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For Drugs ands Drug Addiction

OBSERVATOIRE FRANÇAIS DES DROGUES ET DES TOXICOMANIES

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REITOX

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Summary

1. Drug policy: legislation, strategies and economic analysis

In 2010 and 2011, there were new legislative provisions mainly with respect to drug trafficking profits (the "*loi Warsmann*" law of July 2010 on the confiscation of criminal assets) and domestic security (act of 14 March 2011).

With respect to non substance-related addictions, in May 2010 France authorised online gambling and games of chance. The relevant law entails provisions to prevent excessive or pathological gambling as well as measures to protect minors.

The decrees, circulars and orders that were adopted to put laws into effect between 2010 and 2011 were mainly within the scope of other laws on the vigilance of the public authorities regarding the appearance of new, potentially dangerous substances (e.g., list of narcotics, list of poisonous substances, list of substances and methods prohibited in sports).

The national governmental policy strategies that were implemented in 2010 are defined by the 2008-2011 'Fighting Drugs and Drug Addiction' Government Action Plan. In June 2011, the *Mission interministérielle de lutte contre la drogue et la toxicomanie* (MILDT or the Interministerial Mission for the fight against drugs and drug addiction) announced that nearly all of the 193 planned actions had been carried out. Three other national plans follow from this: the 2009-2012 "hepatitis" plan, the 2009-2013 "cancer plan" and the new 2010-2012 "detainee" plan, the latter being carried out by the French Ministry of Health and Sports with the participation of the French Ministry of Justice. The public health measures stipulated in these different plans reinforce the health section of the 2008-2011 governmental plan.

Nationally, the strategies of the government plan are broken down into inter-ministerial local plans, production of which is the responsibility of the "*département* project leader" The local *départements* monitoring committee, which is responsible for coordination, seeks consistency with the specific plans in the *département* (such as cohesion contracts, town contracts, public health programmes and regional medico-social schemes). The *département* project leader mobilises the local stakeholders to apply national prevention or anti-drug trafficking strategies. In health policy, the *département* project leader liaises with the regional project leader, who is the special contact of the *Agence régionale de santé* (ARS, or Regional Health Agency) which, since the adoption of the HPST law in July 2009, has become a sort of "one-stop-shop" for the national healthcare offering.

Overall French public expenditure to implement the drug policy in 2010 was estimated at € 1,086.13 M, according to ministerial sources (budget voted in the 2010 *Loi de finance initiale*, or government budgetary law – which determines the budget for all governmental expenditures).

The French government is not solely responsible for implementing the drug policy; it is also part of the remit of the National Health Insurance Fund (*Assurance maladie*) which covers the health system for drug users. The main item of expenditure of the National Health Insurance Funds in this arena is the funding of addictology centres. In 2010, total Health Insurance Funds expenditure was € 316.78 M, of which € 295.3 M went to personnel expenses and operating costs for existing structures, € 12.25 M went to strengthen or create new structures, € 3.98 M went to creating new programmes in existing structures, and finally, € 5.25 M went to addictology centres that cater specifically to treating addicts being handled in the justice system

within the scope of “Health and Justice” agreements[1]. The second leading item of expenditure for the National Health Insurance Fund was reimbursement of opiate substitution treatments. Since data take three years to be published, the amount of opioid substitution treatment reimbursements is not available for 2010. In 2008, these reimbursements reached € 79.97 M. Despite the clear predominance of high dose buprenorphine (HDB) among opioid substitution treatment (OST) prescriptions, the proportion of methadone reimbursements rose from 8% in 2003 to 17% in 2008. In 2008, the percent change over the previous year reflected an overall decrease of 8% in OST reimbursements (all medications combined). The third largest area of expenditure was the funding of health establishments to implement the measures stipulated in the addictions action plan: in 2010, hospitals received € 39.72 M. This funding was used for four types of actions: the implementation of new “addictology” liaison teams (especially within authorised psychiatric health establishments), the creation or reinforcement of specialised addictology consultations, complex care residential stays and even the operation of highly specialised hospital structures equipped with technical platforms.

The profits from the sale of goods confiscated from legal narcotics proceedings are allocated to a “Narcotics” support fund managed by the MILDT. In 2009, € 3.57 M were contributed to the fund. The MILDT redistributed this sum to the ministries responsible for implementing the drug policy.

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

The latest data available for the general population come from the 2010 Health Barometer. The school surveys and surveys of adolescent populations are currently in progress (ESPAD 2011, ESCAPAD 2011 and HBSC 2010). Finally, a multisite *quanti-festif* study is underway in five French towns.

Data from the general population aged from 15 to 64 shows an overall stabilisation of the levels of current use of cannabis (around 8.3%). The “mechanical” increase in lifetime use of cannabis is linked to a stock effect of former generations of smokers. Among the rarer products, poppers and cocaine show a significant increase with regard to lifetime use and current use (from 2.4% to 3.6% and from 3.8% to 5.2% respectively). The survey furthermore reveals a significant increase in lifetime use of heroin, going from 0.8% to 1.2% and hallucinogenic mushrooms (from 2.6% to 3.1%), whereas ecstasy, in contrast, is in decline.

3. Prevention

The *Guide on preventing addictive behaviour in schools* was updated in 2010. It introduces the principle of a prevention programme lasting from the last year of primary school to the last year of secondary school. This guide was first published in 2005 under the auspices of the French Department of National Education and the MILDT.

With the support of the MILDT, a conference on parenting and the role of parents in preventing drug use took place in May 2010. The aim was to update the discourse to support parents in their role as active players in the prevention of licit or illicit drug use. The debates guided the government awareness campaign entitled “*Contre les drogues, chacun peut agir*” (“Everyone

[1] This is a justice-health agreement scheme that was launched in 1993 and was financed from 1993 to 2009 through regional credits from the MILDT budget. These agreements were created to reinforce the health and social care of drug addicts being handled by the French justice system.

can take action against drugs"), which took place from 13 December 2010 to 3 January 2011 and targeted all referent adults.

In order to define targeted measures suitable for professional settings and to provide consensual and appropriate changes to the labour laws, the MILDT also held a conference on the occupational risks related to the use of illicit drugs ("*Drogues illicites et risques professionnels*") on 25 June 2010.

The third communication measure of the governmental plan took place at the end of 2010. It aimed at encouraging parents and those close to teenagers to ponder their role in prevention. Three different, complementary television spots were broadcast from 13 December 2010 to 3 January 2011. A partial analysis of calls to *Drogues info service* (national telephone helpline) shows the unquestionable, immediate effect of these spots (a 250% increase in calls compared to the week preceding the broadcast of the TV spots). An updated version of the brochure, "*Cannabis, les risques expliqués aux parents*" ("Cannabis, explaining the risks to parents"), was distributed in structures intended for young people or for the professionals likely to be in contact with them. Another communication effort, this time targeting young people in the form of a contest, was conducted by the MILDT in 2010.

4. Problem drug use

A new multi-centre "capture/recapture" study started at the end of 2010 in 6 French cities: Lille, Lyon, Marseille, Metz, Rennes and Toulouse. A new national estimate (based on all problem drug users, injectors and opiate users) should therefore be available in 2012. The 2008 ENa-CAARUD study (see Appendix IV-F) shows the considerable social vulnerability of the harm reduction centres' clients in 2008.

The most striking changes in drug use and methods of use in 2008-2009 were:

- increasingly diverse user populations;
- extension of cocaine diffusion, particularly to young people from working class areas and the suburbs;
- use of heroin by a wider variety of population groups, in particular younger users, those in the party scene and those that are socially well-integrated;
- wider diffusion of ketamine.

Although more marginal, the spread of GHB/GBL use to young groups of "party-goers" resulted in several cases of coma during 2009.

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

A circular published at the start of 2008 described the missions of the Health Care, assistance and addictology prevention centres (CSAPA). From 2009, this name was used to describe the centres which previously received illegal drug users (CSST) and the centres which only received people with alcohol difficulties (CCAA). The missions of the CSAPA are much the same as those of the CSST and CCAA. The CSAPA, however, are required to receive all people with an addiction problem, regardless of the problem substance.

The figures on new patients received in 2009 in the outpatient centres do not show marked changes in their characteristics. As in previous years, their average age has continued to increase. The average age of patients who have never previously been treated however appears to have remained stable since 2007. A small increase in the proportion of those taking opiates as the substance causing the greatest problem was found in 2009 with a fall in the proportion of those with problem cannabis use. Intravenous use of opiates and cocaine has again fallen after increasing in 2008.

In terms of opiate substitution treatments, almost 125,000 people received primary care reimbursements for these during the second half of 2008, with a clear predominance of high dose buprenorphine (specific to France), still making up 80% of all reimbursements. Whilst a proportion of prescribed HDB is misused, and is not always taken as a treatment, misuse has fallen considerably since the introduction of a control plan for opiate substitution treatments by the National Health Insurance Funds. The proportion of people receiving an average daily dose of more than 32 mg/D fell from 6% in 2002 to 1.6% in 2007 according to a recent study.

6. Health correlates and consequences

The number of AIDS cases among injecting drug users (IDUs) has fallen continuously since the middle of the 1990s. This was confirmed in 2010 with less than 5% of injecting drug users amongst new AIDS cases (versus a quarter of persons found positive by the mid-1990s and 8% in 2008).

The prevalence of HCV infection appears to have been falling for several years, both because of public health measures and because of changes in risk practice by most drug users.

The number of overdose related deaths increased again in 2009, confirming the continued upward trend in overdose deaths since 2003. Between 2006 and 2008, the increase in the number of overdoses appears specifically related to an increased number of deaths from heroin and methadone overdose. Several factors may explain this rise: greater availability of heroin, fall in the price of cocaine, new users with poor awareness of harm reduction, increased methadone prescription.

7. Responses to health correlates and consequences

2009 saw a marked rise in the activity of the psychoactive substance health alert system which was started in 2006. Three public alerts were issued (heroin and GHB/GBL) through press releases and several communications only targeting professionals and user associations.

The new 2009-2010 hepatitis plan broadened the scope of infectious disease prevention according to several themes: firstly, with the objective of **preventing the first injection**; and secondly, by extending the measures targeting drug users to the entire population of the most vulnerable people (street youths, new migrants) and by including routes of drug administration other than injection in high risk practices. Similarly, a reintroduction of early vaccination against hepatitis B in the general population should help to protect future drug users.

In terms of practices, the continuing fall in the estimated number of syringes distributed to IDUs between 1999 and 2008 suggests a lower prevalence of injection, but this fall cannot currently be interpreted with certainty.

In addition, the proportion of drug users who have had a screening test has continued to increase, with a fall in the late diagnosis of hepatitis C. The important issue now is repeating these tests (at least annually) and increasing access to treatment.

8. Social correlates and social reintegration

Drug users seen by the specialist services experience major difficulties in terms of their social integration (employment, housing, income, etc.). Whilst common law services (social services, free care, etc.) help alleviate certain problems, drug users find themselves in far more adverse situations than the general population.

Beyond their mission to support access to common law services, the specialist centres are developing innovative social integration programmes and activities, fostered in recent years by the guidelines set out in the MILDT national 2008-2011 plan.

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

Cannabis is still the substance responsible for the largest number of arrests for drug offences, ahead of heroin and cocaine. The number of arrests for simple use remains high (approximately 135,000 procedures annually). It represents nearly 9 arrests for drug offences out of 10. The penal response to drug use is increasingly taking the form of measures other than prosecution, or in the event of prosecution, penalties involving substitution orders or fines.

In contrast to this relative stability in the number and structure of arrests, criminal conviction of drug users, including prison sentences (with a partial effective imprisonment) have increased. The number of convictions for drug-related offences has more than doubled between 1990 and 2009: of this total, convictions for drug use have increased most, since their number has tripled since 1990, and especially since 2004. In 2009, 24,420 convictions have been pronounced for simple use (an increase of nearly 25% compared to previous year). Convictions for drug use represent now half of conviction for drug-related offences, as against one third during the 1990s and the beginning of the 2000s. A lack of information about the application of these sentences makes it impossible to establish whether or not they are actually served.

For road accidents, the convictions for driving under the influence of narcotics have also increased during the previous years (nearly 6,600 in 2008), which represents an increase of 27% compared to the previous year. Among these, around 40% have ended in prison sentencing (most often with suspension), around 40% ended with a fine and 16% ended with measures other than prosecution (most often the confiscation of the driving licence). Sentencing tends to be less severe when it is for an offence of driving under the influence of narcotics alone, or in case of refusal to cooperate; they are more severe in case of body injury.

10. Drug markets

As France is both a transit country and one where the main illegal substances produced world-wide are used, its narcotics market is particularly dynamic.

Substances such as cocaine and heroin (especially brown heroin) are both widely available and accessible. This is promoted particularly by the current switching of importing networks back from cannabis resin towards cocaine hydrochloride and heroin. In addition, the proximity of storage countries (Belgium, Netherlands, Spain) for these two substances enables direct supply to border wholesalers, hundreds of dealing micro-networks, mostly run by user-dealers, who

therefore ensure widespread distribution of cocaine and heroin throughout the whole of France, including rural areas.

For the greater part of 2009, and a part of 2010 the synthetic drugs market saw a severe shortage of MDMA both in “powder” and “tablet” form. With regard to this latter galenic form, dealers continued to supply the market with “ecstasy” and 2010 saw a return of tablets containing MDMA which are once again present on the festive scene.

Although more marginal, it seems that since 2008 there has been increased kétamine availability. There has been of development of the use of ketamine outside the group of regulars in the alternative party scene. Ketamine appears to benefit from an improving image because of better management of the effects of the substance through a harnessing of its use.

Selected Issue 1:

On 1 January 2010, there were in France, 61,604 prisoners distributed among 191 prisons, the highest figure since the mid-nineteenth century (96.8 prisoners per 100,000 inhabitants). This population includes about a quarter of defendants. The state of overcrowding in prisons (108 prisoners per 100 places, on average) varies considerably between the types of institutions and geographical jurisdictions: it mainly concerns remand centres, the most numerous types of establishment in the prison system, that host a majority of defendants (pending a final decision) and of convicted of shorts imprisonment sentences.

The prison population is characterized by demographic, social and health profile very different from that of the general population. Disorders related to mental health and addictions, in particular, are higher than outside prison: half of the inmates suffer from anxio-depressive and addictive disorders. The inmates are also more affected by infectious diseases: people who have experienced at least one episode of incarceration in their lifetime have a prevalence rate of hepatitis C almost 10 times higher than the general population (7.1% vs 0.8%). These observations reveal a contradiction between the objectives set by the Act of January 18, 1994 affirming the principle of equivalence of care between the prison environment and the free environment, and the reality of care practices in detention, as determined by the terms and conditions operating the prison system and constrained by the difficulties of organization of care in some institutions.

This Selected Issue attempts to articulate the policy recommendations and clinical practice developed for the prison (both by WHO and by the French authorities) to reflect on the difficulties of organizing care in the prison context, highlighting the importance of monitoring information on the care of drug users in prison.

Selected Issue 2:

France has 2,970 km of borders with six European countries. There are two types of borders, the first corresponding to the “border melting pot” (an area of contact that associates the territories located on either side into a community of destiny and daily life” (for example, the Nord-Pas de Calais and Belgium, the Lorraine region and Belgium, Luxembourg and Germany), and the second corresponding to the “glacis border (marked by a geographical barrier).

There are movement of French drug users to Dutch coffee-shops although it is difficult measure such movements. There also movements to Barcelona (and its commercial cannabis fairs). But the travelling is above all related to the dance events party scene. Two areas are concerned in

France, the south west and the north (from Nice to Italy, from Lille to Belgian night clubs or alternative techno events, for example). The primary motivation for weekend cross-border migration in the north and southwest of France is the search for an appropriate place to party.

Finally, there are cross border travels on the drug users' initiative which generally involved French people seeking treatment in the border countries of the north and east. There is in particular a significant flow of French people to Belgium each month to receive methadone. On the other hand, there is cooperation between hospital establishments on both sides of the borders and even cooperation between associations and professional networks.

What is striking, from the French viewpoint, is still the significant dissymmetry of the drug related "exchanges" between France and its neighbours: whether regarding using or procuring substances, partying or seeking treatment, travelling mainly occurs from France to a foreign country.

Part A: New development and trends

1. Drug policy: legislation, strategy and economic analysis

1.1. Introduction

Definitions

A narcotic user is an individual who consumes a narcotic substance. The legal authorities often linken the possession of small quantities of narcotics to use. They also often equate growing cannabis for personal use or using drugs for doping (seeking higher professional, intellectual or athletic performance) with use.

Any offence involving the use of narcotic substances may result in arrest (by the police, the gendarmerie or the Customs Department), and will normally be referred to the legal system. Offences are examined on a case-by-case basis by a French public prosecutor who, based on the principle of the "*opportunité des poursuites*" (appropriateness of proceedings), may decide to take legal action against the offender, to simply close the case or to propose other measures as an alternative to legal proceedings. This principle of "*opportunité des poursuites*" allows for a response carefully tailored to each individual situation by gradually increasing the penal response along with the severity of the criminal acts. This also explains the wide disparity in penal responses given by the courts.

Data collection tools

The main data sources used are the French penal, highway, public health, social action & family and sports codes. The sources used to evaluate the public expenditures made in the fight against drugs are the budgets stipulated by the *loi de finances initiale* (LFI, or the governmental budgetary law) and the *loi de financement de la Sécurité sociale* (LFSS, or social security funding law).

Background

Two types of legislation govern drugs in France. On the one hand, the use, possession and supply of legal drugs (alcohol, tobacco) are regulated, but not forbidden. On the other hand, illegal drugs scheduled as narcotics (heroin, cocaine, cannabis and hallucinogens, for example)[2], are subject to a ban, chiefly enshrined in the law of December 31, 1970, the provisions of which have been incorporated within the Penal Code and the Public Health Code. The law of 31 December 1970 makes it illegal to use or traffic in any substance or plant listed as a narcotic (regardless of the substance). It makes no distinctions between drug users and dealers.

Furthermore, it considers the drug user as a patient. The legislation ensures full, free access to the medical-social system: "Addictology treatment, support and prevention centres" (CSAPAs), "Harm reduction support centres for drug users" (CAARUDs), therapeutic communities and to

[2] The list of narcotic substances covered by the law is detailed in an order from the French Ministry of Health, following a proposal from the Director General of the French Health Products Safety Agency (AFSSAPS), in conformity with international regulations.

HIV screening centres[3] affiliated with health establishments (Anonymous free screening centres, CDAGs, and Information screening and diagnosis centre on sexually transmitted diseases, CIDDISTs). People without income or with very low income can also get free access to primary care physicians and hospital care.

Since 1999, drug users living in France can benefit from the CMU (free health care for people on low incomes). The person requesting health care pays the medical expenses up front and subsequently requests reimbursement. For the most underprivileged French resident drug users, the *couverture complémentaire santé gratuite* (free supplementary health insurance) exempts the person requesting health care from having to pay medical expenses up front. Non-residents of France can request state medical assistance.

Vaccination against hepatitis B and viral hepatitis screening are free and anonymous[4] when performed in a CSAPA (Art. L.3411-4 of the French Public Health Code). Drug users treated in a CDAG or a CIDDIST are not required to reveal their identity. Since the adoption of the HPST law[5] of July 2009 (art. 108), CDAG or CIDDIST physicians can lift anonymity provided that the patient provides explicit, express and informed consent. This provision[6] aims to improve treatment support in certain clinical situations (art. L3121-1 of the French Public Health Code). Furthermore, if they expressly request it, drug users who spontaneously go to a dispensary or health establishment can request anonymity at admission (art. L3414-1 of the French Public Health Code).

To maintain the confidentiality of the personal and medical information of the person seeking health care, healthcare professionals are obliged to respect medical and professional secrecy.

The use of narcotics

The legal framework banning the use of narcotics (whether public or private) has not been changed since its inception (1970). The most recent possibility for reform dates back to 2003: fining simple use, while mentioned, was dismissed by the government in July 2004.

Under the terms of article L.3421-1 of the French Public Health Code (formerly art. L.628), the illegal use of substances listed as narcotics constitutes an offence subject to a maximum sentence of one year's imprisonment and a fine of € 3,750. However, article L.3411-1 provides a specific treatment ordering procedure that authorises the prosecutor to suspend proceedings against a narcotics user provided that the user agrees to get treatment.

The strategies of the criminal anti-drug policy have been redefined in various circulars issued by the French Ministry of Justice since the early 1970s. Depending on the period, some focus on improving care, while others emphasise more effective repression of use. As an example, the circular of June 17, 1999 called upon French public prosecutors to "develop more diverse legal responses" to deal with arrested drug users at all stages of the criminal proceedings, with prison sentences being reserved for extreme cases and used as a last resort. Subsequently, health alternatives to prosecution were strongly encouraged and better executed: including court-ordered treatments for dependent drug users, a caution for occasional users (particularly users

[3] Circulaire DGS/PGE/1C n°85 du 20 janvier 1988, relative à la mise en place du dispositif de dépistage anonyme et gratuit (CDAG).
[4] Loi n°2007-1786 du 19 décembre 2007, art. 72.
[5] Loi n°2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires (NOR : SASX0822640L).
[6] Arrêté du 8 juillet 2010 fixant les conditions de la levée de l'anonymat dans les consultations de dépistage anonyme et gratuit et dans les centres d'information, de dépistage et de diagnostic des infections sexuellement transmissibles (NOR: SASP1007832A).

of cannabis), or dismissal of the case with referral to an addictology health/social care centre for other types of drug-related behaviours.

The "delinquency prevention law" of March 5, 2007 further reinforced the range of law enforcement measures available for use against drug users. Firstly, this law enabled judges to deal with narcotics offences using a simplified, “fast-track” procedure in order to provide a systematic penal response to narcotics use. It introduced a new, *ad hoc* sanction: a drug awareness-building training session focusing on the dangers of the use of narcotics products (up to a maximum of €450, equivalent to the cost of a class 3 fine). Provided for in articles L 131-35-1, R131-46 and R131-47 of the French Penal Code in application of decree n °2007-1388 of September 26, 2007, the aim of this measure is to make offenders fully aware of the danger and harm generated by the use of narcotics as well as the social impact of such behaviour. The training session may be proposed by the authorities as an alternative to legal proceedings and penal agreements. An obligation to complete the course may also be included in the ruling as an additional measure. It applies to all adults and to minors over the age of 13[7].

The law of March 5, 2007[8] also extends the scope for the application of court-ordered treatments, which can now be ordered at any stage of the legal proceedings. Originally conceived as an alternative to legal proceedings (resulting in a suspension of the legal process), court-ordered treatments can now be ordered as a sentence enforcement measure, including for those persons having committed an offence related to alcohol consumption.

The law of 2007 reinforces the available measures concerning the monitoring of the application of court-ordered treatments. It introduced the notion of "intermediate doctor" whose task it is to assess the medical appropriateness of the measure, inform the doctor chosen by the user of the legal framework in which it is being applied, verify the enforcement of the court-ordered treatment and inform the legal authorities of changes in the offender's medical situation.

Narcotics use and road safety

In the fight against narcotics use, the authorities may adopt a more severe stance in certain cases, such as when this use affects road safety.

The law of February 3, 2003 introduced a new offence concerning any driver whose blood test reveals the presence of narcotics. These drivers risk a sentence of two years’ imprisonment and a € 4,500 fine, and drivers who simultaneously use narcotics and alcohol risk up to three years' imprisonment and a € 9,000 fine. The law of June 18, 1999 and its application decree of August 27, 2001 introduced mandatory drug use screening for drivers involved in a road accident that was immediately fatal or for drivers suspected of having used narcotics who were involved in an accident that caused bodily harm. Since the adoption of the LOPPSI 2 law (on the orientation and programming for performance of domestic security)[9] and its application circular[10] (March 28, 2011), narcotics screening has become mandatory following road accidents that cause bodily harm, whether fatal or not. Moreover, the circular of March 28, 2011 on reinforcing the fight against unsafe road conditions enables, upon requisition of a French public prosecutor, random

[7] Décret 2007-1388 du 26 septembre 2007 et circulaire du 9 mai 2008
[8] Loi n° 2007-297 du 5 mars 2007 relative à la prévention de la délinquance. (NOR : INTX 0600091L)
[9] Loi n° 2011-267 du 14 mars 2011 d'orientation et de programmation pour la performance de la sécurité intérieure (NOR:IOCX0903274L).
[10] Circulaire d’application du 28 mars 2011 de la LOPPSI en ce qui concerne l’amélioration de la sécurité routière (NOR : IOCD1108865C).

narcotics controls on all drivers (art. L.235-2 of the French Highway Code, modified by article 83 of LOPPSI).

The use of narcotics in professional environments

The law increases the penal sanctions applicable to employees in a position of public authority (or those carrying out a public service activity or involved in national defence) committing drug use offences. They now risk a five-year prison sentence and a total maximum fine of € 75,000. The staff of public transport companies committing drug use offences while on duty are also subject to these penalties, in addition to sanctions prohibiting them from carrying out their professional activities in the future and (where applicable) an obligation to undergo, at their own cost, an awareness-building training course concerning the dangers of narcotics use. A July 2011 bill stipulates that occupational physicians can determine employees' aptitude to hold their position, inform the employer and, if necessary, refer the employee to a detoxification programme.

Drug trafficking

The law aimed at combating narcotics trafficking, which is one of the most severe in Europe, was toughened up even further in the late 1980s. Aggravating circumstances are considered to exist when the incident involves minors or takes place in an educational or administrative establishment. The current legal rules provide for separate punishments according to the type of trafficking-related offence: minimum penalties are used to punish the proposal and sale of drugs for personal use (an offence created by the law of January 17, 1986) while maximum penalties can include life imprisonment and a fine of € 7.5 million (the law of December 16, 1992) for certain laundering operations (as defined in the law of December 31, 1987, and categorised as a criminal offence by the laws of December 23, 1988, July 12, 1990, and May 13, 1996).

The law provides for specific, anti-trafficking procedures and instruments, including some that are exceptions to common law. Consequently, the "immediate appearance" fast-track procedure can be used to organise action against small-scale traffickers following the introduction of the law of January 17, 1986 making it possible to immediately judge user-dealers following their arrest, in much the same way as the instigators of organised criminal networks. The legal provisions for cracking down on money laundering – provisions that have been in place since the 1990s – also help hunt down traffickers by focusing on their visible signs of wealth. As result, the fact that an individual "is unable to account for resources corresponding to his lifestyle when in frequent contact with a drug user or trafficker" is considered an offence under the terms of the law of May 13, 1996 which outlaws "living off the proceeds of drugs".

The law of March 9, 2004 allows for reductions in the sentences handed down to offenders for offences ranging from the proposal of drugs to all forms of trafficking if, “having informed the administrative or legal authorities, the offender has made it possible to put a stop to the offence and possibly identify other guilty parties”. This possibility for "criminals-turned-informers" to avoid a sentence for trafficking is a new feature in the French legal process. The law also extended the special procedural arrangements that already existed for trafficking (including the use of confiscation as a penalty in cases involving the sale or proposal of narcotics) to other offences.

Finally, the "delinquency prevention" law of March 5, 2007 provides for more severe penalties in the event of "directly inciting a minor to transport, possess, propose or sell narcotics" (up to 10 years in prison and a fine of € 300,000). The penalties for offences committed under the influence of a narcotic substance or in a state of drunkenness have also been beefed up.

Furthermore, the law organises new investigatory measures (searches based on the use of New Information and Communication Technologies (NICTs), deals under surveillance or procedures for determining upstream risks).

Finally, law n° 2010-768 (the so-called "*loi Warsmann*" [11]) established a new criminal procedure for seizing and confiscating the assets of narcotics traffickers under investigation.

The trafficking of synthetic drugs

The production and sale of "precursor" products that may end up being used to produce narcotics has been controlled ever since the introduction of the law of June 19, 1996.

Opioid substitution treatments

Along with Germany, Ireland and Greece, France was one of the last European countries to introduce opioid substitution treatments. Methadone only shook off its strictly experimental status in the mid-1990s, when its marketing authorisation was granted in 1995 (circular DGS/SP3/95 n °29 of March 31, 1995). The methadone marketing authorisation was followed a year later by the authorisation for high-dose buprenorphine (in February 1996).

Seen as being safer than methadone (and not scheduled as a narcotic), Subutex® can be prescribed by any doctor, outside specialised treatment centres: this flexible prescription system (whereas methadone was reserved for specialised centres only - at least for the initial treatment phase) has led to a major surge in high dose buprenorphine (HDB) substitution, which today accounts for approximately 85% of the total "market" for substitution drugs. As a result, a second "doorway" to substitution by means of health establishments was opened with circular DGS/DHOS n° 2002/57 of January 30, 2002. This circular made it possible for any physician practising in a health establishment to initiate methadone-based substitution treatment.

Since 1993, a series of official texts and circulars have been published by the public authorities in order to "balance" the prescription and dispensing of substitution treatments in France. In April 2008, the health authorities cracked down on prescription and dispensing conditions for buprenorphine and methadone. To obtain reimbursement, patients are now required to provide their physician with the name of the pharmacy that will dispense the medication. The physician must mention this pharmacy on the prescription.

The legal framework for harm reduction activities

The harm reduction policy for drug users is the responsibility of the state (article L3121-3 of the French Public Health Code modified by law n° 2004-809 of August 13, 2004 - art. 71). This harm reduction policy seeks to prevent the spread of infectious diseases and death by overdose because of intravenous injection and the social and psychological damage caused by the use of drugs classified as narcotics (article L3121-4 of the French Public Health Code modified by law n° 2004-809 of August 13, 2004 - art. 71). The law of August 9, 2004 which set up the "Harm reduction support centres for drug users" (CAARUDs) states that along with the numerous other schemes and measures, CAARUDs should be used to further improve the harm reduction policy (article L3121-5 of the Public Health Code). Thus, the "Harm reduction and support centres for drug users"[12] receive both individuals and groups, in addition to providing tailored advice and

[11] Loi n° 2010-768 du 9 juillet 2010 visant à faciliter la saisie et la confiscation en matière pénale (NOR: JUSX0912931L).
[12] Article R3121-33-1 modifié par le décret n° 2005-1606 du 19 décembre 2005 - art. 1 JORF 22 décembre 2005 en vigueur le 1er janvier 2006.

information for drug users. They also provide support for drug users in obtaining access to treatment, which includes hygiene systems and access to basic emergency care, referral to specialised or general treatment systems, encouragement to undergo screening for transmissible infections, support for users in exercising their rights and gaining access to housing and professional reintegration, the availability of infection prevention equipment, and localised intervention outside the centre with a view to establishing contact with users. CAARUDs provide social mediation to ensure good integration in their neighbourhood and prevent the public disturbances related to drug use. Their coordination with other organisations has been stipulated in a circular[13].

Since May 1987[14], the unrestricted sale of syringes has been authorised in retail pharmacies, pharmacies located inside healthcare establishments and establishments that focus exclusively on selling medical, surgical and dental equipment or that have a specialised department for such equipment. Since March 1995[15], these may be issued free of charge by any non-profit association carrying out AIDS prevention or harm reduction activities among drug users, meeting the requirements described in the decree from the Minister of Health (article D. 3121-27 of the French Public Health Code). Providing syringes and needles to minors is only authorised by prescription (art. D.3121-28 of the French Public Health Code). However, neither pharmacies nor associations are legally bound to ask users to provide their identity or age since the 1987 suspension of the provisions of the 1972 decree.

It is not legal to arrest someone on the sole charge of narcotics use in immediate proximity to a harm reduction or syringe exchange structure (for example, pharmacy Syringes exchange programmes, SEPs). Furthermore, simply carrying a syringe is not sufficient evidence to justify an arrest.

A national harm reduction standard for drug users has been prepared (art. D. 3121-33 of the French Public Health Code) and approved via decree n° 2005-347 of April 14, 2005. Among other things, this stipulates that all participants, health professionals, social workers or members of associations, in addition to any persons to whom these activities are addressed, must be protected from accusations concerning the use or the incitation to use drugs during their work.

Emerging trends in the national anti-drugs strategy

The first interministerial anti-drug plan dates back to 1983. The current 2008-2011 government plan to fight drugs and drug addiction includes almost 200 measures in terms of prevention, supply reduction, health/social care, research, observation and training or international cooperation. In the field of prevention, priority is given to the goal of preventing people from taking drugs for the first time, as the age at which first time use begins has fallen. This targets young people and those close to them (e.g., parents, teachers).

The 2008-2011 plan mentions several priorities when enforcing the law: alcohol abuse among the youngest users, offences related to the use of narcotics and/or tobacco in public areas, cannabis trafficking, seizure and court-ordered confiscation.

[13] Circulaire DGS/S6B/DSS/1A/DGAS/5C n° 2006-01 du 2 janvier 2006 relative à la structuration du dispositif de réduction des risques, à la mise en place des centres d'accueil et d'accompagnement, à la réduction des risques pour usagers de drogues (CAARUD) et à leur financement par l'assurance maladie.

[14] Décrets n° 87-328 du 13 mai 1987 et n° 88-894 du 24 août 1988 portant suspension des dispositions du décret n° 72-200 du 13 mars 1972 et Décret n° 89-560 du 11 août 1989 modifiant le décret du 13 mars 1972 réglementant le commerce et l'importation des seringues et aiguilles destinées aux injections parentérales, en vue de lutter contre l'extension de la toxicomanie.

[15] Décret n° 95-255 du 7 mars 1995 modifiant le décret du 13 mars 1972 réglementant le commerce et l'importation des seringues et aiguilles destinées aux injections parentérales, en vue de lutter contre l'extension de la toxicomanie.

It provides for new treatment and social integration modalities, particularly for minors, pregnant women or parents of young children, cocaine or crack users and released prisoners. The plan aims to reinforce the housing capacity for vulnerable, addicted people.

Finally, with respect to international policy, the 2008-2011 plan has three major objectives:

- reinforcing (within a multilateral, European and bilateral framework) action deployed at every stage of the trafficking routes (particularly in western Africa and the Mediterranean), in order to choke off the source of supply to cannabis and cocaine outlets in Europe and heroin outlets in central Europe and the Balkans;

- increasing the number of agreements reached with the states concerned in order to simplify international action against the misuse of chemical precursors (particularly concerning Afghanistan)

- boosting Mediterranean cooperation to coordinate the fight against drugs in the Mediterranean area, etc.

The preceding plan (2004-2008) was inspired by a policy that mainly targeted young people and prevention, and particularly “halting the spread of cannabis” among adolescents and young adults. Without giving up these goals, the 2008-2011 plan adopts an approach of rigorously applying the law and using targeted communication campaigns. The government plan can also be seen as a continuation of the Ministry of Health’s 2007-2011 Addiction, Treatment and Prevention plan (so-called “Addictions” plan), adopted in November 2006[16] which seeks to structure and enhance the availability of the existing facilities and programmes (in hospitals, addictology health/social care centres or in primary care settings).

Public expenditure and budgets

Since the introduction of the Organic law relative to the finance laws of 2001, the state’s general budget credits allocated to the public authorities are now presented on a "per mission" and "per programme" basis. In the fight against drugs, the government runs 30 or so ministerial programmes. Therefore, it is possible to retrace the government’s policy even in actions with broader scope. This includes the credits allocated to the MILDT under the terms of programme 129, "Coordination of governmental work". This is not the case for the expenditure of the French national health insurance fund, which nevertheless remains identifiable. The contributions of the French national health insurance fund finance the addictology centres and hospitals in their missions to treat problem drug users; they also reimburse substitution therapies for people receiving such treatments. Public expenditure on the drug prevention policy, treatment, or drug supply curtailment measures has been the subject of numerous studies in France[17.] A recent assessment of public expenditure devoted to the drug problem was carried out in 2007, concerning the credits allocated in 2005 {Ben Lakhdar 2007}. As the calculation methods were specific for each estimate, tracking changes by means of a comparative analysis is not possible.

[16] http://www.sante.gouv.fr/htm/actu/plan_addictions_2007_2011/sommaire.htm
[17] http://www.ofdt.fr/ofdtdev/live/publi/pointsur.html

1.2. Legal framework

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

Regarding illegal substances, lawmaker's efforts were dedicated to fighting narcotics trafficking and, in particular, modernising the procedural framework for conducting investigations on profits made through crime. In July 2010, law n° 2010-768[18] (the so-called "loi Warsmann") completed certain provisions of the French Code of Criminal Procedure enabling the search of "anything that seems to have been the direct or indirect result of the crime" (Art. 54 of the French Code of Criminal Procedure), […] as well as "the seizure and confiscation of assets suspected to be the result of trafficking". Circular n° CRIM-10-28-G3 presents the joint provisions of national law provided by the law of July 9, 2010. This law transposed the European Framework Decision[19] of 2006 on the application of the principle of mutual recognition of confiscation orders. It enabled a recast of the preceding applicable provisions beyond the EU to extend their reach to all international conventions endowed with recognition mechanisms for confiscation orders. Finally, the July 2010 law provided a precise legal framework for performing cross-border confiscations on the basis of the principle of international reciprocity, when no applicable international agreement exists. The specific provisions of international penal cooperation on seizures and confiscations are presented in the circular[20] of December 22, 2010. Moreover, the July 2010 law gave rise to the *Agence de gestion et de recouvrement des avoirs saisis et confisqués, (AGRASC, or Agency for Managing and Recovering Seized and Confiscated Assets*). Thanks to this agency, lawmakers want to improve the management of proceeds from assets confiscated from people found guilty of drug trafficking offences. Its application decree[21] was adopted in February 2011. It stipulates the internal organisation of the Agency (art. 54-1 et seq. of the French Code of Criminal Procedure). The Agency's missions and concrete modalities for submitting cases to court and cooperating with courts are presented in the February 3, 2011 circular[22]. One of the missions of this Agency is to monitor contributions to the "Narcotics" support fund (see the "Budget" section of this chapter).

National security was another field of action for lawmakers during this period. The executive branch had law n° 2011-267[23] on the orientation and programming for performance of domestic security (the so-called "*LOPPSI 2*" law) adopted on March 14, 2011.

Finally, cybercriminality: since the adoption of LOPPSI 2, the fraudulent use of personal data on an online public communication network constitutes an offence punishable by a one-year prison sentence and a € 15,000 fine (Art. 226-4-1 of the French Penal Code). Furthermore, the law of March 14, 2011 stipulates measures for preventing delinquency and promoting road safety.

[18] Loi n° 2010-768 du 9 juillet 2010 visant à faciliter la saisie et la confiscation en matière pénale (NOR : JUSX0912931L).
[19] Décision-cadre 2006/783/JAI du 6 octobre 2006 relative à l'application du principe de reconnaissance mutuelle aux décisions de confiscation.
[20] Circulaire du 22 décembre 2010 relative à la présentation des dispositions spécifiques de la loi n° 2010-768 du 9 juillet 2010 visant à permettre l'exécution transfrontalière des confiscations en matière pénale (articles 694-10 à 694-13 et 713 à 713-41 du code de procédure pénale) (NOR : JUSD1033289C).
[21] Décret n° 2011-134 du 1er février 2011 relatif à l'Agence de gestion et de recouvrement des avoirs saisis et confisqués (NOR: JUSD1025713D).
[22] Circulaire du 3 février 2011 relative à la présentation de l'AGRASC et de ses missions (NOR : JUSD1103707C).
[23] Loi n° 2011-267 du 14 mars 2011 d'orientation et de programmation pour la performance de la sécurité intérieure (NOR: IOCX0903274L).

To the list of possible educational sanctions against a delinquent minor, the LOPPSI application circular[24] on the prevention of delinquency added the establishment of an administrative and legal curfew (from 11 pm to 6 am) for children under the age of 13. The Prefect is thereby authorised to enforce orders that limit the freedom of these youths to come and go as they please in public between 11 pm and 6 am. Expanding video surveillance has been facilitated to prevent narcotics trafficking. This measure completes article 10 of law n° 95-73 of January 21, 1995.

Since LOPPSI was adopted, screening for narcotics use has become mandatory in the event of a traffic accident that causes bodily harm, weather fatal or not (application circular of March 28, 2011 on fighting against unsafe road conditions)[25]. This circular authorises random controls for narcotics use on all drivers upon requisition of a French public prosecutor (art. L.235-2 of the French Traffic Code, modified by article 83 of LOPPSI).

Regarding non-substance related addictions, in May 2010, France authorised online gambling. The legal framework for the government policy on opening the market for gambling and games of chance is provided by the law of May 12, 2010[26]. By authorising online gambling and betting, lawmakers wished to control gambling and, in particular, control gambling operations. Preventing excessive or pathological gambling and protecting minors are among the main objectives (art. 3). Gambling is prohibited for minors. Gambling companies are required to prevent minors from participating in gambling or betting online. On their website, operators are required to request the birth date of the player as soon as they register, and on each subsequent visit (art. 5).

Gambling companies are also required, when a potential customer wishes to register on their website, to contact the online gambling Authority, which determines whether or not the potential customer is on the list of people registered as being banned from gambling with the French Ministry of the Interior. Any person banned from gambling by virtue of current regulations, or excluded from gambling at their own request, is on this list. In order to prevent abuse, gambling companies must implement mechanisms to encourage moderation and self-limitation in depositing and betting. They must constantly provide each player with their account balance and display warning messages. They must provide information on how to register on the lists of people banned from gambling (art. 26 to 30). These legislative provisions gave rise to numerous application texts (seven decrees and three orders). These include:

- Decree[27] n° 2010-509 of May 18, 2010, which specifies the obligations of approved gambling or online betting companies for the purposes of allowing the online gambling Authorities to control online gambling data;

- Decree[28] n° 2010-623 of June 8, 2010, which lists and establishes the obligations for approved online gambling or betting companies to provide information for preventing the risks related to gambling;

[24] Circulaire du 28 mars 2011 d'application de la LOPPSI en ce qui concerne la prévention de la délinquance (NOR : IOCD1108861C).
[25] Circulaire du 28 mars 2011 d'application de la LOPPSI en ce qui concerne l'amélioration de la sécurité routière (NOR : IOCD1108865C).
[26] Loi n° 2010-476 du 12 mai 2010 relative à l'ouverture à la concurrence et à la régulation du secteur des jeux d'argent et de hasard en ligne (NOR : BCFX0904879L).
[27] Décret n° 2010-509 du 18 mai 2010 relatif aux obligations imposées aux opérateurs agrées de jeux ou de paris en ligne en vue du contrôle des données de jeux par l'Autorité de régulation des jeux en ligne (NOR : BCRB1012570D).

- Decree[29] n° 2010-624 of June 8, 2010 on informing players of the risks related to gambling;

- Order[30] of June 8, 2010 defining the modalities and content for displaying information messages on how to become registered on the list of people banned from gambling.

- Finally, the decree[31] of March 9, 2011 created a body responsible for issuing an informed opinion on any gambling-related issue to the government. To be more specific, this is a gambling consultative committee comprised of a college, a gambling monitoring institute[32] and two specialised commissions.

Screening for the use of psychoactive substances in a professional environment was the subject of a bill on the organisation of occupational medicine[33]. It enabled occupational physicians to determine whether or not employees are able to occupy their position, to inform the employer and, if necessary, to refer the employee to a detoxification programme. Adopted by the French Senate after the initial reading on January 27, 2011, the bill was examined by the French National Assembly on July 6, 2011 and adopted without modification after the 2nd Senate reading on July 8, 2011[34]. It follows opinion[35] n° 114 of the French National Ethics Advisory Committee (CCNE). The MILDT called upon the committee to acquire more in-depth feedback on drug screening possibilities in the workplace. An initial CCNE opinion was issued in 1989, but the progress in screening test reliability and the changes in the legal and competitive context in which companies work justified this new submission. This opinion was on the ethical challenges of detecting drug use in the workplace.

1.2.2. Laws implementation

The health authorities have made several decisions since 2010 that affect the vigilance of the public authorities regarding the appearance of new, potentially dangerous substances:

- In 2010, “Tapentadol and its salts[36] and “4-methylmethcatinone or mephedrone, and its salts” [37]were scheduled as narcotics. The classification of mephedrone was made because of its psychoactive effects and its high addictive and toxic potential. It corresponds to the proposal by the French Health Products Safety Agency (AFSSAPS) following the opinion of the French narcotics and psychotropics commission.

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[28] Décret n° 2010-623 du 8 juin 2010 fixant les obligations d’information des opérateurs agréés de jeux ou de paris en ligne pour la prévention des risques liés à la pratique du jeu et modifiant le décret n°2010-518 du 19 mai 2010 relatif à la mise à disposition de l’offre de jeux et de paris par les opérateurs agrées de jeux ou de paris en ligne (NOR : BCRB1013829D).
[29] Décret n°2010-624 du 8 juin 2010 relatif à la règlementation des communications commerciales en faveur des opérateurs des jeux d’argent et de hasard ainsi qu’à l’information des joueurs quant aux risques liés à la pratique du jeu (NOR : BCRB1013925D).
[30] Arrêté du 8 juin 2010 relatif au contenu et modalités d’affichage du message d’information relatif à la procédure d’inscription sur le fichier des interdits de jeu (NOR : BCRB 1015075A).
[31] Décret n° 2011-252 du 9 mars 2011 relatif au comité consultatif des jeux (NOR : BCRB1102248D).
[32] Arrêté du 11 mars 2011 portant nomination à l’observatoire des jeux (NOR : BCRB1103934A).
[33] Bill proposed by Mr. Nicolas ABOUT and several of his colleagues on the organization of occupational medicine, no. 106, submitted on November 10, 2010.
[34] Loi relative à l’organisation de la médicine du travail, n° 2011-867 du 20 juillet 2011.
[35] Advisory opinion n° 114 of the 5th may 2011 issued by the National Ethics advisory committee for the sciences of life and for of health on alcohol use, on drugs and addiction in work environment, on the ethical issues related to their risks and their detection.
[36] Arrêté du 11 mai 2010 modifiant l’arrêté du 22 février 1990 fixant la liste des substances classées comme stupéfiants (NOR : SASP1012703A)
[37] Arrêté du 7 juin 2010 modifiant l’arrêté du 22 février 1990 fixant la liste des substances classées comme stupéfiants (NOR : SASP1014839A)

- In 2011, 4-fluroamphetamine[38] was scheduled as a narcotic upon a decision of the French Ministry of Labour, Employment and Health by public order in the French Official Journal on March 16, 2011. This classification was motivated by the drug's pharmacological properties, effects and toxic risks, which are similar to those of amphetamines or MDMA (ecstasy), as well as by its diffusion throughout Europe.

For the fight against the diffusion of synthetic drugs via the Internet, the competent authorities (AFSSAPS) created a generic classification (by molecule family) that completed the classification by molecule.

"Butorphanol"[39] joined the list of psychotropic substances. The following were added to the list of poisonous substances[40]: "Bazedoxifene", "Catumaxomab", "Eslicarbazepine", "Mifamurtide" and "Tramadol". The sale of poppers was banned in 2011[41] (Order of June 29, 2011). This ban follows their more widespread use in the general population. According to the 2010 *Baromètre santé* health survey (see appendix IV-A), lifetime use affects 5.3 % of people aged 18-64 *vs.* 3.9 % in 2005. Poppers (alkyl nitrite-based substances) were popularised by the gay population in the 1970s and 1980s. They create a state of euphoria and are frequently used at parties or to facilitate sexual relations.

The sale of GBL may soon be subject to control measures. The AFSSAPS is examining legal methods for controlling and regulating the sale of the substance to the public, while it is freely sold for household use.

Two new orders were issued in 2010 to prevent medication misuse: the order of January 25, 2010 on the dispensing of certain Fentanyl-based medications[42], which are now subject to splitting, and the order of October 12, 2010 limiting the prescription duration of clonazepam-based medications[43] to 12 weeks.

A new European Union[44] (EU) regulation, in effect since March 7, 2011, governs the manufacture and sale of "precursor" products. Its application is immediate and mandatory in all Member States. It completes the provisions applied within the EU on the specific control measures required when exporting drug precursors from Europe in order to take into consideration the classification of phenylacetic acid in the list of substances to monitor established by the United Nations convention.

[38] Arrêté du 7 mars 2011 modifiant l'arrêté du 22 février 1990 fixant la liste des substances classées comme stupéfiants (NOR : ETSP 1106697A.

[39] Arrêté du 12 juin 2009 modifiant l'arrêté du 22 février 1990 fixant la liste des substances psychotropes (NOR :SASP0913395A).

[40] Arrêté du 25 janvier 2010 portant classement sur les listes des substances vénéneuses (NOR : SASP1002251A).

[41] Arrêté du 29 juin 2011 portant application d'une partie de la réglementation des stupéfiants aux produits contenant des nitrites d'alkyle aliphatiques, cycliques ou hétérocycliques et leurs isomères (NOR : ETSP1117877A).

[42] Arrêté du 25 janvier 2010 relatif au fractionnement de la délivrance de certains médicaments à base de fentanyl (NOR : SASP1002259A).

[43] Arrêté du 12 octobre 2010 fixant la durée de prescription des médicaments contenant du clonazépam administrés par voie orale (NOR: SASP1026222A).

[44] Règlement (UE) n° 225/2011 de la Commission du 7 mars 2011 modifiant le règlement (CE) n° 1277/2005 de la Commission établissant les modalités d'application du règlement (CE) n° 273/2004 du Parlement européen et du Conseil relatif aux précurseurs de drogues et du règlement (CE) n° 111/2005 du Conseil fixant des règles pour la surveillance du commerce des précurseurs des drogues entre la Communauté et les pays tiers.

The list of substances and methods banned for athletes from decree n° 2009-93 of January 26, 2009[45] was modified by the order[46] of June 25, 2010 (L. 232-26 of the French Sports Code). Regarding the therapeutic use of banned substances and methods[47], possessing or using such substances is subject to mandatory submission of a declaration of use to the French Anti-doping Agency. In 2011, the scheme for authorising therapeutic use and the concept of declaring use introduced into the French Sports Code by order of April 14, 2010 on the protection of the health of athletes was amended by the decree[48] of January 13, 2011. Also in 2011, there were two other decrees pertaining to anti-doping measures: the first on the checks[49] to be performed and the other on the disciplinary sanctions[50] to be applied.

Several decrees and orders on anti-money laundering measures were adopted in 2010 and 2011. They are part of the framework of order n° 2009-104 of January 30, 2009 on preventing the use of the financial system for the purposes of laundering capital and financing terrorism and on the fight against tax fraud. The order[51] of September 7, 2010 established the professional accounting rules for preventing the use of the financial system for the purposes of laundering money and financing terrorism. Decree[52] n° 2010-1160 of September 30, 2010 reinforces the resources for the money laundering service of the French Ministry of Finances (TRACFIN). The organisation and methods of operation of TRACFIN are established by decree[53] n° 2011-28 of January 7, 2011 and developed by the order[54].

For access to infectious disease screening, two orders were promulgated in 2010. They establish the conditions for performing rapid diagnostic tests (RDT) for HIV (orders of May 28, 2010 and November 9, 2010).

Since May 28[55], the rapid screening test for the AIDS virus has been able to be performed in "emergency situations", namely in accidents involving exposure to blood, in events of recent sexual exposure, during birth and in the event of diagnostic emergency. This rapid diagnostic testing can, since November 9, 2010[56], be performed on anyone, in their own interest and for their sole benefit, after the person has been informed and provided their free and informed consent. The list of people authorised to perform such testing has lengthened. The tests may be able to be used in different structures and by different types of healthcare workers:

[45] Décret n° 2009-93 du 26 janvier 2009 portant publication de l'amendement à l'annexe de la convention contre le dopage, adopté le 13 novembre 2008 à Strasbourg, et à l'annexe 1 de la convention internationale contre le dopage dans le sport, adopté le 17 novembre 2008 à Paris (NOR : MAEJ0901116D).

[46] Arrêté du 25 juin 2010 fixant la liste des substances ou méthodes dont la détention par le sportif est interdite en application de l'article L. 232-26 du code du sport (NOR: SASV1017161A).

[47] Arrêté du 25 juin 2010 fixant la liste des substances et méthodes nécessitant pour leur utilisation ou leur détention par le sportif une autorisation d'usage à des fins thérapeutiques ou une déclaration d'usage (NOR : SASV1017154A).

[48] Décret n° 2011-59 du 13 janvier 2011 portant diverses dispositions relatives à la lutte contre le dopage (NOR: SPOV1028918D). Consolidated version of January 16, 2011.

[49] Décret n° 2011-57 du 13 janvier 2011 relatif aux contrôles en matière de lutte contre le dopage (NOR : SPOV1017553D).

[50] Décret n° 2011-59 du 13 janvier 2011 relatif aux sanctions en matière de lutte contre le dopage (NOR : SPOV1017568D).

[51] Arrêté du 7 septembre 2010 portant agrément des règles professionnelles relatives aux obligations des professionnels de l'expertise comptable pour la prévention de l'utilisation du système financier aux fins de blanchiment de capitaux et de financement du terrorisme (NOR : ECET1023254A)

[52] Rapport relatif au décret n° 2010-1160 du 30 septembre 2010 portant transfert de crédits (NOR : BCRB1017391D).

[53] Décret n° 2011-28 du 7 janvier 2011 relatif à l'organisation et aux modalités de fonctionnement du service à compétence nationale TRACFIN (NOR: EFIP1027334D). Consolidated version of January 9, 2011.

[54] Arrêté du 7 janvier 2011 portant organisation du service à compétence nationale TRACFIN (NOR: EFIP1027335A)

[55] Arrêté du 28 mai 2010 fixant les conditions de réalisation du diagnostic biologique de l'infection à virus de l'immunodéficience humaine (VIH 1 et 2) et les conditions de réalisation du test rapide d'orientation diagnostique dans les situations d'urgence (NOR : SASP0908446A)

[56] Arrêté du 9 novembre 2010 fixant les conditions de réalisation des tests rapides d'orientation diagnostique de l'infection à virus de l'immunodéficience humaine (VIH 1 et 2) (NOR : SASP1026545A).

- a physician in private practice;

- a physician, medical biologist or midwife as well as a nurse or laboratory technician working in a healthcare establishment or department;

- a physician, medical biologist, midwife or nurse working in a prevention or associative structure involved in prevention in the area of healthcare (provided that this structure is authorised), or an employee, volunteer or non-healthcare professional, working in a prevention or associative structure (provided that they have followed training on how to use rapid diagnostic tests.

Furthermore, in order to improve support regarding healthcare treatment in certain clinical situations, the order[57] of July 8, 2010 authorises the physician of the Anonymous free screening centre (CDAG) or of the information screening, diagnosis centre on sexually transmitted diseases (CIDDIST) to proceed with lifting anonymity, provided that the patient gives express, informed consent (art. L3121-1 of the French Public Health Code).

Finally, in the area of "general public" information, the mandate for the telephone service, "*Addictions drogues alcool info service*" (ADALIS or Drugs and Alcohol Addiction Information Service,) was renewed on January 18, 2011[58] for a duration of three years starting on January 1, 2011. Funded and placed under the direct authority of the French national institute for prevention and health education (INPES) since 2009, this public service offers counselling, information, support and guidance to anyone concerned by problems related to illegal drugs, alcohol and gambling. The service answers seven days a week from 8 am to 2 pm. Several phone numbers are available.

1.3. National action plan, strategy, evaluation and coordination

1.3.1. National action plan and/or strategy

France-wide, the interministerial anti-drug strategies promoted in 2010 by the government are those set out in the 2008 government "drugs" plan (see National French Report, 2008). This plan's "health" section includes the measures adopted by the French Ministry of Health within the scope of its 2007-2011 "addictions" plan (see National French Report, 2007). Also placed under the supervision of the health authorities, two other long-term plans recently reinforced the health section of the government hepatitis prevention and treatment plan.

2009-2012 "Hepatitis" plan

In preparation since 2007, the national hepatitis B and C plan was released on February 24, 2009 by the French Ministry of Health. A four-year plan (2009-2012), the hepatitis plan follows the National hepatitis C plan (1999-2002), the national hepatitis B and C plan (2002-2005) and the measures taken on December 8, 2005. The plan's priority populations include drug users, and especially injecting drug users, drug use being considered as the primary mode of HCV

[57] Arrêté du 8 juillet 2010 fixant les conditions de la levée de l'anonymat dans les consultations de dépistage anonyme et gratuit et dans les centres d'information, de dépistage et de diagnostic des infections sexuellement transmissibles (NOR: SASP1007832A).
[58] Arrêté n° 17 du 18 janvier 2011 approuvant la reconduction du groupement d'intérêt public « Addictions drogues alcool info service »

transmission. Other people targeted by the plan include those engaging in risky behaviours (multiple sexual partners), those in unstable situations and those in prison.

The plan is also consistent with the observations in the assessment report on the 2004 Public Health Law {HCSP, 2010 #598}. The five-year law of August 9, 2004 set a general goal of reducing deaths from chronic hepatitis by 30%, reducing the number of infected patients from 10-20% to 7-14% in 2008. It does not appear particularly relevant to monitor death rates over a five-year period for a disease with a long clinical course and the National Committee for Public Health (HCSP) experts therefore decided to place more emphasis on prevention of viral hepatitis.

The strategy entailed a combination of improved prevention and more accessible screening, while improving access to effective treatments and to care. The priorities of the new hepatitis plan are: reducing HCV and HBV transmission, increasing screening and access to care, and introducing additional measures suitable for prisons. The plan pays particular attention to the quality of care and quality of life of people suffering from chronic hepatitis B and C.

The 2004 public health law set other, more specific objectives for fighting hepatitis: reaching 80% in the primary vaccination cover against hepatitis B in children and 75% in 15-year-old adolescents; increasing screening of people infected with the hepatitis virus by 25% and reducing, in the space of 5 years, the prevalence of HCV infections in illegal drug users under 25 years old by at least 20%. The HCSP assessment report also examined the achievement of these objectives. Its conclusions and propositions will serve to devise the next public health law, which will decide on the policy to be adopted by the health authorities, including that regarding addictions. The hepatitis plan also envisages the implementation of an inter-organisational monitoring committee responsible for its assessment. This task will be entrusted to an external assessor and is intended to be in operation in 2012.

The 2009-2013 “Cancer” plan

Adopted in 2009, the 2009-2013 cancer plan launched by the President of France on November 2, 2009 comprises measures for the fight against hepatitis. A budget of € 732.65 M was allocated to enable the 118 actions of the plan programmed over a five-year period to be followed-through. The 2009-2013 cancer plan was based on the report by Prof. Jean-Pierre Grünfeld. It is a continuation of the preceding cancer plan (2003-2007). It capitalises on experience and follows new directions, particularly regarding three new challenges addressed by the plan’s three transversal, priority themes:

- To better take account of health inequalities for greater care equity and effectiveness in all measures to combat cancer.

- To analyse and take account of individual and environmental factors in order to personalise the health response before, during and after the disease.

- To increase the role of the general practitioner at all steps in care, in particular to help to improve life during and after the disease.

The "Health/Prison" Plan

In 2010, the French Ministry of Health and Sports, with the contribution of the French Ministry of Justice and Liberties, devised a strategic action plan[59] that, for the period 2010-2014, defined the health policy for persons referred by the justice system. This was the first national plan for improving the health of detained people. The relevant central administration departments[60], the French National Institute for Prevention and Health Education (INPES), the National Institute for Public Health Surveillance (InVS), the Agency for Shared Information Systems (ASIP Santé) and a general advisor for health establishments were involved in preparing this "Health/Prison" Plan. This plan addresses all aspects of prison health policy through plans to improve the government's awareness of the state of health of detainees, to strengthen the existing health systems and develop them, to provide for reinforced measures for certain detainee categories (especially addicted prisoners), and so on. The plan emphasises the importance of continuity of care after release from prison and, in addition to creating *appartements de coordination thérapeutique* or *lits halte soins santé* (housing and health services for people in very unstable situations in France), provides for consistently organising housing for people released from prison to ensure continuity of care and the implementation of joint reference systems and training. An institutional supervisory committee is responsible for monitoring action plans and preparing an annual progress report. The French Ministry of Health and Sports is responsible for assessing the plan.

The 2008-2011 government "drugs" plan spearheaded by the MILDT provides for the cascading of its national strategic directions in the local "drugs" plans. The *département* local drug project leader, working under the authority of the Prefect of the *département*, is responsible for producing the "plan *départemental*" (local "drugs" plan)[61]. The project leader takes the national policy and adapts it to local situations and characteristics. The plans are produced in a local steering committee which brings together the different State services. The monitoring committee is also responsible for seeking consistency with the existing specific plans in the *département* (social cohesion contracts, road safety plans, delinquency prevention measures, town contracts, public health programmes, planning with regard to the organisation of regional ambulatory and hospital care and regional health/social care services and facilities). Local plan measures that fall within the usual activities of decentralised services or national health insurance are funded by their respective budgets. The experimental actions of the interministerial projects are financed using credits delegated by the MILDT (€ 15 M in 2009, € 13 M in 2010 and € 11 M in 2011). These experimental actions entail decentralised services that pertain to joint objectives. For example, interministerial training, joint information and prevention or awareness tools for all services. The MILDT note of November 4, 2009[62] to local drug project leaders reaffirms their legitimate right to stimulate the local activities run by the administrative and institutional organisations and provides guidance for actions in 2010-2011:

- Prevention: priority should be given to local actions that relay the messages of the national communication campaigns conducted in 2009 and 2010 on the danger of products, the legal status of substances and the role of parents. Furthermore, a major part of the local plan is to mobilise the local actors in both management and labour to drive preventive activities in the

[59] 2010-2014 Strategic Action Plan: Health policy for people referred by the justice system, French Ministry of Health and Sports and French Ministry of Justice and Liberties

[60] Direction générale de l'offre de soins (DGOS), Direction générale de la santé (DGS), Direction de la sécurité sociale (DSS), Direction générale de la cohésion sociale (DGCS).

[61] Note n° 578 du 18 septembre 2008 du Président de la MILDT à l'attention de chefs de projet *départemental*aux sous couvert des préfets de *départements*.

[62] Note n° 683 du 4 novembre 2009 de la MILDT à l'attention des chefs de projet *départemental*aux sous couvert des préfets de *départements*.

workplace and activities promoting the involvement of adults in prevention of drug use. Continuing on from the strategic approaches for 2008 and 2009, the project leaders are responsible for developing preventive activities with schools, universities, leisure centres and particularly in populations in the hands of the legal system. As part of the delinquency prevention policy driven by the government “drugs” plan, developing training courses to build awareness of the dangers of illegal drug use for occasional users is strongly encouraged.

- In terms of health policy, the local drug project leaders are encouraged to act in coordination with the regional project leader, the preferred contact for the regional health authorities. Since the HPST law[63] of July 2009, which established the principle of regionalising care systems, health actions must be planned and assessed regionally. In this situation it is the responsibility of the local drug project leader to ensure that local health activities contained in the regional programme meet the requirements of users in the *département* in terms of health education, care offered, social support and harm reduction.

- The local plan must also incorporate activities to combat local dealing. More specifically, it must help identify places where minor dealing, which feeds into the black economy and generates significant social disturbances, particularly around school establishments, commonly occurs. The local drug project leader is responsible for mobilising local and regional workers in their efforts to combat dealers and their criminal assets.

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

In June 2011, the MILDT announced that nearly all of the 193 actions of the 2008-2011 government plan had been carried out.

Information, communication, prevention

A new national “general public” information and communication campaign was launched in December 2010 (see chapter 3). The “Everyone can take action against drugs” campaign targeted adults so that they could examine their role in preventing drug use in their children. It follows the campaigns of 2009: The "*Drogue, ne fermons pas les yeux*" (Drugs, keep your eyes open) campaign in October 2009 and the "*La drogue, si c'est interdit, ce n'est pas par hasard*" (Drugs: if it’s forbidden, it’s not by accident) campaign in November 2009.

The government plan intended to involve parents together with actors in both management and labour concerned by addictions in the workplace in preventing addictive behaviour. Two national conferences were organised by the MILDT in 2010: one on parenting was held on May 6-7, 2010, and the other, on addictions in the workplace, in June 2010. The purpose of the national conferences was to take stock of the situation with regard to the main problems and make recommendations (see chapter 3).

Implementing the law and combating trafficking

Adopted by the delinquency prevention law of March 5, 2007, the compulsory “drug awareness-building training session” measure for occasional illegal drug users continued its impetus after a series of awareness-raising activities for the prosecution services. The MILDT's report

[63] Loi n° 2009-879 du 21 juillet 2009 portant réforme de l’hôpital et relative aux patients, à la santé et aux territoires (NOR : SASX0822640L).

announced that these measures were used in more than 70% of courts. The Ministry of Justice entrusted its assessment to the OFDT. This study should be published in 2012.

International cooperation in the fight against drug-trafficking was reinforced through joint investigatory teams working in the fight against cross-border criminal activity. The MILDT had 24 international teams set up in mid-2011 (in France, Spain, Belgium, Holland, Germany and Romania). In 2009, two platforms for European liaison officers in West Africa (Dakar and Accra) were created to facilitate the exchange of operational information on international narcotics trafficking affairs.

Targeted drug money activities were pursued: organisational measures, training for the Regional Intervention Groups (GIR) with the aim of improving measures for seizing criminal assets, actions to raise awareness in law enforcement agents, funding for different countries classified as sensitive in the fight against narcotics trafficking. The MILDT credits enabled a new GIR to be established in Guadeloupe, and branches to be established in Nice and Bastia. An information and strategy division, funded mainly by the MILDT, was created at the Central Office for the Repression of Narcotics Trafficking (OCRTIS) in order to assess the extent of narcotics trafficking and its development. “Cyberpatrols” were created within law enforcement agencies to fight against cybercriminality, and good practice was formalised for internet service providers. Finally, new detection tests were launched to fight against chemical precursors.

Care

In 2009 and 2010, the MILDT and the Health Authorities adopted experimental programmes for particularly vulnerable populations (young people in difficulties, people in prison, pregnant women and women with children, people experiencing social difficulties, etc.) within the health/social care system. These programmes provided for the creation of exchanges between the medico-social sector and the legal youth protection structures or youth support centres or even so-called “generic” social structures intended to promote the social integration and re-integration of people with addictions (see 1.4.1.2. on National Health Insurance credits). Promoting the quality of professional practices is also one of the priorities of the government plan. Subsequently, in cooperation with the French Ministry of Health, the MILDT mobilised the professionals concerned by the importance of improving professional practices within the scope of counselling clinics for young users. This type of measure is still becoming more widespread (38 new clinics for young users since 2008, € 627,000).

In 2010, the National Authority for Health (HAS) published recommendations for treating cocaine users. They were integrated into the terms of reference to tender opened to CSAPAs and, in particular, were taken into consideration in the treatment of crack users. It was agreed to promote integrated healthcare practices for patients presenting with comorbidities, both somatic and psychiatric, coordinated between various departments of hospital establishments as well as between CSAPAs and hospitals. The MILDT supports this measure for improving hepatitis C treatment for patients followed in CSAPAs and CAARUDs and in Outpatient Treatment/Consultation Hospital Units (UCSAs) in the prison setting. The MILDT subsequently funds a dozen or so Fibroscans (€ 500,000 budget out of the 10% of the support funding earmarked for prevention) within the scope of quantitative and qualitative clinical research on the development of units for hepatitis prevention, care and harm reduction.

With regard the strategies for combating drugs at local level, the MILDT note n° 683 of November 4, 2009 to the local drug project leaders recalled the merits of assessing new projects, so that these could continue or new projects be adopted. The task of assessing

activities conducted in 2009 was entrusted to a commission working under the Prefect. It delegates the assessment mission to a specialised sub-committee that, moreover, defines the territorial strategies and projects to be implemented from January 2010. The 2009 MILDT note reiterates the creation in each region of a system for providing methodological support to project leaders. The purpose of this support is to elucidate their strategic choices and define relevant indicators for assessing their effectiveness. This system integrates the methodological advice and observation work of the Centres for Information and Resources on Drugs and Addictions (CIRDD) established by the MILDT in 2005. The MILDT note of July 28, 2009[64] for the attention of regional drug project leaders renewed the former regional support system provided by the associations in order to move from a network funding process to a system of funding projects and to strengthen the interministerial nature of the system. It specifies that the MILDT is to provide subsidies to regional project leaders. These subsidies will fund the organisation that wins the bidding process and with which a service agreement is signed. In 2009, the CIRDD budget was € 2.8 M. In 2010, the regional allocation for tenders remained unchanged.

1.3.3. Other drug policy developments

The decriminalisation of cannabis was at the forefront of French public debate during the summer of 2011, following the Vaillant commission's proposal for "controlled legalisation" of cannabis {Vaillant et al. 2011}.

1.3.4. Coordination arrangements

National interministerial coordination

In order to improve the central coordination of interministerial actions, the State, through article 38 of the amended finance law for 2008, provided the MILDT with a permanent supervisory mechanism for the drug and drug addiction policy: the transverse policy document (DPT), the first version of which was produced in 2009 in the finance law for 2010. The “drugs” DPT was produced by MILDT in collaboration with the senior ministerial officers responsible for running the programme and is an organisational tool to mobilise ministerial workers. It was drafted using the annual project performance indicators (PAP) related to the ministerial programmes.

Local interministerial coordination

Despite the reforms introduced by the HPST law conferring upon the region the planning and implementation of health policy, and despite the desire of the MILDT to keep its new “drugs” support system on a regional level, the operational running of government drug policy on a local level was not questioned. The legitimate right of the *déparment* drug project leader to boost the administrations’ actions regionally was reaffirmed in the MILDT note of November 4, 2009 to *department* project leaders. Coordination will be provided by the local drug project leader within the monitoring committee, ensuring that the local health activities stipulated in the regional plan meet the needs of users in the *département* (see 1.3.1.).

[64] MILDT note n° 451 of July 28, 2009 for the attention of regional project leaders on behalf of the regional Prefects.

1.4. Economic analysis

1.4.1. Public expenditure

The funding for the fight against drugs and drug addiction comes mainly from the government (the governmental budgetary law and any subsequent budgetary changes) and the National Health Insurance Fund (social security funding law and the National file of the National Health Insurance (AMELI) list presenting amounts for medication reimbursement).

State funds

The State's financial contribution to the drug policy is based on credits allocated to the MILDT and to the relevant ministries. Locally, the MILDT and Ministries devolve part of their funding to the local drug project leaders and decentralised state services, respectively. The credits allocated by the public authorities in 2010 and 2011 to the fight against drugs and drug addiction are grouped in the transverse policy document annexed to the 2011 finance law. It provides the amounts actually disbursed in 2009.

MILDT funds

The sums allocated to the MILDT are intended to drive and coordinate the interministerial activities to combat drugs, both nationally and locally. They are intended to fund common information, communications, scientific knowledge and training tools provided by the MILDT to the Ministries concerned. They fund support actions for innovative prevention projects, for health and social care, for law enforcement and for national and international anti-drug trafficking efforts. The MILDT also devolves some of its funding to the drug project leaders ("*Chefs de projet*") to apply the national policy on a local *(département)* level. For 2009, the budget implemented by the MILDT was € 31 M, up 19% from 2008. The budgets allocated for 2010 and 2011 were decreased to € 29.78 M (governmental budgetary law (LFI) for 2010[65]) and € 23.85 M (LFI for 2011[66]).

Ministerial funds

In 2009, the expenditure of the ministries and decentralised services for the transversal policy against drugs and drug addiction was € 1,018.45 M (budget executed in 2009); € 1,056.35 M in 2010 (LFI for 2010). For 2011, ministerial expenditure is estimated to be € 1,124.58 M (LFI for 2011). These figures are, nevertheless, approximate and should be considered with precaution. These funds represent the expenditure to be incurred to implement thirty or so ministerial programmes or related actions. The estimation of funds for the transversal policy was established by each ministerial manager responsible for carrying out the programme. The estimation method used varies from one programme to another. For certain programmes or actions, it was not possible to determine the extent to which they were specifically allocated to the implementation of the drug and drug addiction policy. It is likely that the assessment of the ministerial resources used for the drug policy is overestimated.

[65] Loi n° 2009-1673 du 30 décembre 2009 de finances pour 2010 (NOR: BCFX0921637L). Version consolidée du 1er janvier 2011.
[66] Loi de finances n° 20010-1657 du 29 décembre 2010 pour l'année 2011 (NOR: BCRX1023155L). Version consolidée du 1er janvier 2011.

Assurance maladie funds

Public health resources from the *Assurance maladie* (National Health Insurance Fund) also need to be added to the State's funding contribution towards combating drugs and drug addiction. These are funds allocated to health and social care and the harm reduction policy for drug users mostly delivered by the addiction's health/social care sector[67]. The Assurance maladie also contributes to expenditure incurred by the policy for the prevention and treatment of addictions by reimbursing drugs used for substitution treatment. It also funds health and social care establishments to apply the measures from the specific national drug health plans (2007-2011 "addictions" plan, 2008-2011 government "drugs" plan, 2009-2012 "hepatitis" plan).

Addiction treatment and care services

In 2010, funding for addiction treatment and care services was € 316.78 M, of which € 295.3 M[68] represented personnel and operational expenditures for existing structures, € 12.25 M[69] were to strengthen CSAPAs and CAARUDs, € 3.98 M[70] were to implement the health and reintegration measures provided for 2010 in the 2008-2011 government "drugs" plan and, finally, € 5.25 M were for health-justice actions financed by the MILDT until 2009. The health-justice objectives agreement programme was created in 1993[71], initially on an experimental basis in 15 French *départements* considered to be priorities for urban policy and the Paris *département*, to reinforce health and social treatment measures for drug addicts in the justice system. The health-justice credits were expanded in 1999 to include all of France and new working methods were defined[72] (for example, the educational and social-health orientation of minors or expansion to include people who have committed alcohol-related offences). The supervision of the programme and funding were provided by the MILDT until 2009.

[67] Since the adoption of the 2004 French public health law, the social security funding law must now include a new budget to fund specific medico-social addictology establishments (ONDAM).
[68] Transverse policy document (DPT) for 2011
[69] Circulaire interministérielle DGCS/5C/DSS/DGS n° 2010-330 du 23 septembre 2010 relative à la campagne budgétaire pour l'année 2010 des établissements et services médico-sociaux accueillant des personnes confrontées à des difficultés spécifiques, appartement de coordination thérapeutique (ACT), lits halte soins santé (LHSS), centre d'accueil et d'accompagnement à la réduction des risques pour les usagers de drogues (CAARUD), communautés thérapeutiques (CT), centres de soins, d'accompagnement et de prévention en addictologie (CSAPA) et lits d'accueil médicalisé (LAM) (NOR :MTSA1023248C)
[70] In compliance with the circulars of February 23, 2009 and December 14, 2009, which provide for financing of a therapeutic community (€ 1 M) and a short-term stay unit for released prisoners (€ 0.3 M) respectively. In addition, there is funding for two other therapeutic communities for a total of € 1.26 M, provided for in the circular of October 24, 2006. The total foreseen funding was € 2.43 (see the circular of September 23, 2010). Finally, complementary measures were reported in 2010 (Circulaire interministérielle DGCS/5C/DSS/DGS n°2010/429 du 13 décembre 2010 relative à la campagne budgétaire pour l'année 2010 des établissements et services médico-sociaux accueillant des personnes confrontées à des difficultés spécifiques, Appartement de coordination thérapeutique (ACT), Lits halte soins santé (LHSS), Centre d'accueil et d'accompagnement à la réduction des risques pour les usagers de drogues (CAARUD), Communautés thérapeutiques (CT), Centres de soins, d'accompagnement et de prévention en addictologie (CSAPA) et Lits d'accueil médicalisé (LAM) (NOR : SCSA1032111C).
[71] Circulaire interministérielle du 14 janvier 1993 relative à la mise en œuvre de conventions d'objectifs de lutte contre la toxicomanie. (NOR : INTK 9300009C)
[72] Note d'orientation NM/CT/99-01/123 du 12 février 1999 pour la mise en œuvre des conventions départementales d'objectifs.

