects all drugs, but to different extent depending on the product.

Analysis by product for 2008 reveals the following trends:

- Increased seizures of cannabis mainly resin (108%). In 2008, the volume of seized cannabis found its median level, slightly more than 74.5 tons seized. Decreases in quantities of 2005, 2006 and especially 2007 are explained by the diversification of modes of transportation and supply routes sought by traffickers as a result of severe seizures in 2004.
- The quantities of crack cocaine seized increased by 75%, 12 kg seized in 2008.
- Quantities of ecstasy seized (342,923 doses) have dramatically decreased (- 74.8% compared to 2007).
- Seizures of cocaine rose from 6,579 kg in 2007 to 8,215 kg on 2008 (+24%).
- For the third consecutive year, seizures of heroin were beyond a tone (1,118 kg in 2008).
- Seizures of amphetamines (powder, paste and liquid), recorded a decrease, reaching 109 kg.

⁵⁰ available in English on OFDTs web site : <http://www.ofdt.fr/ofdtdev/live/english-tab/engpubli/tends/tend53eng.html>

Table 10-1: Number and amounts of the main illicit drugs seized in France, 2005-2008

	2005		2006		2007		2008	
	Nb ⁽¹⁾	Amount ⁽²⁾	Nb ⁽¹⁾	Amount ⁽²⁾	Nb ⁽¹⁾	Amount ⁽²⁾	Nb ⁽¹⁾	Amount ⁽²⁾
Cannabis (kg) ⁽³⁾	73 986	86 603	68 049	71 725	77 881	37 282	97 692	74 529
Resin	62396	83 471	57 848	67 892	66500	34 183	85096	71 076
"grass"	10202	3 062	10 205	3 774	11381	3 048	12155	3 423
Base	1141	54	--	36	37	37	2146	54
Oil	15	2	25	2	--	0,07	12	0,334
Seed	232	14	--	58	--	52	429	30,5
Heroin (kg)	3 242	749	3 212	1 052	4 028	1 036	4834	1118
Cocaine (kg)	3 278	5 186	3 135	10 166	4 051	6 579	4 538	8 215
Crack (kg)	687	11	442	9	522	7	847	12
Amphetamines (kg)	317	111	233	78	343	307	387	109
Methamphetamines (kg)			2	0,35	--	0,15	6	0,25
Ecstasy (doses)	1 620	833 648	924	1 488 919	938	1 359 912	781	342 923
LSD (doses)	99	6 323	78	5 589	105	13 107	112	90 021
All substances	83 932		78 287		94 431		112 402	

(1) number of seizures made during the year.
 2) amounts seized during the year.

Source: OSIRIS, OCRTIS 2009

10.3.2. Quantities and numbers of precursor chemicals used in the manufacture of illicit drugs

No information available.

10.3.3. Number of illicit laboratories and other production sites dismantled and precise type of illicit drugs manufactured there

No information available.

10.4. Price/purity

Information about the prices and purity of psychoactive substances has been available in France since 2000. Epidemiological tables n° 14 show the purity of substances over the last three years. The composition and prices of the main illicit substances are shown in epidemiological Tables n° 15 and 16.

10.4.1. Price of illicit drugs at retail level

Cannabis

The average price of herbal cannabis in 2008 was approximately 8 Euros per gram. It appears that users are increasingly opting for the quality of the substance and that this demand is contributing to the slight price rise observed. The average price of a gram of cannabis resin is 5 Euros per gram and remains stable.

In fact the average price masks very contrasting situations: cannabis (resin or "grass") is present on the market in very different forms and qualities and is sold at prices which can vary by as much as 100%. There is therefore a genuine dual market: "quality" products which are expensive and highly sought after (and accessible to a minority of "informed" consumers) and, in parallel, a second market of poorer quality cannabis which is widely available and offered at far lower prices. In addition, the locally produced herbal cannabis (home grown) is generally inexpensive, very different from some herbal cannabis grown in the Netherlands and reputed to be of higher quality (€5 per gram in Metz compared to €15 for herbal cannabis produced in Holland). In Lille, the price of herbal cannabis reputed to be "pure" appears to have increased in 2008 (€60/€80 per 10 grams vs €50 in

previous years). As has always been the case, group purchasing (and therefore of larger amounts) attracts very considerable price discounts.

Cannabis resin prices can also change suddenly during the year depending on “product freshness”. Harvested in Morocco in October, the previous year’s stocks may be discounted in order to allow supplies of the fresh product from the current year to be sold.

Heroin

In 2008, the price of heroin most frequently encountered is 42 Euros depending on the monitoring device developed by OCRTIS and 45 Euros depending on TREND monitoring device.

High dose buprenorphine

Despite the marketing of generics in 2008, the form marketed under the name Subutex® continues to have a near-monopoly on the black market in large urban centres. The 8 mg Subutex® tablet is sold for an average of 5.5 Euros with large regional variations and differences depending on purchase days (more expensive at the weekend). When present on the black market, the generic is sold at a cheaper price due to a lack of demand.

Cocaine

The prices of cocaine hydrochloride and free-base cocaine (crack) vary depending on the site and social environment observed. In mainland France in 2008, the average price of a gram of cocaine hydrochloride was around 60 Euros and has been stable for 3 years.

Amphetamines

The price of the most widely sold form of amphetamine, speed, circulating in powder form, was around 15 Euros in 2008. The great majority of amphetamine powders contain less than 10%. The average price of a tablet of ecstasy is approximately 5 Euros. The tablet price can fall greatly, however, when bought in bulk.

10.4.2. Purity/potency of illicit drugs

Cannabis

The overall average THC content of cannabis resin is 10% and remains stable after the slight increase in 2007. It should be noted, however, that the number of samples containing over 15% THC is increasing.

Heroin

94% of circulating heroin is in the form of the base (a more compact powder than the hydrochloride and brown to whitish in colour).

Heroin concentrations vary very greatly from one sample to another, although the overall average remains stable (slightly less than 10%). The cutting agent found in the very great majority of heroin powders is almost always a mixture of caffeine/paracetamol. Average caffeine concentration is 28% and average paracetamol concentration is 51%. Two psychoactive adulterants (alprazolam and dextromethorphan) have been found in a few heroin samples, although always in very small amounts.

Cocaine

For the last few years, cocaine concentration has appeared to be between 10 and 40%. The three psychoactive cutting agents most widely used in 2008 are levamisole (29% versus 12% in 2007), phenacetin (27% versus 35% in 2007) and diltiazem (27% versus 30% in 2007). Caffeine (17%), hydroxyzine (15%), lidocaine (14%) and procaine (5%) are also found.

Ecstasy

After a fall or even an absence of high strength tablets (>50 mg) in 2007, we are beginning to see these again (8% of tablets) in 2008. The average content of powders containing MDMA is twice that of the tablets (52% MDMA for powders and 24% for tablets).

Part B: Selected issues

11. Cannabis markets and production. The cannabis market in France: between resin imports and home grown herbal cannabis

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Summary

The French market for cannabis is experiencing changes typical of a maturing market. The entry of new competitors, product diversification, price variations and quality improvements all bear witness to this. In addition to highlighting the changes in the French cannabis market and more generally in the THC⁵¹ market, this document discusses the implications of such changes for the traditional supply system and the methods and resources deployed to combat drug use.

11.1. Introduction

Although the hashish club of the mid 19th century (comprised among others of Charles Baudelaire, Gérard De Nerval and Théophile Gautier) attracted a great deal of attention, we know virtually nothing of the period during which cannabis first began to be distributed widely, a period generally placed around the 1950s and 1960s (Yvorel J.-J. 2006). Between the 1850s and the 1950s, cannabis barely got a mention in France. Only the law of July 12, 1916 explicitly referred to cannabis, introducing a ban on the use of toxic substances such as opium or cocaine. To demonstrate the extent to which cannabis was eclipsed by other products, we should note that between 1920 and 1922, the Paris vice squad seized 100 kilograms of cocaine, more than 50 kilograms of opium and just 5 grams of cannabis (Yvorel J.-J. 2006). This lack of knowledge of the growing consumption of cannabis possibly explains why the law of 1970 banning the use of narcotics in France and particularly targeting heroin, was so severely savaged in the media at that time regarding cannabis use (Lefebvre T. 2006; Adès J.-E. and Gandilhon M. 2007)

However, the reality of today's cannabis market, which certainly has nothing in common with that of the 1950s, 60s or even the 70s, is much better understood and currently appears to be undergoing change. Firstly, we know (as this is now measured) that demand is strong and that the supply-side is in a position to meet this demand (or vice versa). Secondly, new cannabis products are appearing, or at least products which differ in terms of both origin and quality from the Moroccan resin which has dominated the French market since the 1960s, with an example being home grown herbal cannabis.

These changes make it necessary for observers to take note of the newly evolved cannabis market, and more precisely to highlight the importance of the new products and new participants in this market, not forgetting the impact of all of this on traditional cannabis resin distributors. This is necessary in order to be able to give careful thought to the future of the fight against the THC market in France.

As a response to this problem, the cannabis market is described in the first section, with a classic assessment of demand, supply and price. In the second section, we highlight evidence of changes in the French cannabis market. Not only are we seeing the nationwide spread of shops specialising in the sale of the equipment needed to grow cannabis, but seizures of plants (sometimes cultivated

⁵¹ THC: tetrahydrocannabinol, and more precisely Delta9 tetrahydrocannabinol is the key active psychotropic substance found in cannabis.

intensively) are rising. Finally, in the third and final section, the implications of these changes will be discussed both from the viewpoint of the cannabis resin importers and from that of the security forces in charge of the fight against drug use.

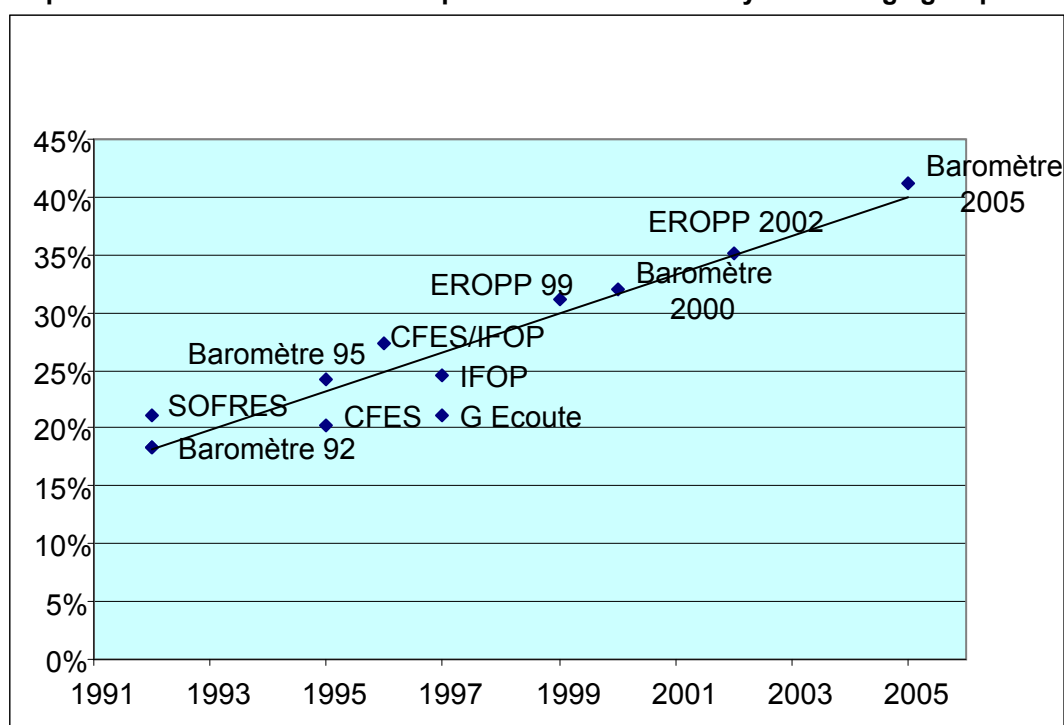
11.2. The cannabis market in France

As with any Marshallian⁵² view of the marketplace, the cannabis market can be assessed based on three aspects: demand, supply and finally the price and quantity resulting from these.