Table 1-1: Budget allocated to addiction treatment and care services for 2010 (Assurance maladie funding law)

Type of expenditure	Funding (in Euros) ONDAM[73] for addiction structures
Expenditure of existing CSAPA and CAARUD on staff and regular functioning	295 300 000 €
Funds to reinforce existing structures[74]	12 250 000 €
Budget allocated to new measures for the health and social part of the "drugs" plan	3 976 287 €
Funds to implement new measures corresponding to the takeover of funding for health-justice actions	5 249 006 €
Total for financing addictology structures	316 775 293 €

The amounts for funding by the National Health Insurance Fund authorised for 2010 and intended for the public health measures of the "government plan" are detailed in the following table. It presents the approved projects and the list of addictology structures implementing them as well as the planned budgets. The regional health agencies must ensure that, on a territorial level, the allocated funds are indeed used and that the structures are able to implement their projects.

Table 1-2: Detail for projects funded to promote the public health measures of the 2008-2012 plan

In EUROS	2010 tenders (circular of July 2, 2010). - Notification (circulars of December 13, 2010 and January 17, 2011)		
Type of measure	Region	Project spearheaded by	Budget
Creation of CSAPA housing spaces for women with children	Aquitaine	Association Suerte	150 000
	Ile-de-France	Association Aurore	149 850
Creation of CSAPA housing spaces for crack users	Midi-Pyrénées	Csapa Le Peyry	160 000
Advanced addiction consultation in Lodging and Social Readaptation Centres (CHRS)	Franche Comté	Csapa Soléa	69 600
	Lorraine	Csapa Centr'aide St Mihiel	70 000
CSAPA mother-child unit with community housing	Aquitaine	Hôpital Avicenne-Csapa Boucebci	169 000
	Ile de France	Perrens HC	169 000
Special centre for women in outpatient CSAPAs and CAARUDs	Basse Normandie	Anpaa 14	6 000
	Centre	CAET Bourges	6 000
	Guyane	Saint Laurent	6 000
	Haute-Normandie	Elbeuf	6 000
	Ile de France	APS Contact	6 000
	Ile de France	Csapa Litoral	6 000
	Languedoc-Roussillon	APSA 30-Caarud Logos	6 000
	Limousin	Csapa Bobillot	6 000
	Lorraine	Caardu Avsea	6 000
	Lorraine	Caarud Echange	6 000

[73] Objectif national de dépenses de l'Assurance maladie (ONDAM, National objective for health insurance expenditure).
[74] Including € 0.7 M for the 2010 "hepatitis" plan: € 500 000 so that the CSAPAs can offer free hepatitis B screening to patients they treat and € 200,000 so that CAARUDs can incite drug users they treat to get screened (hepatitis B and C) within the scope of agreements between the CAARUDs and the free, anonymous screening centres (CDAG).

	Midi-Pyrénées	Anpaa 31	6 000
	Nord Pas de Calais	Caarud Oxygène	6 000
	Pays de la Loire	Caarud AIDES and Csapa La Métairie and Csapa Anpaa 85	6 000
	Rhône-Alpes	Caardu Pause du Diabolo	6 000
	Rhône-Alpes	Csapa GISME	6 000
Advanced consultations in residential reintegration schemes (AHIs)	Lorraine	CMSEA-Csapa les Wads	9 000
	Picardie	Le Mail	9 000
Partnership between CSAPA, CAARUD and AHI structures	Alsace	Csapa ALT	9 000
	Aquitaine	Csapa La Source	9 000
	Bourgogne	Anpaa 71	9 000
	Haute-Normandie	Caarud Adissa	6 000
	Lorraine	Caardu La Croisée	6 000
	Picardie	Caarud SATO	6 000
Cocaine use consultations within CSAPAs	Aquitaine	Ceid	20 500
	Aquitaine	Bizia	20 500
	Ile-de-France	Espace Murger	20 500
	PACA	Bus	20 500
	Rhône-Alpes	LYADE	20 500
Clinics for young users (CJC) within CSAPAs	Centre	CAEF Bourges	16 140
	Centre	APLEAT	16 530
	Haute-Normandie	ADISSA Vernon	16 700
	Haute-Normandie	ADISSA Andels	16 700
	Haute-Normandie	Centre hospitalier de Gisors	11 000
	Ile-de-France	ASCPLT Rivage	16 700
	Languedoc-Roussillon	APSA	16 700
	Midi-Pyrénées	Anpaa 82	16 220
	Nord Pas de Calais	Parachute	16 700
	Picardie	Centre horizon	16 700
	Picardie	Anpaa 60 - CJC Nord Ouest Oise	16 700
	Picardie	Anpaa 60 - CJC Est Oise	16 700
	Poitou-Charentes	Centre hospitalier de Jonzac	16 700
	Rhône-Alpes	Anpaa 74	16 700
Creation of quick access housing places for people released from prison	Ile-de-France	Csst Saint Germain Pierre Nicole	300 000
Therapeutic communities	Ile-de-France		592 520
	Nord Pas de Calais		663 927
	Rhône-Alpes		1 000 000
New measures of the 2008-2012 plan for the 2010 campaign to fund specific addictology structures (ONDAM)			3 976 287

Hospitals

Of the National Health Insurance Fund for health establishments, Hospitals receive for 2010 € 39.72 M[75] to apply the public health measures of the 2007-2011 "addictions" plan. These funds are broken down as follows:

- € 15.7 M to create or reinforce level 2 and 3 structures[76] ;
- € 10.16 M for the creation or reinforcement of hospital addiction consultations
- € 9.24 M to fund complex treatments in hospitals
- € 4.62 M to create or strengthen addictology care and liaison teams

Furthermore, within the scope of untargeted public health actions, the French Health Insurance Fund finances measures to promote care for detainees. In 2010, € 7.41 M in funds were earmarked to finance the creation of new UCSAs in new prison establishments. In addition, € 10.52 M were deployed in 2010 to create or strengthen specially-equipped hospital units (UHSAs). Finally, specific funding was allocated to equip secure rooms[77] in certain public establishments in order to ensure emergency hospitalisation or hospitalisation lasting under 48 hours for detainees.

Reimbursements of Opiate Substitution Treatments

The social security system also reimburses drugs required for opiate substitution treatment, which forms a significant proportion of the Assurance maladie's expenditure for addictions. The most recent reimbursement data is from 2008: € 79.967 M, of which € 66.446 M were dedicated to reimbursing buprenorphine-based medications and € 13.521 M for methadone. Despite the clear predominance of high dose buprenorphine (HDB) in OST prescriptions (the French health authorities made this strategic choice when OST was introduced in France), the proportion of methadone reimbursement continues to rise, from 8% in 2003 to 17% in 2008. In 2008, the rate of change since the previous year reflected a general decline in OST reimbursements of approximately 8% (all medications combined).

1.4.2. Budget

In 2010, the proceeds of the sales of assets confiscated within the scope of legal narcotics proceedings reached € 21,07 M[78]. This amount comes from a "Narcotics" support fund created in March 1995[79] at the initiative of the 1993 interministerial committee against drugs and drug addiction. Since its creation, the courts handling cases of drug seizures and confiscations have

[75] Circulaire n° DGOS/R1/DSS/2010/177 du 31 mai 2010 relative à la campagne tarifaire 2010 des établissements de santé (NOR : SASH1014428C).
[76] Level 2 public health establishments correspond to outpatient and night clinics; level 3 corresponds to hospitals highly specialised in medicine, surgery, obstetrics and psychiatry that have an appropriate technical platform.
[77] Circulaire interministérielle DAP/DHOS/DGPN/DGGN du 13 mars 2006 relative à l'aménagement ou à la création de chambres sécurisées (NOR : JUSKO640033C).
[78] Appendix of the PLF (Projet de loi de finances, or draft budget) for 2010: Summary report on support funds and allocation of proceeds.
[79] Décret n° 95-322 du 17 mars 1995 autorisant le rattachement par voie de fonds de concours du produit de cession des biens confisqués dans le cadre de la lutte contre les produits stupéfiants (BUDB9560005D) et. Arrêté du 23 août 1995 fixant les modalités de rattachement par voie de fonds de concours du produit de cession des biens confisqués dans le cadre de la lutte contre les produits stupéfiants (SANG9502738A).

encountered practical difficulties. In order to improve the functioning of the “Narcotics” support fund, the application decree of the law of July 9, 2010[80] entrusted the centralised management of seized sums to a public establishment to which the courts must refer. This establishment is the Agency for Managing and Recovering Seized and Confiscated Assets (AGRASC) which was placed under the supervision of the Ministry of Justice and the Ministry of the Budget. Among the AGRASC's missions is the responsibility to monitor contributions to the "Narcotics" support fund. The circular[81] of February 2011 stipulates that courts must send the Agency a certified copy of the definitive confiscation decision as well as the copy of the inventory of amounts taken over by the State. When cases fall within the scope of application of the decree of March 17, 1995, the AGRASC is responsible for contributing to the support fund managed by the MILDT. The management of the allocation of the proceeds of the “Narcotics” fund remains under the responsibility of the MILDT: 90% of the amount is redistributed to the ministries in charge of combating trafficking and applying the law to fund the acquisition of equipment or services intended for the fight against drugs. The remaining 10% can be used to fund preventive activities carried out by the relevant ministries.

1.4.3. Social costs

At the initiative of the French Monitoring Centre for Drugs and Drug Addiction, the social cost of legal and illegal drugs has been regularly published for around ten years. The first study {Kopp et al. 1998} dates back to the 1990s and examined the possible calculation methods. The initial estimates were presented in the Kopp and Fenoglio report {Kopp et al. 2000} on the social cost of drugs. This initial work estimated the annual costs to society to be € 2,035.24 M. Regular estimates have been carried out since then. There are two reasons for the need to continually re-estimate these figures: the appearance of new data that were initially unavailable (e.g., treatments for certain diseases) and the need to consider new calculation methods suggested after public debate on previous results. Subsequently, Kopp and Fenoglio[82] {Kopp et al. 2004} assessed the social cost of illegal drugs to be € 2,333.54 M in 2004. A new estimate in 2005 gave a social cost of € 2,824.44 M {Kopp et al. 2006}[83].

[80] Loi n° 2010-768 du 9 juillet 2010 visant à faciliter la saisie et la confiscation en matière pénale (NOR: JUSX0912931L).
[81] Circulaire du 3 février 2011 relative à la présentation de l’Agence de gestion et de recouvrement des avoirs saisis et confisqués (AGRASC) et de ses missions (NOR : JUSD1103707C).
[82] http://www.ofdt.fr/BDD/publications/docs/epfxpkk6.pdf
[83] http://www.ofdt.fr/ ofdtdev/live/publi/rapports/rap06/epfxkm5.pdf

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

2.1. Introduction

One of the missions of the French Monitoring Centre for Drugs and Drug Addiction (OFDT) is to propose a precise vision of drug use phenomena and monitor the evolution of drug use on a national scale. Since 1997, it has contributed to the implementation of quantitative surveys on drug use from samples and/or sub-samples representative of the French population aged from 12 to 75. Repeated regularly, they also enable changes in substance use behaviour to be monitored. It is therefore a question of:

- quantifying the levels of use of the different products;
- describing the diversity of this use;
- measuring links with other factors;
- observing changes and trends;
- performing regional and departmental mapping;
- measuring representations, perceptions and opinions about psychotropic substances.

Surveys of the general population enable information to be obtained particularly about simple use and the most used drugs. They enable use in the socially integrated population to be quantified. They are not suitable for identifying harmful use and dependency on illicit drugs (with the exception of cannabis, which is widely used) or the emergence of new drugs.

Finally, they also enable measurements to be enhanced by distinguishing between different types of use (recent use, regular use, daily use, etc.).

The use of various other additional observational tools such as the OFDT's monitoring systems TREND (see appendix IV-U) and SINTES (See appendix IV-R) or the carrying out of specific qualitative or quantitative studies is necessary to reach the most vulnerable users, to observe more precisely recreational and party-scene users and to improve the understanding of phenomena through qualitative insight.

The survey system

There are five regular surveys at the heart of the survey system used in the general population, conducted on adults or adolescents, via two data gathering methods: a telephone interview of a randomly selected individual and a self-administrated paper questionnaire. The first method concerns the population aged 15 and over. Two surveys resort to this method: the Survey on Representations, Opinions, and Perceptions Regarding Psychoactive Drugs (ERROP) among 15- to 64-year-olds and the survey on illicit drug use integrated into the Health Barometer (see Annex VI-A). The latter has been carried out by the French National Institute for Prevention and Health Education (INPES) since 1992. It asks 15- to 75-year-olds (15- to 85-year-olds in 2010) about their behaviour and attitudes towards health.

These surveys are flawed when it comes to describing all the heterogeneous practices of sub-populations. Hence the development of surveys among adolescents, the age of first time use of psychoactive substances and sometimes the entry into more regular use. The OFDT carries out three surveys among this population by using the most suitable collection method, a self-administrated paper questionnaire. The European School Survey on Alcohol and Other Drugs (ESPAD, see appendix IV-L) enables the drug and alcohol use of 16-year-old youngsters still at school to be observed. To overcome the limitations of this school survey (lack of school dropouts, underestimation of absenteeism, etc.), the OFDT has implemented a survey of 17-year-olds carried out during the National Defence and Citizenship Day (JDC, formerly National Defence and Preparation Day, JAPD). All conscripts present on certain given days complete a questionnaire about their health and licit or illicit drugs use. Finally, the Health Behaviour in School-aged Children (HBSC, see Appendix IV-E), conducted in 41 countries or regions, questions 11-, 13- and 15-year-old youngsters still at school.

These three surveys of the adolescent population enable the distribution of uses throughout young people, between 11 and 17 years, to be observed, particularly the regular use of cannabis. However, it is at the end of adolescence (17 years) that the observation of behaviour enables better distinction between individuals who actively use licit or illicit drugs from those who do not.

Framework data

A hierarchy of products by the number of users is possible with the surveys of the general population (Table 2.1). These figures give an order of magnitude. They are framework data and not exact estimations.

Among illicit drugs, cannabis remains the predominant substance by far, with an estimated 13.2 million lifetime users (who used it at least once during their life). Close to one million people regularly use it in France. The use of cocaine, the second most used illicit substance, is well below this and affects around ten times fewer people, including those who have used these substances at least once in their life or at least once in the previous year.

Table 2-1: Estimation of the number of psychoactive substance users in mainland France among 11- to 75-year-olds in 2010

	Illicit products				Licit products	
	Cannabis	Cocaine	Ecstasy	Heroin	Alcohol	Tobacco
Lifetime users	13.4 M	1.5 M	1.1 M	500,000	44.4 M	35.5 M
Of which users in the previous year	3.8 M	400,000	150,000	//	41.3 M	15.8 M
Of which regular users	1.2 M	//	//	//	8.8 M	13.4 M
Of which daily users	550,000	//	//	//	5.0 M	13.4 M

Sources: Health Barometer 2010 (INPES), ESCAPAD 2008 (OFDT), ESPAD 2007 (OFDT), HBSC 2006 (medical department of the Toulouse Rectorat)
//: not available
Definitions:
Lifetime use: use of the substance at least once during their life (this indicator mainly serves to measure the distribution of a product in the population)
Use in the previous year or current use: consumption at least once during the previous year; for tobacco, this includes people who report that they smoke if only from time to time.
Regular use: at least three consumptions of alcohol per week, daily tobacco, and consumption of cannabis at least 10 times per month or at least 120 times during the previous year.
NB: the number of individuals aged from 11 to 75 in 2009 (date of updating the census) is around 49 million.
These figures are orders of magnitude and should be considered as such. Indeed, a margin of error exists, although this remains reasonable. For example, 13.4 million lifetime users of cannabis means that the number of lifetime users is probably between 13 and 14 million.

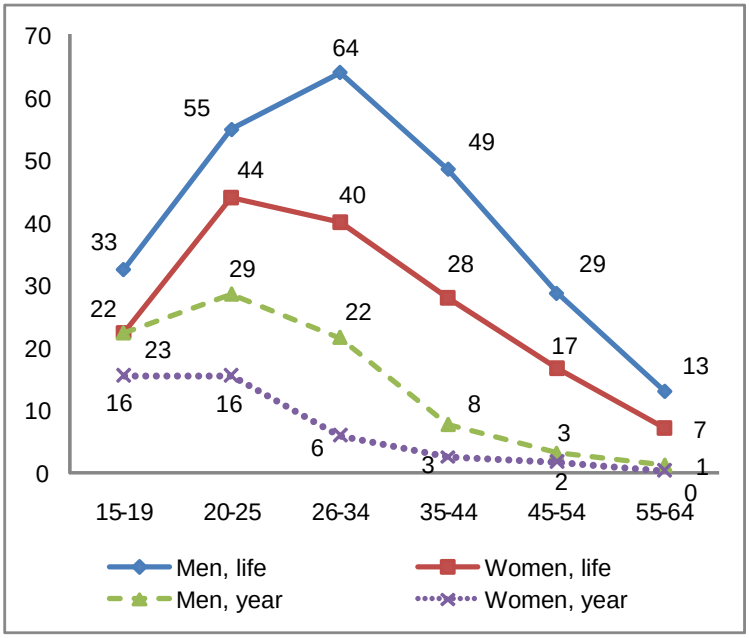
2.2. Drug use in the general population (based on probabilistic sample)

Mechanical increase in the lifetime use and stabilisation of other levels of cannabis use among 15- to 64-year-olds (see standard table 1)

Cannabis is by far the most consumed illicit product in France. In 2010, among adults aged from 15 to 64, around a third (32%) stated having used cannabis at least once during their lifetime. This lifetime use affects more men than women (40% compared with 25%). Current use (in the past 12 months) affects 8% of 15- to 64-year-olds (12% of men and 5% of women), although the proportion of users during the month reaches 5% overall.

Although lifetime use went up from 29% to 32% for all age groups between 2005 and 2010 (Table 2-2), cannabis use remains stable. Indeed, other forms of use also being stable, the slight increase observed is mechanical, linked to a “stock” effect of former generations of smokers. This stability hides some generational disparities: current use (particularly regular use) is increasing for women aged 20 to 25 (from 39% in 2005 to 44% in 2010), although the level of lifetime use is declining for girls aged 15 to 19 and for men aged 15 to 25. The proportion of lifetime users of cannabis is at a maximum in men aged 26 to 34 (64%) and then decreases to 13% for those aged between 55 and 64. In women, the number of people who have used cannabis at least once during their life represents around 37% of 15- to 34-year-olds and only 7% of 55- to 64-year-olds. Current use of cannabis particularly affects the youngest (21% of 15- to 25-year-olds). It then decreases with age. It is almost zero for 55- to 64-year-olds (Figure 2-1).

Graph 2-1: Proportion of people using cannabis at least once in their life and at least once in the previous year, according to gender and age



Source: Health Barometer 2010, INPES, OFDT interpretation

Significant increase in lifetime use of cocaine for both sexes

Since the beginning of the 1990s, the availability of stimulants, cocaine or other synthetic drugs (ecstasy, amphetamines, etc.), has increased in France. The emergence and the related spread of the freebase form of cocaine[84] and crack (whose use is nevertheless rare) occurred during the same decade.

With 1.5 million people who have used it at least once during their life aged from 11 to 75 (i.e. 3% of the general population) and 400,000 users over the course of the year (0.8% of the general population), cocaine ranks second among the most consumed illicit products, way behind cannabis and licit psychoactive substances. In 2010, 3.6% of 15- to 64-year-olds questioned by the Health Barometer had used it at least once in their lives and 0.9% had used it over the course of the previous year (Table 2-2). The increase in its diffusion is nevertheless very marked. It reflects the accessibility of a substance that was once limited to the well-off. For some years, increasingly wide circles of society have experimented with it or used it. Current use (during the year), like lifetime use, affects around three times more men than women.

The proportion of people who have used cocaine at least once during their life is highest among 26- to 34-year-olds (8% of the general population, 11% of men, 4% of women). This proportion decreases in previous generations. Among 15- to 64-year-olds, encountering it occurs, on average, at 22.5 years old.

Use during the year primarily affects 15- to 25-year-olds (1.9% of the general population, 2.8% of men, 1.1% of women) then decreases and becomes practically nil as of age 55.

[84] Smokable form of cocaine obtained after the addition of bicarbonate or ammonia to cocaine hydrochloride (powder).

The proportion of 15- to 64-year-olds who have used cocaine at least once during their life increased three-fold in 15 years, from 1.2% in 1995 to 3.6% in 2010. It increased by a third between the last two Barometer surveys. Use in the previous year almost doubled between 2005 and 2010 among 15- to 64-year-olds, from 0.5% in 2005 to 0.9% in 2010 (Table 2.2).

Table 2-2: level of use by product among 15- to 64-year-olds (%)

	Lifetime use	Current use
Cannabis	32,1	8,4
Poppers	5,2	0,9
cocaine	3,6	0,9
mushrooms	3,1	0,2
Ecstasy/MDMA	2,5	0,3
Glues and solvents	1,9	0,4
LSD	1,7	0,2
Amphetamines	1,7	0,2
Heroin	1,2	0,2

Source: Health Barometer 2010, INPES, processed by the OFDT

Table 2-3: Trends of lifetime use and current use of products among 15- to 64-year-olds between 2005 and 2010 (%)

	Expérimentation			Usage actuel		
	2005	2010	2005 vs 2010	2005	2010	2005 vs 2010
Cannabis	28,8	32,1	↗	8,3	11,8	↗
Poppers	3,8	5,2	↗	0,6	0,9	↗
Cocaïne	2,4	3,6	↗	0,5	0,9	↗
Champignons hallucinogènes	2,6	3,1	↗	0,3	0,2	→
Ecstasy/MDMA	2,0	2,5	→	0,5	0,3	↘
Colles et solvants	1,7	1,9	→	0,1	0,4	↗
LSD	1,5	1,7	→	0,1	0,2	→
Amphétamines	1,3	1,7	↗	0,1	0,2	↗
Héroïne	0,8	1,2	↗	0,1	0,2	↗

Source: Health Barometer 2010, INPES, processed by the OFDT

Increase in the lifetime use of all products except ecstasy/MDMA, glues and solvents and amphetamine.

The use of other drugs remains marginal over the entire population aged from 15 to 64. Nevertheless, certain substances have experienced an increasing diffusion since 2005.

This is the case for heroin, for which the levels of lifetime use and current use are increasing. The prevalence of heroin lifetime use went from 0.8% in 2005 to 1.2% in 2010 among 15- to 64-year-olds. It is higher in men (1.8% in 2010 vs. 1.3% in 2005).

This upward trend confirms the qualitative observations of the TREND system. From 2004 to 2009 it showed an increase in the availability of heroin on the local markets, then an increase in heroin use. Besides increased heroin use in the very vulnerable populations of drug users, what is particularly evident from the 2010 Health Barometer data is the extension of use to socially

integrated (even “very well integrated”) populations and among relatively young people, although this phenomenon remains quantitatively very small. This increase could be due to the spread of the use of heroin to regulate the effects of stimulants consumed in a festive context (“dance events”), but also due to its image, which is increasingly less repulsive for some young people familiar with psychoactive substances. Mainly sniffed (or smoked) by new socially integrated users, heroin has freed itself from the three factors that linked it with decline and death: overdoses, AIDS and addiction, all three wrongly attributed to the sole practice of injecting. Moreover, these young users see the availability of opioid substitution treatment (OST) as a safety net.

Lifetime use of hallucinogenic mushrooms has witnessed a slight increase for both sexes, but current use remains stable.

The levels of lifetime use of amphetamines have only slightly increased over both periods, going from 1.3% to 1.7%. The current use of ecstasy (in the form of tablets and in its powder form) has decreased, although it continues to spread in the population. The low quality of ecstasy tablets, of which the average MDMA purity decreases year after year (see Chapter 10), makes it a substance mainly consumed by the youngest party-scene users. Users are shifting to powder (or capsule) and crystal forms of MDMA, but particularly towards amphetamine, cocaine or other synthetic stimulants.

Poppers

In the 2010 Health Barometer, poppers (which come in the form of small bottles to inhale and which have a special status among illicit drugs) are the psychoactive substances most commonly used after alcohol, tobacco and cannabis: 5.2% of 15-to 64-year-olds reported that they have used them at least once during their life. This figure was 3.9% in 2005. Much more common among men (7% vs. 4% of women), lifetime use of poppers is highest among 15- to 25-year-olds (9% against 5.5% in 2005). Increasing since 2005, the proportion of current users has gone from 0.6% to 0.9% in 2010, with the most marked increase among 18- to 25-year-old men.

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

The HBSC, ESPAD and ESCAPAD (See appendix IV-K) surveys show similar results: cannabis appears to be the most illicit substance used among adolescents and, particularly, among boys. 28% of 15-year-olds stated having already used it at least once during their lifetime (2006) and 42% of 17-year-olds. Use in the month affects 1 in 4 young people aged 17 and 15% of 15-year-olds.

With the exception of cannabis, lifetime use of illegal or misused drugs remains rare. Among 15-year-olds, the most common substances are solvents and products to inhale (5% of people who have used it at least once during their life). These are followed by cocaine and crack (3%), amphetamines and “medicines for getting high”, all around 2% and, finally, heroin and LSD, which do not exceed the 1% mark.

More 17-year-olds have used at least once during their life illicit products and other products: poppers (13.7%), inhalants (5.5%), hallucinogenic mushrooms (3.5%) and cocaine (3.3%). Reported lifetime use is low for GHB (0.4% of 17-year-olds), crack and heroin (1.1%) and amphetamines (2.2%). Thus, there seems to be a renewed interest for stimulants in some

marginal groups of the adolescent population, even if the fashion for ecstasy seems to have passed away.

For all of these products, the sex ratio is close to 1 and the difference between the sexes is insignificant for 15-year-olds, with the exception of “medicines for getting high” for which there is a larger proportion of girls. The insignificant nature of the variations is chiefly due to the low numbers of people who have used these substances at least once during their life concerned at this age. This is confirmed with the results from the 17-year-olds. Indeed, the difference between the sexes is significant among 17-year-olds, regardless of the substance, with sex ratios greater than 2 for LSD, hallucinogenic mushrooms, Subutex® and Kétamine.

The ESCAPAD survey (Table 2-5) shows, for the first time in eight years, an increase in the average age of cannabis lifetime use. It is likely that we are seeing a change in lifetime use behaviour. Some worrying aspects remain: between 2005 and 2008, the increase in the diffusion of cocaine (from 2.5% to 3.3%), amphetamines (from 2.2% to 2.7%), crack, heroin (from 0.7% to 1%) and GHB (from 0.3% to 0.4%), although this behaviour remains marginal.

Table 2-4: Lifetime use of illicit or misused drugs at 15 years old (%)

	Boys (%)	Girls (%)	Sex ratio	All
Inhalants	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	0.3***	2
Ecstasy	1	1	1.6 ns	1
Heroin	1	1	1.3 ns	1
LSD	1	1	0.8 ns	1

Source: HBSC 2006, processed by the OFDT.

Table 2-5: 2005-2008 Changes in levels of psychoactive drug use by gender at 17 years old (% and sex ratio)

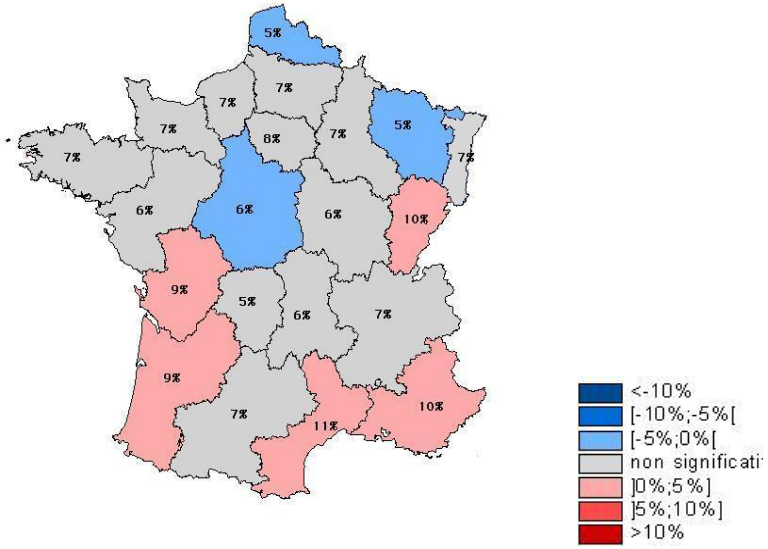
	Boys 2008	Girls 2008	Sex ratio	All 2008	All 2005	Evolution in % (05/08)	Evolution absolute (05/08)
Cannabis/Lifetime use	46.3	37.9	1.2***	42.2	49.4	-15%	-7.2
Cannabis/month	29.5	19.8	1.5***	24.7	27.9	-12%	-3.2
Cannabis/regular (≥ 10 times per month)	10.7	3.9	2.7***	7.3	10.8	-32%	-3.4
Experimentation with							
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 and 0.001.
1: Relative change computed with exact figures.
2: Changes computed with exact figures.
Source: ESCAPAD 2008 OFDT

Regional distribution of regular cannabis use

The prevalence of regular cannabis use was similar to or less than in the rest of the country in the very great majority of regions in 2008, producing a relatively consistent regional map, since variations in regional averages are low. Only five regions (Aquitaine, Poitou-Charentes, Languedoc-Roussillon, PACA and Franche-Comté) stand out with a higher proportion of 17-year-old adolescents reporting that they smoked cannabis, compared with the rest of the country. None of these regions particularly stands out: differences between levels in the region and the rest of the country are all between 0 and 5%. The distribution, however, shows a difference between north (concentration of low-use regions) and south (concentration of high-use regions).

Map 2-1: Regular use (>= 10 times in the previous 30 days) of cannabis in 17-year-olds



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

"Electro" party scene ("dance events"): cocaine - a common denominator

Use in the so-called "socially integrated" population cannot be limited to those frequenting the party scene, whether it be "alternative" events (free parties, raves, teknivals or alternative areas within more general festivals) or commercial settings (clubs, discos, music bars). It should however be noted that, in the intermediate classes of society at least, regular use of cocaine is often associated with the frequenting, at one time or another, of the party scene.

In 2005, lifetime use of cocaine powder affected 81.1% of those attending alternative events[85] and close to half (48.4%) of those seen in commercial festive or "party" establishments playing "electro" music. First time use took place on average at 20.2 years old (study known as "*quanti-festif 2005*").

A new multisite study known as "*quanti-festif*" is underway in five French towns: Marseille, Lille, Metz, Bordeaux and Toulouse. In contrast to the first study, focussing on the "electro" party scene, its scope has extended to the whole of the party scene frequented by young people (18- to 35-year-olds). Indeed, significant diffusion of techno music over the last decade has caused a dilution of the margins of the previously clearly identified "techno" scene (raves, free parties, teknivals) into the general party scene, hence a spread of some of the techno culture markers, particularly familiarisation of some young people with the recreational use of psychoactive substances. The "original" techno scene remains perceptible within the "alternative techno" sub-scene. The results of this study will be available at the end of 2012.

[85] The study identified four affinity groups in this scene comprising individuals perceiving themselves and perceived by others as culturally similar: the alternative, urban party, clubbing and select groups. For the purposes of this article, the "clubbing" and "select" groups were joined together in a "commercial party scene" category. The distinction between the "clubbing" and "select" categories particularly lies in social class, the access routes to the group (co-optation in the "select" category") and in the fact that the "select" group has a lower level of polydrug use since its use is generally limited to alcohol, cannabis and cocaine.
Besides those fully integrated on a professional basis, the alternative scene attracts a significant proportion of people who, although they have a home and a network of family and friends, have a more unstable occupational status ("odd jobs", fixed-term contracts, temping, etc.) and a fringe of marginalised users.

3. Prevention

3.1. Introduction

Main points and references

The drug use prevention policy in France is based on early intervention aimed at youngsters in order to delay the age at which they might begin their drug use. In 1999, the prevention policy also covered the use of legal psychoactive substances (such as alcohol, tobacco and psychotropic medicines), and included measures for curtailing not only "simple" use but also drug abuse. These principles are introduced and disseminated through the "Parquet" report {Parquet 1997}, which constitutes the main theoretical reference for prevention in France. In schools, the general framework for intervention is that of preventing addictive behaviours, which more generally falls within the province of health education.

Historically, governmental plans for fighting against drug use have set mid-term objectives for drug use prevention policy. However, other national policies or regulations have more sporadically contributed to defining policy, such as the "2007-2011 Addictions Treatment and Prevention Plan").

The principles and strategies of these various documents are evidenced in a more practical way in the *Guide de prevention des conduites addictives en milieu scolaire ("Guide on preventing addictive behaviours in schools)*, issued since 2005 by the French Department of National Education and the MILDT, and updated in 2010 {Desco Mildt 2006} {DGESCO-MILDT 2010}. The *Institut national de prévention et d'éducation pour la santé* (INPES or the French National Institute for Prevention and Health Education) also summarised the evidence-based methods of prevention in its *Référentiel de bonnes pratiques*. *Comportements à risque et santé: agir en milieu scolaire* (Good practice guidelines for addressing health and risky behaviours in the school setting) {Bantuelle et al. 2008}. These documents appear to be the only national references for prevention. They discuss the evidence-based approaches, but are still for information purposes only. No specific protocol on drug use prevention is required from civil servants or specialised associations in France.

The concepts of universal prevention, selective prevention or indicated prevention are not yet in widespread use, even though they are increasingly present in professional and institutional circles. Reference to "primary prevention" persists even though comprehension of the notion has had to evolve since actions among young people also began focusing on preventing abuse (essentially because of the consideration of legal drugs in the general issue of addictions). The messages tend to be based more on the type of use being targeted (for example: "simple" use, abuse, binge drinking) or on the institutional status of target publics (students, workers, or people referred by the justice system).

The general context and key players

The prevention of drug use is a logical extension of the services available under common law and guaranteed by the State or delegated to NGOs, based on the logic of proximity. Drug use prevention is mainly universal prevention. The actions directed to young people are most often organised within the scope of secondary education where the school community is widely involved, both for coordination and execution purposes. Three major categories of key players address the youth: actors from specialised associations that focus on prevention or health

education, specialised *gendarme* (FRAD)[86] or police force (PFAD)[87] agents, and school educational, health and social personnel.

In secondary education, each Principal, as chairperson of the *Comité d'éducation à la santé et à la citoyenneté* (CESC, or Health and Citizenship Education Committee), defines the prevention activities to be carried out each year among pupils. The CESCs bring together the school community and qualified external partners so as to define and coordinate drug use prevention policy in secondary schools. Head masters receive recommendations from their local administrative authorities which, in turn, are based on ministerial guidelines. However, the establishments enjoy a high level of independence in this area. Since 2006, prevention of addictive behaviours has gained a new foothold in the basic missions of the French education system through the new "*socle commun de connaissances et de compétences*" ("common base of knowledge and skills"), i.e. the set of knowledge, skills, values and attitudes that all students must master by the end of mandatory schooling as future citizens[88]. The subsets focused on "social and civic skills" and the development of "independence and initiative" (i.e. skill subsets 6 and 7 respectively) illustrate the academic contribution of the French education system to the development of the individual and social aptitudes traditionally associated with lifeskills, and which may be used by students when they are offered drugs. Agricultural secondary and higher education establishments are also relatively free to define their commitment to prevention, but are largely encouraged by the Department of Agriculture and Fishing to invest in such efforts. Since 2001, professionals of agricultural education have enjoyed access to the *Réseau d'éducation à la santé, l'écoute et le développement de l'adolescent* (*RESEDA* or the Health Education, Counselling and Adolescent Development Network), which encourages dialogue, training and contributes to the dissemination of prevention tools and also tenders in the field of health education.

Actions among students (of higher education) are organised by the *services (inter)universitaires de médecine préventive et de promotion de la santé* (S[I]UMPPS, or [inter]university preventive medicine and health promotion services). Several associations or complementary student health insurance companies also participate in this area.

In the workplace, the prevention of alcohol, drug or psychotropic medication use is governed by the French Labour Code, which makes employers and employees responsible for safety. Prevention is supervised by the occupational health departments. For companies with more than 50 employees, it also falls under the *Comités d'hygiène, de sécurité et des conditions de travail* (CHSCTs or Committees on Hygiene, Safety and Working conditions), which are employee representative bodies. Today, other than occupational medicine screening procedures, such prevention is underdeveloped. Nevertheless, specialists of the law enforcement services and associations can also be called upon to become involved in prevention action in the workplace.

Prevention targeting "at risk" populations (referred to as "selective prevention") or users ("indicated prevention") is handled mainly by specialised associations, particularly in neighbourhoods (outside of the school environment) or in legal establishments. This is the case for "*consultations jeunes consommateurs*" (CJC or "clinics for young users") and drug awareness-building training sessions.

[86] FRAD: Formateurs relais anti-drogue (Drug prevention educators).
[87] PFAD: Policier formateur anti-drogue (Drug prevention police liaisons).
[88] Décret 2006-830 du 11 juillet 2006 concernant le socle commun de connaissances et de compétences et amendant le code de l'Education français, NOR: MENE0601554D

The current state of monitoring and observation practices

Since 2006, the OFDT has been working on a national observation system for universal or selective prevention practices related to the use of both licit or illicit drugs in France. This system, entitled "*Recueil d'indicateurs pour l'observation nationale des actions de prévention liées aux drogues licites et illicites*" ("RELIONPREDIL"or "Collection of indicators for the national monitoring of licit and illicit drug use prevention actions", see appendix IV-W), seeks to document and track the evolution of the key characteristics of local prevention actions carried out in this field. It is overseen by a steering committee of ministerial and associative stakeholders in the field. What makes this initiative unique, among other things, is its coverage of numerous sectors (such as the teaching, occupational, legal, and community sectors) and its independence *vis-à-vis* the granting processes. The system has had three phases of local experimentation, the last of which took place in 2011. The adjustments were methodological in nature or related to changes in the resources employed. The complexity of the field of prevention (e.g., unstable principles of intervention and concepts, numerous stakeholders) and the difficulty in eliciting responses (e.g., the lassitude of the targeted professionals in providing information, the lack of time or resources for acquiring feedback) suggest that the survey has not yet reached maturity. The RELIONPREDIL survey remains unique nevertheless. Its more widespread application is being examined, and would not take place but progressively given the difficult conditions of implementation.

Consequently, the description of preventive actions conducted in France is not available at this time.

Despite the absence of national data on preventive practices, certain trends are apparent. Thanks to the efforts made since 1999 to professionalise and harmonise the range of preventive activities, several principles appear to be prevalent today: for example the inability of a purely informative approach alone to bring about a change in drug-related behaviour, the relevance of the preventive role played by parents, an interactive approach or the development of psychosocial skills. Nevertheless, although they are widely known, these interventional principles remain difficult to apply for many actors.

The legislative framework

The French *loi de santé publique* (Public Health act) of 2004, which was incorporated into the French Education Code, sets a minimum target of one annual information session per uniform age group to provide information on "the consequences of drug use on health, and particularly the neuropsychological and behavioural effects of cannabis, in secondary schools (...)"[89].

However, generally speaking, legislation tends to be based more on restricting access to substances or offering legal responses to the problem of illegal use, such as drug awareness-building training sessions implemented since 2008 to increase awareness of the dangers of narcotics, intended for users arrested[90]. Legislation concerning the public use of, advertisement for or conditions of accessibility to alcohol or tobacco has been established for a long time[91].

[89] Loi de programmation de la politique de santé publique (French Public Health Policy Programming Act) 2004-806 of 9 August 2004, NOR: SANX0300055L

[90] Loi n° 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 n° 2007-1388 du 26 septembre 2007 pris pour l'application de la loi n° 2007-297.et circulaire CRIM 08-11/G409.05.2008 du 9 mai 2008 relative à la lutte contre la toxicomanie et les dépendances (NOR JUS D0811637 C.

[91] Citons par exemple : 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,

Since November 2006, the ban on smoking has been generalised to apply to all public places, including the workplace and drinking establishments[92].

National and local coordination and financing

The policies for the prevention of licit or illicit drug use are established by government plans and coordinated by the MILDT. They can reflect or be completed by ministerial programmes or national plans on related themes (e.g., cancer, hepatitis) covered by National Education or Health policies.

The adaptation of national strategies to the local level is entrusted to local (sub-regional) programmes to fight against drugs and addictions. It is supervised by "drug and addiction" project managers (appointed within prefectures) who are local MILDT representatives in regions and *départements* (sub-regional administrative territories). More generally, it is based on the decentralised services of the State. These so-called project managers manage and distribute credits devoted to addiction prevention and professional training.

Since 2007, sales of assets seized during efforts to crack down on illegal drug trafficking have been turned over to the MILDT-managed "Narcotics" support fund. Of the money in this fund, 90% is allocated to the fight against drug trafficking and 10% (or 2.2 million Euros today) is allocated to prevention efforts. The French national health insurance also subsidises prevention activities through tenders issued by the FNPEIS[93]. Various territorial programmes (concerning health, the fight against social exclusion, public safety and/or urban policy) also make it possible to redistribute public credits for drug use prevention. Furthermore, the identification of priority areas for education and town and country planning (based on socio-economic, housing quality and educational indicators) makes it possible to concentrate additional resources on underprivileged populations.

Measures designed to support decision-makers and professionals

The *Institut national de prévention et d'éducation pour la santé* (INPES, the French national institute for prevention and health education) has the task of assessing and developing preventive measures and implementing national programmes (particularly media campaigns).

The *Commission de validation des outils de prévention* (Committee for the approval of prevention tools, coordinated via the MILDT) issues its opinion on the quality and relevance of the tools submitted to it.

In order to be fully represented in public debates and to encourage professional dialogue, the specialised associations are assembled into federated organisations[94]. These organisations

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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).

[92] 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

[93] *Fonds national de prévention, d'éducation et d'information sanitaire* (French National fund for prevention, education and health information)

94 FNES: *Fédération nationale des comités d'éducation pour la santé* (French national federation of health education committees, www.fnes.info); ANPAA: *Association nationale de prévention en alcoologie et addictologie* (French national association for the prevention of alcohol abuse and addiction, founded in 1872, www.anpaa.asso.fr); *Fédération Addiction*, which is the merger of Anitea (*Association nationale des intervenants en toxicomanie et addictologie*/the French national association of drug addiction professionals) F3A (*Fédération des acteurs de l'alcoologie et de l'addictologie*/the French Federation of alcohol and drug addiction professionals) (www.anitea.fr); FFA: *Fédération française d'addictologie* (French federation of addictology, www.addictologie.org); CRIPS: Regional AIDS information and prevention centres (www.lecrips.net/reseau.htm).

implement training, conference cycles, think tanks and document networks on drug demand reduction.

Finally, in certain regions, the “drug and drug addiction” project managers can draw upon the assistance of a technical support structure focused on the observation and local assessment of use and the public responses, in addition to project methodology consulting.

National and local media campaigns

The media campaigns on illegal drugs run by the public authorities seek to inform and/or warn the public of the dangers of using such substances.

For approximately 10 years now, the MILDT has been initiating these campaigns, most often with the French National Institute for Prevention and Health Education (INPES) and the relevant ministries (e.g., Health and Justice).

These media activities are carried out at varying intervals and frequencies. Similarly, the nature of the drug prevention messages, the substances mentioned (depending on whether a global or another approach has been adopted) and the publics targeted as a priority (young people, parents, the whole population and also, occasionally, professionals) vary according to the guidelines of the governmental drug plan.

The media used to deploy these activities are just as diverse and can include: the press, outdoor displays, radio, and television, as well as (and increasingly so) the Internet. Finally, the budget allocated to such activities can vary from campaign to campaign.

These campaigns are most often subject to pre-tests, and can also be subject to post-tests: the purpose of these tests is to assess the impact of the campaigns in respect to audience, message retention and approval, allowing for a number of comparisons to be made.

3.2. Universal prevention

The current governmental drug plan sets down the principle of preventive intervention in all everyday environments of the French population, and particularly in those where the younger members of the population are often found. For the latter population, this is demonstrated by the high expectations directed to the secondary education and higher education systems due mainly to the acute issue of massive alcohol use among students. The aim of such a global response also implies specific efforts directed towards families and referent adults, who should be encouraged and supported in taking action to prevent drug use among young people. The school environment, the family milieu and the workplace are all major areas targeted by governmental drug prevention policy for the 2008-2011 period.

3.2.1. School

Universal prevention of licit or illicit drug use is the main approach developed in the French school environment. It is directed primarily towards secondary students although, since the publication of the school intervention guide in 2005 (under the auspices of the French Department of National Education and the MILDT), the last year of primary school (“*CM2*”, which

is the equivalent of "5th grade" or "Year 6") should be the first scope of a prevention process that continues until the end of secondary school.

The updated guide was finally issued in December 2010 {DGESCO-MILDT 2010}.

In April 2010, the website of the *Instituts universitaires de formation des maîtres* (IUFM or University Institutes for Teacher Training) network for training in health education and the prevention of addictive behaviours was officially inaugurated (http://plates-formes.iufm.fr/education-sante-prevention/spip.php?article39). Among other things, it offers symposium proceedings and tools intended for trainers in health education. In October 2010, the collaboration between this IUFM network and the INPES, which was initiated during the prior government plan for the fight against drugs, finally resulted in the publication of the *Profédus* health education teaching tool (http://www.inpes.sante.fr/index2.asp?page=professionnels-education/outils-profedus.asp), which:

- provides support for instructors to train the future teachers (in initial, master's level training or in continuing education) to develop health education projects in primary or secondary schools;

- facilitates the application of this kind of training by working teachers.

The *Profédus* training pack includes a DVD, a manual, photo training and technical specifications on examples of activities or project engineering. It was designed through the collective efforts of teacher trainers and health education professionals (190 in total, who worked for five years).

The student population (in higher education) is expressly mentioned by the 2008-2011 government plan as a priority target public. In 2000 and 2005, alcohol, tobacco and cannabis use were indeed revealed to be high in students aged 18 to 25, but overall, they were lower than what was observed in the rest of the population in this age group (i.e., working or unemployed 18-to-25-year-olds) {Legleye et al. 2008}. However, the trend is reversed when we focus on alcohol or cannabis use by women, which is higher in students than in other women in the same age group.

Table 3-1: The use of psychoactive substances in students, actively-working individuals and unemployed individuals aged 18 to 25 (%)

	Men and Women combined				Women			
	Students	Actively employed	Unemployed	p	Students	Actively employed	Unemployed	P
Daily tobacco use	24.0	43.5	50.7	***	23.6	37.9	44.0	***
Regular alcohol use	7.0	13.1	7.5	***	3.1	3.0	3.2	Ns
≥ 3 drunken episodes (in the last 12 months)	17.9	16.7	13.8	Ns	11.5	5.5	5.7	***
Binge drinking (a) in the last 30 days	20.9	26.3	23.8	**	12.3	10.0	11.4	Ns
Regular cannabis use	8.5	9.2	11.8	Ns	6.1	4.3	4.4	Ns

Interpretation: *, **, ***: Chi2 test significance level of 0.05, 0.01, 0.001
(a): *binge drinking* of fewer than 6 glasses on a given occasion
Source: INPES Health Barometer 2005, OFDT interpretation

Daily tobacco use and regular alcohol use among students dropped from 2000 to 2005 (men and women combined). However, the regular use of cannabis has risen slightly: in fact, it more than doubled among female students, increasing from 2.5% to 6.5% between 2000 and 2005, but remained stable among male students. According to the available data, the student environment is not the one where the greatest need is observed; however, the health and social protection systems addressing students certainly make it more conducive to organising preventive actions than workplaces or other services dealing with unemployed people. Subsequently, in 2010, three tools dedicated to the student environment were highlighted by the MILDT on the governmental www.drogues.gouv.fr site: The Addict'prev website, the "*Guide d'organisation de soirées étudiantes*" ("Guide to organising student parties") and the www.montetasoiree.com site are all the result of local initiatives that can be easily reproduced on a larger scale. The Addict'prev website (http://www.univ-bpclermont.fr/article798.html), designed by the SIUMPPS (Interuniversity preventive medicine and health promotion services) of the Clermont-Ferrand universities (in the Auvergne region of France), was inaugurated in 2010 with the support of the MILDT. Based on the principle of brief intervention and a motivational approach, it not only distributes general information on addictive behaviours, preventive measures and help services, but it also offers resources for self-assessing alcohol, tobacco and cannabis use. People demonstrating harmful use practices are referred to the university healthcare system. The "*Guide d'organisation de soirées étudiantes*" drafted by the *Union nationale des mutuelles étudiantes régionales* (USEM, or the French national union of regional student supplemental health insurance companies) and the www.montetasoiree.com site designed by the *Avenir santé* association with the support of the Paris Prefecture, received the approval of the "*Commission nationale de validation des outils de prevention"* (Commitee for the approval of prevention tools) in May 2010 and November 2010 respectively. They provide the student event organisers with useful advice for helping these gatherings take place safely for participants and comply with current legislation on alcohol use or public events. The www.montetasoiree.com site also indicates where to find appropriate methodological, human, material and financial resources.

3.2.2. Family

The family circle is crucial in encouraging adult referents to take an active role in prevention.

With this objective in mind, the role of the *Réseaux d'écoute d'appui et d'accompagnement des parents (REAPPs* or Parental counselling and support networks) was reaffirmed. However, the activity statistics for these community services do not clearly indicate which interventions are related to problems of drug use or addiction. After a marked decrease in 2009 of the budgets allocated by the *Directions départementales des affaires sanitaires et sociales* (DDASS or French *Département* Directorates of Health and Social Affairs) {ASDO 2009}, 10 million euros in additional credits were granted to the REAAPs in 2010. Upstream, the purpose of the "*points info famille*" family information sites (of which there are approximately 500) is to inform families of the parental assistance and support services available and to guide them towards the most appropriate measures for their needs.

The MILDT brought the debate on parenting and prevention to the public stage. The parenting conferences organised in May 2010 enabled various areas of expertise (such as paediatric psychiatry, education, law, the legal protection of minors, and childhood protection) to come together to argue about parental authority, the legitimacy of parental intervention and parenting support. The discussions helped to direct the governmental campaign to increase the awareness of parents and other adult referents, which took place from 13 December 2010 to 3 January 2011 (see 3.5). In the spring of 2010, an opinion poll revealed that 21% of parents with a child under 26 years of age had never mentioned the dangers of illegal drug use to their children, and 22% had never reminded their children of the illegal nature of this use.

In May 2010, the French Ministry of Health announced the creation of a website dedicated to parenting and a telephone helpline for parents in difficulty. The project for a website for providing support, exchanging ideas and rapidly identifying resources may be inspired by the German "Quit the shit" experience, borrowing the concept of regular monitoring by a team of professional helpline counsellors[95]. This measure is currently being developed.

3.2.3. Community

In the French context, prevention work in the community refers to everything that is done outside of the school or university environment. Community-based universal prevention is defined with reference to two areas: the workplace and the realm of leisure, culture and sports.

The workplace is the main area to reach adult populations, but it is an environment in which it is difficult to organise collective prevention actions. Although 20% of absenteeism cases could be related to alcohol, psychotropic or narcotic use, the barriers to preventive measures are as much psycho-sociological (e.g., taboo, denial, overlap between the public and private) as they are financial or legal. Following interregional preparatory forums in July and November 2009, the MILDT organised conferences on "Illegal drugs and occupational risks" on 25 June 2010. The aims were to adopt targeted measures and bring appropriate consensus changes to the French Labour Code. These events encouraged both discussions on the current law, regulation and responsibilities sharing out - particularly in the area of prevention – and the coordination needed between the specialists in relevant areas. They also involved promoting the collective drafting of proposals that would be acceptable by all those involved. They reflect the willingness of public authorities to place value on the current ideas surrounding these issues in order to incorporate them into the public debate and provide visibility and recognition for an issue that has been

[95] "Quit the shit" is a support programme for stopping cannabis use that was launched in 2004 through a website dedicated to young users wishing to reduce or stop their cannabis consumption. The focal point of the programme is an interactive journal in which users regularly discuss their progress and hurdles. A team of counsellors supports each participant in reaching their personal goal by maintaining contact and providing regular advice (at least once a week) during the 50-day monitoring period.

evaded in the workplace until now. Nevertheless, the *Plan de santé au travail 2010-2014* (2010-2014 Occupational Health plan) drafted by the French Ministry of Labour, Solidarity and the State service does not discuss psychoactive substance use in the workplace or its consequences. The 2008-2011 government plan mentions specific objectives for developing the prevention of drug use in recreational sports and cultural activities (in addition to the prevention of doping). The OFDT has not noted any special measures in this area for 2010

3.3. Selective prevention in at-risk groups and settings

3.3.1. At-risk groups

The selective prevention of drug use is closely tied to the prevention of drug trafficking and recidivism.

The government plan provides for multidisciplinary teams to perform global prevention actions against risk behaviour in the penal population, particularly minors (point 1-11). For populations in neighbourhoods identified by urban policy, the government wants to model strategies in order to improve the coordination of decision-makers and other stakeholders and to combat the underlying causes of delinquency related to drug use and trafficking (point 1-12).

On 2 and 3 December 2010, the *Direction de la protection judiciaire de la jeunesse* (DPJJ, or the Directorate for the Youth Protection Service) and the MILDT opened expert hearings on the theme of "the impact of narcotics on the modes of socialisation among minors". Nearly 80 professionals and experts (psychiatrists, addiction specialists, educators, magistrates, police officers and sociologists) took part to exchange their knowledge on education good practices for preventing and fighting against drug trafficking and the black market. The announcement of a specific framework for this subject concluded these two days of hearings.

3.3.2. At-risk families

The interministerial activities to combat drugs do not directly target families deemed "at-risk" because of drug use or addiction. Public actions with regard to these families are the shared responsibility of the French administrative *départements* and the legal authorities. This largely decentralised policy (under the *département*) is coordinated by the *directeur général de l'action sociale* (General Director for Social Action) and relies on community assistance systems. We note, however, that the law of 5 March 2007 reforming child welfare[96] aims, amongst other things, at improving prevention in children at risk for abuse or negligence, particularly when related to drug use or addiction problems.

3.3.3. Recreational settings (including drug and alcohol related harm reduction)

The recreational environment groups together the alternative festive scene and the commercial festive scenes (bars and clubs). Since the so-called "*Mariani et Vaillant*" decree of 2002[97], the institutional approach to prevention in the festive or recreational setting has not seen any

[96] Loi n°2007-293 du 5 mars 2007 réformant la protection de l'enfance, NOR: SANX0600056L.
[97] Décret no 2002-887 du 3 mai 2002 pris pour l'application de l'article 23-1 de la loi no 95-73 du 21 janvier 1995 et relatif à certains rassemblements festifs à caractère musical, NOR : INTD0200114D.

particular changes apart from the July 2009 law[98]. This law introduces the legal ban on offering or selling alcoholic beverages to minors (under the age of 18) in public places (article 93) and the legal ban on selling on an inclusive basis or providing on an unlimited basis alcoholic beverages (open bars) (article 94).

Since 2002, however, specialists have noted the split of the festive scene into smaller, but more numerous and more clandestine events, thereby complicating the efforts of harm reduction workers. These workers have endeavoured to increase their activity at the different sites and keep informed of the events, which are increasingly advertised through social networks (e.g., Facebook). Finally, with increasing intravenous use amongst participants, syringe distribution now forms a regular part of these events..

3.4. Indicated prevention

Indicated prevention measures are largely tied into the legal system as it applies to drug users.

Drug awareness-building training sessions are offered, as an alternative to prosecution, as a "*composition pénale*[99]" or as an additional sentence, to people aged 13 and over arrested for use. This system is described in more detail in chapter 9.1.1.

The *consultations jeunes consommateurs* (CJC or clinics for young users) are clinics for young users and their parents that provide information and counselling as well as therapies for young users. Their classification in the indicated prevention field or in the treatment one is not clear-cut among professionals. The CJC are described in more detail in chapter 9.4.1.

3.5. National and local media campaigns

The third communication measure of the 2008-2011 government plan to fight against drugs and drug addiction took place in late 2010. Entitled *Contre les drogues, chacun peut agir* (Everyone can take action against drugs) it was launched jointly by the French Ministry of Health, the MILDT and the INPES. After the "*Drogues ne fermons pas les yeux*" ("Drugs, keep your eyes open") campaign of October 2009, and then the "*La drogue si c'est illégal ce n'est pas par hasard*" ("Drugs: if it's forbidden, it's not by accident") campaign of November 2009, the objective of this final chapter of the triptych was to highlight the role of parents, family and close friends in preventing drug use among adolescents. It involves encouraging the family and friends to question their role in prevention and informing them of the actions to be taken. Three different, complementary television spots were broadcast from 13 December 2010 to 3 January 2011.

The first staged a scene with a mother requesting help for her cannabis-using daughter. The second presented a teenager taking cocaine without any reaction from his family or friends. Finally, the third spot showed a young man refusing to take ecstasy by following the recommendations of someone close. These three TV spots referred viewers to the *Drogues info service* national telephone helpline; the spots were supported by concurrent press ads (TV, women's press and daily news) featuring the same protagonists. Finally, an updated version of the brochure entitled "*Cannabis, les risques expliqués aux parents*" ("Cannabis, explaining the

[98] Loi n° 2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires, NOR: SASX0822640L.

[99] A procedure allowing the Public Prosecutor to offer one or more measures to a person admitting to having committed an infraction or offence punishable by a period of imprisonment of five years or less.

risks to parents"), which was created for the 2005 "*Le cannabis est une réalité*" ("Cannabis is a reality") campaign, was distributed in structures intended for young people or for the professionals likely to be in contact with them.

Although the campaign was not assessed by a traditional post-test, an analysis can be established by examining the calls to *Drogues info service* just before and during the campaign. The immediate impact of the campaign on the target was irrefutable, since the number of calls to and handled by *Drogues info service* increased by more than 250% over the week after the campaign; furthermore, the number of calls from the relatives was much higher than the number from users, while the opposite is true in general. The family and friend callers were mainly mothers seeking advice because they did not know how to react to certain behaviours of their children. The substance most often mentioned was cannabis. Overall, this campaign reached its main target with calls regarding cannabis use from parents, grandparents, and young people under the age of 20.

Another campaign, this time targeting young people, was conducted by the MILDT in 2010. Not unlike the 2009 campaign's message on illegality, a musical talent contest called "*Talents vs drogues*" was launched on 4 October 2010 in partnership with Warner Music France®[100] and NRJ®[101]. This competition entailed creating music, a video and an album cover that the candidates could upload to a dedicated site on the Web. The winners of the three categories were chosen from among candidates preselected by site visitors, the MILDT and the sponsors. The three winners then worked on a project together, leading to the release of a single in early 2011.

The dedicated site received 135 000 visits; 586 creations were submitted and 50 000 votes were cast.

[100] A music producer.
[101] A radio station for youth

4. Problem drug use

4.1. Introduction

France has estimates of the number of problem drug users, (regular users of opioids, cocaine or amphetamines, whose use habits have led to them encountering major problems regarding both their health and their social situation) since the mid-1990s. The latest estimate was drawn up recently by the OFDT. This concerns data from 2006 and follows on from the estimates previously established in 1995 and 1999. This work also offers an estimate of the number of regular heroin users and intravenous drug users.

This estimate has been made based on three of the methods recommended by the EMCDDA and applicable to the French situation: a multivariate method based on indirect indicators covering problem drug users and local prevalence estimates drawn up in application of the capture/recapture technique; a multiplicative method based on treatment data; and a multiplicative method based on police data.

It is believed that there were somewhere between 210,000 and 250,000 problem drug users in France in 2006, i.e. a prevalence level of between 5.4 and 6.4 per 1000 inhabitants aged 15 to 64 years old, placing France in the average for the European Union. Half of these drug users are involved in a medical substitution treatment for opioids. Indeed, it is also estimated that approximately 120,000 people used opioid substitution drugs during the first half of 2007. When examining the various surveys to establish the proportion of heroin users and applying this to the number of problem users, the number of active heroin users (i.e. those who took the drug during the last month) is estimated at almost 75,000. The same approach when applied to intravenous drug users gives a figure of 81,000 people taking intravenous drugs during the month gone by and 145,000 over the course of their lifetime.

Increasing from 160,000 in 1993 to 230,000 in 2006, the raw data could lead us to believe that we are seeing a major increase in this phenomenon. However, this impression is deceptive for at least two reasons. The first is that the methods and, above all, the purpose of the estimates have changed. We have moved away from the notion of "heroin addicts" (1993) to that of "problem users of opioids" (1995) and subsequently to the definition of "problem users of opioids or cocaine" (1999) and finally to that of "users of drugs by intravenous means or regular users of opioids, cocaine or amphetamines" (2006). Thus, the subject of these estimates has widened over time. The second reason is the scope of the confidence intervals applicable to the central estimates. Just like the confidence intervals obtained with the application of the capture/recapture method (which is central to all of the methods used), we have noted in the estimates calculated for 2005-2006 that the national estimates ranged from 144,000 to 367,000. For these reasons, it is difficult to issue a clear opinion on the apparent increase in estimates. We should simply underline the fact that an increase in the number of problem drug users would appear to be possible. Indeed, other information sources point firstly to "an ageing of this population group" which is less often subject to high mortality levels following the increase in the availability of substitution treatments in the late 1990s, and secondly a certain "renewal" of this population group, due to the circulation of stimulants, the appearance of new opioid users and changes on the festive scene.

Secondly, multicentre studies into local estimates of the prevalence of problem drug use (the NEMO study) have been carried out periodically by the OFDT. The most recent was carried out in 2005/2006 and involved six French towns and cities. These relatively convergent estimates

indicate that problem drug use in these cities concerned between 6 and 15 people per 1000 inhabitants aged 15 to 64 years old.

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 et al. 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

	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

	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 2010 {Beck et al. 2006}.

Table 4-3: Estimates of cocaine and heroin life time and last year users, 2010

	Life time users	Last year users
Cocaine	1 500 000	400 000
Heroin	500 000	

Sources: Baromètre santé 2010 (INPES), ESCAPAD 2008, OFDT; ESPAD 2007, OFDT ; HBSC 2006, service médical du rectorat de Toulouse.

In view of these findings, we could have expected the estimates of the number of drug users in the general population (not only the problem drug users) to be significantly higher than those provided by the three methods used for problem drug users. Social disintegration often seen among problem drug users partly explains this gap because 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 et al. 2004b};{Costes et al. 2004};{Escots et al. 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-Taïrou et al. 2004a} (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 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, P. Y. 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 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 users[102] 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.

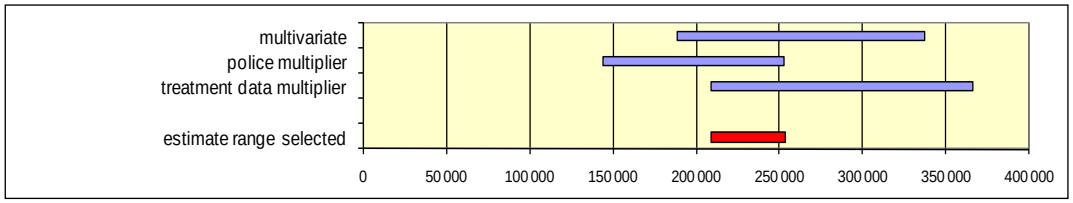
Results summary

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

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

and 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 2009}.

Table 4-4: 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

Towards a new estimate

The OFDT's midterm activity programme includes the performance of a national estimate. A new multicentre study of the "capture/recapture" type will be launched in late 2010, involving six French cities: Lille, Lyon, Marseille, Metz, Rennes and Toulouse. The EMCDDA protocol is scheduled to be implemented following the results from this study. A new national estimate (covering all PDUs, injectors and opioid users) should therefore be available in early 2012.

4.2.2. Estimates of incidence of problem drug use

No publications are currently available in France concerning the incidence of problem drug use. This question will be dealt with as part of the previously mentioned study programme concerning prevalence. The study programme scheduled by the OFDT for 2010-2012 and designed to produce a new national PDU prevalence estimate will explore the possibility of applying the EMCDDA guidelines to the incidence estimates.

4.3. Data on PDUs from non treatment sources

4.3.1. PDUs in data sources other than treatment demand indicators (TDI)

CAARUD's clients {Cadet-Taïrou et al. 2010b}

From a quantitative viewpoint, the data used in order to describe those users most heavily involved in drug use is that obtained from the surveys carried out in the Harm reduction support centres for drug users (CAARUDs). Although a certain percentage of the clients of these centres are also enrolled on treatment programmes, these users tend to be more focused on managing their drug addiction than on receiving healthcare. The CAARUDs also welcome users who, on the whole, tend to be more inclined to use several types of drugs and who lead more precarious lifestyles than those seen by the various treatment systems. However, this data is insufficient when it comes to describing all non-recreational drug users. By its very nature, this system (being based on quantitative information) tends to overlook those drug users who do not visit the CAARUDs.

We should also note that this data probably under-represents the youngest users, itinerant users seeking an alternative lifestyle or otherwise, or *travellers* from the festive scene accompanied by dogs who tend to use such centres on a more occasional basis than other users. For their part, the best integrated drug users are even less likely to use the CAARUDs facilities.

The general precariousness of drug users

According to the 2008 ENa-CAARUD (see appendix IV-F) study, the drug users visiting harm reduction centres in urban settings are on average quite "old" (at 34.1 years of age). Half of them (48.8%) are at least 35 years old while the under 25s accounted for 18.2% of the entire sample {Cadet-Taïrou et al. 2010b}.

This is a predominantly male population group (78.3%). The percentage accounted for by women tends to be higher among the youngest users. Consequently, although only 14.4% of the men were aged under 25, this was the case with 31.8% of the women. They account for 38.0% of the under 25s.

More than half the people encountered live alone (55.6%) and 18.9% live as part of a couple, with the others living with friends, parents or alone with their children. Women are less likely to live alone than the men and are more likely to live as part of a couple or alone with their children (1.2% *vs* 9.9%). Among these, 68% have no children while 20% have a child {Cadet-Tairou et al. 2010}.

In 2008, drug users visiting the harm reduction facilities in urban environments displayed a high degree of social vulnerability {Cadet-Tairou et al. 2010}.

- Among these, half (49.3%) are experiencing unstable housing conditions, with 60% of them being homeless or living in a squat while the others have some form of temporary housing[103].

- Almost a quarter has a salary or receives unemployment benefits (21.8%). More than half (51.7%) receive a social income benefit: the RMI (basic guaranteed income, 35.2%) or a disabled adult's allowance (13.9%). Finally, a further quarter have no legal income at all (and instead live off begging, illegal resources or prostitution) while just 1.1% are helped by their family or third parties. Furthermore, the PRELUD 2006 study (see appendix IV-G) shows that the income structure differs greatly according to the age-group concerned. Indeed, we should note that more than half of the under 25s had no legal income {Cadet-Taîrou et al. 2008}.

- Overall, only 4.6% of clients of low threshold facilities have no social cover whatsoever[104], while 2.9% receive the AME (State Medical Aid Allowance). Half of the drug users visiting the CAARUD's (50.2%) are covered by the health insurance system thanks to the CMU scheme (Universal Health Cover).

- In terms of education, only 23.4% of them had reached baccalaureate level (A-level/High School Diploma) with or without sitting the exam. The majority (63.6%) possess a secondary education level vocational qualification (the CAP or BEP vocational training certificates) or did not progress beyond middle school.

- The vast majority are in possession of valid identity papers (whether French or foreign). However, 11% have no ID papers. Among these, half are living in France illegally, while the other half have lost their identity papers or had them stolen.

Furthermore, the CAARUD's facilities clients are frequently in contact with the law enforcement system. In 2008, 17.4% of them were incarcerated at least once during the year, a proportion identical to that recorded in 2006. This concerned one male in five (19.9%) while only 8.7% of females were incarcerated.

According to the information provided by the health and social organisations, the psychosocial and health treatment programmes are often hindered by these legal problems.

Heavy consumers of psychoactive substances

The products most frequently consumed by the 3,129 users interviewed in the low threshold services in 2008 continue to be cannabis and alcohol.

A third of the users interviewed had used heroin during the previous month although the most frequently consumed opioid continues to be HDB (high dosage buprenorphine). In 2006, among those users who stated that they had taken it during the previous month, only half stated that they had used it purely for therapeutic reasons[105] {Cadet-Taîrou et al. 2008}. In 2008, among the

[103] Available for a period of less than six months
[104] Neither health insurance nor state medical aid.
[105] The question concerned the purpose of the drug use concerned. The person could choose between the following options: 1/To get off heroin or to try and cure yourself (the so-called "therapeutic" objective), 2 /To "get stoned", including coming down off a stimulant or to control cravings, 3/ Both.

recent users of HDB, three quarters stated that they received it as a substitution treatment. HDB is also the product most regularly consumed by its users, three quarters of whom use it on a daily basis.

The use of cocaine in its hydrochloride (powder) form or in the form of freebase concerns almost half of all drug users seen by the CAARUDs (45.7%). Regarding the use of crack (cocaine purchased in its freebase form) the national data tends to mask a major variation between the Paris region and the rest of France, as its usage prevalence in these localities are respectively 43.4% and 4.9%.

The consumption of MDMA, amphetamines and hallucinogenic drugs among drug users visiting the frontline structures is chiefly accounted for by those users who also frequent the techno/party settings (with the exception of certain natural hallucinogenic products).

Table 4-5: Drug consumption prevalence during the last month among drug users visiting the CAARUDs, N=3132, 2008

	Recent users (used during previous month)	% of recent users who are daily users
Cannabis	71.6%	53.5%
Alcohol	62.7%	48.7%
HDB	40.3%	74.2%
Heroin	29.3%	20.0%
Methadone	26.3%	68.7%
Morphine sulphate	14.8%	38.6%
Cocaine powder/ freebase	36.3%	9.5%
Crack	16.6%	25.1%
Amphetamines	14.1%	3.4%
Ecstasy	10.6%	0.6%
Benzodiazepines	27.9%	56.9%
Hallucinogenic mushrooms, plants and herbs,	8.6%	3.9%
LSD	10.8%	3 .3%
Ketamine	7.4%	4.7%

Sources: ENa-CAARUD, 2008, OFDT/ DGS

Interviewed in 2008 on the subject of which drug posed the most problems for them, in first place the drug users mentioned an opioid (43.5%), with the main one being HDB (21.6%). Heroin was only mentioned by 12.6% of them.

Alcohol was mentioned by almost one user out of five (18.7%)

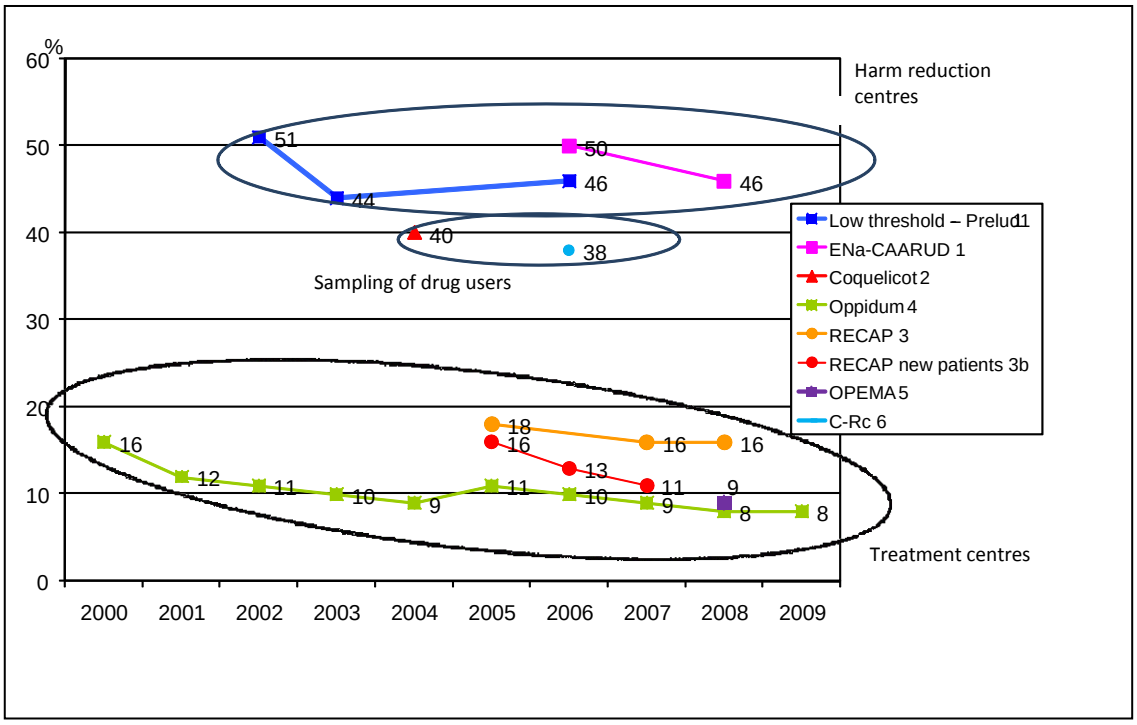
Among the stimulants (mentioned as most problematic by 16.1% of users interviewed) this chiefly concerned cocaine (7.7%) and crack (7.7%).

In 2008, among low CAARUD's clients, 64.4% had injected at least once during their lives. The average age of the first injection was 20.7 years old (the median being 20 years old) {Cadet-Tairou et al. 2010}. Among CAARUDs clients, the percentage of persons *who had never* injected seems to be increasing (from 27% to 32% in the Première ligne-PRELUD survey between 2003 and 2006 and from 31% to 36% in ENa-CAARUD 2006 to ENa-CAARUD 2008). This observation is perfectly coherent with the increasing proportion of users employing snorting as their preferred route of administration and to a lesser extent the number of people smoking drugs among new drug users, and particularly those among them with the least precarious lifestyles.

When we consider the subject of recent injection, the concordance of the available quantitative data suggests a reduction in the prevalence of this practice despite the fact that the situation appeared somewhat less clear around 2006 and that the qualitative data seems to point to a rather more complex situation.

Indeed, an increase in the practice of injection is reported (in the qualitative data) around the mid-2000s, although this practice appears to be concentrated, not only on certain sites but also among certain non-integrated population groups referred to as "*travellers*" (please see population description in urban settings).

Graph 4-2: The percentage of recent injectors in the various surveys carried out among drug users in the "urban environment" as defined by the TREND scheme.



1 Injection during the month, CAARUDs clients (or low threshold structures)
2 Injection during the month, a composite population comprised of individuals who have injected or sniffed at least once during their life and users of the CAARUD, CSAPAs, networked general practitioners,
3 Injection during the month, All patients, specialised treatment centres (CSAPAs, former CSSTs)
3b Injection during the month, New patients in specialised treatment centres (CSAPAs, former CSSTs)
4 Injection during the week, chiefly specialised treatment centres (CSAPAs, former CSST)
5 Injection during the week, general practitioners networks
6 Injection during the month, population of problem drug users recruited by method, C-rC (CAARUDs, CSAPAs, general practitioners, hospital services, police, justice system),
Source Première ligne / PRELUD TREND / OFDT, OPPIDUM and OPEMA CEIPs / AFSSAPS, Coquelicot InVS

The use of injection appears to be a majority practice in order to consume opioids, with the exception of methadone, cocaine (which is injected by more than half of CAARUD clients) but also ketamine and amphetamines.