Demand has doubled in 15 years but has remained stable since 2005.

When we analyse the demand aspect of the French cannabis market, we can see that this has expanded significantly since the early 1990s, if we refer to the general population surveys documenting the prevalence levels (Graph 11-1).

Graph 11-1: Lifetime cannabis use prevalence in the 18-44 years old age group

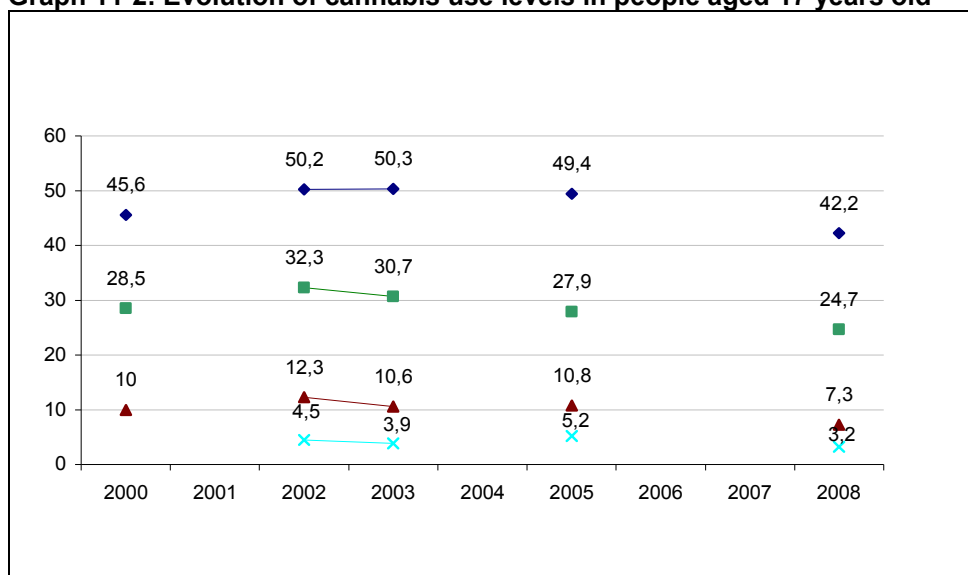


In the early 1990s, around 20% of French people aged between 18 and 44 declared they had already used cannabis. This figure had virtually doubled by 2005.

Thus, demand for cannabis intensified in the 1990s and since the early 2000s. However, we are today witnessing stagnation or even a slight decline in demand particularly among young people, as suggested by Graph 11-2.

⁵² The Marshallian vision of the market is traditionally represented by a supply curve intersecting with a demand curve, consequently establishing the prices and the quantities traded in the market.

Graph 11-2: Evolution of cannabis use levels in people aged 17 years old



A consumption peak appears to have been reached in 2003. Since then, we have seen a slight decline in consumption levels for all categories of consumers. Demand appears to be falling but we will need to wait for the next major general population survey in 2010 in order to be able to confirm this trend.

In addition to prevalence, young people's perceptions of access to the product are also revealing a slight decline for cannabis, and accordingly a slight contraction of the cannabis market. Thus, the perceived accessibility of cannabis has been the subject of two contradictory changes between 1999 and 2007: firstly, it appeared to be easier to obtain cannabis in 2003 than in 1999 (with fewer people considering this "impossible" and more people claiming that it is "easy"), although this trend was then completely turned on its head with the emergence of a situation similar to that of 1999 (with fewer people claiming that it is "easy" to obtain and more people considering it "impossible") (Legleye S., Spilka S. et al. in press).

The other major change is a significant increase in the percentage of young people unable to answer this last question, which doubled between 2003 and 2007, probably because cannabis consumption has fallen, with the result being that it is now less visible and consequently less available.

This appears to be all the more likely as cannabis is chiefly obtained from among the individual's circle of friends. Among regular consumers, 78% stated that they obtain their cannabis from friends and 65% are given it free of charge, while 59% of users stated that they purchase it from small-scale dealers. For the latter, the favoured location of the transaction is the dealer's apartment. Carrying out the transaction in the dealer's home reduces the risk of arrest both for the dealer and the purchaser. Additionally, for the latter, buying from a dealer creates the impression of belonging to a circle of "select" clients (BELLO, TOUFIK et al. 2005) and encourages a feeling of "trust" which is influential during transactions.

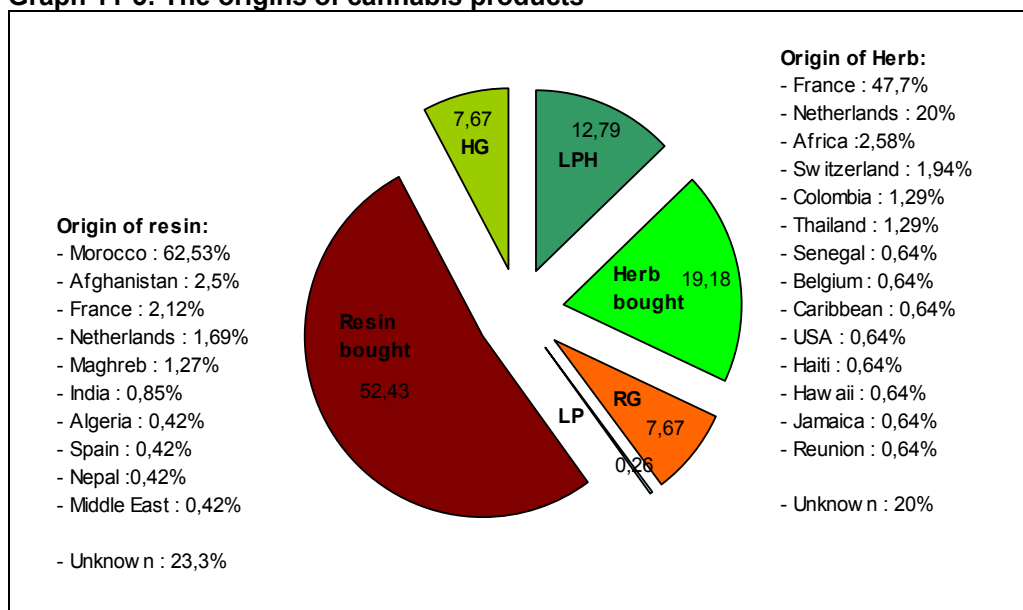
Finally, even if demand for cannabis appears to be declining slightly, the fact nevertheless remains that in 2005 almost 12 million French people had already experimented with cannabis⁵³, of whom 3.9 million were occasional consumers and 1.2 million regular consumers, with 550,000 taking cannabis on a daily basis (BECK, LEGLEYE et al. 2006).

⁵³ As a comparison, the number of consumers experimenting with cocaine is estimated at 1.1 million, with ecstasy at 900,000 and with heroin at 360,000 (Beck et al., 2006).

11.3. A supply side historically based around the importation of Moroccan resin

The cannabis seized by the security forces in France, whether herbal cannabis or resin, originates from various parts of the world and is intended for various final destinations such as the UK for example. Although France is a transit country for cannabis resin and herbal cannabis, it is also obviously a final destination country too (Tables B, C, D and E in the Appendix). The cannabis consumed in France is logically mainly obtained through importation. A survey carried out among 400 regular cannabis users in which they were asked to state the geographical origin of their products confirmed that cannabis resin originates from Morocco while the herbal cannabis comes from the Netherlands... and from France. Graph 11-3 below shows the geographical breakdown stated by users for herbal cannabis and resin.⁵⁴ This graph also shows the breakdown in percentage terms of the products according to whether they are purchased, supplied free of charge or home-grown.

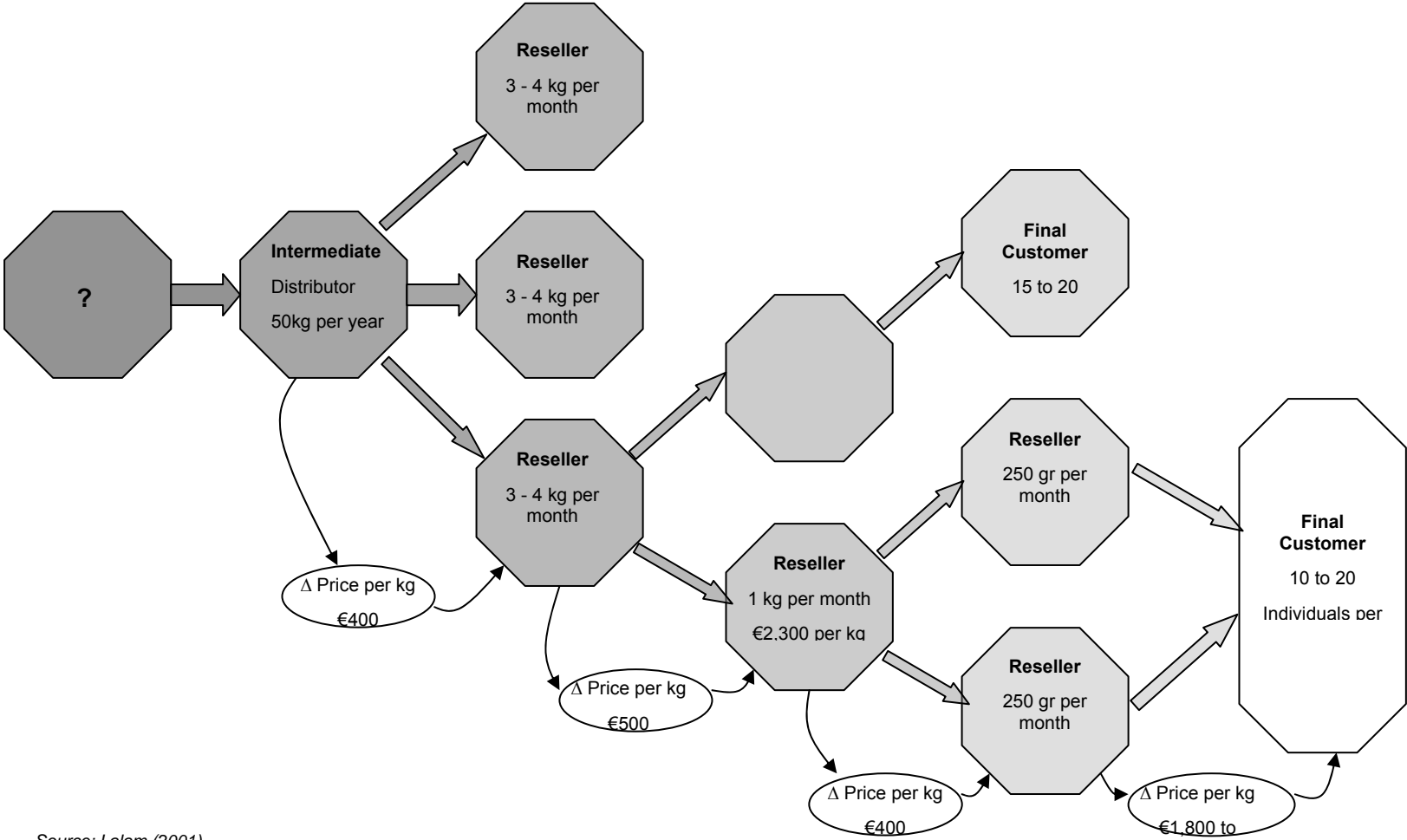
Graph 11-3: The origins of cannabis products



As shown in the graph above, the cannabis market is largely dominated by resin imported from Morocco. The imports of cannabis resin mainly arrive by road. The traffickers load their cargo on the southern coasts of Spain and then make their way to France in high speed, large engine vehicles ("go fasts") while discreetly blending in with the road traffic among more basic "go slow" vehicles, indistinguishable from the rest. The importation of cannabis by road is also carried out using heavy goods vehicles, camping cars or coaches (OCRTIS (Office central pour la répression du trafic illicite de stupéfiants) 2008). Once imported into France, the cannabis resin is marketed by means of a distribution system of varying degrees of complexity. This cannabis distribution system was described for the first time thanks to ethnographic studies performed during the 1990s. Lalam (Lalam N. 2001) has refined and summarised this acquired knowledge, with a description of a general commercial distribution system for cannabis in France, as shown in Figure 1.