Table 4-6: Routes of administration of drugs used during the last month preceding the interview by CAARUDs clients, 2008

	N	injection	Oral	Snorting	Smoking/Inhalation
Morphine sulphate	463	87.3%	9.6%	8.0%	0.5%
Heroin	921	63.6%	0.5%	42.0%	24.2%
Buprenorphine, Subutex	1264	56.4%	44.1%	18.4%	4.3%
Cocaine or Freebase	1138	53.3%	1.3%	42.1%	23.3%
Ketamine	231	39.4%	6.9%	66.1%	2.3%
Amphetamines (speed)	441	38.8%	28.1%	52.4%	3.3%
MDMA, ecstasy	333	13.9%	81.0%	22.0%	3.1%
Crack	521	8.3%	0.5%	1.8%	95.5%
Benzodiazepines	874	7.3%	93.5%	2.1%	1.3%
Methadone	740	2.5%	97.4%	0.6%	0.8%
Hallucinogenic herbs	269	2.0%	91.0%	1.6%	9.4%
LSD, acids	328	0.3%	98.0%	1.4%	1.0%
Cannabis	2247	0.2%	1.9%	0.3%	98.5%

Notes:
1/ Several routes of administration may be used by a consumer for the same drug. Consequently, the total percentages per drug may exceed 100%.
2/ Products listed according to the injection usage frequency

The TREND data: Key changes in 2008-2009 concerning uses and modalities of use {Cadet-Taïrou et al. 2010a}

Information on the main trends (particularly related to the market) can be found in chapter 10 (mainly drug trafficking via the Internet and emerging drugs).

The increasing diversity of drug users

The circulation of a number of substances outside the groups which initially consume such drugs should be understood from both a sociological but also a geographical perspective. Consequently, cocaine, which was already present in extremely diverse social circles, is continuing to spread, particularly to youngsters from working-class districts and inner city areas, who mainly consumed cannabis up until now. Heroin (although in altogether incomparable proportions) is also beginning to reach increasingly varied groups, and particularly young users, the festive/party scene and individuals who are socially well-integrated. For their part, other products (GHB/GBL, poppers, or even ketamine) are also moving out of the relatively restricted circles in which they once circulated. As prices stabilise, a number of elements are driving this phenomenon: the "generalisation" of polydrug use which tends to make experimentation with new products a commonplace occurrence, the presence (particularly in party/techno settings) of younger "experimenters" constantly seeking new experiences, and finally the growing availability of drugs through the rise in micro-trafficking and drug trading over the Internet, which now provides large swathes of the country with access to drugs.

Indeed, we are witnessing a clear extension of drug use to outlying urban/suburban districts and even rural areas. This is first and foremost the result of the geographical diffusion of drug use as a result of the factors mentioned above but also to the increasing mobility of drug users themselves. In addition to the relocation of squats (particularly due to evictions) which are driving the more precarious users to the nearby suburbs, we are also witnessing the migration of individuals living on social benefits or minimum wages, who are already drug users, and who are

today moving to rural areas, "driven out" of the towns by the high levels of rent and the housing shortages.

Furthermore, young, itinerant drug users (who may occasionally be minors and who find themselves without any support after having left the family home whether voluntarily or against their wishes) or who have left a social institution upon reaching adulthood, are now being mentioned and described as increasingly numerous and visible among CAARUD's clients. With some of them adopting behaviour patterns typical of the techno trend, these individuals are characterised among other things by high proportion of young women within the groups and their willingness to undertake risky behaviour (including prostitution and injection with frequent equipment sharing, etc.).

A revival in heroin use

The increased availability of heroin since 2006 has apparently been warmly welcomed by new drug users. Today less frequently associated with the negative images of degeneration and death which prevailed back in the 1980s, heroin now has a less repulsive image in the eyes of new consumers. This is due to the removal of three taboos (AIDS, overdoses and addiction) wrongly associated with the practice of injection alone by new heroin users who today begin their consumption of the drug by snorting it. The availability of Opioid substitution treatment is also perceived by them as providing an added safety net. Consequently, heroin is becoming the first choice drug for young consumers, believing that they can master their consumption of the drug with or without substitutes. In other cases, it can also be seen as a substitute enabling them to get off HDB or methadone which are viewed as being more restrictive. The most striking result of this "Heroin Renaissance" can be seen in the number of overdoses (see chapter 6).

Increased experimentation with freebase cocaine

The growth in the practice of freebasing cocaine is still underway among user groups well removed from the alternative techno underground scene to which it was largely confined in the early 2000s: drug users operating in the alternative party setting, some of them very young (18-20 years old) but also young people (aged 20-25) from comfortable backgrounds, socially well-integrated or from disadvantaged suburban areas. Users of crack cocaine (cocaine already freebased before being sold) tend to be clustered in the north-east of Paris where there are an estimated 6,000 to 8,000 of them.

The growing availability and use of Ketamine

This extremely controversial product (including among illegal drug users) which is notoriously difficult to handle (bringing on hallucinations, psychiatric disorders and comas, etc.) is chiefly circulated among a fringe group of the most precarious users in the alternative "party" setting and itinerant youngsters. Although in the past this was a product encountered by chance, at random, it is today actively desired and sought out by new users. Ketamine is in the process of becoming a "first experimentation" product for some users, although the substance crops up much later in the previous generation's "psychotropic career". Its use is becoming increasingly frequent. At the extreme end of the scale, observers in Toulouse have now reported that we have started seeing the first daily users of the drug.

We can currently distinguish three types of ketamine users:

- Moderate users: generally found among the older users, they take low doses of ketamine, often combined with other stimulants, for its exhilarating, mind-blowing and "cottony" effects (the user has the impression that he/she is walking on cotton) and the unusual feeling of intoxication, inducing jerky movements likened to "*Egyptian dancing*".

- Extreme users: have higher dosage levels (in relation to the "tolerance" of a given user). The effects the users are seeking (or those they encounter whether they seek them or not!) are hallucinations similar to those brought on by LSD, but also more radical and heightened dissociation effects[106] including out of body experiences (the sensation of being outside your own body) or "*putting out the fires*" to quote an expression used by a harm reduction professional (i.e., lying down and no longer being able to move without losing consciousness). Such practices are only used by a very small group of users, often people aged over 35 and experienced, seeking mystical experiences (such as "astral trip") or young people belonging to the more radical fringes of the festive/party setting and particularly young *wanderers* visiting the festive environment seeking an alternative lifestyle or drug, who are also found in the urban environment. It appears to be among these people that we find the most radical practices, and in particular injection to bring on effects which can be difficult to control.

- Drug users in the gay clubbing scene. In a festive context, usage is comparable to that of other drug users. In a sexual context, it brings on heightened tactile sensations but may also be used as a local anaesthetic during hard-core sexual practices.

Intramuscular injections

This is an extremely marginal phenomenon but one which is becoming increasingly visible on several TREND system sites. This practice concerns ketamine, the injection of which (a high risk activity) is reported to be increasing in Rennes, Marseille, Bordeaux and Paris, and Diazepam (Valium®) in Rennes. Although this type of injection is currently extremely rare in France, changes in its usage frequency must be carefully monitored due to the particularly high risk of infection related to the use of this route of administration (including the risk of tetanus and botulism among others).

The practice of freebasing cocaine in order to be able to smoke it continues to gain ground in various young population groups (the 18-25-year-olds). These include users visiting the techno events, relatively comfortably off users consuming the product at private parties or young consumers from disadvantaged environments in the suburbs. The use of crack, (a form of cocaine which is purchased directly freebased) by population groups with highly precarious lifestyles and often living in squats, continues to be a phenomenon encountered specifically in Paris and its inner suburbs, where this product has a significant presence.

[106] Dissociation is one of the aspects of a psychotic state and involves a breakdown of the conscious unit.

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

4.4.1. Description of forms of drug use falling outside the EMCDDA's PDU definition (in vulnerable groups)

Young people involved in the commercial party settings are encountering GHB and GBL

The spread of GHB/ GBL use and the comas accompanying such usage, ranging from the gay party circuit to groups of relatively inexperienced young ravers (aged 17-25) on the commercial party scene, resulted during 2009, in a series of comas, as was previously the case on the Paris gay festive scene from 2006 onwards. The consumption of this product, often combined with alcohol or stimulants, is carried out with the aim of getting drunk on the cheap, or simply of experiencing something new. The spread of this product has particularly concerned towns and cities possessing *gay friendly* festive establishments (i.e. establishments open to all, but visited by large numbers of people belonging to the gay community, who tend to be the trendsetters).

The localised misuse of methylphenidate

The misuse of Ritalin® (methylphenidate) has emerged since 2004 in Marseille and 2005 in Paris, among two separate population groups. In Marseille, where it has already been experimented with by most of CAARUDs' clients, this concerned users living highly precarious lifestyles and seeking a product to help stimulate action and communication. For economic reasons, Ritalin® is also believed to be used by drug users as a substitute for cocaine, when money is short. Among this population group, the product is chiefly injected. In Paris, the users are comprised of small groups of comfortably off and socially well-integrated young people (aged 20-25) who almost always take it orally, combined with alcohol or even with cocaine as a "party" stimulant.

Benzodiazepines and alcohol are still widely consumed

Alcohol is frequently reported by outreach workers as being one of the most problematic substances. In 2006, 34% of CAARUD clients stated that they consume more than 10 glasses of alcohol per drinking session.

Consumed by almost a third of CAARUD clients, either for therapeutic reasons or in order to get "stoned", these products have a particular status of their own in the drugs field. They constitute what could be referred to as a "non-subject". The use by the polydrug clients of these harm reduction facilities has become "commonplace", considered as normal, with prescriptions for BZD frequently accompanying those for buprenorphine.

4.4.2. Prevalence estimates of intensive, frequent, long-term and other problematic forms of use not included in PDU definition

In late 2008, the OFDT introduced an additional survey for teenagers aged 17 years old, the goal of which was to approve a test to identify the problem use of cannabis (the CAST) in comparison with other existing tests (the SDS and the MINI). The results of this survey have not yet been analysed. We will shortly be in a position to define the approved thresholds for the CAST and consequently to estimate the prevalence of problem cannabis use among the general population.

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

5.1. Introduction

Definitions

A system for recording demands for treatment conforming to the European TDI Protocol (Common Data Collection on Treatment and Drug Addiction or "RECAP") was introduced in France in 2005 in the various specialised centres dealing with drug users (see appendix IV-Q). Up until 2009, the centres were referred to as Specialised Drug Addiction Treatment Centres (CSSTs). Since 2010, the centres have been called Addictology Treatment Support and Prevention Centres (CSAPAs).

A patient is a drug user having been seen at least once in the year during a face-to-face interview. An incoming patient is a drug user seen for the first time by a centre which he has contacted (or who returns after a loss of contact of at least six months). An untreated patient is a drug user who has never been seen for his addiction problems by a drug treatment professional.

Data collection tools

RECAP makes it possible to obtain individual data collected on a continuous and theoretically exhaustive basis concerning all patients coming forward to seek aid from the CSAPAs. RECAP replaces the survey carried out on a regular basis between the late 1980s and the late 1990s involving drug users seen by the various types of establishments during the month of November. The move from this survey to the RECAP survey was made necessary by the need to adopt the European protocol for the recording of treatment demands, required for all countries of the European Union.

The aim of RECAP is to be able to track the number, the characteristics and the patterns of use of legal and illegal drug users seen in the CSAPAs at both a regional and national level. RECAP is based on the information systems already in place in the various specialised centres (reception sheets, computerised management of patient files, etc.) and a minimum core set of questions to be used by all staff operating in the drug addiction field.

Virtually all of the centres today manage their patient files using specialised software. A feature included within the software makes it possible to obtain the RECAP data for patients seen during the year in an anonymous file based on a predefined format. The data, which is sent to the OFDT by e-mail, is then verified and merged to render it exploitable.

Background

The treatment policy concerning users of illegal drugs can be characterised by several major distinctive periods in France. Before the 1970s, illegal drug users were treated in psychiatric hospitals.

The first major turning point dates back to the adoption of the French Drug Law of 1970. This law provided the possibility for any drug user to obtain anonymous, free treatment to wean themselves off drugs. It promoted the development of special outpatient centres or residential centres, with the latter welcoming drug users after withdrawal. On the one hand, the psychiatric institutions did not wish to specifically deal with ever-increasing numbers of drug users, while on

the other hand, the teams from the various associations proved to be ready and willing to get involved in treating these patients. Treatment was provided via both treatment systems (psychiatric institutions and non governmental organisations, NGOs), and over time, associations gradually gained in importance vis-à-vis the former.

The second major milestone in treatment policy was brought about by the rise of the AIDS epidemic. The French authorities did not adopt substitution and harm reduction measures until the early 1990s, which was late in comparison to other countries.

In France, it was decided to quickly make high-dose buprenorphine substitution treatment widely available. Subsequently, general practitioners played an increasingly important role in the treatment of opioid drug users. At the same time, the rapid spread of AIDS and the adoption of a harm reduction policy as a direct result of this, raised the question of the drug users' access to general hospitals rather than psychiatric establishments to deal with their somatic problems and/or their addictions. Following the example of the measures adopted for the treatment of alcoholism, liaison teams were established for drug users. The purpose of these teams was to promote treatment in somatic care departments. The aim was also to prevent drug users seen for physical health problems from leaving the hospital without an addiction diagnosis and treatment. This incorporation of addiction services into the hospital setting was achieved with the 2007 adoption of a plan issued by the French Ministry of Health. This plan will be detailed in the following section.

As in most developed countries, the policy for treating drug use in France is based both on specialised treatment and harm reduction centres, as well as on general physicians and hospitals. Above and beyond the effects of publicity and choice of communication tactics, these policies are based in practice on a relatively stable combination of the various sectors and resources available.

5.2. General description, availability and quality assurance

5.3. Strategy and Policy

The recent care policies issued by the French public authorities were defined in two plans adopted in 2006 and 2008. The first, the 2007-2011 Plan for the care and prevention of addictions, only focuses on care and prevention. It was drafted by the French Ministry of Health at the request of the French President. The second, the 2008-2011 government drugs and drug addictions plan, mentioned in the previous report, was produced by the president of MILDT, Étienne Appaire (see chapter 1). It, however, deals with *both* care and prevention. The repression section incorporates the strategies of the preceding plan while outlining new, specific objectives.

The 2007-2011 government plan for the treatment and prevention of addictions {Ministere de la Sante et des Solidarités 2006} re-affirms the need to implement a policy on all addictive behaviours: illegal drug, alcohol and tobacco use as well as non-substance addictions such as gambling. This plan primarily concerns increasing the resources for care for addictions in the hospital system. It envisages the creation of addictology consultation services or addictology liaison teams in all hospitals with an emergency department. These consultation services or liaison teams must be able to group together all existing consultations in smoking cessation, alcohol, and drug addiction in a single place and within a single department. Addictology

services offering simple or complex withdrawal regimes are to be created during the period covered by this plan (2007-2011) for patients requiring more specific care or hospitalisation. The plan also stipulates that each university hospital (i.e. 26 establishments) will have an addictology sector which will be both an addictology service for patients and a regional reference training and research centre.

This plan incorporates some already-familiar objectives: bringing the specialist drug and alcohol addiction services into the framework of CSAPA (Addictology Treatment, Support and Prevention Centres), extending the facilities for therapeutic residential care for illegal drug users through the creation of several therapeutic communities and the involvement of primary care medicine by strengthening addictology health networks. The plan states the need for precise reference texts to be produced for the patient care strategy before, during and after their care.

All of these objectives are restated in the 2008-2011 Government drugs and drug addictions plan {Mildt 2008} which, however, stresses some of these more specifically and proposes new objectives. The following are the objectives set by the MILDT:

- improving professionals' skills in targeted individual prevention and care through different training programmes;
- improving the health and social care of young users of psychoactive substances by increasing the number of consultations for young users and, in particular, by the availability of forms of advanced consultations in generalist centres which receive young people;
- creating new therapeutic communities, centres in which the aim of abstinence must be clearly stated;
- developing new care measures for cocaine users;
- improving the care and continuity of care for drug and alcohol users in prison;
- preserving the health of the unborn child and mother and taking account of the particular features of women who use drugs and alcohol;
- reducing the health risks from drug use;
- reducing the morbidity and mortality from hepatitis C in drug users;
- improving the social integration and reintegration of people with addictions.

5.4. Treatment systems

Two schemes are available for dispensing treatments to illegal drug users: the specialised addictology treatment scheme (in social medicine establishments) and the generalist scheme (hospitals and general practitioners).

5.4.1. Organisation and quality assurance

The specialised scheme

These centres were created in application of the 1970 French drug law. This law included a number of measures guaranteeing free and anonymous treatment for all users of illicit drugs wishing to receive treatment. Virtually all of the French "departments" today have at least one of these centres, known as Addictology Treatment, Support and Prevention Centres CSAPA.

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

There are three types of CSAPA:

- Outpatient treatment centres (203 in 2010). In nearly all cases, these centres follow patients receiving treatment on an outpatient basis. However, some of them can also manage the residential treatment apartments used to provide housing for patients for a few months. Only a very small percentage of outpatients are actually housed in these centres (1 to 2%).

- Inpatient treatment centres including therapeutic communities. There were 41 of these in 2010. They are "post cure" rehabilitation centres that treat post-withdrawal patients or patients receiving substitution treatment. Residential withdrawal most frequently takes place in general hospitals.

- Treatment centres in penal establishments. These centres could be compared to outpatient centres, located inside the prison, which only treat people that are presently in prisonl. Drug free quarters in prison do not exist in France.

The outpatient CSAPAs are designed to meet the outpatient withdrawal requirements of patients. They can also organise and support patients wishing to undergo drug withdrawal in a hospital setting. Since 1993/1994 and until quite recently (2002) the doctors working in a CSAPA were the only doctors authorised to initiate methadone treatments, with repeat prescriptions subsequently being issued by community physicians. CSAPA physicians can also prescribe high-dose buprenorphine (HDB) to patients. Moreover, patients can seek psychotherapeutic support, counselling and assistance to facilitate their social integration.

In France, the concept of "drug-free treatment" is not really used. It is difficult to compare this to an existing treatment type. However, a very limited number of "therapeutic communities" that only accept abstinent people have been recently created. They are currently under evaluation. The results of this assessment are not yet available.

A circular[107] dated 28 February 2008 describes the missions of the CSAPAs. They are nearly identical to those of the CSSTs. The CSAPA are responsible for receiving, informing and ensuring the psychological, medical and social assessment and onward referral of all people with an addiction problem to any substance or a non-substance addiction coming to their premises. CSAPAs also ensure medical, psychological and socio-educational treatment as well as treatment with regard to harm reduction measures. CSAPA can specialise in treating addictions to illegal drugs or alcohol.

[107] 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.

Treatment via the general healthcare system

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

A - Hospitals

As referred to in the health policy section, the addiction prevention and care plan stipulated a new organisation for addictology care in hospitals. The administrative circulars of 16 May 2007 and 26 September 2008[108] gave precise instructions on the organisation to be established within the hospital system. Hospital addictology care is organised into an addictology sector bringing together different components, with the aim of allowing each person with addictive behaviour to access nearby escalating global management and, if necessary, a specialist technical platform. This sector involves three distinct levels.

Level 1 structures are responsible for simple, residential withdrawal courses and liaison and consultation activities. Created by the circular dated April 3, 1996, the liaison and addictology treatment teams, which usually comprise three people including one hospital doctor, have the task of training and assisting teams of care staff in hospitals, drawing up therapeutic protocols, and working with hospitalised patients and emergency patients. They carry out prevention, information and awareness-building activities within the care establishment. Patients can also be seen in outpatient addictology consultations.

Level 2 structures offer the same services as level 1 structures with the additional possibility of providing complex residential care through full or day hospitalisation.

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

The circular of 26 September 2008 also states that the hospital addictology care sectors must act in coordination with the CSAPA and CAARUD specialised schemes, primary care doctors and health networks.

B - General practitioners

General practitioners today play a key role in France when it comes to prescribing opioid substitution treatments. Since 1996, they have been able to prescribe HDB to opioid-dependent patients. Since 1995, they may also issue prescriptions for methadone after a methadone treatment programme has been initiated for the patient by a treatment centre.

Furthermore, the general practitioners are the first to intervene regarding patients just beginning their use of illicit drugs. 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.

[108] Circulaire n°DHOS/O2/2008/299 du 26 septembre 2008 relative à la filière hospitalière de soins en addictologie.

5.4.2. Availability and diversification of treatment

Medical treatments (substitution, withdrawal)

Withdrawal in an outpatient setting

In 2007, an average of approximately 19 patients per centre underwent outpatient withdrawal through an outpatient CSST (see Table 5-1). An average of nearly 14 patients per establishment initiated inpatient withdrawal treatment with the support of a centre. The data shown in table 5-1. reveals a major increase in the number of withdrawal treatments initiated between 2003 and 2004. However, this change was 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. To put this change into perspective: the total number of people welcomed by the specialist centres has also increased sharply since the late 1990s.

Moreover, these average numbers of patients undergoing withdrawal treatment also include people withdrawing from alcohol. People admitted to these centres for problems with alcohol only make up a small proportion of the total number of people seen. However, the involvement of alcohol in a larger number of these withdrawal treatments cannot be ruled out.

Table 5-1: Average number of patients undergoing a withdrawal treatment per outpatient CSST 1998-2007

	1999	2000	2001	2002	2003	2004	2005	2006	2007
Average number of patients per CSST having undertaken outpatient withdrawal treatments provided by the CSST.	5.7	6.2	8.4	10.6	11.0	16.8	16.1	17.5	18.9
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	10.3	13.2	12.8	13.8

N. Av.: not available

Source: Review of the standard activity reports of CSSTs in 2005, DGS/OFDT.
Guide to the table: on average, 5.7 patients per CSST undertook an outpatient withdrawal treatment provided by the CSST in 1999.
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.

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%), while a third received methadone (32%). Finally, a minority (4%) received morphine sulphate-based treatment.

On average, users receiving a substitution substance tended 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% of the cases, the treatment was morphine sulphate, with HDB for 59% of the cases and with methadone for only 16%. The substitute drug was also mentioned among those substances used for extra-therapeutic purposes. 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% and 42% respectively). Indeed, among the

active drug users interviewed via the CAARUDs, a majority use injection as the preferred route of administration, with sniffing or smoking being less common. On the other hand, among those receiving methadone, this drug was mentioned as problematic in only a small number of cases (9%), largely outpaced by heroin (24%) and cocaine/crack (19%). Unlike the other two substitute drugs, methadone (when used outside the scope of a therapeutic programme) was almost exclusively used orally (96%) {Toufik et al. 2008}.

The issuing of substitution treatments

After first being marketed in 1996, HDB very quickly became the leading treatment for opiate dependency in France. It should be mentioned that, since 2006, products other than Subutex® have become available. Generic preparations appeared on the market (particularly HDB Arrow® in 2006, and then HDB Merck® in 2007[109]). The generic form was accepted above all by a number of users who were at an earlier stage in their drug addiction trajectory than the average user, better integrated into a care protocol, and more stable. The 2008 iteration of the OPPIDUM[110] survey (see appendix IV-O) showed that the average age of the 31% of patients receiving generic HDB in specialist care centres was two years younger than the others and that their average daily doses were approximately 1 mg less than doses taken by other patients.

Recent data from the Caisse nationale de l'assurance maladie (CNAM or French National Health Insurance Organisation System) show that almost 145,000 people received reimbursements for opiate substitution treatments (primary care) in the first half of 2010, with the particular French feature of a clear predominance of HDB which made up almost 75% of the total. Generics still represent approximately one-third of all HDB reimbursements.

The proportion of patients treated with methadone, however, continues to rise and it should be noted that improving access to this drug was one of the recommendations of the Consensus Conference on substitution treatments in June 2004. French National Health Insurance Fund data also show that reimbursements for HDB increased by 29.3 % compared to 276 % for methadone over 6 years, between 2004 and 2010[111].

The graph below shows the estimated numbers of patients treated with HDB and methadone in France. These data come from the sales figures for the two substitution drugs provided by GERS[112] with the starting hypothesis that the average daily doses prescribed over a year were 8 mg for Subutex® and 60 mg for methadone. The amounts of Subutex® sold therefore are equivalent to 76,793 theoretical patients receiving a daily dose of 8 mg throughout 2009. A similar calculation for methadone produces a theoretical 37,711 patients (based on primary care and hospital reimbursement data on the liquid and capsule forms).

These are theoretical patients, as not all actual patients are as compliant and not all take treatment from 1 January to 31 December. In a given year, some may stop their treatment and others may start it. The number of people with at least one prescription for one substitution treatment is therefore logically higher than this theoretical patient number.

HDB generics introduced in France since 2006 offset, to an extent, the actual reduction observed in the number of patients receiving Subutex® since that year. An extrapolation helps

[109] HDB Merck became HDB Mylan® in 2008

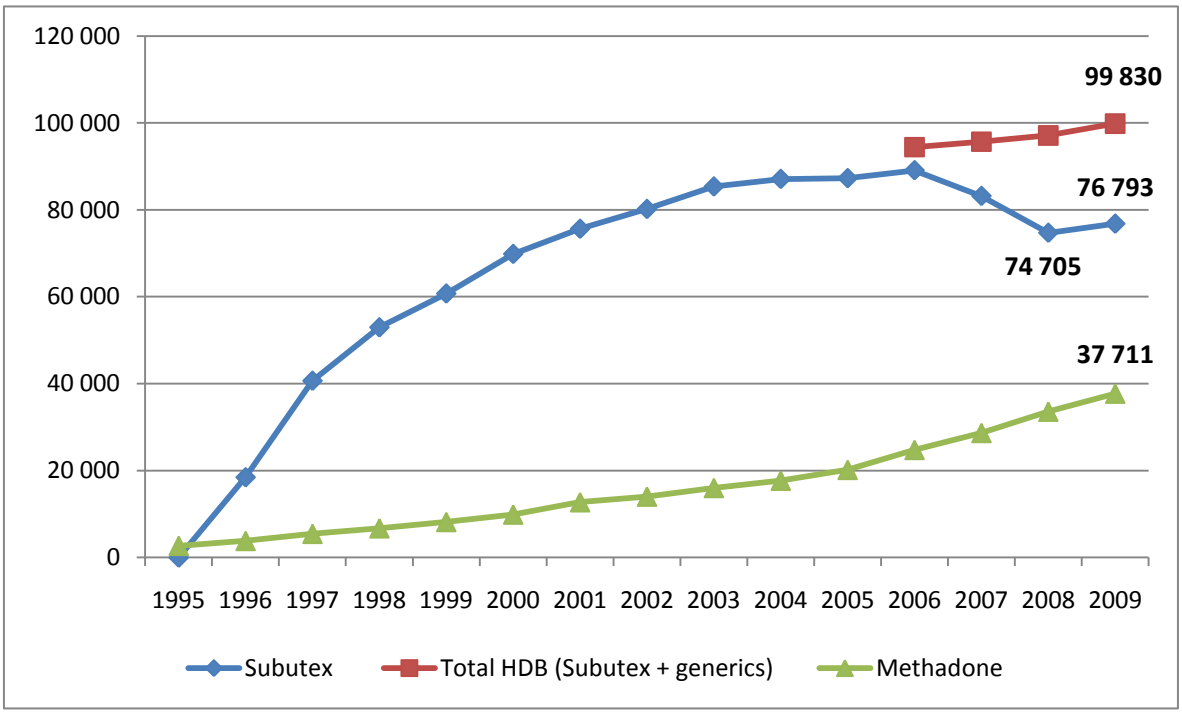
110http://www.afssaps.fr/var/afssaps_site/storage/original/application/4a43ffc0f2afeec432f0bb9b00b29cdc.pdf

111 The 2008 marketing authorisation of methadone capsules contributed to this increase. In fact, capsules represent 28% of all dispensed methadone.

112 Groupement pour l'élaboration et la réalisation de statistiques (Statistics Production and Analysis Group)

estimate the number of patients receiving generic forms, for which there has been a progressive increase, up to one-third of all HDB patients in 2009 (see graph). Almost 99,900 theoretical patients have received HDB, either in its proprietary or its generic form.

Graph 5-1: Opiate substitution treatments: estimated number of people receiving opiate substitution treatment (Subutex® 8 mg, Methadone 60 mg) between 1995 and 2009



Source: GERS/SIAMOIS/InVS

Diversion and misuse of HDB

It is important to recognise that some prescribed HDB is misused and that it is not always taken for treatment. This proportion has diminished since the implementation of the French National Health Insurance Fund's plan to control opiate substitution treatments[113]: One of the main indicators for HDB misuse (average daily dose higher than 32 mg/d[114]) fell by two-thirds between 2002 and 2007. At the time, six per cent of people had been receiving more than 32 mg/d of HDB versus 2 % in 2006 and 1.6 % the following year according to a recent study {Canarelli et al. 2009}. Similarly to the previous 2002 study, this study also found that two-thirds of people who had received reimbursements for opiate substitution treatments in 2006 and 2007 were taking regular treatment and therefore, in principle, were included in a treatment pathway. Not all of the other recipients of these treatments, however, are necessarily outside of any care process.

[113] The *Assurance maladie* testing introduced since 2004 mostly attempted to identify dealers ("patients" and also a few doctors and pharmacists) through reimbursement data and to correct the situation with users who have at least 5 prescribers or being given an average dose of more than 32 mg

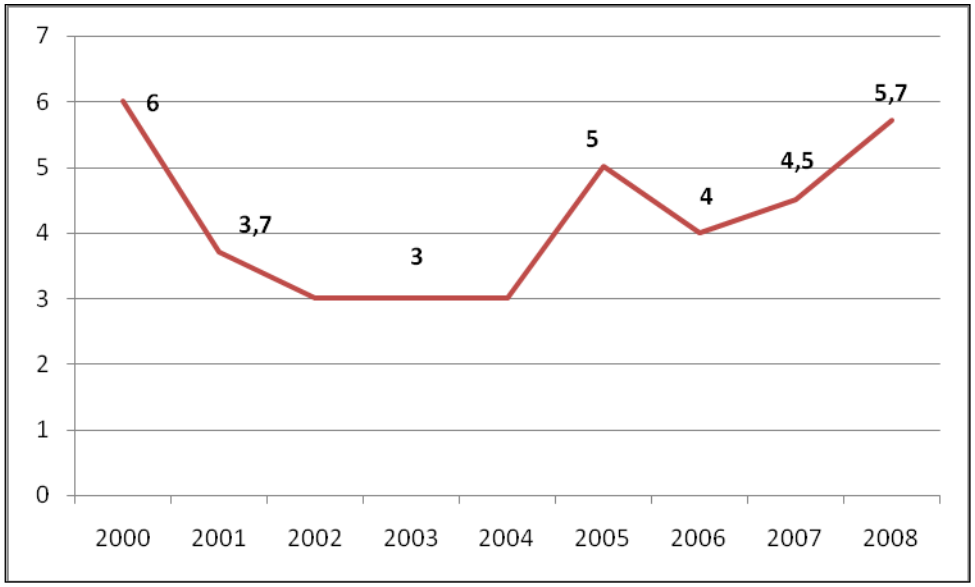
[114] The maintenance dose of HDB is 8 mg/D with a maximum dose of 16 mg/D. An average daily dose of more than 32 mg/D is an indicator of very suspicious HDB use (dealing and/or resale).

With the exception of the city of Toulouse, it appears that the measures taken only had a limited impact on HDB availability in the black market. More organised dealing has developed in some regions, particularly the Paris and Marseilles regions and, to a lesser extent, the East of France, since 2007. Fewer users re-sold their excess, but there was better organised health insurance fraud carried out by a collective organisation of "doctor shopping" (e.g., theft of the *"carte vitale"* national insurance cards that grant health treatment rights in France, recruitment of "false users", consultations in several departments, etc.).

Field observations in the techno dance events scene have revealed that this substance is only used marginally and that its availability is also marginal except in very large events.

In 2008, HDB was therefore once again described as being readily available and easily accessible on the black market although it is still more expensive (average 5.7 euros for an 8 mg tablet) and has therefore returned to the same price level as in 2000 (Graph 5-2) {Cadet-Taïrou et al. 2010b}.

Graph 5-2: Annual change in price of an 8 mg HDB tablet on the black market between 2000 and 2008



Source: TREND / OFDT

Misuse involves three types of administration: injecting, sniffing and less often, smoking. Whereas injection remains the most widely used route of administration when the drug is not used for its therapeutic purpose, sniffing is the method used by "long-standing" injectors. Sniffing allows these injectors to offset their deteriorating venous access and health complications from their frequent injecting. In 2009 {Afssaps 2009}, 7% of users in a substitution protocol seen for treatment purposes injected HDB, while 8% sniffed and a tiny proportion of users inhaled. Amongst those people also seen for treatment purposes, but who reported that they used HDB outside of a treatment protocol, 16% injected, 46% sniffed and 49% took the drug orally. The prevalence of HDB injection has continued to fall annually in this second group (34% in 2005)

and this fall has accelerated markedly since 2006. Sniffing, however, has seen the reverse change (34% in 2007).

Methadone misuse

Despite the emergence of more visible methadone misuse in parallel to its wider distribution, misuse remains limited compared to HDB. This always involves patients who are actually taking substitution treatment and who save some of it for bartering, for emergency situations or for sale. The capsule form available on the market since 2008 is not affected by this black market. The use of methadone self-substitution had already been reported in 2006, and is a developing practice in different sites {Cadet-Taïrou et al. 2010b}.

Substitution treatment in the hospital setting

A survey conducted in 2007 by the OFDT {Obradovic et al. 2008b} to assess the impact of circular no. 2002/57 of 30 January 2002 on initial methadone prescribing by doctors practising in health institutions (hospitals and prisons) demonstrated that access to methadone had increased in these two areas six years after this circular was introduced.

The hospital arm of this survey showed that general practitioners played an important role in access to specialist care by opiate-dependent users. This holds true both early on, when they referred their patients to hospitals to start treatment and later, when they took over care from hospital treatment. This survey also demonstrated the importance of the link between the different partners in the care system to avoid substitution treatment being stopped when the patient left hospital.

Substitution treatment in prison

Whereas half of the hospital services surveyed reported that more than 50% of patients were receiving methadone, this is reported by only a third of the prison medical services (excluding CSSTs). Average initial prescribed amounts in prison are similar to those seen out of prison, which would appear to indicate some consistency in following the therapeutic indications. Progress still needs to be made in terms of generalising access to methadone in all healthcare institutions and more effective maintenance care (particularly when leaving prison).

Furthermore, a national survey on the prevalence of HIV, HCV and opiate substitution medications (OSMs) in prison was conducted in 2010 in mainland France and in the overseas French departments ("DOM")[115]. The initial results indicated a prevalence of OSMs in prisons of 7.9% [6.49-9.79], which corresponds to fewer than 5,000 prisoners, one-third (31%) of whom had treatment initiated during their incarceration. Furthermore, the predominance of HDB is less marked than outside of prisons, since it was found that 68.5% of the subjects were receiving HDB and 31.5% methadone (data to be released).

[115] This is the PREVACAR survey, for which the results will be issued in the last quarter of 2011. It is based on a questionnaire regarding "available treatments" sent to 169 UCSAs (outpatient consultation and treatment units), excluding establishments for minors, and a "patient" questionnaire sent to a random sample of 27 establishments. One thousand, eight hundred and sixty-one (1,861) individual questionnaires were able to be used.

5.5. Access to treatment

5.6. Characteristics of treated clients (TDI data included)

Total number of patients receiving treatment

Data compatible with the EMCDDA's TDI protocol are only recorded from people seen in the CSAPAs in France. This data collection is not exhaustive, since approximately one-third of CSAPAs did not provide data in 2010. Moreover, the TDI data only concern people who are starting or restarting treatment. It is therefore necessary to use other sources to provide a quantitative assessment of the total number of people seeking aid from professionals because of their problems with illegal drug use.

We currently have relatively accurate information about the number of people receiving care in the specialist system. The CSAPAs are required to provide the administrative authorities with an annual activity report containing certain information about people received during the previous year (see appendix IV-P). The response rate for these reports is close to 90% annually and almost 100% over a two-year period. Based on these activity reports, it is possible to estimate at approximately 96,000 the number of people who were seen in outpatient CSAPAs in 2008 for their illegal drug problem. This includes overlapping, although these should not make up more than 5% of the total. Compared to the outpatient CSAPA, very few people, slightly fewer than 2,000, appear to be accommodated in a residential treatment centre, some of whom are already included in the figures for the outpatient CSAPA. A large proportion of patients accommodated in the residential centres were in fact referred there by an outpatient CSAPA. The number of people seen for a problem with illegal drugs in 2008 in the prison CSAPAs can be estimated at 5,300.

The only national data available for primary care is for people receiving substitution treatment. In 2010, approximately 145,000 people were reimbursed for their substitution treatment by the Social Security organisations. Some of these people are also included in the figures for people having benefited from a CSAPA services in 2010.

National data are available for hospitals from the PMSI[116] medico-economic information system about the number of hospitalisations with a main diagnosis of behavioural disorders due to use of psychoactive substances, excluding alcohol and tobacco (diagnoses ICD-10: F11 to F16, F18 and F19). There were 7,830 hospitalisations in 2010. It should be noted that these results do not include visits to emergency departments. Overlapping also exists between hospitalised patients and those seen in specialist centres or primary care. Other findings from 2005, from a liaison team activity report, which was only requested for one year, estimated the number of people seen in hospital outpatient consultations (i.e. people who are not hospitalised) for problems with illegal drug use at approximately 8,000. Again, it is not possible to add these figures to the others because of the many risks of overlapping between these people and those who are hospitalised or recorded in the other sectors described above. Hospital data are very patchy. Nevertheless, it appears to be relatively clear that the number of people who have problems with illegal drug use and who were seen at hospital (excluding CSAPAs) over a year was, until recently, relatively small compared to the total number of people seen in the CSAPAs (maximum 10%).

[116] http://stats.atih.sante.fr/mco/diagone.php

Characteristics of patients initiating treatment in specialised centres

Patients seen in outpatient centres

In 2010, 137 outpatient CSAPAs participated in the RECAP study, which was slightly over two-thirds of all outpatient treatment centres. The total number of centres participating in 2010 declined compared to 2009 due to mergers. The RECAP response rate was a bit lower in 2010 than in 2009. Several of the centres failing to communicate data in 2010 mentioned software-related problems (lost data, change in software). Other centres provided information, but did so very late. The data shown below concerns more than 44,000 patients (referred to as “new patients”) who started a new episode of treatment in one of these centres during the year.

Those patients receiving treatment for the first time in their life (referred to as "first treatment patients") accounted for 30%[117] of all new patients seen, and this percentage was even lower in women (26% vs. 31% in men). For the other patients, these were new requests for treatment in a given centre or a renewal of treatment following a break in contact with the treatment centre in excess of six months. The percentage of first treatment patients among all patients should be considered with caution since information concerning the existence of previous treatments is unknown in 24 % of cases.

Socio-demographic characteristics of patients

In 2010, nearly four out of every five (81%) new patients were men. The mean age of these men was 30.7 years. The women were slightly older than the men on average (32.2 vs. 31.6). This mean age is actually the result from the mix of two subpopulations, cannabis users on one hand, with a mean age between 25 and 26 and opiate and cocaine users on the other hand with a mean age of around 34. The most widely represented age groups among new patients was 20- to 24-year-olds and 25- to 29-year-olds, each representing approximately 20 % of new patients. The under 25s represented 41% of the total. A little more than 19 % of the patients were over 40.

Men are slightly more represented (83%) among patients seeking treatment for the first time in their lives than among all new patients. Above all, first treatment patients were much younger. Their mean age was 26.4. Approximately half of these patients were under 25 and 9 % were aged forty or over.

Table 5-2: Breakdown of patients by age group (in %), in 2010.

Age	All treatments	First treatments
< 20 y.o.	11.5	22.2
20-24 y.o.	19.6	27.7
25-29 y.o.	20.5	20.9
30-34 y.o.	15.9	12.6
35-39 y.o.	13.0	7.9
40-44 y.o.	9.7	4.7
45-49 y.o.	5.4	2.2
50 and over	4.3	1.9
Total	100.0	100.0

Source: RECAP / OFDT – 2010.

[117] Unless stipulated otherwise, all percentages are calculated based on the totals excluding missing responses and “do not know” responses.

New patients most frequently enter into contact with treatment centres on their own initiative (36%) or after being referred by the justice system or the police (29%). The latter method of contact has much lower representation among women (12% vs. 33% in men). Of first treatment patients, nearly half (48%) were referred in this way. Most of the people referred by the courts or the police were cannabis users.

Table 5-3: Breakdown of patients by treatment origin (in %), in 2010.

Origin of the treatment	All treatments	First treatments
Patient's own initiative	35.9	23.7
Family or friend	9.5	9.5
Other specialised centres for drug users	7.5	3.1
General practitioners	6.9	5.1
Hospital or other medical establishment	5.0	3.5
Social services	3.8	3.6
Police, courts or court-ordered treatment	28.6	48.1
Others	2.8	3.4
Total	100.0	100.0

Source: RECAP / OFDT – 2010.

New patients most frequently lived with their parents or alone (35 % and 29 % respectively) and most often lived in stable housing (78 %). Nevertheless, 20 % of them stated that they were living in unstable housing conditions. The situation for women differed from that of men: they lived 10 times more often than men alone with their child (11% vs. 1%), and more often with a partner (19% vs. 10%). In contrast, they much less frequently lived with their parents (23% vs. 37%). Due to the higher proportion of younger people among them, first treatment patients were less likely to live alone and lived more frequently (45%) with their parents.

Table 5-4: Breakdown of patients by living status (with whom) (in %), in 2010.

Living status (with whom)	All treatments	First treatments
Alone	28.9	22.9
With parents	34.6	45.1
Alone with child	3.0	2.2
With partner (alone)	12.8	12.1
With partner and child(ren)	11.4	9.8
With friends	3.3	2.6
Others	6.0	5.3
Total	100.0	100.0

Source: RECAP / OFDT – 2010.

Table 5-5: Breakdown of patients by age group (in %), in 2010.

Living status (type of housing)	All treatments	First treatments
Stable housing	77.7	86.1
Unstable housing	19.2	12.3
Institutional housing	3.1	1.7
Total	100.0	100.0

Source: RECAP / OFDT – 2010.

Regarding their socio-professional situation, economically inactive or unemployed patients accounted for a total of 46 % of new patients, while just over a quarter (26 %) have a regular job and 13% are still at school or students (please see Table 5-6). The percentage of economically inactive patients was clearly higher among women than men (28% vs. 21%). First treatment patients differed from patients as a whole in that there was a higher percentage of high school pupils and post-high school students and a lower percentage of economically inactive people.

Where the patients' educational profiles are concerned, nearly two-thirds (63%) stated having reached secondary school level, 4% had not got past primary school level and 33 % indicated that they had an educational level above the baccalauréat (A-level/High School Diploma). The women were characterised by a much higher percentage of post-secondary level education (46% vs. 30%). The breakdown of educational level remained unchanged among first treatment patients.

Table 5-6: Breakdown of patients by professional situation (in %), in 2010.

Professional situation	All treatments	First treatments
Regular employment	26.2	28.6
Student, secondary school pupil	13.4	22.0
Economically inactive	22.0	14.5
Unemployed	24.4	20.3
Others	14.0	14.7
Total	100.0	100.0

Source: RECAP / OFDT – 2010.

Drug use

Almost half of the new patients (46%) sought help from the specialised treatment centres in 2010 for problems related to cannabis use. A majority (58%) of them stated using cannabis every day. The percentage of people treated for their cannabis use was much lower among women (32% vs. 49%). The proportion of people using it daily was slightly lower among women, but this difference was not very marked (58% vs. 62%).

The proportion of first treatment patients stating cannabis as their primary drug (i.e., the substance causing the most problems) was higher than for all new patients, reaching two-thirds. The breakdown of the frequency of use was similar in the two groups. The large number of cannabis users among patients in treatment in France is partly the consequence of the large and still increasing number of arrests for cannabis use. A portion of the arrested users was referred to treatment centres by the courts.

Opiates were identified as the primary drug by 43 % of patients. Of these patients, 80 % stated heroin, 4 % methadone and 16% other opiates (primarily HDB)[118] . Of these patients, heroin was most frequently sniffed (62%), but one of every five heroin users still injects. The percentage of injectors was much higher (40%) among users of other opiates, a category comprised mainly of HDB. Among the opiate users, almost 80% consumed these substances on a daily basis and 11 % took them regularly (i.e., several times a week).

[118] For methadone and HDB, this means use outside of the therapeutic framework.

Less often treated for their cannabis use than men, women were, in contrast, treated much more often for their opiate consumption (53% vs. 42%), and this regardless of the type of opiates in question. They used the injection route slightly less often than men to consume heroin (17% vs. 21%), but as often for the other opiates.

The proportion of first treatment patients stating opiates as their main drug was much lower than for all new patients (24 % vs. 43 %). Distribution of frequency of use is similar in the two groups although there is a slightly higher proportion of daily use among first treatment patients. Injection was used much less often as a route of administration for opiates in this group (13% vs. 23%).

Table 5-7: Breakdown (in %) by main drug, 2010.

Main drug	New patients	First treatment patients
1. Opiates (total)	43.0	24.0
11 heroin	34.4	20.2
12 methadone	1.8	0.7
13 other opiates	6.9	3.0
2. Cocaine (total)	6.9	5.6
21 cocaine	5.3	5.0
22 crack	1.6	0.7
3. Stimulants (total)	0.5	0.4
31 amphetamines	0.2	0.2
32 MDMA and derivatives	0.3	0.1
33 other stimulants	0.0	0.0
4. Hypnotics and sedatives (total)	2.1	0.9
41 barbiturates	0.1	0.1
42 benzodiazepines	1.6	0.5
43 others	0.4	0.2
5. Hallucinogens (total)	0.3	0.3
51 LSD	0.2	0.1
52 others	0.1	0.2
6. Volatile inhalants	0.2	0.3
7. Cannabis (total)	45.9	67.8
9. Other substances (total)	1.0	0.8
Total	100.0	100.0

Source: RECAP / OFDT – 2010.

After cannabis and opiates, cocaine was far behind as the third most frequently used substance; it was mentioned as the primary drug for slightly more than 5% of patients. Among them, the frequency of use of the primary drug was much lower than for opiates: 35% of cocaine users used it every day and 25% frequently. Cocaine was sniffed (68%) or smoked (18%). It was also injected by a non-negligible percentage of patients (13%). Cocaine was slightly less frequently mentioned among first treatment patients, but the difference was not very important. In this patient group, the percentage of people injecting cocaine was lower than for all new cocaine-using patients (6% versus 13%). The vast majority of them sniffed (72%). Cocaine was also slightly more frequently mentioned as a secondary product than as a primary drug. Of the new patients for whom there was information on the primary drug, 8% mentioned the use of cocaine as a secondary product. As a secondary product, cocaine was encountered in three-quarters of patients stating opiates as their primary drug.

Among new patients seeking treatment in 2010, nearly three-quarters (73 %) stated that they had never used injection as a route of administration. Of patients that had already used the

intravenous route, 15% had not used this route recently and 11% stated that they had injected during the month preceding the interview. Those who used injection during the last month by are mostly opiate users (82%): two-thirds were heroin users and 30% used other opiates. Women, who are more often treated for their opiate use than men, use injection slightly less often to use these substances (20% vs. 24%). The persons welcomed by the CSAPAs for the first time in their lives tend to use intravenous administration less often than patients who have already received treatment. Thus, in 2010, approximately 92% of first-time outpatients (all products combined) had never used injection as an administration method (vs. 73 % among all new patients).

Patients seen in residential centres

The number of patients seen in residential treatment centres only represented a very low proportion of the patients seen in outpatient centres. In 2010, 25 residential centres provided RECAP data on nearly 740 patients.

Nearly all of the patients housed in these residential centres had already benefited from healthcare services for their addiction. It is rare for the patients themselves to request treatment directly from these centres. In the majority of cases, they are referred, at least the first time, by other treatment centres. The data on patient referrals indicates that two-thirds of those housed in residential centres had been referred by the healthcare sector. One quarter of the patients stated coming on their own initiative. Nevertheless, it can be surmised that, for the majority of these patients, it was not their first stay in such a centre.

The patients seen in residential centres were on average older than those seen as outpatients (32.6 years of age vs. 30.7 years of age). These centres tended to treat patients with the most serious addiction problems. These people were also more often in a situation of social exclusion. This partially explains the very low representation of minors and people under the age of 20, for whom the situation can seem less unfavourable from an addiction and social rehabilitation standpoint than for older patients. The lack of sufficient residential treatment for the youngest users is often pointed out by addictologists. Minors and adults under the age of 20, whose situation would justify a stay in a residential centre, will have much difficulty in finding an available spot. Although there are very few of the youngest users represented, just over 40% of new patients treated in these centres were under the age of 30.

The most significant evidence of social exclusion characterising this population was the still-high percentage of patients, compared to those seen on an outpatient basis, who were living alone (45%), who had unstable housing conditions (45%) or who were unemployed or economically inactive (47% and 31% respectively).

Higher ages, the seriousness of the addiction problems and exclusion were more often related to opiate and cocaine use, which was seen much more frequently in this population (57% and 17% respectively) than in the population being followed on an outpatient basis. The percentage of people being followed in these centres for their cannabis use was, in contrast, much lower (17%). Due to the seriousness of the addiction problems, the proportion of people who had injected in the last 30 days was much higher in this population: it reached nearly 35% in people for whom opiates were the primary drug and 38% in people for whom cocaine was the primary drug.

5.7. Trends in patients treated in specialised centres

Data on patients compatible with the IDT protocol have been available in France only since 2005. Hence, developments can only be truly followed on a fairly short period. As for the inpatient centres, large variations in numbers, related to the variations of the response rates, make it difficult to interpret trends. Therefore, only trends in ambulatory patients seen will be discussed in this section.

From one year to another, the characteristics of new patients seen in specialised outpatient centres are very stable. Between 2009 and 2010, given the variation in the number of centres that participated in the survey, it would be risky to highlight developments that are mostly lower than one percentage point. The observation of changes over several years, however, did show some trends.

As can be seen from the chart data below, the average age of patients is increasing continuously between 2005 and 2010 from 28 years old to nearly 31 years old. The observation of the evolution of the distribution by age group (Table 5-8) shows that this aging is mainly related to a decrease of about 10 points of the 15-24 age group for the benefit of the elderly 40 years old and more, whose share has almost doubled from about 11% in 2005 to over 19% in 2010. Between 2005 and 2007, the decrease was more pronounced among the 15-19 age group. Between 2007 and 2010, the decline appears particularly among 20-24 years old. An increase of the average age also appears for the first treatment demands. To interpret these changes we must keep in mind that according to reports provided by the CSST, the number of clients tends to increase year by year. A decrease in the proportion of younger does not necessarily mean that their number is decreasing in absolute terms.

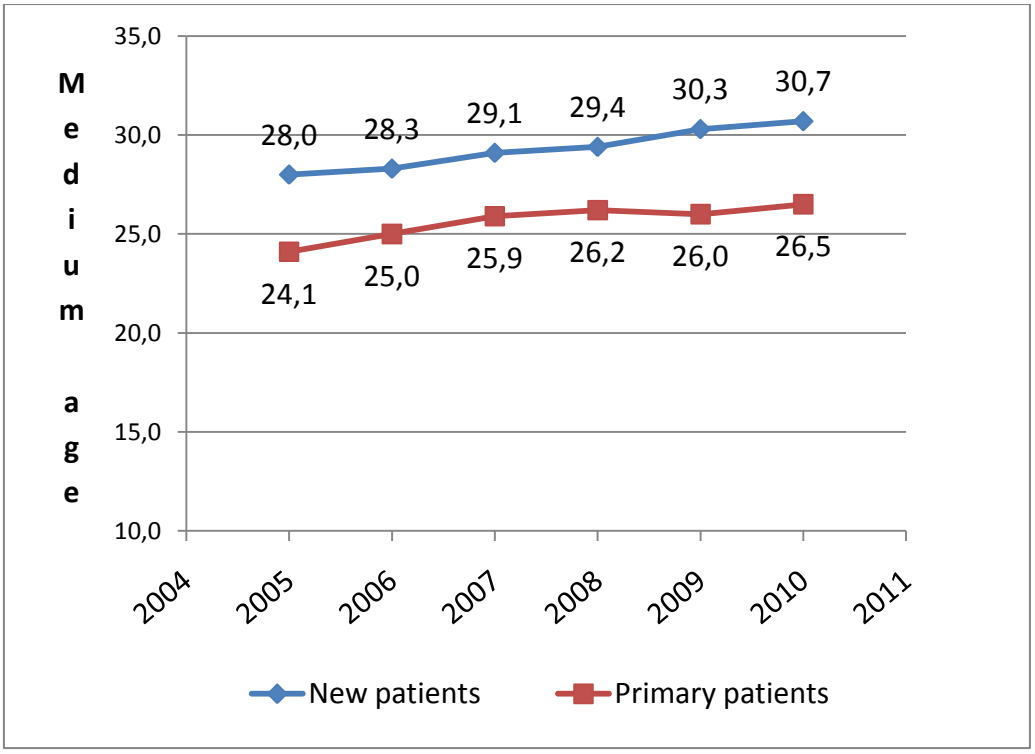


Tableau 5-1 : Distribution of patients by age (in %), changes between 2005 and 2010

	2005	2006	2007	2008	2009	2010
<15	0,6	0,8	0,7	1,4	1,2	1,1
15-19	16,0	14,8	11,9	11,3	11,4	10,4
20-24	24,8	25,2	24,7	23,3	20,4	19,6
25-29	19,0	19,4	21,2	21,4	20,2	20,5
30-34	16,6	15,4	14,9	14,6	14,8	15,9
35-39	12,3	12,3	12,5	12,7	13,4	13,0
40-44	6,8	7,1	8,4	8,4	9,3	9,7
45-49	2,5	3,2	3,5	4,2	5,4	5,4
50-54	0,8	1,2	1,4	1,7	2,3	2,5
55-59	0,3	0,5	0,6	0,7	1,0	1,1
60-64	0,2	0,2	0,2	0,3	0,4	0,5
>=65	0,1	0,1	0,1	0,2	0,3	0,3
Total	100,0	100,0	100,0	100,0	100,0	100,0

Source: RECAP / OFDT – 2005 - 2010.

The aging of persons seen in the centres has implications for certain patient characteristics. Thus, consistent with the declining share of 15-24 year olds, the percentage of people living with their parents has been steadily declining from 42% to less than 35%, while the share of people living alone increased from 25% to 29%. For reasons also related to the change in the distribution by age, the proportion of pupils and students has been declining from 17% in 2005 to 13% in 2010.

As for primary substances, it is worth noticing a rising trend of the percentage of patients having problems with cocaine or crack between 2005 and 2008 (from 5.7% to 7%), a percentage which then stabilised. The percentage of drug users seen mainly for a problem of heroin increased between 2007 and 2010 from 31,1% to 34,4%. This increase, in relative terms, is accompanied by a decline in 2009 almost equal of the share of those who came for a problem of cannabis (49,4% in 2007 to 45,9% in 2010). The evolution of the distribution of primary substances is not the same for first time clients (primary patients): the share of heroin has decreased and that of cannabis is on the whole period increasing.
With regard to routes of administration, data over the years 2005 to 2010 show a decrease in the percentage of persons treated for a problem of opiate and cocaine use currently using intravenous injection. However, the decline is more obvious in 2007. Since this year, the figures show rather a stabilisation of the percentage of current injectors.

Tableau 5-2 : Percentage of current injectors by primary product, evolution between 2005 and 2010

	2005	2006	2007	2008	2009	2010
1. Opiates (total)	24,8	24,6	20,9	21,2	20,9	20,6
11 heroin	20,6	20,5	17,0	17,8	17,2	17,1
12 methadone	17,4	13,2	11,3	10,3	12,0	14,8
13 other opiates	44,1	44,3	39,6	39,9	39,5	39,0
2. Cocaine (total)	15,4	16,2	13,1	14,4	13,7	13,7
21 cocaine	18,0	18,1	14,4	15,5	15,2	14,7
22 crack	6,6	8,8	7,8	10,7	9,3	10,7

Source: RECAP / OFDT – 2005 - 2010.

6. Health correlates and consequences

6.1. Introduction

The use of drugs can result in morbid processes such as viral diseases (i.e. HIV/AIDS and hepatitis), sexually transmissible diseases or resurgent diseases related to precarious living conditions such as tuberculosis. Psychiatric comorbidities related to this use are also typically encountered. Deaths also occur and are recorded and categorised based on a number of information gathering systems in France.

HIV/AIDS and viral hepatitis

Infectious diseases account for most of the somatic morbidity observed. Estimates of prevalence levels among drug users are based on:

- The declared prevalence of HIV, hepatitis B and hepatitis C: initially recorded by the so-called "November" survey (information concerning patients visiting the CSSTs), this data was later supplied via the RECAP scheme (patients seen by the CSSTs and CSAPAs) from 2005 onwards {Palle et al. 2007}, and via the surveys carried out involving patients seen by so-called low threshold services, and particularly the PRELUD and ENa-CAARUD surveys. The declared prevalence of HIV, hepatitis C and hepatitis B vary according to the studies and the routes of administration adopted by the users (injection and sniffing, etc.).

- The biological prevalence of HIV and hepatitis C (blood samples) supplied via the Coquelicot survey (see appendix IV-C) {Jauffret-Roustide et al. 2006}. The survey, which is intended to eventually become a national information system, has highlighted the variation between declared prevalence and measured prevalence of hepatitis C, particularly among the youngest users.

- The biological prevalence of HIV and hepatitis C (saliva samples) among users attending low threshold services: the PRELUD survey (the TREND report, 2007) which began in February 2006 in nine French towns and cities.

- Incidence estimates applied to cases of AIDS and those of HIV infection. The declaration of AIDS cases (InVS) has been in force since the early 1980s and has been compulsory since 1986. A new, anonymous declaration scheme was introduced in 2003 via a circular from the Directorate General for Health -DGS- (n° 2003/60 of February 10, 2003), making it also 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 falling constantly since 1994.

Cases of acute hepatitis B have been reported since 2004 (reporting has been made mandatory since this date). Of the 894 cases subsequently reported from 2004 to 2009, 23 cases (2.6 %) were related to drug use.

STIs and tuberculosis

No specific information system exists in France to record the declared or biological presence of tuberculosis or any possible sexually transmissible diseases among drug users.

Other infectious morbidity

No specific information system exists in France to record the declared or biological prevalence of other infectious diseases among drug users.

Behavioural data

In France, quantitative informations are available (ENa-CAARUD study conducted by the OFDT and Coquelicot conducted by the InVS) as well as qualitative information (TREND scheme and qualitative section of the Coquelicot survey). They inform us on the drugs users own perception of their state of health and their at risk behaviours {Cadet-Taïrou et al. 2010a};{Cadet-Taïrou et al. 2008; Jauffret-Roustide et al. 2006}. The surveys carried out as part of the TREND system among the drug users attending the low threshold services previously supplied information concerning the perception of their state of health and the appearance of certain pathologies {Bello, P. Y. et al. 2004; Bello, P. Y. et al. 2005}.

Psychiatric comorbidities

The small number of studies available in France does not make it possible to draw any consistent conclusions concerning the prevalence of miscellaneous psychiatric pathologies among drug users.

Drug-related deaths

The information system available in France is based on several schemes, each covering part of the causes of deaths related to drug use. This concerns death:

- By drug dependence (CepiDc-INSERM). This category concerns all deaths for which the death certificate mentions drug dependence. For reasons related to the information circuit used, the availability of this data is however subject to a lead time of two years. The number of deaths through drug dependence fell between 1995 and 2002 before rising again after 2003. Some overdoses are listed as deaths with poorly defined causes.

- With the presence of psychotropic substances in the blood: the DRAMES scheme (see appendix IV-D) (Death involving the abuse of medicines and substances – AFSSAPS) lists cases of death having resulted in a legal investigation and a request for a toxicological analysis and/or post-mortem. The key objective of the DRAMES scheme is not to draw up an exhaustive description of the number of overdoses but rather to assess the substances causing the deaths and their combinations (particularly with medicines). The number of laboratories involved in the scheme has constantly increased (7 in 2002 and 19 in 2008). The number of deaths by opioid overdoses has increased in addition to that resulting from the misuse of substitution treatments (methadone and HDB) and stimulants.

- By overdose when the death results in legal proceedings (OCRTIS). This statistical source covers only those deaths notified to the police or the gendarmerie. It does not include deaths of French citizens by overdoses abroad and deaths occurring in hospitals. Since 1995, the number of deaths due to overdose recorded by the security forces fell continuously (- 80 %

between 1995 and 2003) before rising again. The OCRTIS has published no new overdose data since 2008.

- Related to AIDS, among intravenous drug users (InVS). The number of deaths by AIDS among intravenous drug users has been falling continuously since 1994.

Numerous studies have highlighted the problem of the underestimation of the official number of fatal overdoses related to the use of illegal substances in France during the late 1990s and early 2000s {Janssen 2010; Lecomte et al. 1994; Lepère et al. 2001}. The amalgamation of the three information sources already mentioned (OCRTIS, AFSSAPS, INSERM) concerning overdoses recorded in 2007 was carried out in 2009 in order to verify whether this bias still exists.

6.2. Drug related Infectious diseases

6.2.1. HIV/AIDS and viral hepatitis

Surveillance system for HIV infection, new cases of AIDS

Since the introduction of mandatory HIV reporting in March 2003, 32,594 people have been found to be HIV positive. Taking reporting time delays and under-reporting into consideration, the number of reports of seropositivity in 2008 was estimated to be 6,500, a relatively stable figure compared to the previous year (6,400 in 2007), in line with the general downward trend compared to previous years (7,000 in 2006 and 7,500 in 2005).

In 2010, people infected through injecting drug use (IDUs) represented no more than 1.5% of these new cases of infection (Table 6-1). The most common mode of transmission is heterosexual intercourse (43.4 % of cases), with more women infected than men (66% of cases) and followed by homosexual intercourse (23 % of cases or 37 % of infections in men).

Table 6-1: People found to be HIV positive in 2003-2009, by mode of transmission (France, data as of 30 June 2010)

	Women		Men		Total	
Methods of contamination	na	%	na	%	na	%
Heterosexual intercourse	8 553	65.6	6 723	30.4	15 276	43.4
Homosexual intercourse	-	-	8 112	36.6	8 112	23
IV drug use	102	0.8	409	1.8	511	1.5
Other	196	1.5	180	0.8	376	1
Not known	4 200	32.1	6 724	30.4	10 924	31.1
Total	13 051	100	22 148	100	35 199	100

a: Number of provisional cases not adjusted for under-reporting
b: mother to child transmission, homosexual drug users, transfused individuals (in France or elsewhere), haemophiliacs contaminated in the 80s and other unspecified cases
Source: InVS mandatory HIV infection reporting system (data as of 30 December 2009)

The number of new AIDS cases among IDUs has fallen continuously since the mid-1990s. Whereas IDUs accounted for a quarter of the people diagnosed at the AIDS stage at that time, they represented only slightly fewer than 8% in 2008 and approximately 5% in 2010 (provisional data).

Table 6-2: New cases of AIDS in IDUs, 2000-2010

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010*
IDUs	248	260	207	176	168	121	98	85	75	23	11
Total new AIDS cases	1 745	1 685	1 658	1 489	1 397	1 339	1 146	983	990	536	205
IDU proportion (%)	14.2	15.4	12.5	11.8	12	9.0	8.6	8.6	7.6	4.3	5.4

*: provisional data not adjusted for under-reporting and reporting delays as of 30 June 2010
Source: InVS AIDS monitoring system. (Data as of 30 June 2010)

PRELUD data

The survey among drug users attending low threshold services (PRELUD) conducted by the OFDT in 2006 provided a review of practices and use of psychoactive substances in a high prevalence user population. This was conducted voluntarily in "low threshold" services which have since become CAARUD[119]. In 5 of the 9 PRELUD sites in 2006 (Dijon, Lyon, Metz, Rennes and Toulouse), each user interviewed was asked to give a salivary sample to test for marker antibodies of HIV and HCV infection. This PRELUD "bio" survey found that the prevalence of HIV infection was 8.5% amongst the people seen (ST9 Part 2). 5.0%[120] of those who said that they were negative had a positive test.

Table 6-3: Estimated prevalence of HIV infection from salivary samples among low threshold services clients participating in the Prelud Bio survey (according to injecting status and age group).

			Injected at least once during their life		Injected and/or sniffed at least during their life
			No	Yes	
		Total	N = 136	N = 348	N = 467
Total	N = 484	8.5%	8.0%	9.6%	8.8%
< 25 years	N = 134	6.0%	-	5.6%	6.2%
From 25 to 34 years	N = 211	7.1%	-	5.5%	7.4%
> 34 years	N = 139	13%	-	13%	13%

Source: PRELUD 2006, Trend / OFDT

Reported data (the only data available to observe changes in France to date) obtained in the nine towns showed a decrease in reported HIV virus infection between 2003[121] and 2006 from 10.2% to 6.2%.

For laboratory findings on the hepatitis C virus, the PRELUD "bio" survey found a prevalence of hepatitis C of 32% in 2006. Estimated prevalence in injectors was 42% (ST9 Part 2). The proportion of patients with a positive test amongst those who said they were negative was 8.5%.

[119] Reception and harm reduction support centres for drug users
[120] Differences observed with the results of the Coquelicot survey can be explained by the following: :
- The population is different (one involves injectors and "sniffers" seen in a wide range of institutions/centres and the other exclusively considers users from low threshold services who are, on average, 5 years younger);
- The method is different (in terms of laboratory testing and recruitment plan);
- The towns surveyed were also different.
[121] Last version of the "Low Threshold" survey in 2003 replaced in 2006 by the PRELUD survey.

Table 6-4: Estimated prevalence of HCV infection from salivary samples among low threshold services clients from the Prelud Bio survey (according to injecting status and age group)

			Injected at least once during life		Injected and/or sniffed at least once during life
		All	No	Yes	
	Total	N=500	N=138	N=362	N=483
Total	N=500	32%	7%	42%	33%
< 25 yrs	N=138	13%	-	16%	14%
25-34 yrs	N=214	31%	-	44%	32%
> 34 yrs	N=148	51%	-	63%	53%

Source: PRELUD 2006, Trend / OFDT

Reported information from the PRELUD survey between 2003 and 2006 showed a decrease in the prevalence of reported hepatitis C positivity (43.4% to 34%) particularly in younger people (under 25 years old), in whom it fell by half (from 17.6% to 8.4%). This phenomenon is not, however, due to a fall in injection practices in these people as the proportion of users under 25 years old who had injected at some time in their lives increased from 51% in 2003 to 59% in 2006, and the proportion of those who had injected more than ten times during their lives increased over the same period from 41% to 50%.

More screening, however, also took place in younger people in 2006 than 2003, which may be responsible for a change in the responder population (only those who had undergone screening can answer the question). The proportion of people who had never had a screening test amongst the under-25-year-olds fell from 39% to 25% between 2003 and 2006.

For hepatitis B virus, more than a third of users from urban harm reduction support centres did not know their hepatitis B viral status in 2006. This virus can be transmitted by needle-sharing or sexual intercourse. Far more people over 34 years old, however, reported that they had been infected compared to the younger people (17% compared to 4% of 25- to 34-year-olds and 2.1% of those under 25 years old). 45% of those who reported that they had been vaccinated in 2006 reported 3 injections, 25% claimed to have been given two and 28% only one.

ENa-CAARUD data

The aim of this national survey, conducted for the second time in 2008 among 3,138 users seen in 122 certified CAARUD[122], is to take account of the diversity and methods of use in a large population of current drug users. In particular, it provides information about the reported serological status of users seen in these centres (HIV and Hepatitis C). The majority of drug users in 2008 had had these screening tests performed (87.2% for HIV and 83.8% for HCV) of which 6% reported that they were positive for HIV and 28% for HCV. Similar screening rates were seen in the previous survey in 2006, (84% for HIV and 81% for HCV) although there were more positive declarations. In the same way as for the reported data from the PRELUD survey, data obtained from CAARUD users show a fall in declaration of HIV seropositivity (6.3% compared to 7.3% in 2006), although this fall is not significant. They do suggest, however, a significant fall in the prevalence of hepatitis C (28% compared to 35% in 2006, $p<0.01$).

This fall in reported seropositivity is particularly apparent in young people under 25 years old (reported HIV seropositivity rates of 2.6% and 0.5% in 2006 and 2008 and 14.9% and 10.1% for HCV in the same years).

[122] The 2006 survey included on 3,349 users recruited in 114 CAARUD

More women than men reported that they had had a screening test in 2008 both for HIV (88.6% compared to 86.8% of men at sometime in their lives) and HCV (85.3% compared to 83.3%). They had also had their tests more recently (within 6 months) than men for both HIV (47.6% compared to 39.7% for men) and HCV (47.6% compared to 40.7%).

More of these tests were positive for HIV (6.5% compared to 5.9%), unlike HCV (25.5% compared to 28.4%) in women.

In the same way as for the PRELUD[123] survey, the proportion of users from low threshold facilities who had never had a screening test appears to have fallen over time with 13% in 2008 compared to 16% two years earlier for HIV and 16% compared to 19% for HCV.

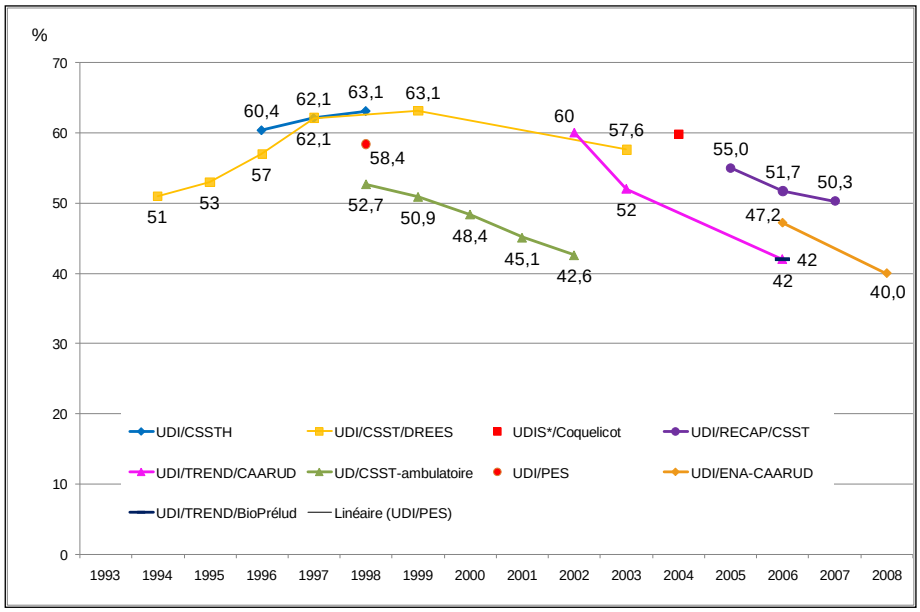
The great majority of HIV seropositive people (90%) consulted at least one physician during the previous 12 months for the disorder in 2008 and 78% received treatment over the same period (compared to 68.5% in 2006). 70% of HCV seropositive people consulted a physician over the same period although, unlike the case of HIV, only 28% had been treated for their disease. This finding, however, does appear to represent an advance compared to the same survey in 2006 when 22.5% had been treated.

Summary

It appears that for HCV, since the beginning of the 2000s, there has been a dip in the prevalence curve for the disease in injecting drug users (Graph 6-1). This can be explained by several factors: the impact of the different public health measures taken in France, greater accessibility to treatment, greater access to screening and changes in practices by most drug users.

[123] 10% of drug users seen in the PRELUD 2006 edition stated that they had never had a screening test for HIV in 2006 compared to 18% in 2003 (Low threshold surveys) and 16% declared that they had never had a test for HCV compared to 21% 3 years earlier.

Graph 6-1: Change in reported prevalence of hepatitis C virus infection in DU in France



Sources:
UDI/CSSTH: Injectable drug users in residential structures
UD/CSST-outpatient: Drug users treated in specialist care centres
UDI / RECAP/CSST: Drug users treated in specialist care centres
UDI/TREND/CAARUD: Injectable drug users who are low threshold facilities clients (CAARUD)
UDI/ENa-CAARUD: Injectable drug users using the CAARUD
UDI/PES: Injectable drug users using a SEP (syringe exchange programme)
UIDS /Coquelicot: Injectable and sniffing drug users, laboratory data
UDI/TREND bioPRELUD Injectable drug users who are CAARUD's clients, laboratory data

A national viral hepatitis B and C plan[124] was also started in France by the Ministry of Health in 2009 and envisages activities over 4 years (2009-2012). This involves 5 major objectives: increasing preventative activities to reduce the number of new possible infections, increasing screening activities[125] and access to care, setting up appropriate complementary measures in prisons (particularly for screening) and improving epidemiological knowledge on the subject.

Psychiatric comorbidities

Almost half of drug users consider that they are in poor psychological health (according to 45% of those seen in the CAARUD 2006). This impression increases with age (with 38% of those under 25 years old reporting this compared to 46% of 25- to 34-year-olds and 49% of those over 35 years old). Users described depressive or anxiety symptoms, suicidal ideation and even episodes of delusions. Almost a quarter of hospitalisations reported by CAARUD clients during the previous 12 months were due to psychiatric problems in 2008, particularly in women (30.1% were hospitalised for psychiatric problems compared to 21.5% of men).

[124] This follows two other plans. The 1999-2002 Hepatitis C Plan and the 2002-2005 hepatitis B and C Plan
[125] The proportion of people aware of their hepatitis C seropositivity increasing from 57% to 80% and those aware of their hepatitis B seropositivity increasing from 45% to 65%

6.2.2. STIs and tuberculosis

There is no specific information system in France providing information on the reported or laboratory prevalence of tuberculosis or of sexually transmissible diseases amongst drug users.

6.2.3. Other infectious morbidity

Different, particularly infectious, diseases may occur with injection of buprenorphine or other substances. The different, particularly infectious, effects which were found amongst CAARUD clients interviewed in 2006 are shown in the table below (PRELUD survey)

Table 6-5: Consequences of injection reported by low threshold centre users in 2006

Injection during previous month	HDB (n=239)	Other substance(s) (n=232)	Total (n=471)
Injection difficulties	68%	56%	62%*
Skin abscesses	36%	22%	29%*
Blocked veins, thrombosis, phlebitis	46%	29%	38%*
Swollen hands and forearm	43%	30%	37%*
Swollen feet or legs	16%	12%	14%
The shakes (febrile episodes)	31%	24%	27%

* difference significant at a statistical threshold, error of <1%

6.2.4. Behavioural data

Information about injection can be found in chapter 4 (CAARUD's data).

Whilst most drug users have adopted the concept of not sharing syringes, the same does not apply to other equipment. Some users prepare the substance in a group and "pump" it in turn through the filter, each person using their own syringe, which may have already been used. Slightly under 10% of users (9.3%) interviewed in the CAARUD in 2008 reported that they had shared their syringe in the previous month compared to 17.9% for their spoon, 14.3% for their filter, 16.7% for the preparation water and 10.1% for their rinse water. A total of 24.9% had shared at least one tool of injection equipment during the month. These results are all higher than the estimated equipment sharing rates in 2006 in the first edition of the ENa-CAARUD survey, although only the differences on sharing preparation water and at least one tool of equipment are statistically significant.

According to the TREND system, the increase in official controls by the police appears to have induced the adoption of high risk behaviour. The risks of injection appear to be increased by the need for some users to use the substance they have bought very quickly to avoid being arrested while carrying it on them. Sent away by the dealers from the point of sale, these people are then forced to inject in dirty surroundings (parking lots, stairwells, etc.). This rushed injection is often not successful and is repeated several times, resulting in a lack of sterile equipment, and therefore promotes equipment sharing. The most vulnerable users also appear to avoid carrying their equipment, a sign of drug use which could make them liable to be searched by the police.

It would appear that the younger the users, the more prevalent these sharing practices. Depending on the piece of equipment concerned, recent injectors under 25 years old are two to three times more likely to share than those under 35 years old ($p<0.01$).

In addition, the ENa-CAARUD survey findings show that for identical ages and vulnerability, women are approximately twice as likely to share their injection equipment than men ($p<0.01$). Several studies have recently identified higher risk practices in women {Jauffret-Roustide et al. 2006; Cadet-Taïrou et al. 2010b}, particularly in the youngest.

Several TREND sites have described populations of socially marginalised young people with no family or institutional support and completely penniless young migrants usually from Eastern Europe, since 2002. These users most often have extreme practices (anarchic polydrug use, injection), live in extremely vulnerable conditions and make little use of the care systems. The new generation of vulnerable users (under 25 years old) is therefore one with cumulative health risks from wider sharing of injection equipment and a higher prevalence of prostitution {Rahis, A. C. et al. 2010}.

TREND also shows greater attendance at techno party events by injecting users. Injection has been completely rejected by the techno culture but is tending to become increasingly visible on the margins of the least well controlled alternative music gatherings. It remains, however, a marginal phenomenon affecting a more vulnerable population whose use of psychoactive drugs is not limited to just the party setting. This practice poses new challenges to harm reduction: completely inadequate health conditions, users extremely ignorant of harm reduction procedures and the difficulties experienced by harm reduction workers in controlling the entire techno scene, which is increasingly characterised by the organisation of small events that are not publicised {Sudérie et al. 2010}.

Finally, a study was conducted in 2007 for the OFDT on the gay party scene in Paris and Toulouse. Amongst other aims, this study intended to increase understanding of the link (based on statistical findings) between the use of psychoactive substances and high risk sexual behaviour in people attending these male homosexual parties {Fournier et al. 2010}. The results of this study are considered in the findings on specific populations (chapter 2)

6.3. Other drug-related health correlates and consequences

In 2008, more than a third of CAARUD's clients (35% in 2006) felt that they were in poor or very poor physical health, this proportion remaining stable between 2001 and 2008. Whilst the most commonly reported morbidity was infection (bronchitis, colds, abscesses), trauma was also reported (fractures, violence, accidents) together with skin and tooth (fungal infections, wounds, ulcers), gastro-intestinal (constipation, diarrhoea) and cardiac problems {Bello, P. -Y. et al. 2010}. 38% of CAARUD clients in 2008 had been hospitalised at least once during the previous year, 44% of women and 37% of men.

6.3.1. Non-fatal overdoses and drug-related emergencies

7.4% (224) of the users interviewed in 2008 in the ENa-CAARUD survey reported that they had had an episode of loss of consciousness after taking psychoactive substances in the previous twelve months {Cadet-Taïrou et al. 2010b}.

In slightly more than half of the cases (52.1%) when a substance was reported, the subjects described at least two (scheduled substances) and 21.8% reported three.

The leading substance presumed responsible for this loss of consciousness (N=211), according to users, was heroin in 21.3% of cases, alcohol in 19.0%, followed by cocaine (18.5%). Benzodiazepines were also reported for 11.8% of cases and other substances in only 4%.

Benzodiazepines were most often reported as second (n=110) or third substances (N=46) (27.3% and 26.1%) as were cocaine and alcohol.

Excluding the ranking, four substances were involved at very similar frequencies (between 25% and 30%) in “overdoses” defined by users. In descending order of frequency, these were benzodiazepines, alcohol, cocaine and heroin. Other substances were reported far less often, between 7.6% (BHD) and 0.4% (GHB, poppers, glues/solvents).

6.4. Drug-related deaths and mortality of drug users

6.4.1. Drug-induced deaths (overdose/poisonings)

Fatal overdoses from drug use are shown in the following table. Thre mains sources are included: data from the police; the General Mortality Register (CépiDc) data from death certification processing follow the EMCDDA selection B[126], although the T codes are very rarely used in France. There is an increasing divide between all deaths recorded and those in people between 15-64 years old due, to a large extent, to deaths in elderly people receiving palliative treatment (these deaths are most often coded X42), as well as data retrieved the forensic laboratories (the DRAMES file).

Due to significant under-reporting, the police data proved unreliable and are not available anymore. Here again, the increase in overdoses in 2006 seen in the DRAMES data is partly explained by the increasing number of forensic laboratories taking part in the data collection. To the notable exception of Strasbourg and Nice, all other laboratories were included Numbers have remained almost stable since then and we may conclude that there is an upward trend in the number of overdose deaths between 2006 and 2009. This source also provides valuable information about the substances used, as it is based entirely on the results of toxicological tests. The definition applied here is very similar to the EMCDDA's selection B.

[126] Common definition of fatal overdoses applied to all European countries: http://www.emcdda.europa.eu/situation/diseases-and-deaths/3

Table 6-6: Fatal overdoses in France from three sources

Year	OCRTIS (police)	Deaths register (EMCDDA, selection B definition)			DRAMES (laboratories)
		All	15-64 years old	15-49 years old	
2000	120	248	225	219	101
2001	107	274	243	232	na
2002	97	244	225	208	74
2003	89	233	212	204	64
2004	69	268	239	226	86
2005	57	303	264	241	68
2006	na	305	275	260	168
2007	93	333	287	260	192
2008	na	374	322	298	217
2009	na	365	321	305	260

na: not available. Sources: OCRTIS, DRAMES, CépiDc, various reports

According to data from the General Mortality Register, the continuous upward trend observed since 2003 seems to come to a halt, with a lesser number of cases (-9) recorded in 2009. Although this apparent break is belied when age is restricted to admittedly active users' ranges, in order to exclude false positives (deaths induces by the misuse of prescribed opioids painkillers), in which case a slight increase is observed. This figure is confirmed by data from the forensic laboratories, showing an even sharper rise. Plausible explanations of the rise in the number of drug induced deaths are: increasing availability and purity (heroin in particular); lowering prices (cocaine); emerging new types of poly-substance users, steering clear of treatment centres or low threshold facilities and unaware of harm reduction practices; harmful and riskier uses for fear of being arrested {Cadet-Taïrou et al. 2010b}. It should be underlined that women represented almost one fifth (19%) of the deaths recorded in 2000 and a little less than 15% only in 2009.

Illegal drugs were the main substances responsible in slightly more than half of the cases (53%) in 2009, substitution treatments in approximately 34% of cases and opiates (excluding substitution) in almost 13% of cases. Overall, opiates were the main cause in 87% of deaths, and cocaine, either alone or combined with other substances, in approximately 12%. The increasing number of overdoses between 2006 and 2009 is explained by an increase in the number of deaths from heroin (+ 44 cases) and methadone (+ 27 cases) overdoses.

Table 6-7: Substances mainly responsible in fatal overdoses in 2006-2008, DRAMES data

	2006		2007		2008		2009	
	N	%	N	%	N	%	N	%
Heroine, alone or in combination	59	35.1	69	35.9	79	36.4	103	39.6
Cocaine, alone or in combination	31	18.,5	39	20.3	30	13.8	32	12.3
Other illicit substances, alone or in combination	5	3.0	2	1.0	4	1.8	2	0.8
Methadone, alone or in combination	31	18.5	61	31.8	63	29.0	58	22.3
Buprénorphine, alone or in combination	20	11.9	11	5.7	21	9.7	31	11.9
Other opiates, alone or in combination	18	10.7	10	5.2	19	8.8	34	13.1
Others	4	2.4	0	0.0	1	0.5	0	0.0
Total	168	100.0	192	100.0	217	100.0	260	100.0

Source: AFSSAPS. Only deaths directly due to drug use are reported.

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

Following the recommendations of the EMCDDA, a prospective cohort study is currently being performed (see the *selected issue* at the end of the report). This is based on the voluntary participation of treatment centres (both outpatient and hospital) and some harm reduction centres throughout France. For identification and follow-up reasons, this study requires anonymity to be completely removed for all of the people concerned. This requirement has led a number of harm reduction centres to refuse to take part as they are strongly wedded to this privilege which was not easily won. To date, more than half of the users approached have refused to take part in any way. The questionnaire used in this survey is an adaptation of the RECAP questionnaire (*Treatment Demand Indicator* protocol adapted for the French context), well-known by the participating centres. The survey was approved by the CNIL (French Data Protection Authority) in September 2009. It began in December 2009 and should continue until the end of 2010.

950 individuals were included during a first draft (from December 2009 to May 2010). A second draft has been undertaken (from June to November 2011). A third draft is expected to take place from May to November 2012. So far, no results are available: data linkage is a difficult matter as it involves two separate institutions (namely the National Institute of Statistics, dealing with the vital status of all individuals on one hand; and the GMR, informing the causes of decease on the other hand). Moreover, the GMR is known to suffer long delays in its own process of validation (at least 2 years).

6.4.3. Specific causes of mortality indirectly related to drug use

There are no information sources in France at present to answer this specific question. It should be noted that the main institutions concerned seek above all to establish a consensus about the direct causes and a uniform measurement of the prevalence of fatal overdoses. The question of indirect causes is not currently seen as being of primary importance.

7. Responses to health correlates and consequences

7.1. Introduction

The response to drug users health problems over the last two decades have largely been focused on injecting-related infectious diseases (HIV and hepatitis) {Bello, P. -Y. et al. 2010}. For this reason, the oldest and best structured programs concern the fight against these diseases (point 2). The measures employed target the various stages of the morbid process: primary prevention with harm reduction, secondary prevention with an encouragement to undertake screening and early treatment and, finally, the treatment itself, with improved access to this treatment and its follow-up for users. Other pathologies related to drug use, psychiatric comorbidity, or arising as a result of serious incidents for example, have not been the subject of specific responses from the public authorities up until now.

With the exception of substitution treatments[127] [128] , changes in the supply and availability of treatment and harm reduction measures have not been closely monitored in France until recently due to the difficulty in gaining access to the necessary data. However, a number of indicators exist, making it possible to monitor the geographical coverage of ad hoc services provided for drug users. Two surveys among respectively pharmacists and doctors, carried out by the INPES (National Institute for Health Education and Prevention) make it possible to measure the number and density of the health professionals (pharmacists and doctors) contributing to the harm reduction measures or treatments (the Health Barometer survey for Pharmacists and the Health Barometer survey for doctors).

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

Up until 2008-2009, no national policy or specific measures existed in France concerning the reduction of acute serious pathologies and drug use-related death. Access to substitution treatments and the harm reduction policy (access to sterile injection equipment through pharmacies, syringe exchange programmes, addictology centres and access to health care and social entitlements in so-called "low threshold" services) offer a number of indirect means of preventing deaths caused by opioid usage. The increasingly widespread use of high dosage buprenorphine, even when misused, which results in relatively few overdoses compared to heroin is considered as one of the reasons behind the fall in the number of overdoses recorded between 1994 and 2003 in France.

From 2008-2009 onwards, two specific actions began to emerge:

1) The health warning system, related to the use of psychoactive products, and organised as of 2006, is now operational and is gradually coming on stream.

Nationally, this includes the DGS (the addictions office and the alert warning unit), the InVS, the AFFSAPS, the OFDT, the MILDT, the local networks of each of its institutions (hospitals, GPs, addictology centres, regional monitoring units, low threshold services, pharmacists, etc.) and their international networks (the Early Warning System, and the European Centre for Disease Prevention and Control, etc.).

[127] Circulaire DGS/MC2/2008/79 du 28 février 2008 sur la creation des CSAPA (centres de soins d'accompagnement et de prévention en addictologie) et la création des plans régionaux sur le traitement médicosocial de l'addiction. NOR: SJSP0830130C.
[128] Legal framework for substitution treatments: please see chapter 1

Its purpose is to identify, analyse and respond rapidly to:

- Signals related to human cases (deaths, unusual symptoms, syndromes or pathologies, possibly occurring together around the same time or in the same locality and having an obvious or suspected link to the occasional or repeated administration of a psychoactive substance or a combination of such substances)

- Substance-related signals: currently circulating, seized or already-consumed psychoactive substances or substance combinations of an unusually dangerous nature likely to pose a lethal risk or entail serious health consequences (including factors such as the presence of specific additives, the level of purity, the extent to which the substance is new or established, or usage pattern of use, etc.).

Following an analysis of the signals in question, the response can range from a simple monitoring of the phenomenon to a health warning concerning the toxicity of certain currently circulating substances or a formal reminder of the dangers of certain "at risk" practices {Lahaie et al. 2009}.

2) Specific tools and resources aimed at preventing drug-related deaths (currently being prepared).

The upsurge in drug-related deaths, namely related to heroin use (please see chapter 6) has made the health authorities more aware of the gradual spread of heroin to younger sections of the population, who tend to be better integrated socially and, above all, insufficiently informed of the risks of taking opioids and the means available to reduce these risks. Thus, the INPES (National Institute for Health Education and Prevention) is currently working with professionals in this field to prepare brochures and information leaflets aimed at specifically preventing overdoses. A coalition of harm reduction and self-help associations has also produced information resources aimed at drug users (DUs).

Apart from the non-specific result indicators described in chapter 6 (the number of overdoses, the percentage of CAARUD clients stating that they have experienced a non-fatal overdose during the last year, etc.) the tools for monitoring these actions have not yet been defined. Currently, the early warning unit's activities can be gauged very roughly by the number of cases dealt with by the unit annually or by the number of alerts issued to the public or to professionals.

The prevention and treatment of drug-related infectious diseases

The prevention of drug-related infectious diseases initially targeted only HIV until the years 1999-2002, when the first national plan against hepatitis C was adopted. The prevention measures in this plan mainly pertained to DUs, which represented the vast majority of new cases in France. This plan contained measures concerning prevention, screening, access to treatment and improvements to treatment. With the decline of HIV infection prevalence in drug users, the fight against viral hepatitis in this group has now become a central issue. The 2002-2005 plan entitled "the national hepatitis B and C plan" also includes hepatitis B. In December 2008, while awaiting the publication of a new plan, measures were taken aimed in particular at building awareness among health professionals of the need to vaccinate "at risk" individuals, including drug users[129]. The new plan (2009-2012) is based on the same issues, but more

[129] In France, vaccination against hepatitis B has never been compulsory although a campaign aimed at encouraging vaccination in infants and teenagers existed until 1988. After the end of this campaign, the general level of vaccinations tended to drop. In

extensively identifies the "at risk" groups to better reach them. The prevention aspect is also aimed at the most vulnerable and precarious individuals in society, and particularly migrant populations. The plan further stipulates working on preventing the first injection. Furthermore, it also covers possible contamination by snorting or smoking, whereas up until now the French preventive system had scarcely considered this aspect.

The preventive measures used in France include:

1) A harm reduction policy[130]

The prevention of infectious diseases related to drug use constitutes the main trunk of the harm reduction policy in France. It is based on:

- The distribution and recovery of sterile, single-use equipment[131]. Syringes and injection kits are sold without restriction in pharmacies (no prescription required since 1987). Injection kits are also distributed or exchanged by low threshold structures (CAARUDs) or dispensing machines. For several years now, the availability of preventive equipment has gradually been extended to routes of administration other than injection, with the distribution of sniff kits and base kits for crack smokers. Finally, distributing condoms (and encouraging their use) also contributes to reducing HIV virus contamination.

- The circulation of information on drug-related risks and the promotion of health education.

- The distribution of substitution treatments from 1995 onwards (please see the chapter 5) which seeks to reduce injecting drug use (preventing the first injection and/or encouraging users to give up the intravenous route) by reducing heroin use, but also to encourage access to treatment by providing a joint objective for both doctors and drug users, making it possible to develop a strong therapeutic relationship between them.

The harm reduction system is chiefly based on local pharmacies (for the sale of equipment and participation in syringe exchange programmes), the specialised medical/social system comprised of CAARUDs and the non-medical/social services offered by the associations. This scheme is essentially involved in recreational settings and in the management of syringe exchange machines. Finally, there are the municipal schemes essentially involved in managing syringe distribution machines (a third of the schemes in France). Treatment access points also contribute to reducing risks, either directly (through the provision of information or equipment, etc.) or indirectly (information and substitution treatments). In particular, general practitioners and pharmacists also contribute to the harm reduction policy by prescribing and dispensing HDB. In order to provide substitution treatment access to the most vulnerable drug-using populations (e.g., pregnant women, prisoners), health care professionals[132] can initiate

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2004, the vaccination levels were 29% for children under the age of 24 months and 42.4% for teenagers aged 15 (BEH 2009 20/21 box 1).

[131] Decree of 1987 on the unrestricted sale of syringes through retail pharmacies, circular dated 15 Sept. 1994 authorising the widespread sale of Stéribox through pharmacies, decree of March 1995 establishing the appropriate legal bases for syringe exchange programmes and the provision of free syringes by associations, letter from the DGS of October 1995 concerning cooperation programmes with local authorities regarding access to equipment. See Art. D. 3121-27 of the French Public Health Code

[132] Circulaire DGS/DHOS no. 2002/57 du 30 janvier 2002 sur la prescription de la méthadone par les médecins exerçant dans les établissements de santé, dans le cadre de l'initiation d'un traitement de substitution pour les usagers de drogues fortement dépendant des opiacés.

methadone substitution treatment in a hospital or prison setting. This possibility has been limited to physicians working in CSAPAs until now.

2) Encouragement to undergo screening for HIV, hepatitis C or hepatitis B infection and ease of access to this screening.

The plan stipulates carrying out activities more systematically in all structures visited by drug users, as well as providing information on the importance of screening and the efficacy of the treatments available to drug users in areas that generally attract unstable and migrant populations. It also includes an information campaign aimed at the general population and health professionals.

Whereas the cost of screening for HIV and hepatitis C infection is 100% covered by the French national insurance scheme, the search for chronic hepatitis B markers is only 65% covered.

The aim is to reduce the percentage of cases in which the disease is already highly advanced by the time it is detected by screening.

The screening programme is chiefly carried out in CDAGs (free of charge and anonymous screening centres). In 2006 there were 307 CDAGs in France in addition to 73 CDAG units operating in prisons. Users can visit them, and may be referred there or accompanied by CAARUD staff members. There are also local harm reduction or addictology centre initiatives which organise the collection of samples directly on site in the concerned centres. Finally, access to screening is also possible via traditional treatment channels.

3) Encouragement to undergo vaccination against hepatitis B.

In addition to continuing to encourage "at risk" people to get vaccinated (in particular in treatment centres and harm reduction structures), the new plan also seeks to encourage vaccination among the general population, for infants and teenagers.

These data, which were unavailable for several years and are once again being collected by the OFDT, help monitor the quantities of injection equipment provided to DUs. The OFDT gathers this data from information on sales of Beckton-Dickinson syringes to pharmacies, from the information system based on the CAARUD's (ASA-CAARUD, see appendix IV-V) standardised annual reports supervised by the OFDT and the French Ministry of Health, and finally, from the assessments produced by various associations involved in the distribution of syringes.

The information system developed with these CAARUD reports also helps monitor the activities deployed to prevent infectious diseases, through the number of condoms distributed, and the average annual number of acts per client concerning access to screening for viral disease and vaccination against hepatitis B.

The monitoring of the policy aimed at encouraging access to screening is chiefly based on the ENa-CAARUD survey carried out every two years by the OFDT among CAARUD clients. The percentage of users having already undergone screening for HIV or hepatitis C is now very high (above 85%). It is important that this screening needs to be repeated. The OFDT monitors this, also measuring the percentage of users for whom the most recent HIV negative result dates back less than six months.

Finally, although measurements are being carried out, a number of indicators are not available on a sufficiently regular basis, such as the percentage of infected drug users for hepatitis C (or HIV) unaware of their infection. The Coquelicot survey carried out by the InVS in 2004 found that a large part of hepatitis C infected drug users were unaware of their infection status (27 %) {Jauffret-Roustide et al. 2006}. Similarly, the measurement of drug users' knowledge of their hepatitis B status (vaccinated, contaminated, cured or otherwise) was carried out in 2006 with the PRELUD study (OFDT) without being subsequently repeated {Cadet-Taïrou et al. 2008}.

Finally, facilitating access to treatment for infected persons is the main point of the "treatment" aspect, but also a harm reduction measure for those users who are not yet infected.

Ministerial measures introduced in December 2005 created "a co-ordinated treatment procedure for hepatitis C" organised around hospital contact points in order to improve liaison between GPs and the specialised medical services, in addition to the quality of treatment offered to patients and their overall quality of life. A "doctors" guide for hepatitis C was produced by the HAS in 2006 and was supposed to be updated every three years. In 2011, it hadn't been yet. A hepatitis B guide should follow.

Particular attention will be paid to alcohol use among patients identified as infected after screening.

Infectious disease prevention is also planned for drug users in prison. The new Hepatitis plan sees prevention in prison as one of its five strategic areas for attention. Access to HIV and hepatitis screening is also a main strategy of the 2010-2014 "health/prison" plan (see the chapters 1 and 9).

Responses to other health-related consequences of drug use

Other health-related consequences of drug use have not been the subject of any specific responses in France. Addiction services and harm-reduction structures have to facilitate access to care, with certain treatments provided on-site (skin treatments, etc.). The activities carried out by the CAARUDs in this particular field can be measured. Furthermore, drug users also make use of the general treatment system (emergency care, hospitals, independent doctors, etc.).

For economically disadvantaged population groups, access to treatment is possible thanks to the Universal Health Cover Scheme. Foreign nationals "without papers" (illegal migrants) can benefit from State Medical Aid if they ask for it. Nevertheless, a number of drug users living in extremely unstable conditions no longer have documents entitling them to coverage. Some minors, who are still covered by their parents with whom they no longer have any contact, are also without insurance. Consequently, a small percentage of users frequenting CAARUDs (around 5 %) have no social cover whatsoever (ENa-CAARUD).

Concerning drug users' psychiatric comorbidities, their treatment in France remains a problem still requiring a solution. Although there are psychiatrists in the addictology field and although some psychiatric hospitals have developed treatments for drug addicts over recent years, these initiatives are few and far between and remain marginal when compared to needs. Doctors treating drug addicts experience major difficulties in finding suitable treatment establishments for those requiring residential and complex treatments.

No national monitoring indicators exist concerning the treatment of psychiatric comorbidities.

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

In 2010, the organisation of health warning measures for psychoactive substance use improved by promoting and inciting coordination among players likely to receive, process and respond to signals on a regional level: Regional Health Agencies and Drug Dependency Information/Evaluation Centres (CEIP) of the AFSSAPS network, if there are any in the region, and TREND/SINTES sites of the OFDT if need be. This measure also ensures that these players are able to inform potential targets (e.g., harm reduction structures, specialised treatment centres for DUs, networks of physicians specialised in drug addiction, users associations, and hospital emergency departments).

This explains in part why the warning system only issued one national public alert in 2010 through a press release[133].

- 19 January 2010, press release: "Cas groupés de maladie du charbon chez des consommateurs d'héroïne en Écosse et en Allemagne" (Grouped cases of Anthrax among Scottish and German heroin users).

Moreover, SINTES information notices were issued by the OFDT:

- "Analyse d'héroïne et de cocaïne fortement dosées à Strasbourg" (Analysis of high-dose heroin and cocaine in Strasbourg), SINTES information notice, 31 March 2010[134]

- "Identification de cocaïne à la lidocaïne" (Identifying cocaine with lidocaine), SINTES information notice 31 March 2010[135]

An increasing number of dossiers were coordinated by the warning system over the year, but no risk was identified on a national level. The various players were able to conduct regional investigations that gave rise, when necessary, to communication targeting only drug professionals and users associations. Other alerts were followed without giving rise to communication, such as the circulation of high-dose heroin or heroin associated with alprazolam like in 2009, or suspected grouped cases of cannabis psychoses.

The experience gained with this system clearly shows the merits of active surveillance systems such as TREND and SINTES, which allow the significance of the signal to be interpreted very quickly thanks to relatively accurate knowledge of users, practices, contexts and markets.

7.3. Prevention and treatment of drug-related infectious diseases

Some of the data provided in this section come from relatively old surveys (2003). Nevertheless, they are all that is available in 2011. The new results of these surveys will be made public in late 2011.

[133] http://www.ofdt.fr/BDD/publications/docs/cpmcharbon100119.pdf
[134] http://www.ofdt.fr/BDD/sintes/ir_100331_herococa.pdf
[135] http://www.ofdt.fr/BDD/sintes/ir_100331_lidocaine.pdf

HR (Harm Reduction) Accessibility

In order to guarantee wide access for drug users to HR, the health authorities have, from the outset, promoted local access based primarily on pharmacies, GPs and dispensing machines. The medico-social system (CAARUDs and CSAPAs) supplements and develops this local access offering. The following indicators are useful to assess the actual scope of the systems in place.

Level of involvement and location of professionals from the pharmacy based device

In 2003, the last year for which data are available, the very large majority of pharmacists saw at least one drug user in their pharmacy with requests for equipment (syringes or prevention kits) or for opiate substitution treatment. Pharmacists practicing in city areas where drug addiction problems are most prevalent received far more requests from drug users than those in rural areas {Gautier et al. 2005}.

This involvement of pharmacies in HR activities rose significantly in the late 1990s. However, it remains limited to basic functions of distributing syringes and/or substitution medicines. The majority of pharmacists in 2003 were not ready to take part in a needle exchange programme.

Table 7-1：Change in involvement of pharmacies in HR between 1999 and 2003

	1998/1999	2003
Proportion of pharmacies receiving at least 1 DU per month in their pharmacy (the basis on which the other % are calculated).	54%	85%
Of which:		
Proportion of pharmacists responding to requests for syringes or prevention kits and requests for OST	30%	70%
Proportion of pharmacists only dispensing syringes or prevention kits	5%	16%
Proportion of pharmacies only responding to a request for OST	16%	12%
Proportion of pharmacists taking part in an SEP	nr	6%
Proportion of pharmacists prepared to take part in an SEP	nr	30%
Proportion of pharmacists who refused to take part in an SEP	nr	57%

Source: INPES, Health Barometer - Pharmacists

An average of 6.1 people were seen per month in a dispensing pharmacy in 2003 for a request for syringes or Stéribox® and 5.9 [5.3-6.5] for a request for OST (opiate substitution treatment). The next edition of the INPES survey of pharmacists is planned for 2012-2013. Another national survey of retail pharmacies was conducted in 2010. According to the preliminary results issued by the AFFSAPS, 48% of the retail pharmacies surveyed stated providing information on preventing infectious diseases and 41.5% stated having syringe retrieval services (report to be published).

Level of involvement of GPs

A new edition of the Baromètre santé médecins généralistes[136] survey on general practitioners took place in 2009, six years after the prior version {Gautier 2011}.

- Two thirds of general practitioners saw at least one opioid-addicted drug user in the last year. The proportion of those seeing at least one user per month clearly increased from 2003 (when it was one third) to 2009 (when it was one half) {Gautier 2011}. Although the

[136] Telephone survey of general practitioners. In 2009, n=2083.

percentage of physicians prescribing substitution treatment did not significantly change, the prescription structure did change. More than one third of them now prescribe methadone (theoretically to ensure continuity of care after an initial prescription in a specialised centre in a hospital or a prison) while the percentage prescribing HDB diminished. The latter differ from their colleagues in certain ways. Their profile type is as follows: a man in group practice who carries out over 20 medical acts a day and for whom at least 10% of his patients have *Couverture maladie universelle* (CMU[137] or universal medical coverage). These physicians more frequently than other GPs feel that they can easily broach the subject of drug use. Finally, physicians who participate in a drug use, hepatitis or HIV network are more inclined than others to treat these kinds of patients (74.8% vs. 47.2%, p<0.001[138]). However, unlike the 2003 situation, the age of the physician seems to be unrelated to his propensity to treat drug users. Moreover, there are now more physicians treating opioid-addicted people in communities of fewer than 20,000 inhabitants than in more populated communities.

- Although the percentage of these physicians prescribing substitution treatment did not significantly change, the prescription structure did. More than one-third of these physicians now prescribe methadone (theoretically to ensure continuity of care after an initial prescription in a specialised centre in a hospital or a prison) while the percentage prescribing HDB diminished.

Table 7-2: Change in involvement of general practitioners in HR between 1999 and 2003

	1998/1999	2003	2009
Proportion of general practitioners seeing at least one DU (opioids) per month	35%	34%	49 %*
Of which:			
Proportion of GPs prescribing OST	78.9%	90.3%*	87.2 %
HDB (High Dosage Buprenorphine)	71.9%	84.5%*	76.9 %*
Methadone	12.6%	26%*	37.7 %*
Others	13.5%	7.4%*	14.9 %

Source: INPES, Health Barometer – Physicians
(*: Significant dif. P < 0.001 compared to the previous edition)

In 2009, physicians saw an average of 1.8 [1.7-1.9] opioid-addicted drug users per month, which was not significantly different from the number they saw in 2003 (1.6). However, the physicians who saw at least one opioid-addicted patient per month saw 3.6 [3.4-3.8] per month, which was significantly lower than in 2003 (4.6).

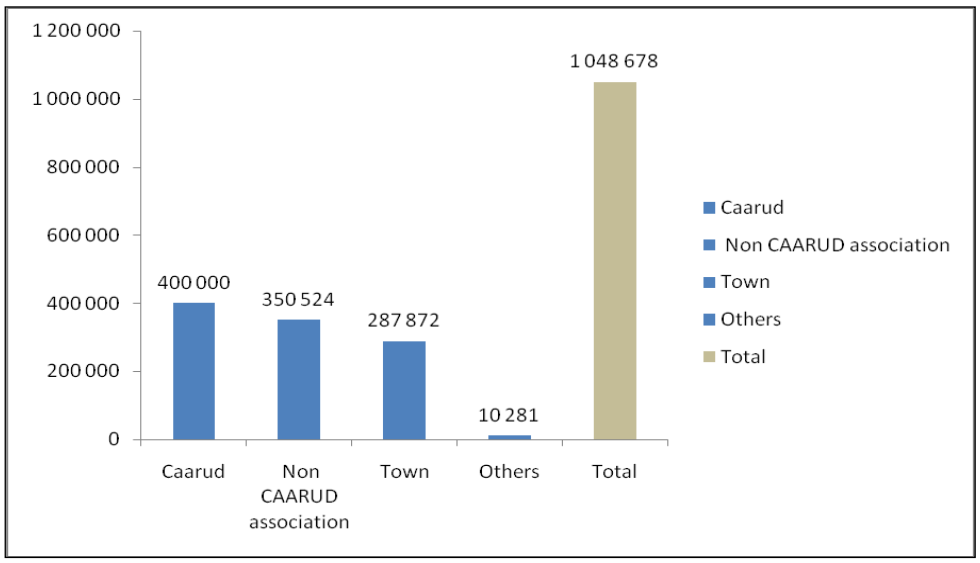
Actual scope of dispensing machines and operational status

Dispensing machines for Stéribox® injection kits contribute considerably to making injection equipment accessible, not so much quantitatively (they distribute slightly under 10% of the total number of syringes sold or distributed in France), but rather through the way they offer their service (anonymously and 24/7), allowing them to reach a different population than other

[137] Couverture médicale universelle: health coverage available to French people not paying into the system or to foreign nationals who are authorised to be in France.
[138] Inclusion in the logistical model of participation in a drug user, HIV or hepatitis network does not change the results (OR=2.9, p<0.001).

systems (Graph 7-1). There were 255 prevention kit distribution outlets and 224 syringe collection points in 2007 throughout 56 French administrative departments. Therefore, slightly over 40% of French departments did not have either of these services. These outlets/collection points distributed more than a million syringes and collected more than 600,000 used syringes. Nevertheless, the system is vulnerable, since more than a quarter of the machines are old or in poor condition. {Duplessy-Garson 2007}.

Graph 7-1: Number of syringes distributed through dispensing machines by operator type in 2007 (Source: SAFE, 2007 and ASA-CAARUD/OFDT, 2007 surveys)

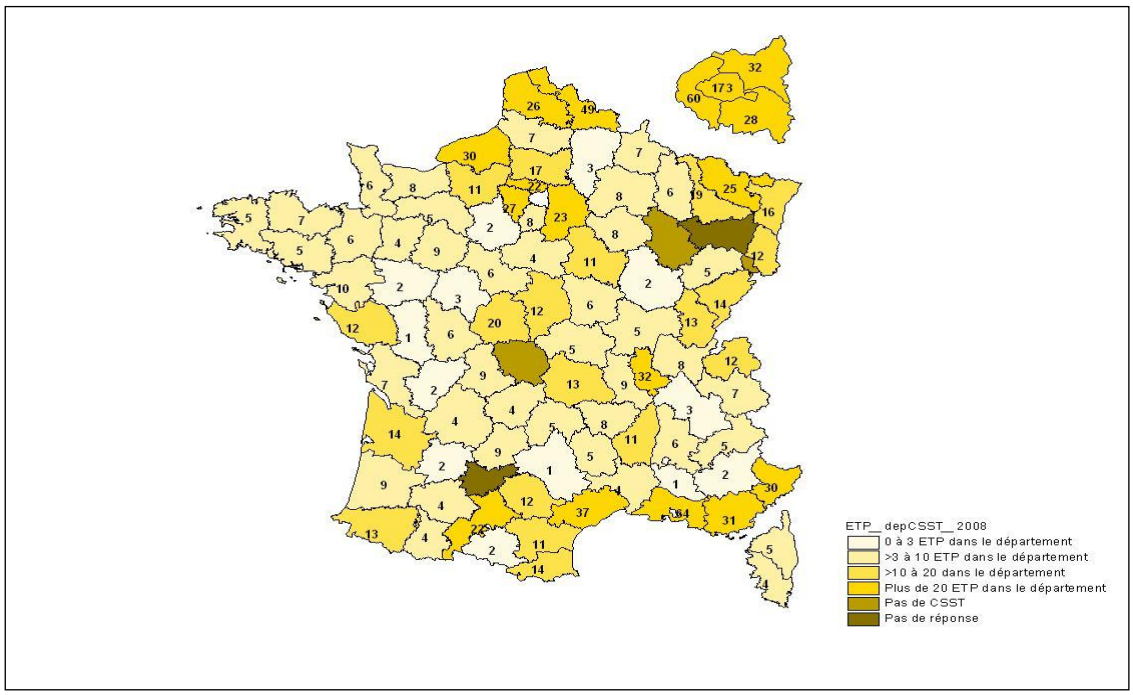


X-axis = CAARUD, Non-CARRUD associations, Communities, Other, Total
Y-axis = Number of syringes distributed by dispensing machines

National coverage by the HR socio-medical system (CAARUDs in addition to CSAPAs)

In 2008, the medico-social harm reduction system covered most of France, although 27 (out of 100) departments did not have a CAARUD, and two of them had neither a CAARUD nor a CSAPA.

Map 7-1: Breakdown of human resources in outpatient CSAPAs in the various French regions in 2008 (former Outpatient Alcoholism Treatment Centres (CCAA) not included)



ETP = Education thérapeutique de patient = Therapeutic Patient Education Centres
CSST = Centre de Soins Spécialisés aux Toxicomanes = Drug Addiction Treatment Centre
0 à 3 ETP dans le département = 0 to 3 in the département
>3 à 10 ETP dans le département = >3 à 10 in the département
>10 à 20 dans le département = >10 to 20 in the département
Plus de 20 ETP dans le département = More than 20 ETP in the département
Pas de CSST = No CSST
Pas de réponse = No response

Source : According to the Assessment Report on the objectives of the 2008-2011 'Combating Drugs and Drug Addiction' Government Action Plan

HR Awareness

TREND system reveals that groups of users who make little or no use of urban CAARUD services have little awareness of HR measures. This particularly involves errant, poorly integrated young people as well as "socially integrated" users who are beginning to inject, young people from working class neighbourhoods and younger goers to "dance events"(party scene) {Cadet-Taïrou et al. 2010b}.

CAARUD HR activities

In 2010, 135 CAARUDs existed throughout France. These are medico-social centres funded by the French social security system. They operate in various places with diverse methods. Of these, 95% offer a stationary reception service ("drop-in"), 66% have street teams, 47% operate in squats, 40% have mobile teams, 39% work with teams on the party scene and 28% have developed prison activities. They largely contribute to distributing clean injection equipment (3.8 million syringes in 2008) and other preventative equipment (e.g., ancillary injection equipment, condoms).

The major activities undertaken by these units are: providing assistance with hygiene and first aid care, offering health education promotion activities, helping people get access to social services, following-up on administrative and legal procedures and seeking out urgent accommodations.

More specifically, the 2008 CAARUD activities pertaining to distributing preventative equipment were:

- Syringes: 2.3 M syringe units and 530,000 kits (2 syringes per kit) handed over personally to individual users, 200,000 kits (2 syringes per kit) distributed via dispensing machines managed by the centre;
- Small injection equipment: 1.1 M filters and the same number of "cookers", 1.7 M water vials, 2 M alcohol wipes;
- Condoms: 782,000, 91% of which were male condoms;
- Gel: approximately 292,000 units.

Providing assistance in gaining access to OST and general care is one of the CAARUD's primary missions:

- 83% of the CAARUDs reported that they had set up access to OST (referral or monitoring);
- Of all of their activities involving access to hygiene and first aid, the most common procedures (35%) were body care, followed by nursing care (26%);
- 84.7% of CAARUDs developed health education promotion activities, 75% of which were individual interviews and group sessions focussing on the risks related to substances and to modes of contamination.

The CAARUDs saw 48,000 people in 2008, with an average of approximately 200 subjects seen at least once during the reference period, although in reality the figures varied greatly: 41 centres saw fewer than 200 people whereas 11 CAARUDs saw more than 1,000 [139] {Chalumeau 2010}.

The role of CSAPAs in harm reduction, one of their missions, cannot be specified because there is insufficient data due to the newness of the system.

HR on the party scene

Nearly 4 out of every 10 CAARUDs have a team that works on the party scene. In addition, a number of associations (particularly certain humanitarian, community health and specialist associations) carrying out HR activities are not part of the medico-social system. They are not certified as CAARUDs for various reasons: no fixed reception sites, failure to carry out all of the official mandates in the decree of 19 December 2005, no employees, administrative burden, concerns about a possible lack of independence or ability to innovate, the requirements formulated by some DDASS (e.g., according to these requirements, small associations or those

[139] See chapter 4 for a description of the clients seen at least once within the reference period ("*file active*" in French).

that do not implement all of the reference mandates should be grouped together. This particularly applies to HR associations working in the party scene).

There is no information available to compare the care offered and the needs of users on the party scene. Qualitatively, since the publication of the "*Mariani et Vaillant*" decree of 2002 [140], which describes the means by which parties are organised, the TREND system has observed a fragmenting of the non-commercial party scene into many small, undeclared free parties that are not advertised and take place in locations announced at the last moment to circles of people "in the know". These parties are increasingly less accessible to the HR associations, which do not have enough teams to attend all the events.

Since 2007, the considerable intensification of police controls in or around declared parties appears to have heightened this trend. This has not helped the task of HR workers, who occasionally are subjected to the same controls as the party attendees themselves.

The intervention methods on the party scene therefore depend primarily on the type of event organised and on the ability of the workers to attend them and organise their intervention (Table 7-3) {Reynaud-Maurupt et al. 2007}. Private parties can very easily escape the attention of HR workers. Therefore, it is only when the initiative is taken by the event organisers that the HR associations can intervene and set up targeted actions. These involve promoting and distributing information (leaflets about the risks related to drug use and how to prevent these risks) and/or HR tools. In the case of public parties, information and prevention materials are distributed along with food and beverages, and there are reception and counselling areas, areas for calming and reassuring drug users ("chill-out" areas), and even first aid services. When used, on-site substance testing is one way for workers on the party scene to make contact with drug users.

[140] Décret n° 2002-887 du 3 mai 2002 (the so-called "Mariani et Vaillant" Decree)

Table 7-3: Prevention activities in the party scene

Type of event	Main interventions	Population
Free party: party event with fewer than 500 people or raves with entrance fees (without prefect permission)	Downloadable flyers for participants and organisers and the possibility of ordering HR materials If there is knowledge of such a party: information leaflets and materials ("flyers")	Tekno music regulars, socially integrated people
"Legal" free party: "multi-sound" party event with more than 500 people (2 days)	Stand or "chill out"	Large proportion of Techno scene newcomers (most at risk).
Teknival: party event with more than 50,000 people (several days)	Creation of one or more "HR" villages: reception, information, equipment, counselling, reassurance, first aid, TLC facilities.	Often young new participants, minority proportion of IVDUs
Clubbing or urban parties (free or entry fee)	"Flyers" (information and equipment leaflets) or stand for prevention activities	Generally mixed audience, poor hygiene conditions
Town parades, festivals…	"Flyers" (information and equipment leaflets), mobile "stand" or " chill out" area	Many very young people

Source: OFDT from Techno+ activity reports and the 2004-2005. Quanti-festif survey (OFDT/GRVS)

Availability of injection, smoking and sniffing equipment

From the different information sources, we can estimate that approximately 14 million syringes were sold or distributed to drug users in France in 2008. Comparing this number to the number of IV drug users (81,000 recent IV users) produces a ratio of approximately 170 syringes per user per year {Costes et al. 2009}. This figure, which only represents an order of magnitude, may indicate high accessibility to syringes in France for IV drug users. However, this figure is difficult to interpret firstly because there is no reliable assessment of needs and, secondly, because of the likely geographical differences (particularly in rural areas). Pharmacies play a central role in providing this equipment.

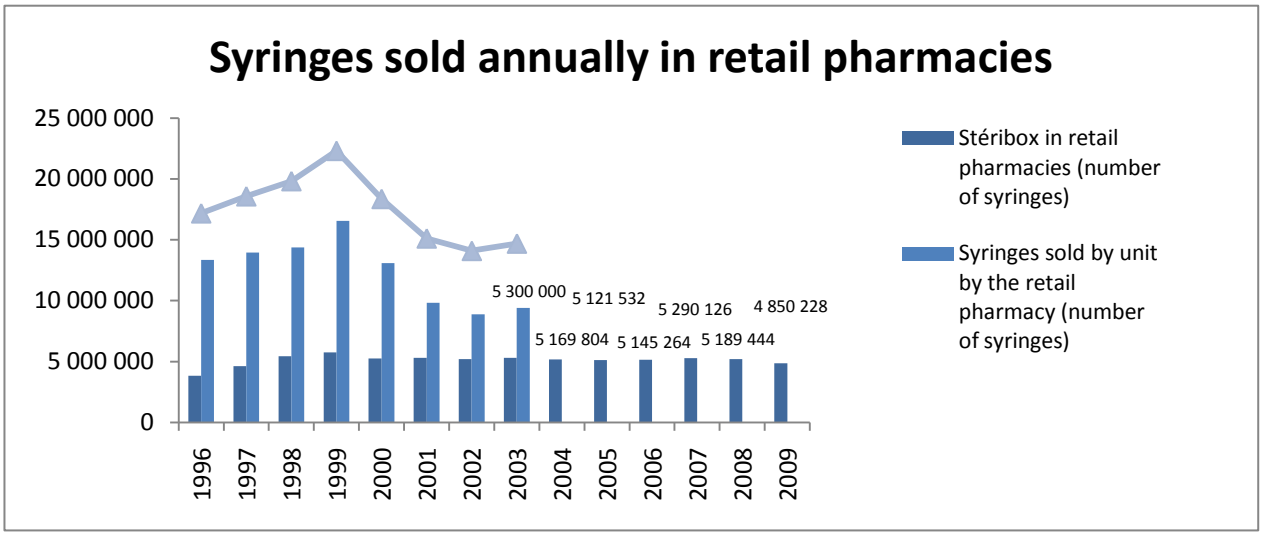
Table 7-4: Number of syringes dispensed by pharmacies or distributed by CAARUDs and dispensing machines in 2008

2008	Number of syringes sold or distributed (millions)
Pharmacy: in units	4,3
Pharmacy: in Stéribox®	5,2
CAARUD: in units	2,3
CAARUD: in Stéribox®	1,0
Dispensing machines (2007 data)	1,0
Total	13,8

Source: from the OFDT, InVS, GERS, Becton Dickinson, Asa-Caarud and SAFE data

Following a significant increase up to the late 1990s, syringe sales to drug users in pharmacies have fallen markedly since. This significant drop is only partially offset by the increase in the distribution of injection equipment by the CAARUDs. The CAARUD centres currently only represent less than a quarter of all syringes sold or distributed to drug users.

Graph 7-2: Change in the number of syringes sold annually in retail pharmacies to drug users



Source: OFDT from InVS, GERS and Becton Dickinson data

Two hypotheses may be put forth to explain the fall in the number of syringes distributed to drug users during the last ten years.

One positive hypothesis would be a fall in the number of injections due to fewer new IV drug users and preferences for other routes of administration (snorting and smoking). These routes of administration are largely predominant in drug users who began taking drugs on the party scene and have been adopted by some vulnerable users.

Another possible explanation may be that users are stopping intravenous drug use as a result of the diffusion of substitution treatments or, for some people, reduced injection frequency with injection becoming only an occasional habit. While there was an increase in the number of drug users between 1999 and 2005, the proportion of injectors appears to have fallen overall in the drug user population, except in some specific groups {Bello, P. -Y. et al. 2010; Cadet-Taïrou et al. 2010b}.

One negative hypothesis would be a return to syringe sharing and reuse, observed among some drug users, particularly the most vulnerable ones.

In 2008, moreover, 28,500 crack pipes were also distributed by the CAARUDs. Eighty percent of these were from centres in the Paris region and in Guiana.

Finally, 197,000 sniffing equipment items (rolling papers or sniff kits) were also distributed, mostly by the CAARUDs working on the party scene {Chalumeau 2010}.

Promotion of screening and vaccination

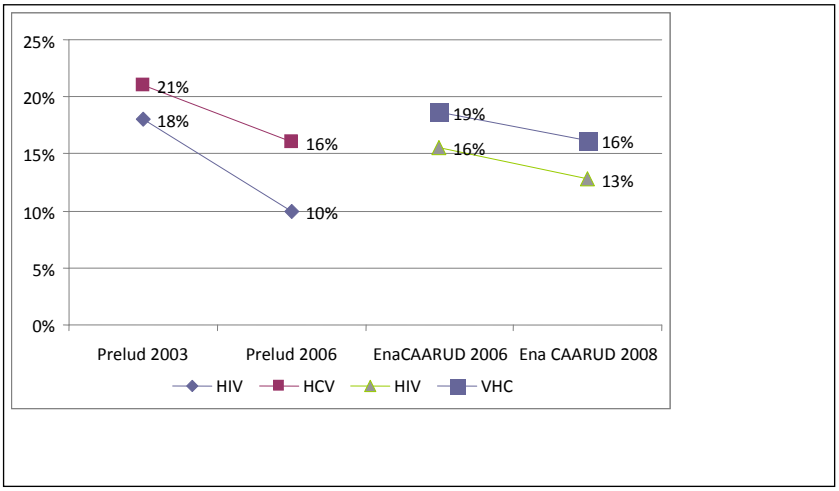
In 2008, of the approximately 55,600 drug users seen at least once, the CAARUDs organised almost 32,000 hepatitis B or C and HIV infection screening tests (HCV: 12,200, HIV: 11,000, HBV 8,800). There were 1,300 interventions to provide access to hepatitis B vaccination in this framework.

These data only represent orders of magnitude. It will be possible to assess their reliability and the credit that can be given to them by regularly monitoring them and studying their changes over time.

Interim results: screening rates for drug users in France

The ENa-CAARUD study showed that the vast majority of drug users frequenting low threshold centres in 2008 had already been screened for HIV and HCV infection (see chapter 6.2). Only 8.9% of those who had already injected at least once during their life had never had a hepatitis C screening test, compared to 7.7% for HIV {Cadet-Taïrou et al. 2010b}.

Graph 7-3: Proportion of CAARUD users who have never had a screening test for HIV and HCV



Sources: Première ligne 2003, PRELUD 2006 / TREND OFDT, ENa-CAARUD 2006 and 2008 /OFDT, DGS

The proportion of CAARUD users who have never had a screening test appears to have fallen over time (Graph 7-3).

As high risk behaviour continues, however, the screening tests rapidly become obsolete: in more than half of the people who had a negative result, the result was at least 6 months old (Table 7-5).

Table 7-5: HIV and HCV infection screening practices in users attending CAARUDs, ENa-CAARUD 2008

	HIV		HCV	
	Numbers treated	%	Numbers treated	%
Had had the test	2722	87,2 %	2599	83,8 %
Had not had the test	400	12,8 %	504	16,2 %
Of those HIV negative *, date of last test				
Less than 6 months ago	961	41,0 %	711	43,1 %
6 months to one year ago	646	27,5 %	463	28,1 %
More than one year ago	739	31,5 %	474	28,8 %

* Self-reported
Source: ENa-CAARUD 2008, OFDT, DGS

The proportion of positive users aware of their serological status appeared to be the best indicator of the screening outcome, although this requires measurement of laboratory serological status, which France struggles to do regularly.

In 2004, the Coquelicot study conducted in 5 French towns estimated that 2% of HIV positive users were not aware of their current serological status. The bio-PRELUD study conducted in 2006 on 5 sites also estimated this figure to be 5% {Cadet-Taïrou et al. 2008; Jauffret-Roustide et al. 2009}. The corresponding figures for HCV-positive users were 27% in Coquelicot (2004) and 8.5% in bio-PRELUD (2006). The difference can be explained, firstly, by the significant difference between the sites. Next, Coquelicot measured blood serology and bio-PRELUD saliva serology. Furthermore, in the second case, only patients whose viremia was detectable were positive; cured patients were therefore no longer positive. Third and finally, two years passed between these two studies (see ch. 6.2). In 2006 (PRELUD), 36% of CAARUD users stated that they did not know their hepatitis B status (vaccinated, unvaccinated, uninfected or infected). Finally, a study conducted from the "*pôles de référence pour l'hépatite C*" (hepatitis C reference poles) information system, which treats a portion of patients carrying the hepatitis C virus, made it possible to monitor *the proportion of late screening tests* in newly treated patients {Brouard et al. 2009}. In this case, a late test is defined as one performed in the year the patient started treatment, i.e., the patient is tested when they are at a stage of the disease that already requires treatment. This proportion fell between 2001 and 2007 from 42.7% to 33.4% ($p< 0.01$) in the total patient group (regardless of the source of the infection). The proportion of intravenous DUs in these late-tested patients did not change significantly (39.6% in 2001 compared to 35.5% in 2007 in men and 15.9% compared to 12.7 % in women) and it can be concluded that late testing is falling in DUs in the same way as the group average. The same applies to late testing in DUs who exclusively snort.

Access to treatment

Data obtained in 2008 from CAARUD users show that the majority of users aware of being infected by HIV are followed up medically, since 89.8% had at least one medical consultation for their infection during the year. Only 77.9% were prescribed treatment for the infection. This result was higher than that obtained in 2006 (68.5%), although not significantly so {Cadet-Taïrou et al. 2010b}.

The same survey showed that two-thirds (70.5%) of the people surveyed who said that they had tested positive for hepatitis C had had at least one consultation for their infection in the 12 months prior to the survey. Slightly over one quarter (28%) had been prescribed treatment for

this infection. This result appears to have increased from the previous 2006 survey, since only 22.5% of CAARUD users who were HCV positive reported that they had received treatment (p=0.02).

2009-2012 national viral hepatitis B and C plan

The content of the plan is mentioned in chapter 1. An assessment of the national hepatitis plan is scheduled for 2012.

7.4. Responses to other health correlates among drug users

In the absence of a specific response to other health problems, access to care is the only factor that can be observed.

Only 4.6% of drug users seen in CAARUDs in 2008 did not benefit from social health insurance (National Health Insurance, State Medical Assistance). More than half (54.8%) were covered by social funding (Universal Medical Cover, State Medical Assistance) and 6.3% had all of their costs paid because of a “long-term illness” (LTC) {Cadet-Taïrou et al. 2010b}.

Provision of care and access to care both represented the second leading activity of the CAARUDs in 2008 after social-integration activities.

8. Social correlates and social reintegration

8.1. Introduction

Concepts and definitions

Social harm

The notion of social harm arising from drug use and the decision to associate such harm with the substances themselves, with the past history and lifestyle choices of the drug users or with the public policies employed is not one which is universally accepted. The following conceptions and positions have been put forward: the drugs themselves constitute a form of social harm which can only be removed through their elimination; the use of drugs results in a number of social problems and nuisances, particularly in the case of abusive use; some forms of social harm act more as factors creating a predisposition to abuse psychoactive substances rather than being consequences of their use; we see a complex and bidirectional interaction at work: certain factors create a predisposition to abuse which, for its part, reinforces already deviant behaviour; and finally, for a latter group, the social harm in question (particularly that affecting individuals) tends to be due more to the penal policies focusing on banning drugs than on the drugs themselves.

Social

The "social" objective used to describe the harm in question also includes numerous aspects: the costs and consequences for society as a whole (concerning the health and justice systems or economic output); with a reduced quality of life in a particular geographical area for example; and more generally social harm concerning individuals in as far as their ability to function is impaired. Most studies focus on this last aspect {Sansfacon et al. 2005}

The notion of cause and effect

We can observe numerous forms of social harm which appear to be related to the use of alcohol or illegal drugs, for which a direct "cause and effect" link cannot be formally identified. Consequently, it is more common to talk of risk factors identified as encouraging the occurrence and intensity of social harm. Generally, the social harm related to the use of psychoactive substances tends to increase if:

- the age at which the individual starts taking drugs is significantly lower than the average;
- the variety of the products used early in the addict's "career" is significantly higher than the average;
- a significant pattern of long-term use sets in;
- use occurs against a backdrop of personal and social difficulties;
- the individual enters the justice system and in particular is sentenced to detention.

Social reinsertion/social reintegration

In the absence of a clear and universally accepted definition of this concept, we are keeping to a simple and extremely generalised definition: i.e. *the subject's return to a social and professional environment guaranteeing him maximum autonomy.*

Scope

Although the initial available data and work has been focused on improving situations in terms of employment, housing and to a certain degree health, the negative consequences of drug use can also be tackled in light of the social problems they generate including delinquency, insecurity, social exclusion, poverty, prostitution, educational difficulties and failure, difficulties in family or personal relations, or occupational and recreational accidents.

In France, social policies are "universal", (i.e., they are aimed at all legal residents without distinction, and therefore to drug users too, even if they are not specifically named as a "target group"). Nevertheless, people with drug addiction problems receive dedicated health and social assistance provided by specialised organisations (the CSAPAs and CAARUDs) and constitute the focal point for the "national drug policy" run by the Interministerial mission for the fight against drugs and drug addiction (MILDT).

Automatic access to national social policies…

Problem drug users benefit from the health protection provided under common law: the provision of general and specialised medical care and hospitals on the one hand and schemes, measures and benefits on the other, concerning improvements in their training-related situations, financial situations, or employment/housing situations, etc.

The state and more recently the local authorities have implemented major public policies aimed at reducing or eliminating social exclusion and encouraging the integration of individuals, including the provision of public resources and the creation of schemes aimed at improving and developing integration programmes.

In France, since the early 1980s a key principle has emerged which has formed the basis for all integration policies and which has had a high degree of influence on social integration schemes: access to (or a return to) employment is seen as the best means of combating poverty and is viewed as a vital factor underpinning social integration. The RMI (*revenu minimum d'insertion:* minimum benefits paid to those with no other source of income) introduced in 1988 entitles anyone to receive a minimum level of resources in addition to protection in the event of illness. On March 31, 2009, a total of 1.13 million households in France received the RMI. Since 2009 the RMI has been replaced by the RSA[141].

In addition to the employment issue, social integration policies in France have also focused on housing, economic poverty and health. Thus, the most recent "French report on national strategies for social protection and social inclusion - 2008-2010[142]" (reports submitted by each member state to the European Commission since the Council of Lisbon in 2000) includes the

[141] The Revenu de solidarité active (Active Solidarity Benefit) guarantees an increase in revenue and tops-up the existing resources of those whose earnings are limited. The payment of the RSA is not subject to any time limit: the person may continue to receive the same sum as long as his or her situation does not change. Law number 2008-1249 of December 1, 2008 implemented the widespread availability of the Active Solidarity Benefit and introduced a reform of social integration policies NOR: PRMX0818589L

[142] http://www.cnle.gouv.fr/Un-nouveau-rapport-pour-la-periode.html

following major themes among its priorities for action: access to or a return to employment – housing – pensions and health. Additionally, four "population groups" are specifically identified: young people, persons from immigrant families, the disabled and the elderly.

Concerning medical treatment and particularly the provision of treatment for persons living in precarious situations, in 2000 France introduced the CMU (basic universal medical cover). This provides access to medical insurance for all persons living in a stable and legal manner in France for more than three months, who are not entitled to medical insurance by other means (through their professional activity, etc.). The beneficiaries of the CMU are exempted from the patient's contribution towards costs and are not required to pay any fees in advance. As an additional supplement, the CMUC (supplementary medical insurance) has also been introduced, which guarantees an entitlement to supplementary health cover free of charge (mutual insurance, private insurance or welfare fund). Patients therefore have the possibility to access doctors and hospitals etc. with nothing to pay from their own pocket and no advance payments to be made. Finally, the State Medical Aid (AME), introduced at the same time, seeks to provide access to treatment for foreigners living in France on a continuous basis for more than three months but whose papers are not in order (lacking a residence permit or a receipt to prove that one has been requested).

…and dedicated social support

Consequently, among their various activities the CSAPAs are involved in social problems too. They issue information and handle social assessments, providing guidance to the persons concerned or their families in addition to social and educational assistance which includes access to social entitlements and help with integration and reintegration. For their part, the CAARUDs provide support for users when it comes to exercising their rights, gaining access to housing and to vocational integration assistance. Although special intervention programmes are developed by these professionals, access to the general system remains a central theme and the main means for improving people's social situations.

At a political level, as part of its 2008-2011 government plan, the MILDT has listed improvements to the social integration and reintegration of addicts among its priority areas for action. This initiative is organised around the six following factors:

- Drafting social reintegration indicators;
- Introducing a "best practices guide" to improve cooperation between professionals in the addiction field and those working with other vulnerable sectors of the population;
- Extending the "medical micro-structure" model;
- Experimenting with new social assistance solutions for drug users treated via private practice physicians;
- Encouraging the supervision of drug users after they leave prison within the scope of the residential reintegration schemes (AHIs);
- Developing partnerships between medical/social centres specialising in addictions and the residential reintegration and reception schemes.

In this chapter we will describe the socio-economic characteristics of specific persons and groups chiefly seen by the specialised centres (CSAPAs and CAARUDs) and more generally their social situation (level of studies, housing situation, employment, lifestyle and personal situation, etc.). Subsequently, we will be analysing the measures and solutions deployed in order to encourage the social integration of these people, details of their scale and all known obstacles and results from such interventions.

When documenting this issue, we have chiefly drawn upon the following resources:

- Information Systems concerning the CSAPAs (annual activity reports and the standardised RECAP data collection system);
- Information Systems concerning the CAARUDs (ASA-CAARUD activity reports and the biannual ENa-CAARUD survey);
- Quantitative information derived from the annual TREND survey from the OFDT;
- Results of the EMCDDA qualitative survey number 28, produced based on the opinions of a group of experts;
- Other official reports and techniques.

8.2. Social exclusion and drug use

No recent work has specifically examined the interactions between drug use and social exclusion.

The social situation of problem drug users in France is known mostly through the specialized addiction care systems: the Addictology Treatment Support and Prevention Centres (CSAPA) and the “low threshold” centres (CAARUD).

A recent survey conducted by the OFDT in the Lodging and Social Readaptation Centres (CHRS) will ultimately produce prevalence data on drug use in people with social difficulties seen in these “all comers” accommodation and rehabilitation centres for persons of no fixed abode (see chapter 2.4).

The OFDT TREND system provides annual information on recorded changes in substances used, their routes of administration, the people concerned and contexts: the social situation of users and information about specific populations (errant youths, migrants, women, etc.) may be examined in this context.

8.2.1. Social exclusion among drug users

The table below summarises the social situation of people seen in the specialist care centres. It illustrates the large proportion of people receiving care who are in unstable housing, employment, economic and educational situations. People seen for problem cannabis use are distinguished from those using “other drugs” because of the clearly distinct features of these two sub-groups (particularly age).

Table 8-1: Social instability of people enrolled in specialist centres in 2009

	Sex		Mean age	Unstable housing (1)	No fixed abode	Unstable occupational status (2)	Unstable financial resources (3)	Educational level below senior high school/upper secondary schooling (4)
Problem users, other drugs	M 77.6%	F 22.4%	35.3 years	20.5%	6.9%	65%	61%	23%
Problem users, cannabis	M 87.6%	F 12.4%	25.4 years	11.6%	2%	48.5%	59%	22.5%

Source: OFDT RECAP 2009
(1) Temporary or institutional residence and prisoners
(2) Intermittent, paid activities, unemployed persons and other non-workers
(3) Unemployment payments, social welfare payments (RMI, AHH…), funds from third parties and other financial resources (including those without income).
(4) Below baccalauréat level (roughly equivalent to British 'A' levels) and equivalent, CAP-BEP and equivalent. The unemployment rate in France is inversely proportional to the level of education achieved, which may be used as an indicator of qualification status for workers, although it does not take account of improvements in said qualification status through continuing education and occupational experience. During the first four years after leaving initial education, a worker without a diploma or with only a BEP (roughly equivalent to the British GCSE) was more than two times more likely to be unemployed in 2008 than a worker with an upper secondary schooling diploma.

Drug users seen by the low threshold centres (CAARUD) are even more vulnerable. These people are usually not involved in an active care process or have withdrawn from the care system. Being seen without condition is the keystone of the work of these centres: guaranteeing anonymity and free provision of care. In addition, beyond their mission of receiving patients (almost always as outpatients; only 4 CAARUDs in France offer lodging), the CAARUDs are developing a number of “services”, to reach out to the most marginalised drug user populations and those furthest away from the health and social services: street work, work in squats, mobile units, interventions in the party scene etc.

Most people seen by the CAARUD (77%) are deemed to live in moderately or severely unstable situations {Toufik et al. 2008}: More women (43.2%) than men (33.4%) are in “highly unstable” situations. More than a quarter (26.2%) has no fixed abode whereas 18.8% are living in temporary accommodation. More than half of the users live off social welfare payments, particularly RMI (minimum income) (38.2%). A minority (22.7%) report income from employment (15.5%) or unemployment payments (7.2%). Almost nine out of ten users depend on the general social security system, either directly (30.9%), with more than 13.5% having top-up payments from a mutual fund or through CMU (free health care for people on low incomes, 51.6%) or ALD (long term diseases, 4.8%). 2.3% of users fall under AME (State Medical Assistance), but more than 7.1% have no healthcare coverage.

Observations made by CAARUD workers in 2008 through their activity reports {Chalumeau 2010} show an increase in marginalisation (poverty – vagrancy) of people seen, partly associated with the adverse economic climate and safety policies which can be disadvantageous to this population: the closing of squats, removals of people from town centres, more frequent arrests (sometimes close to the care services), and certain difficulties CAARUD workers have in reaching these populations.

The CAARUDs have also seen an increased number of convictions and/or legal measures (*jour amende,* a fine in the form of a fixed amount to be paid per day; failing total or partial payment of said fine, the offender will be incarcerated for the number of days corresponding to the monies due, electronic tagging, etc.) and longer sentences. Almost 3,500 “legal files” were opened in

2008 and almost a third of the CAARUDs took action in prison settings (visits, preparation for release, etc.). They are also seeing deterioration in housing-related issues. Access to emergency housing such as hostels or CHRS remains difficult and housing overall is the major problem, particularly in the Paris region. “Housing rights” cases have been filed. A difficulty shared by many CAARUDs is that of resolving housing problems for people with dogs.

The Guadeloupe, Guyana and Réunion CAARUDs have pointed out the absence of and need for residential treatment solutions. There are no suitable housing solutions for people suffering from psychiatric disorders.

Lastly, people living illegally in France are constantly faced with the combined problems of housing, money and social integration.

8.2.2. Drug use among socially excluded groups

At the dawn of the millennium, the “profile” of the problem drug user is a 29-year-old male, predominantly French. His image is that of a marginalised person, the shadow cast by multitudes of young people from working class areas in large towns facing mass instability following the economic crisis. Their social status is very low, because of the combined effects of drug use and risk taking, very limited means of subsistence and repeated imprisonment.

In the 2000s, there was a marked underscoring of changes already underway, such as:

- Increased instability;
- The ageing of drug users;
- A continued upward trend in specific groups of people who are extremely poorly integrated, such as crack users in North-East Paris, Seine St Denis and the overseas départements.

The last few years have seen the emergence of new “groups” of users living in very unstable, precarious situations: “street youths” and young men from Eastern Block countries that started to use drugs before immigrating to France. In addition, the presence of under-25-year-old women at the low threshold centres has led drug workers to intervene even more massively because of their extreme practices and persistent high risk drug use {Rahis, A. C. et al. 2010}.

“Nomads” (claiming marginalisation as a lifestyle) and **“street youths”** (younger people marginalised by extreme social and health difficulties) are polydrug users although, like with all injection practices, their use of opiates is tending to increase. Nevertheless, in an attempt to move away from the typical image of problem drug users, their use of the “low threshold” system appears to be more occasional and directed more towards meeting their immediate needs than requests for care. Their precarious lifestyle and “resourcefulness” gives them an illusion of paradoxical, alternative integration.

“New migrants” are mostly from central and eastern Europe but also from Northern Africa and to a lesser extent Asia. Whilst Paris brings together a very wide range of origins, other parts of France see mostly immigrants from former Soviet block countries (Russia, Bulgaria, Georgia, Ukraine, Belarus, Romania, Moldavia and countries making up the former Yugoslavia). These populations live in very precarious conditions, worsened by the illegal nature of their residence in France. They are mostly heroin and amphetamine injectors who also have high levels of medical

drug use (particularly Subutex®). CAARUD workers are striving to make these populations aware of the risk of viral transmission (HIV and hepatitis) as a result of their living conditions and the disapproval of injection within the groups they belong to. Major tensions are reported between these groups and the other more “historical” beneficiaries of the low threshold facilities.

Although the proportion of **women** attending specialist centres does not appear to be on the rise, professionals are worried about the population's increasing youthfulness and the extreme practices which have been observed. Most of these young women belong to the groups of poorly socially integrated young people listed above. They are less involved in dealing but more involved in money collection activities (prostitution, begging), presence in the CAARUDs (injection equipment) and administrative processes. More extreme drug use behaviour has been widely noted, particularly with a very rapid escalation to high risk injection (equipment sharing). In addition to prostitution, these women encounter the specific problems linked with promiscuity and the violence which characterises life on the street: vaginal infections, unwanted pregnancies, lack of contraception, etc.).

8.3. Social reintegration

Social support for drug users on treatment is provided, to a very large extent, by the specialist CSAPA and CAARUD services in France, through specific projects and programmes developed by these medical-social structures, acting as relays to the health and social protection systems provided under common law.

Through its 2008-2011 national plan, the MILDT has included the improvement of social integration and reintegration for persons with an addiction amongst its top priorities {Mildt 2008}. This strategy is structured around 2 main objectives:

Objective 1: Give priority to the accommodation of persons in difficulty with their consumption of alcohol or illegal drugs within the integration accommodation reception system (AHI) on their release from prison:

- by setting up CSAPA advanced consultations in these structures and cross-discipline training;
- by writing a multi-disciplinary reference document in preparation for reintegration of prisoners with addictions;
- by creating short and quickly accessed reception programs offering care, social integration activities and accommodation.

Objective 2: To develop partnerships between medical-social structures (CAARUD and CSAPA) and the integration accommodation reception system; experiment with setting up consultations by professionals in medical-social structures in about twenty accommodation structures, and with setting up courses offering training in the two fields concerned.

In order to implement these strategies, on 23 February 2009, the MILDT launched a call for projects, in particular to apply measures on social integration. The projects chosen were announced in a circular of 14 December 2009, and it is far too early to give a detailed description of the projects adopted and funded, and especially to measure their impacts.

In terms of inter-institutional national partnerships, a working framework agreement was signed between the MILDT and the DGCS (General Directorate for Social Cohesion) in order to improve the link between the government action plan and social integration.

Through their annual activity reports, the specialist CAARUD structures report the measures implemented (number and nature). Reintegration measures (access to rights, housing and training-employment) are described, although they only represent a small part of their total activity, which is primarily centred on first line reception ("refuge" services, food, basic hygiene, etc.), harm reduction and care {Chalumeau 2010}. Procedures carried out in 2008 for access of people seen in these structures to their rights are shown in the table below.

Table 8-2: Number of procedures carried out for access to rights 2008 by the CAARUDs

Access to rights		Accommodation and housing		Training and employment	
Administrative	8,369	Emergency housing	6,651	Employment	2,754
Social	7,027	Social housing	1,996	Training	1,263
Health	5,095	Private housing	1,761		
Justice	3,447	Residential treatment	1,001		
23,938 (61%)		11,409 (29%)		4,017 (10%)	

Source: ASA-CAARUD 2008/OFDT, DGS

Apart from the CAARUD activity reports, there are no tools available to precisely trace the programs followed in the different pathways of social integration for people on treatment. CAARUD activity reports give very little or no details about either the needs or actions-programmes undertaken. Work is currently ongoing to define and apply relevant indicators.

Hence, the information given in the following three paragraphs (on accommodation, education and employment) only provides a limited view of the national situation. This information is essentially the result of observations made by a group of experts (see structured questionnaire 28 – year 2009).

8.3.1. Housing

In 2009, only 77% of people on treatment for problem drug use lived in stable accommodation (independently, with friends/family or in an institution) {Observatoire français des drogues et des toxicomanies 2009}.

The question of housing remains one of the social integration priorities, particularly in large towns, and desperately so in the Paris region.

The main options available are: **social housing, emergency social housing and residential treatment.**

Social housing in France essentially comprises HLM housing (low rent/council housing): 10 million people currently live in the 4.2 million homes managed by HLM administration centres, whose mission is to provide accommodation under optimal conditions for all those who cannot afford the rents proposed on the market. However, for several years now, the housing offer has been far short of demand. Whilst addicts on treatment are not subject to any demonstrable

discrimination in terms of allocation procedures, they too suffer the effects of this shortage, unless they fulfil certain conditions giving them priority status. In mainland France in 2006, 1.2 million requests for HLM housing were not satisfied, 550,000 of which were from households which were already HLM tenants.

Some centres (particularly the CSAPA) are developing services facilitating access to individual accommodation, for example:

- "Sliding" tenancies *("baux glissants"* in French): initially, the centre takes on the rental of the housing which belongs to private or public owners in order to sub-tenant legally. It signs the inventory of fixtures and lease and pays the rent to the owner. The housing allocation is directly paid to the centre and the remaining rent (rent minus housing allocation) is paid for by the sub-tenant. After a “probationary period” which may range from six months to a year, the tenancy “slides” and the sub-tenant then becomes the official tenant of the premises.

- “Educational” tenancy support: helping the tenant to optimise budget management and complete administrative tasks such as paying his bills, purchasing furniture, etc.

There are no data on the frequency or volume of these programmes.

Emergency social housing is a solution used by the specialist structures. This involves unconditional reception, i.e. with no selection of clientele. Accommodation is short term. The main structures and facilities which provide emergency social housing are:

- The CHRS (Lodging and Social Readaptation Centres): 360 CHRS in France report handling an emergency department;

- hostel overnight stays;

- night accommodation centres, sometimes in dormitories, and sometimes more individual;

- centres which operate throughout the day and offer accommodation for sometimes very short periods of time (a few nights), sometimes similar to the CHRS (usually in the region of 6 months, renewable);

- emergency accommodation centres (called “Sleep-ins” and now CAARUD) intended exclusively for drug users (three towns in France have this type of service, and one in French Guiana: Paris, Lille, Marseilles and Cayenne).

Apart from these latter centres, the emergency accommodation centres favour reception of “stabilised” people who do not present any behavioural disorders. This may exclude a number of people on treatment. Residents in all of these centres are asked to comply with the various in-house rules (no alcohol or drugs, no physical or verbal abuse, etc.).

Temporary housing or integration housing selects its residents and develops an integration project, while providing longer-term reception. A team of professionals is present continuously. The main structures which exist are:

- The residential social reintegration centres CHRS (there are 827 of these): the aim of the CHRS is to enable the people it receives to become personally and socially independent. They provide accommodation, reception services, particularly in emergency situations, help

and social support and aid in adaptation to working life and social and occupational reintegration. The population which may be accommodated in the CHRS is wide, and includes people or families in serious financial, family, health or integration difficulties, particularly because of a lack of housing or poor housing conditions. The “categories of people admitted” may differ from centre to centre.

- Half-way houses: these are small social residences, each with ten to twenty-five lodgings, intended to receive extremely marginalised people. They offer them independent housing without length-of-stay conditions, common areas and increased assistance with everyday life (health, hygiene, food). Their aim is to fully integrate these structures into the local environment.

- Social residences: these offer a temporary furnished housing solution to households with limited income or those with difficulties in accessing ordinary housing for financial or social reasons, and who may require social support.

Despite the major efforts made by the specialist structures and these social “generalist” housing centres to offer solutions to people on treatment, the different players in the field have reported significant access difficulties. In an attempt to remedy the situation, the 2008-2011 Government Action Plan has promoted partnerships and joint working between the specialist addiction sector and the social housing sector: a call for projects was launched to promote these exchanges and 30 projects were selected and will be funded.

Finally, several specialist **“residential treatment”** centres, dedicated specifically to people on treatment, are available in France. All of these residential centres are administered by specialist medical-social structures (CSAPA):

- Post-treatment alcohol addiction centre or centre for care, follow on support and rehabilitation in alcohol addiction. They receive people dependent on alcohol after detoxification, who show a need to consolidate their abstinence in a protected environment. Length of stay varies from 1 to 3 months and exits and visits are controlled.

- The Community Treatment Centre (CTC), also called the therapeutic community, is a care centre with community accommodation. The treatment community is similar to a structured, hierarchical, organised family unit. Each resident belongs to a group, with a group leader. Each group is responsible for different tasks such as cleaning, cooking, gardening and household maintenance. The community treatment centres can accept up to 50 people.

- The residential treatment centre (CTR), also called the post-treatment centre, is a care centre with community housing which accepts all drug addicts undergoing a voluntary care process. The CTR can accept up to 20 people. Initial length of stay is approximately 6 months, renewable. Some have long waiting times.

- Follow-on treatment apartments (ATR): individual or community apartments made available to former drug users who have begun a treatment process. The absence of permanent staff limits these centres to people able to live on their own. Some apartments can take couples and people with children.

- Temporary or emergency housing is offered to the dependent or formerly dependent person who is between two periods of care or in a “transition period”: before withdrawal, during stabilisation of withdrawal or substitution treatment, waiting for post-treatment admission or

stable housing. This period can be adjusted according to the person's health and social needs. During this short stay (1 to 4 weeks), the person is accommodated in an individual or community apartment, and sometimes in a hotel room.

- The family reception network is a group of families trained and organised by professionals, which volunteer to take in a person on treatment for a period of time. The host families offer the drug addict a personalised relationship in a family environment, and are paid depending on the actual time a person spends with them.

Despite this range of residential treatment schemes, the overall service offer is still inadequate.

8.3.2. Education and training

In 2009, almost 23% of people on treatment had not successfully completed secondary level education, i.e. they had no general education or occupational training[143].

People undergoing treatment do not have any specific programmes or schemes for training or refresher courses. Like the general population, and particularly those looking for work, they can however rely on the public and private occupational training organisations.