⁵⁴ In Graph 3, HG stands for Herb Gifted; LPH: Locally-Produced-Herb; RG; Resin-Gifted; LP: Locally-Produced Resin.

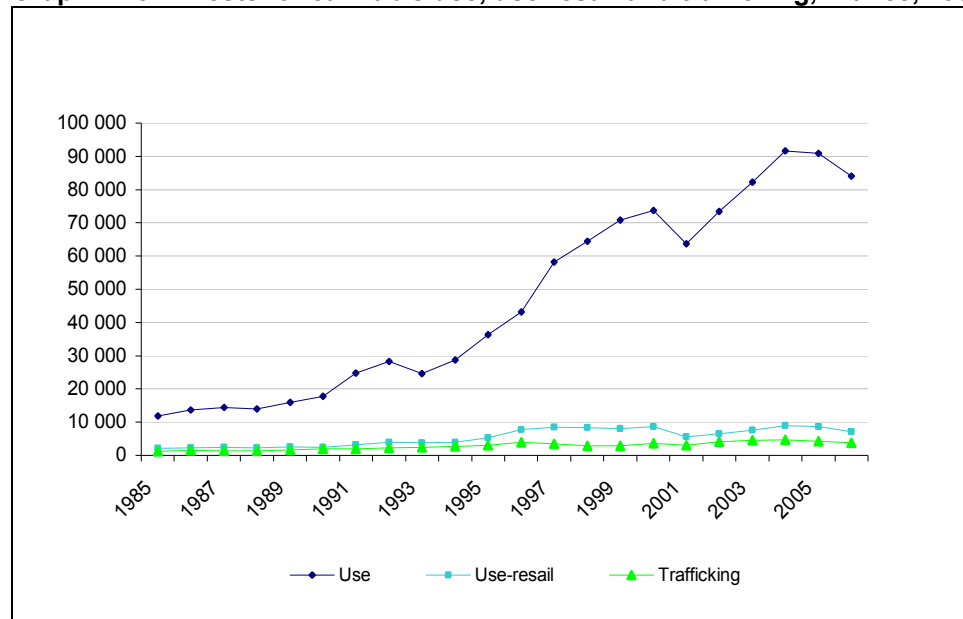
Graph 11-4: Cannabis distribution network



This system includes four different distribution levels. We should note that there is no description of the importation method and that this system begins with the semi-wholesaler ranging down to the final end user. The profit margins related to the progression from wholesale to retail sales are shown in the figure.

We should also note in Graph 11-5 that the probability of arrest is far higher for simple users of cannabis than for user-resellers and even for traffickers. This idea is obviously borne out when we consider the number of seizures performed according to the weight of cannabis seized: in 2007, just under 47,000 seizures of less than 5 grams were carried out compared to 400 seizures of between 1 and 5 kilograms or 30 seizures of between 100 and 500 kilograms (Appendix, Table A).

Graph 11-5: Arrests for cannabis use, use-resale and trafficking, France, 1985-2007



Cannabis trafficking can therefore appear to be a relatively risk-free and lucrative activity for cannabis traffickers in France. On this particular point, thanks to a methodology combining ethnographic observations and mathematical-economic modelling, Ben Lakhdar (BEN LAKHDAR 2007) has estimated the number of semi-wholesalers (i.e. those distributing between 140 and 300 kilograms of cannabis per year) at between 700 and 1,500. The latter individually generate an annual turnover of between 250,000 and 550,000 Euros. Further down this distribution chain as described by Lalam (2001), the second intermediary earns between 35,000 and 77,000 Euros per year. He sells between 16 and 35 kilograms annually. At this stage in the distribution chain, there are estimated to be between 6,000 and 13,000 dealers. The third and fourth intermediaries earn much smaller sums (less than 10,000 Euros per year). There are on average 85,000 third level intermediaries while the number of final intermediaries is estimated at 140,000 individuals. At these levels of the distribution chain, the quantities sold are below 4 kilograms per year.

To sum up, with around 208 tonnes of cannabis sold each year, generating a retail sales turnover of 832 million Euros (Legleye S., Ben Lakhdar C. et al. (2008), cannabis supply seems to be doing well in France.

11.4. Two key variables, the price-quality and price-quantity relationships

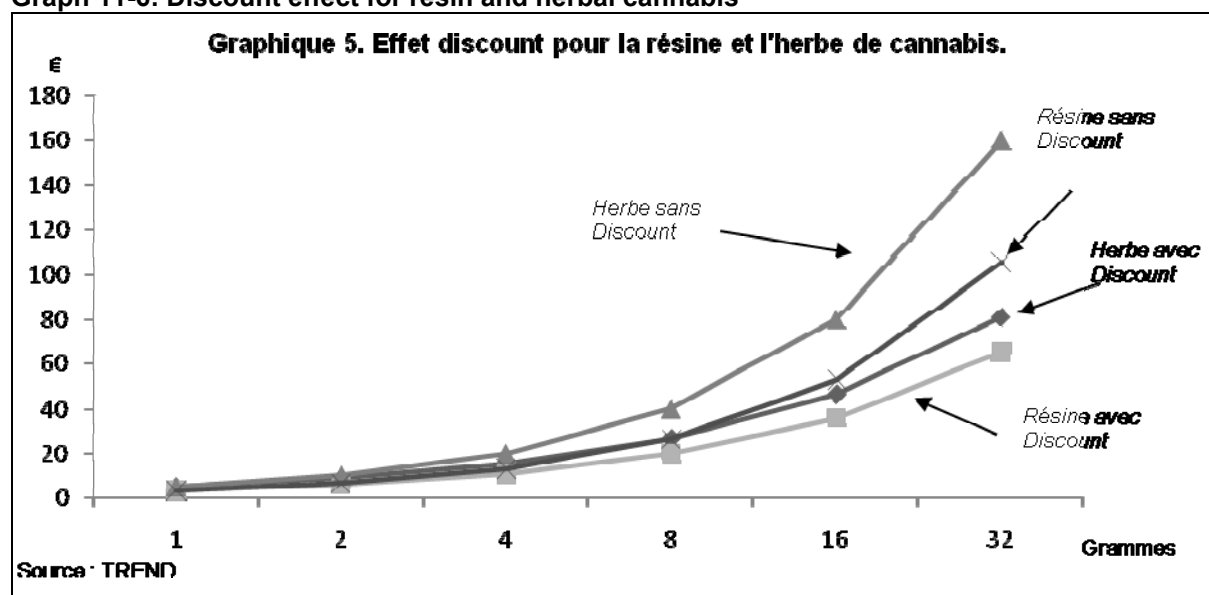
The price-quality relationship for illegal drugs is a vital factor when studying these markets and the manner in which they are developing (Caulkins J. and Padman R. 1993). Indeed, although the price of a product may fall, leading us to believe that supply is rising, this fall may in fact be due to a reduction in the intrinsic quality of the product in terms of pure psychoactive substances. In such a scenario, the price reductions are not the outward sign of

the greater availability of the product but rather of stagnation in the price per gram of the pure psychoactive substance concerned.

Naturally, quality is not the only factor affecting price levels. The quantity purchased in a single batch must also be taken into account. A discount effect exists when illegal drugs are purchased in bulk. In other words, the higher the quantity purchased, the lower the price per gram. This discount effect is a response to the need to limit stocks and thereby to reduce the risks of the seller encountering problems with the authorities. Traffickers seeking to dispose of their cannabis as quickly as possible thus attempt to motivate buyers by reducing prices according to the quantities purchased.

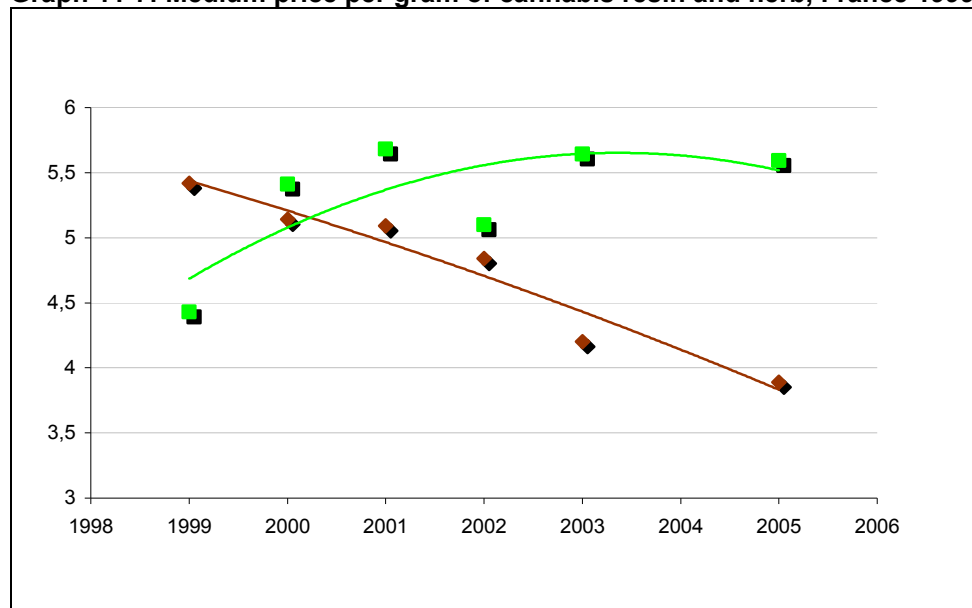
Where cannabis (resin and herbal cannabis) is concerned, it has also been shown that the price-quantity index for cannabis resin is 0.823 and 0.845 for herbal cannabis (BEN LAKHDAR 2007). In other terms, when the quantity of resin purchased doubles, the price does not increase by 100% (i.e. doubling) but by 82.3%. This discount effect can be seen in Graph 5 below.

Graph 11-6: Discount effect for resin and herbal cannabis



If we consider the price per gram of the resin and herbal cannabis sold in France (Graph 11-6), we see major changes occurring over the period 1999-2005. The average price per gram of cannabis resin fell sharply over the period in question while the price per gram of herbal cannabis increased.

Graph 11-7: Medium price per gram of cannabis resin and herb, France 1999-2005 (retail)



Over the same period, the quality of the cannabis products also changed, chiefly for herbal cannabis. Indeed, the concentration of THC rose for herbal cannabis, increasing from roughly 5% in 1998 to 7 or 8% in 2004 (BELLO, TOUFIK et al. 2005). At the same time, the average THC content for cannabis resin of around 10% remained at this level over the period from 1998 to 2004.

Consequently, we may conclude that only the resin market has changed significantly.

As the price of herbal cannabis has increased in line with improvements in its quality, we may consider that the price per gram of pure THC has not significantly changed for this type of product, unlike resin, for which the price has fallen while the THC content has remained identical. Thus, the price per gram of resin-based THC has fallen while the price per gram of herbal cannabis-based THC has remained stable.

Based on the above, to explain the significant fall in the price of resin-based THC we may assume that the rise in the popularity of herbal cannabis, and above all its attraction for consumers due to its high quality, has led resin sellers to lower their prices in order to ensure that their product continues to remain competitive faced with this high-quality competitor. This hypothesis therefore suggests the existence of competition between these two products, products which are also in the hands of very different market players.

This hypothesis is backed by a number of signs.

11.5. Signs of change

As shown by Jansen's analysis (Jansen A.C.M. 2002), Europe has the potential to become self-sufficient in cannabis production, and no longer dependent upon imports. More precisely, according to Jansen (2002), thanks to the illegal use of the latest technological innovations, it is now possible to use intensive farming methods for cannabis, circumventing climatic constraints. These technical developments and greater access to the knowledge and skills required mean that Europe now has the possibility to produce its own cannabis. As the Internet provides access not only to the knowledge required in order to grow cannabis but also to the tools and resources needed (through online sales) to cultivate and boost the efficiency of cannabis production, a number of European nations are now approaching self-sufficiency in the field of cannabis production. Switzerland and Great Britain are particularly striking examples (EKDF 1999; Druglink March/April, 2007).

The Internet is not the only source of access to the material needed to grow cannabis. Shops exist specialising in indoor growing, clearly dedicated to cannabis production. Additionally,

we have seen a worrying correlation between the number of these specialised shops and the number of arrests for cannabis growing in Canada (Brochu S., Bearegard V. et al. 2008; Bouchard M. and Dion C.B. 2009). In France, the number of such shops was estimated at between 60 and 197 in 2005-2006 (Lefour J. 2006; TOUFIK, Legleye et al. 2007). More recent estimates mention between 200 and 400 growshops in 2008. Furthermore, when we examine this type of business in detail we discover geographical variations which appear to show that the demand for this type of equipment is concentrated in the suburbs of major cities.

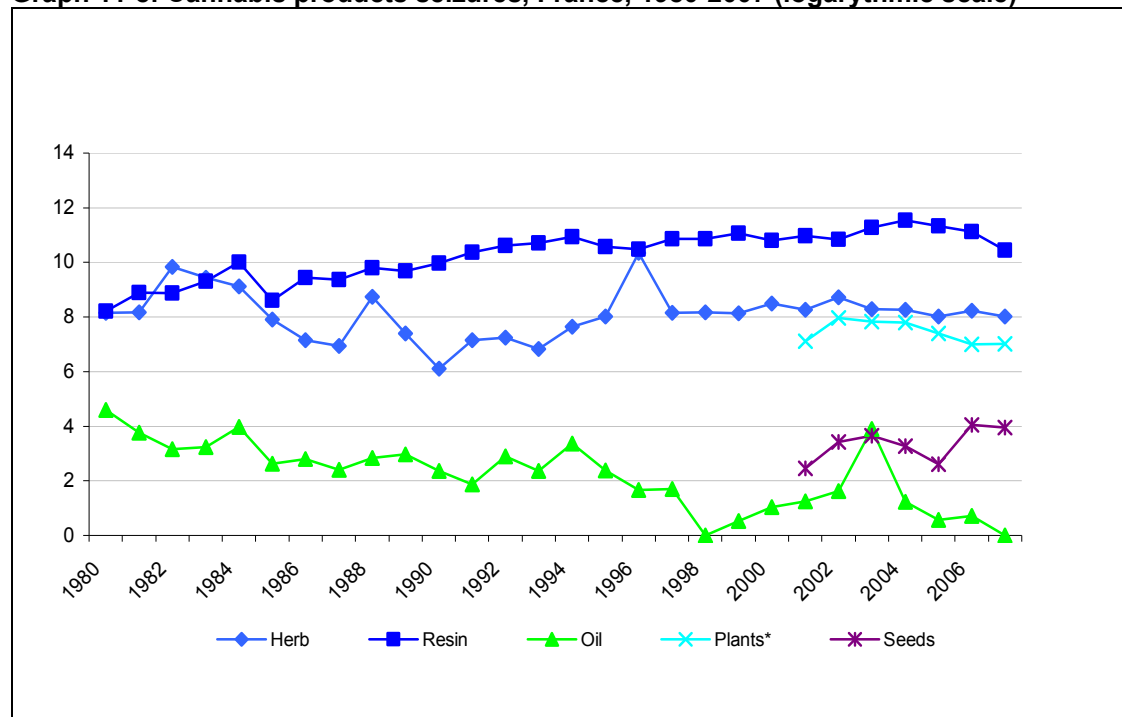
Some of the shops, referred to as head shops, also sometimes sell hemp seed in various forms including packets from seed producers in the Netherlands such as the sensiseed bank, or seed referred to as hemp seed (birdseed). However, although it is not illegal to sell indoor growing equipment (as this can be used for perfectly legal purposes) the sale of seed is tightly regulated.

Since these factors of production are now available to large numbers of people, the domestic production of cannabis is no longer a marginal activity. In a total market estimated at 277 tonnes of cannabis consumed in 2005, of which 208 were marketed, generating 832 million Euros in turnover (Legleye, Ben Lakhdar et al. 2008), at least 32 tonnes were produced in France (BEN LAKHDAR 2009).

This estimate of 32 tonnes means that we can estimate the market share for self-grown cannabis at 11.5% of the total market. In value terms, this would account for 160 million Euros, enabling us to estimate the number of plants harvested annually at between 950,000 and 1.3 million. Due to the methodology used, only "small-scale" growers are taken into consideration here, each growing between 6.8 and 9.3 plants if we consider the total number of self-growers at between 140,000 and 200,000 (TOUFIK, Legleye et al. 2007).

In Graph 11-8, we should note that the problem of the self-production of cannabis has been featured in police statistics since 2001 as it was from this year onwards that seizures of cannabis seed and plants were recorded.

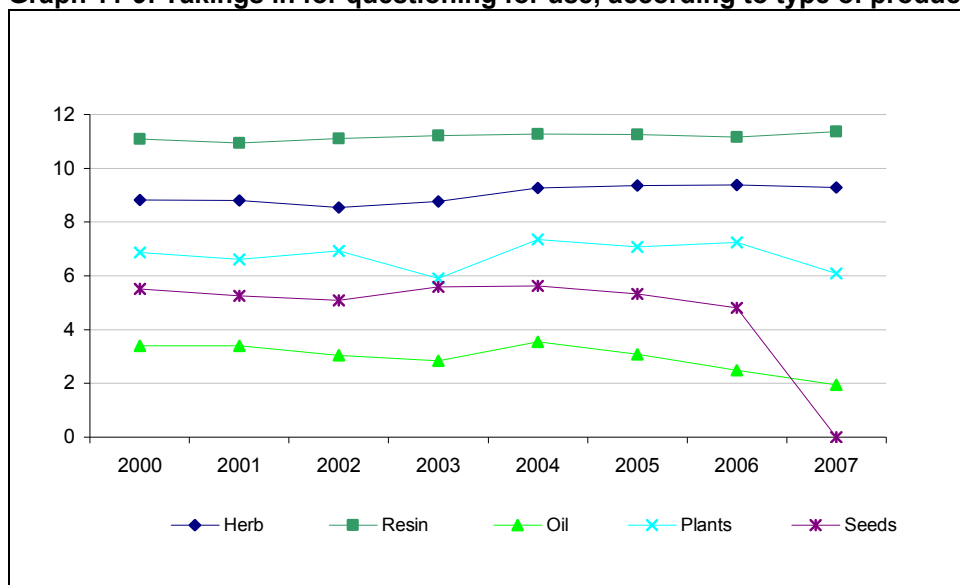
Graph 11-8: Cannabis products seizures, France, 1980-2007 (logarithmic scale)



Based on the assumption that a cannabis plant produces 30 grams of flowering tops⁵⁵ (Toonen M., Ribot S. et al. 2006), seizures of cannabis plants in France are below the level of seizures of herbal cannabis. Naturally, among the seizures of herbal cannabis, part of this quantity originated in France. Ultimately therefore, it is impossible to say whether the herbal cannabis seized chiefly originated in France or abroad. It should be borne in mind however that users state that the herbal cannabis they consume is mainly produced in France (Graph 11-3). The fact nevertheless remains that the majority of seizures in France are for cannabis resin. Seizures for oil are becoming ever rarer.

Regarding the production sites for the plants seized, we may assume that the cannabis plants seized come from plantations of various sizes. Bouchard (Bouchard M. 2007) has effectively shown for Canada that the risk of discovery is greater for large plantations than for small ones, but that despite this the small-scale growers tend to be arrested more often than the larger ones. We can consequently assume that the seizures are comprised of plants from larger plantations while the arrestees tend to be small-scale producers.

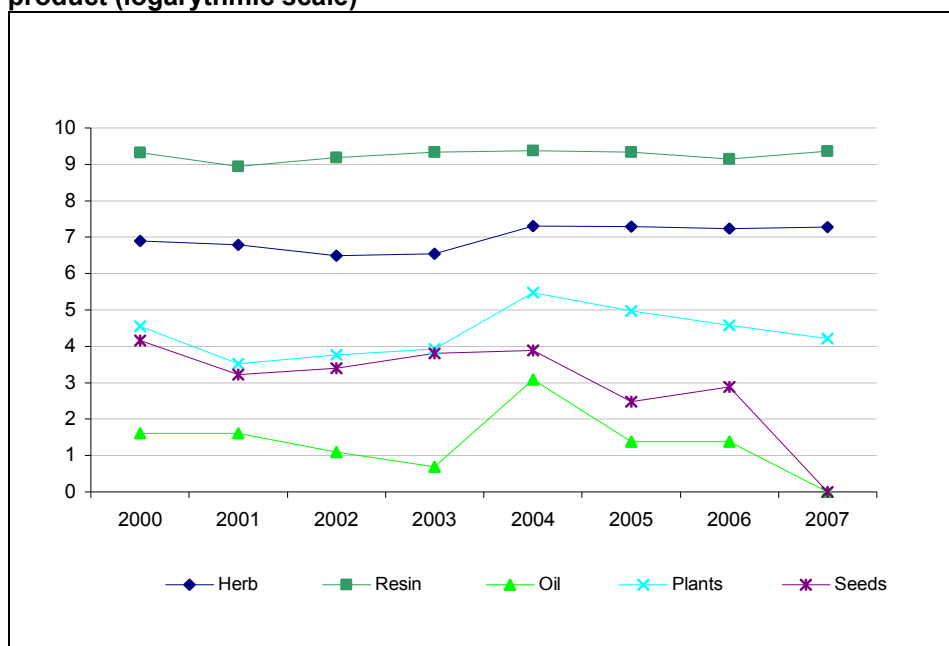
Graph 11-9: Takings in for questioning for use, according to type of product (logarithmic scale)



Similarly, the users, user-resellers and traffickers arrested are mainly arrested for the possession of resin, followed by that of herbal cannabis and finally cannabis plants (Graphs 11-8 and 11-9).

⁵⁵ This is a high-end assumption as Toonen et al. (2006) have estimated the yield from a plant under virtually optimal production conditions (indoor hydroponics).

Graph 11-10: Takings in for questioning for use-resale and trafficking according to type of product (logarithmic scale)



With 1,583 cannabis plantations discovered in 2007 and 2,106 dismantled in 2008, the number of cases involving cannabis growing increased by a third in just a year. However, these cases remain marginal as they account for less than 2% of all cases centralised by the OCRTIS (Central Office for the Repression of Drug Trafficking).

In 2007, the security forces (the Police, Gendarmerie and Customs Department) brought cases against 1,950 individuals, of whom only a quarter were prosecuted for the possession of cannabis plants, the others being accused of other offences. This data also shows that most cannabis growers were prosecuted for offences other than cannabis growing: the discovery of the plants occurred during searches carried out for other offences (most of which were drug-related, but also other types of offences including armed robbery, possession of stolen goods, etc.).

The 450 people sentenced for the possession of cannabis plants in 2007 were mostly labelled as "users". Despite the fact that the penal code categorises this type of offence as a crime, the courts can punish cannabis growing based on the circumstances, i.e. by taking account of the personal situations and intentions of those brought before the court.

Although outdoor growing is frequently encountered in the French overseas departments and in the south of France, indoor growing clearly predominates. According to the data supplied by the OCRTIS, this growing method accounts for 3 cases out of 4. This change can be explained by a number of factors including an increasingly urban population, easier access to the knowledge and equipment required, greater discretion than outdoor growing and above all a method making it possible to grow reputedly high-quality cannabis (with more flowering tops per plants and more THC).