An identical situation exists for vocational skills training. The relevant measures are incorporated in the employment policy: the main operator is the National Agency for Employment (ANPE), whose mandate includes training advice, guidance and funding. There is no dedicated, specific training for vulnerable people, although three priority public targets have been identified: people who have been unemployed for a long time, young people and immigrants (particularly women). The *Validation des acquis de l'expérience* (VAE or Validation of acquired experience) and classical vocational skills training are the two main measures used.

8.3.3. Employment

Almost 24% of people on treatment in 2009 were unemployed, i.e. twice as many as in the active French population[144].

There are no particular administrative barriers in France to access to employment on the "open work market" for people on treatment (such as screening or discriminatory medical situations), although it may be assumed that employers are reluctant to employ such people. The high unemployment rates seen are undoubtedly due to lower levels of training, often chaotic careers and a very tight job market.

In France, there is also an "intermediary job market" which is very well structured and recognised by the Labour Regulations (art. L 5121-1); it is covered by the term "integration through economic activity (IAE)". Since 1977, "assisted contracts" have also existed (reducing the wage bill for the employer), intended for the most vulnerable people.

With effect from January 2010, these different assisted contracts will be grouped together within a single integration contract (CUI) for the commercial sector and a professionalization contract for the non-commercial sector.

[143] OFDT RECAP information system
[144] OFDT RECAP information system

The IAE system consists of different organisations dedicated to integration through economic activity (SIAE). These organisations are employers which must be accredited by the State. They sign agreements which define the conditions under which their activities take place, the assistance given to them and result objectives. The four main SIAE are:

- intermediary associations (AI);
- temporary integration work companies (ETTI);
- integration workshops and ateliers (ACI);
- integration companies (EI).

253,000 people were estimated to be employed by the different SIAE in 2006 (61,000 full time equivalents), but such job offers remain well below demand and “selection” occurs naturally top down; those encountering the greatest difficulties are, in fact, generally excluded from the schemes because of this.

Nevertheless, some specialist structures have developed their own occupational integration scheme or promote reorientation pathways and co-operation, in light of the difficulties encountered in assisting their beneficiaries with finding a job {Maguet et al. 2010}.

Occupational activities should be considered as separate from integration/back-to-work activities, although they do offer a “foretaste” of the work environment. The “Espace association” (CAARUD) has set up a low-requirement-threshold workshop in which the persons received recover books, register them in a computerised database, package them, and distribute them to partner associations which run educational or humanitarian projects. This organisation has also created an in-house post entitled "social integration manager", whose role consists in establishing a network of companies across his/her area of intervention, and facilitating contacts between candidates and potential employers, reassuring both parties with regard to their mutual concerns. This person’s extensive knowledge of both the companies and people received in the centre enables him to adapt employment offers to the expectations and skills of the latter.

The *“Drogues et société”* CSAPA invites patients from the care centre to take part in creative arts workshops in order to increase their sense of social utility: their creations can subsequently be used to illustrate information and prevention documents produced by the centre. This organisation also offers *"ateliers de redynamisation" (*"reinvigoration" workshops).

The *Fleuve* (Gironde) treatment community has an integration workshop and atelier (ACI). Residents are supported by a social-occupational worker and can join the integration aworkshop as part of a personal integration project for a period of six months.

The ALIA CSAPA (City of Angers) has set up integration assistance workshops in which work is described as a “treatment tool”. The work environment includes elements specific to working life: commuting, biological and work cycle times, compliance with instructions, income management. These workshops (with multidisciplinary workers) offer a chance at immersion in the world of work and specific support for adults with an addiction problem.

Partnerships have been established between care centres and *régis de quartier* (integration companies). An essential pre-requisite for these partnerships to operate successfully is dialogue between the professionals from these two types of organisations, in order to better understand

each other and discuss the specific features of drug addicts. These integration companies are not, in fact, trained or prepared to receive this type of population.

National organisations, such as the Aurore association, are developing in-house partnerships to promote access by people undergoing treatment (care centre) to the "integration through economic activity" services (integration ateliers and companies).

Work is currently underway to define social situation and social reintegration indicators, which should foster better identification of needs and therefore promote relevant national and local measures for people undergoing treatment.

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

9.1. Introduction

Definitions

According to the applicable laws, any person using and/or possessing narcotics is liable to a punishment ranging up to prison penalties. Simple drug users may face arrest and sentencing, with the possibility of imprisonment (see the description of the legal framework in chapter 1).

For minor offences, the Public Prosecution may decide to impose alternatives to prosecution instead of criminal proceedings before a court. These measures deferring criminal proceedings may take several forms such as a caution, a drug treatment referral order, a conditional discharge with a social or treatment referral, a settlement, a compensation measure or a penal mediation.

The range of penal responses to drug use also includes alternatives to imprisonment, such as community service, court-ordered supervision in the community, drug treatment order, home detention with electronic monitoring, probation.

On 1 January 2010, there were 191 penal establishments in France with 56,779 "operational"—available—places at:

- 106 remand centres and 30 remand wings (situated in penal institutions) holding pre-trial detainees, (remand prisoners), prisoners with less than one year of their sentence left to run and newly sentenced prisoners awaiting transfer to another prison setting: detention centre or high security prison for prisoners having been convicted and sentenced).

- 37 '*centres pénitentiaires*' (penitentiaries) including at least 2 wings for prisoners of different detention statuses (remand centre, detention centre and/or high security);

- 24 '*centres de détention*' (detention centres) and 34 detention centre wings, holding sentenced adults with the supposedly best prospects of social reinsertion. Their detention programme is chiefly aimed at "re-socialising" prisoners;

- 64 '*maisons centrales*' (high security prisons) and 9 high security wings situated in penal institutions.

- 12 '*centres de semi-liberté*' (open prisons) and 4 open prison wings, which are located in the penitentiaries. These centres house convicted offenders who have been admitted there by the judge responsible for the execution of sentences with an outside placement without monitoring or open prison regime; 6 penal establishments for minors, which are provided for in the French law of September 2002 on the orientation and programming of the justice system. The first of these was opened in mid-2008; 4 '*quartiers centres pour peines aménagées'* (resettlement prison wings), which are located in penitentiaries.

- 1 '*établissement public de santé national*' (national public health establishment at Fresnes,EPSNF).

Data collection tools

The data from the police or criminal justice system concerning drug offences has the advantage of being regular, sufficiently historical and easily accessible. On the other hand, theses data do not provide a complete overview of the manner in which offences are dealt with from arrest through to sentencing and possibly concerning the enforcement of the sentence.

Arrests for drug offences are divided into two major categories: use and trafficking (broken down into use-resale, local trafficking and international trafficking); these data have been available since 1971.

The sentences recorded by the National Crime Register (computerised since 1984, see appendix IV-B) contain details of the judgements issued against the persons brought before the courts for drug offences. Consequently, we have access to a homogeneous statistical processing system enabling us to monitor changes in these sentences, both in terms of volume and structure, between 1984 and 2008. As changes in the drug laws during this period were limited, this offers a satisfactory degree of comparability enabling us to analyse changes in the penal sentences issued by the courts during this period.

A sentence can cover several offences but sentences are usually listed based on the main offence. The statistical categories used are as follows: illegal use of narcotics, incitement to drug use, possession/acquisition, manufacturing/use/transportation, sale, gift distribution or possession with intent to sell, importing/exporting and other narcotics offences.

Until 2003, it was the statistical processing of the data contained in the National Prisoners' Register which made it possible to analyse prison population flows and to track the persons incarcerated (whether for narcotics or other offences) during the detention period.

Since 2003, when the new version of the "National database of offenders" application was implemented, all offences resulting in a sentence are recorded (previously, only the main sentence was recorded). Yet, the current state of the new version of this database does not indicate the ranking of the offence concerned (i.e. whether it is the main offence or a subsidiary offence): therefore, it is not possible to identify the cases for which a narcotics offence was the main reason for incarceration. This limitation is particularly acute for drug use as these cases are often accompanied by more serious offences possibly constituting grounds for incarceration (the number of people incarcerated for drug use solely is currently unknown).

Over and above the regular activity indicators, the French framework for the production of knowledge concerning the use of drugs in prison also includes:

- Institutional surveys. Initiated, designed and carried out by the government information services (the Ministry of Health or the Ministry of Justice, etc.), the results are published by the same authorities. They often comprise follow-up analysis of existing data (medical consultations for offenders received into prison, number of substitution treatments prescribed in prison, data derived from the activity reports for the CSSTs (see appendix IV-P) operating in penal environments, etc.). The samples involved are large and seek to be as representative as possible of the prison population. The frequency of the surveys is irregular, just like the health survey conducted among new prison inmates (see appendix IV-H). Among the surveys carried out by the various ministries' research departments, the most important has been carried out by the Directorate for Research, Studies and Evaluation of Statistics (DREES under the ministries of employment and social welfare) in 1997 and 2003: it offers insight into the health characteristics of offenders entering prison (use of

psychoactive substances, substitution treatments, risk factors and pathologies recorded) reported during the initial medical examination in the remand centres and remand wings in penitentiaries (see the list of detailed sources, Appendices VI-C). Similarly, the data supplied by the General Directorate for Health, and especially the Directorate of Hospital Care and Treatment Organisation (DGS-DHOS) survey between 1999 and 2004 concerning substitution treatments in penal environments make it possible to track changes in the number of treatments (continued or new treatments) and the drug maintenance treatment methods involved (methadone, Subutex®). Finally, the surveys carried out "on a specific day" by the DHOS among detainees infected by HIV or hepatitis C known by the medical teams operating in penal establishments (from June 23-27 2003, for example) describe the profile of known HIV-positive patients and hepatitis C sufferers admitted in the outpatient treatment/consultation units operating in penal establishments.

- Epidemiological surveys. Often backed by research institutes (for example the Monitoring Centre for Health of the PACA region, ORS PACA, and the National Institute for Health and Medical Research, INSERM), these are local or national and are also based on pre-existing data.

- Quantitative sociological studies and research. Based on quantitative interviews with small samples of respondents, these surveys seek to describe user profiles and to document their routes through the incarceration and drug addiction process. This data is collected outside the period of incarceration.

- Studies carried out by health care professionals. These quantitative or qualitative descriptive studies are initiated by professionals operating in penal establishments. They may suffer from a lack of methodological discipline but nevertheless provide an opportunity to benefit from the views and experiences of the professionals concerned.

- Official reports. Motivated by changes in the law or regulation, by political issues or by an official appraisal or inspection role, their purpose is to put forward recommendations based on observations and assessments documenting the subject in question.

- Publications from the NGOs. Their content may include a structured compilation of official reports (observations and recommendations), although the tone and form are different. More rarely, they may be based on a selection of data from a digest of data sources {Observatoire International des prisons 2005}.

To these sources should be added a number of more general documents concerning prisons, generally sociological or demographical works making it possible to understand the general context of the prison environment. Additionally, we should mention the use of various articles and documents which are often summaries of other works.

Background

Delinquency and drug use

The numerous surveys carried out on this topic have shown that drug users are more frequently responsible for serious and less serious offences. The number of acts of delinquency tends to increase in line with the frequency of use of psychoactive substances (including alcohol).

The well-documented link between drug use among young people and problematic behaviour (acquisitive delinquency, absenteeism and expulsion from school, involvement in fights or vandalism, etc.) has also been established in a number of French studies {Barre et al. 2001}.

In France, the survey carried out since 1998 at the request of the Ministry of Justice involving youngsters aged 14 to 21 years old processed by the courts' Youth Protection Service teams (*Protection judiciaire de la jeunesse*, PJJ) has revealed high prevalence levels: 60% of these youngsters had already used cannabis in their lifetimes (Ministry of Justice, 1998).

However, a distinction should be made between drug offences in the strictest sense of the word, crimes and offences indirectly attributable to the abuse of psychoactive substances and other lifestyle factors common to deviant behaviour characterised by substance abuse and delinquency.

- The first of these categories and the easiest to understand includes all crimes and offences directly related to drugs, such as use, possession, trafficking or manufacturing of illegal substances, all of which represent drug offences. To this, we should add cases involving driving under the influence of narcotics for example.

- The second group of offences which are indirectly attributable to the use of psychoactive substances includes acts of delinquency associated with drug use (so-called "acquisitive" delinquency carried out in order to obtain the money needed to buy drugs).

- The third and final category (the one category which is most likely to highlight the complex relationship between drugs and criminality): addictive and delinquent behaviour can be seen as two joint aspects of a deviant form of socialisation and lifestyles {Joubert et al. 1995}. From this virtually ethnological viewpoint, the use of psychoactive substances should be seen as one occurrence among others in the risky behaviour pursued by the individuals in question. Most of the epidemiological and sociological work in France tends to favour this approach.

Drug use in prison

The 2003 issue of the DREES health survey among new inmates showed that addicts are over-represented in the prison setting {Mouquet et al. 2005}. One-third of new inmates report long-term, regular use of illegal drugs before incarceration, including cannabis (29.8 %), cocaine and crack (7.7 %), opiates (6.5 %), abused prescription drugs (5.4 %), and other products (LSD, ecstasy, glues, solvents: 4.0%). Nearly 11% of inmates reporting use of illegal drugs on a regular basis used multiple substances before their incarceration. This high rate of psychoactive substance use is associated with the frequency of incarcerations resulting from drug-related offences[145] since, with the exception of cannabis, the reported use of illegal drugs is marginal in the general population.

The existing studies show that all products smoked, sniffed, injected or swallowed before incarceration continue to be used (albeit in reduced proportions) during incarceration {Rotily 2000}. Furthermore, the use of more easily accessible products (such as medicines) tends to develop in penal environments. Generally speaking, there is an observed relative transfer of use from rare and illegal drugs to medicines {Stankoff et al. 2000}.

[145] In fact, thanks to the French Prison Service's statistics, it is known that approximately 15% of convictions are primarily related to drug-related offences.

This use of narcotics, whether initiated or continued in prison, can seriously affect health condition and result in a rise in the numbers of serious abscesses, accidents combining use of medicines and other products, severe and longer cravings and psychological or psychiatric disorders. Moreover, detainees constitute a population group combining numerous risk factors considering the health and social consequences of drug use. The low levels of access to treatment experienced by this population group and more fundamentally the situations of precariousness and social exclusion they have often faced before incarceration (including a lack of stable accommodation or social security cover) contribute to explaining the prevalence of "at risk" use behaviour among new detainees.

The prevalence of injection appears to be higher among this precarious population group, although the number of intravenous drug users seems to be declining: 6.2% of newly sentenced prisoners reported use of intravenous drugs during the year preceding their incarceration in 1997 {Mouquet et al. 1999}; in 2003, only 2.6% of them reported injection {Mouquet et al. 2005}. According to research outcomes, between 60 and 80% of detainees stop injecting during their incarceration. The 20 to 40% who carry on injecting tend to reduce the frequency of their injections, although increasing the quantities injected. They also tend to be more often affected by HIV and/or hepatitis C, with a high risk of contamination from shared equipment, unprotected sex and tattooing. Finally, detainees appear to be more affected by infectious diseases than the general population. The most recent data indicate that the prevalence of HIV in penal establishments is between 3 to 4 times higher than that encountered outside and that of hepatitis C is 4 to 5 times higher. However, as in the general population, the prevalence of HIV has declined in prison while that of hepatitis C has increased sharply.

Upon arrival in prison, approximately 7% of newly incarcerated detainees state that they are receiving a substitution treatment. Eight times out of ten, buprenorphine (referred to as Subutex®) is used (accounting for approximately 85% of all patients receiving substitution treatments) {Drees 2005}.

During incarceration, this figure tends to decrease as in a certain number of establishments the treatments are not reconducted despite the requirements of the law of January 18, 1994 (which introduces an obligation to treat incarcerated patients in the same way as outpatients). The level of interrupted courses of treatment fell sharply between 1998 and 2004 but nevertheless concerned more than 1 treatment in 10 (data from the DHOS, and the DGS). A survey conducted by the French Monitoring Centre for Drugs and Drug addiction (OFDT) has shown that access to methadone rose in penal institutions: among opioid-dependent detainees, 35% were treated by means of a methadone-based opioid substitution treatment in 2006 {Obradovic et al. 2008b}, as compared to the proportion of 22% in 2004 (DGS/DHOS, Health Ministry). Today, one third of French prison settings report more than 50% of their patients undergoing substitution using methadone (despite major disparities). The average initial prescription levels in detention establishments are now similar to the levels recorded for opioid-dependent outpatients (i.e. in hospitals), standing at between 23 (minimum) and 76 (maximum) mg per day. The OFDT has also established that the first prescription of methadone by medical teams operating in prisons has been rising: 28% vs. 72% of treatment continuations among detainees undergoing substitution with methadone {Obradovic et al. 2008b}.

Since the law of January 18, 1994, which transferred the responsibility for health in prisons from the Ministry of Justice to the Ministry of Health, with the implementation of the Outpatient treatment/consultation hospital units intervening in prison, known as the ‘UCSA’ (‘*Unités de consultation et de soins ambulatoires*’ reporting to the local hospitals and operating in all penal establishments), the treatment of addiction in detention centres is now based on a threefold

system: the Outpatient treatment units, which are present in all penal establishments, have responsibility for the somatic health of detainees; the Regional Hospital Medical/Psychological services ('SMPRs'), based in each of the 26 French regions, handle the mental health aspects of drug addicts in those establishments in which no local unit exists; and finally the "local addiction units" (addiction specialized CSSTs implemented in a number of penal institutions) have been involved since 1987 in the 16 largest establishments in France (covering approximately a quarter of the penal population). This general scheme is also accompanied by another, set up on an experimental basis: the Pilot Care Units for Prison Leavers ('*Unités pour sortants*') existing in seven establishments.

At the same time, the legal risk and harm reduction scheme operating in penal environments also offers various possibilities for drug addicted detainees to have access to treatment (the circular of December 5, 1996):

- Screening for HIV and hepatitis, theoretically proposed at the time of arrival (CDAG - Free and anonymous screening centres – voluntary) although this is not automatic for hepatitis C (POPHEC, *Premier observatoire en prison de l'hépatite C* / First hepatitis C prison's observatory;

- Prophylactic measures (hygiene measures and the provision of post-exposure treatments for both staff and detainees);

- The availability of condoms with lubricant (theoretically accessible via the UCSA);

- Access to opioid substitution treatments and the availability of bleach to disinfect any equipment in contact with blood (injection, tattooing and body piercing equipment).

No syringe exchange programme is available in the French prisons (an initiative considered "premature" by the Health and Justice Mission of 2000) nor any specific information programme in detention centres concerning contamination resulting from injection.

9.2. Drug-related crime

9.2.1. Drug law offences

Arrests for drug-related offences

The number of drug offences skyrocketed over the last 30 years (cf. Graph 9-1). Almost 90% of all reported drug offences in France are related to drug use or possession for use. Police reports recording drug offences have increased consistently since the 1980's. This evolution can be attributed to increased police activity but also possibly to an increase in drug use and trafficking and a better performance of the data gathering systems (or other factors that we may not even guess) {Ocrtis 2009}.

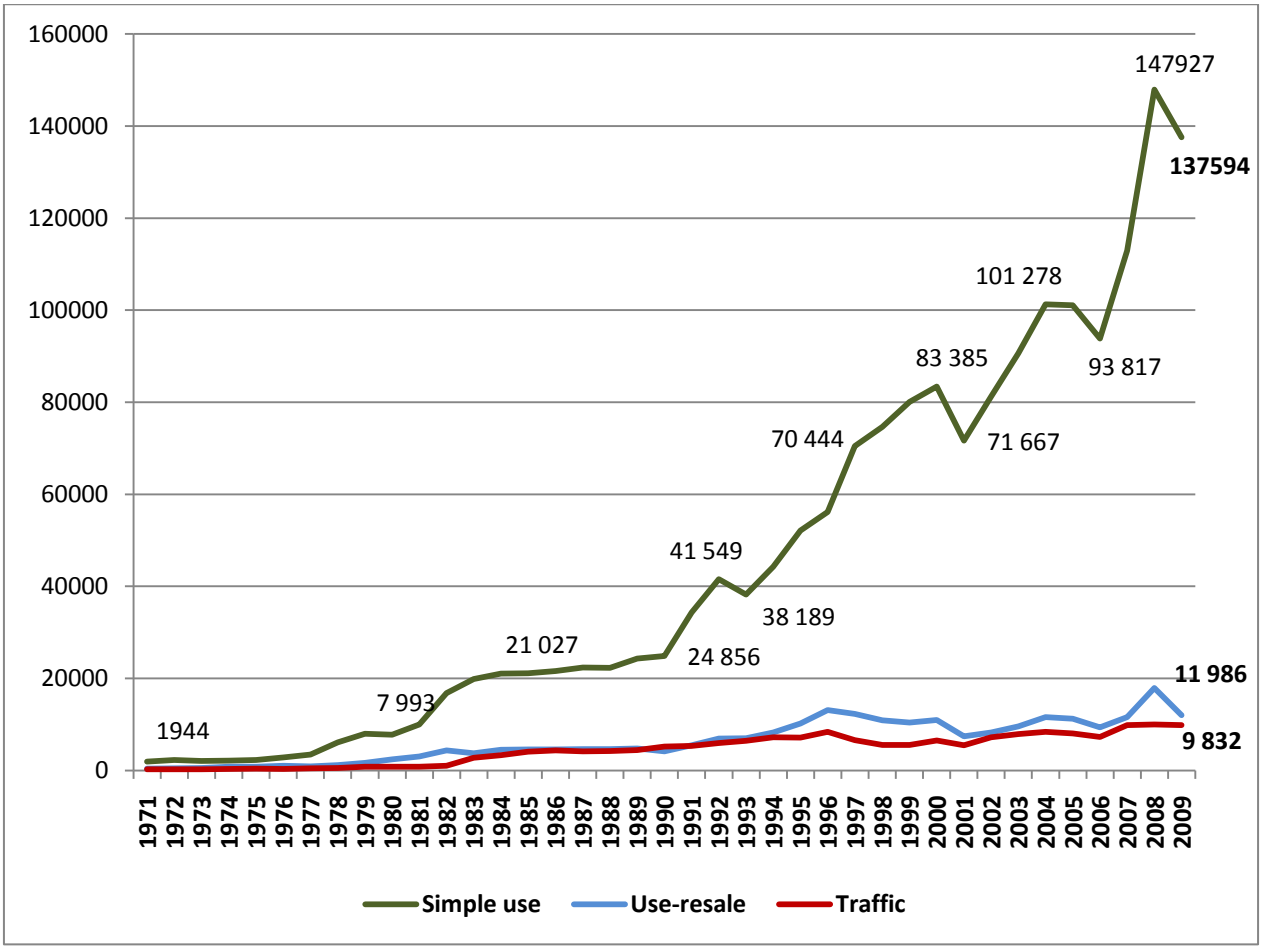
Reasons for arrest

The "one-off" (or simple) use of narcotics remains the main reason for arrest, accounting for a total of 135,417 in 2010, i.e. 86% of all arrests for drug-related offences in that year. This

proportion has risen slightly since 1998. In 2010, 11,277 arrests for use-resale were recorded, the second leading reason for arrest, i.e. 7.2 % of all arrests for drug-related offences.

The 10,889 arrests for drug trafficking recorded in 2010 can be split up into two categories, i.e. arrests for international trafficking and arrests for local trafficking, accounting for 7% of all arrests for drug-related offences.

Graph 9-1: Drug law offences (1971-2010)



Source: FNAILS[146], OCRTIS

Substances involved in the drug-related offences

In 2010, cannabis remained the main substance involved in the arrests for drug-related offences, regardless of the grounds for arrest. Cannabis accounts for 90.4 % of arrests for drug use and 69.9% of use-resale and trafficking cases.

[146] See list of detailed sources, Appendix 6-8

Table 9-1: Arrests for drug-related offences (by substance), 2010

	Use	%	Use/dealing and trafficking	%	Total	%
Cannabis	122439	90.4%	15302	69.9%	137741	87.5%
Heroin	7255	5.4%	3382	15.4%	10637	6.8%
Cocaine	3926	2.9%	2452	11.2%	6378	4.1%
Crack	753	0.6%	334	1.5%	1087	0.7%
Ecstasy	203	90.4%	63	0.3%	266	0.2%
Medicines (1)	376	5.4%	198	0.9%	574	0.4%
Amphetamines	290	0.2%	70	0.3%	360	0.2%
Mushrooms	81	0.1%	7	0.0%	88	0.1%
Other drugs (2)	704	0.5%	86	0.4%	790	0.5%
Total	135447	100.0%	21894	100.0%	157341	100.0%

Source: OSIRIS, OCRTIS
(1) Subutex®, methadone, skenan®, rohypnol®, other
(2) Khat, methamphetamines, LSD, opium, morphine, solvents, other

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 (5.4% vs. 2.9 %) with a similar picture for arrests for use-resale and trafficking: heroin (n=3,382) accounted for 15.4% of all arrests for use-resale/trafficking whereas cocaine accounted for just 11.2%.

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, used in spite of the absence of any proof of a prescription), and those for hallucinogenic mushrooms.

Information from the Ministry of Justice: sentencing

Sentencing statistics are published within a two-year interval. The information presented below reports the trends and figures recorded in 2009. These data should *not* be considered as definitive {Ministère de la Justice 2010}.

The number of convictions for drug-related offences more than doubled between 1990 and 2009 (rising from 20,428 to 46,603). Convictions for narcotics use rose most steeply (trebbling since 1990) but the rise has been particularly significant since 2004 (when they were three times less numerous than in 2009). Convictions for narcotics use now account for half of the convictions for drug-related offences. They represented only one third in the 1990's and the beginning of the 2000's. All other sentences for the possession, sale, dealing or trafficking of drugs rose at the beginning of the 2000's but have flattened out since 2004 {Timbart 2011}.

Convictions for road traffic offences have also sharply increased over the last two decades (+58%). This trend has been continuous but sharper between 2000 and 2009. It reflects the effects of the campaign against drinking and driving (+36% since 1990) and the introduction of driving under the influence of narcotics as a penal offence in 2003.

The fraction of convictions involving more than one charge is markedly higher for drug-related offences (58%) than for driving under the influence of alcohol (16%).

In 2009, 24,420 sentences were issued for drug use (an increase of 25 % in comparison to the previous year). Accounting for more than 50% of convictions, drug use has become by far the leading category of conviction for drug-related offences.

Information from the Ministry of Justice: incarceration

The number of drug-users sent to prison has been stable over the last five years. In 2009, 11,823 drug offenders were incarcerated, according to the National Prisoner Register (FND, see appendix IV-N).

9.2.2. Other drug-related crimes

Driving under the influence of narcotics ("Drug Driving"): screening and sentencing in 2005-2006 {Ministère de l'Intérieur 2006}.

The law of June 18, 1999 and its application decree (of August 27, 2001) introduced automatic screening for narcotics in all drivers involved in a road traffic accident resulting in an immediate death, and the launch of an epidemiological study (carried out between October 2001 and 2003). 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.

The French LOPPSI 2 Law (on the orientation and programming for performance of domestic security) adopted in February 2011 completes the current legal arsenal by defining strategic orientations for domestic safety policy for 2009-2013. The Law generalises the additional sentence of vehicular confiscation and, in some cases, makes it obligatory, notably for offenders with a prior conviction for driving under the influence of alcohol or narcotics. The law also creates an additional sentence in the form of a prohibition after driving under the influence of alcohol or narcotics, for five years or more, to drive any vehicle that is not fitted with an accredited anti-start system based on an electronic ethanol test.

For a number of years, a special drug screening procedure has been performed on the road. 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[147]. 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 being under the influence of drugs have been screened using saliva tests according to French law (notably the decree of July 24, 2008), i.e. Drugwipe® tests although both RoadSIde Testing Assessment (Rosita) [148]Reports concluded that there was room for improvement in the detection of cannabis and benzodiazepines. The screening and detection cut-off concentrations for THC, amphetamine-type stimulant drugs, cocaine and opiates in oral fluid are respectively 15 ng/ml, 50 ng/ml, 10 ng/ml and 10 ng/ml[149]. False positives are supposed to be minimised by a blood test performed in a medical setting whenever the saliva test

[147] 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, promouvant le recours aux tests oraux de fluides réalisés sur le bord de la route et l'introduction systématique des tests salivaires (*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).

[148] 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%).

[149] Décret du 24 juillet 2008 : http://www.legifrance.gouv.fr/jopdf//jopdf/2008/0730/joe_20080730_0044.pdf

(performed on the roadside) proves positive for drivers tested for cannabis, amphetamine-type stimulant drugs, cocaine and opiates.

In 2008, 52,000 kits were 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).

In February 2010, the Interministerial Committee on Road Safety announced an increase in the number of roadside saliva tests. The new measures settled on for 2010 resulted in the number of tests for narcotics rising to almost 100,000 per annum, notably through an increase in the number of salivary tests (compared with 10,000 in 2003).

Screening in 2009

Approximately 63,500 narcotics tests were performed in 2009, 34.6% of which produced a positive result. The Ministry for the Interior statistics did not state whether these only concerned the saliva tests or whether this figure also included laboratory tests.

Sentencing in 2008

According to the most recent figures, the number of convictions for driving under the influence of drugs has risen in recent years: 2,976 in 2005, 3,988 in 2006, 5,185 in 2007, 6,589 in 2008 (source: National Crime Register).

In 2008, 6,589 sentences were issued, i.e. an increase of 27 % in comparison to 2007. Of these sentences, 42.2% resulted in a prison sentence (of which only 15% involved partial or total imprisonment without remission); another 42.2% involved a fine and 15.6% an alternative sentence (most often a driving license confiscation).

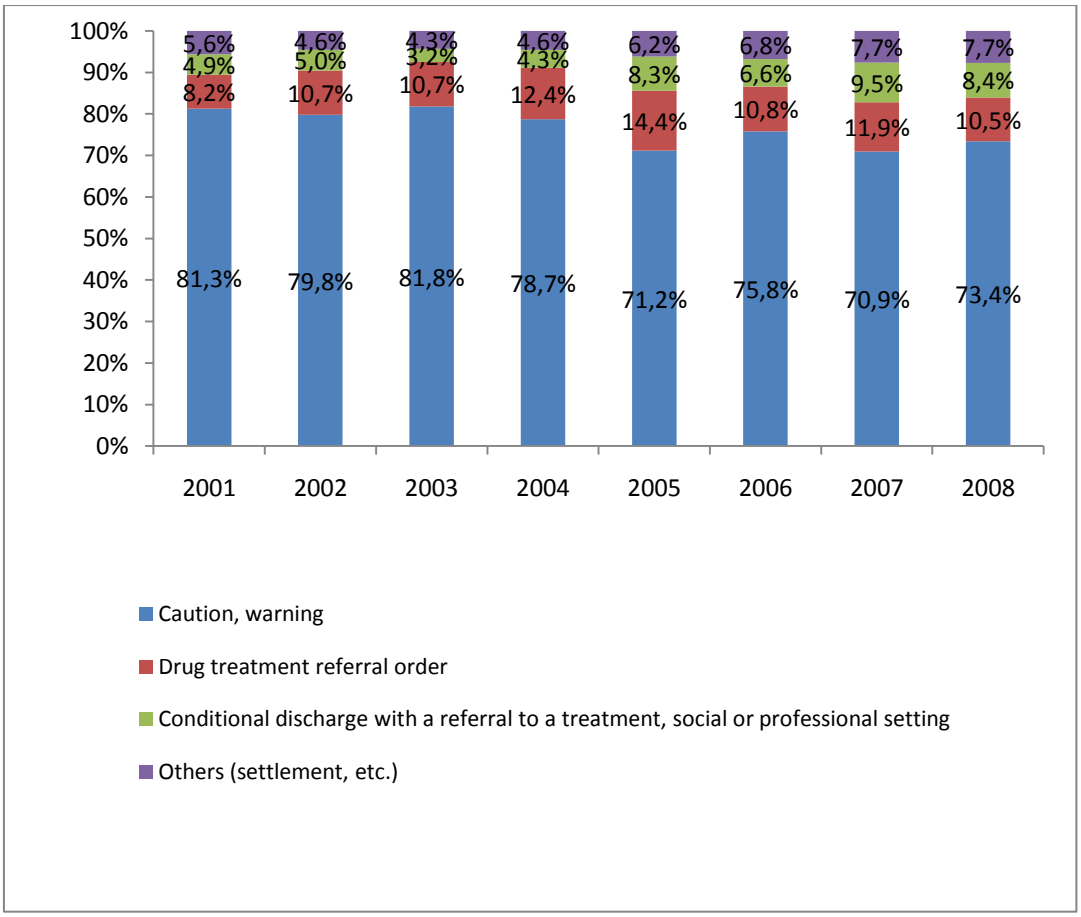
Punishments tend to be less severe for driving under the influence of narcotics alone or for refusing to cooperate. However, they are more severe in the event of injury (8.4 sentences out of 10 result in imprisonment) and especially in the case of manslaughter, 45% of which result in imprisonment without remission, for an average duration of 9.6 months each.{Obradovic 2010}

9.3. Prevention of drug-related crime

The French criminal justice system contains an array of court-ordered treatment options, some of them including quasi-compulsory treatment (conditional discharge with a drug treatment referral, mandatory treatment, 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, mandatory treatment ["*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).

Review of penal statistics for the Paris region (which represents 25% of national prosecutions for drug offences) reveals an increase in the number of narcotics use cases handled by the courts over the decade beginning in 2000: this figure has almost doubled, going from 10,261 to 17,353. At the same time, amongst all of the decisions, the proportion of case closures (proceedings closed) fell and the proportions of alternatives to legal action conversely increased. Whilst rare until the end of the 1990s, alternatives to legal proceedings now make up 70% of the decisions issued with regard to drug users, whereas the proportion of cautions issued has fallen {Obradovic 2010}.

Graph 9-2: Distribution of the alternatives to prosecution prescribed to drug use offenders, 2001-2008



Source: Data collected from the Cassiopée Infocenter, Ministry of Justice (Paris region only)

9.4. Interventions in the criminal justice system

9.4.1. Alternatives to prison

The most recent examples of the extension of the sanitary options can be found in the counselling cannabis clinics for young users which have been in operation since 2004. Outpatient clinics for young users (CJC) are aimed at young people with drug related problems and at their families. These support units, established within CSAPAs, are anonymous and free

of charge. They provide for prevention counselling to users or their relatives but also for psychological treatment. Patients address the CJC on their own initiative or are reffered by the legal system. 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, especially among males and young adults {Obradovic 2009}.

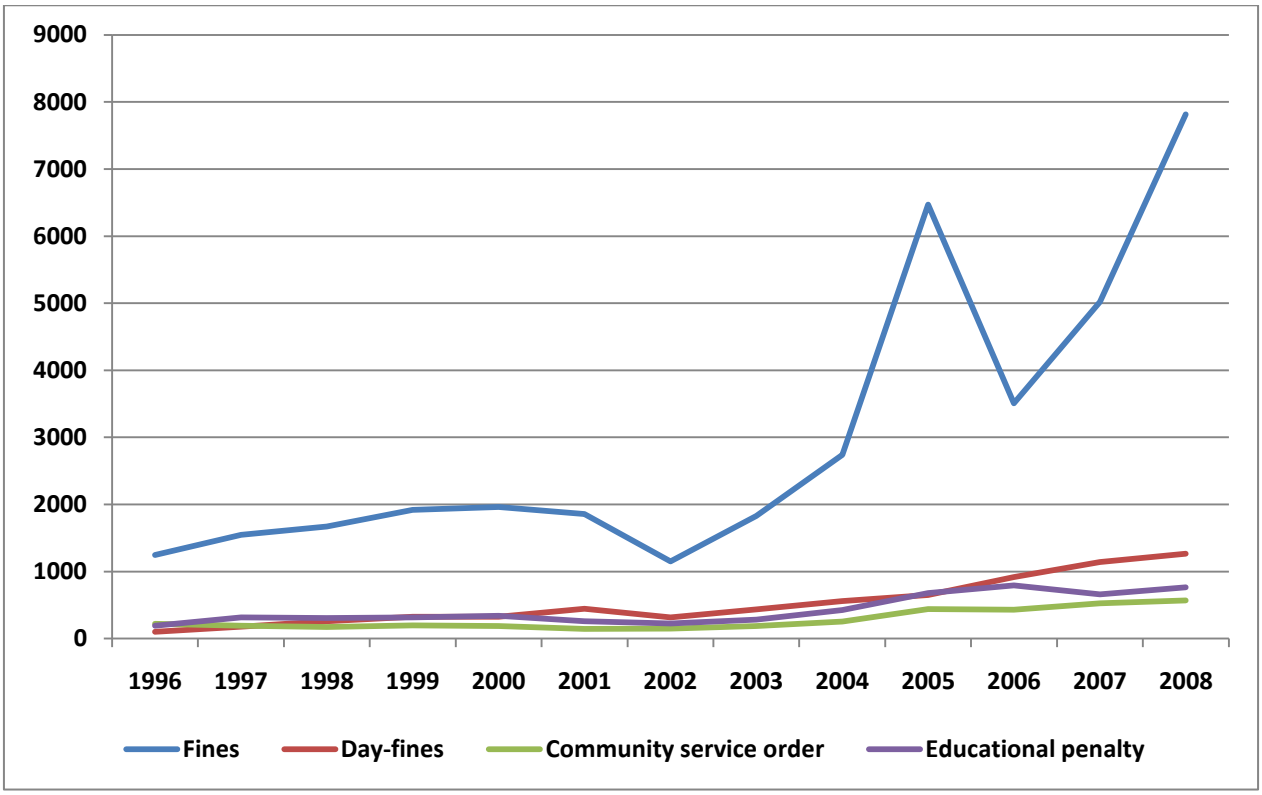
In addition to these different treatment options, the range of alternatives to prosecution offered to drug offenders has been extended since the law of March 5, 2007 and the April 16, 2008 decree (cf. chapter 1.1.). Adults and minors arrested for possession of cannabis have to pay for and attend a compulsory drug awareness-building training session on the dangers of using narcotic substances. As outlined in Justice circular n° 08/11 dated May 9, 2008[150], all people who use even small amounts of illegal drugs should be sentenced to penalties of this type. The educational goal of these compulsory training courses is to inform offenders about drugs, their use and misuse, and their dangers as well as the existing drug-related policies and laws and the consequences of violating them.

According to the Justice Ministry figures for 2008, about 1,600 persons were sentenced to compulsory drug awareness-building training session, including 300 minors (i.e. less than 20%). The Ministry of Justice set up a monitoring system to assess the implementation of the sessions over the first year, during the last three trimesters of 2008 and the first trimester of 2009 (Ministry of Justice, 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 sessions (n=2,311, in 42 of the 82 responding courts) and 14% were under mandatory treatment (n=3,815, in 44 of the 82 responding courts): 95% of these penalties were delivered as alternatives to prosecution. Additionally, 395 drug awareness-building training sessions concerned drug users under 18 (17% of penalties) and 1,916 implied adult drug users (83%). As far as Drug testing and treatment orders (DTTOs) are concerned, 467 of them involved minors (12%) and 3,348 adult drug users (88%). The survey conducted by the Ministry for Justice among the courts of law also highlighted a wide disparity in the responses: while some courts make widespread use of mandatory treatment and awareness-raising courses, drawing on the support of a dynamic network of associations within their jurisdiction, others appear less willing to use this new system.

Further along in the criminal procedure, the individuals convicted for infringing the 1970 Drug Law may benefit from an alternative to imprisonment penalty, and thereby avoid a prison sentence or a fine. These alternatives to imprisonment may take various forms: community service, '*jours-amendes*' penalties (day-fines, literally, corresponding to days in prison paid off by fines), or other types of penalty. Although the national data on this topic are fragmentary, they show a rise in the numbers and proportions of these measures applied to simple drug users.

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

Graph 9-3: Distribution of the alternatives to imprisonment prescribed to drug use offenders, 1996-2008



Provisional 2008 data.
Source: Data from the Statistical Yearbook of the Ministry of Justice 2009

9.5. Drug use and problem drug use in prison

A more complete view of this section can be found in chapter 11 (selected issue: drug-related health policies and services in prison). The main elements of analysis are synthesized here.

With 61,604 inmates for 56,779 operational places, there are 108 inmates for every 100 places in France. Overcrowding is one of the distinctive characteristics of French prisons, as well as poor detention conditions, regularly denounced by the various international bodies[151]. This helps account for some of the difficulties encountered in accessing treatment. Prison overcrowding varies considerably between mainland France and the overseas departments and territories, and especially between the different types of establishments. Of the surplus inmates, 96% are in remand centres, since the assignment of convicted offenders to penal establishments is managed by the Prison Service according to the *numerus clausus* principle. Overcrowding particularly affects remand centres and remand wings in penitentiaries, i.e. the most common establishments in the prison system, which are supposed to house a majority of pre-trial detainees and convicted offenders with short sentences (with less than a year remaining of their sentence).

[151] On several occasions, the European Committee for the Prevention of Torture (CPT) condemned France for the state of its prisons (overcrowding, insalubrity) and the "inhuman and degrading treatment" of the inmates.

There are more mental health and addiction-related problems in the incarcerated population than outside of prison. The first large-scale epidemiological survey of mental health in prisons was conducted in 2003-2004, and it showed that 80% of male inmates and 70% of female inmates had at least one psychiatric problem, and that the great majority were suffering from more than one {Rouillon et al. 2007}. This study also showed that nearly 40% of the inmates incarcerated within the preceding six months were addicted to illegal substances and 30% were alcohol-dependent. Mental problems combined with addiction are common in the prison population, especially anxiety disorders and drug or alcohol dependence (each of these combinations affects approximately one out of every five inmates).

A 2003 inquiry into the health of new inmates conducted by the DREES confirms the overrepresentation of addictions in the prison setting {Mouquet et al. 2005}. One-third of new inmates state having engaged in the long-term, regular use of illegal drugs during the year preceding their incarceration, including cannabis (29.8 %), cocaine and crack (7.7 %), opioids (6.5 %), abused prescription drugs (5.4 %), and other products (LSD, ecstasy, glues, solvents: 4.0%). Nearly 11% of inmates stating that they used illegal drugs on a regular basis used multiple substances before their incarceration. This high rate of psychoactive substance use should be linked to the frequency of incarcerations resulting from drug-related offences[152] since, with the exception of cannabis, the reported use of illicit drugs is marginal in the general population.

Infectious diseases also more frequently affect inmates than the general population. People who have already been incarcerated at least once have a prevalence of hepatitis C that is nearly 10 times higher than that of the general population (7.1% versus 0.8%), as is shown by the biological data of the Coquelicot survey (INVS, CNAMTS, CTAFCES, 2005). Depending on the source, the prevalence of HIV in prison varies from 1.1% to 1.6%, and that of HCV (the hepatitis C virus) from 3.1% to 7.1%. The most representative survey to date is that carried out by the DREES covering all remand centres and all remand wings in penitentiaries in 2003: it indicates that the prevalence of HIV in the prison setting is 1.1%, or three to four times higher than what is observed outside of prison, and that the prevalence of HCV is 3.1%, or four to five times higher than outside of prison {Mouquet et al. 2005}. Moreover, 0.2% of new inmates state that they are infected by both HIV and HCV, and 0.1% state that they are seropositive for three viruses (HIV, HCV, HBV).

According to the unpublished, preliminary results of the *Prévalence en milieu carcéral,* PREVACAR survey {Michel et al. 2011b} (DGS/InVS), 2% of inmates are HIV-positive (i.e. fewer than 1,220 inmates), three-quarters of them being immunocompromised (with a CD4 count of under 350). The prevalence of HIV infection is comparable in men and women (2.5% vs. 2.0%). HIV+ inmates are characterised by longstanding infection (diagnosed 9 years before on average). The infection was discovered in prison in 25% of HIV+ inmates and one-third of them are suffering from full-blown AIDS. In addition, 72% of HIV+ detainees are receiving treatment. Moreover, it is believed that 4.8% of inmates carry HCV (i.e. fewer than 3,000 detainees), with a higher proportion of women infected: 11.8% vs. 4.5% male inmates: injecting drug use is the most common mode of transmission (70%).

Older figures showed that the risk of viral transmission in prison is higher since drug users tend to share equipment {Ben Diane et al. 2001}. Hence, among the 43% of intravenous drug users who were active users before being incarcerated and who continue to inject drugs in prison, 21%

[152] In fact, thanks to the French Prison Service's statistics, it is known that approximately 15% of convictions are primarily related to drug-related offences.

state that they share their equipment {Rotily 2000}. While prison is a place where the prevalence of HIV and viral hepatitis infections is elevated, due mainly to the high percentage of intravenous drug users, it is also an environment that is conducive to risky behaviour: of incarcerated intravenous drug users, 13% to 23% started injecting in prison {Rotily 2000}. Moreover, not all of those infected with HIV or HCV are aware of this when entering prison: only 40% have already had an HIV screening test, 27% an HCV screening test and 31% an HBV screening test {Mouquet et al. 2005}.

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.

9.5.1. Illegal drug market in prison

Although it is known that illicit drugs are available in prison in France, it is difficult to define the magnitude of the problem. A veil of silence - sometimes lifted thanks to odd mentions in the media[153] - covers this problem which the French Prison Service is very reluctant to discuss. In France, the sparse official information available on the subject goes back to 1996 and is found in a report submitted to the Justice Ministry, "*Rapport sur l'amélioration de la prise en charge des toxicomanes incarcérés et sur la lutte contre l'introduction de drogues en prison*", by Jean-Paul Jean {Jean 1996} who was then Inspector of Prisons. This document revealed the dimensions of the phenomenon of drug trafficking in prison, showing that 75% of French penal establishments were concerned. In 80% of cases, the illicit substance seized was cannabis, a medicinal product in 6%, and heroin or another drug for the rest[154].

Fifteen years later, the evidence suggests that little has changed and that cannabis remains the most trafficked substance. Perhaps more so than ever because, since the introduction of opioid substitution treatment in prisons in 1996, it is reasonable to expect that, as has been the case for drug users in general, the demand for heroin has significantly fallen. However, similarly to what is happening outside prison, the dispensing of high-dose buprenorphine gives rise in certain establishments to the traffic of tablets, which are highly sought after for their sedative effect.

Although cannabis is the most common illicit substance circulating in French prisons, it seems that the traffic of cocaine hydrochloride is on the increase. This phenomenon is logical and, in the end, is only a reflection of what is happening in society in general with a marked increase in use observed in France over the last fifteen years - largely due to expansion of the supply. In any case, there is today a considerable demand for cocaine in prison. The DREES survey on the

[153] The latest "scandal" to date is a report on the France 2 TV channel's show "Envoyé spécial" in April 2009 on daily life at the prison of Fleury-Mérogis. This documentary was based on the work of two inmates who succeeded in secretly filming certain aspects of prison life as it is these days in France. The "report" showed extensive trafficking and consumption of cannabis, cocaine and Subutex® in the biggest prison in Europe.

[154] See the entry "Prison" in the *Dictionnaire des drogues et des dépendances, op. cit,* Richard, D., Senon, J.L. and Valleur, M. (2004). Dictionnaire des drogues et des dépendances. Larousse, Paris.

use of psychotropic substances by new inmates showed that between 1995 and 2003, the proportion of users consuming cocaine in the hydrochloride or freebase form (crack cocaine) had substantially risen {Mouquet et al. 2005}. In addition, epidemiological surveys conducted in low threshold structures - the CAARUDs (“Harm reduction & support centres for drug users”) - show that use has significantly expanded among the most marginalised addicts (a significant proportion of whom enter prison at one point or another) because cocaine replaced heroin as the most widely used product in the month before the study {Toufik et al. 2008}.

In terms of supply, the fact that on its way to the European market cocaine is passing increasingly more via West and North Africa, i.e. the traditional routes for cannabis resin {Gandilhon, M. et al. 2010b}, means that this substance is increasingly becoming part of the contraband sold by dealers in the French housing estates - who are highly present in prisons. The large numbers of inmates involved in narcotics trafficking – notably cannabis resin from Morocco - who continue to bring cannabis and, to a lesser extent, cocaine into prisons from their contacts outside, contributes to the expansion of the use of these two substances. Most of these networks are run by North African crime bosses who reproduce inside prisons their gangs from the suburban housing projects on the outskirts of the main French urban centres. Although it is difficult to measure this phenomenon because of the lack of evidence, it nevertheless seems to be a major problem, notably in the French penal establishments close to the main French urban centres in which the percentage of patients jailed for drug-related offences can reach 40 - 50% of all prisoners.

The observations of a prison governor on this subject, questioned by the sociologist Farhad Khosrokhavar in his survey on "Islam in prisons" {Khosrokhavar 2004}, are very interesting in this respect:

"*There is a highly significant phenomenon in this prison: drug addiction. This has repercussions at the psychological level and it requires specific attitudes on the part of prison staff. Here, many prisoners are youths from the low-income suburban districts, delinquency is compact. The drug networks found outside the prison setting tend to re-form inside the prisons, but this is not something that is tolerated. Prison authorities react with repression, or by informing the Public Prosecutor, etc. It is not something that is allowed [...]. On 10 August, two detainees escaped which led to reinforced surveillance inside the prison. That stopped much of the trafficking and the atmosphere deteriorated. Drugs go round—we know and try to stop it. When there is tension with the inmates, you feel it. It is important to find a balance between repression and a hands-off approach. But I do not have the resources to do a better job combating these behaviour patterns. And too much repression turns prisons into time-bombs.*"

In countries like Brazil and Mexico, criminal organisations have effectively taken control of certain prisons, using their ability to intimidate and corrupt the Prison Service. Although it is not the same in French prisons, hierarchies nevertheless exist in which a certain caste reigns supreme. Usually not drug-users themselves, these individuals rule a band of addicts who have been imprisoned for the use/dealing of drugs or related offences.

The development of new information technology tools, notably in the form of mobile telephones (the trafficking of which is a very intense business activity in prisons), makes it possible to direct networks from a prison cell, and supply the prison on a just-in-time basis depending on prisoners' needs.

9.6. Responses to drug-related health issues in prisons

Regularly, data emerge showing how difficult it is to provide inmates with personalised care against a background of overcrowded prisons.

All inmates have a compulsory medical consultation of admission when they enter prison. This visit is performed by the UCSAs with a possibility to screen for infectious diseases. To guarantee application of harm reduction measures, now embodied in the August 9, 2004 law[155], two main ways of preventing the spread of infectious diseases have been implemented in penal establishments since 1996[156]. The 5 December 1996 circular first and foremost stipulates access to OST in prison: inmates receiving substitution treatment must not only be able to continue their treatment in prison, but also be able to initiate treatment if they wish, and especially High-Dose Buprenorphine (HDB) therapy. Since 2002, OST can also be initiated for methadone[157].

In addition to substitution, prevention and decontamination tools for fighting against HIV are available in prison settings: in line with the Gentilini report's recommendations {Gentilini 1996}, periodically distributing bleach in set quantities and concentrations became generalised in prison in order to clean any equipment that comes into contact with blood (such as injection, tattooing and piercing equipment). Distributing bleach chlorometrically titrated to 12° has occurred systematically since 15 December 1997, and since 2001, the Prison Service has been encouraging health personnel to inform prisoners on how to use bleach as a product to disinfect injection equipment. The legal measures implemented by the 5 December 1996 circular to fight against the spread of HIV also stipulate making condoms available free of charge (NF-compliant condoms) with lubricants (theoretically obtainable through UCSAs). Prisoners can keep these items on their person or in their cell. Access to prophylactic antiretroviral therapy after accidental exposure to blood is also available for health and prison personnel as well as for inmates. Subsequently, for intravenous drug users, the only current way to protect against contracting AIDS, other than post-exposure antiretroviral prophylaxis and access to condoms and lubricants in the event of sexual relations, is to disinfect syringes with bleach. These measures for cleaning injection equipment with bleach have been proven to be effective in eliminating HIV: however, it has been established that these measures are not effective enough in combating the hepatitis C virus {Crofts 1994}. Outside of the prison setting, messages on disinfecting with bleach have furthermore been largely abandoned in favour of messages on refraining from reusing injection equipment ("*À chaque injection, du matériel neuf*"/“New equipment for each injection”).

In contrast to the situation outside of prison, support for drug users is limited in the prison setting (counselling, peer education, primary health care) and access to sterile injection equipment (alcohol wipes, vials of sterile water, sterile cups, sterile syringes), which has been authorised outside prison since 1989, is absent from all penal establishments. There is no medicalised heroin programme in prison.

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[155] Loi n° 2004-806 du 9 août 2004 relative à la santé publique. This law proposes an official definition of the harm reduction policy (“the policy of harm reduction for drug users aims to prevent the transmission of infection, death by overdose of intravenous drugs and the social and psychological harm related to abuse of drugs classified as narcotics", art. L. 3121-4) and places the responsibility for defining this policy with the State (art. L. 3121-3).

[156] As the main priority of the authorities since 1994 Coppel, A. (2002). Peut-on civiliser les drogues ? De la guerre à la drogue à la réduction des risques. La Découverte, Paris.; Bergeron, H. (1999a). L'Etat et la toxicomanie : histoire d'une singularité française. PUF, Paris., harm reduction (HR) is prescribed by a circular in 1996 for prisons: DGS/DH Circular n° 96-239 of 3 April 1996 related to drug addiction treatment strategies in 1996; DGS/DH/DAP Circular n° 739 of 5 December 1996 on the fight against human immunodeficiency virus (HIV) infection in prisons: prevention, screening, health care, preparation for release and personnel training.

[157] Circulaire DGS/DHOS n° 2002-57 du 30 janvier 2002 relative à la prescription de la méthadone par les médecins exerçant en établissement de santé.

Despite the World Health Organisation's (WHO) repeated recommendations since 1993, incarcerated intravenous drug users in France subsequently do not benefit from access to sterile injection equipment. The principle of equivalence of treatment for both incarcerated patients and outpatients, embodied in the Law of 18 January 1994, is therefore not applied to the letter in France. However, various action plans are designed to improve access to health care. The 2010-2014 Strategic Action Plan on health policy for inmates provides for acting on inmates' health determinants (practices exposing them to a risk for infection) and making screening programmes available for detainees. It provides for the establishment of suitable harm reduction measures that can be applied in detention to remedy the observed shortcomings in France: distributing bleach with instructions for use, providing access to condoms, taking into consideration the infection risk of certain behaviours (e.g., sniffing, tattooing, injections), providing access to harm reduction sterile equipment related to drug abuse, access to Fibroscan® testing in prison, improving prevention measures (inviting professional tattoo artists to prisons) and screening (developing screening during incarceration). The strategies of this plan are to improve care and complement the objectives of the last national plan for the fight against hepatitis (2009-2012)[158]. The latter plan defines a general framework for intervening in the prison setting, limiting itself to restating the need for hepatitis screening for new inmates and assessing the Health/Justice memorandum of 9 August 2001. The 2007-2011 government Addiction, Treatment and Prevention Plan[159] provides no specific actions for the prison setting.

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

Between 8% and 9% of inmates benefit from substitution treatment, i.e. about 5,000 people on OST in prison {Michel et al. 2011a}. Upon their arrival in prison, 7% of inmates state being on substitution treatment, high-dose buprenorphine being the declared drug used 8 times out of 10 (as in the general population) {Mouquet et al. 2005}. In contrast, a third of courses of OST are started in prison (31%), as confirmed in the results of the 2010 PREVACAR survey.

The predominance of HDB over methadone in OST supply seems to be less marked in prison than in the general population: 68.5% HDB vs. 80% outside. This figure drops during incarceration because treatments are not always continued, despite the recommendations of the law of 18 January 1994. Stoppages of courses of treatment - an indicator of the importance attached to the continuity of support in prison - concern about one inmate in 10 although the figure dropped between 1998 and 2004 (cf. Selected issue 2011).

Although in nine out of ten cases, substitution treatment is continued upon entry in prison, the challenge of providing consistent treatment to opioid addicts consists in making accessible in prison all of the treatments that are available outside of prison. Over recent years, the total number of inmates receiving substitution treatment and the number of medical services refusing to prescribe OST has decreased[160]. Nevertheless, accessibility to these treatments varies. In France, there is still a "pocket of resistance" with some establishments stating that they have not

[158] Strategic committee for the French national viral hepatitis plan, 2009-2012 national viral hepatitis B and C plan), January 2009, p. 17 (http://www.sante-sports.gouv.fr/IMG/pdf/Plan_hepatites_2009_2012.pdf)

[159] Addiction Commission, 2007-2011 government plan for the treatment and prevention of addictions, November 2006 (http://www.sante.gouv.fr/htm/actu/plan_addictions_2007_2011/plan_addictions_2007_2011.pdf)

[160] Between 1998 and 2004, the number of inmates receiving substitution treatment increased faster than the prison population. The prison population receiving substitution treatment subsequently increased from 2% in 1998 to 6.6% in 2004. Concurrently, the proportion of medical services (UCSAs, SMPRs or CSSTs) not providing substitution treatments diminished (see table 3).

initiated OST[161] {Morfini et al. 2001/2004}; {Obradovic et al. 2008b}, {Michel et al. 2010}, while others engage in practices that are likely to compromise the efficacy of the treatment (crushing pills or making solutions) {Michel et al. 2003}. In the 2010 PRI2DE inventory {Michel et al. 2011a}, 19% of establishments stated that they crushed or diluted high dose buprenorphine, mainly in order to limit its misuse. Moreover, methadone doses were limited in 17% of establishments, while the marketing authorisation (AMM) does not contain any dosing limitations. Despite repeated ministerial circulars and clinical practice guidelines, access to substitution treatment for heroin-addicted inmates remains, despite real progress, more limited than outside of prison, even though it has been demonstrated that the number of incarcerations (or re-incarcerations) is lower in people who received substitution treatment prior to or during incarceration {Rotily 2000} ; {Levasseur et al. 2002}

The PREVACAR survey helps update knowledge on available care, especially regarding OST in France. Conducted in June 2010 at 145 penal establishments, the participation rate was 86% representing 56,011 inmates, i.e. 92% of the incarcerated population on 1 July 2010. With respect to the provision of OST, it shows that 100% of UCSAs were offering at least one of the two forms, either high-dose buprenorphine or methadone. However, a few establishments only offer one treatment: HDB only in four establishments and methadone only in four others. Continuity of OST care upon release is only ensured by half of the establishments (55%), and 38% of the establishments state that they do not have a formalised procedure.

Regarding harm reduction services, 18% of the UCSA teams were aware of used syringes in the establishment and 29% in the establishments with fewer than 500 detainees. The discovery of syringes mostly involves large-capacity establishments with over 150 places. These data concur with those collected during the Coquelicot survey (see Appendix IV), which revealed that 12% of drug users had injected at least once in their life {Jauffret-Roustide et al. 2006; Jauffret-Roustide et al. 2009}.

Although we do not know how many inmates began OST during their incarceration, we do know that the Subutex® proportion (70 %) tends to decline among treatments initiated in prison, which is explained in part by the risks associated with taking the treatment[162]. Moreover, since the governmental plan to fight illegal drugs, tobacco and alcohol (2004-2008), the authorities have been aiming to improve access to methadone OST by making it accessible in all penal establishments. This objective, which was confirmed in a circular issued by the French Ministry of Health on 30 January 2002, was assessed by the OFDT {Obradovic et al. 2008a}. The survey conducted among UCSAs and SMPRs (with a 65% response rate) revealed a remarkable progression in access to methadone. In 2006, 35% of opioid-addicted inmates were being treated within the scope of methadone OST vs. 22% in 2004 ({Obradovic 2006}; DGS/DHOS, Ministère de la Santé, 2004), representing 40% of the entire opioid-dependent penal population.

[161] In 2004, nine prison establishments alone, representing 20% of the prison population, prescribed one-third of substitution treatments, and one of these nine establishments prescribed more than 10%. The successive editions of the survey demonstrated that there were still penal establishments where no substitution treatment was prescribed, even though this number is declining, and that certain establishments only prescribe methadone OST. Complementary qualitative studies confirmed these findings by revealing the application, in certain sites, of quotas for substitution treatment, criteria for receiving substitution treatment (estimated sentence duration, for example) or administration methods that do not correspond to the proper prescription rules: Subutex® that is crushed or diluted before administration, for example (Delfraissy, J.-F. (2002). Prise en charge des personnes infectées par le VIH. Rapport 2002. Recommandations du groupe d'experts In: DELFRAISSY, J.-F. (Ed.) Flammarion, Paris.

[162] Although high dose buprenorphine is the main treatment prescribed in non-hospital practice (Canarelli, Coquelin, 2009), in the prison setting, it is "relatively easy to misuse" (Pradier, 1999) in addition to the fact that it can be "injected" or "sniffed". Since the method for dispensing methadone (as an oral solution to be taken daily in front of the treatment personnel at the dispensing medical centre) is not conducive to this kind of abuse, the French Ministry of Health authorised in 2002 initial methadone prescriptions in all health establishments, including UCSAs and SMPRs.

In 2010, this percentage remained stable (2/3 of OST inmates received high-dose buprenorphine and 1/3 methadone) {Michel et al. 2011a}. The evolution of medical practices is evidenced in a second figure: approximately 70% of the establishments surveyed stated that they had at least one initial methadone prescription during the second half of 2006 (most often among the large remand centres, where the organisation of health care was simplified with a single prescription service). However, in 2010, 13% of the establishments that had responded to the PRI2DE inventory stated that they never initiate substitution treatment {Michel et al. 2011a}. The OFDT assessment also demonstrated that, although the rules for organising prescriptions were heterogeneous, the medical practices for dispensing and monitoring showed little variation from one establishment to another[163]. Furthermore, it appears that approximately 8% of establishments give priority to a withdrawal strategy and nearly 10% of professionals foresee the risk of overdose as a barrier to methadone prescription {Obradovic et al. 2008b}, since the known lethal risk is set at approximately 1 mg/kg/d for a non-opioid-tolerant subject (Michel, 2006). The structure of accessible OST treatment in the prison setting has therefore evolved over the past ten years: although HDB (Subutex®) is still the predominant treatment used in prison, methadone treatment is on the rise, especially since the 30 January 2002 circular allowing physicians to prescribe methadone as first-line therapy: in 2004, 30% of the treatments initiated were methadone-based (versus 12% prior to the circular).

9.6.2. Prevention and treatment of drug-related harm

Harm minimisation strategies are directed towards reducing harm, in many cases by altering drug using behaviours and effects (acquisition, drug use, and withdrawal). A number of strategic documents (2008-2011 governmental plan, 2010-2014 Strategic Action Plan on health care policy in prisons) address public problems encountered at three different levels of drug-related damage:

- Drug acquisition harms may be related to the risks of being exposed to high-risk situations, such as criminal behaviour (either being exposed to or conducting criminal acts such as drug dealing, robbery, etc.).

- Drug use harms related to the drug used, the amount consumed, and the method of administration, generating pharmacological effects and consequences on the individual's health (for example, injection drug use may lead to open wounds, vein problems, abscesses, skin breakdown, HIV and other infectious diseases when sharing needles and paraphernalia, and, of course, the risk of overdose).

[163] In nearly two-thirds of cases, methadone prescriptions are shared with or delegated to a service other than the UCSA, although the latter is designated as competent in the legislation (UCSAs only carry out their mission in one-third of cases). The modalities for dispensing methadone-based treatment are, however, very homogeneous: dispensing is mainly done on a daily basis at a treatment site (dispensing is performed in cells in less than 10% of establishments) and, in general, under the supervision of a physician or nurse (except for rare cases when the treatment is handed over to the inmates themselves without monitoring of administration). The average levels of initial prescription in prisons are close to what is observed outside of prisons (in hospitals), i.e., between 23 mg/day and 76 mg/day (minimum/maximum), which translates into the proper application of the therapeutic indications, promoting caution: 60% of the treatment units state giving minimal initial doses lower than the daily initial doses indicated in the 2002 circular ("20 to 30 mg, depending on the level of physical addiction"). In contrast, one-quarter of services (generally UCSAs) state giving high initial maximal doses of at least 100 mg per day. This observation is reminiscent of the results recorded in the international literature, which reveal high, or even very high methadone doses (from over 100 mg to over 1,000 mg per day), justified by a pharmacological necessity for certain patients (Maremmani, I. and et al. (2000). Methadone dose and retention during treatment of heroin addicts with axis I psychiatric comorbidity. Journal of Addictive Diseases vol. 19(2) 29-41.; Leavitt, S.B., Shinderman, M., Maxwell, S., Eap, C. and al., e. (2000). When "enough" is not enough: new perspectives on optimal methadone maintenance dose. The Mount Sinai Journal of Medicine vol. 67 (n° 5 & 6) 404-411.

- Drug withdrawal harms related to the effects of reducing or eliminating drug use that may impair the individual's work and social functioning.

In terms of prevention, inmates have access to bleach, but it is not systematically distributed and is, in most cases, not accompanied by useful harm reduction information. Moreover, bleach is considered to be a poor HIV decontamination solution under illicit conditions of use {OMS (WHO) 2005} and a very poor HCV decontamination solution {Hagan et al. 2003}. In fact, the prevalence of infectious diseases in penal establishments remains much higher than outside the prison setting, at over 1% for HIV, approximately 3% for HBV and 7% for HCV {Bello, P. -Y. et al. 2010}. Moreover, injection practices are well-known in prisons {Michel et al. 2010} where 1 to 3 out of every 5 drug users share equipment {Rotily 2000; Jauffret-Roustide et al. 2006; Jauffret-Roustide et al. 2009}, and these populations often carry the HIV and HCV viruses. Nevertheless, imprisoned drug users do not benefit from all of the harm reduction measures that are available outside of prison, especially Syringe Exchange Programmes (SEP) (National AIDS Council, 2009 and 2011).

9.6.3. Prevention, treatment and care of infectious diseases

Infectious diseases are more prevalent among prisoners than among the general population. The prevalence of HIV in the prison population is 3 to 4 times higher than in the population as a whole, and that of hepatitis C virus 4 to 5 times higher.

New arrivals are screened for substance misuse problems. Upon their arrival in prison, all detainees are offered a medical consultation provided by a Counselling/treatment hospital 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. The 2008-2011 'Fighting Drugs and Drug Addiction' Government Action Plan set an aim of improving "care and continuity of care provided to drug and alcohol users in prison" in order to reduce the associated risks and prevent relapse, considering that "the means offered within the existing system are insufficient to control these problems". It thereby proposes to change the regulations so that the UCSAs can control care for addictions. It also calls for the introduction of a 'genuine prison addiction plan', including in particular the set-up of hepatology consultations, including the supply of Fibroscan®, addiction and hepatitis training for health professionals and information about hepatitis C for users.

In terms of information and prevention, the PREVACAR survey conducted in 2010 shows that three-quarters of the UCSAs run health information and prevention campaigns for inmates but only one-third had done so in the preceding 6 months. The survey also showed that screening for infectious diseases has improved in the last decade: three viruses (HIV, HBV and HCV) are more or less systematically screened for in prison. 93% of UCSAs offer such screening but only one in two offers subsequent screening. Just over half of the UCSAs (52%) offer a specialised HIV consultation, mainly in the largest penal establishments. A slightly higher fraction of UCSAs provide specialised hepatology consultations (57%) to inmates. In terms of HCV care in prison, 50% of UCSAs perform a HCV RNA test + HCV control + ELISA.

9.6.4. Prevention of overdose-risk upon prison release

Discharge from prison is associated with a high risk of relapse, sometimes fatal, in inmates on OST {Harding-Pink 1990}; {Seaman et al. 1998}; {Marzo et al. 2009a}. According to a study conducted in 2001 on prisoners released from the Fresnes Remand Centre, the risk of death by overdose in former inmates was 120 times that of the general population {Prudhomme et al. 2001} {Verger et al. 2003}. This same study established particularly high excess mortality by overdose in released prisoners under the age of 55.

The continuity of care for drug addicts released from prison is deemed a "'fundamental" issue in all the legislation organising care in prisons since the act of 18 January 1994. For example, the *Guide méthodologique relatif à la prise en charge sanitaire des personnes détenues* (Methodological guide for the sanitary care of addicted inmates) established by the DHOS to help professionals clearly summarises the specific conditions for providing health care to inmates at the different stages of their incarceration. It specifies that the modalities for release need to be planned sufficiently early, before the planned definitive release date. The preparation for release needs to engage the coordinated efforts of internal health and prison teams and external specialised structures. The necessary continuity of care must be in place to provide health and social support (housing, care, social protection) as well as social and professional rehabilitation support upon release. For pre-trial detainees with a bail order, information on outside health and social services for continued care must be provided upon their release. Therefore, theoretically, upon release, a prescription for methadone or Subutex® substitution treatment needs to be provided to the inmate in order to avoid any interruption in treatment while awaiting a consultation. This requires that the UCSA or the SMPR be informed beforehand of the release by the clerk of the establishment, which is not always the case. In order to receive treatment upon release, patients must know an identified, informed prescriber outside of prison to which he or she can refer for follow-up medical and/or psychiatric treatment: this can be in a specialised structure (CSAPA), a hospital structure or with a general practitioner (preferably belonging to a network that has been contacted beforehand). To promote this continuity, meetings must be organised and contacts must be made during incarceration – which often proves to be complex in practice – since admission to a CSAPA or a post-cure centre is done upon medical prescription. Prisoners who wish to benefit from such follow-up care upon release must furthermore request such care from the UCSA or SMPR physicians. The SPIP and the UCSA or SMPR personnel are responsible for informing detainees about the treatment possibilities after release.

Given the complexity of these prerequisites to be ensured in a prison setting, in practice, the recommendations are not systematically followed and the health treatment of newly-released prisoners is often insufficient. The assessment of initial methadone prescriptions given by UCSAs revealed that in 2007, the UCSA professionals deemed that the continuity of care is correctly carried out for patients under methadone treatment, most often in the form of post-prison referrals to an outside CSAPA, to a general practitioner or, far less frequently, to a hospital {Obradovic et al. 2008b}. More recently, the 2010 PREVACAR survey showed that only 52% of UCSAs have established a formal procedure to ensure continuity of care upon release from prison.

In compliance with the recommendations of the 2008-2011 Government Action Plan, a good professional practice guide (particularly concerning opiate substitution treatment), is being compiled under the aegis of the MILDT.

9.7. Reintegration of drug users after release from prison

The 2008-2011 Government Action Plan also envisages the creation of "short and quickly accessed reception programmes for released prisoners, within existing social and medical-social structures, in relation with the hospital related to the prison", highlighting great needs for accommodation […] by the time of release from prison". This programme has not been evaluated yet.

10. Drug markets

10.1. Introduction

Any attempt to understand the market for illegal drugs requires an assessment of the *availability* and *accessibility* of a given substance, of changes in the quantities seized and an analysis of changes in its street price.

Finally, monitoring the supply of a drug also means monitoring its composition (its level of purity and the products used to cut it).

Availability and accessibility

The *availability* of a drug can be defined as the overall presence of a substance in a given geographical area. This availability is referred to as "noticeable" when it is spotted by special observers, referred to as "sentinels", specifically devoted to this role.

Accessibility refers to the degree of effort required by an average user, who has the necessary financial resources to obtain the substance they are seeking. Consequently, a substance may well be available but not particularly accessible. There are several degrees of accessibility, which can be measured based on factors such as the time needed to gain access to the substance, the location (public/private), the time (night or day) and the type of network involved.

The main source of information in this area is provided by the ongoing monitoring scheme *Tendances récentes et nouvelles drogues* (TREND, or "Recent Trends and New Drugs"), which has provided chiefly qualitative information (accessibility, availability and price) since 1999 concerning the users and the various key players in the fields of prevention, treatment or repression. This scheme focuses its observational efforts on two environments: the urban environment and the "festive" environment. The first includes areas frequently visited by active drug users (squats, the street, low threshold structures and transit areas, etc.) while the second refers to festive or "party" events or establishments mainly related to the techno, alternative (teknival, free-party, etc.) or commercial scenes (clubs).

The product analysis scheme referred to as the *Système national d'identification des toxiques et substances* (SINTES, or National Poison/Substance Identification System), a participant in TREND, provides information concerning the circulation of rare and emerging products.

Surveys among the general population on the noticeable accessibility, supply and availability of the various illegal substances can provide us with data concerning the most widely available products.

Seizures and the structure of trafficking activities

France is a transit country particularly for substances intended for the Netherlands, Belgium, the United Kingdom, Italy and beyond. Therefore, it is difficult to distinguish between the drugs intended for the French market and those that are only in transit. Trafficking in France must therefore be assessed based on the products encountered, as the acquisition and destination countries vary depending on the drug in question.

In France, three main types of supply networks for illicit drugs can be distinguished:

- Networks linked to major criminal organisations which are often encountered at the "bulk" or "semi-bulk" sale stage;
- Networks of "retailers" based on a strict organisational structure (manager / dealer / tout / lookout, etc.);
- "Micro-networks" of user-dealers.

The main source of information is the data from the law enforcement services (the police, customs and gendarmes) produced and published on an annual basis, in the form of a report, under the responsibility of the OCRTIS (the Central Office for the Repression of Drug Related Offences). This report includes, among other things, the quantities of illicit drugs seized in France, the number of arrests (for usage, usage-resale or trafficking) related to narcotics offences, the prices involved and any information concerning the structure of the trafficking networks.

Additionally, the TREND scheme provides qualitative information concerning access to the products and micro-trafficking.

Prices

Two useful resources make it possible to gather details of the unit sales prices of illegal products:

- The TREND network, based on qualitative questionnaires completed by the low threshold centres and staff operating in the techno/party environment on each site involved in the scheme, where for each substance concerned (illicit drugs or misused medicines) the retail price and an estimate of the lowest, highest and general price are requested.
- A periodic survey by the OCRTIS (based on data collected at 69 sites spread throughout metropolitan France), which records the median semi-bulk and retail prices of illegal substances.

Drug composition and purity

The composition of a product refers to all of the substances present in a sample of the product.

The purity (or content) corresponds to the percentage of the psychoactive product in the sample.

The product also includes cutting agents and additives. These terms refer to any substance added to the main product. They may or may not be pharmacologically active.

The detection threshold is the minimum quantity of a substance allowing for its identification in a sample.

The quantification threshold is the minimum quantity of a substance allowing for its dosage in a sample.

Two further information sources are used by the OFDT in order to document the composition of products currently in circulation:

- Analysis of chemical composition of substances seized. This data is supplied by the law enforcement services' laboratories and grouped together in the report from the OCRTIS (Central Office for the Repression of Drug Related Offences).

- Analyses derived from data collection campaigns involving drug users as part of the OFDT's SINTES scheme (National Detection System of Drugs and Toxic Substances).

Analyses of seizures

The analysis of seizures by law enforcement laboratories provides the main source of information on the composition of illicit products in France. The annual report from the OCRTIS provides a summary of all of the data on the composition of the illicit substances seized and analysed by all French law enforcement services (customs, the police and the *gendarmerie*) during the year, for the whole country. This offers a set of results from the analysis of seizures without taking account of the volume of each seizure, with the exception of cocaine for which a distinction is made between airport seizures and street seizures. However, not all of the seizures are analysed.

The main psychoactive substance content is determined; the other substances, with a few exceptions, are simply identified.

The exchange of information between the EWS (Early Warning System) and the SINTES scheme (the national correspondent of the EWS) also allows for the identification of new drugs.

Finally, the SINTES is also linked to the laboratories of the various legal authorities (the Customs Department, *gendarmerie* and the police) by an agreement which officially establishes and authorises an exchange of information concerning drugs in circulation. Following a specific request from the OFDT, these services provide information on the nature and composition of drugs recently seized or attracting particular attention from the OFDT and/or the EMCDDA.

The SINTES scheme

The SINTES scheme is based on the principle of the collection of samples of illicit drugs obtained directly from drug users. The drugs collected are forwarded to a toxicological analysis laboratory, which determines their composition. At the same time, the drug user is asked to complete a questionnaire in order to identify the context of use for the product and its purchase price. This makes it possible to directly correlate the price and purity of a given product. It includes two aspects:

- The *observation* aspect provides an annual overview of the composition of a particular illicit product. (2006, cocaine; 2007-2008, heroin; 2009, synthetic substances; 2011, heroin). The SINTES-Observation scheme is largely based on the national TREND network which is itself organised into seven regional coordination units. Each "collector" is selected and trained according to his networks and his skills by the regional coordinator under the responsibility of the OFDT which then supplies him with his collector's card. Each year, about 350 to 450 samples of the product being studied are collected from as many different users. This is consequently the main aspect of the SINTES scheme when it comes to obtaining details of the composition of the product on a national basis for a given year.

- The *monitoring* aspect is more particularly specific to the health alert system. Any professional working with drug users may ask the OFDT for authorisation to collect an illegal product on condition that this product has generated undesirable and unusual effects for users or if it is new in some way. The annual number of samples collected is generally between 60 and 100. The contributions made by this aspect are limited exclusively to the identification of newly circulating drugs and up-to-date information concerning the composition of certain substances at a given moment and in a given location.

All of the pharmacologically active substances are identified, provided that they are included in the laboratory database. However, only the main psychoactive substances undergo a content estimate, unless requested otherwise.

10.2. Availability and supply

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

Cannabis

Cannabis is the most frequently used narcotic in France. Due to well-established French drug networks, which import the substance either directly from Morocco or indirectly from Spain, cannabis resin is still widely available regardless of the fluctuations that can arise on certain local markets. Nevertheless, there is an observed growing preference shown by users in France and in the rest of the European continent for herbal cannabis, which appears to be increasingly available. In fact, in 2010, there seemed to have been fewer periods of the types of supply shortages seen in other years. Nevertheless, the quality of the product depends largely on the network to which the user has access. Home-grown cannabis for personal use is developing in France and elsewhere. This past year also revealed the appearance in France of semi-industrial cultivation.

Heroin

In France, heroin is available in two chemical forms: the "white" hydrochloride form and the "brown" freebase form. The white form accounts for a very small share of the market and only circulates through highly specific channels, for example in certain sections of the Asian immigrant community (the Chinese community in particular), and among Greater Paris-based users, who by their very nature are not particularly visible. In contrast, the freebase form dominates the market. After a period of decline following the introduction of substitution treatments in France in the second half of the 1990s, observers of drug markets noted that brown heroin has become more available since 2006. This is the case both for the most marginalised users frequenting low threshold structures and for users being seen in specialised treatment centres or who frequent certain festive alternative and underground scenes similar to the electronic music scene {Cadet-Taïrou et al. 2010b}. In 2009, this trend was confirmed by all parts of the TREND system (including Marseilles, a city in the southeast of France that has remained untouched by this phenomenon until now). According to OCRTIS 2010 data, brown heroin is *quite readily* available. In French regions, the latter was determined by proximity to the developing Afghan heroin markets of the Netherlands, Belgium and Switzerland. Subsequently, it is in northeast France and the Rhône-Alpes region that heroin is the most widely available.

Cocaine

Cocaine availability has been constantly increasing in France since the late 1990s and the early 2000s. This is a regular, ongoing process which does not appear to have experienced any decline or lagging. Indeed, the demand for cocaine hydrochloride is extremely dynamic in widely varying sections of the French population, ranging from the very well-off to the most marginalised low threshold services' clients {Cadet-Taïrou et al. 2010b}. In 2010, the availability measured by TREND remained just as high, both in the urban and the festive environment. According to the OCRTIS, cocaine is widely available in the main urban centres of metropolitan Lille, Paris, Lyon and Marseille.

Ecstasy, amphetamines and other synthetic drugs

To correctly understand the current ecstasy market, and supply in particular, a distinction needs to be made between the different forms of the substance, which include tablets, capsules and powder. Although the tablet is the most widespread form found in France, it is true that the market is much less dynamic than it was when the techno movement began growing in the mid-1990s. After a 2010 characterised by a drop in the availability of tablets containing MDMA, it seems that this ecstasy form is once again present on the festive scene.

For several years now, the powdered MDMA form has become increasingly available in various party settings. This form benefits from the growing appeal of cocaine hydrochloride, to which it is frequently assimilated, and from the growing popularity of "snorting". In view of its relatively high price, it only concerns a specific clientele in the "party" market (discotheques and nightclubs) that contribute to the extremely discreet nature of distribution networks, of which we currently know relatively little.

Amphetamine (speed) supply remains dynamic and targets a specific, clearly-identified segment of users who view speed as a cheap alternative to cocaine because it is available in powdered form and is snorted. This product is predominantly available in the alternative scene (the techno/party settings) but also appears to be gaining ground in nightclubs and discotheques as increasing numbers of consumers become dissatisfied with ecstasy tablets.

Although methamphetamines are sometimes reported in some foreign capitals (in the gay party milieu) and in spite of rare accounts of its artisanal manufacturing for users' private needs, this substance is not yet really available in France. Probably for commercial reasons, the dealers present as methamphetamines samples which are mainly composed of MDMA.

Hallucinogens

The market for hallucinogens is divided into two sub-markets: one for synthetic products such as LSD and the other for natural products such as hallucinogenic mushrooms or *Salvia divinorum* (Seer's sage).

For about 10 years, the LSD market in France has been extremely volatile due to the ups and downs of a supply side that depends greatly on the law enforcement services' activities in the substance producer countries, such as Belgium or the Netherlands. Consequently, in some years, TREND observers report virtually zero LSD availability, while at other times LSD appears to be extensively present on the market. Since 2006, supply of the drug appears to have experienced no major interruptions and LSD has been particularly available in "festive" settings associated with free parties and teknivals, where the drug appears to be actively sought after by a fringe consumer group of young thrill seekers.

It seems that, since 2008, there has been increased ketamine availability. While it appeared occasionally on the alternative festive scene, where it was mainly used by a specific fringe group of the festive population (travellers), ketamine appears to be much more available there. Depending on the site, ketamine's availability also extended either to the conventional techno scene (clubs in Metz, for example) or to urban settings (Lille, Bordeaux and Toulouse, for example). It is consumed there by new user groups, particularly young, itinerant, marginalised drug users or more integrated users and people experimenting with multiple drugs. The supply of these two products does not appear to be driven by organised networks; instead, the drugs are produced on an amateur basis or acquired via the Internet. Although its availability is increasing, ketamine supply is still more or less erratic on the festive scene. It is very difficult to obtain information on the origin of circulating ketamine: is it intended for human or animals? Does it come from the United Kingdom, the Netherlands, India, China or even Mali?

GBL (the precursor to GHB) is easily accessible through the Internet and in certain automotive equipment retail outlets. Until 2007, its use was mainly limited to sexual contexts in the gay party scene. In 2007, it spread from Paris to the provinces and from private settings to clubs. Around 2009, the use spread to clubs and discotheques, mainly in the cities of southern France (Toulouse, Bordeaux, Montpellier, Aix en Provence), thereby extending beyond the gay party scene to reach a young clubber population. In 2010, use by the gay party population was once again confined to the private sphere, and it seems that use in the young population once again became rather discreet.

Regarding natural hallucinogens, the situation is the same as for herbal cannabis: the supply of these substances is stimulated by high demand. This supply is boosted by a strong demand for so-called organic products with high "mystical" content, such as herbs used in traditional societies for inducing shamanic trance states, like *Salvia divinorum* or Datura {Reynaud-Maurupt 2006}. Furthermore, supply is further encouraged by the use of the Internet as a channel, allowing users to obtain their supplies without taking major risks, generally from the Netherlands and the United Kingdom.

10.2.2. Drug origins: national versus imported production

Herbal cannabis is the only illicit substance to be produced in France by "Grow your own" enthusiasts, often at home and on an amateur basis.

This phenomenon is related to several factors. The first is the current developing trend that promotes the development of so-called "organic" products, which are presumed to be of better quality. The second lies in the increasing care taken by users to avoid arrest, by avoiding the black market and dealers, and instead using "home grown" products or obtaining products from friends who themselves use this method. The phenomenon appears to have increased sharply over the last decade. The latest data, which dates back to 2010, estimates the number of cannabis growers at somewhere between 100,000 and 200,000 people {BECK et al. 2011} and total tonnage of domestic grown cannabis at around 30 tonnes {Toufik et al. 2007}. The various law enforcement services have noted an increase in the cross-border trading of weed from Belgium and the Netherlands. In the latter country, cannabis growing has reached considerable levels due to the involvement of organised crime in large-scale production {Weinberger 2011}.

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

Cannabis

The cannabis resin consumed in France comes from Morocco, usually through Spain. It is imported by well-organised transnational criminal networks established mainly in vulnerable housing estates on the outskirts of major French cities. According to certain law-enforcement services, there are approximately sixty such networks comprised of approximately one thousand people. These networks, which are at the zenith of the resin-trafficking pyramid in France, supply semi-wholesalers, of which there are anywhere from 689 to 1,504 {Ben Lakhdar 2007}. It would seem that the resin coming from Afghanistan, the second largest producer worldwide, is increasingly present on the French market. Today, the cannabis resin market seems to be less dynamic. There are several reasons for this slowdown: the increasing competition from weed produced in France and the rest of Europe, the effects of policies aimed at eradicating cannabis production in the Kingdom of Morocco and a growing trend for the criminal networks which traditionally import this product to also import cocaine hydrochloride alongside the cannabis resin, resulting in the latter being occasionally abandoned altogether since it is much less profitable.

Heroin

The trend towards an increasing availability of heroin in the French market is encouraged by the renewed dynamism of the supply side seen over the last decade in Afghanistan, the source country for 90% of the heroin consumed in France. The rise in opium and heroin production has encouraged the growth of criminal organisations (particularly Turkish and Albanian gangs) that import heroin through the Balkans into France and sell it on a semi-wholesale or wholesale basis to networks of retailers. The latter are also generally involved in the trafficking of cannabis resin imported from Spain or Morocco and are based on housing estates around the main French urban centres.

Alongside these networks which are controlled by organised crime, we also find what the police refer to as *secondary networks*, i.e. small-scale organisations chiefly comprised of user-resellers. They obtain heroin in countries bordering on France such as Belgium and the Netherlands. These two countries are traditional storage sites for heroin arriving via the Balkan route {Ocrtis 2009} All of these factors contribute to the increasingly diffuse nature of this product's presence in France and, to a certain extent, have helped to "rehabilitate" the product in the eyes of specific groups of drug users.

High dose buprenorphine (HDB)

Ever since its 1996 launch, the high-dose buprenorphine prescribed for heroin substitution treatments has been the subject of trafficking on the urban black market, often targeting extremely marginalised drug users {Toufik et al. 2010}. This trafficking is organised by two types of groups. The first group, which displays a certain degree of organisation, has major quantities of tablets available for sale on the black market by falsifying prescriptions and obtaining multiple prescriptions, while the second group (chiefly comprised of users receiving the substitution treatments themselves) chooses to carry out small-scale dealing in the products. This small-scale dealing tends more to concern users helping one another out when they are out of stock, rather than highly organised drug dealing operations. In 2010, it appears that despite enhanced monitoring and control methods employed by health insurance funds in the French regions,

demand remains buoyant although occasional shortages may occur in one city or another. The availability of the drug is therefore high, as is its level of accessibility, since (in stark contrast to the situation with illicit drugs such as heroin or cocaine) an open drug scene for the sale of HDB drugs exists in many French cities.

Cocaine

Cocaine supply has been steadily rising.

The supply of cocaine has benefited from the restructuring underway over the last 10 years which has encouraged its spread throughout the whole country. This restructuring has been driven by the fact that importers of cannabis resin produced in Morocco have converted over to the sale of cocaine, the trafficking of which is far more profitable than that of resin (with a wholesale price of € 30 per gram for cocaine compared to approximately €2 per gram for cannabis resin).

This trend is further encouraged by changes to the major international cocaine trafficking routes, which increasingly tend to follow the cannabis routes. The law enforcement services estimate that between 20 and 30% of the cocaine seized in Europe is smuggled via western Africa, continuing through the countries of North Africa which are traditional sources for cannabis resin. Another factor is also contributing to this trend for cocaine to replace cannabis resin, namely the relative dissatisfaction of European consumers with resin. In any case, the development of multi-drug networks solidly established for decades now in the suburbs around the French urban areas has encouraged the growth of a major supply side for cocaine.

The second key factor which explains the large availability of cocaine also lies in the development (as is the case with heroin) of networks of user-resellers supplying a small clientele obtaining their supplies from the countries bordering on France: Spain, Belgium and the Netherlands {Gandilhon, M et al. 2010a}. These hundreds of "micro-networks" have ensured the greater availability of cocaine, which now reaches into both urban and rural areas alike.

The second type of cocaine found in the French market is known as "crack" or "freebase". These two different expressions actually refer to the same product but are used by different client groups.

Unlike hydrochloride, the distinctive feature of crack is that it is found in highly specific markets in particular geographical areas. Indeed, in the vast majority of cases, crack is intended for a clientele comprised of extremely marginalised users chiefly found in Paris and in the overseas departments of Guiana, Guadeloupe and Martinique {Merle et al. 2010} In 2010, the traditional crack scenes established in the 18th and 19th *arrondissements* of Paris had shifted to Seine-Saint Denis, the administrative department directly to the north of the city. They have returned. Moreover, it has been confirmed that at least part of the Parisian crack supply chain is being increasingly handled by networks of individuals specialised in the resale of cannabis resin, to the detriment of traditional resellers who are usually from West Africa and particularly from Senegal.

In 2009, there was an observed appearance of a small crack market (i.e. the sale of free-based cocaine) in Toulouse (in the southwest of France). This market catered to unstable users, and the trend continued in 2010. This phenomenon is isolated among the non-Parisian TREND sites.

Freebase (unlike crack) is not marketed via a drug user's resale system put in place by organised networks. In most cases, the product is manufactured by the users themselves.

Furthermore, free base involves a completely different clientele than that of the “crackers”: namely a population group comprised of members of the underground techno movement (travellers and nomads, etc.) generally found at “free party” dance events.

Ecstasy

It appears that the low level of demand for ecstasy in its "tablet" form has caused criminal organisations to lose interest in this product {Girard et al. 2010}. In 2010, most of the supply side found in the French market was comprised of micro-networks that obtain their supplies abroad (from Belgium, the Netherlands or Germany) or less commonly from Eastern Europe’s organised crime networks.

Other synthetic drugs: growth of Internet trafficking

Like everyone else, French people have access to Internet sites which sell psychoactive substances. These sites have considerably grown in number these past years, and particularly since 2009. Although the SINTES scheme was able to identity some of the new synthetic stimulants sold by these sites and seen on the party scene, the distribution of these substances has remained limited in France.

A fringe of experienced users accustomed to buying substances on the Internet (particularly users from the Parisian gay party scene) seemed to have used these substances, as did groups of young people in specific areas (the Lorraine region of France, for example). However, in 2009, these substances remained unknown to the vast majority of users on the party scene, where they are sold under other names[164]

10.3. Seizures

10.3.1. Quantities and numbers of seizures for all illicit drugs

In 2010, the number of narcotics seizures[165], all substances combined, was 129,529, an increase of nearly 20 % compared to the previous year. These remain at historically high levels compared to the late 1990s and the early 2000s.

[164] « Méphédrone et autres stimulants de synthèse en circulation ». Note d’information SINTES, March 2010; Cadet-Taïrou, Trend report.
[165] This year, we do not have data on the number of seizures performed for each of the illegal substances in question.

Table 10-1: Quantities of drugs seized (in kilograms), from 2006-2009, and changes from 2009-2010 (%)

Drugs seized	2006	2007	2008	2009	2010	Change 2009-2010
Herbal cannabis	3,773 kg	3,047 kg	3,422 kg	3,495 kg	4,564 kg	30.59 %
Cannabis resin	67,891 kg	34,182 kg	71,075 kg	56,073 kg	52,795 kg	-5.84 %
Cannabis seeds	57 kg	51 kg	30 kg	45 kg	22 kg	-51.45 %
Heroin	1,051 kg	1,035 kg	1,117 kg	970 kg	1,087 kg	12.11 %
Cocaine	10,166 kg	6,578 kg	8,214 kg	5,211 kg	4,125 kg	-20,84 %
Crack	8 kg	6 kg	12 kg	12 kg	14 kg	12.61 %
Amphetamines	77 kg	307 kg	109 kg	564 kg	176 kg	-68.78 %
Ecstasy (tab)	1,488,919	1,359,912	342,923	106,597	663,595	552.52 %
LSD (units)	5,589	13,107	90,021	10,209	28,411	178.29 %
Ketamine	5 kg	2 kg	65 kg	3 kg	14 kg	274.87 %

Source: FNAILS, OCRTIS 2010

Regarding cannabis resin, the downward trend witnessed since 2004 (the year which marked the historical high point of seizures in France with around 100 tonnes seized), has continued in 2010 with a fall in seizures of almost 6% compared to 2009. The seizure of cannabis seeds and plants was also down compared to 2009 by -51.45% and -3.05% respectively. In contrast, weed seizures have increased since 2004 (+49% between 2004 and 2010).

Heroin seizures in 2010 remained high, at more than one tonne (1,087 kg) after a new upward trend that started in the early 2000s. This is almost three times higher than what was seized in France in 1999 or 2001.

Contrastingly, seizures of cocaine have fallen by almost 21%, for a total of 4,125 kg in 2010. This fall is significant when compared to the historical peak reached in 2006 with more than 10 tonnes. However, when looking back over the last 15 years, we soon see that cocaine seizures in France remain at a historically high level: more than six times the quantity seized when cocaine began to circulate in the early 1990s. The decrease in seizures recorded over recent years can be explained by changing trafficking strategies to develop new routes to supply the north of the continent through France (the Balkans, or even the Baltic Sea).

Crack seizures have been variable since the early 2000s. Although they have been on the rise since 2007, it is difficult to discern a long-term trend.

In 2010, ecstasy tablet seizures reached 663,595 units, or a 552.52% increase compared to 2009. This represents the highest quantities seized in the past fifteen years. It is necessary to specify that 2009 was exceptional due to the MDMA shortage following the massive destruction in Cambodia of a precursor needed for its manufacture. This significant increase, given the reestablishment of the market, is therefore not surprising and the quantities seized remain low compared to the 2000s.

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

There is no data concerning seizures of precursor chemicals because France is currently not (or is only marginally) an illicit drug-producing country (with the exception of herbal cannabis).

10.3.3. Number of illicit laboratories and other production sites dismantled and specific types of illicit drugs manufactured there

The last major case involving the dismantling of a production laboratory dates back to 2005. This was a cocaine production unit located at Le Perreux in the Val-de-Marne département.

10.4. Prices and purity

10.4.1. Retail prices of illicit drugs

Cannabis

According to OCRTIS[166] the median price for herbal cannabis in 2010 was approximately 7 euros, and ranged from 5 to 10 euros per gram. This price is slightly up compared to previous years. This phenomenon is explained by the fact that an increasing percentage of consumers appear to display a marked preference for high-quality products.

The wholesale price of herbal cannabis, as measured by the police, stands at 3,500 euros per kilogram.

The median price of cannabis resin has remained stable. In 2009, this stood at 5 euros per gram. The wholesale price for the same year was 1,950 euros per kilogram.

Heroin

In 2010, the median price per gram of brown heroin was approximately 40 euros and has remained at around this level since 2006 after having fallen sharply since the late 1990s when its price hovered around the 70 euro level. The wholesale price for brown heroin has also remained unchanged at around 12,000 euros per kilogram.

High-dose buprenorphine

Since 2008, the price per 8 mg tablet of HDB marketed as Subutex®, the only (or almost only) form available on the black market in major urban centres, rose slightly to 5.5-5.6 euros in 2008 and 2009 compared to 4 euros in previous years {Cadet-Taïrou et al. 2010b}. This price increase is believed to be related to difficulties in keeping the market supplied due to the strict prescription control measures put in place by health authorities.

Cocaine

The price per gram of cocaine hydrochloride has remained stable for five years after having been halved compared to the late 1990s. In 2010, the median price was approximately 60 euros per gram. The wholesale price, which also remained stable, was 30,000 euros per kilogram.

Ecstasy

It is necessary to differentiate the tablet form from the powder form.

[166] The retail and wholesale prices of cannabis, heroin, cocaine and ecstasy have been obtained from the OCRTIS publication *Les prix des stupéfiants en France en 2009* (Narcotics prices in France in 2009).

According to the 2009 SINTES survey on synthetic products, the average price of an ecstasy tablet was 7.3 Euros. The fall in the price of tablets observed over recent years appears to have ended in 2009. This may be the result of the low levels of availability of MDMA tablets seen during 2009; this drop did not continue into early 2010. The OCRTIS data revealed an increase in price from 5 Euros in 2009 to 6 Euros in 2010. The wholesale price (1,000 tablets) was approximately 2,500 Euros per kg.

10.4.2. Purity/potency of illicit drugs

Cannabis

The average content of THC in cannabis resin has increased progressively over the past 10 years (from 6% in 2000 to 11% in 2010) {Institut national de police scientifique 2010}. This comes mainly from wider circulation of high-dose resins (>15%). The maximum content seen in 2010 was 38%. Average THC content in herbal cannabis seemed to increase (10%). It may be interesting to check the validity of this hypothesis next year. This trend can be explained by wider circulation of high-dose herbal cannabis (>15%). The maximum content seen in 2010 was 40%.

Heroin

Average heroin content rose from 10% in 2003 to 13% in 2010. This trend is the result of wider circulation of high-dose samples (>30%). This purity does not reflect the major purity differences observed from sample to sample {Ocrtis 2011};SINTES, 2010 #1734}.

The regional differences (higher content in the north than in the south of France) observed in 2007 during the national SINTES survey will need to be confirmed in 2011.

Cocaine

The cocaine content of the samples seized on the street stood at between 10 and 40% (average 30%) and has not changed since the early 2000s {Ocrtis 2011}.

Ecstasy

The average MDMA purity (“content” was between 60% {Ocrtis 2011} and 70 % {LAHAIE 2011}. The content was much lower for tablets (approximately 15%).

10.4.3. Composition of illicit drugs and drug tablets

Heroin

Since the beginning of the 2000s, more than nine out of ten heroin samples have been found to contain a mixture of caffeine (20% to 40%) and paracetamol (40% to 60%), which consequently remains the main cutting product.

The remainder is comprised of inert products such as sugars and mannitol.

Pharmacologically active adulterants, such as diazepam, phenacetin, dextromethorphan and alprazolam, were identified in several samples in 2010. In most cases their concentration was below 1%.

Cocaine

When cocaine arrives in France it has already been cut using psychoactive substances such as levamisole, hydroxyzine and diltiazem. It is then re-cut with other psychoactive substances such as phenacetin and lidocaine, and sugars before being resold on the street.

Levamisole is seen most often (present in 60% of the circulating samples), although in low proportions (average of 8% of the total volume of a sample). Phenacetin is present in 41% of the circulating samples at an average purity of 32% - nearly as much as the cocaine itself.

Ecstasy

In 2010, caffeine was the ingredient most often combined with MDMA. The presence of mCPP has dropped since 2009.

Part B: Selected issues

11. Drug-related health policies and services in prison

Although drug use is almost always mentioned in French research on prisons {Chauvenet et al. 1996}, {Observatoire international des prisons 2000; Observatoire International des prisons 2005}, {Combessie 2004}, {Chantraine et al. 2006}, it is rarely investigated as such {Bouhnik et al. 1996}, {Fernandez 2010}. Of the many studies that have examined health in prison settings ({Revue française des affaires sociales 1997}, {Haut comité de la santé publique (HCSP) 2004}), few have dealt with defining a Harm Reduction (HR) policy specifically adapted to the context of institutional confinement (prison) ({Lebeau 1997}, {Michel et al. 2008}). In 2010, a collective expert report conducted by the French National Institute of Health and Medical Research (INSERM) examined, for the first time, the idea of applying the concept of HR in France, and particularly in penal establishments. It concluded that, although various preventative tools exist in France, "there is currently no real harm reduction policy geared towards prisons" {Michel et al. 2010}. It also pointed out that the principle of equivalence of treatment with an obligation to treat incarcerated patients in the same way as outpatients, required by French law and recommended by the WHO, is not effectively applied in French prisons. The need for a policy adapted to the prison setting is nonetheless crucial: nearly one-quarter of French drug addicts go through the prison system each year {Hyest et al. 2000}.

The inequality of access to treatment for drug users in prison, when compared to outpatients, is explained by different factors that are first and foremost related to the way the prison system operates and to how treatment is organised within prisons. The objectives of the law on the one hand and the reality of prison treatment practices on the other are therefore contrasted. They need to be compared with the clinical practice guidelines and standards of quality of treatment developed in France. The purpose here is to clarify the discussion on the resources for guaranteeing equal access to treatment for both incarcerated patients and outpatients. In the last section, the weaknesses in the system of information on care provided to drug users in prison will be listed so that this problem can be better monitored in the years to come.

11.1. Prison systems and the prison population: background

11.1.1. Background information on the French prison system and prison population (Characteristics of the prison system)

French penal establishments

On 1 January 2010[167], the *administration pénitentiaire* (the Prison Service, or "PS" for the purposes of this document) had 191 penal establishments in mainland France and the French overseas departments and territories:

[167] These figures have been provided by the *administration pénitentiaire* (French Prison Service), valid as of 1 January 2010 (www.prison.justice.gouv.fr).

- 106 *maisons d'arrêt* (remand centres, or “RC”) and 35 remand wings, (“RCW”), situated in penitentiaries, for carrying out provisional detention and for prisoners with two years or less of their sentence remaining (since the November 2009 French penitentiary act)

- 37 *centres pénitentiaires* (penitentiaries, or “PI”) including at least 2 wings for prisoners of a different detention status (remand centre, detention centre and/or high security prison);

- 24 *centres de détention* (detention centres, or “DC”) and 34 detention centre wings (“DCW”) for inmates serving a sentence of one year or more and who have favourable social rehabilitation prospects;

- 6 *maisons centrales* (high security prisons, or “HSP”) and 5 high security wings (“HSW”) that house the most difficult convicted offenders, who require reinforced security and who will not be ready for social rehabilitation for a long time;

- 12 *centres de semi-liberté* (open prisons, or “OP”) and 4 open prison wings (“OPW”), which are located in the PIs. These centres house convicted offenders who have been admitted there by the judge responsible for the execution of sentences with an outside placement without monitoring or open prison regime,

- 6 penal establishments for minors ("PEM"), which are provided for in the French law of September 2002 on the orientation and programming of the justice system. The first of these was opened in mid-2008.

- 4 *quartiers centres pour peines aménagées* (resettlement prison wings or “RPW”), which are located in penitentiaries.

The management of 43 of these establishments is outsourced to private companies. Such establishments represent 4.4% of all penal establishments.

In order to manage the prison settings, the Prison Service was allocated a 2010 budget of 2.17 billion Euros (excluding pensions), or more than one-third of the Justice budget. This was up 10% compared to 2009. These budgetary credits (payment credits, excluding pensions) are broken down as follows: 54% for personnel costs, 28% for operating costs, 14% for investment costs and 4% for intervention costs (French Ministry of Justice, 2011).

According to the most recent data (1 May 2010)[168], the French Prison Service had 57,411 places in mainland France and the French overseas departments and territories[169]: 56,779 of them are "operational". In other words, they are effectively available. The others are most likely being refurbished or used temporarily for another purpose. These places are broken down according to establishment type as follows:

- 34,136 places in remand centres or remand wings (60%)

- 19,365 in detention centres or detention wings (34%)

- 1,981 in high security prisons or high security wings (3.5%)

[168] *Direction de l’administration pénitentiaire* (Prison Administrative Directorate), monthly report of the prison population and population entered on the prison register as of 1 May 2010.
[169] Within the meaning of the capacities defined in a circular dated 3 March 1988 and updated on 17 May 1998.

- 316 in resettlement prisons or wings (0.6%)
- 659 in open prisons or open prison wings, excluding “open” places in other types of establishments (1.2%)
- 322 in establishments for minors (0.6%).

The prison population

On 1 May 2010, the number of people entered on the prison register in France was 67,851 (throughout France). This population includes inmates (61,604 people) and people who are not detained but benefitting from a resettlement (6,247 people in total, with 5,611 under home detention with electronic monitoring and 636 benefitting from outside placements).

With 61,604 inmates, France had reached its highest ever prison population since the statistics began being recorded in 1852 (not taking into account the 60,000 prisoners recorded during the *Libération*, nearly one-third of whom were suspected collaborators). Of these 61,604 inmates, 15,963 were pre-trial detainees (25.9%) and 45,641 were convicted offenders (74.1%) - all occupied 56,779 operational places, representing a difference of 4,825 between the operational capacity of the penal establishments and the effective number of inmates, i.e., an overall prison density of 108 inmates per 100 prison places.

To rigorously account for the overcrowded prison conditions, we must compare the prison density with the surplus inmate indicator: 9,493 people on 1 May 2010 France-wide {Tournier 2010}. This figure better represents the overcrowded prison conditions in France because it adds the number of surplus inmates above available capacity (4,825) and the number of unoccupied operational places[170] (4,668).

Prison overcrowding varies considerably between mainland France and the overseas departments and territories, and especially between the different types of establishments: of the surplus inmates, 96% are in remand centres, since the assignment of convicted offenders to penal establishments is managed by the Prison Service according to the *numerus clausus* principle. The prisons for sentenced detainees, where the number of inmates per 100 places (85 in 2010) is decreasing, are therefore exempt from the overcrowding phenomenon. The latter pertains especially to remand centres and remand wings of penitentiaries[171], i.e., the most widely found establishments in the prison system, and which are supposed to house a majority of pre-trial detainees and convicted offenders with short sentences (with less than a year remaining of their sentence).

Developments and outlooks

Since 2008, the number of inmates has stabilised at a high level (approximately 61,000). This figure corresponds to a detention rate[172] of 96.8 prisoners per 100,000 inhabitants, (Kensey 2010), which is one of the highest in Europe (Aebi et al., 2010a). Although, for the first time this decade, the number of inmates declined significantly in 2010 (-2%), France continues to stand

[170] As Tournier mentions, this figure is especially high due to the recent opening of new establishments, such as the penitentiaries in Bourg-en-Bresse, Rennes and Le Havre (Tournier, 2010).
[171] The occupancy rate in remand centres (56% of the establishments) is 125 inmates per 100 places.
[172] The detention rate for 100,000 inhabitants reflects the ratio between the number of detainees and the number of inhabitants. It makes it possible to assess the changes in the prison population while taking into account the demographic movement of the general population.

out with its consequential prison overcrowding - the highest of the 47 countries of the Council of Europe, along with Spain, Cyprus, Bulgaria, Serbia and Croatia (Aebi, Delgrande, 2010a).

The overcrowding of French prisons can be explained by a cumulative two-phase development over time. From the mid '70s to the mid 2000s, France experienced a 30-year prison population climb {Tournier 2002}, during which the prison population increased eight times faster than the general population (+120 *vs.* +15%)[173]. This spectacular increase can be explained by the combination of three phenomena: a lengthening of the prison sentences handed down[174], the low number of resettlements until the mid 2000s (conditional discharge, suspended sentence for medical reasons, open prison regime, outside placement or home detention with electronic monitoring), the relatively low number of sentences used as alternatives to prison (e.g., community service, *jour-amende,* a fine in the form of a fixed amount to be paid per day, etc.)

Since the middle of the last decade, each of these factors has evolved, slowing down (although not reversing) the upward demographic trend. With the rise in resettlements, the number of convicted offenders receiving sentences not involving imprisonment[175] increased 15-fold between 2004 and 2010 (+ 4,200). The number of people entered on the prison register and benefitting from a resettlement increased three times faster than the prison population[176]. Moreover, alternative sentences clearly rose, especially community service and *jour-amende* penalties (day-fines), which increased by approximately 50% since 2004 {Timbart 2011}. This recent development in alternatives to prison can be interpreted as France's attempt to "catch up" {Portelli 2010}, even though France remains one of the European countries (along with Italy) where the rate of "alternative to prison" sentencing is the lowest (34.5 per 100,000 inhabitants), whereas the mean is 209 {Aebi et al. 2010b}.

Stabilisation of the inmate population, decrease in the number of surplus inmates[177], detention rate per 100,000 inhabitants and provisional detention rate (see Table 1): the French penitentiary situation seems to have evolved since the 2008 report by the Council of Europe Annual Penal Statistics {Aebi et al. 2010b}. This trend, if it is confirmed, can be explained by an increase in prison capacity that has risen four times faster than the increase in inmate numbers[178] since the 2000s[179]. Nevertheless, these transformations are insufficient to change the French situation in Europe: France remains in a median position with respect to its gross detention rate and provisional detention rate, and continues to stand out due to its elevated

[173] The ratio even reached 10 to 1 during the period from 1975 to 1995: the prison population increased by 100% vs. the 10% increase seen in the population as a whole (Tournier, 2002).

[174] Especially after the entry into force of the new 1992 French Penal Code, which increased the maximum sentence possible for a large number of offences (Kensey, Cardet, 2001). The average detention period thus increased from 4.6 months in 1980 to 7 months in 1990, then to 8.7 months in 2000 and 9.4 months in 2009.

[175] Home detention with electronic monitoring (PSE) or outside placement.

[176] +5,000 *vs.* +2,000 persons. Home detention with electronic monitoring was significant following this increase in resettlements (Kensey, 2010). It can also be related to repeated ministerial encouragement to systematically use resettlement measures during sentences: Warsmann report (Warsmann, 2003), laws aimed at fighting recidivism in December, August 2007, March 2010 and the November 2009 French Penitentiary Act (see Legal Framework).

[177] Today, the number of surplus inmates is almost one-quarter the level seen in 2004, when France had reached its highest prison overcrowding level ever (6,086 surplus inmates, and 121 inmates per 100 places).

[178] The number of prison places increased from 48,572 to 56,463 between 2004 and 2010 (+ 16.2 %), while the number of inmates rose from 58,942 to 60,978 (+3.5 %) for that same period.

[179] Since the LOPSI (the *Loi d'Orientation et de Programmation pour la Sécurité Intérieure*) French domestic security act, which authorised the state to entrust prison construction to private companies, the State launched a progressive privatisation of prison construction (with the 13 200 property programme, which was carried out as a public-private partnership) and management. The *Agence Publique pour l'Immoblier de la Justice* (APIJ, the French Public Agency for Judicial Properties) acts as project owner and private companies (like Bouygues) take care of the construction, and then the management. The Ministry foresees the creation of 13,200 new prison places by 2012.

prison density, which is much higher than that of Germany or Great Britain. In other words, the severity of France's penal policy - measured by the proportion of its inhabitants held in detention - does not distinguish it from its European neighbours. However, prison overcrowding, i.e., the ratio of the number of inmates to the number of prison places, puts France in a critical position with respect to European recommendations[180]. According to the demographic projections of the Prison Service[181], the population entrusted to the Prison Service could reach 80,000 [people entered on the prison register] by 2017 {Bérard et al. 2008}, which would assuredly oblige France to further develop alternatives to imprisonment and resettlements {Portelli 2010} to fight against overcrowded prison conditions.

Table 11-1: Increases in the prison population France-wide (2004-2010)

Year	Number of detainees on 1 January	Annual growth rate (%)	Population France-wide (in thousands)	Inmates per 100,000 inhabitants	Proportion of pre-trial detainees	Proportion of convicted offenders	Detention rate per 100,000 inhabitants
2004	58942	N.av	62251	94.7	36.9	63.1	34.9
2005	58231	-1.2	62730	92.8	34.6	65.4	32.1
2006	58344	+0.2	63186	92.3	33.8	66.2	31.2
2007	58402	+0.1	63578	91.9	31.6	68.4	29.1
2008	61076	+4.6	63937	95.5	27.5	72.5	26.3
2009	62252	+1.9	64303	96.8	25.6	74.4	24.8
2010	60978	-2.0	64700	94.2	25.2	74.8	23.8

Source: Prison Service (Ministry of Justice)

overcrowded prisons and poor detention conditions: what still ails the french prison system

Overcrowding is one of the distinctive characteristics of French prisons, as well as poor detention conditions, regularly denounced by prison unions, prison employees and French associations fighting for the fundamental rights of incarcerated people, such as *Ban public* or *the Observatoire International des Prisons* {Observatoire international des prisons 2000};{Observatoire international des prisons 2003; Observatoire International des prisons 2005}. Protests against detention conditions deemed “inhumane and degrading” reached their peak in national public debate in 2000, when the testimony of the Head Physician of one of the largest penal establishments in France was published {Vasseur 2000}. The work by Véronique Vasseur, which received wide media coverage {Décarpes 2004}, led the French Parliament to examine the issue through two Parliamentary inquiry commissions, which characterised the prison situation as “a humiliation for the French Republic” in the senatorial inquiry report ({Mermaz et al. 2000}; {Hyest et al. 2000}). The international authorities themselves stigmatised the French prison situation. On several occasions, the European Committee for the Prevention of Torture (CPT) condemned France for the state of its prisons (overcrowding, insalubrity) and the “inhuman and degrading treatment” of the inmates[182]: failure to respect privacy, promiscuity,

[180] The Council of Europe affirmed that expanding the French prison system should be an exceptional measure, since it does not offer a long-term solution to overcrowding. See recommendation No. R(99) 22, adopted by the Committee of Ministers of the Council of Europe on 30 September 1999.

[181] Established according to changes in inmate age, nationality, detention periods, provisional detention, type of sentence and resettlements (see PS executive summary presented during the establishment of the *Comité d'orientation restreint* [COR] - the committee responsible for the future Prison Act of 11 July 2007, mentioned in an article in the French daily *Le Monde* on 14 July 2007).

[182] In 2007, as during its preceding 1996 and 2003 visits, the European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment (CPT) was concerned about the high prison overcrowding rate seen in the visited remand centres in France (CPT, 2007). It also emphasised that housing pre-trial detainees and convicted offenders in remand centres for long, or even very long periods, in the same cell, went against the European Prison Rules. The CPT reiterated its recommendation

breaches in the continuity and quality of care, sublevel general hygiene, rare activities (sports, work-related, training), and numerous acts of aggression and violence among inmates.

According to the French Health Minister himself, these “unacceptable living conditions”[183] help explain the high prevalence of suicide risk among inmates - even though it has not yet been possible to establish a correlation between prison conditions and the suicide rate[184]. About a hundred suicides occur in prison each year, which is twice as many as twenty years ago. They tend to take place during the first two years of imprisonment. This represents a suicide rate that is five to six times higher than the national average. France is one of the European countries reporting the highest "excess suicide rates" in prison, {Lecerf 2009}, with 18 suicides per 10,000 inmates (2009). Hence, this problem has received particular public attention in France {Lecerf 2009}.

These repeated criticisms led to the 2008 creation of a *contrôleur général des lieux de privation de liberté* (CGLPL or "general controller of the jails")[185]. In its last annual activity report (2010), the CGLPL emphasised that the current prison situation is still often characterised by dilapidation “and at times, squalidness, in old, poorly maintained establishments” {Contrôleur général des lieux de privation de liberté 2011}.

11.1.2. Characteristics of the prison population, health and social status (Characteristics of the prison population)

Pre-trial detainees and convicted offenders

Twenty-five percent of the prison population is represented by pre-trial detainees, still awaiting trial. This is the lowest proportion ever recorded (15,395 people in provisional detention, or 25% of the prison population, as of 1 January 2010). Since 2004, the steady decrease in the proportion of pre-trial detainees has been accompanied by an increase in the number of convicted offenders {Danet 2008} and in their subsequent proportion in the prison population {Timbart 2011}. The provisional detention rate per 100,000 inhabitants decreased by 11 points over seven years, dropping from 34.9 per 100,000 inhabitants in 2004 to 23.8 in 2010 (see Table 1).

Demographic profile and living conditions

The prison population is characterised by a socio-demographic profile that is very different from the general population. The latest surveys conducted by the DREES (Directorate for research, studies, evaluation and statistics) in 1997 and 2003 revealed a population that was primarily of

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to the French authorities to develop a strategy against prison overcrowding which was aggravated, according to the CPT, by the escalating number of increasingly heavy sentences handed down. It also acknowledged the importance of the conclusions of the “*Etats généraux de la condition pénitentiaire*” (Convention on Prison Conditions) organized by the International Prisons Observatory in 2006.

[183] Memorandum of Thomas Hammarberg, Commissioner of Human Rights of the Council of Europe, following his visit to France from 21 to 23 May 2008 (20 November 2008)

[184] See the Ministry of Justice, response to written question no. 12634 by Deputy Alain Néri, OJ of 8 June 2004. This point of view goes against the words of the Ministry of Health, who claimed that "suicide prevention in the prison setting must, first and foremost, be addressed by a global approach to upgrade the prison environment and detention conditions for inmates. It is a question of promoting the continued mental health of inmates." (French Ministry of Health / Ministry of Justice, *Guide méthodologique relatif à la prise en charge sanitaire des personnes détenues*, September 2004).

[185] The CGLPL is an independent authority created through the French act of 30 October 2007 following France’s adoption of the United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. The CGLPL effectively began operations on 13 June 2008, when Jean-Marie Delarue was appointed to supervise it.

French nationality (82%)[186], male (96.6% men vs. 3.4% women) and young (34.2 years on average): nearly half of the inmates were under the age of 30 {Mouquet et al. 2005}. However, the population is aging: while in 1978, inmates over the age of 40 represented only 15% of the prison population; today they represent nearly 30%. The ageing of the prison population namely poses problems with regard to care for very old inmates: on 1 January 2010, 3.6% of the prisoners were aged 60 or over (2,356 people, 370 of whom were over the age of 70), which is twice as many compared with 10 years ago (French Prison Service, annual figures).

The education level of the inmates is much lower than that in the general population: 68% have secondary education or higher, 23% have primary education and 2% state that they are illiterate {Mouquet et al. 2005}. The survey conducted by the INSEE (French National Institute of Statistics and Economic Studies) on the family history of the male inmates revealed their low educational level {Insee 2002}: only 39% had received secondary education or higher, 50% had no higher than a primary school education and 10% stated that they were illiterate; moreover, 64% had no diploma or certificate and 30% had reading problems. These education indicators are even lower among the youngest adult inmates, 80% of whom have no diploma or certificate and nearly 40% have trouble reading. The survey conducted among incarcerated subjects, compared to subjects seen in outside health structures, revealed that the inmates are younger and less socially integrated than the outpatients seen in health structures: 14% had secondary or higher education versus 35% for the outpatients; moreover, fewer of them had a regular income (31% vs. 48%) and a professional activity (27% vs. 40% {Pauly et al. 2010}). All of the available studies establish that this population is also characterised by a low level of professional activity: the rate of professional activity when entering prison is less than 50%, while the general rate for men aged 15-64 is approximately 75%, and even reaches 91% for 25- to 29-year-olds {social 2005}.

This population therefore presents a number of social vulnerability characteristics. Nearly one out of every five inmates stated that they did not have a stable home (17%) and 13% had no social protection ({Mouquet et al. 1999}; {Mouquet et al. 2005}). These difficult housing conditions are more rampant among women: slightly more than one out of every five women entering prison stated living in an unstable household prior to incarceration, and approximately one out of seven declared being homeless. Furthermore, 60% of detainees live below the poverty line {Marchetti 2001}.

Mental health and addictive behaviour

The prison population exhibits pathologies related to social exclusion and marginalisation. In particular, there are more mental health and addiction-related problems than outside of prison. A survey published in 2002 on mental health and psychiatric care revealed the existence of psychiatric disorders in nearly 55% of incoming inmates {Coldefy et al.}. The symptoms described by psychiatrists were varied, ranging from anxiety-depressive and addictive disorders (in 55% of these inmates) to psychoses (in nearly 20% of them). The survey further demonstrated that the mental disorders observed in this population had considerably worsened over the course of a few years. The study also revealed a high frequency of harmful alcohol and illicit drug use and addiction: 15% of incarcerations and a third of remand centre detentions were related to a drug-related offence. The general trends in psychoactive drug use revealed increased polyuse, a diversification of administration routes (increased sniffing frequency) and the increasingly frequent use of psychostimulants, cocaine and crack.

[186] The proportion of foreign inmates or inmates of unreported nationality has been steadily declining for several years (20.5% in 2005, 18% in 2009).

The first widespread epidemiological study[187] conducted in 2003-2004 on mental health in prisons objectivised the prevalence of mental disorders in the prison setting {Rouillon et al. 2007}. It indicated that 80% of male inmates and 70% of female inmates had at least one psychiatric disorder, and the large majority had several disorders. Anxiety disorders are the most frequent (more than half of the inmates in mainland France have at least one), followed by mood disorders. Of the revealed disorders, the study showed that 40% were depressive syndromes, 33% were generalised anxiety, 20% were traumatic neuroses, 17% were agoraphobia, 7% were schizophrenia and 7% were paranoia or chronic hallucinatory psychoses. More than two-thirds of the inmates had experienced various, diverse, early traumatic events, making them vulnerable to depressive and anxiety disorders. It would appear that a quarter of the inmates in metropolitan France, regardless of whether male or female, had a psychotic disorder. A suicide risk has been identified through the MINI assessment for 40% of male inmates and 62% of female inmates, and this risk is deemed to be high for nearly half of the people concerned. Moreover, nearly 40% of the inmates incarcerated for less than six months are addicted to illegal substances and 30% are alcohol-dependent. Multiple disorders are frequent in these populations, and are seen mainly as mood and anxiety disorders (3 to 4 out of every 10 inmates), anxiety disorders and drug or alcohol dependence, mood disorders and addiction, or anxiety and psychotic disorders (each of these combinations affects approximately one out of every five inmates). Depending on the population, 35% to 42% of inmates are considered by the investigators as markedly ill, severely ill, or extremely ill (on the Clinical Global Impression - Severity scale (CGI-S)). However, only two-thirds of the detainees stated having consulted a psychologist, psychiatrist or a general practitioner for a psychiatric reason before the incarceration period. This high prevalence of psychiatric disorders in prison is explained in part by the decrease in the number of cases where criminal irresponsibility is invoked[188].

The second edition of the DREES 2003 health survey of new inmates corroborates these observations. It also confirms the overrepresentation of addictions in the prison setting {Mouquet et al. 2005}. One-third of new inmates report long-term, regular use of illegal drugs before incarceration: cannabis (29.8 %), cocaine and crack (7.7 %), opioids (6.5 %), abused prescription drugs (5.4 %) and other products (LSD, ecstasy, glues, solvents, 4.0%). Nearly 11% of inmates stating that they used illegal drugs on a regular basis used multiple substances before their incarceration. This high frequency of psychoactive substance should be linked to the frequency of incarcerations resulting from drug-related offences[189] since, with the exception of cannabis, the reported use of illegal drugs is marginal in the general population.

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[187] This study, which was the first to assess the prevalence of mental disorders in the prison population, had three phases. The first was transverse on 1,000 prisoners, 800 of whom were men, selected randomly from penal establishments in mainland France (cluster sampling plan according to the type of penal establishment), 100 female and 100 male inmates in an establishment from a French overseas department; the second was a longitudinal study with a nine-month follow-up of 300 prisoners incarcerated for the first time; the third phase was a retrospective study on 100 detainees who received sentences of a long duration (Rouillon, F., Duburcq, A., Fagnani, F. and Falissard, B. (2007). Etude épidémiologique sur la santé mentale des personnes détenues en prison conduite entre 2003 et 2004. Inserm.

[188] Since the 70s, when it involved approximately 5% of crime convictions, criminal irresponsibility has stabilised at approximately 0.5% since the mid 80s, representing approximately 250 to 300 subjects declared irresponsible each year. According to Marc Bessin, "there is a strong observed trend towards declaring delinquent mentally ill people criminally responsible. Experts increasingly systematically conclude that people with significant psychiatric disorders can be criminally punished, especially if they have committed serious crimes. There is a resultant transfer of duties from the health system to the justice and prison system, which is evidenced by the increasingly high number of new inmates who were previously followed psychiatrically." Bessin, M. and Lechien, M.-H. (2000). Soignants et malades incarcérés. Conditions, pratiques et usages des soins en prison. Centre de sociologie européenne, EHESS, Paris.

[189] In fact, thanks to the French Prison Service's statistics, it is known that approximately 15% of convictions are primarily related to drug-related offences.

Viral infections

Infectious diseases also more frequently affect inmates than the general population. People who have already been incarcerated at least once have a prevalence of hepatitis C that is nearly 10 times higher than that of the general population (7.1% versus 0.8%), as is shown by the biological data of the Coquelicot survey {Institut national de veille sanitaire (InVS) et al. 2005}. Depending on the source, the prevalence of HIV in prison varies from 1.1% to 1.6%, and that of HCV (the hepatitis C virus) from 3.1% to 7.1%. While awaiting the results of the PREVACAR survey (performed by the DGS, the Directorate General for Health and the InVS, the National Health Monitoring Institute), which should be issued in the second half of 2011, the most representative survey available to date is in fact the DREES survey, which was performed among all remand centres and penitentiary remand wings in 2003: it indicates that the prevalence of HIV in the prison setting is 1.1%, or three to four times higher than what is observed outside of prison, and that the prevalence of HCV is 3.1%, or four to five times higher than outside of prison {Mouquet et al. 2005}. Moreover, 0.2% of new inmates state that they are infected by both HIV and HCV, and 0.1% state that they are seropositive for three viruses (HIV, HCV, HBV).

In addition to these figures, there were two other 2003 studies on HIV and viral hepatitis in prisons: the survey carried out "on a specific day" by the DHOS among detainees infected by HIV or hepatitis C including nearly 85% of the UCSAs and the data from the Premier observatoire en prison de l'hépatite C / First monitoring group for hepatitis C in prisons, which involved approximately 50% of the UCSAs. The DHOS study – which is not a prevalence survey since it only describes known HIV+ and HCV+ patients - revealed that 1.6% of new inmates received by the medical teams are infected with HIV, which is three to four times the rate in people not in prison (0.5%), and that 4.4% of new inmates are infected with HCV, which is four to five times the rate seen outside of prison (1%). The rates were especially high among injecting drug users (13% and 55% respectively). It underlines that 5% of the prisoners are infected either by HIV, or by HCV, or by both (DHOS, 2004). POPHEC assessed the prevalence of HCV in prisons to be 7.1% {Sanchez 2006}.

The risks of viral transmission are even higher in the prison setting since injecting drug users have a higher tendency to share their equipment {Ben Diane et al. 2001}. Hence, among the 43% of intravenous drug users who were active users before being incarcerated and who continue to inject drugs in prison, 21% state that they share their equipment {Rotily 2000}. While prison is a place where the prevalence of HIV and viral hepatitis infections is elevated, due mainly to the high percentage of intravenous drug users, it is also an environment that is conducive to risky behaviour: of incarcerated intravenous drug users, 13% to 23% started injecting in prison {Rotily 2000}. Moreover, not all of those infected with HIV or HCV are aware of this when entering prison: only 40% have already had an HIV screening test, 27% an HCV screening test and 31% an HBV screening test {Mouquet et al. 2005}.

11.2. Organisation of prison health policies and service delivery

11.2.1. Prison health (Organisation of care in prison)

Organisation of care in the prison setting

The organisation of healthcare in prison is governed by the act of 18 January 1994[190], which transfers the authority over inmate health care from the French Prison Service to the French public hospital system. By separating the health and surveillance functions, the 1994 act allowed hospitals to enter French prisons through the implementation of a system of agreements between hospitals and prisons. Today, each penal establishment is tied to a hospital establishment that is responsible for the healthcare of the inmates. This reform represents a real break with the pre-1994 situation: it helped structure the healthcare process in the prison setting by separating physical care from mental care.

The implementation of UCSAs, which are responsible for the physical care of inmates, represents the first part of the 1994 reform. Established within each prison, these units are hospital departments under the responsibility of a department head. These departments are responsible for overseeing the diagnostic testing and treatment for prisoners, and do so in the hospital environment as well, if necessary; these departments are also responsible for implementing prevention and health education actions in the penal establishments. UCSAs have therefore replaced infirmaries. In establishments with over 1,000 inmates, a pharmacist can organise and manage an internal pharmacy; in other establishments, the hospital pharmacy is used. Today, there are 178 UCSAs, or one UCSA per establishment, with the exception of open prisons.

The second part of the reform applies to the national hospitalisation scheme for detainees, which was made official by the interministerial decree of 24 August 2000. It provides for the creation of *Unités Hospitalières Sécurisées Interrégionales* (UHSI, or secure, interregional hospital units) located in eight sectors[191] in order to facilitate inmate hospitalisation. The physical healthcare provided by the UCSAs includes ambulatory care requiring technical resources in hospitals (for consultations, special testing or hospitalisation) that can only be made available to the inmates under special conditions (i.e., with a prison escort for hospital transfers and with police guards in the event of hospitalisation). Such services are costly in terms of time and personnel, and require the coordination of multiple partners and institutions. It is to limit such difficulties that UHSIs were implemented in February 2004; UHSIs can accommodate prisoners needing to undergo a scheduled hospitalisation of over 48 hours (total capacity: 170 short-stay beds). Offering medical/surgical expertise, the seven UHSIs, which have been open since 2004, are located within university hospital centres.

For mental care, treatment for inmates is provided by a Regional medico-psychological hospital service (SMPR), when there is one; some of these SMPRs have day hospital treatment available. The 26 SMPRs (one per administrative region), which were created in 1986[192], are units linked with a public health establishment and contractually affiliated with the penal

[190] French act 94-43 of 18 January 1994 regarding public health and social protection, completed by the 27 October 1994 decree and the 8 December 1994 interministerial circular.
[191] Nancy, Lille, Lyon, Bordeaux, Toulouse, Marseille, Paris Pitié Salpêtrière. The 8th UHSI will open in Rennes by the end of 2011.
[192] Décret 86-602 du 14 mars 1986 concernant la lute contre la maladie mentale et l'organisation de la sectorisation psychiatrique, et Ordonnance du 14 décembre 1986 sur la création d'unités psychiatriques dans les prisons.

establishment in which they are located. The SMPRs provide standard psychiatric care for detainees in their associated penal establishment: in addition to providing standard psychiatric care, the SMPRs are also responsible for treating alcoholism and drug abuse. They are responsible for screening for mental disorders, working towards suicide prevention, providing the quality of care that the general population receives, promoting access to health care for certain inmates who, outside of prison, generally have little or no recourse to psychiatric care, and organising continuity of care during transfers and when prisoners are released.

Since 1987, 16 penal establishments have been equipped with specialised, on-site, drug addiction treatment centres for the purpose of specifically handling drug abuse-related problems (formerly known as "*antennes toxicomanie*" or "local addiction units"). These centres are dependent on the SMPRs and complete the prison psychiatric treatment system. These Centres for Treatment, Assistance and Prevention of Addiction or "CSAPAs", which are located within the major French remand centres (covering one quarter of the incarcerated population), are officially responsible for identifying drug abusers, collecting epidemiological data on them, providing their follow-up care and preparing them for release. Since 1994, SMPRs have been replaced by the general psychiatric units that work within the UCSAs. There were 152 at the end of 2010 (versus 93 at the end of 2009).

Finally, since 2010, *Unités Hospitalières Spécialement Aménagées* (UHSA - specially equipped hospital units) have been established. Set up in hospitals[193], these UHSAs must enable psychiatric hospitalisations (with or without consent) for inmates with mental disorders when it proves to be impossible to keep such inmates in a traditional penal structure. The creation of UHSAs must, in particular, facilitate the implementation of the automatic hospitalisation provisions provided for in the 2002[194] law.

Any person who arrives in prison must meet with a physician "as soon as possible" (art. D 285 of the French Code of Criminal Procedure). This admission medical visit is mandatory. It must provide the inmate with the opportunity to report any illness requiring treatment. If the new inmate is currently undergoing treatment with drugs, the physician must be informed so that he or she can determine what should be done with the treatment (art. D 335 of the French Code of Criminal Procedure).

In light of the diverse interpretations of current legislation, in which, for example, withdrawal can be understood to be the only foreseeable method of treatment, certain laws have been drafted to specify the organisation of treatment specifically aimed at drug addicts in the prison system. The decrees of 5 December 1996 and 30 January 2002 specify the organisation for dispensing Opioid Substitution Treatments (OST). They indicate that OSTs can be initiated and followed in prison. This was the case first with High Dose Buprenorphine (HDB) which, since 5 December 1996, can be prescribed by any physician practicing in the prison setting, then methadone, able to be prescribed under the same conditions since 30 January 2002.

Equivalence of care

Inspired by the guidelines of the HCSP {Haut comité de la santé publique (HCSP) 1993}, the 1994 reform goes beyond a simple reorganisation of care: it suggests the principle of equivalence of treatment with an obligation to treat incarcerated patients in the same way as

[193] The first was opened in Lyon-Le Vinatier in May 2010. The UHSAs of Toulouse and Nancy will be completed in 2011.
[194] Article 48 of French Law 2002-1138 of 9 September 2002 on the orientation and programming of the justice system stipulated that "hospitalization with or without consent of a detainee with mental disorders takes place in a health establishment within a specially equipped unit."

outpatients by stating the objective of "ensuring prisoners a quality and continuity of treatment equivalent to what is offered to the population as a whole". The 1994 act subsequently grants prisoners social protection (article 3), which translates into a recognition of the prisoner as a citizen with the same rights as free people. The legal principle of equivalence of care (instituted by the act of 18 January 1994) according to which prisoners should be able to benefit from the same rights as the general population, was reaffirmed in the penitentiary act of 24 November 2009[195]: "the quality and continuity of care are guaranteed to prisoners under conditions that are equivalent to those of the general population" (article 46).

The general prevailing principle is therefore one of equivalence of care. Nevertheless, the State more specifically manages treatment for imprisoned people with a drug addiction by delegating said treatment to two services (general medicine and psychiatric medicine) that are dependent on the hospital service: UCSAs and SMPRs, alongside specialised, intraprison drug-addiction treatment centres operating under the responsibility of the SMPRs.

Funding for health care in the prison setting

Before 1994, health treatment and the organisation of health care for prisoners in France were the exclusive responsibility of the French Prison Service through "prison medicine"[196]. By applying a public health approach to the prison setting, the 1994 reform creates a link with the hospital environment and brings about a change of scale regarding the budget allocated to medicine in the prison setting. However, the French Prison Service continues to carry out two missions in the prison setting: that of setting out the UCSA sites according to the standards set by the French Ministry of Health and that of ensuring the safety of UCSA hospital personnel and the surveillance of detainees who come for a consultation.

The treatment of detainees is therefore the exclusive responsibility of the French Ministry of Health. Since all inmates are registered with and covered by the French Social Security, the credits for the health care of detainees (including the funding for operating the UCSAs and SMPRs) are covered by the French National Health Insurance scheme within the scope of the *Mission d'Intérêt Général* (general interest mission) budget. The funding for inmate health insurance contributions is, however, provided by the French Ministry of Justice[197].

Given the prison demographics and the prolongation of imprisonment time, the sums dedicated to health care in the prison setting are on the rise. According to the most recent figures, in 2007, the amount allocated to hospital establishments for UCSAs was 136.6 million euros, while SMPR financing was 27.7 million euros, for a population of 58,402 inmates (on 1 January 2007). Before the act of 18 January 1994, the Prison System earmarked 46 million euros in credits (300 million French Francs) for a prison population of 53,777[198]. Right after the reform, the budget for prison health care was increased to 69 million euros (393 million French Francs) in order to finance the creation of UCSAs and complement the pre-existing medical-psychological treatment system.

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[195] Acte pénitentiaire 2009-1436 du 24 novembre 2009 (NOR: JUSX0814219L)

[196] One or more temporary physicians being appointed by the regional prison service director for each establishment.

[197] Registration with the health and maternity insurance of the French general social security scheme has been mandatory for all detainees, whether French or foreign, since 1994. The state pays the corresponding social contributions through a budgetary allocation by the French Ministry of Justice to the French national health insurance fund. It also funds the portion of health care that is not covered by national health insurance: the patient's contribution for health care and the fixed hospital costs incurred during hospitalisations.

[198] As of 1 July 1993. Figures cited by Claude Huriet, professor of medicine and former French senator, in report 49 (1993-1994) written by him on the French public health and social protection bill.

The French Prison Service dedicates one million euros per year to prevention in the prison setting, which is an integral part of the overall health treatment of a detainee Since the first review of the 1994 reform, which was performed in 1996, demonstrated insufficient human resources with regard to the level of health care needed for the prison population and the constraints of the prison setting (which require significant health care human resources), measures have been taken to reinforce human resources in the psychiatric (in 1996) and physical (in 1997) sectors.

Health care personnel

The UCSA budget corresponds to approximately 470 health care personnel full time equivalents (FTEs): 306 medical personnel FTEs for physical care and 163 medical personnel FTEs for psychiatric care. In addition to these FTEs are non-medical personnel. The health personnel assigned to prison health care structures represent an estimated total of 2,400 agents (approximately 7% of the 34,000 public servants working within the French Prison Service in 2010). The number of medical full time positions assigned to prison health units increased by nearly 50% in ten years (see Table 3), whereas before 1994, health personnel were volunteers recruited by the Red Cross[199].

Nevertheless, given the concurrent increase in the number of incarcerated persons, inmate access to healthcare personnel improved less rapidly. In 2007, fewer than one medical FTE was available per 100 inmates (0.52 physical care physicians and 0.28 psychiatric care physicians). Today, there are eight physicians per 1,000 inmates, while the medical density in the general population is 3.38 physicians per 1,000 inhabitants (all specialities combined, which includes 0.22 psychiatrists per 1,000 inhabitants according to the INSEE, French National Institute of Statistics and Economic Studies). Given that the extent of the health care needs of the prisoner population is six to seven times higher than that of the general population, this difference in accessibility is deemed to be weak: regarding psychiatric disorders, the prevalence is 47% for depressive disorders in prison vs. 8% in the general population (nearly six times more) and 3.8% for schizophrenia in prison vs. 0.5% in the general population (nearly eight times more). Furthermore, the rate of inmate medical coverage is a mean rate that does not take into consideration extensive differences among establishments and geographical regions: it subsequently translates into a theoretical ease in accessing care.

[199] On 1 January 1994, there were nearly 250 physicians, 141 prison nurses and 172 nurses recruited by the Red Cross to treat inmates in application of the 17 February 1987 agreement between the French Ministry of Justice and the Red Cross.

Table 11-2: Medical personnel in the prison system (1997-2007)

	Number of inmates	Provided physical medical FTEs	Provided medical psy FTEs	Total medical FTEs	Number of medical FTEs per 1,000 prisoners
1997	54,269*	199.99	114.31	314.29	5.8
2001	47,005	257.31	146.10	403.41	8.6
2006	58,344	267.72	149.34	417.06	7.1
2007	58,402	306.00	163.09	469.09	8.0
Evolution 1997-2007	N/A	+ 53.01 %	+ 42.68 %	+ 49.25 %	+ 37.73 %

Source: Department of Hospital Care and Treatment Organisation (Dhos), French Ministry of Health
*The figure available from the French Ministry of Justice for the year 1997 corresponds to all persons entered on the prison register, whether in prison or not. The number of "actual" inmates is therefore lower.

11.2.2. Drug-related health policies targeting prisoners (Treatment policies for drug use among inmates)

Prison-related targets in national drug policies

The continuity of care for drug users upon their release has been one of the French government's strategic objectives in the fight against drugs since the first action plans drafted by the interministerial coordinating body for the fight against drugs in the 80s. It is the 1999-2001 Interministerial Mission to Fight against Drugs and Drug Addiction (MILDT) Plan that first identified incarcerated users as a priority target population for which treatment is "to be developed and reinforced"[200] {Mission interministérielle de lutte contre la drogue et la toxicomanie 2000}. This is also the first national programme document that affirms that "harm reduction in prison is a major public health issue" and supports its diagnosis with concrete proposals aimed at improving health treatment for inmates and preparing their release from prison:

- Create places for released prisoners in residential and social reintegration centres (CHRS).
- Design programmes to prepare for release with the development of Care Units for Prison Leavers (UPS) which were first tested in 1997.
- Improve the coordination and control of addictology care with the transfer of the responsibility for this coordination to UCSAs for all penal establishments[201]
- Monitor the work of the health-justice think-tank on reducing HIV and viral hepatitis transmission risks in the prison setting {Stankoff et al. 2000}.
- Reinforcement of the interministerial coordination of the prison and health services through the health-justice interministerial memorandum of 9 August 2001[202] that aimed to unite all services to reflect on the health needs of inmates and to define a way to organise services to

[200] 1999-2001 Triennial Plan, p.91.
[201] DGS/MC2/DGOS/R4/2010/390 instruction of 17 November 2010 on the organisation of addictology care in prison settings.
[202] Interministerial memorandum of 9 August 2001 on the strategies for improving the health and social care of addicted detainees who abuse legal or illegal substances.

meet these needs; the strategies presented in this interministerial memorandum[203] were integrated into several more recent administrative texts[204]

- Focus on systematically assessing the improvements provided by the measures of the Plan: the health-justice interministerial memo of 9 August 2001 was subsequently accompanied by an OFDT assessment {Obradovic 2004}, as were the UPSs ({Prudhomme et al. 2001}, {Prudhomme et al. 2003}).

Less committed to the issue of drug use in the prison setting, the 2004-2008 Plan provides for "developing a prevention programme" in the prison setting {Mission interministérielle de lutte contre la drogue et la toxicomanie 2004}. The vagueness of the objectives in this Plan lead to a low level of implementation of the recommendations from the health-justice mission {Stankoff et al. 2000} and the Delfraissy report on the treatment of HIV-infected people {Delfraissy 2002}, which was denounced by prison professionals and associations, including the AFR (French Association for Harm Reduction).

In continuity with prior plans, the 2008-2011 'Combating Drugs and Drug Addiction' Government Action Plan aims to "improve the treatment and continuity of care provided to incarcerated drug and alcohol users"[205] {Mildt 2008}. Like its predecessors, it highlights the inadequacies of treatment for drug users in the prison setting and identifies several areas for improvement. Firstly, it observes that the resources of the system for treating drug and alcohol users in the prison system are inadequate compared to the needs. Secondly, the Plan denounces the high frequency of hepatitis in incarcerated drug users and highlights the impediments to access to treatment (needing to leave the prison for hepatic consults and/or hospitalisations for hepatic biopsies, which prolong the time to treatment). Finally, it emphasises the persistence of difficulties in obtaining housing and continuity of care upon release from prison, particularly in remand centres.

Based on these observations, the Plan makes several proposals. Firstly, to improve the social rehabilitation of prison leavers, it aims to ensure that at least one housing unit is accessible per prison region to prison leavers. To this end, and through a national call for projects, the Plan created a possibility for funding 4 short and quickly accessed reception programmes for released prisoners, within existing social and medical-social structures (with housing), in relation with the hospital related to the prison. Two CSAPAs were financed in this way in 2009 (they received 300,000 euros each). Two others were similarly funded in 2010, offering a dozen places for prison leavers within units whose purpose is to offer immediate accommodation upon their release. The aim is to enable ex-prisoners to continue receiving the support they received while in prison and to establish, upon release, medical-social and social integration relays[206].

[203] The 2001 interministerial memorandum specifies the rules related to harm reduction in the prison setting: monitoring of the person throughout their imprisonment, proposal of appropriate treatment, reinforcement of risk prevention, preparation for release and the proposal of resettlements.

[204] French Ministry of Health and Social Protection, French Ministry of Justice, *Guide méthodologique relatif à la prise en charge sanitaire des personnes détenues*, September 2004, p. 36 (http://www.sante-prison.com/les_docs/000116.pdf); interministerial circular DHOS/DGS/DSS/DGAS/DAP no. 2005-27 of 10 January 2005 on the update of the *Guide méthodologique relatif à la prise en charge sanitaire des personnes détenues et à leur protection sociale* (http://www.sante-sports.gouv.fr/fichiers/bo/2005/05-02/a0020046.htm)

[205] 2008-2011 Plan, sheet no. 3-6, p. 67.

[206] Interministerial circular DGS/MC2/MILDT n° 2009-63 of 23 February 2009 regarding the call for projects to implement the health, social rehabilitation and harm reduction measures for the medico-social addiction aspects of the 2008-2011 government plan to combat drugs and drug addiction (http://www.sante.gouv.fr/fichiers/bo/2009/09-03/ste_20090003_0100_0154.pdf); interministerial circular DGS/MC2/DGAS/DSS/MILDT no. 2009-371 of 14 December 2009 regarding the selection of projects within the scope of the call for projects to implement the health, social rehabilitation and harm reduction measures for the medico-

Financing was also planned for five projects to implement an advanced CSAPA consultation service within the integration accommodation reception system for addicted prison leavers[207]. One single project in the *Pays de la Loire* region of France received 9,000 euros in funding through this project (additional funding for the *CSAPA Accueil Info Drogues* of the Montjoie association by the medical-social ONDAM within the framework of new full-year measures in addition to the CSAPA's overall operating budget).

The 2008-2011 Plan furthermore defined objectives for treating addicted prisoners, through provisions for the creation of 100 new alcohol addictology clinics, the establishment of hepatic clinics with Fibroscan© access[208], the training of health professionals on addictions and infectious diseases including hepatitis, the drafting and distribution of guidelines for good professional practices, particularly for opioid substitution treatments, the informing of inmates on HIV and hepatitis and, in particular, on the need for screening and re-screening when markers are negative. The Plan also suggests assessing the available HIV and HCV screening services and care, as well as the opioid substitution treatments in the prison setting, and drafting a multidisciplinary reference for preparing the social rehabilitation of addicted prisoners. For the time being, these objectives have not been assessed.

Finally, in 2010, the French Ministries of Health and Justice published the first national action plan for improving the health of detainees for 2010-2014 {Ministère de la Santé et des Sports et al. 2010}. This plan addresses all aspects of prison health policy through plans to improve the government's awareness of the state of health of detainees, to strengthen the existing health systems and develop them, to provide for reinforced measures for certain detainee categories (especially addicted prisoners), and so on. The plan emphasises the importance of continuity of care after release from prison and, in addition to creating *appartements de coordination thérapeutique* or *lits halte soins santé* (housing and health services for people in very unstable situations in France), provides for consistently organising housing for people released from prison to ensure continuity of care and the implementation of joint reference systems and training.

Policies on drug prevention, harm reduction and care for imprisoned drug users

The 2010-2014 strategic action plan on inmate health policy includes 6 main themes, including one on health prevention and promotion and one on access to care. The section dedicated to prevention, which was inspired by recommendations resulting from collective expert reports on harm reduction {Bello, P. -Y. et al. 2010}, is broken down into five measures. These measures namely aim to strengthen suicide prevention actions in prison, to assess the enforcement of the recommendations of the harm reduction policy, to act on the determinants of inmate health (practices exposing them to a risk for infection) and to make screening programmes accessible to detainees. The 2010-2014 Plan especially aims to implement HR measures that are appropriate and applicable to prisons in order to compensate for the observed weaknesses in France: distributing bleach with instructions for use, providing access to condoms, taking into consideration the infection risk of certain behaviours (e.g., sniffing, tattooing, injections), providing access to HR sterile equipment related to drug abuse, access to Fibroscan® testing in prison, improving prevention measures (inviting professional tattoo artists to prisons) and screening (developing screening during incarceration). The section of the Plan that focuses on

social addiction aspects of the 2008-2011 government plan to combat drugs and drug addiction (http://www.sante.gouv.fr/fichiers/bo/2010/10-01/ste_20100001_0100_0063.pdf)

[207] 2008-2011 Plan, sheet no. 3 -10, p.74.

[208] Blood test used to monitor patients with hepatitis C. It helps assess the degree of liver fibrosis (i.e., liver elasticity) without the need for liver biopsies, which are painful for the patients and do not provide immediate results.

treatment details six measures, especially those for reorganising available mental health care, improving the organisation, management and monitoring of inmate health care structures and organising the preparation and continuity of care upon release. Moreover, the plan defines strategies for research and surveillance by suggesting conducting repeated research on HIV and hepatitis prevalence in prisons, by implementing the Prevacar survey (sponsored by the General Health Department, and coordinated by the National Health Monitoring Institute).

The strategies of this plan are to improve care and complement the objectives of the last national plan for the fight against hepatitis (2009-2012)[209]. The latter plan defines a general framework for intervening in the prison setting, limiting itself to restating the need for hepatitis screening for new inmates and assessing the Health/Justice memorandum of 9 August 2001. The 2007-2011 government plan for the treatment and prevention of addictions[210] provides no specific actions for the prison setting.

Models of service delivery for drug users in prison

Preventing infectious diseases and harm reduction

All inmates must have an admission medical visit when they enter prison. This visit is performed by the UCSAs with a possibility to screen for infectious diseases.

To guarantee HR, which is henceforth provided for by law[211], two main tools for preventing infectious diseases have been implemented within penal establishments since 1996[212]. The 5 December 1996 circular first and foremost stipulates access to OST in prison: inmates receiving substitution treatment must not only be able to continue their treatment in prison, but also be able to initiate treatment if they wish, and especially High Dose Buprenorphine (HDB) therapy. Since 2002, OST can also be initiated for methadone[213].

In addition to substitution, penal establishments offer prevention and decontamination tools for fighting against HIV: in compliance with the recommendations of the Gentilini report {Gentilini 1996}, periodically distributing bleach in set quantities and concentrations became generalised in prison in order to clean any equipment that comes into contact with blood (such as injection, tattooing and piercing equipment). Distributing bleach chlorometrically titrated to 12° has occurred systematically since 15 December 1997, and since 2001, the Prison Service has been encouraging health personnel to inform prisoners on how to use bleach as a product to disinfect injection equipment. The legal measures implemented by the 5 December 1996 circular to fight against the spread of HIV also stipulate making condoms available free of charge (NF-compliant

[209] Strategic committee for the French national viral hepatitis plan, 2009-2012 national viral hepatitis B and C plan), January 2009, p. 17 (*http://www.sante-sports.gouv.fr/IMG/pdf/Plan_hepatites_2009_2012.pdf*)

[210] Addiction Commission, 2007-2011 government plan for the treatment and prevention of addictions, November 2006 (*http://www.sante.gouv.fr/htm/actu/plan_addictions_2007_2011/plan_addictions_2007_2011.pdf*)

[211] Loi 2004-806 du 9 août 2004 de santé publique. This law proposes an official definition of the harm reduction policy ("the policy of harm reduction for drug users aims to prevent the transmission of infection, death by overdose of intravenous drugs and the social and psychological harm related to abuse of drugs classified as narcotics", art. L. 3121-4) and places the responsibility for defining this policy with the State (art. L. 3121-3).

[212] As the main priority of the authorities since 1994 (Coppel, A. (2002). Peut-on civiliser les drogues ? De la guerre à la drogue à la réduction des risques. La Découverte, Paris.; Bergeron, H. (1999b). L'état et la toxicomanie : histoire d'une singularité française. PUF, Paris. HR is prescribed by a circular in 1996 for prisons: DGS/DH Circular no. 96-239 of 3 April 1996 related to drug addiction treatment strategies in 1996; DGS/DH/DAP Circular no. 739 of 5 December 1996 on the fight against human immunodeficiency virus (HIV) infection in prisons: prevention, screening, health care, preparation for release and personnel training.

[213] DGS/DHOS Circulaire no. 2002-57 du 30 janvier 2002 sur la prescription de méthadone par des médecins exerçant en établissements de santé.

condoms) with lubricants (theoretically obtainable through UCSAs): prisoners can keep these items on their person or in their cell. Access to prophylactic antiretroviral therapy after accidental exposure to blood is also available for health and prison personnel as well as for inmates. Subsequently, for intravenous drug users, the only current way to protect against contracting AIDS, other than post-exposure antiretroviral prophylaxis and access to condoms and lubricants in the event of sexual relations, is to disinfect syringes with bleach. These measures for cleaning injection equipment with bleach have been proven to be effective in eliminating HIV: however, it has been established that these measures are not effective enough in combating the hepatitis C virus {Crofs, 1994 #1647}. Outside of the prison setting, messages on disinfecting with bleach have furthermore been largely abandoned in favour of messages on refraining from reusing injection equipment ("À chaque injection, du matériel neuf"/"New equipment for each injection").