Most discoveries of cannabis plants are modest in size. For instance, 50% of the plantations discovered in 2007 by the security forces did not exceed 5 cannabis plants and only 10% exceeded 50 plants (Office central pour la répression du trafic illicite des stupéfiants (OCRTIS) 2007). This data alone means that we can presuppose that the vast majority of cannabis growers grow herbal cannabis for their own consumption. According to estimates by Toonen et al. (2006) who have assessed the average production of cannabis indoors, 5 plants make it possible to produce 150 g of herbal cannabis per harvest, i.e. a maximum of 600 g for four harvests per year (or the equivalent of 1.6 g per day).

These small-scale cannabis growers prefer to join forces when growing cannabis. As this activity requires time, not to mention a fairly hefty initial investment (between 300 and 1,000 Euros for an indoor plantation of 5 to 10 plants), it is frequently found that a couple or a group of friends pool their money and spare time to grow the plants. Furthermore, the younger the cannabis growers are, the higher their propensity to grow the plants as a group. These cannabis growers, who have been referred to as "social cannabis growers" (INHES-MILDT 2009), produce more than they consume and tend to be motivated more by the feeling of belonging to a group, in addition to the challenge and the possibility of saving money, rather than by the prospect of personal enrichment. Giving or swapping cannabis has become the norm among these individuals, although some may decide to try and offset the cultivation costs and sometimes to earn a little money.

A comparison of the socio-demographic and legal data for these cannabis growers confirms that the vast majority of cannabis growers have no relationship whatsoever with the organised crime networks involved in cannabis trafficking. The cannabis growers arrested are older and socially better integrated (they are often employed, with virtually no criminal record) than cannabis traffickers. This qualitative data has emerged in a context in which a majority of magistrates tend to view most cannabis growers as being "less dangerous than the traffickers".

Additionally, analyses of the available statistics also suggest that large-scale cannabis plantations tend to be rare. Only around 10 of the dismantled plantations exceeded 500 plants in 2007, these being outdoor plantations created in French Polynesia. This modest size of the plantations is all the more striking when we compare them to the size of the cannabis factories discovered in the United Kingdom and the Netherlands, which can include several thousand plants per site.

However, the most recent trends appear to show a non-negligible change in the number of plantations operating for financial gain. The security forces dismantled 34% more plantations in 2008, and tore up more than twice as many plants as the previous year. This rise chiefly concerns plantations of more than 50 plants and appears to indicate a degree of professionalization creeping in for certain cannabis growers. These French cannabis factories rarely exceed 250 plants. Approximately 10 sites with more than 250 plants are discovered each year and in 9 cases out of 10 these are in French Polynesia.

Among these rare sites, we encounter organised groups, although we cannot link these groups to the "traditional networks". Nevertheless, they display an operating method resembling the methods used by British and Dutch organised groups, namely a network boss who finances and organises the plantation⁵⁶, followed by a front man who rents the premises, often on the edge of a major city, and who handles the work necessary to setting up the plantation (a growing room with lighting and irrigation systems, a drying facility and another intended for propagation via cuttings - the best plants are selected and then cloned from a cutting guaranteeing better results than those achieved with seed).

At this stage, it is by no means unusual to discover the involvement of an expert, who may sometimes be a biology student recruited by the plantation boss, although he may also be a specialist (frequently from Holland) renting out his services to different cannabis growers.

Finally, the network boss recruits a gardener to handle the day-to-day upkeep of the plants. As he is the person most at risk of arrest, this gardener has very little contact with the rest of the team. He communicates with only a single member of the team and has no knowledge of the distribution chain as a whole. We should note that in contrast with the observations carried out in France, criminal groups in the Netherlands and the UK tend to recruit

⁵⁶ The financing generally exceeds 20,000 euros (for 200 plants) which in theory will be recovered with the proceeds from the first harvest.

gardeners from among illegal immigrants who do not speak the language. Highly vulnerable, they often pay for their journey to Western Europe by carrying out these gardening activities.

Information gathered by the security forces confirms that cannabis growing is gradually gaining ground within the cannabis market. These growing activities tend to be fragmented (i.e. large numbers of small plantations), located close to demand (on the edge of major cities) and corresponds to the changing needs of consumers (who are seeking herbal cannabis with a high THC content), unconnected with the traditional, dangerous resin supply networks.

11.6. Supply-side implications

The emergence of herbal cannabis produced in France constitutes a new source of supply within the THC market. The market for resin is believed to be facing competition from the market for herbal cannabis - itself divided between commercially produced herbal cannabis (whether imported or produced in France) and self-grown herbal cannabis. Taken together, all of these factors comprise the THC market. For several years we have been witnessing the increased segmentation of this market, with one group lowering the price of their products (resin) while the others opt for higher quality (herbal cannabis). However, it appears that part of the self-grown herbal cannabis is grown precisely in order to avoid the "commercial" market for THC and to achieve greater control over the quality of the product consumed (Lefour J. 2006). This is true for grower-users, i.e. those who in principle have no commercial ambitions when growing their cannabis.

The current ease with which local production can be carried out does not only concern "small-scale" growers. Other countries (the USA, Canada and the UK) have seen criminal networks setting up, specializing in the indoor production of cannabis. The criminals' skills differ between the specialist in the importation of narcotics and the specialist in the large-scale production of herbal cannabis. Could they be the same individuals in France, who have made the transition from one activity to the other in order to meet demand and to protect their market share? Currently, we cannot answer this question with any degree of precision, although it appears that this is not the case. Firstly, organised crime concerning this particular criminal niche is still in its infancy in France, and secondly we have recently noted that the criminal networks specializing in the importation of cannabis are diversifying their product range by now importing cocaine (GANDILHON 2007).

Even if, at first sight, France is only marginally affected by these criminal organisations specialising in the production of herbal cannabis, the public authorities have fully appreciated the threat and are currently equipping the security forces with the tools they need to detect indoor growing, in addition to building awareness among them and providing them with training concerning this new source of drug supply (MILDT 2008).

Finally however, another key player has come along to further disrupt the traditional THC supply system. The online sale of synthetic cannabinoids over the Internet was still legal up until recently in France. The synthetic substances are now listed as narcotics and have been since February 2009. The fact nevertheless remains that in the THC market (natural or synthetic) this new source of supply continues to produce its effects as the producers are relatively unaffected by the actions taken by the authorities. The supplier is almost inevitably situated abroad and can only be located with great difficulty.

11.7. Conclusion

Today, it can be said that the cannabis market in France is a market reaching maturity. Apart from the high level of demand being met, a number of factors point to the fact that cannabis, or more precisely the market for THC, has made the transition from a monopolistic market to a competitive market, benefitting from technical innovations, and experiencing price variations and the differentiation of products based on their quality.

As Jansen (2002) highlighted, the technical capacity and expertise which is now known to and available to the European countries mean that imported cannabis (chiefly from Morocco) now faces stiff competition. It is possible for all European countries and particularly France to boost their potential for cannabis production, and to eventually cease to be dependent upon imports.

The consequences for the THC market are numerous including falling prices for certain products, quality increases, and a wider range of products available including the appearance of innovative cannabinoidic products.

The economic model used by the traditional sellers of cannabis resin has also been thrown into turmoil. Their logical reaction faced with heightened competition from herbal cannabis (whether imported or produced locally) has been to cut their prices. It has also been (perhaps faced with the strong preference shown by consumers for herbal cannabis) to diversify their activities, using their skills in the field of the importation of illegal products to import cocaine instead (GANDILHON 2007).

The security forces have been encouraged to react: the 2008-2011 government plan to fight drug use stresses the need to combat the local production of cannabis. The security forces are being equipped with new detection equipment, and are building awareness among, and training their field staff in this new form of criminal activity. However, it appears that alongside this new form of obtaining THC, not only is the Internet proving to be a tough opponent in as far as suppliers go (concerning the sale of synthetic cannabinoids) but furthermore the former cannabis importation networks are now adding psychoactive substances to their range of available drugs.

Appendices

Table 11-1: The structure of cannabis resin seizures (in weight) in 2007

Band	Quantity	% of total	Number of seizures
< 5 gr	94,451 kg	0,28	47706
6 to 20 gr	116,717 kg	0,34	11112
21 to 50 gr	108,750 kg	0,32	3318
51 to 100 gr	128,412 kg	0,38	1681
101 to 500 gr	354,887 kg	1,04	1631
501 to 1000 gr	267,001 kg	0,78	359
1001 to 5000 gr	906,642 kg	2,65	403
5001 to 10 000 gr	616,887 kg	1,8	83
10 001 to 50 000 gr	2 569,754 kg	7,52	120
50 001 to 100 000 gr	3 029,560 kg	8,86	41
100 001 to 500 000 gr	9 277,789 kg	27,14	31
500 001 to 2 000 000 gr	14 441,86 kg	42,25	14
> 2 000 001 gr	2 270,000 kg	6,64	1
Total	37 182,710 kg	100%	66500

Source: OCRTIS

Table 11-2: The country of acquisition for cannabis resin seized in France (in Kg)

	2002	2003	2004	2005	2006	2007
South Africa	-	-	-	-	-	21,179
Algeria	11,924	2 147,960	192,845	499,753	205,755	387,596
Germany	-	1,039	-	30,260	5,053	-
Belgium	90,572	810,908	2 703,056	604,611	1 782,870	521,020
Brazil	-	-	-	-	-	2,800
Cameroon	-	-	-	-	-	14,696
Spain	38 077,214	52 422,202	55 578,179	61 026,360	41 547,854	19 475,693
France	92,254	530,276	826,203	740,205	603,060	536,960
India	-	-	-	-	-	7,600
Luxembourg	-	-	-	10,000	1,000	-
Morocco	3 341,226	10 872,474	18 402,803	10 551,495	8 264,012	6 559,114
Netherlands	803,688	626,996	1 169,281	1 306,288	558,276	431,531
Portugal	-	139,940	6 161,400	61,233	1,000	-
Surinam	-	-	-	1,953	-	-
Not stated	8 419,235	10 796,125	18 671,282	8 638,583	14 923,103	6 224,520
Total	50 836,113	78 347,920	103 705,049	83 470,741	67 891,983	34 182,709

Source: OCRTIS

Table 11-3: The destination country for cannabis resin seized in France (in Kg)

	2002	2003	2004	2005	2006	2007
Germany	1 691,899	2 137,394	45,052	3 849,845	5 064,040	3 368,250
Austria	-	-	-	70,160	-	13,278
Belgium	1 244,088	1 337,981	3 983,239	5 042,740	2 750,498	1 626,850
Denmark	374,320	306,664	35,000	24,480	569,700	217,160
Spain	14,350	6,700	0,361	93,000	3,565	2 983,900
France	10 791,500	23 503,542	21 452,598	12 423,511	13 346,839	10 337,069
Greece	-	-	486,000	30,260	3,180	-
Hungary	-	-	-	-	20,068	-
Ireland	1 914,000	2 070,338	-	4 563,152	1 048,630	1 596,025
Italy	6 096,543	5 523,328	6 684,775	3 973,482	3 755,413	3 065,367
Jersey (UK)	-	-	-	-	-	8,000
Lithuania	-	-	-	-	-	93,000
Netherlands	7 179,899	16 100,964	38 916,648	43 579,122	26 881,289	2 628,578
Poland	-	-	-	80,000	-	-
UK	17 159,630	21 389,322	19 753,523	4 763,448	4 099,126	4 168,399
Switzerland	17,598	32,000	-	38,975	1,230	-
Sweden	-	-	-	-	30,500	30,240
Not stated	4 352,286	5 642,687	12 347,853	4 938,566	10 317,905	4 046,594
Total	50 836,113	78 050,920	103 705,049	83 470,741	67 891,983	34 182,710

Source: OCRTIS

Table 11-4: The country of acquisition for herbal cannabis seized in France (in Kg)

	2002	2003	2004	2005	2006	2007
South Africa	-	-	-	-	22,371	39,950
Angola	65,700	23,000	-	-	-	80,900
Belgium	1 186,764	255,826	331,693	112,057	438,850	98,428
Benin	9,260	-	10,500	5,207	5,042	-
Cameroon	-	-	69,930	37,000	62,618	113,005
Congo	271,370	24,000	26,000	-	-	-
Dominica	-	55,500	-	-	126,600	-
Spain	-	37,000	-	16,000	9,375	13,420
France	127,775	130,982	119,765	69,822	71,442	135,718
Ghana	63,000	-	-	2,500	-	-
Guyana	-	-	-	-	4,260	2,753
Luxembourg	-	-	-	-	44,000	-
Mali	-	3,850	-	-	11,307	-
Morocco	-	-	-	-	-	97,300
Nigeria	-	-	-	-	-	47,160
Netherlands	132,907	881,602	681,214	759,466	641,058	168,717
Poland	-	-	-	-	-	2,884
St-Vincent	149,000	-	220,000	491,600	368,550	356,600
Saint Lucia	211,400	-	83,995	42,100	68,460	328,820
Switzerland	54,500	20,304	-	-	-	1,200
Surinam	67,912	91,142	24,750	41,600	51,814	16,930
Thailand	-	-	-	-	4,210	1,000
Togo	1 047,000	-	2,050	12,400	2,910	-
R.D.C. (ex Zaire)	5,070	-	-	142,000	-	-
Not stated	2 755,042	2 471,421	2 361,992	1 330,671	1 840,666	1 542,738
Total	6 146,700	3 994,627	3 931,889	3 062,423	3 773,533	3 047,523

Source: OCRTIS

Table 11-5: The destination country for herbal cannabis seized in France (in Kg)

	2002	2003	2004	2005	2006	2007
Germany	-	-	1,335	-	-	-
Anguilla	-	-	-	-	-	232,000
Barbados	-	-	-	491,600	-	-
Dominica	-	-	-	-	350,550	-
Spain	5,750	18,004	-	-	-	70,000
USA	-	-	-	-	-	10,000
France	2 292,624	800,680	903,707	1 026,010	1 126,571	1 580,838
Greece	-	-	10,339	-	-	-
Hungary	-	-	-	-	3,650	-
Mauritius	-	23,000	-	-	-	-
Ireland	-	-	-	-	2,775	83,892
Italy	21,954	16,300	31,331	19,681	184,173	8,324
Japan	-	1,767	-	8,114	-	-
Netherlands	10,840	1,272	220,000	-	18,000	6,700
UK	1 716,191	1 169,247	674,725	781,744	816,636	15,800
St-Vincent & Gr.	-	-	-	-	126,600	-
Slovenia	-	-	4,975	-	-	-
Taiwan	-	1,830	-	-	-	-
Not stated	2 099,341	1 962,527	2 085,477	735,274	1 144,575	1 039,969
Total	6 146,700	3 994,627	3 931,889	3 062,423	3 773,530	3 047,523

Source: OCRTIS

12. Treatment and care for older drug users

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Foreword

The drug issue appeared in France at the end of the 1960s, and was seen as a problem essentially affecting young people at the time. The heroin-related death of a young girl in the south of France at the end of the 1960s was extensively covered in the media and played a major role in the adoption in 1970 of the law setting the framework for the repression of drug-related offences and the treatment of users, a law which is still in force today. The first specialised drug addiction treatment centres were created at the start of the 1970s and dealt with mostly young people under the age of 20, according to the limited information available from that time. Forty years later, the phenomenon has grown tremendously. In 2007, the figures had risen from a few hundred to 100,000 people seeking care at specialised treatment centres. A significant proportion of these people are now over 40 years old. It is therefore clear that today, the drug issue is no longer a purely “youth-related” one.

12.1. Ageing of problem drug users

12.1.1. Age trends in drug users in and out of treatment

TDI data

In France, data collection on the demand for treatment, compatible with the TDI protocol, started in 2005. Therefore, TDI data is available only from 2005 to 2007. Even in this limited period of time, a user ageing process emerges for all substances, except stimulants, for which there is a very limited number of cases recorded.

Table 12-1: Percentage of people 40 years old starting a new treatment course in specialised centres by substance and regardless of substance, 2005-2007

Year	%>=40 all (n*=32,542)	%>=40 heroin (n*=7,970)	%>=40 cocaine (n*=1,757)	%>=40 stimulants (n*=207)	%>=40 cannabis (n*=12,453)	%>=40 others known drugs (n*=3 132)
2005	10.6	11.7	17.5	8.3	3.9	18.3
2006	12.1	12.1	20.2	8.1	4.5	21.3
2007	14.4	15.1	21.6	7.7	5.5	26.1

Source: RECAP/OFDT, 2005-2007

*number of TDI patients in 2007

Although increasing, the percentage of people aged 50 or older remains very small: 2.3% for all recorded people, with a maximum of 4% for consumers of other known drugs. The largest increase is seen in the 40-49 age group.

The highest proportion of people aged 40 or older is be found in the “other known drugs” group and in the group with cocaine, as primary drugs. Age increases very rapidly among people in the first group, which mainly includes users whose main drugs belong to the “other opiates” category, namely methadone and, less often, benzodiazepines. The increase in the proportion of people aged 40 or older amongst benzodiazepine users is particularly high, from 19% in 2005 to almost 30% in 2007.

TDI data in France are obtained from the RECAP survey, carried out for the first time at a national level in 2005. The RECAP survey (Recueil commun sur les addictions et les prises en charge, *i.e.* Data Retrieving for Drug Treatment Demands) provides access to individual data collected on an ongoing and theoretically exhaustive basis for all patients treated in the Outpatients Specialised Drug Addiction Treatment Centres (CSSTs). There are 210 such centres in France and 117 of them participated in the RECAP survey 2005, 136 in 2006 and 137 in 2007. The number of “patients” included in the RECAP was 44,820 in 2005, 59,856 in 2006 and, 67,113 in 2007.

Other studies

French TDI data cover a very limited observation period. It is however possible to use data from the previous survey on treatment demand carried out in France from 1987 to 1997, and then again in 1999, and in 2003. The methodology used in this survey is not fully compatible with TDI: it is a one-month census of all people undergoing treatment in specialised centres. Details on age groups have only been available since 1993. As described above, TDI data in France are part of the RECAP survey, which includes all people undergoing treatment, whether they are about to start or have already started treatment. It is therefore possible to have more or less comparable data on average age from 1993 to 2007, bearing in mind, however, that the census period was one month before 2005 and a full year after. Nevertheless, it remains impossible to analyse ageing trends using the primary drug classification (heroin, cocaine, stimulants, cannabis, others/unknown) before 2005.

Table 12-2: Percentage of people aged 40 or older undergoing treatment in specialised centres, 1993-2007

Year	% ≥40	%>50
1993	3.8	-
1994	-	-
1995	5.3	-
1996	-	-
1997	7.0	0.5
1998	-	-
1999	9.8	0.7
2000	-	-
2001	-	-
2002	-	-
2003	16.2	1.7
2004	-	-
2005	16.5	
2006	18.1	3.5
2007	21.2	4.3

Source: 1987-2003: November survey on care and treatment for drug addicts, DREES; 2005-2007: RECAP/OFDT

Data going back to 1993 provide a more striking illustration of the ageing of people seeking help in the specialised drug addiction treatment centres. The proportion of people aged 40 or older has increased over 14 years from less than 4% to over 21%. The increasing proportion of this age group is continuous if we exclude the period 2003-2005. The apparently stable figures between these two years are undoubtedly related to the increased percentage of cannabis users amongst people seeking help in specialised centres and to the change in survey method. The increase in the percentage of cannabis users who, on average, are younger, reduces the average overall age. The increasing proportion of cannabis users can already be seen in the one-month surveys: cannabis was reported as the main substance by 17.6% of people in November 2003 compared to 13.5% in November 1999. However, a “given month” survey logically underestimates the proportion of these users. On average, cannabis users stay for far shorter times on treatment than opiate users. Moving from month to year, all other things being equal, increases the number of cannabis users far more than that of opiate users. In 2005, the proportion of cannabis users amongst all those who went to specialised treatment centres during the year exceeded 30%. The policy adopted by the public authorities in 2004/2005 aimed at increasing the awareness of the population concerning the dangers of cannabis through a communication campaign accompanied by the creation of specific clinics for young users, mostly attached to the specialised treatment centres, undoubtedly partly explains the increase in the proportion of cannabis users amongst treatment request applicants. When measured over a single month, however, the increase would most likely have been smaller.

The average age of all patients starting treatment in 2007 is 29.2 years old; however, this average is influenced by the large number of generally younger cannabis patients. In fact, the average age of cannabis drug users is 25.1 years, followed by the users of stimulants with an average age of 27.7 years, 30.7 years for heroin users, 33.0 years for cocaine users and 34.1 years for patients using other known primary drugs.

Historical data on MMT and other substitution treatment patients

In France, a theoretical estimation of the number of patients receiving opiate substitution treatment is available from 1995 to 2007 but without distinction of age or sex.

Information on the age of people receiving opiate substitution treatment can, however, be found in studies based on social insurance data. The population studied is that of people registered with the French National Health Insurance general scheme having received reimbursement for a substitution treatment prescription. The first study is based on exhaustive reimbursement data in 13 French towns in 2001 and 2002. The second study was based on two random samples of people having received reimbursement throughout all of France, one in January 2007 and the second in January 2008. To simplify the analysis, only the 2002 and 2008 data have been used.

The average age of people receiving substitution treatment in the 13 towns in 2002 was 34.4 years old for high dose buprenorphine and 35.9 years old for methadone. The average ages calculated from the national sample in 2008 were 35 years old for high dose buprenorphine and 34.7 years old for methadone. Average ages therefore have remained mostly stable over these five years. This stability, however, masks an increase in the proportion of users aged 40 or over for high dose buprenorphine, increasing from an average of 21.4% in 2002 for all sites to 29.3% in 2008 in the national sample. It should be noted that the proportion of people aged 40 or over in 2002 varied greatly from town to town, ranging from a maximum of 36.6% in Paris to a minimum of 7.8% in Lille. Paris and its suburbs were the first geographical areas affected by opiate use. These are the sites in which the oldest opiate users emerge for all the surveys.

Conversely, for methadone, there was a slight fall in the proportion of people aged 40 or over from almost 29% in 2002 to 27% in 2008. This change, which is different from what is seen for high dose buprenorphine, may be explained by the policy of the public authorities intended to make access to methadone treatment less restrictive. Originally indicated for opiate users with the most difficult use backgrounds, methadone treatments have since been prescribed to slightly younger and perhaps less dependent people. Consistent with this relative decline in age, there has also been a reduction in the average doses of methadone prescribed between 2002 and 2008 (Canarelli T. and Coquelin A. 2009).

Results from studies conducted at national or local level which have revealed an ageing trend in PDUs in and out of treatment

DRD: trends in the proportion of cases ≥ 40 years

Information on the proportion of people aged 40 or over suffering drug-related deaths has only been available since 2000. This was slightly over 30% in 2000, and the figure appears to have increased to 34% to 35% in the middle of the decade, increasing even further to 43% in 2007. A rapid increase in the age of people dying from illicit drug-related use can therefore be observed. One might question, however, the respective proportions represented by ageing drug users and accidental deaths or suicides of people who are generally relatively old and have access to these drugs for pain treatment. Recent awareness in France about the need to improve pain management may have resulted in less restrictive prescribing and a few additional cases of accidents or suicides sufficient to influence the statistics.

Table 12-3: Drug related deaths, number and proportion of cases \geq 40 years old, 2000-2007

	2000	2001	2002	2003	2004	2005	2006	2007
Numbers	75	73	67	74	92	106	105	145
%	30.2	26.7	27.6	31.8	34.3	35.0	34.4	43.5

Source: Cepidc/Inserm

12.1.2. Factors related to the ageing and increasing life expectancy of drug users (Particular focus: “survivors” of the heroin epidemics)

Only one article (Lagrange H. and André Mogoutov A. 1997) was found, published in 1997, about the question of ageing illicit drug users in France. The authors analysed the results of a survey conducted in 1995 in five sites (Paris, some districts located in the Paris suburbs, Lille, Metz and Marseilles) including 1,700 “drug addicts”. The sampling method for inclusion into the study is not clearly defined and it does not appear to be random. The authors show that the average age at the time of the first injection increased considerably between the generation falling into drug addiction before and those who became addicts after 1988, from 18 to 23 years old. The authors’ explanation for older people falling into drug addiction was based on the idea that drug addiction in the 1980s was the end result of a series of hard times and failures. The authors stressed changes in the social conditions of drug addicts decreasingly coming from privileged, artistic or intellectual family backgrounds, and increasingly born into the most disadvantaged social groups. The authors therefore concluded that there was a shift, during the 1980s, from a sort of post-adolescent drug addiction phenomenon, rooted in a process of reflection on oneself and society as a whole to “compensation” drug addiction for people coming from disadvantaged families, faced with increasing difficulties to integrate socially.