In contrast to the situation outside of prison, support for drug users is limited in the prison setting (counselling, peer education, primary health care) and access to sterile injection equipment (alcohol wipes, vials of sterile water, sterile cups, sterile syringes), which has been authorised in the general population since 1989, is absent from all penal establishments. There is no medicalised heroin programme in prison.

Despite the World Health Organisation's (WHO) repeated recommendations since 1993, incarcerated intravenous drug users in France subsequently do not benefit from access to sterile injection equipment. Since 1997, the refusal by the public authorities to implement syringe exchange programmes in prison has remained consistent: in 2000, the authorities deemed that implementing syringe exchange programmes was "premature" from a public opinion point of view, and mentioned the legal framework (which bans the use of illegal substances) and the counterproductive effects of introducing syringe exchange programmes in prison (risk of developing syringe exchange networks, risk of users returning to injection) {Stankoff et al. 2000}; more recently, while reviewing the penitentiary bill in 2009, the National AIDS Council reissued this proposal, recommending the immediate and progressive establishment of syringe exchange programmes in all penal establishments[214] (Conseil national du sida [CNS] 2009). These recommendations were not incorporated into the 24 November 2009 French Penitentiary Act.

Treating addiction

The UCSAs and SMPRs, which are responsible for complying with hygiene rules and implementing prevention, health education and prophylaxis actions (making post-exposure treatments available to personnel and prisoners), are also responsible for ensuring that prevention and HR tools are accessible to prisoners. All of the establishments are required to offer substitution treatment to users addicted to opioids when they enter prison: prescribing substitution medications, which is theoretically possible under the same conditions as for outpatients, to initiate or continue a treatment with methadone or high dose buprenorphine (Subutex® since 1994 and/or the generic Arrow® and Mylan®) is, however, performed dissimilarly among the establishments (see 3. Supply). In practice, access to substitution treatments depends, most often, on the UCSA physicians.

The interview with the physician during the obligatory visit upon entry into prison helps assess the drug-addicted inmates' state of health and requirements. The physician then makes the decisions that he or she feels are appropriate: withdrawal, continuing or initiating substitution treatment, referrals to specialists, detoxification, and so on. The physician can also refer

[214] National AIDS Council, opinion memorandum of 10 September 2009 on experimentation with syringe exchange programmes in penal establishments (http://www.cns.sante.fr/spip.php?article306&artpage=1-4)

prisoners to the psychiatric services (general psychiatry or SMPR, which works in partnership with the medical service, i.e., the UCSA). The 16 SMPRs that have a CSAPA (which are under the responsibility of the psychiatrist in charge of the SMPR) delegate to the CSAPAs treatment for addictions in collaboration with the UCSA. The other SMPRs (that do not have a CSAPA) work to promote the medical and psychological treatment and socio-educational follow-up of drug-addicted inmates with the integration and probation team. However, as noted by the Pradier report {Pradier 1999}, the high number of people who take part in fighting against drug addiction can sometimes be counterproductive from an access-to-care standpoint: UCSA, SMPR, CSAPA, CISIH (Centres for the Information and Care of Human Immunodeficiencies), associations... Since the DGS/MC2/DGOS/R4/2010/390 directive of 17 November 2010 regarding the organisation of care for addictions in prison, the control and coordination of addictology care have been entrusted to UCSAs; however, such care can also be contractually entrusted to a person providing psychiatric care in the establishment or in the SMPR, when there is one.

11.3. Provision of drug-related health services in prison

11.3.1. Prevention, Treatment, Rehabilitation, Harm Reduction

“Can prisoners be treated?”, ask certain health professionals who work in prisons, who answer in the affirmative to this question, but with certain reservations {Kanoui-Mebazaa et al. 2007}. In practice, access to care in prison is available, but with dual restrictions: that of sentence duration and that of a location requiring both confinement and surveillance. Although overall, emergency and basic daily care are satisfactory, the treatment of chronically ill patients proves to be insufficient, with major difficulties in access to specialist care {Contrôleur général des lieux de privation de liberté 2011}. Insufficient psychiatric care nevertheless persists and a certain number of fundamental rights still remain “ignored in prison”, such as “the right to health care” and "the protection of medical confidentiality” {Contrôleur général des lieux de privation de liberté 2011}. In other words, access to consultations within UCSAs takes place without hindrance for the most part {Kanoui-Mebazaa et al. 2007}, but not in all establishments, and for certain inmates, such as drug abusers or prisoners with serious illness, such access is more complex because their treatment is largely incompatible with imprisonment conditions.

Drug use assessment as part of the routine examination upon entry into custody

The prison population constitutes a group with a high prevalence of drug use. While the oldest survey, which was conducted in 1986 by the French Prison Service’s research department, estimated that the proportion represented by drug addicts among new inmates was 10.7% {Kensey et al. 1989}, one-third of new inmates in 2003 stated during the required admission medical visit that they had engaged in long-term, regular illegal drug use during the year preceding their incarceration {Mouquet et al. 2005}. As in the general population, cannabis is by far the most frequently used substance (29.8%), followed by cocaine and crack (7.7%), heroine and opioids (6.5%), misused medical drugs (5.4%) and other substances (4.0%), which are often amphetamines. More than one out of every ten new inmates is a polyuser of illegal drugs. Moreover, more than three out of every ten new inmates stated problem alcohol use[215] (31%)

[215] Defined, in the survey, as five or more drinks per day for men and three drinks per day for women for regular drinking, and five or more consecutive drinks at least once a month for irregular drinking.

and, although 80% of prisoners are smokers, 15% are heavy users (at least 20 cigarettes per day).

Compared to the situation observed during the prior edition of the survey, six years previously, the proportion of regular cannabis users among new inmates was on the rise in 2003, while that of opioid or cocaine users was declining ({Mouquet et al. 1999}; {Mouquet et al. 2005}). The percentage of polydrug abusers also fell, from 15% to 11%.

All products smoked, sniffed, injected or swallowed before incarceration continued to be used (albeit in reduced quantities) during incarceration {Rotily 2000}.

The prevalence of injection is high in prisons, even though the number of intravenous users seems to be declining among new inmates: 3% state having engaged in intravenous drug use in the year prior to incarceration in 2003 vs. 6% in 1997 {Mouquet et al. 2005}. The majority (61%) of drug users seen outside of prison in a specialised centre (high threshold, low threshold, general practitioners) state having been incarcerated at least once in their life: and of these, 12% injected products in prison ({Jauffret-Roustide et al. 2006}; {Jauffret-Roustide et al. 2009}). An older study established that 13% of injectors (of opioids or other substances) who were active in the year preceding incarceration injected themselves with substances during the first three months of their incarceration and half of them shared syringes, since syringe exchange programmes were prohibited {Rotily 1997}. As a result, prisons are places with a high risk of infection: they bring together a population that is often affected by drug use, instability, a high prevalence of HIV, HCV and HBV infection, and an over-representation of tattooing and piercing. This population is also frequently in and out of prison, and therefore frequently in contact with the outside world. In the 2004 French national survey on hepatitis B and C prevalence, the relative risk of contracting hepatitis B and C during incarceration was calculated: it is tenfold for HCV and fourfold for HBV {Direction de l'hospitalisation et de l'organisation des soins (DHOS) 2004}.

According to research, 60 to 80% of prisoners stop injecting during their incarceration {{Stankoff et al. 2000}: the 20 to 40% who carry on injecting seem to reduce the frequency of their injections, although they increase the quantities injected {ORS PACA 1998}. They also seem to be more often infected by HIV and/or HCV, with a very high risk of contamination from shared equipment, unprotected sex and tattooing as a result. The risks of viral contamination are even higher in prison than outside of prison, given the prevalence of HIV and HCV in prison, and the rarity of available equipment for injection: it would appear that 6 to 7% of imprisoned drug users begin injecting in prison {ORS PACA 1998}.

Furthermore, the use of more easily accessible products (such as medicines) tends to develop in prison: generally speaking, there is an observed relative transfer of use from rare and illegal drugs to medicines {Stankoff et al. 2000}. The study conducted on new inmates within the OPPIDUM programme (an annual, national pharmaco-epidemiological study) confirms that the misuse of medications is higher in the prison population than among subjects encountered outside of prison: illegal supply is twice as high and daily intake is doubled, and higher than what is authorised; nearly twice as many new inmates take substances nasally and more of them use benzodiazepines and illegal substances {Pauly et al. 2010}.

Drug prevention, information and educational activities for prisoners

In terms of information, each person entering prison receives a reception booklet from the French Prison System as well as a UCSA presentation booklet. These two documents should, in

particular, inform prisoners of the HIV/HCV/STD prevention services available in the prison setting, of access to condoms, of how to request health care, and so on. When his period of incarceration is over, a remand centre inmate has the right to access the information in his medical file; he can appoint a person of trust and define that person's role in the treatment process; inmates can consent to or refuse the care proposed to them.

In addition to the right of inmates being treated by the care system to be informed, supported by the 4 March 2002 patient rights act and the 29 April 2002 decree, the 1994 legislators wanted to make prevention and health education a major part of the penitentiary reform in addition to curative measures. The prevention and health education actions available in the prison setting fall within the scope of the UCSAs: the physician in charge of a UCSA coordinates the information and prevention actions for transmissible diseases, and does so in cooperation with the French Prison Service and in partnership with governmental services, general councils, health education committees, health insurance bodies, specialised networks and associations, and so on. In France, health education efforts can take the form of individual interviews (during consultations), group information and prevention meetings (often conducted within the penal establishment by outside workers), or initiatives to make information available (in the form of brochures and other informational documents).

In terms of prevention, inmates have access to bleach, but it is not systematically distributed and is, in most cases, not accompanied by useful harm reduction information {Michel et al. 2010}. Moreover, under illicit conditions of use, bleach is considered to be a poor HIV decontamination solution {OMS (WHO) 2005}, and a very poor HCV decontamination solution {Hagan et al. 2003}. In fact, the prevalence of infectious diseases in penal establishments remains much higher than outside the prison setting, at over 1% for HIV, approximately 3% for HBV and 7% for HCV {Bello, P. -Y. et al. 2010}. Moreover, injection practices are well-known in prisons {Michel et al. 2010}, where one to three out of every five drug users share equipment ({Rotily 2000} ; {Jauffret-Roustide et al. 2006};{Jauffret-Roustide et al. 2009}), and these populations often carry the HIV and HCV viruses. Nevertheless, imprisoned drug users do not benefit from all of the harm reduction measures that are available outside of prison, especially Syringe Exchange Programmes (SEP) ([Conseil national du sida, or CNS 2009; Conseil national du sida 2011]).

In terms of health education, efforts to support the implementation of this type of programme in a prison setting were initiated by the French Institute for Health Promotion and Health Education (INPES)[216] since the 1994 reform. Established in a dozen pilot sites and supervised by Health Education Committees, "training actions" helped group together guards, teams from the consultation and ambulatory care units, members of the Penitentiary Services for Reintegration and Probation and teachers in order to develop a shared culture for health actions. The purpose of this type of initiative is to enable professional practices to evolve by promoting coordination, the lack of which remains the main barrier to implementing prevention and education activities under the conditions and constraints of the prison setting[217]. In practice, the health education programmes are generally not implemented {Commission consultative des droits de l'homme 2006} and have only been set up in certain establishments. Theoretically, the public health establishments are responsible for working with the Penitentiary Services for Reintegration and Probation in each department, the senior management at the penal establishment and the other partners to design an annual or long-term health education programme. Nevertheless, it seems

[216] The former *Comité français d'éducation à la santé* (CFES, or the French Health Education Committee).

[217] Short speech by Philippe Lamoureaux, General Director of the INPES, "La prevention et l'education pour la sante en milieu penitentiaire: une démarche à approfondir, à interroger, au besoin à réorienter", proceedings of the symposium organised by the French ministries of health and justice and the INPES, 7 December 2004, Paris ("Dix ans apres la loi: quelle evolution dans la prise en charge des personnes detenues ?").

that generally speaking, even when such a plan exists, it becomes a dead letter. Many activity reports established by the UCSAs describe this situation. The overcrowding situation in remand centres very frequently comprises a barrier to implementing these programmes. Moreover, the medical services, when confronted with increasing numbers of new patient intakes, focus their actions on administering the care itself. In addition, the UCSAs often come up against the inadequacies in outside structures specialised in promoting health.

The section related to prevention and health education has three themes that still need to be developed[218]:

- the understanding of the mission and the role of the various health education workers
- -the legitimacy of the health education actions in the detainee rehabilitation assistance pathway
- a better adaptation of the "project methodology"[219] and the cooperative, multidisciplinary work to the prison environment[220].

Other limiting factors are often cited by professionals, such as the lack of health personnel or space, the prison conditions and the prison overcrowding, the lack of detainee motivation, their high "turnover", the lack of communication regarding projects intended for detainees and prison personnel, and finally, the search for funding.

In terms of good practice, the implementation of "health workshops" in detention centres, for example, helps disseminate information on a health issue selected by the inmates themselves within the scope of discussion groups that integrate artistic expression and entertainment that is related to the theme being discussed. With five to six sessions over a two-month period, the workshops are run jointly by a health professional and an actor with the participation of the SPIP and the UCSA.

Health education provided in prison is different from the actions taken outside of prison since the characteristics of the audience change the relationship with prevention: the inmates constitute a population with low levels of education and literacy (which can pose a problem with regard to the transmission of information messages), that is often deprived of communication (so much so that the actions can be interpreted either as being a distraction or as being an opportunity to express anger towards the legal system) and that tends to favour anything conducive to an early release. Therefore, the public is attentive, but not necessarily receptive beyond its immediate interests.

[218] Source: The "Santé en prison Dix ans après la loi: quelle evolution?" symposium organized by the French Ministers of Health and Justice and the INPES on 7 December 2004 in Paris, round table: Prevention and Health Education.

[219] Well adapted to promoting health, the methodology of the project should enable all players to create, within the establishment, conditions conducive to good health: detainees, health professionals, social and educational service professionals, guards and the Prison Service. However, in prison, organising cooperative prevention actions meets with reticence from potential partners or funding providers (the French national health insurance fund, General Councils, supplemental insurance networks). Moreover, participants do not really use the "Helath promotion and the prison setting" guide issued in 1998 by the French Ministries of Health and Justice with the CFES (*Comité Français d'Education pour la Santé*, or the French Committee for Health Education, known today as the INPES).

[220] Françoise Demichel, head of the health action unit, Regional Directorate of Lyon Prison Services, "Quelle évolution dans la prise en charge des personnes détenues ?", Proceedings of the symposium "Santé en prison" (Ministry of Health / Ministry of Justice / INPES), Paris, 7 December 2004.

Providing drug treatment and the numbers and characteristics of prisoners receiving such treatments

The treatments available in prison include opioid substitution treatments, medical support for withdrawal and counselling. There is no therapeutic community in the prison setting.

Available sources

Six main sources help (or will help) document the change in opioid substitution availability in prison, and the first two come directly from the services of the French Ministry of Health.

The first source comes from surveys conducted by the DREES, first in 1997 and then again in 2003, on a total of 134 remand centres and penitentiary remand wings. It provides the proportion of new inmates who claim that they are receiving methadone or Subutex® substitution treatment during the admission medical visit.

The second source comes from surveys on access to substitution treatments in prison. These surveys were conducted regularly by the General Health Department and the Hospital Department of the Ministry of Health *(*DGS / DHOS) among the physicians in charge of UCSAs, SMPRs or general psychiatric units on a given day between 1998 and 2004.

The third is the Common Data Collection on Treatment and Drug Addiction or “RECAP” information system implemented by the OFDT since 2005. This compendium comprises data on patients seeking assistance from drug addiction treatment centres operating in prison. It therefore only contains data from the 16 remand centres with on-site CSAPAs (Centres for Treatment, Assistance and Prevention of Addiction, formerly known as CSSTs or CCAAs, this new name coming into effect as of 2008), which were formerly known as “antennes toxicomanie” or “local addiction units”, representing one-quarter of the prison population.

The fourth source is a specific survey conducted in 2006 among UCSAs and SMPRs at the request of the DHOS, the DGS and the MILDT. These bodies commissioned the OFDT to conduct a survey to assess the impact of the 30 January 2002 decree, which provided any physician practicing in a health establishment with the ability to offer methadone substitution treatment to opioid-addicted drug abusers. This survey had a hospital section as well as a prison section.

The fifth, complementary source was the inventory of infection harm reduction measures carried out in 2010 in all French penal establishments within the scope of the ANRS-PRI2DE programme (Programme for Research and Intervention on the Prevention of Infection Risk in the Prison Setting). Through a questionnaire addressed to all USCA and SMPR department heads, this inventory explored the existence of and accessibility to infection harm reduction measures (including bleach, opioid substitution treatments, condoms, post-exposure prophylaxis, screening and information-education-communication, as well as the existence of health care for potentially risky drug use-related practices). Of the 171 penal establishments that received the questionnaire, 103 returned it completed, covering 69% of the prison population at the time of the survey.

Finally, a sixth source may be available for use in the near future: the PREVACAR survey, implemented in June 2010 by the DGS and the InVS, will help provide the first national data, in 2011, on the prevalence of HIV, HCV and STD in the prison setting thanks to the implementation of a survey plan. The survey also comprises a section on available treatments, used in 2010, which helps describe the OST services available in the penal establishments, the available HIV

and HCV care and screening, and HBV vaccine availability. The results of this second section will be presented here. Furthermore, the survey provides for an analysis of the socio-demographic characteristics of prisoners receiving OST, with a sample of 2,000 detainees from 27 penal establishments chosen at random to respond to a questionnaire.

Access to OST in the prison setting

In 2010, 9% of all inmates received substitution treatment {Michel et al. 2011a}. Furthermore, it has been established that, upon their arrival in prison, approximately 7% of inmates state being on substitution treatment, Subutex® being the declared drug used 8 times out of 10 (just like in the general population) {Mouquet et al. 2005}. This figure drops during incarceration, since treatments are not systematically continued, despite the recommendations of the 18 January 1994 act. Treatment interruption, which is an important indicator of the importance attached to continuity of care in prison, affects approximately one out of every ten inmates, even though this figure dropped between 1998 and 2004 (see Table 3).

Table 11-3: Access to substitution treatments in the prison setting

	March 1998	November 1999	December 2001	February 2004
Penal establishments	160/168 (95%)	159/168 (95%)	168 (100%)	165/168 (98%)
Prisoner pop. at the time of the survey	52 937	50 041	47 311	56 939
Number of substitution treatments	1036	1653	2548	3793
Subutex®	*879 (85%)*	*1381 (84%)*	*2182 (86%)*	*3020 (80%)*
Methadone	*157 (15%)*	*272 (16%)*	*366 (14%)*	*773 (20%)*
Total penal pop. receiving substitution	2.0%	3.3%	5.4%	6.6%
Those among new inmates receiving substitution treatment	Not collected	5.8%	12.4%	7.5%
Treatments initiated				
Subutex®	*Not collected*	*Not collected*	*88%*	*70%*
Methadone	*Not collected*	*Not collected*	*12%*	*30%*
Treatments continued				
Subutex®	*Not collected*	*86%*	*85%*	*82%*
Methadone	*Not collected*	*14%*	*15%*	*18%*
Interrupted treatments	21%	19%	5.5%	11.2%
Medical services that do not provide substitution	Not collected	34	19	6
Gen. population receiving substitution treatment (nationwide)	Not collected	70 000	92 000	100 000
Subutex®	*Not collected*	*Not collected*	*80 000 (87%)*	*85 000 (85%)*
Methadone	*Not collected*	*Not collected*	*12 000 (13%)*	*15 000 (15%)*

Source: DGS / DHOS surveys of March 1998, November 1999, December 2001 and February 2004

Although in nine out of ten cases, substitution treatment is continued upon entry in prison, the challenge of providing consistent treatment to opioid addicts consists in making accessible in prison all of the treatments that are available outside of prison. Over recent years, the total number of inmates receiving substitution treatment increased and the number of medical services refusing to prescribe OST decreased[221]. Nevertheless, accessibility to these treatments varies. In France, there is still a "pocket of resistance" with some establishments stating that they

[221] Between 1998 and 2004, the number of inmates receiving substitution treatment increased faster than the prison population. The prison population receiving substitution treatment subsequently increased from 2% in 1998 to 6.6% in 2004. Concurrently, the proportion of medical services (UCSAs, SMPRs or CSSTs) not providing substitution treatments diminished (see table 3).

have not initiated OST[222] {Morfini et al. 2001/2004}, {Obradovic et al. 2008b}, {Michel et al. 2010}), while others engage in practices that are likely to compromise the efficacy of the treatment (crushing pills or making solutions) {Michel et al. 2003}. In the 2010 PRI2DE inventory {Michel et al. 2011a}, 19% of establishments stated that they crushed or diluted high dose buprenorphine, mainly in order to limit its misuse. Moreover, methadone doses were limited in 17% of establishments, while the MA does not contain any dosing limitations. Despite repeated ministerial circulars and clinical practice guidelines, access to substitution treatment for heroin-addicted inmates remains, despite real progress, more limited than outside of prison, even though it has been demonstrated that the number of incarcerations (or re-incarcerations) is lower in people who received substitution treatment prior to or during incarceration {Rotily 2000}; {Levasseur et al. 2002}).

The PREVACAR survey helps update knowledge on available care, especially regarding OST in France. Performed in June 2010 among 145 penal establishments, this survey had an 86% participation rate, representing 56,011 detainees or 92% of the incarcerated population on 1 July 2010. Regarding available OST, the survey revealed that 100% of the UCSAs provide access to at least one of the two types of OST, either high dose buprenorphine or methadone. However, a few establishments only offer one treatment: HDB only in four establishments, and methadone only in four others. Continuity of OST care upon release is only ensured by half of the establishments (55%), and 38% of the establishments state that they do not have a formalised procedure.

Regarding harm reduction services, 18% of the UCSA teams were aware of used syringes in the establishment and 29% in the establishments with fewer than 500 detainees. The discovery of syringes mostly involves large-capacity establishments with over 150 places. These data concur with those collected during the Coquelicot survey, which revealed that 12% of drug users had injected at least once in their life ({Jauffret-Roustide et al. 2006}; {Jauffret-Roustide et al. 2009}).

The very high PREVACAR survey participation rate among establishments, thanks to the mobilisation of the treatment team personnel, helps provide epidemiological data representative of the inmate population (the missing data rate did not exceed 3%). The main limitations of the survey are seen in the declarative method of data collection and the existence of a social desirability bias on the part of the respondents, reinforced by the institutional nature of the survey. Since this survey was coordinated by the French Ministry of Health, it is possible that the participants perceived it as a monitoring of practices, thereby encouraging them to emphasise their compliance with good OST and health education practices. Furthermore, the questionnaire was filled by the physician in charge of the UCSA, who is not always the most aware of the reality of field practices, since such physicians are in less contact with the detainees. Finally, the imprecise nature of certain questions, especially those on the existence of formalised continuity of care procedures upon release, may have made certain questions difficult to understand for the respondents. The more specific information on syringes, of which the UCSAs are not always aware, comes from workers other than those of the UCSAs: they therefore represent a somewhat objective indicator of injection practices in prison.

[222] In 2004, nine prison establishments alone, representing 20% of the prison population, prescribed one-third of substitution treatments, and one of these nine establishments prescribed more than 10%. The successive editions of the survey demonstrated that there were still penal establishments where no substitution treatment was prescribed, even though this number is declining, and that certain establishments only prescribe methadone OST. Complementary qualitative studies confirmed these findings by revealing the application, in certain sites, of quotas for substitution treatment, criteria for receiving substitution treatment (estimated sentence duration, for example) or administration methods that do not correspond to the proper prescription rules: Subutex® that is crushed or diluted before administration, for example (Delfraissy, J.-F. (2002). Prise en charge des personnes infectées par le VIH. Rapport 2002. Recommandations du groupe d'experts In: DELFRAISSY, J.-F. (Ed.) Flammarion, Paris.

Although we do not know how many inmates began OST during their incarceration, we do know that the Subutex® proportion (70 %) tends to decline among treatments initiated in prison, which is explained in part by the risks associated with taking the treatment[223]. Moreover, since the governmental plan to combat illegal drugs, tobacco and alcohol (2004-2008), the authorities have been aiming to improve access to methadone OST by making it accessible in all penal establishments. This objective, which was confirmed in a circular issued by the French Ministry of Health on 30 January 2002, was assessed by the OFDT {Obradovic et al. 2008b}. The survey conducted among UCSAs and SMPRs (with a 65% response rate) revealed a remarkable progression in access to methadone. In 2006, 35% of opioid-addicted inmates were being treated within the scope of methadone OST vs. 22% in 2004 ({Obradovic et al. 2008b}, {Direction de l'hospitalisation et de l'organisation des soins (DHOS) 2004}), representing 40% of the entire opioid-dependent penal population. In 2010, this percentage remained stable (2/3 of substitute-receiving inmates received high-dose buprenorphine and 1/3 methadone) {Michel et al. 2011a}. The evolution of medical practices is evidenced in a second figure: approximately 70% of the establishments surveyed stated that they had at least one initial methadone prescription during the second half of 2006 (most often among the large remand centres, where the organisation of health care was simplified with a single prescription service). However, in 2010, 13% of the establishments that had responded to the PRI2DE inventory stated that they never initiate substitution treatment {Michel et al. 2011a}. The OFDT assessment also demonstrated that, although the rules for organising prescriptions were heterogeneous, the medical practices for dispensing and monitoring showed little variation from one establishment to another[224]. Furthermore, it appears that approximately 8% of establishments give priority to a withdrawal strategy and nearly 10% of professionals foresee the risk of overdose as a barrier to methadone prescription {Obradovic et al. 2008b}, since the known lethal risk is set at approximately 1 mg/kg/d for a non-opioid-tolerant subject (Michel, 2006). The structure of accessible OST treatment in the prison setting has therefore evolved over the past ten years: although HDB (Subutex®) is still the predominant treatment used in prison, methadone treatment is on the rise, especially since the 30 January 2002 circular allowing physicians to prescribe methadone as first-line therapy: in 2004, 30% of the treatments initiated were methadone-based (versus 12% prior to the circular).

[223] Although high dose buprenorphine is the main treatment prescribed in non-hospital practice Canarelli, T. and Coquelin, A. (2009). Données récentes relatives aux traitements de substitution aux opiacés. Premiers résultats d'une analyse de données de remboursement concernant plus de 4 500 patients en 2006 et 2007. Tendances (65) 1-6., in the prison setting, it is "relatively easy to misuse" Pradier, P. (1999). La gestion de la santé dans les établissements du programme 13 000 : évaluation et perspectives. Administration pénitentiaire, Paris. in addition to the fact that it can be "injected" or "sniffed". Since the method for dispensing methadone (as an oral solution to be taken daily in front of the treatment personnel at the dispensing medical centre) is not conducive to this kind of abuse, the French Ministry of Health authorised in 2002 initial methadone prescriptions in all health establishments, including UCSAs and SMPRs.

[224] In nearly two-thirds of cases, methadone prescriptions are shared with or delegated to a service other than the UCSA, although the latter is designated as competent in the legislation (UCSAs only carry out their mission in one-third of cases). The modalities for dispensing methadone-based treatment are, however, very homogeneous: dispensing is mainly done on a daily basis at a treatment site (dispensing is performed in cells in less than 10% of establishments) and, in general, under the supervision of a physician or nurse (except for rare cases when the treatment is handed over to the inmates themselves without monitoring of administration). The average levels of initial prescription in prisons are close to what is observed outside of prisons (in hospitals), i.e., between 23 mg/day and 76 mg/day (minimum/maximum), which translates into the proper application of the therapeutic indications, promoting caution: 60% of the treatment units state giving minimal initial doses lower than the daily initial doses indicated in the 2002 circular ("20 to 30 mg, depending on the level of physical addiction"). In contrast, one-quarter of services (generally UCSAs) state giving high initial maximal doses of at least 100 mg per day. This observation is reminiscent of the results recorded in the international literature, which reveal high, or even very high methadone doses (from over 100 mg to over 1000 mg per day), justified by a pharmacological necessity for certain patients (Maremmani, I. and et al. (2000). Methadone dose and retention during treatment of heroin addicts with axis I psychiatric comorbidity. Journal of Addictive Diseases vol. 19(2) 29-41.; Leavitt, S.B., Shinderman, M., Maxwell, S., Eap, C. and al., e. (2000). When "enough" is not enough: new perspectives on optimal methadone maintenance dose. The Mount Sinai Journal of Medicine vol. 67 (n° 5 & 6) 404-411.

Characteristics of inmates receiving OST

The characteristics of inmates receiving substitution treatment are documented by the RECAP survey (OFDT) on drug users seen in CSAPAs operating in prisons. The population of the nine CSAPAs in penal establishments that responded to the latest edition of the survey (out of a total of 16) is more homogeneous than outside of prison (see Table 4): it is comprised mainly of men (96% vs. 79%), more than half of whom are 25 to 40 years of age and often economically inactive before incarceration (approximately one-third) with a low educational level (nearly 40% state having an education level at or below middle school (the French "BEPC"). They state twice as often as CSAPA outpatients that they have alcohol and polydrug use problems. Fewer of the patients treated in prison CSAPAs for opioid problems receive OST. Furthermore, although the percentage of patients treated for an opioid problem with Subutex®-based OST in CSAPAs is comparable both inside and outside of prisons (nearly 20%), far fewer of those in prison are treated with methadone (10 % vs. 22.5 %). Finally, inmates have been on substitution treatment for longer: 44% have been on substitution treatment for more than five years vs. 31% of substitution treatment outpatients in non-prison CSAPAs.

Table 11-4: Substitution in the Nine Prison-based CSAPAs that Responded to the 2009 RECAP Survey

	CSAPAs in prisons		CSAPAs outside of prisons		2009 All CSAPAs	
	Numbers treated	%	Numbers treated	%	Numbers treated	%
Breakdown by current opioid substitution treatment						
No	**1 808**	**70.0**	37 651	56.9	39 459	57.4
Yes, Methadone	**255**	**9.9**	14 882	22.5	15 137	22.0
Yes, Subutex®	**515**	**19.9**	12 973	19.6	13 488	19.6
Yes, other	**6.0**	**0.2**	611	0.9	617	0.9
Total "usable" substitution responses	**2 584**	**100.0**	66 117	100.0	68 701	100.0
Response rate		**85.1**		76.9		77.2
Breakdown by current opioid substitution treatment duration						
Less than 6 months	**49**	**12.1**	2 958	18.0	3 007	17.9
6 months to 1 year	**39**	**9.6**	1 722	10.5	1 761	10.5
1 year to 2 years	**51**	**12.6**	2 343	14.3	2 394	14.2
2 to 5 years	**89**	**22.0**	4 221	25.7	4 310	25.6
Over 5 years	**177**	**43.7**	5 155	31.4	5 332	31.7
Total "usable" substitution duration responses	**405**	**100.0**	16 399	100.0	16 804	100.0
Response rate (in reference to the total number of patients receiving substitution treatment)		**52.2**		57.6		57.5

Source: OFDT, RECAP 2009

Preparing for release and continuity of care

Release from prison is linked to a high risk of relapse, which is sometimes fatal, for inmates receiving substitution treatment ({Harding-Pink 1990}; {Seaman et al. 1998}; {Marzo et al. 2009b}). According to a study conducted in 2001 on prisoners released from the Fresnes Remand Centre, the risk of death by overdose in former inmates was more than 120 times that of the general population [{Prudhomme et al. 2001}; {Verger et al. 2003}]. This same study established particularly high excess mortality by overdose in released prisoners under the age of 55.

The continuity of care for drug addicts released from prison is deemed a "'fundamental" issue in all the legislation organising care in prisons since the act of 18 January 1994. The 1994 act subsequently recommends preparing continuity of health care for released prisoners, in

coordination with the Penitentiary Services for Reintegration and Probation, which was reiterated in the 9 August 2001 interministerial memo and the 30 January 2002 circular, which stated that the continuity of care upon release should be "planned with the patient from the moment a prescription is indicated". More recently still, the recommendations of the Consensus conference on the follow-up of persons placed under substitution treatment[225] suggest improving "*planning for release, in cooperation with outside partners, and the generalisation of addictology consultations, aiming in particular to promote access to care, reduce harm, and prevent overdoses upon release*".

The *Guide méthodologique relatif à la prise en charge sanitaire des personnes détenues* established by the DHOS to help professionals clearly summarises the specific conditions for providing health care to inmates at the different stages of their incarceration. It specifies that the modalities for release need to be planned sufficiently early, before the planned definitive release date. The preparation for release needs to engage the coordinated efforts of internal health and prison teams and external specialised structures. The necessary continuity of care must be in place to provide health and social support (housing, care, social protection) as well as social and professional rehabilitation support upon release. For pre-trial detainees with a bail order, information on outside health and social services for continued care must be provided upon their release. Therefore, theoretically, upon release, a prescription for methadone or Subutex® substitution treatment needs to be provided to the inmate in order to avoid any interruption in treatment while awaiting a consultation. This requires that the UCSA or the SMPR be informed beforehand of the release by the clerk of the establishment, which is not always the case. In order to receive treatment upon release, patients must know an identified, informed prescriber outside of prison to which he or she can refer for follow-up medical and/or psychiatric treatment: this can be in a specialised structure (CSAPA), a hospital structure or with a general practitioner (preferably belonging to a network that has been contacted beforehand). To promote this continuity, meetings must be organised and contacts must be made during incarceration – which often proves to be complex in practice – since admission to a CSAPA or a post-cure centre is done upon medical prescription. Prisoners who wish to benefit from such follow-up care upon release must furthermore request such care from the UCSA or SMPR physicians. The SPIP and the UCSA or SMPR personnel are responsible for informing detainees about the treatment possibilities after release.

Given the complexity of these prerequisites to be ensured in a prison setting, in practice, the recommendations are not systematically followed and the health treatment of newly-released prisoners is often insufficient. In 2003, only 30% of released prisoners who were housed in apartments of the addiction unit of the ARAPEJ 93 (an association that provides housing and follow-up care for prisoners carrying out alternative sentences to imprisonment) benefitted from the CMU Universal Health Cover scheme with complementary CMU, whereas 100% coverage of healthcare expenditures can only be guaranteed with this scheme[226]. Moreover, the OFDT's assessment of the implementation of the 2001 memorandum regarding the treatment of incarcerated people with addiction problems revealed that the "*continuity of care upon release from prison*" was among the "*treatment frameworks identified as being the most problematic*" in two-thirds of the 157 observed establishments {Obradovic 2004}. Often, drug-addicted inmates are released with a Subutex® tablet for the day and need to manage on their own, without a prescription, for the days that follow.

[225] Consensus Conference, Lyon; France, 24-25 June 2004 (http://extra.istnf.fr/portail-site/_upload/ISTNF/e-mediatheque/a_docs_ISTNF/substitution220206.pdf).
[226] Source: Observatoire International des prisons (2005). Rapport annuel. Les conditions de détention en France. 285.

Due to the difficulties involved in establishing support upon release, specific measures were implemented. In 1992, structures dependent on the SMPRs were created in order to prepare drug-addicted inmates for their release from prison: 7 Care Units for Prison Leavers (UPS), only half of which still exist today, were set up in the largest establishments, as well as a *quartier intermédiaire sortant* (an intermediary wing for released prisoners) in the Fresnes penitentiary (Val-de-Marne), which has been closed for several years. The UPS teams, which are comprised of specialised educators, social workers, psychologists and nurses, must help facilitate access for addicted inmates to housing and allow them to develop a professional project while ensuring the update of their social rights. In principal, and “to the greatest extent possible”, the people released from UPSs can, if they so desire, continue to be monitored for at least three months after release. Voluntary "interns" are recruited within the penal establishments of the region falling within the scope of the SMPR. People wishing to integrate into a UPS, but who are incarcerated in a region where there are none, should be able to request a transfer for this reason.

This specific measure targeting drug-addicted inmates was the subject of a two-tiered assessment conducted from 1999 to 2003 {Prudhomme et al. 2001}, {Prudhomme et al. 2003}). The assessment revealed difficulties in how the UPSs function: insufficient “intern” numbers, poor acceptance of the project by prison teams, poor integration of UPSs into the life of the establishments, difficulty attaining the most troubled inmate target population, difficulty recruiting interns, malfunctions related to prison constraints, and problems coordinating participants (SPIPS, the Prison Service, SMPRs, UCSAs and so on). Subsequently, improvements were planned by the MILDT, but the plan has barely evolved, other than the removal of a few UPSs (like Metz or Lyon).

More recently, the assessment of initial methadone prescriptions given by UCSAs revealed that in 2007, the UCSA professionals deemed that the continuity of care is correctly carried out for patients under methadone treatment, most often in the form of post-prison referrals to an outside CSAPA, to a general practitioner or, far less frequently, to a hospital {Obradovic et al. 2008b}. In the absence of additional data on the continuity of care upon release, it will be necessary to wait for the implementation of the new measures planned by the MILDT and the French Ministry of Health to start reflecting on the conditions for supporting opioid-addicted inmates upon release from prison. The implementation of “short and quickly accessed reception programmes for released prisoners, within existing social and medical-social structures, in relation with the hospital related to the prison"[227] will be examined closely in the years to come.

The issue of preparing the release and post-release support should be planned in relation to the future rehabilitation of the prisoner. The Prison Service carries out its rehabilitation missions through SPIPs in partnership with fifteen or so local and national associations, including, for example, Sidaction, which offers programmes for preventing HIV and hepatitis in prison, or AIDES, which performs actions within penal establishments that target HIV, hepatitis and sexually transmitted diseases (STD). In 2010, 5.4 M Euros were given to associations by the French Prison Service.

[227] These reception programmes for prison leavers were created by interministerial circular DGS/MC2/MILDT/2009/63 of 23 February 2009 regarding the call for projects to implement the health, social rehabilitation and harm reduction measures for the medico-social addiction aspects of the 2008-2011 government plan to combat drugs and drug addiction. The idea is to create group housing units, each for approximately 10 people, to provide immediate housing for prison leavers, without any time lapse between the release day and the day the prison leavers are received in these units, thereby enabling support and the continuity of medico-social and rehabilitation care.

11.3.2. Screening

Screening in prison (mandatory/optional): programme description, sampling, coverage, and evaluation

In addition to mandatory tuberculosis and syphilis screening[228], inmates are also offered optional, confidential HIV testing. All prisoners must be able to receive, if they agree to it, personalised AIDS information and counselling and, if necessary, undergo (optional) screening. The results must be given by a physician.

Likewise, hepatitis (B and C) screening is offered, but not required, even though the 8 December 1994 circular recommends offering it to high-risk people (teenagers, young adults and intravenous drug users). The hepatitis B vaccine can also be offered, but it is not mandatory.

AIDS and viral hepatitis screening is organised either directly by the UCSAs or through the free and anonymous screening centres (CDAG), which are themselves dependent on the State or the *département* (*Conseil Général,* or General Councils of each French *département*).

Depending on the practices survey, only two-thirds of the UCSAs systematically offer screening: "the HIV, AIDS and hepatitis prevention actions are not effective in all establishments" {Rotily 2000}. The consultations for giving results are more or less systematic in the event of positive results, and less frequent in the event of negative results. The Hepatitis B vaccine should be offered systematically {Bello, P. -Y. et al. 2010}.

However, the situation seems to have evolved: in the 2010 ANRS-PRI2DE inventory, 90% of all establishments (n=103) that completed the questionnaire stated that they systematically offer HIV and hepatitis screening to new inmates upon their entry in prison. The remaining 10% are prisons for sentenced detainees to which the inmates are transferred after a stay in a remand centre, where they are supposed to have already been offered screening. However, fewer than 70% state that they give the inmates negative test results {Michel et al. 2011a}. The percentage of inmates who effectively undergo HIV and hepatitis screening in prison nevertheless remains low: for example 41% of inmates were screened for HIV in eight establishments in the Paris region in 2005, 38% were screened for HCV and 37% for HBV {DRASS Ile-de-France (DRASSIF) 2007}.

11.4. Quality of Service

11.4.1. Practical guidelines and standards for drug-related health services for prisoners (Practical guidelines and standards for dispensing care)

Quality assurance for drug-related services in prison

Several documents, with varying statuses, provide guidelines for medically treating, in prison, HIV- or viral hepatitis-infected persons or drug users. First and foremost, the legislation and regulations establish governmental positions on harm reduction and the dispensing of care in prison. Hence, the 18 January 1994 act and the application circulars for the directives of the Ministries of Justice and Health (see Legal Framework), the first of which is the circular of 1994

[228] All new inmates are systematically X-rayed. Reporting tuberculosis is mandatory: the diagnosing physician reports the information to the UCSA head physician. Syphilis screening is also mandatory for the purposes of preventing STD.

authorising the prescription of methadone in prison for opioid substitution purposes, provide the main guidelines for implementing the changes introduced by the law. Moreover, in 2004, one of these circulars was accompanied by a Methodological guide on the health care of inmates, drafted by the departments of the Ministries of Justice and Social Affairs, of Health and the City. In seven chapters, it provides the modalities for organising physical care and coordinating prevention actions (ch.1), psychiatric care in a prison setting (ch.2), the coordination between the public prison service and the public hospital service (ch.3), the situation of the health personnel previously employed by the Prison Service (ch.4), the ways of providing health care to inmates (ch.5), the procedure and execution deadlines (ch.6) and the social protection of prisoners (ch.7).

In addition to these general policy strategies, various reports for guiding the organisation of health care were drafted. They also address the issue of substitution treatments in the prison setting: assessment report of the ministerial inspection corps on the organisation of inmate care {Inspection général des affaires sociales (IGAS) et al. 2001}, report of the Health-Justice mission on reducing the risk of transmitting HIV and viral hepatitis in the prison setting {Stankoff et al. 2000}, reports of the parliamentary inquiry commissions ({Mermaz et al. 2000}; {Hyest et al. 2000}). Other texts, which more specifically pertain to the policies for the fight against AIDS, also refer to care for drug-using inmates: opinion of the French National AIDS Council {sida 2011} on the risks related to drug use, the first of which dates back to 1993, expert reports on, for example, access to methadone {Caumon et al. 2002} or HIV {Delfraissy 2002}, a report by the Financial Courts {Cour des comptes 2010}, a report by the French High Authority for Health (HAS) on HIV screening {Haute autorité de santé (HAS) 2009}, and so on. Clinical practice guidelines have also been drafted on a national level for the specific aspects of prison health policy: "*Guide des bonnes pratiques de substitution en milieu carcéral*" (Good Practice Guidelines for substitution in the prison setting) in 2003[229], guidelines on the medical treatment of HIV-infected persons , the so-called "Yeni report"[230] {Yeni 2008}. These guidelines were often commissioned by the institutional authorities, even though others are the result of associative initiatives. Subsequently, the French section of the OIP published, in 2006, the first practical guide for prison leavers, with the support of the French Federation of Support and Social Rehabilitation Centres (FNARS), which brings together 750 associations working to provide support, housing, professional and social integration, and access to housing and employment for people in unstable situations. The objective of this Guide, which was completed with a supplement in 2008 to integrate the regulatory changes affecting resettlements, the preparation for release from prison and verification measures, is to provide information to prison leavers on all resources for fostering their integration upon release (OIP, 2006). This legal access tool was

[229] In 2003, the *Commission Nationale Consultative des Traitements de Substitution* (National Consultative Committee on Substitution Treatments) entrusted Laurent Michel, Head of the SMPRCSST of the Bois d'Arcy Remand Centre, and Olivier Maguet, Head of AIDES, with drafting a good practice guide to enable professionals to adapt their practices to the prison setting and to the local system. This report issued several recommendations, including an across-the-board recommendation to prescribe OST not as an end in itself, but rather as an integral part of a comprehensive, patient-focused treatment project (Michel, Maguet, 2003). The other recommendations, each of which describes the conduct to adopt in different possible situations, encourages the systematic renewal of OST upon entry in prison, the initiation of OST during incarceration to make detention serve as a springboard for treatment, the performance of urine drug testing to confirm the use of OST upon entry into prison or to resolve "therapeutic impasse" situations, and so on. See Michel, Maguet, 2003, pp. 42-51.

[230] Under the chairmanship of Professor Patrick Yéni of the CHU Bichat-Claude-Bernard, this group of mainly hospital-based experts attempted to summarise the knowledge acquired in HIV and put it into perspective to optimise patient treatment. He issued recommendations for each of the 17 policy areas identified in the document, some of which pertain to prisons: for example, he recommends systematically offering screening for HIV, hepatitis C, B/D and STDs when people enter prison, then several times during their prison stay, or in the event of antiretroviral therapeutic success, making better use of the measures allowing prisoners whose state of health is incompatible with long-term imprisonment to leave detention (*http://www.sante.gouv.fr/IMG/pdf/Rapport_2010_sur_la_prise_en_charge_medicale_des_personnes_infectees_par_le_VIH_sous_la_direction_du_Pr-_Patrick_Yeni.pdf*).

sent to all of the libraries of the 190 prisons of France for Human Rights Day on 10 December 2008.

Furthermore, the bodies specifically responsible for monitoring the health situation in prisons, like the CGLPL, make observations and recommendations in their annual report or in the guidelines for specific establishments[231].

Finally, the international[232]or national[233] consensus conferences regularly disseminate guidelines on the social care and health care of drug-using inmates. The 2004 OST conference recommended, for example, to make OST dispensing the main viral infection (HIV, HBV, HCV) harm reduction tool in the prison setting by improving training for prison treatment teams and Prison Service agents, by generalising addictology consultations for the inmates and by preparing the continuity of treatment outside of prisons and the release of inmates (prevention of overdose).

The majority of the research conducted concurs regarding six general guidelines, which sometimes correspond to existing legal obligations that are deemed to be insufficiently enforced:

1. Inform each inmate about HIV/HCV/STD prevention, access to condoms and post-exposure treatment for seropositive inmates.
2. Systematically offer HIV and viral hepatitis screening for new inmates upon their entry in prison and regularly renew the proposal during incarceration, while providing access to health information and education.
3. Train prison personnel on prevention, harm reduction and the benefits of post-exposure treatment.
4. Make condoms freely available.
5. Ensure opioid substitution strategies and syringe exchange programmes to reduce HIV, hepatitis and STD transmission.
6. In coordination with the UCSAs, involve associations that work within prisons in the prevention efforts deployed among inmates.

In addition to these national recommendations, there are, of course, international recommendations, such as the 2007 WHO/UNAIDS/UNODC report entitled, "*Effectiveness of interventions to manage HIV in prison. Needle and syringe programmes and bleach and decontaminations strategies"* {OMS (WHO) 2005}.

This review of the practical guidelines and standards for dispensing care that are in effect in France should nevertheless be examined with respect to the assessment results made available to the authorities on the efficacy of the harm reduction tools available today in the prison setting, and particularly OST and the free availability of bleach. Even though, according to the law, OSTs should be systematically offered, they still present inadequate guarantees with respect to HR, as was pointed out recently by the French National AIDS Council {Conseil national du sida 2009}. This led to several assessments of HR programmes recommending a combination of harm reduction measures, including OSTs and SEPs {Darke et al. 1998}. Likewise, the use of bleach presents difficulties. Although certain assessments demonstrate a relatively satisfactory

[231] See the "recommendations" page on the CGLPL's website (http://www.cglpl.fr/rapports-et-recommandations/dernieres-recommandations/).
[232] International consensus conference on Hepatitis C, *Gastroenterol Clin Biol*, 1999; 23: 730-5.
[233] Consensus conference. *Stratégies thérapeutiques pour les personnes dépendantes des opiacés : place des traitements de substitution*. 23 and 24 June 2004

distribution of bleach and a widespread dissemination of information on the benefits of HR {DRASS Ile-de-France (DRASSIF) 2007}, others highlight inadequacies in the access and information provided for the purposes of HR. The PRI2DE inventory of HR measures in prison and their accessibility demonstrates that in certain establishments, bleach is not provided according to the guidelines: before the recent national standardisation of the purchase of bleach by the Prison Service, the chlorometric degree (12°) was not always respected and clear information on the use of bleach for HR was only provided in 22% of the establishments that responded to the survey. The information regarding HR does not always seem to be correctly understood by the inmates or even by the prison and health personnel. It should be remembered that, although the Prison Service is responsible for distributing bleach, the information regarding its use for HR purposes should be dispensed by health personnel in compliance with the indications in the 2004 methodological guide on the health care of detainees {Michel et al. 2011a}. Moreover, the conditions of bleach disinfection efficacy are not guaranteed. Since drug use is prohibited, injection and equipment disinfection are performed in haste while, in order to ensure appropriate disinfection, significant time must be spent on the task. Finally, even when correctly used, bleach does not eliminate HCV with certainty. International organisations recommend that penal establishments distribute single-use injection equipment, since bleach distribution programmes can only be considered as a back-up strategy {OMS et al. 2007}.

Description of the existing guidelines on drug treatment (prevention, treatment, rehabilitation, harm reduction) including standards for prison OST: medications, delivery models, and control of misuse

Several initiatives that aim to set up frameworks for good practice or guidelines were carried out in France. A report on the organisation of substitution treatment in the prison setting was commissioned in 2001 by the National Consultative Committee on Substitution Treatments. It was the culmination of efforts by an observation team comprising a physician working in the Bois d'Arcy remand centre and a community activist of the AIDES association for the fight against AIDS. The report led to a “Good Practice Guide” for substitution treatment in the prison setting, which enabled professionals to adapt their practices to the prison context and to local systems {Michel et al. 2003}. After meeting inmates as well as health and prison personnel, the authors observed many difficulties in the organisation of substitution treatment. The difficulty in clarifying the “treatment” purposes in prison was highlighted in view of the security pressures related primarily to psychotropic substance trafficking, as well as the lack of resources and training for professionals. Various guidelines were formulated on access to care and treatment organisation. One of the main guidelines pertained to the need to work around an individual therapeutic project for each inmate undergoing substitution treatment and to reach a level of treatment that is equal to what is provided for outpatients. The importance of systematically renewing substitution treatments that existed before incarceration was mentioned, as was the indication to massively initiate these treatments among prisoners with opioid addiction upon entry into prison or that develops during incarceration (withdrawal related to incarceration is not, by definition, a chosen option, but it is also part of the preparation for release: integration into a healthcare process, prevention of overdose upon release and resumption of drug use with the associated consequences). The methods for delivering high dose buprenorphine, which is highly influenced by the fear of abuse and misuse that exists in prison (at levels comparable to what exists outside of prison, although more visible in prisons), should help both to trivialise delivery to “autonomous” inmates in order to avoid the useless stigmatisation and personalise delivery with dispensing in front of a care giver for the most fragile patients (i.e., the victims of racketeering or those suspected of misuse). Dispensing methadone, however, can only be performed on a daily basis in front of a care giver due to the lethal potential associated with the product in the absence of opioid tolerance or the potentiation when used with other sedative psychotropics.

Preparing for release from the moment of entry in prison is another essential recommendation, and includes organising, as soon as possible and during incarceration, contacts with future continuity of care structures. Other guidelines include training and supporting teams, the medical file, removals, urine drug testing, confidentiality of care and co-prescriptions. The report resulting from this work was distributed jointly by the French Ministry of Health and Ministry of Justice to all heads of UCSAs and SMPRs of French prisons, as well as to all Penal establishment Directors and Regional Departments of the Prison Service.

This type of measure continues today with the preparation of a good professional practice guide for opioid substitution treatments in the prison setting, in application of the 2008-2011 governmental plan. This guide, based not only on the updated guidelines of the preceding report but also supported by numerous visits with health workers in prison settings, should be available before the end of 2011.

11.4.2. Training (Personnel training)

Training prison staff in drug-related prevention, risk awareness and harm reduction

In order to implement its missions, the Prison Service (PS) relies on 34,147 agents (as of 1 January 2010) who perform various jobs: surveillance personnel, management personnel, integration and probation staff, administrative staff and technical personnel. In addition to these PS-paid personnel are health personnel affiliated with the French Ministry of Health.

The surveillance personnel represent the largest staff category (75%): this group is in constant, direct contact with the inmates. They ensure the safety inside and outside the establishment and help customise sentences and rehabilitation for people who are deprived of their freedom. They have represented 70 to 80% of the new recruits each year since September 2002, when the Ministry of Justice announced the recruitment of nearly 10,000 public servants in the prison sector over a five-year period. The management personnel represent the smallest group (approximately 1%): this group includes Prison Service Directors, who are responsible for managing establishments, and Directors of Prison Integration and Probation Services, who are in charge of the Penitentiary Services for Reintegration and Probation (SPIP). The SPIP personnel (11.5% of the PS agents) are divided into social workers (heads of reintegration and probation departments), Reintegration and Probation Counsellors and social assistants. In the prison setting, they are responsible for providing social rehabilitation assistance through individual detainee monitoring; they organise various socio-education activities within the establishment under the guidance of a department head; they prepare and monitor resettlement measures. The technical personnel (less than 2% of PS staff) have a dual role: they ensure infrastructure maintenance and help provide professional training for inmates and manage workshops. Finally, the administrative personnel (7%) provide clerk duties and accounting services. They are also responsible for the material and administrative management activities linked to the operation of the establishment and services.

In 2006, 1.6 M euros in operating funds (excluding wages and travel costs) were allocated to continuing education for agents at the *Ecole nationale d'administration pénitentiaire* (National Prison Service School); this amount represented 15,638 training days for 3,153 people (or 9% of personnel). The published figures do not specify which categories of agents received this training.

There are few specific training courses for harm reduction and prevention among all of the continuing education courses offered by the ENAP. One 12-person training class exists per year for the past few years: intended for surveillance personnel identified by the establishment, the purpose of this training course is to provide the knowledge and tools needed to become a “drug addiction specialist” and implement drug-related actions for prison personnel. These drug-addiction specialists can then follow a second training session to update their knowledge and take advantage of opportunities to exchange with their counterparts.

To complete the common law training measures, the 2008-2011 ‘Combating Drugs and Drug Addiction’ Government Action Plan provided for the implementation of interministerial training for instructors in drugs and drug addiction and basic and continuing education in each of the involved Ministries (sheet 4-1). Continuing education sessions have thus continued to be offered to civil servants on these issues (at the *Ecole nationale de la magistrature,* magistrate’s school, *Haute école de la santé publique* school of public health, and the *école nationale de l’administration pénitentiaire*, among others) although no particular initiative has been agreed upon regarding health issues.

11.4.3. Discussion, methodological limitations and missing information. Equivalence of care

Discussing the available information on drug-related health policies and services with a focus on ‘equivalence of care’

More than fifteen years after the 1994 reform entered into force, the objective of equivalence of care inside and outside of prisons is far from being attained. First and foremost, the implementation of the legal HR measure raises many issues. Regulated by the circular of 5 December 1996, the French HR measure restricts, when compared with the non-prison setting, the modalities for accessing harm reduction tools, in contradiction with the WHO’s 1993 recommendations on the equivalence of prevention and treatment for both incarcerated patients and outpatients. For example, this circular does not provide for the possibility of making sterile injection equipment available to inmates who are actively using drugs. Moreover, the various studies that have been conducted since 2001 demonstrate that HR suffers from a lack of coordination within the health care system: the reality of drug abuse is poorly understood and often negatively perceived by the administration, the coordination of those involved is limited and role-sharing between UCSAs and SMPRs remains unclear {Inspection général des affaires sociales (IGAS) et al. 2001}, {Obradovic 2004}, which limits the accessibility of inmates to care.

Furthermore, addiction treatment is not provided in the same way in all establishments ({Pradier 1999}, {Michel et al. 2003}, {Michel et al. 2005}) due in part to the differences in treatment resources. It continues to meet with opposition from certain players, particularly in establishments where there are no CSAPAs {Obradovic 2004}. Although the encouragement by the authorities to use methadone since 2002 facilitates initial prescriptions in the prison setting, it does not eliminate the refusals to prescribe observed in 2006, then again in 2010, in several establishments ({Obradovic et al. 2008b}, {Michel et al. 2008}, {Michel et al. 2011a}). Yet, the French National Consultative Committee for Ethics emphasised how the disparities in available substitution treatments is harmful to inmates (Comité consultatif national d’éthique pour les sciences de la vie et de la santé, 2006). Finally, it should be reiterated that OSTs, although they should be systematically offered, do not represent sufficient guarantees with respect to HR, and the same goes for the bleach distribution conditions.

The conditions of use for bleach do not, in fact, always comply with the guidelines (see 4. Quality of Service/Quality assurance). The PRI2DE inventory of the accessibility of HR measures in prison hence demonstrated that before the implementation of a national bleach purchasing plan by the French Prison Service, the chlorometric degree (12°) was not systematically respected; moreover, clear information on its use for HR purposes was only distributed in 22% of establishments {Michel et al. 2010}. The information on HR does not always seem to be correctly understood by the inmates or even by the prison and health personnel. It should be remembered that, although the distribution of bleach is the responsibility of the Prison Service, the information regarding its use for HR purposes should be dispensed by the health personnel in compliance with the indications in the 2004 methodological guide on the health care of detainees {Michel et al. 2011a}. Moreover, the conditions of bleach disinfection efficacy are not guaranteed, since injection and equipment disinfection are often performed in haste while, in order to ensure appropriate disinfection, significant time must be spent on the task. The benefits of an HR approach are sometimes invalidated by its very use.

Regarding access to condoms, the availability of male condoms is nearly systematic. However, in the large majority of cases, they are only available at UCSAs. Lubricants are only available in half of establishments; finally, access to female condoms in women's prisons is far more limited {Michel et al. 2011a}.

Although post-exposure prophylaxis is theoretically accessible to inmates in all penal establishments through UCSAs or the emergency centres of affiliated health establishments, 47% of the UCSA heads who responded to the PRI2DE questionnaire believe that the inmates are not informed that they can have this prophylactic treatment and 31% state that they are not in a position to answer the question. Furthermore, during the 12 months prior to this survey, only three post-exposure prophylaxis prescriptions were reported, but none of them as a result of risky drug-use behaviour. This is despite the report, in 34% of prison health care establishments, of abscesses potentially related to injection practices. Certain specify, however, that these abscesses had been acquired prior to incarceration {Michel et al. 2011a}. Sniffing among inmates was also frequently reported by treatment personnel during the survey (results not published).

Within the scope of this PRI2DE inventory, the investigation of the availability and accessibility of the various harm reduction measures in prison in France helped calculate a score to represent compliance with national guidelines (based on the December 1996 framework circular and the 2004 Methodological guide on the health care of detainees) as well as international guidelines, using as a reference the 2007 WHO/UNAIDS/UNODC report entitled "*Effectiveness of interventions to manage HIV in prison. Needle and syringe programmes and bleach and decontaminations strategies"* (see 4. Quality of Service/Quality Assurance). The objective was, within a context where access to HR measures was more limited than outside the prison setting, to assess the level of enforcement of measures recommended on a national as well as an international level, and indirectly, to assess the risk of infection in prison. The low national and, particularly, very low international score indicated to authors an overall deficiency in the application of harm reduction measures in prison in France, which reveals the absence of a public health and harm reduction policy appropriate to the needs observed {Michel et al. 2011a}.

This general assessment highlights the difficulties in enforcing the January 1994 act - difficulties that are due to four main factors.

- The difficult cohabitation of the prison and medical sectors first and foremost hinders the availability of care to inmates. For certain authors, the difference between the reform

measures “on paper” and “in practice” is explained by the insufficient preparation of professionals for the changes introduced by the law, which subsequently contributed to reinforcing the systems of opposition that structure inmate treatment: the 1994 act gives rise to conflicts between the two main categories of professionals working in the field, since it weakens the boundaries between jobs {Lechien 2001}. The medical and prison personnel, in fact, represent two opposing schools of thought: that of surveillance and security, and that of care, when, for example, the security measures imposed by the PS (handcuffs, shackles, escorts, police guards, and so on) complicate and delay, or even prevent, treatment due to a lack of material resources. The results of this antagonism is an increase in the number of internal procedures needed to resolve the health problems experienced by the inmates, such as drafting medical certificates.

- The second barrier to enforcing equivalence of care is related to the barriers encountered by the integration and probation services. The PS's rehabilitation mission, which is carried out through SPIPs, implies that inmates suffering from chronic diseases can benefit from a release medico-social plan during incarceration. This preparation for release comprises a medical component, entailing the handing over of a summary of the prisoner's file a few days prior to release, and a social component, which proves to be more difficult to organise. Often, release means returning to unstable living conditions, which disrupts the medical and therapeutic continuity planned upon release. The lack of coordination that is observed at times between the outside medical structures and the SPIPs cannot solely explain this failure: SPIPS are, in fact, confronted with insufficient social services continuity upon release, particularly in terms of housing and reception upon release from prison. Moreover, social care is usually organised within the social services of hospital departments or through patient associations. The organisation of this post-prison treatment is complicated by the fact that the reinstatement of social rights can only take place after release, and only for people whose administrative situation is in order. The contrast between the need to organise medical care for newly-released inmates and the absence of a specific social policy for prison leavers largely explains the difficulties in promoting access to care in this special population, which is already vulnerable on several levels.

- The third factor representing a barrier to the principle of equivalence of care is, specifically, related to the characteristics of the prison population, where instability, psychiatric disorders and comorbidities related to drug-addiction - objective barriers to medical care - are overrepresented. Moreover, the nature of the chronic pathologies with which patients are confronted, and their modes of treatment, which require long-term follow-up and therapeutic discipline[234] are insufficiently adjusted to the cognitive abilities of a population characterised by a low level of education.

- Finally, a fourth barrier to the application of the principle of equivalence of care is found in the special conditions of maintaining medical confidentiality in prison. Due to the lack of privacy, prisons are places where medical confidentiality is difficult to maintain: the required presence of a guard for any appointments, medical or otherwise, the closeness of quarters and the relative lack of soundproofing of treatment premises, the consultation days and the name of the physician conducting the specialised consultation, and the intake of treatments in the presence of other inmates, are all situations that contribute to breaches in confidentiality. The Prison Service regularly requests provisions for medical confidentiality to be reviewed for security reasons. Hence, the 1994 reform had paradoxical effects: it not only

[234] The treatment of HIV and chronic viral hepatitis B and C has no clinically visible translation for years. The benefits may therefore seem abstract to certain patients, which does not encourage them to undergo regular follow-up care.

made prisons a place where drug addiction could arise, it also did not even facilitate obliging prisons to become a place for giving up drugs, even temporarily ({Bouhnik et al. 1996}; {Brillet 2009}).

Although prisoner health care has made real progress since 1994, after shifting from "compassionate medicine" to hospital medicine in a prison setting, the practice contradicts the desire of lawmakers to offer prisoners care that is equal to what is received by the general population, first because the status of inmate seems to be incompatible with the principle of equivalence of care: the overcrowding of penal establishments combined with insufficient medical staff numbers (particularly psychiatric staff) and the constraints related to being in confinement automatically limit inmate access to physical and/or psychological care. Generally speaking, the health care system for detainees still has many weaknesses in terms of hygiene, waiting periods (for specialised care or hospitalisations), permanency of care (absence of permanent medical staff on nights and during weekends in the majority of penal establishments), access to specialised care (problems with escorts for outside consultations) and respect for medical confidentiality (Moreau, 2010). To ensure equality of care and long-term medico-social care after release, the necessary conditions seem to be to continue improving the medical care of prisoners within penal establishments and to develop prevention actions and harm reduction policies during incarceration.

11.4.4. Methodological limitations and missing information

The overall observation is that there is a relative lack of information on the French health care situation in prisons compared to other European countries. The data on the use of psychoactive substances among inmates in France are old {Bonnevie et al. 1996}, since the most recent data is from 2003. This relative disinterest in prison drug use as a research topic is not new. Before the 1994 reform, rare were local surveys conducted on health in prison by associations fighting against HIV or health research organisations – like ORS PACA (the regional health institute of Provence, the Alps and the Côte d'Azur in France). The first epidemiological studies dedicated specifically to the use of drugs in prison were conducted after the reform. Conducted by the National Institute of Health and Medical Research (INSERM), these surveys observed available health care limited to the treatment of drug addicts by the local addiction units, as a whole {Facy et al. 1995} or in targeted penal establishments, like the Baumettes penitentiary, where two INSERM surveys were conducted in 1996 and 1997. Even today, surveys on HIV, hepatitis and risky behaviour in prison are few and far between. The data available are often old and the way there were collected often proves to be methodologically questionable {Michel et al. 2008}.

For many years, the health of inmates was only studied, on a national level, through a general survey conducted by the Directorate for Research, Studies, Evaluation and Statistics (DREES) of the French Health and Social Ministries on the health of new inmates. The survey was conducted first in 1997 then again in 2003. The first edition of this representative survey estimated that approximately 30% of new inmates used several high-risk substances (alcohol, tobacco, drugs, psychotropic substances) and that the physicians prescribed a specialised psychiatric consultation for nearly one out of every ten new inmates (excluding addiction-related reasons) {Mouquet et al. 1999}. Psychiatric disorders in the prison setting and the special treatment provided were, however, ill-known until a specific survey was conducted in June 2001 on SMPR treatment teams responsible for prevention and psychiatric care in prisons: this survey aimed to better describe the state of health of inmates, who were questioned during the induction interview upon entry in prison or followed regularly in SMPRs {Coldefy et al.}. However, the first, large-scale epidemiological survey of the mental health of inmates, conducted

among 1,000 people and coordinated by a group of experts, was funded by the French Ministry of Health in 2003-2004, ten years after the equivalence of care act.

Since the last "new inmate health" survey conducted by the DREES in 2003, no new study on this theme has been conducted by the studies department of the French Ministry of Health: the Ministry ceased entrusting its regular surveys on substitution and on HIV/HCV prevalence to its central departments: the General Department of Health and the Department of Hospital Care and Treatment Organisation which in 2010 became the *Direction générale de l'offre de soins*. Henceforth, knowledge on the prevalence of HIV and hepatitis in prisons will be updated through the PREVACAR survey, for which the scientific coordination was entrusted to the National Health Monitoring Institute (InVS) by the General Department of Health. This decision falls within the framework of the 2010-2014 Strategic Action Plan on Health Policy for Inmates, which suggests defining a "shared corpus of data for inmate health monitoring measures that include relative indicators for monitoring chronic illnesses, mental health and infectious diseases", particularly by conducting repeated studies. The first issue of the PREVACAR survey, whose preliminary results were discussed in this paper, took place in 2010.

Moreover, the figures available on the prevalence of infectious diseases in detention sites are incomplete: they are often old, frequently declarative, aggregate data on a limited sample of inmates, and they do not help determine the proportion of drug users in prison or the established number of cases of transmission through syringe exchange. Obtaining a reliable sample is complex to the extent that certain patients cannot be questioned for disciplinary or security reasons. As a result, there is wide variability in the profile of questioned prisoners, depending on the study, since these surveys most often target populations based on legal status (provisional detention or sentencing, short sentence or long sentence) and establishment type (with variable security levels and sentence durations). The selection biases are therefore consubstantial with the practice of surveys in prison, and the existing studies need to be interpreted in accordance with the defined selection criteria. Extrapolating data proves to be tricky, especially since objective testing (such as urinary or blood testing) is rarely performed. Furthermore, traditional, standardised diagnostic instruments have not been approved for inmate populations. In addition, the fear of not respecting medical confidentiality can distort inmate reporting, likewise for the inmate psychological profile itself, which reveals a high prevalence of antisocial personalities. More generally, the surveys on drug use and high-risk practices in prison are difficult to conduct due to the reticence prisoners have in talking about illegal practices at their site of punishment and the reticence of political decision-makers. The latter are not keen to acknowledge drug use practices in a place that supposedly houses people to be tried for drug-related offences: 20% of inmates committed drug-related offences {De Bruyn et al. 2010}. Finally, the conduct of reliable studies, methodologically speaking, also encounters other obstacles in prison: Prison Service resistance, ambiguous consent in a place where freedoms are curtailed, multiple technical difficulties related to accessing establishments and inmates, and the risk of stigmatising target populations. It therefore appears necessary to impose a strong awareness of the health challenges in prison on all those involved, from politicians to people working in the field, so that the conditions needed to implement a public health policy in prison comparable to the policy implemented outside of the prison setting can exist.

Finally, in addition to their limited scope, their irregular frequency and sometimes questionable methodology, studies on the prevalence of infectious diseases, the incidence of high-risk behaviours on HIV and HCV and, more generally, the use of drugs and injection in prison, are relatively infrequent in France {Michel et al. 2008}. The 2008 report of the HIV expert group demonstrates, for example, the near absence of reliable data on HIV infection and treatment in prisons {Yeni 2008}. Other "blind spots" regarding quantitative information measures can be

mentioned: the prevalence of abuse/addiction in the general prisoner population (including prisoners with long sentences), use practices (little data on sniffing, for example), methods of drug supply in prison, the evolution of drug use prevalence during incarceration, and viral contamination during imprisonment. Although we know the prevalence of HIV and viral hepatitis, the incidence of new contaminations has never been assessed in prison, since the Prison Service opposes this type of study on the basis of principle. The little-known issue of contamination in prison would nevertheless be worthwhile to explore in order to be considered within the scope of a prison public health policy recommending, as an objective, equivalence of treatment with an obligation to treat incarcerated patients in the same way as outpatients.

11.5. Conclusion

Studies on addiction in prison are still few and irregular, which makes it impossible to follow trends. Furthermore, it is challenging to compare them with each other due to the selection bias of each survey and the methodological difficulties inherent in surveys in prison. Nevertheless, the following observations can be made: drug users are overrepresented among those in provisional detention and convicted offenders with short sentences; the substances used in prison do not seem to be prison-specific and the proportions of reported substances vary little over time; the use of injection is frequent and takes place under sanitary conditions that cannot guarantee the prevention of diseases transmissible through blood; the prison setting often fosters the initiation of illegal drug use. The non-negligible proportion of prisoners using drugs intravenously in prison, when added to the high prevalence of HIV and HCV in drug addicts, exposes inmates to a high risk of contamination since France prohibits the distribution of sterile kits.

One of the main conclusions of the collective expert report on harm reduction conducted in France in 2010 is that, although various harm reduction tools currently exist, regulated by the 1996 circular, there is no actual harm reduction policy specifically targeting prisons in France at the present time {Bello, P. -Y. et al. 2010}. In fact, despite the existence of voluntarist public health legislation addressing the health of inmates, the implementation of harm reduction tools is far from systematic: screening is still not performed; access to opioid substitution treatments (considered by the WHO as a first-line measure in prisons) remains very irregular and inappropriate practices (e.g., crushing HDB and making solutions with the substance) compromise the efficacy of these treatments; the bimonthly distribution of bleach to each inmate (considered by the WHO as second-line treatment, particularly compared to syringe exchange programmes) is infrequently observed and, in most cases, no clear instructions for use are provided; access to condoms has been generalised but the conditions of access remain unsatisfactory (information provided to inmates, confidentiality, discretion, access often only in treatment premises); finally, the prevalence of AIDS and viral hepatitis remains much higher in the prison population than outside of prison, while the treatment of these illnesses is characterised by insufficient access to specialised consultations (e.g., infectology, hepatology, psychiatrics, and addictology). Therefore, the principle of equivalence of treatment and prevention measures provided for both incarcerated patients and outpatients, recommended since 1993 by the WHO, is still not applied properly in France.

12. Cross-border travel, drug use and drug services.

12.1. Introduction

France has 2,970 km of borders with six European countries – Spain, Belgium, Luxembourg, Germany, Switzerland and Italy[235]. In addition to the long-standing movement of goods and people between the country and its neighbours, France experiences cross-border travel related to drugs and to the party scene (dance events). Although the migration during the 19th century and the first half of the 20th century enabled France to play host to economic immigrants of mainly European origin, this movement tended to reverse direction at the north-eastern and eastern borders of France, across which many French go to work in Luxembourg, Germany, Belgium and Switzerland {Plancke et al. 2010}.

The 1995 signature of the Schengen Agreement introduced free movement for people and goods and removed border controls for the twenty-four signatory countries, helping make cross-border travel commonplace in the area governed by this treaty. Among the twenty-four signatories are all of the countries that border France (except for Switzerland, which signed the Agreement but does not apply it).

The French situation is not conducive to using a plan that successively deals with inflows and outflows. In fact, within the scope of drug use, the available data - although they are not exhaustive and do not cover all borders or the entire recent period (the last ten years) - all point towards significant dissymmetry between inflows and outflows. It seems that, for partying, illegal drug acquisition and treatment, cross-border travel mainly involves French people going elsewhere. Reasons will be given later. The first part of this article will propose framework elements: differences in borders and available information sources. The second part will discuss the movement of French people abroad related to drug use primarily, but not always, in a party context (dance events, night clubs). Finally, the last section will discuss cross-border "exchanges", the purpose of which is to use treatment or harm reduction services.

12.2. Framework data

12.2.1. Two main border types

Drug-related travel is part of a wider range of exchange behaviours, such as numerous trips for the purposes of procuring petrol, tobacco (in Spain and Luxembourg in particular), or even alcohol for items that are more heavily taxed in France (e.g., alcoopop).

To expand its scope, an inventory of cross-border cooperative health efforts identified two major types of border territories involved in more or less intense cross-border interactions {Mission opérationnelle transfrontalière 2001}:

The first type corresponds to a “border melting pot”, i.e., “an area of contact that associates the territories located on either side into a community of destiny and daily life”. These territories are often not delineated physically by a river or the landscape, and include the Nord-Pas de Calais

[235] The coast along the English Channel and the United Kingdom beyond is also a border area, especially since the cross-channel tunnel was put into service. However, this need to cross the channel, which remains expensive, and maybe also the absence of the United Kingdom's signature of the Schengen treaty, limit the free movement of border populations in this area.

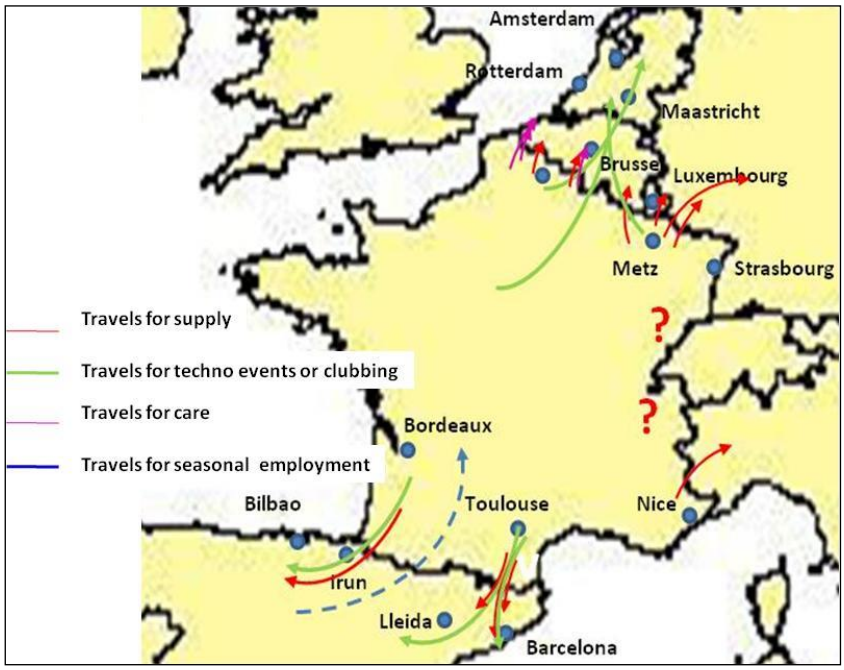
region (France) and Belgium, the Lorraine region (France), Belgium, Luxembourg and Germany, and even the French-Swiss border near Geneva (Pays de Gex and Annemasse in the Rhône-Alpes region for France, Genevois for Switzerland). As for Spain, only the Basque Country constitutes an area of cross-border life. For some of these territories, the border is located in an urban continuum that makes all boundaries invisible. In general, these border areas share a historical, linguistic and cultural community. In the case of Alsace, the French region on the French-German border, this historical and cultural community helps overcome a natural border that is not very permeable (the Rhine). The intensity of the relationships that link these territories to each other can be seen in the daily movements of cross-border workers {Mission opérationnelle transfrontalière 2001}. For example, in 2007, 71,500 French people living in the Lorraine region went daily to work in Luxembourg; 19,000 went to Germany for this purpose and approximately 4,800 went to Belgium. In the Nord-Pas de Calais region of France, 24,000 French people went to work in Belgium and 5,300 Belgians came to France {Plancke et al. 2010}.