At the time when that article was written, opiate substitution treatments had only just been introduced in France and the authors could not yet assess their impact. It is clear, however, that the considerable development of substitution treatments in the second half of the 1990s greatly contributed to the decline in drug-related deaths and to their stabilisation in treatment (Costes, Cadet-Taïrou et al. 2004), helping to maintain the overall ageing trend of people seeking help in specialised centres.

The development of substitution treatments is one factor explaining the ageing of people already in contact with the care system, although ageing is also seen in those requesting treatment for the first time. In this latter category, the proportion of people aged 40 or over increased from 5.2% in 1997 to 9.2% in 2003. This increase is slower than that of the proportion of people aged 40 or over amongst all those starting treatment (7% in 1997 and 16% in 2003), but it is nevertheless significant, particularly since the overall numbers have greatly increased between these two years.

How can this increase in the number of people who access care for the first time over the age of 40 be explained? An initial explanation may be the fact that substitution medicines, primarily HDB, are widely accessible on the black market and therefore the first contact with the care system, for some drug users, may occur later. However, this is only a logical hypothesis. In parallel, the trend of increasingly older people falling into drug addiction described by the authors of the article cited above may also perhaps be continuing. Lastly, it is also possible that some responses to the question about the first treatment request are unreliable because of forgetfulness or a poor understanding of the question. Some of the “never treated” responses may also, in fact, have been given by people who were never treated in the centre where they were asked the question, but who had already had some contact with an addiction treatment professional previously.

12.2. Drug use, health and social characteristics of current older drug users

12.2.1. Characteristics of older drug users

All patients entering treatment (TDI) in 2007

The TDI data for 2008 is still unavailable; the results were therefore produced for 2007 TDI data.

The average age in the group of people aged 40 or over is 45. The vast majority of these drug users (approximately 84%) are within the 40-49 age group. The average age of the under-40s is 26.5 years, explained to a large extent by the fact that this group contains almost all cannabis users (as the leading substance) who are, on average, far younger than the users of other substances. These two groups therefore contain people of very different ages, some of whom do not use the same substances.

A good deal of the differences between the group aged 40 or over and the under-40s is the almost natural consequence of this age difference: the older users differ from the younger ones in that a higher percentage of them have children and a smaller percentage live with a parent or are students or pupils. The differences which perhaps better reflect the specific characteristics of older drug users emerge in the particularly high proportion of people in this age group who live alone (45% vs 25% of those under 40) or who have no fixed abode (9% vs 5%). The differences are also a mechanical result of a large proportion of under-40s living with their parents (43%). This, however, does not mean that these findings do not indicate the increasing isolation of older users.

In terms of educational status, slightly over one quarter of those aged 40 or over have a low level of educational achievement (BEPC or under), with this proportion being smaller for younger users (approximately one fifth). The category seen most commonly in the 40+ age group (42%) is CAP or BEP technical training, with this category being even more popular among younger users (48%). Fewer of the 40+ users have attained the level of the *baccalauréat* (roughly equivalent to English "A" levels) than the younger users, although slightly more appear to have continued studies beyond the *baccalauréat*. These differences are, however, difficult to interpret because of the very large difference between average ages: a significant proportion of the under-40s are still too young to have been able to reach the highest levels of education.

Less than 40% of the 40+ users report that they have paid work, a smaller proportion than in the under-40 age group, some of whom are not old enough to work. The proportion of people in paid work therefore appears to be lower in the 40+ age group, a quarter of whom report that they are unemployed and one third that they are not part of the working population. The proportion of unemployed people is not particularly different in the under-40 age group (23%). The main difference lies in the smaller proportion of those belonging to the non-working population (18%), compensated by a larger proportion of students or pupils (16% vs less than 1% in the 40+ age group).

More of those aged 40 and older seek help on their own initiative than the younger users (44% vs 32%) and fewer are referred by the legal authorities following an arrest. This method of referral to the treatment centres particularly involves young people using cannabis, both because eight to nine times more arrests take place for cannabis use than for the use of other illicit drugs but also because older users of other drugs (more often arrested already and therefore in contact with the specialised treatment system) are probably less likely to have this type of measure proposed to them by the magistrates.

In terms of the substances, as described above, users aged 40 or over less often report cannabis as the leading substance (22% vs 52%) and much more often report opiates (56% vs 37%)

cocaine and crack (12% vs 6%) and psychotropic medicines (6% vs 2%). The age at which use is begun is higher overall in the 40+ age group than among the under-40s. This difference is not only related to the extent of cannabis use in the younger group as it is also seen for each individual substance. Among cocaine drug users under 40, for example, only 21.6% started using drugs when they were over 25 years old, compared to 43.7% for the 40-49 age group.

The percentage of patients who have injected in the previous 30 days is far higher in the 40+ age group than among younger users (22% vs 10%), partly explained by the large proportion of cannabis users in the younger category. Nevertheless, a comparison of administration methods by substance reveals a generation difference: the proportion of intravenous heroin users is twice as high in the 40+ age group than among those under 40 (43% vs 19%); two-thirds of the younger users sniff. A two to one difference also emerges for intravenous cocaine use between the two groups (26% vs 13%). Conversely, the very high percentage injecting HDB does not differ between the groups (44%). The median age of the first injection is 20 years old in both groups.

More than half of those aged 40 or over are receiving substitution treatment compared to a third of the under-40s. This difference is also related to the large proportion of people with problem cannabis use in the under-40 age group.

This description of user characteristics can be supplemented with a few questions which do not form part of the common core of the TDI questions (core item list) but which nevertheless appear in the RECAP.

Approximately a third of the 40+ age group have already been hospitalised in psychiatry departments for a reason other than detoxification. The proportion is markedly smaller in the under-40 age group (20%). Slightly under a quarter of those aged 40 or over has already made a suicide attempt during their life. The proportion in the under-40 age group is lower (18%), although the difference is relatively small. Almost half of those aged 40 or over have already been imprisoned in their life compared to a quarter of the under-40s. As can be seen, more drug users aged 40 years old and over face major difficulties.

Table 12-3: Characteristics of people starting treatment in specialised drug addiction treatment centres depending on whether they are under 40 or 40 years old and over, 2007

	Total			Cannabis excluded	
	< 40 years	>= 40 years		< 40 years	>= 40 years
Number of people included	27,932	4,610		12,538	2,851
Average age	26.5	45.0		29.0	44.4
% men	81.8	80.0		77.8	80.9
% living alone	25.4	45.2		30.0	43.6
% living with parents	39.3	11.2		30.2	11.1
% no fixed abode	4.9	9.2		7.1	9.0
% with paid work	43.0	39.7		41.3	37.5
% unemployed	22.9	26.7		30.5	27.6
% students, pupils, trainees	15.9	0.7		5.2	0.7
% not working	18.0	32.1		22.6	33.1
% who came on their own initiative	32.3	43.8		46.8	46.3
% sentenced to drug treatment orders	34.1	13.2		13.2	12.4
% cannabis as substance 1	52.4	22.3		8.2	6.2
% heroin as substance 1	30.2	38.6		58.3	46.6
% other opiates as substance 1	7.3	17.5		14.1	21.0
% cocaine or crack as substance 1	6.2	12.3		11.9	14.9
% psychotropic medicines (benzodiazepines and others)	1.8	5.9		3.4	8.1
% who have injected in the previous 30 days	9.7	21.8		17.7	26.2
% receiving substitution treatment	34.4	55.4		61.1	67.5
% with past history of psychiatric hospitalisation	20.3	32.3		22.7	32.8
% with past history of suicide attempt	18.0	23.1		20.4	24.0
% with past history of imprisonment	25.7	47.6		36.2	53.4

Source: RECAP/OFDT

The differences in user characteristics between those aged 40 or over and those under 40 are partly related to the proportion of cannabis users in the younger group. In order to refine the analysis, the data have been recalculated excluding people seeking help at the centres only or

almost only because of a problem with cannabis⁵⁷. Excluding cannabis users particularly affects the results in the under-40 age group. As might be expected, the average age of under-40s is markedly higher than in the previous analysis, increasing from 26.5 years to 29 years old. The percentage of women in this group also increases (from 18% to 22%) and differs more markedly from the percentage of women among the older users (19% of women among those aged 40 or over).

The differences reported in the analysis conducted with cannabis users remain for a large number of questions, although the values sometimes differ slightly less markedly between the two groups. In the question about methods for referring drug users to treatment centres, for example, the distributions among the different answers become very similar. Results also become very similar for the question about substitution treatments, although the percentage of people receiving methadone substitution treatment is slightly higher in the 40+ age group than among those under 40 (28% vs 23%). For substances, however, once cannabis is excluded, fewer of those aged 40 or over report heroin as the primary drug than the younger users (47% vs 58%) and more report other opiates (7% vs 2%) and crack (5% vs 1%).

All patients undergoing treatment (TDI)

The profile of all patients undergoing treatment is very similar to that of all patients starting treatment. The average age is higher both for people under forty (29.6) and those aged over forty (45.7), although there are still all the differences described above when the data are calculated for all patients.

Other sources containing data on drug use and social characteristics of older drug users in and out of treatment: people in contact with low-threshold facilities (CAARUD⁵⁸)

Data from the Ena CAARUD survey were obtained from a listing of all people seeking help during one week in the month of November 2008, in all authorised CAARUD centres. The questionnaires were filled out in face to face interviews with a member of the care team and 3,123 valid questionnaires were obtained during the period in 122 CAARUD.

The proportion of those aged 40 or over amongst all people seeking help in the low-threshold facilities was 30% in 2008, i.e. a higher proportion than in the CSST (21% in 2007). The average age was 45 years old in the 40+ age group compared to 29 in the under-40 age group. These average ages are identical to those found for people seeking help in the CSST for substances other than cannabis.

There is a higher percentage of men (85% vs 75%), non-French (21% vs 11%), people living long term in independent lodgings (43% vs 32%) and people living alone (67% vs 50%) in the 40+ age group compared to the under-40s amongst the people seeking help in the low-threshold facilities. In terms of income source, the only difference in the 40+ age group was a far higher proportion of people receiving adult handicap allowance (24% vs 10%).

The percentages of users over the previous month for the different substances were lower in the 40+ age group than among those under 40, particularly for heroin (16% vs 34%), cocaine (25% vs 41%) and amphetamines (5% vs 18%). The only substance which had a higher proportion of users in the 40+ age group was crack (21% vs 14%). In terms of patterns of use, fewer of those

⁵⁷ Excluding all people reporting cannabis as substance 1 (primary substance) unless they are receiving substitution treatment.

⁵⁸ Reception and harm reduction support centres for drug users

aged 40 or over were currently using intravenous injection (last 30 days) than the under-40-year-olds (36% vs 51%), although more had used it previously (26% vs 15%). Those aged 40 or over appear to have less risky behaviour than the younger users: they tend to share syringes (6% vs 10%), preparation water (10% vs 19%), swabs (10 vs 16%) or straws to sniff (20% vs 32%) less.

The reported prevalence of HIV and HCV was higher among those aged 40 or over than in the younger users: there were 14% HIV positive users in the older group compared to 3% in the younger. These are almost identical to the percentages of people receiving treatment in the specialised treatment centres (excluding cannabis) of 15% and 2% respectively. The prevalence figures for HCV were 41% and 23% respectively. The very great majority (between 80% and 90%) had performed a test to establish their serology both for HIV and for HCV. Slightly more of the older users had performed this test although the differences were relatively small (91% vs 85% for HIV and 88% vs 82% for HCV). Almost the same number of people in the two groups consulted a doctor when the test was positive although far more of the older users were prescribed treatment than the younger users (86% vs 58% for HIV, 36% vs 21% for HCV).

It can also be noted that the proportion of people reporting that they were taking substitution treatment was identical in both groups (19 to 20% for methadone, 32 to 33% for HDB).

12.3. Treatment, management and care of older drug users

12.3.1. Policies

There are no national policies or laws addressing the needs of older drug users in France at the moment.

12.3.2. Health and social response

There are no specialised services dedicated to older drug users in France. Information on services and practices addressing older users' drug and drug-related problems is not available in France.

A survey was conducted recently in France to study drug user accommodation problems (Coquelin A. and Palle C. 2009). All specialised outpatient centres were asked to include all people seen in the month of March 2007 who had an accommodation problem and for whom a professional had searched for a solution. The questionnaire asked them to state the solution sought and the situation of the person after three months in terms of accommodation and, in the absence of a solution, the reasons why the process had failed. One of the reasons put forward was that the person was too old. Approximately 600 questionnaires were completed by slightly over 60 specialised outpatient centres. The reason "too old" was reported for 4% of people who had not been able to obtain the desired accommodation following a refusal from the centre where the application was sent. This reason, therefore, was not common.

12.3.3. Quality assurance and best practice

No information on these topics.

12.4. General conclusions

Data available for the period 1993-2007 reveal a marked trend in the ageing of drug users seeking help in the specialised centres, the proportion of those aged 40 or over increasing from less than 4% to over 21%. This change is particularly striking as it occurred alongside a marked increase in the proportion of cannabis users who, on average, are younger. Unfortunately, there is no information over this period enabling changes in age distribution by substance to be

analysed. These data would undoubtedly have shown an even larger rise in the proportion of those aged 40 or over amongst those people with problem opiate or cocaine use. Although increasing rapidly, the proportion of those aged 50 and older is still relatively low. The very great majority of those aged 40 and older in 2007 were under 50. This increasing trend in the proportion of those aged 40 or over is also seen amongst people receiving substitution treatment and victims of drug-related deaths.

Many factors explain this change. Firstly, France is a country particularly affected by opiate use. The treatment of opiate-type addictions is known to be a long, restricting process, characterised by a succession of withdrawal attempts and relapses spread out over many years before the introduction of substitution treatments. The introduction of substitution treatments has only reinforced this ageing process by making drug users loyal to the care system and helped reduce drug-related deaths. These factors promoting an increase in the number of older users is added to by the trend towards later entry into illicit drug use. Drug use, initially a symptom of troubled youth, progressively became a sign of the social crisis which affected France at the end of the 1970s and in the 1980s. By spreading in the geographical areas and social layers most affected by the crisis, it would seem, according to this analysis, that drugs once again took on their classical role of distraction and refuge from the increasing social integration difficulties faced by some groups.

The image, albeit very patchy, which emerges from the information available in the TDI on users aged 40 or over in contact with the care system is one of a population mainly with problem opiate and cocaine use. They face even more pronounced isolation and social inadaptability problems which characterise most opiate dependent users than their younger peers. A large minority of these people use drugs intravenously, a markedly higher proportion than among the under-40s, except for HDB which is as commonly injected in both groups. It should be noted that injecting is far more common regardless of age amongst users, generally in the working population, and in contact with low-threshold facilities than in people in contact with treatment centres. However, in terms of the low-threshold facilities, this practice is markedly more widespread among the younger people than among the older users. In general, amongst those people seeking help at the low-threshold facilities, the older users appeared to adopt less risky behaviour and use drugs less than the younger ones.

Today, in France, there appears to be almost no thought given to the treatment of the oldest drug users. Difficulties finding accommodation for the oldest drug users, whilst clearly present amongst the concerns of drug addiction workers questioned in a survey, remain low priority issues, far behind the problems associated with psychiatric co-morbidities or treatment problems for young users. The fact that most drug users aged 40 or over are in their forties may explain the lack of interest in this question.

Part C: Bibliography

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II - Alphabetic list of relevant databases available on Internet

- Bdsp. Banque de données en santé publique:
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- Ireb (Institut De Recherches Scientifiques Sur Les Boissons). Base de données bibliographiques:
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- Ofdt. Atlas régional des consommations de produits psychoactifs des jeunes Français - Exploitation régionale de l'enquête ESCAPAD 2005:
<http://www.ofdt.fr/ofdtdev/live/donneesloc/atlas.html>. 15/09/2009.
- Ofdt. ILIAD - Indicateurs locaux pour l'information sur les addictions:
<http://www.ofdt.fr/ofdtdev/live/donneesloc/indic.html>. 15/09/2009.
- Ofdt. Répertoire des sources statistiques:
<http://www.ofdt.fr/ofdtdev/live/donneesnat/sources.html>. 15/09/2009.
- Ofdt. Séries statistiques:
<http://www.ofdt.fr/ofdtdev/live/donneesnat/series.html>. 15/09/2009.
- Ofdt. SIMCCA. Système d'information mensuel sur les consultations cannabis:
<http://www.ofdt.fr/ofdtdev/live/donneesnat/simcca.html>. 15/09/2009.

III - Alphabetic list of Internet addresses

AFR (Association française pour la réduction des risques): <http://a-f-r.org>

AFSSAPS (Agence française de sécurité sanitaire des produits de santé): <http://www.afssaps.fr>

ANITeA (Association nationale des intervenants en toxicomanie et addictologie): <http://www.anitea.fr>

ANPAA (Association nationale de prévention en alcoologie et addictologie): <http://www.anpaa.asso.fr>

ASUD (Auto-support et réduction des risques parmi les usagers de drogues): <http://www.asud.org>

CRIPS (Centres régionaux d'information et de prévention du sida): <http://www.lecrips.net>

F3A (Fédération des acteurs de l'alcoologie et de l'addictologie): <http://www.alcoologie.org>

FNORS (Les Observatoires régionaux de la santé et leur fédération): <http://www.fnors.org/index.html>

Hôpital Marmottan: <http://www.hopital-marmottan.fr>

INPES (Institut national de prévention et d'éducation pour la santé): <http://www.inpes.sante.fr>

MILDT (Mission interministérielle de lutte contre la drogue et la toxicomanie): <http://www.drogues.gouv.fr>

OFDT: <http://www.ofdt.fr>

SFA (Société française d'alcoologie): <http://www.sfalcoologie.asso.fr>

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III - List of abbreviations

AAH	Adult disability allowance
AFSSAPS	French Health Products Safety Agency
AMM	Marketing authorisation
ANAES	National Agency for Health Accreditation and Evaluation
ANIT	National Association of Drug Addiction Workers
ANPAA	National Association for the prevention of alcoholism and addiction
ANRS	National AIDS research agency
ASSEDIC	French unemployment benefits department
ASUD	Drug users' self-support association
BEP	Vocational diploma
BHD	High dose buprenorphine (HDB)
CAARUD	Reception and harm reduction support centres for drug users
CAMPS	Early Medicosocial Services Centres
CAP	Vocational training certificate
CAST	Cannabis abuse screening test
CCAA	Outpatient Alcoholism Treatment Centres
CDAG	Anonymous free screening centre
CDO	Departmental agreements on objectives in Health and Justice
CEIP	Drug Dependency Information/Evaluation Centres
CEL	Local educational contract
CépiDC	Centre for epidemiology of the medical causes of death
CESC	Health and Citizenship Educational Committees
CFES	French committee for health education (now INPES)
CHRS	Accommodation & rehabilitation centre for persons of no fixed abode
CIFAD	Interministerial training center for the fight against drugs
CIM	International classification of diseases (ICD)
CIRDD	Centres for information and resources on drugs and dependencies
CJN	National police (criminal) records
CLS	Local security contracts
CNAMTS	National State Health Insurance Office for Salaried Workers
CNRS	National centre for scientific research
COM	Pacific French overseas territories

CPAM	French government department dealing with health insurance
CPDD	Drug & dependencies project leaders
CRIPS	Regional AIDS information and prevention centre
CSAPA	Addictology treatment, support and prevention centres
CSST	Specialised centres for drug addicts
DAP	Prison service (Ministry of Justice)
DAPSA	Support facility for Parenthood and Addiction Care
DATIS	National “Drugs, Alcohol and Tobacco Information Service” telephone helpline
DDASS	Direction of Health and Social Affairs at local level - for the Département
DESCO	School education Office (Ministry of youth, education and research)
DGS	General Health department (Ministry of health and Welfare)
DH	Hospitals directorate (Ministry for Health and Welfare)
DLPAJ/CSR	Directorate of civil liberties and legal affairs, sub-department for traffic and road safety (Ministry of the Interior and Regional Planning)
DOM	French overseas territories
DRAMES	Death involving abuse of medicines and substances (AFSSAPS)
DRD	Drug related Death (EMCDDA definition)
DRESS	Directorate for research, studies and evaluation of statistics (Ministry of health and welfare; Ministry of social affairs, labour and solidarity)
DSM	Diagnostic and statistical manual of mental disorders
DTTO	Drug Treatment and Testing Order
ENVEFF	National Survey on Violence Against Women
EROPP	Survey on Representations, Opinions, and Perceptions Regarding Psychotropic Drugs (OFDT)
ESCAPAD	Survey on Health and Use on Call-Up and Preparation for Defence Day (OFDT)
ESPAD	European School Survey Project on Alcohol and other Drugs (INSERM- OFDT- MJENR)
ESSAD	Specialized Home Care Unit
FFA	French federation of addictology
FNAILS	File of Police Questioning for the Use of Narcotics (OCRTIS, Ministry of Interior)
FNES	National Federation of Health Education Committees
FRAD	Anti-drug shift trainers (Gendarmerie)
GECA	Group of Studies on Pregnancy and Addictions
GIP	Public interest group

IC	Confidence range
ILS	Drug-related offences
INPES	National Institute for Health Education and Prevention (former CFES)
INRETS	National Institute for Research on Transport and Safety
INSERM	National Institute for health and medical research
INVS	National health watch institute
IST	Sexually transmitted infections
IT	Treatment order
IVG	Termination of pregnancy
JAP	Judge responsible for the execution of sentences
JAPD	Day of defense preparation
JO	Journal Officiel
LOLF	Organic Law Pertaining to Finance Laws
M€	Million(s) of Euros
MILAD	Mission for the Fight Against Drugs (Ministry of the Interior)
MILC	Interministerial mission for the fight against cancer
MILDT	Interministerial mission for the fight against drugs and drug addiction
MST	Sexually transmissible diseases
OCRTIS	Central Office for the Repression of Drug-related Offences
OEDT	European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)
OFDT	French Monitoring Centre for Drugs and Drug Addiction
OMS	World Health Organisation
OPPIDUM	Monitoring of illegal psychotropic substances or those that are used for purposes other than medicinal (CEIP)
OR	Odd ratio
PA	person-year
PAEJ	Youth reception and counselling centre
PES	Syringe exchange programme
PFAD	Anti drug trainer / police officer
PRAPS	Programmes for access to preventive measures and health care for people in vulnerable situations
PRS	Regional health programmes
PRSP	Regional Public Health Programmes
RDR	Risk and harm reduction (policy)

RECAP	Common data collection on addictions and treatments
RMI	Minimum income
RSM	Standardised mortality ratio
SAM	Road Safety epidemiological survey on narcotics and fatal road accidents
SFA	French Society of Alcoholology
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
SPIP	Prison service for integration and probation
TDI	Treatment demand indicator
THC	Tetrahydrocannabinol
TREND	Recent trends and new drugs (OFDT)
UCSA	Outpatient treatment/consultation unit
UDC	Coordination Unit for Maternity and Risk Situations
UDVI	Intravenous (or injectable) drug users
UPS	Care unit for prison leavers
VHB	Hepatitis B virus