The second type of border corresponds to a so-called “glacis border”: these borders, which have often been in existence for longer than the first type of border, are marked by a geographic barrier (e.g., the Jura, Alps or Pyrenees mountain ranges) and prove to be fairly impermeable, with corridors that let through more international than local traffic. The rate of linguistic interpenetration on both sides of these borders appears to be weak. The following French regions belong to this category: the Franche-Comté region (at the French-Swiss border), the rest of the Rhône-Alpes region (French-Italian border), the majority of the Provence-Alpes-Côte d’Azur region (French-Italian border) and the Aquitaine region (French-Spanish border). In contrast to the preceding zones, these areas are mainly rural with few urban centres {Mission opérationnelle transfrontalière 2001}.

Finally, this report considers the Mediterranean edge of the French-Italian border as an intermediary type of area.

This distinction between two border types provides useful insight into the differences between the two border types mentioned further on: the north and northeast regions of France and their relationship with Belgium, Germany and Luxembourg on the one hand, and the Toulouse region and its relationship with Spain on the other hand. It explains in part the quantitative imbalance the cross-border exchanges observed in the northeast of France and those at the other borders.

Map 12-1: Map of French people drug related travels (inflows and outflows)



12.2.2. Sources

There are few sources, and it is subsequently difficult to piece together the information available.

The first study identified on drug-related, cross-border travel between France and its neighbours dates back to the late 1990s {Tuteleers et al. 1998}. This exploratory report by the European Forum for Urban Security focused primarily on drug users perceived as problematic from a collective (nuisance) or individual (treatment need) point of view. Dance events goers are only mentioned.

In contrast to this approach, the observation issued by the first report of the OFDT's TREND System {Ofdt 2000} focused on the reasons that motivate drug users to travel across-borders. Although it mentioned so-called "urban" drug users (precarious users in city downtowns), the party dimension of cross-border travel was the focus of the report. The study already examined border areas, which later constituted the field of observation in the TREND System: the Nord-Pas-de-Calais region in the north of France (city of Lille) located right next to Belgium, the Lorraine region in the northeast of France located where Belgium meets Luxembourg and Germany (city of Metz), and finally the Midi-Pyrénées region in the south, and especially the city of Toulouse[236] close to the Spanish border. Although Toulouse is not located close enough to the border to enable daily round trips, as is the case for Lille and Metz, it maintains long-standing, close cultural ties with Spain, and especially the cities of Barcelona (3h), Lleida (3h30) and further away, Bilbao. These close relationships make Spain accessible for holidays, partying and procuring petrol, alcohol, cigarettes... and illicit drugs. Some data from the area of Nice, near the Mediterranean and in close proximity to the Italian border, was gathered at the time. Drug-related cross-border travel was then followed in a non-specific manner by TREND for several years, until 2008, when such activity was once again the subject of a more in-depth

[236] It takes 2 to 2:30 hours by car to get to the border.

study of the three mentioned sites {Plancke et al. 2010};{Suderie 2011}. This is why this article focuses mainly on these areas.

Furthermore, for this research, a study was conducted in 2004 and 2005 within the scope of a partnership between TREND and the *Office central de répression des traffics illicites de stupéfiants (*Central Office for the Repression of Drug-related Offences or "OCRTIS"); this study was on arrest procedures for minor cocaine trafficking and helped reveal the significance of the cross-border dimension, through micro-trafficking, in cocaine consumption in particular {Gandilhon, Michel 2007}.

Furthermore, another study was conducted within the scope of the TREND system in 2007 and 2008 on the gay party scenes in Paris and Toulouse. The purpose of this research was to note the specificities of narcotics use by male homosexuals frequenting this scene and to study any possible relationships between risk-taking (particularly with regards to the human immunodeficiency virus) and narcotics use {Fournier et al. 2010}. This study was prolonged through the implementation of a systematic, biennial, ethnographic observation of the Paris gay party scene due to the trend-setting role played by this group of users. Incidentally, this study gives evidence of the international party practices that characterise this population, which is professionally well-established and often has a comfortable income level.

Finally, Lille'sTREND local annual report provides data on French people arrests for drug use in Tournai's district (Belgium) where the "megadancings" attended by young Lilles inhabitants settle {Plancke et al. 2011}. These data are indeed held up to date by the Belgian police services. They distinguish the arrests in "dancing" context, i.e. near a nightlife establishment, and the ones in other contexts. These data probably exist for other border zones and could certainly be required.

Regarding travel related to treatment-seeking, once again, there is paucity of identified sources of information. These sources come from researchers (studies of travel by French patients to see Belgian physicians to receive their substitution treatment {Jeanmart 2005} or brief press articles on joint initiatives. A report published in 2001 under the auspices of the *École nationale de santé publique* (French National School of Public Health) by a group named "*Mission opérationnelle transfrontalière*" (Operational cross-border mission) and drafted in collaboration with the *Fédération hospitalière de France* (French hospital federation) and the *Centre hospitalier de la côte basque* (the Basque hospital centre) provided an inventory of cooperative French cross-border health activities based namely on a survey conducted among *Directions régionales des affaires sanitaires et sociales* (DRASS, or French regional directorates of health and social affairs)[237] and hospital establishments located in border regions. This report established a summary of the existing partnerships involving healthcare establishments, the relevant healthcare areas, the local efforts leading to the implementation of these projects, the legal tools used and the difficulties encountered. The major problem with this work is when it was conducted (2001).

[237] DRASS directorates, which are now grouped within regional health agencies (ARS) along with all institutions that play a healthcare role on a regional level, are responsible for the regional organization of healthcare, i.e., the regional distribution of available care.

12.3. Cross-border travel and drug use

12.3.1. Drug use abroad

Before substitution: the attraction to heroin

The aforementioned report of the European Forum for Urban Safety documented, with the help of numerous interviews conducted mainly among healthcare workers or law-enforcement agents in the Belgian cities of Liège and Antwerp, in the Dutch cities of Rotterdam and Maastricht, and in the French city of Lille, an image of users in the late 1990s – users of *hard* drugs – as being extremely unstable and coming from disadvantaged neighbourhoods, and described their procurement practices {Tuteleers et al. 1998}. The report already mentioned the “drug tourism” that brings users from France, Germany and Belgium (for a period lasting from several days to a year) to Rotterdam and, to a lesser extent, to Maastricht (mostly for Belgians) for easier access to less expensive, higher quality heroin and for cocaine, the use of which was becoming increasingly frequent in this population. Medications (benzodiazepines, apparently), and Rohypnol® in particular, also appeared to be very frequently used and present on the markets of Dutch and Belgian cities. These medications, which seemed to be less expensive and more accessible in Belgian pharmacies, were thought to be brought primarily to Maastricht by Belgian users (from Liège). For the same reason, these medications were the reason for trips made by Dutch people to Belgium (and to Antwerp in particular). These trips, made by users who stay and use on site, were coupled with very high volumes of professional trafficking and large numbers of users who, coming from the North of France, sent one of their people to Rotterdam to bring back supplies for the entire group. The trips were made by car and by train.

The TREND data from 1999 confirmed this view of marginalised “urban" users, noting that in this population, the purpose of cross-border travel was frequently minor trafficking and on site use of heroin, cocaine and medications that were less expensive or of higher quality. With the exception of the market for benzodiazepines, and particularly that of Rohypnol®, which is likely to attract Germans and Spaniards to France, all travel took place from France, where the illegal substances appeared to be expensive and of poor quality in the case of heroin, to other countries (to Holland and Belgium, and even Italy for people coming from the south-eastern border of France, for heroin and to Holland, Belgium and Spain for cocaine).

Finally, the report of the European Forum for Urban Security insists on the role played by urban legend in making Rotterdam the city of *hard* drugs - a myth largely perpetuated by the media {Tuteleers et al. 1998}.

After substitution: Dance events, supplying and trafficking

After 2000, the French-language literature on drug-related, cross-border phenomena no longer seemed to focus on the settling of precarious French drug users abroad. It is known that the more widespread use of substitution treatments disrupted the French heroin market for a time by providing, with HDB in particular, a rather accessible withdrawal management tool and thereby probably making being close to an affordable source of heroin less critical {Toufik et al. 2010}. However, cross-border comings and goings of a commercial nature increased with a rise in micro-trafficking in France (see below) {Gandilhon, M et al. 2010a} and illegal drug use abroad took place mainly during trips of a festive nature (see below).

Until now, Dutch coffee shops have been a procurement and use destination for more demanding cannabis users than those who buy on the traditional French market. It is difficult to measure such movements. The figures available in the press are not explained. They generally pertain to cities and mix nationalities. An article in the French daily *Libération* on 13 September 2009 mentioned that 25,000 drug tourists, mainly French and Belgian, went to two cities in the southern Netherlands (Bergen-op-Zoom and Roosendaal) every week[238]. The regional French paper, *Le Républicain Lorrain*, mentioned in its 6 August 2011 issue that 1.4 million mainly Belgian, German and French "drug tourists" visit Maastricht annually[239]. An article in the *Courrier international* on 9 August 2011 mentioned higher figures for the city of Maastricht[240] : "Opinions differ on the number of customers to which this measure applies. According to certain estimations, the size of the total customer base in Maastricht is between 2.3 and 3 million people per year. According to the COT (Dutch institute for safety, security and crisis management), 41% of these people come from Belgium, 41% from the Netherlands, 6% from Germany, 6% from France and 6% from other countries". Some of these individuals come to supply themselves, perhaps for trafficking purposes, rather than simply to use the drugs on site.

We can also cite commercial cannabis fairs organised in Barcelona or even participation in World Cannabis Day, which takes place in Spain in early May and mainly attracts socially integrated young men (high school students, university students and active adults). These young adults frequent the changing alternative scene and seek experimentation rather than adhesion to a counterculture that they moreover do not handle very well {Suderie 2011}[241].

12.3.2. The dance events party scene and drug use abroad

Within this framework, travelling is above all related to the dance events party scene. The substances only make up part of the party scene, which has traditionally been an opportunity for psychoactive drugs use and abuse {Plancke et al. 2010};{Suderie 2011};{Madesclaire 2010, non publié}.

Two areas in France are characterised by cross-border substance use related to frequenting the techno party scene: the southwest and the north. It was also noted in 2000 that young people in the region of Nice (Alpes Maritimes administrative department of France) travelled to large techno gatherings in northern Italian cities, such as Bologna and Genoa {Ofdt 2000}[242].

In the report by the European Forum for Urban Safety {Tuteleers et al. 1998}, Lille drug users care providers briefly mentioned a *group* of young people (16 to 20 years of age) who used ecstasy and speed during their evenings out in Belgian night clubs or alternative techno events. Moreover, this study mentioned how this "nightlife" in Antwerp (Belgium) attracted the Dutch, French and German to purchase and use ecstasy, speed and cocaine there.

Box 1: The techno party movement in France: some data for greater clarity

The techno movement appeared in France in 1990. The first raves were not free. They were organised in unusual places (e.g. chateaux, catacombs, forests) and grouped several hundred people, and particularly members of the homosexual community. Once British regulations cracked down in the early 1990s, the British founders of the Free Party movement shifted

[238] http://www.liberation.fr/monde/0101590624-les-pays-bas-veulent-reserver-le-cannabis-aux-hollandais
[239] http://www.republicain-lorrain.fr/france-monde/2011/08/06/maastricht-pas-de-drogue-aux-francais
[240] http://www.courrierinternational.com/article/2011/08/09/fumeur-de-joints-passe-ton-chemin
[241] Described in the TREND system as "experimenters".
[242] The observations could not be pursued at this site.

towards continental Europe, and France in particular, spreading a new kind of party scene. In 1993, the first French *Teknival* free party was organised. In the French population, techno rapidly became associated with ecstasy consumption. In 1995, the French interministerial circular: “rave evenings, high-risk situations” set the tone. The event organisers were divided; certain chose the legal route and commercialised their parties - raves; others refused any social control and organised free parties {Suderie et al. 2010}. May 2001 saw the appearance of the “*Mariani*” amendment on *certain festive gatherings of a musical nature* corresponding to article 53 of the *Loi sur la sécurité quotidienne* (LSQ, or the French Daily Security Act) 2001-1062 of 15 November 2001. The amendment subjected all rave parties to a prefectural declaration specifying the identity of the organisers, the location, the security and hygiene measures, and the name. French application order 2002-887 (aka "*Mariani et Vaillant*") stipulated that rave party organisers are required to report their project to the prefects of the departments involved once "the foreseeable number of people present on the gathering site exceeds 500" and provided for varied regimes depending on whether or not the organisers agreed to commit to good practice. After this order was issued, there was an observed restructuring of the festive alternative techno scene in France; it broke down into small, discreet free parties, and large-scale, non-commercial events all but disappeared. There was an increase in club and discothèque attendance by substance users from the techno scene {Suderie 2011};{Sudérie et al. 2010};{Cadet-Taïrou et al. 2010b}. Likewise, starting in 2002, the organisers of French free parties began regularly settling across the border: in Spain for those from the region of Toulouse, in Germany for the *Sound systems*[243] of the Lorraine region. The consequences of this was a more widespread use of certain substances (stimulants, and even hallucinogens) in the commercial party scene, where up until now they had not been very available, and an increase in cross-border party attendance.

At the same time, the techno movement, which received significant media attention during teknivals that assembled up to nearly 100,000 people {Sudérie et al. 2010}[244] was increasing in magnitude and opening this alternative scene to curious populations that had generally been far removed from the movement. Losing part of its distinctiveness, the movement also expanded in France to include more traditional party locations, led by discothèques and nightclubs {Cadet-Taïrou et al. 2010b}. Concurrent to this “commercialisation” of the techno party scene, purists demanding an alternative culture tended to retreat to the confidential free party scene and preferred remaining among themselves. Finally, *teuffers* (as people who frequent techno parties are called in French) of the 2010s did not constitute a uniform group. There were major differences, in terms of drug use, between the travellers who cross Europe and the “young wanderers” searching for alternative groups or those who go out occasionally or weekly to “*teufs*” (French slang for parties) after a work week.

Motivations: urban legend, parties and narcotics

The fantasy dimension

Even before putting forth rational arguments, simply crossing the border opens up the party scene - a special moment characterised by freedom. “Leaving one’s country is already leaving the ordinary” whether in Lille or in Metz {Plancke et al. 2010}. The rules at home do not apply anymore. “Anything is possible”. This is how, for the people of Toulouse, Spain embodies the “utopic freedom to use drugs" *{Suderie 2011}.* Perhaps even more so than Belgium or Holland for the cities of the north and east of France, Spain exudes, for the people of Toulouse, an *elsewhere* dimension. The investigations at the sites over the past 10 years have demonstrated,

[243] The term Sound system refers to all of the sound equipment needed to play music at a rave party or a free party. By extension, the term also refers to the group of people who use the system.
[244] The 2004 Chambley Teknival: 97,000 people

for example, the importance of the *initiation trip to Spain* for the young people of Toulouse. Finally, the urban legend dimension was preponderant when "*international night spots in Ibiza or elsewhere*" *{Uriely et al. 2006}* or *"vacations in Barcelona"* were mentioned *{Suderie 2011}.*

The other motivations mentioned were of two types: those related to parties and those related to substances.

The variety and quality of the parties

Since 2000, it has appeared that the main reason motivating the French public to travel to foreign party sites was the attractiveness of the party scene abroad {Ofdt 2000}.

Like Belgium, Spain, with its more established tradition, has long had special sites for techno music that are likely to host large-scale gatherings {Ofdt 2000}. Regarding the traditional (commercial) party scene, the size of the establishment (nightclubs in Spain, *megadancings* along the Belgian border that can host 3,000 to 4,000 people) was regularly mentioned. Size played a role regarding both the possibility of travelling as a group and the quality of the atmosphere {Plancke et al. 2010};{Suderie 2011}.

The ambiance of the party itself was a distinctive element in these establishments. Hence, people from Toulouse like the Spanish culture, which is perceived as being more festive in a context where social control is experienced as less restrictive – there is greater tolerance than in France for festive expression, and especially illicit drugs use in public {Suderie 2011}. Subsequently, Barcelona was described as *a Mecca for festive freedom that is unequalled in France* {Suderie et al. 2010}. Likewise, young people from the Lorraine region (18-to-25-year-olds from Metz) stated seeking an ambiance of "*madness*" in these establishments {Plancke et al. 2010}.

The music was also a decisive criterion. This was the case for, on the one hand, the older age group (aged 25-35), which frequented Luxembourg nightclubs mainly for the music, for example, and on the other hand, for the proponents of the alternative culture seeking free parties or parties with a specific sound (e.g., hardcore) (Metz). In the Lorraine region, a portion of the hardcore public did not hesitate to travel far to Belgium (Brussels) or Germany (Mannheim and Karlsruhe) for evenings in concert halls or hardcore nightclubs with international DJs {Plancke et al. 2010}.

Easier access to festive establishments can also be mentioned, with lower admission fees (excluding the price of drinks and drugs) in Belgium or in Spain, longer hours of operation in Belgium *megadancings* compared to French establishments, and even less rigorous controlling of age when entering clubs in Belgium, Luxembourg and Germany.

Substances within reach

The accessibility of drugs has been of high priority for all three sites since the initial observations: more affordable alcohol was mentioned, but there was more focus on the better availability and supposed lower cost of illegal substances than in France: cannabis, MDMA and the powdered amphetamines favoured since the loss of interest in ecstasy tablets, cocaine especially in the nightclubs of Spain and Luxembourg, and even ketamine in Spanish nightclubs {Plancke et al. 2010}; {Suderie 2011}. Thus, in Lille, the majority of the synthetic drugs used by French people were thought to be consumed in Belgium on the weekends. The availability of MDMA in Belgian party settings was highly appreciated since it helped "*control the frenzy*" {Suderie 2011}.

The aforementioned tolerance of public drug use in festive settings also had a decisive influence on the ambiance.

"Watch people are not there to prevent you from taking drugs…As a result, people have great experiences with their drugs"[245]

At the Dour festival in Belgium, which attracts many French people, drug use was not hidden.

The quality of substances was not really emphasised in this context. Only the TREND observations of 2000 mentioned the quality of ecstasy tablets in Italy that alone "would have been worth the trip" despite the higher price. It is highly unlikely that this difference still exists.

Party and population types

The alternative scene and the counterculture

In the Lorraine region, like elsewhere in France, the *Mariani et Vaillant* amendment (2002) has caused French alternative festive gatherings to become increasingly rare. While certain departments of the region nevertheless still have a free party type of festive scene, others, like Meurthe-et-Moselle, have seen their party scene nearly disappear {Schleret et al. 2011}. Moreover, as was previously mentioned, since the techno movement has been largely diluted in a young "run-of-the-mill" population that is at times rather unfamiliar with the alternative mindset, the purists of the movement – hardcore and free party fans – do not hesitate to travel beyond nearby festive sites across the border. For example, this group frequents establishments located in Baden-Württemberg near the Alsatian border or even, for those who have the means, deeper into Germany (Mannheim or Karlsruhe) or Belgium (Brussels). In particular, they followed the French Sound system that settled in Germany and organised free parties, which until the late 2000s could attract up to 1,000 people {Plancke et al. 2010}.

According to the Lille site, festivals taking place in Belgium, like the July Dour festival, are also attended by many French people. Illicit drugs are ostensibly consumed there.

In Spain, the alternative festive scene reached its peak between 2000 and 2005. The cross-border events gathering the highest numbers of the alternative electronic population were still the teknivals and free parties occurring during the New Year and traditionally during the summer. Moreover, like what is observed on the northeast border, many free parties are now organised by French people in Spain. French *teuffers* (partygoers) went to these parties for an evening, a weekend or a week. After 2005, these events slowly stopped being organised due to the burning out of the local electronic culture and the intervention of *La Guardia Civil*. In 2010, private evenings could be organised at the Spanish border for a birthday or a special event, but the recurrence of such events is rare today {Suderie 2011}.

Parties, drugs, counterculture and policy: the Okupas movement[246]

Of the French people who organised parties in Spain between 2000 and 2005, two groups can be distinguished: those who were living in France and organised occasional, outdoor free parties in Spain, generally between March and September, and those who decided to move temporarily

[245] For users, the stress and vigilance related to illegal narcotics use in an environment that condemns such use supposedly favour bad trips and/or ill-being.

[246] "Okupas" refers to a movement during which squats became legalised in Spain: see Bouillon, F "Les mondes du squat" (The worlds of squatters), Le Monde, PUF, 2009

to Barcelona[247]. The latter group perceived the Catalan political climate as being more lenient, both regarding organising free outdoor or squat parties and organising authorised festivals. Some then joined the Okupas movement. These groups, which had not been accustomed to living in squats in Toulouse, shifted from being affiliated with an alternative *lifestyle* to moving to Barcelona to live in 'expat squats' where there were few Spaniards and mostly people who had recently arrived from France as well as from Italy and the UK" {Suderie 2006}. The Barcelona squats documented by the Toulouse TREND investigations from 2005 to 2007 were indeed largely populated by French people. Although they came to party, they ultimately decided to stay due to extreme left-wing political activism and in turn, attracted other French people. Hence, the investigations indicated that short-term stays (lasting from one evening to a week) were also or primarily motivated by a certain "political-recreational activism". In other words, beyond exclusively festive travel (for teknivals, free parties or rave parties), they went to Catalonia for a day demonstration followed by a free party or an evening in an okupa specifically associated with the event {Suderie 2007};{Suderie 2008}.

Traditional clubbing

In the Lorraine region, traditional clubbers are a group of techno music enthusiasts described as "happy dancing technos". While the 18-25 set more willingly go to cities in southern Belgium, near Luxembourg, for *megadancings* – techno clubs that can group 3,000 to 4,000 people, the 25-35 set more often went to Luxembourg clubs primarily selected for their music and more intimate atmosphere. The former are characterised as having abundant MDMA in powder form. The latter has more cocaine and amphetamines.

Both groups most often travel for one weekend evening (Friday or Saturday). Some stay the night if they have someplace to stay (i.e. people they know). Others return home without having slept.

Young people living near the northern border, around Lille, frequent the Belgian *megadancings* near Tournai on the weekend. In 2010, one notes the installation of buses bringing to these discotheques {Plancke et al. 2011} Some of these establishments host a mainly French customer base. The fraction of French people among those arrested for simple drugs use "in "dancing context" i.e. near these discotheques, in the district of Tournai (Belgium) is close to 70% (66.7 % in 2010)[248]. However, their number decreases in the same way as downwards of the total number of the local arrests of the same type (130 in 2007, 46 in 2010) {Plancke et al. 2011}. Here, drug deals occur in *megadancing* parking lots, where club owners are very tolerant, and sometimes participate. Regardless of whom the customer base is, the dealers are French. They buy the products in Belgium and sell them in Belgium, thereby minimising risk by coming back to France "empty-handed". These quasi professional dealers, who come from the working-class neighbourhoods of Greater Lille and operate during the week in Lille's drug dealing sites, have replaced the techno-enthusiasts substance users who sold small quantities to fund their nights out starting in the mid-2000s.

The primary international destination for Toulouse partygoers is still Barcelona and the surrounding areas. It is not uncommon for a group of young people to decide, after early drinks, to make "*a trip to Barcelona".* This process of festive migration associated with more or less regular narcotics use of varying duration - for a weekend or for a holiday period – affect people from all social backgrounds who take part in the commercial party scene. This can only be understood in reference to the symbolic codes of festive freedom described elsewhere. Strictly

[247] Moreover, some of these people decided to stay.
[248] In parallel the fraction of French users among the arrests for use in urban context decreases from 38 % in 2007 to 4 % in 2010.

speaking, festive moments seemed to take place only in nightclubs at night, i.e., before sunrise. For these groups, it was not so much about partying round the clock to a specific type of music[249] as it was about taking advantage of “holidays in Barcelona”. The activities surrounding the party-scene observed within these groups were as important as, if not more so than, the nocturnal festive moments: “going to a restaurant", "going to a museum", "going to the beach", or "shopping".

The special case of the gay party scene

The party scene proclaimed by gay men constitutes the archetypal international festive tourism surrounding techno music that developed in the 1990s.

Clubbing abroad scintillated people and evoked a recent golden age for the gay community: “*It was in 1997 and 1998, (...) I quickly made the tour. It was really incredible, from a club in Brussels to a weekend in Barcelona or London, we went to meet people… From that moment on, there was a sudden explosion in Europe, people started going to other countries, you see, to meet gay people who were also from abroad, and all of a sudden, it was like… (he rolled his eyes) and I really love to travel, and all of this was, I think it was what gays liked... As for me, it's my idea of life, to have fun, to gain optimal pleasure, and finally… Travel, fun, outings..."* (Stéphane) {Madesclaire 2010, non publié}.

The aforementioned ethnographic study of the gay party scene, conducted in 2007 and 2008, revealed the festive migrations to European or even American cities - migrations that were frequent in this group, which especially loved the party scene and illicit drugs and often had the financial resources to enable such travel. Berlin, London, Amsterdam and Brussels were the most frequently mentioned party destinations for Parisians in this framework. The people of Toulouse more often mentioned Barcelona, Sitges or Ibiza, but mentioned London and Berlin as well[250]. The majority of them mentioned a preference for these cross-border parties {Fournier et al. 2010}. Most of the motivations differed little from those mentioned by other partygoers: the limited availability of parties and festive sites, in Paris as in Toulouse, where, furthermore, these people lamented the absence of specifically gay sites[251] and an insufficiently hip party scene[252] {Suderie 2011}; the high price of partying in Paris (entry fees, alcohol and narcotics); lower drug availability, especially for those drugs that remain preferred by this French user group, such as the crystal meth (methamphetamine) found more easily in Berlin and London; the perception of greater social tolerance towards recreational drug use (Spain, England, Germany, the Netherlands, Belgium); finally, a festive atmosphere that was felt to be more convivial {Fournier et al. 2010}. Other reasons appeared, however, to be more specific, such as anonymity, especially in Toulouse: the size of the city where "everyone knows everyone" is not very conducive to the use of illicit drugs, particularly when the user has a high-level social position. The inhibition-reducing effects of certain substances may promote behaviours deemed to be negative by others in a context where using narcotics is far from being accepted by all {Suderie 2011}. Likewise, for the cities of Northern Europe, there was a perception of much higher social tolerance for homosexuality, allowing homosexual couples to conduct themselves like heterosexual couples in public {Fournier et al. 2010}.

[249] This type of partying is what was found in alternative environments.
[250] Hence, Paris and Montpellier are not cross-border destinations.
[251] There are strictly gay establishments in Paris, whereas in Toulouse, there are gay friendly places where gay men are seen as trend setters, but where young “hetero” partygoers go as well.
[252] Like the thirty- and forty-somethings of Metz, who sought more “sophisticated” music playlists in Luxembourg clubs, the gays of these age groups only attended more “specialised” music events in Toulouse, during which there was generalised recreational drug use.

It should be noted that the ethnographic observations of 2010 revealed a drop in public substance use compared to the 2007-2009 period, when public substance use reached paroxysmal levels and GHB-induced comas in gay clubs became commonplace. In 2010, there was a return to moderation and a decline in the numbers of “release parties”. The motivations behind clubbing abroad were also affected: the main reason for the trip was no longer clubbing or drug availability, but rather discovery, friends and meeting new people {Madesclaire 2010, non publié}.

12.3.3. Dance events and drugs in France for foreigners: grape harvest

In the area of Bordeaux, during the grape harvest time, the TREND system’s observers note “an Europeanization” of the public with, notably, the presence of Spanish agricultural seasonal workers in the free parties which are held in rural areas. These free events are attended by 100 to 250 people. More than techno cultural events, they are actually festive gatherings with sound systems in the open air {Rahis, AC et al. 2011},

12.3.4. Procurement abroad

The cocaine micro-trafficking study conducted in 2004 and 2005 on arrests by French law enforcement officers helped reveal the large extent of cross-border use in France. To benefit from more attractive prices, some users tended to, within increasing frequency, procure cocaine, heroin or ecstasy from wholesalers in Belgium, Holland or Spain {Gandilhon, Michel 2007}. Rotterdam and Antwerp constituted the places where this activity occurred most, but “branches” have opened in other Belgian cities, particularly Charleroi and border communities, where large French vendors store part of their merchandise before selling it {Plancke et al. 2010}. This helped users obtain their substances of choice in purer form and for half the price they would have paid on the retail market in their respective regions. Subsequently, for example, in cities like Antwerp, Gent or Bruges, the price of a gram of cocaine purchased from a semi-wholesaler was from 25 to 40 Euros, versus 60 Euros for a retail gram purchased in France {Gandilhon, Michel 2007}. This motivation was largely present in the lowest socioeconomic levels and may have led certain users to develop local traffic for personal gain {Gandilhon, Michel 2007}. In addition to drug traffickers, for whom this business was the main source of income, there was, for many users, grouped purchasing, leading to intense “small-scale” trafficking. The organisation of deals was very structured, and French buyers were welcomed as soon as they crossed the border by touters who guided them to the deal site (usually apartments) {Plancke et al. 2010}.

French living in the Region of Acquitaine (Altantic side) tend to go to Bilbao for heroin and cocaine, and to Irun for cannabis resin. Those living in the region of Toulouse get supply from Barcelona or Lerida.

The big musical events can also be a source of supply. Thus, Bordeaux’s TREND site notices that the boom festival which proceeds in Portugal is the occasion of preliminary supply travels to the Netherlands and Belgium. Moreover, it is followed by a diffusion in France of substances brought back from the festival {Rahis, AC et al. 2011}.

12.3.5. A lack of impact data

In the 1990s, it seemed that the major impact of “drug tourism” was seen in the number of overdoses. As if bearing witness to the presence of French drug addiction, half of all people who died from drug overdose in Rotterdam from 1993 to 1995 were French[253] ! Since 1995, the number of overdoses has fallen following a more systematic policy of expulsion of "drug tourists".

The compiled bibliography did not identify scientific sources estimating the impact of current cross-border drug use. It was mainly through press coverage of the field’s stakeholders that “nuisances” were mentioned, although their existence and severity could not be validated. For example, the free French daily “20 minutes” of 5 August 2011 explained the prohibitory measures taken by coffee shops against foreigners other than Belgians and Germans in Maastricht, writing: “The city wishes to reduce the problems related to drug tourism, such as traffic, disturbance of the peace and increased numbers of drug dealers on the streets..."

When examining the festive aspect of cross-border travel by young French people, it seems that, despite the absence of quantitative data, risk-taking is unsurprisingly seen as narcotics use and travel being made dangerous by speed and narcotic use.

Finally, the small-scale trafficking generated by many users who grouped together to organise trips or by users who resold placed part of the responsibility on the spread of cocaine, and then of heroin, which have become accessible to increasingly wider spheres of the population throughout the country, i.e., in smaller cities and even in rural areas {Cadet-Taïrou et al. 2010b; Gandilhon, M. et al. 2010b}.

12.4. Cross-border travel and use of drug services

It seems that treatment services available to drug users, which were more developed in the Netherlands and neighbouring countries than in France, did not motivate travel or cross-border stays for the unstable users of the 1990s living for a time in Belgium or the Netherlands, since European foreigners were a minority in these treatment structures[254]. In contrast, foreign drug-addicted prostitutes (especially French ones) tended to stay in Rotterdam for extended periods because they claimed being able to work there under better conditions and hoped to have access to the systems in place for prostitutes there {Tuteleers et al. 1998}. However, it was in the nearer cross-border area that French drug users went to get care after the development of substitution treatments.

12.4.1. Travel at the initiative of drug users

Cross-border travel solely on the drug users’ initiative generally involved French people seeking treatment in the border countries of the north and east.

[253] It can be hypothesised that, for these people, the first encounter, or one of the first encounters, with “high” quality heroin may have been fatal.

[254] For example, the statistics of a Rotterdam methadone centre show that 18% of patients registered between 1991 and 1995 (i.e., 500 to 700 patients) were of “foreign nationality” (excluding those from Surinam, Turkey, the Maghreb or the West Indies). The authors deduced from this value that only few foreign heroin addicts requested access to methadone. It was also mentioned that the Europeans who spend a long time on site are those who were the most unstable and desocialised.

France implemented its harm reduction and opioid substitution programmes later than its neighbours. In the early 1990s, this encouraged the migration of users in the north and northeast of the country towards treatments that were not very developed yet in France {Plancke et al. 2010; Panunzi-Roger et al. 2002}. Starting in 1995, methadone programmes began to develop in France beyond the few experimental spots available before this time. However, in its launch phase, the very rigorous French methadone programme remained very selective due to its low reception capacity and the rigidity of its framework: only physicians in specialised centres for drug users could initiate methadone treatment, and the conditions for entry into the programme were draconian. General practitioners could then ensure continuity of care. At the same time, in Belgium for example, methadone could be prescribed by general practitioners and there were no special regulations to limit its prescription. Nevertheless, the more unstable users slowly entered specialised French centres and the increased access to substitution treatment in France through the introduction of high dose buprenorphine (1996), which could be prescribed by general practitioners, redirected the demand for substitution treatment towards France. As of 2002, methadone could also be prescribed by hospital physicians.

Nevertheless, there is still a significant flow of French people to Belgium each month to receive methadone. The person in charge of monitoring the methadone programme in Belgium confirmed in 2008 that there were still more than 2,000 French people treated in Wallonia. These people were generally characterised by professional stability, contributing to their low visibility and the desire for discretion {Plancke et al. 2010}. According to Belgian physicians, certain patients even came from non-border areas, such as the cities of Paris or Marseille {Jeanmart 2006-2007}.

The reasons mentioned by these patients were either the French system or the treatments offered in France {Jeanmart 2006-2007; Jeanmart 2005}:

- Easier access to methadone - this can be related to a shorter distance to travel for border users due to the absence in certain French regions of nearby specialised treatment centres. Certain users mentioned the hours of operation for French centres, which are incompatible with a professional activity, as well as the waiting times for certain centres[255]. Finally, the restrictions on the prescription and dispensing of methadone in France[256] were highlighted. Physicians who talked at “meeting days” for cross-border practitioners even mentioned French physicians organising continuity of care with their Belgian colleagues so that a patient who needed to travel for an extended duration could receive a prescription for a period exceeding 15 days {Jeanmart 2006-2007}. Some Belgian substitution users were “disappointed with Subutex®” after being prescribed this drug in France {Jeanmart 2006-2007}. Finally, the search for methadone capsules, which are easier to use than the liquid form (in terms of sugar content and volumes) and have only been available in France since 2009, was also a frequent motivator.

- The search for discretion and anonymity (seeking treatment far from home, not needing to have dealings with any administration).

[255] This situation probably improved following the efforts made since the 2004 substitution treatments conference to shift the balance of HDB/methadone to methadone. However, this particular point was reported by Belgian physicians based on what the French patients tell them, and it was also mentioned by physicians as a rumour running among their patients.

[256] In France, the prescription of methadone by physicians in private practice is limited to 14 days and the drug must be dispensed within 7 days of prescription; this dispensing can be extended to 14 days if the physician indicates this in writing. During the treatment initiation period in a specialised centre, prescription and dispensing are initiated at 7 days.

- The refusal to go to specialised centres (France) to avoid stigmatisation and encountering the marginalised and violent drug addicts who tend to go to these centres. Certain users thus also avoided the psychosocial monitoring that they deemed to be unnecessary.

These regular trips to gain access to treatment have represented, until now, a costly practice for drug users who, unless they work in Belgium, are not covered by Belgian national health care and must pay for their consultation and treatment costs out of their own pockets. However, the European Union is progressing towards making it possible for each EU citizen to be reimbursed for treatment voluntarily "consumed" within the EU[257].

These trips can also put Belgian general practitioner prescribers in a difficult situation.
Although all Belgian physicians can prescribe methadone, in reality, monitoring drug users becomes the responsibility of a few physicians belonging to networks or working with treatment structures {Jeanmart 2006-2007}.

At the time when some of these physicians spoke up, some doctors working in Hainaut were following more than one hundred French patients per month, leading to back-ups. The physicians also complained that they needed to adapt their practices to patients who are not always close by or for whom they could not establish follow-up care because such patients returned to France for such treatment. Difficulties also appeared when patients needed to undergo additional examinations. In 2010, the low threshold facilities[258] and the specialized health care centres near the city of Metz point out the fact that French patients would be less and less well accepted by the Belgian doctors. They notice a progression in France of the requests for regularization of methadone treatment initiated abroad {Schleret et al. 2011},

From the viewpoint of utilising services related to drug use, the Spanish border, considered from the region of Toulouse, was very different from the north-eastern border areas. No methadone substitution programs were found there. Injection rooms, or rather, the Barcelona injection room (la Sala Baluard), was too far to be the reason for travel. Although the Toulouse partygoers did not identify the Harm Reduction measures in the commercial party scene of Barcelona, they do exist (Energy control, Somnit or Ai Laket), and it is likely that French people take advantage of them like others do. However, travel to Spain for French free parties in the mid-2000s following the *Mariani et Vaillant* amendment stripped such parties of these HR measures, since French associations could no longer legally intervene there {Suderie 2011}

Cross-border travel in search for treatment or harm reduction facilities, such as injection rooms, is also part of the framework for more institutional cross-border projects.

12.4.2. Cooperation between hospital establishments

In general, and not just within the area of drug addiction, there are agreements between hospital establishments, generally of similar size, on both sides of borders. Initiatives or even individual activism are basically at the origin of these cross-border partnerships. The treatment of drug addiction, among other fields of cooperation (oncology, dialysis, diagnostic equipment, expertise sharing), is an area that arouses interest from cross-border French hospital establishments {Mission opérationnelle transfrontalière 2001}.

[257] www.europarl.europa.eu/fr/pressroom/content/20110119IPR11941/html/Le-droit-de-se-faire-soigner-%C3%A0-l'%C3%A9tranger-des-r%C3%A8gles-plus-claires
[258] CAARUD, harm reduction centres

The report drafted by the "*Mission opérationnelle transfrontalière*" (Operational cross-border mission) in 2001 noted that hospital establishments located near the borders of Belgium, Luxembourg and Germany were much more active in this area than those located in the south of France.

Hence, the *Centre spécialisé de soins aux toxicomanes de Besançon* (the Besançon specialised drug addiction treatment centre, in the Doubs administrative department of the Franche Comté region in the east of France) and the *Fondation pour la prévention et le traitement de la toxicomanie de Neufchâtel* (the Neufchâtel foundation for the prevention and treatment of drug addiction, in Switzerland) had signed an agreement when the report was drafted by the *Mission operationnelle transfrontalière* in 2001. This agreement included first-time prescription of methadone for 3 months to drug users from the Haut-Doubs by two Swiss centres and follow-up care by a French centre. Similarly, the Sarreguemines hospital centre in the Lorraine region and the Sarrebruck methadone centre in Germany, near the crossroads of France, Germany and Luxembourg, had already established relationships to ensure better treatment for drug dependent French or German patients of the region {Mission opérationnelle transfrontalière 2001}.

12.4.3. Cooperation between associations

The partnerships that have been built across-borders between associations or professional networks seeking to adapt to user practices pertained mostly to harm prevention and reduction.

For example, five organisations working in five European regions (Wallonia, Luxembourg, Rhineland-Palatinate, Saarland and Lorraine) have joined forces within the scope of a cross-border project on preventing addiction in schools and on the party scene. For the French region of Lorraine, this means providing support to several thousands of young Lorraine inhabitants who spend their Saturday evenings in the discothèques and parties of Luxembourg or Saarland. In the same way, French Harm reduction associations Spiritek, Techno + and the Cèdre Bleu, take part to the general harm reduction system of the Dour Festival (Belgium) coordinated by Belgian association, Modus Vivendi {Plancke et al. 2011}.

Moreover, within the framework of their health and social harm reduction policy, Germany, Belgium and Luxembourg have authorised and approved structures to manage sites for injecting drugs under medical supervision, which are often integrated into emergency shelters for drug addicts. This is how the population of Moselle-Est wishing to do so has, 10 to 20 km away, access to an injection room in Sarrebruck managed by the Drogenhilfzentrum (DHZ). The population of Longwy or Thionville in France can have access to similar facilities that were opened more recently, in 2005, in Luxembourg-Ville (the Fixerstuff) or Esch-sur-Alzette.

Box 2: French users seek an injection room

The oldest example of these structures, the DHZ of Sarrebruck, is interesting to examine to gain an understanding of the cross-border impact of injection rooms. The capital of the Saare region welcomes many French people from Moselle-Est every day to work, shop or enjoy recreational activities. In addition to this traditional, cross-border economic activity, Sarrebruck is also a daily or weekly destination for many drug addicts from Moselle-Est who, in addition to having easier access to the substances they feel they need, find services provided by the DHZ in the city centre.

The DHZ is a shelter and treatment centre with a low threshold structure, like what exists in France, as well as medical and social personnel to treat and support users, housing opportunities and tools, all implemented within the context of a syringe exchange programme like that encountered in Lorraine. However, the DHZ also provides drug addicts with a dozen or so places equipped for risk-free drug injection.

According to the data provided by the DHZ, 20% of people using these measures are French people attracted to such centres to buy drugs there and sell them on the black market near the DHZ as well as to use them on site. Officially, the French public should not have access to the DHZ, which is reserved for German nationals. For all that, the authorities of the region and the city of Sarrebruck tolerate their presence, especially given the significant role of cross-border regional capital sought by this city. Nevertheless, this tolerated acceptance quickly reaches its limitations to the extent that French users cannot then integrate into the official German drug or substitution treatment system. Of the services offered by the DHZ, today we can include the intention of the Sarre authorities to soon legalise heroin distribution under medical supervision. If the project comes to fruition, the picture of cross-border users will become even more complex.

In the south, the Basque Country is also a territory where a cross-border programme to reduce the harm related to drug use in the North and South Basque Country has been created between the CSAPA BIZIA (Addictology Treatment, Support and Prevention Centre) of Bayonne (French) and the Munduko MediKuak association. An injection room was set up in Bilbao in 2003. It is funded in part by European INTERREG funds obtained through this cooperative programme.

12.5. Conclusion

The picture painted here of cross-border drug use and the treatment practices related to this use remains highly impressionistic. This is due to the absence of quantitative measurements of phenomena, as well as to the existence of areas that are very poorly documented in the French scientific and grey literature. The use of injection rooms abroad by French people is poorly documented for example; the data evoking the organisation of cross-border care networks through agreements between healthcare structures on both sides used here are already old. Without a site of the TREND observation network of the OFDT in these areas, we find little or no data - even qualitative data - on the borders with Switzerland, Italy, and the western portion of the Spanish border.

What is striking, from the French viewpoint, is still the significant dissymmetry of the drug related “exchanges” between France and its neighbours: whether regarding using or procuring substances, partying or seeking treatment, travelling mainly occurs from France to a foreign country.

Part C: Bibliography

A - Alphabetic list of all bibliographic references used

Aebi, M. and Delgrande, N. (2010b). Annual penal statistics SPACE 2. Non-custodial sanctions and measures served in 2007. Conseil de l'Europe, Strasbourg.

Afssaps, C. (2009) Oppidum, Résultats de l'enquête 21.

ASDO (2009). Evaluation qualitative des REAAP.

Bantuelle, M. and Demeulemeester, R. (Eds.) (2008) *Référentiel de bonnes pratiques. Comportements à risque et santé : agir en milieu scolaire. Programmes et stratégies efficaces,* Paris, INPES.

Barre, M.C., Pottier, M.L. and Delaitre, S. (2001). Toxicomanie, police, justice : trajectoires pénales. 192 p.

BECK, F., GUIGNARD, F., RICHARD, J.-B., TOVAR, M. and SPILKA, S. (2011). Les niveaux d'usage des drogues en France en 2010 - Exploitation des données du Baromètre santé. Tendances (76).

Beck, F., Legleye, S., Spilka, S., Briffault, X., Gautier, A., Lamboy, B.*, et al.* (2006). Les niveaux d'usage des drogues en France en 2005. Exploitation des données du Baromètre santé 2005 relatives aux pratiques d'usage de substances psychoactives en population adulte. Tendances (48) 6 p.

Bello, P.-Y., Cadet-Taïrou, A. and Halfen, S. (2010). L'état de santé des usagers problématiques". Costes, J.M., Les usages de drogues en France depuis, 1999. OFDT

Bello, P.Y. (1998). Estimations locales de la prévalence de la toxicomanie : rapport final. 104 p.

Bello, P.Y., Toufik, A., Gandilhon, M. and Evrard, I. (2005). Phénomènes émergents liés aux drogues en 2004. Sixième rapport national du dispositif TREND. 176 p.

Bello, P.Y., Toufik, A., Gandilhon, M. and Giraudon, I. (2004). Phénomènes émergents liés aux drogues en 2003. Cinquième rapport national du dispositif TREND. 2-11-094938-4 271 p.

Ben Diane, M.-K., Rotily, M. and Delorme, C. (2001). Vulnérabilité de la population carcérale française face à l'infection VIH et aux hépatites. In: JOUBERT M, C. P., FACY F, RINGA V. (Ed.) Précarisation, risque et santé. Inserm, Paris.

Ben Lakhdar, C. (2007). Le trafic de cannabis en France. Estimation des gains des dealers afin d'apprécier le potentiel de blanchiment. 21.

Bérard, J. and Chantraine, G. (2008). 80 000 détenus en 2017 ? Réforme et dérive de l'institution pénitentiaire. Paris.

Bergeron, H. (1999a). L'Etat et la toxicomanie : histoire d'une singularité française. PUF, Paris.

Bergeron, H. (1999b). L'état et la toxicomanie : histoire d'une singularité française. PUF, Paris.

Bonnevie, M.-C. and Wcislo, M. (1996). Enquête "un jour donné" en milieu pénitentiaire sur l'"infection par le VIH. Principaux résultats année 1996. ministère de la Justice, ministère du Travail et des Affaires sociales, Paris.

Bouhnik, P. and Touzé, S. (1996). Héroïne, sida, prison, système de vie et rapport aux risques des usagers d'héroïne incarcérés. RESSCOM, ANRS, Paris.

Brillet, E. (2009). La prise en charge des conduites addictives en milieu carcéral : politiques et éthique. Archives de la police criminelle 2009/1 (31) 107-143.

Brouard, C. and et al. (2009). Evolution du dépistage de l'hépatite C en France à partir des système de surveillance Rena-VHC et des pôles de référence, 200-2007. Surveillance et traitement des hépatites B et C en France : bilan et perspectives). BEH (20-21) 199-204.

Cadet-Taïrou, A. and Cholley, D. (2004a). Approche régionale de la substitution aux opiacés à travers 13 sites français, 1999-2002, Pratiques et disparités régionales. CNAMTS / OFDT, Paris.
Cadet-Taïrou, A., Costes, J.M., Bello, P.Y. and Palle, C. (2004b). Quel est le nombre d'usagers d'opiacés sous BHD ? Les traitements de substitution en France : résultats récents 2004. Tendances (37) 1-2.
Cadet-Taîrou, A., Gandhilhon, M., Toufik, A. and Evrard, I. (2008). Huitième rapport national du dispositif TREND. Tendances (58) 1-4.
Cadet-Taïrou, A., Gandilhon, M., Lahaie, E., Chalumeau, M., Coquelin, A. and Toufik, A. (2010a). Drogues et usages de drogues en France. Etat des lieux et tendances récentes 2007-2009. Neuvième édition du rapport national du dispositif TREND. 280.
Cadet-Taïrou, A., Gandilhon, M., LahaieE, E., Chalumeau, M., Coquelin, A. and Toufik, A. (2010b). Drogues et usages de drogues en France ; état des lieux et tendances récentes 2007-2009. Neuvième édition du rapport national du dispositif TREND. OFDT, Saint-Denis.
Cadet-Taïrou, A., Gandilhon, M., Toufik, A. and Evrard, I. (2008). Phénomènes émergents liés aux drogues en 2006. Huitième rapport national du dispositif TREND. 189.
Cadet-Tairou, A., Reynaud-Maurupt, C., Costes, J.M. and Palle, C. (2010). Quantitative surveys in hard-to -reach populations: the experience of the “Observatoire français des drogues et des toxicomanies”. Methodological innovations on line.
Canarelli, T. and Coquelin, A. (2009). Données récentes relatives aux traitements de substitution aux opiacés. Premiers résultats d'une analyse de données de remboursement concernant plus de 4 500 patients en 2006 et 2007. Tendances (65) 1-6.
Caumon, M.-J., Bloch-Lainé, J.-F., Lowenstein, W. and Morel, A. (2002). L'accès à la méthadone en France. Rapport réalisé à la demande du ministre de la Santé.
Chalumeau, M. (2010). Les Caarud En 2008, Analyse Nationale Des Rapports D'activitÉ Asa-Caarud. 21.
Chantraine, G. and Mary, P. (2006). Introduction. Mutations pénales, nouvelles perspectives d'analyse. Déviance et société 30 (2006/3) 267-271.
Chauvenet, A., Faugeron, C. and Combessie, P. (1996). Approches de la prison. De Boeck-Université/Montréal, Presses de l'Université de Montréal/Ottawa, Bruxelles.
Chevallier, E. (2001). Estimations locales de la prévalence de l'usage d'opiacés et cocaïne en France : une étude multicentrique à Lens, Lille, Marseille, Nice et Toulouse. 112 p.
Coldefy, M., Faure, P. and Pietro, N. La santé mentale et le suivi psychiatrique des détenus accueillis par les services médico-psychologiques régionaux. DREES, Etudes et résultats (181).
Combessie, P. (2004). Sociologie de la prison. La Découverte, Paris.
Commission consultative des droits de l'homme, C. (2006). Etude sur l'accès aux soins des personnes détenues. Propositions. Résolution adoptée par l'Assemblée plénière le 19 janvier 2006.
Conseil national du sida, C. (2009). Note valant avis l'expérimentation des programmes d'échange de seringues dans les établissements pénitentiaires, 10 septembre 2009.
Contrôleur général des lieux de privation de liberté, C. (2011). Rapport d'activité 2010. Dalloz, Paris.
Coppel, A. (2002). Peut-on civiliser les drogues ? De la guerre à la drogue à la réduction des risques. La Découverte, Paris.
Costes, J.M. (1995). "une estimation de prévalence". Drogues et toxicomanies : indicateurs et tendances. Edition 1995. OFDT, Paris.
Costes, J.M., Cadet-Taïrou, A., Thirion, X., Bello, P.Y. and Palle, C. (2004). Du point de vue de la santé publique, quels sont les résultats positif que l'on peut attribuer aux traitements de substitution aux opiacés et quels sont leurs effets défavorables ou non souhaitables ?

Alcoologie et Addictologie 26 (4 (Suppl.), Texte des experts de la conférence de consensus, Lyon, 23 et 24 juin 2004) 61S-74S.
Costes, J.M., Vaissade, L., Colasante, E., Palle, C., Legleye, S., Janssen, E.*, et al.* (2009). Prévalence de l'usage problématique de drogues en France - estimations 2006. 29.
Cour des comptes (2010). Rapport public annuel 2010.
Crofts, N. (1994). Hepatitis C infection among injecting drug users: where do we go from here? Drug Alcohol Review (13(3)) 235-237.
Danet, J. (2008). Cinq ans de frénésie pénale. In: MUCCHIELLI, L. (Ed.) La frénésie sécuritaire. La Découverte, Paris.
Darke, S., Kaye, S. and Finlay-Jones, R. (1998). Drug use and injection risk-taking among prison methadone maintenance patients. Addiction (93(8)) 1169-1175.
De Bruyn, F. and Cognet, J.-C. (2010). Usage et trafic de produits stupéfiants des personnes prises en charge par l'Administration pénitentiaire. In: BAUER, A. (Ed.) La criminalité en France. Rapport de l'Observatoire national de la délinquance et des réponses pénales (ONDRP). CNRS, Paris.
Décarpes, P. (2004). Topologie d'une prison médiatique. Champ pénal, Nouvelle revue internationale de criminologie vol. 1.
Delfraissy, J.-F. (2002). Prise en charge des personnes infectées par le VIH. Rapport 2002. Recommandations du groupe d'experts In: DELFRAISSY, J.-F. (Ed.) Flammarion, Paris.
Desco Mildt (2006). Prévention des conduites addictives. Guide d'intervention en milieu scolaire.
DGESCO-MILDT (2010). Prévention des conduites addictives. Guide d'intervention en milieu scolaire. CNDP, Paris.
Direction de l'hospitalisation et de l'organisation des soins (DHOS) (2004). Enquête un jour donné sur les personnes détenues atteintes par le VIH et le VHC en milieu pénitentiaire : résultats de l'enquête de juin 2003. Direction de l'hospitalisation et de l'organisation des soins (DHOS).
DRASS Ile-de-France (DRASSIF) (2007). VIH/IST/hépatites en milieu carcéral en Ile-de-France. Etat des lieux et propositions, septembre 2007.
Drees (2005). Enquête sur la santé des entrants. 12.
Duplessy-Garson, C. (2007). Résultats de l'enquête nationale 2007 sur les automates de réduction des risques.
Escots, S. and Fahet, G. (2004). Usages non substitutifs de la Buprénorphine haut dosage investigation menée en France en 2002-2003. Graphiti/ORSMIP/OFDT, Paris.
Facy, F., Laurent, F., Poulain, J.P., Chevry, P. and Bienvenu, B. (1995). Toxicomanes incarcérés vus dans les antennes toxicomanie : enquête épidémiologique 1994. 44 p.
Fernandez, F. (2010). Emprises. Drogues, errance, prison : figures d'une expérience totale. Larcier, Bruxelles.
Fournier, S. and Escots, S. (Eds.) (2010) *Homosexualité masculine et usage de substances psychoactives en contextes festifs gais,* Saint-Denis.
Gandilhon, M. (2007). Le petit trafic de cocaïne en France. Tendances 53 4.
Gandilhon, M. and Hoareau, E. (2010a). Les évolutions du petit trafic d'héroine et de cocaïne en France. In: OFDT (Ed.) Les usages de drogues illicites en France depuis 1999 vus au travers du dispositif TREND. Saint-Denis.
Gandilhon, M. and Hoareau, E. (2010b). Les évolutions du petit trafic d'héroïne et de cocaïne en France. Costes, J.M., Les usages de drogues en France depuis, 1999. OFDT
Gautier, A. (2011). Baromètre santé médecins généralistes 2009. Inpes, St Denis.
Gautier, A. and et al. (2005). Baromètre santé médecins/pharmaciens 2003. 271.
Gentilini, M. (1996). Infection à VIH, hépatites, toxicomanies dans les établissements pénitentiaires et état d'avancement de l'application de la loi du 18 janvier 1994. Rapport au garde des Sceaux et au secrétaire d'Etat à la Santé.

Girard, G. and Boscher, G. (2010). L'ecstasy, de l'engouement à la 'ringardisation'. Costes, J.M., Les usages de drogues en France depuis, 1999. OFDT

Hagan, H. and et al. (2003). Does bleach disinfection of syringes help prevent hepatitis C virus transmission? Epidemiology (14) 628-629.

Harding-Pink, D. (1990). Mortality following release from prison. Med. Sci. Law Vol. 30 (n° 1).

Haut comité de la santé publique (HCSP) (1993). Santé en milieu carcéral : rapport sur l'amélioration de la prise en charge sanitaire des détenus. Ecole nationale de la santé publique, Rennes.

Haut comité de la santé publique (HCSP) (2004). La santé en prison. Actualité dossier santé publique (adsp) (n° 44).

Haute autorité de santé (HAS) (2009). Dépistage de l'infection par le VIH en France : stratégies et dispositif de dépistage. Recommandations en santé publique.

Hyest, J.-J. and Cabanel, G.-P. (2000). Rapport de la commission d'enquête sur les conditions de détention dans les établissements pénitentiaires en France. Sénat.

Insee (2002). L'histoire familiale des hommes détenus. Synthèse (n° 59).

Inspection général des affaires sociales (IGAS) and Inspection générale des services judiciaires (IGSJ) (2001). L'organisation des soins aux détenus. Rapport d'évaluation. La Documentation française.

Institut national de police scientifique (2010). Statistiques 2009. 41.

Institut national de veille sanitaire (InVS), Caisse nationale de l'assurance maladie et des travailleurs salariés (CNAMTS) and Centre technique d'appui et de formation des centre d'examents de santé (CTAFCES) (2005). Estimation du taux de prévalence des anticorps anti-VHC et des marqueurs du virus de l'hépatite B chez les assurés sociaux du régime général de France métropolitaine, 2003-2004. InVS, Saint-Maurice.

Janssen, E. (2010). Estimating the levels of acute drug-related deaths in France, 2001–2002: A simple technique to measure bias in overdoses recording. Journal of Substance Use 15 (2) 105-112.

Jauffret-Roustide, M., Couturier, E., Le Strat, Y., Barin, F., Emmanuelli, J., Semaille, C., *et al.* (2006). Estimation de la séroprévalence du VIH et du VHC et profils des usagers de drogues en France, étude InVS-ANRS Coquelicot, 2004. BEH - Bulletin Epidémiologique Hebdomadaire (33) 244-247.

Jauffret-Roustide, M. and et al. (2009). A national cross-sectional study among drug-users in France : epidemiology of HCV and highlight on practical and statistical aspects of the design. BMC Infectious diseases 9 (113).

Jean, J.P. (1996). Rapport sur l'amélioration de la prise en charge des toxicomanes incarcérés et sur la lutte contre l'introduction de drogues en prison, rapport du groupe de travail constitué à la demande du Garde des Sceaux, présidé par Jean-Paul Jean, magistrat et inspecteur des services judiciaires. Paris.

Jeanmart, C. (2005). Des usagers, des drogues et des familles. Analyse de trajectoire de recours en territoires transfrontaliers franco-belge. CNRS-Clersé-IFRESI, Lille.

Jeanmart, C. (2006-2007). Médecins généralistes et usagers de drogues. Pour une analyse des pratiques en territoire transfrontalier franco-belge. ALTO-SSMG, G&T59-62, CLERSE.

Joubert, M. and et al. (1995). Trafics de drogues et Modes de vie, ENSP,(http://www.bdsp.ehesp.fr/base/scripts/ShowA.bs?bqRef=117880). (N°4 p:1-29).

Kanoui-Mebazaa, V. and Valantin, M.-A. (2007). La santé en prison. Les tribunes de la santé 2007/4 (17) 97-103.

Kensey, A. and Cirba, L. (1989). Les toxicomanes incarcérés. Ministère de la Justice-Direction de l'administration pénitentiaire, Paris.

Khosrokhavar, F. (2004). L'islam dans les prisons. Editions Balland, Paris.

Kopp, P. and Fenoglio, P. (2000). Le coût social des drogues licites (alcool et tabac) et illicites en France. 277 p.

Kopp, P. and Fenoglio, P. (2004). Coût et bénéfices économiques des drogues. 121 p.
Kopp, P. and Fenoglio, P. (2006). Le coût des traitements et de la mise en œuvre de la loi dans le domaine des drogues. (Rapport) 584 p.
Kopp, P. and Palle, C. (1998). Vers l'analyse du coût des drogues illégales. Un essai de mesure du coût de la politique publique de la drogue et quelques réflexions sur la mesure des autres coûts. 80 p.
LAHAIE, E. (2011). Enquête 2009 SINTES sur la composition des produits de synthèse. OFDT, Saint Denis.
Lahaie, E. and Cadet-Taîrou, A. (2009) The SINTES monitoring system, OFDT Contribution to the National, Alert Unit in France. Lisbon.
Leavitt, S.B., Shinderman, M., Maxwell, S., Eap, C. and al., e. (2000). When "enough" is not enough: new perspectives on optimal methadone maintenance dose. The Mount Sinai Journal of Medicine vol. 67 (n° 5 & 6) 404-411.
Lebeau, B. (1997). La réduction des risques et l'esprit des lois. Psychotropes - Revue internationale des toxicomanies (4).
Lecerf, J.-R. (2009). L'administration pénitentiaire face au risque suicidaire. Avis n° 104 (2008-2009) fait au nom de la commission des lois, déposé le 20 novembre 2008 sur le projet de loi des finances 2009. Sénat.
Lechien, M.-H. (2001). L'impensé d'une réforme pénitentiaire. Actes de la recherche en sciences sociales (n° 136-137).
Lecomte, D., Hatton, F., Michel, L. and Le Toullec, A. (1994). Décès par usage de stupéfiant en Ile-de-France. BEH - Bulletin Epidémiologique Hebdomadaire (35) 159-161.
Legleye, S., Le Nézet, O., Spilka, S. and Beck, F. (2008). Les usages de drogues des adolescents et des jeunes adultes entre 2000 et 2005, France / Drug use among adolescents and young adults between 2000 and 2005, France. BEH - Bulletin Epidémiologique Hebdomadaire (13) 89-92.
Lepère, B., Gourarier, L., Sanchez, M., Adda, C., Peyret, E., Nordmann, F.*, et al.* (2001). Reduction in the number of lethal heroin overdoses in France since 1994. Focus on substitution treatments. Annales de Médecine Interne 152 (suppl. n°3) 1S5-1S12.
Levasseur, L., Marzo, J.N., Ross, N. and and Blatier, C. (2002). Fréquence des réincarcérations dans une même maison d'arrêt : rôle des traitements de substitution. Etude rétrospective préliminaire. Annales de Médecine Interne . 153 (Suppl 3) 1S14-11S19.
Madesclaire, T. (2010, non publié). Première et deuxième notes de synthèse sur les consommations de substances psychoactives en contextes gais parisiens - observations ethnographiques. Association Charonne / OFDT, Paris.
Maguet, O. and Calderon, C. (2010). Insertion par l'emploi des usagers de drogues. 56.
Marchetti, A.-M. (2001). La France incarcérée. Etudes Tome 395 (9) 177-185.
Maremmani, I. and et al. (2000). Methadone dose and retention during treatment of heroin addicts with axis I psychiatric comorbidity. Journal of Addictive Diseases vol. 19(2) 29-41.
Marzo, J.N., Rotily, M., Meroueh, F., Varastet, M., Hunault, C., Obradovic, I.*, et al.* (2009a). Maintenance therapy and 3-year outcomes of opioid-dependent prisoners: a prospective study in France (2003-2006). Addiction 104(7) 1233-1240.
Marzo, J.N., Rotily, M., Meroueh, F., Varastet, M., Hunault, C., Obradovic, I.*, et al.* (2009b). Maintenance therapy and 3-year outcomes of opioid-dependent prisoners: a prospective study in France (2003-2006). Addiction 104 1233-1240.
Merle, S. and Vallart, M. (2010). Martinique, Guyane : les spécificités de l'usage ultra-marin. Costes, J.M., Les usages de drogues en France depuis, 1999. OFDT
Mermaz, L. and Floch, J. (2000). Rapport fait au nom de la Commission d'enquête sur la situation dans les prisons françaises. Tome I : rapport. Tome II : auditions. Assemblée nationale.

Michel, L., Carrieri, P. and Wodak, A. (2008). Preventives measures and equity of access to care for French prison inmates: still limited knowledge, but urgent need for action. Harm Reduction Journal (5:17).
Michel, L., Jauffret-Roustide, M., Blanche, J., Maguet, O., Calderon, C., Cohen, J*., et al.* (2011a). Limited access to HIV prevention in French prisons (ANRS PRI2DE): implications for public health and drug policy. BMC Public Health.
Michel, L., Jauffret-Roustide, M., Blanche, J., Maguet, O., Calderon, C., Cohen, J*., et al.* (2011b). Prévention du risque infectieux dans les prisons françaises. L'inventaire ANRS-PRI2DE 2009. Bulletin épidémiologique hebdomadaire (n° 39/2011).
Michel, L. and Maguet, O. (2003) L'organisation des soins en matière de traitements de substitution en milieu carcéral. Rapport pour la commission nationale consultative des traitements de substitution.
Michel, L. and Maguet, O. (2005). Traitements de substitution en milieu carcéral : guide des bonnes pratiques. L'Encéphale 31 (cahier 1) 92-97.
Michel, L. and Maguet, O. (2010). Réduction des risques infectieux chez les usagers de drogues. INSERM, expertise collective.
Mildt (2008). Plan gouvernemental de lutte contre les drogues et les toxicomanies 2008-2011. 111.
Ministère de l'Intérieur (2006). Bilan du comportement des usagers de la route, année. 77 p.
Ministère de la Justice (2010). Les chiffres clés de l'administration pénitentiaire 2010. DAP/Ministère de la Justice.
Ministere de la Sante et des Solidarités (2006). La prise en charge et la prévention des addictions : plan 2007-2011. 19.
Ministère de la Santé et des Sports and Ministère de la Justice et des libertés (2010). Plan d'actions stratégiques 2010-2014. Politique de santé pour les personnes placées sous main de justice. Ministère de la Santé et des Sports/Ministère de la jJustice et des libertés,.
Mission interministérielle de lutte contre la drogue et la toxicomanie (2000). Plan triennal de lutte contre la drogue et de prévention des dépendances (1999-2001). Documentation française, Paris.
Mission interministérielle de lutte contre la drogue et la toxicomanie (2004). Plan gouvernemental de lutte contre les drogues illicites, le tabac et l'alcool : 2004-2005-2006-2007-2008. 76 p.
Mission opérationnelle transfrontalière (2001). Etat des leiux de la coopération transfrontalière sanitaire. Editions de l'Ecole nationale de la santé publique, RENNES.
Morfini, H. and Feuillerat, Y. (2001/2004). Enquête sur les traitements de substitution en milieu pénitentiaire. Ministère de la Santé.
Mouquet and et al. (1999). La santé des entrants en prison: un cumul de factures de risque. DRESS Etudes et résultats 4 (10).
Mouquet and et al. (2005). La santé des personnes entrées en prison en 2003. DRESS Etudes et résultats.
Obradovic, I. (2004). Addictions en milieu carcéral. Enquête sur la prise en charge sanitaire et sociale des personnes détenues présentant une dépendance aux produits licites ou illicites ou ayant une consommation abusive, 2003. 2-11-094940-6 100 p.
Obradovic, I. (2006). Premier bilan des « consultations cannabis ». Tendances (50) 6 p.
Obradovic, I. (2009). Caractéristiques du public reçu dans les Consultations jeunes consommateurs pour un problème d'addiction, 2005-2007. BEH - Bulletin Epidémiologique Hebdomadaire (30) 332-336.
Obradovic, I. (2010). La réponse pénale à l'usage de stupéfiants, OFDT. Tendances (n° 72).
Obradovic, I. and Canarelli, T. (2008a). Initialisation de traitements par méthadone en milieu hospitalier et en milieu pénitentiaire. Analyse des pratiques médicales depuis la mise en

place de la circulaire du 30 janvier 2002 relative à la primoprescription de méthadone par les médecins exerçant en établissement de santé. OFDT, Saint-Denis.
Obradovic, I. and Canarelli, T. (2008b). Primoprescription de méthadone en établissement de santé. Tendances (60) 1-4.
Observatoire français des drogues et des, t. (2002). Drogues et dépendances : indicateurs et tendances 2002. OFDT, Paris.
Observatoire français des drogues et des toxicomanies (1999). Drogues et toxicomanies : indicateurs et tendances. Edition 1999. OFDT, Paris.
Observatoire français des drogues et des toxicomanies (2009). Drogues, chiffres clés. (Brochure) 6 p.
Observatoire international des prisons (2000). Prisons : état des lieux. L'Esprit frappeur, Paris.
Observatoire international des prisons (2003). Les conditions de détention en France. Rapport 2003. La Découverte, Paris.
Observatoire International des prisons (2005). Rapport annuel. Les conditions de détention en France. 285.
Ocrtis (2009). Usage et trafic des produits stupéfiants en France en 2008.
Ocrtis (2011). Usage et trafic des produits stupéfiants en France en 2010. Ministère de l'Intérieur, Direction générale de la police nationale, Direction centrale de la police judiciaire.
Ofdt (2000). Les consommations transfrontalières. Tendances récentes, rapport TREND. PARIS.
OMS, ONUDC and ONUSIDA (2007). Interventions to Address HIV/AIDS in Prisons: Needle and Syringe Programmes and Décontamination Strategies.
OMS (WHO) (2005). Effectiveness of sterile and syringe programming in reducing HIV/AIDS among injecting drug users. Evidence for Action. Technical papers. World Health Organization.
ORS PACA (1998). Réduction des risques de l'infection à VIH et des hépatites en milieu carcéral : prévalence des pratiques à risques et analyse des contraintes et de la faisabilité des programmes de réduction des risques en milieu carcéral. Rapport final. ORS PACA.
Palle, C. and Vaissade, L. (2007). Premiers résultats nationaux de l'enquête RECAP. Les personnes prises en charge dans les CSST et les CCAA en 2005. Tendances (54) 1-6.
Panunzi-Roger, N. and Castel, B. (2002). Les soins de toxicomanie en zone frontalière : situation dans le Hainaut et le département du Nord. Psychotropes 7 (3-4) 102-125.
Parquet, P. (1997). Pour une politique de prévention en matière de comportements de consommation de substances psychoactives. CFES, Vanves.
Pauly, V., Frauger, E., Rouby, F., Sirere, S., Monier, S., Pauler, C.*, et al.* (2010). Evaluation des conduites addictives chez les personnes entrant en milieu pénitentiaire à partir du programme OPPIDUM du réseau des centres d'évaluation et d'information sur la pharmacodépendance (CEIP). L'Encéphale (n° 36) 15-28.
Plancke, L., Lose, S. and Wallart, S. (2011). Usages de drogues sur le site de Lille en 2010. Etat des lieux et endances récentes Le Cèdre Bleu / OFDT.
Plancke, L. and Schleret, Y. (2010). Les déplacements transfrontaliers liés aux drogues dans le Nord et l'Est de la France. In: COSTES JM (DIR) (Ed.) Les usages de drogues illcites en France depuis 1999, vus à travers le dispositif TREND. OFDT, Saint-Denis.
Portelli, S. (2010). Les alternatives à la prison. Pouvoirs 4 (n° 135) 15-28.
Pradier, P. (1999). La gestion de la santé dans les établissements du programme 13 000 : évaluation et perspectives. Administration pénitentiaire, Paris.
Prudhomme, J., Ben Diane, M.K. and Rotily, M. (2001). Evaluation des unités pour sortants (UPS). 117 p.

Prudhomme, J., Verger, P. and Rotily, M. (2003). Fresnes mortalité des sortants : étude rétrospective de la mortalité des sortants de la maison d'arrêt de Fresnes. Second volet de l'évaluation des unités pour sortants (UPS). 60 p.

Rahis, A., Charmetant, A. and Delile, J. (2011). Bordeaux, rapport TREND 2010. CEID / OFDT, Bordeaux.

Rahis, A.C., Cadet-Taïrou, A. and Delile, J.M. (2010). Les nouveaux visages de la marginalité, in Les usages de drogues illicites en France depuis 1999. In: OFDT (Ed.) Costes, J.M., Les usages de drogues en France depuis, 1999. OFDT, Saint-Denis.

Revue française des affaires sociales (1997). La santé en prison : un enjeu de santé publique. Revue française des affaires sociales (RFAS) (numéro spécial).

Reynaud-Maurupt, C. (2006). Usages contemporains de plantes et champignons hallucinogènes - Une enquête qualitative exploratoire conduite en France. 160 p.

Reynaud-Maurupt, C., Chaker, S., Claverie, O., Monzel, M., Moreau, C., Evrard, I., *et al.* (2007). Pratiques et opinions liées aux usages des substances psychoactives dans l'espace festif "musiques électroniques". 143 p.

Richard, D., Senon, J.L. and Valleur, M. (2004). Dictionnaire des drogues et des dépendances. Larousse, Paris.

Rotily, M. (1997). L'infection à VIH en milieu carcéral. ORS, Marseille.

Rotily, M. (2000). Stratégies de réduction des risques en milieu carcéral.

Rouillon, F., Duburcq, A., Fagnani, F. and Falissard, B. (2007). Etude épidémiologique sur la santé mentale des personnes détenues en prison conduite entre 2003 et 2004. Inserm.

Sanchez, G. (2006). Le traitement du VHC en prison : le foie, une bombe sous les barreaux. Journal du sida (n° 185) 9-12.

Sansfacon, D., Barbechat, O., Lopez, D. and Valade, C. (2005). Drogues et dommages sociaux. Revue de littérature internationale. 456 p.

Schleret, Y., Monzel, M. and Romain, O. (2011). Phénomènes émergents liés aux drogues en 2010, Tendances récentes sur le site de Metz. CMSEA / ORSAS/ OFDT, Metz.

Seaman, S.-R., Brettle, R.-P. and Gore, S. (1998). Mortality from overdose among injecting drug users recently released from prison: database linkage study. British Medical Journal 316 426-428.

sida, C.n.d. (2011). Note valant avis sur l'impact des politiques relatives aux drogues illicites sur la réduction des risques infectieux, 20 janvier 2011.

social, C.é.e. (2005). Les conditions de la réinsertion socio-professionnelle des détenus en France. Rapport présenté par Decisier D. Journal officiel.

Stankoff, S. and Dherot, J. (2000). Rapport de la mission santé-justice sur la réduction des risques de transmission du VIH et des hépatites en milieu carcéral.

Suderie, G. (2006). Phénomènes émergents liés aux drogues, tendances récentes sur les usages de drogues à Toulouse en 2007. Graphiti - CIRDD Midi-Pyrénée / OFDT, Toulouse.

Suderie, G. (2007). Phénomènes émergents liés aux drogues, tendances récentes sur les usages de drogues à Toulouse en 2006. Graphiti - CIRDD Midi-Pyrénée / OFDT, Toulouse.

Suderie, G. (2008). Phénomènes émergents liés aux drogues, tendances récentes sur les usages de drogues à Toulouse en 2007. Graphiti - CIRDD Midi-Pyrénée / OFDT, Toulouse.

Suderie, G. (2011) Phénomènes transfrontaliers concernant l'usage et l'achat de drogues et l'usage de dispositifs de soins ou de réduction des risques ; Contribution du Pôle TREND de Toulouse. In: NOTE À L'OFDT (Ed.) Toulouse.

Suderie, G., Monzel, M. and Hoareau, E. (2010). Evolution de la scène techno et des usages en son sein. In: OFDT (Ed.) Les usages de drogues illicites en France depuis 1999. Saint-Denis.

Sudérie, G., Monzel, M. and Hoareau, E. (2010). Evolution de la scène techno et des usages en son sein. In: OFDT (Ed.) Costes, J.M., Les usages de drogues en France depuis, 1999. OFDT, Saint-Denis.

Timbart, O. (2011). 20 ans de condamnations pour crimes et délits. Infostat Justice (n° 114).

Toufik, A., Cadet-Tairou, A., Janssen, E. and Gandhilhon, M. (2008). Profils, pratiques des usagers de drogues - ENa-CAARUD. Résultats de l'enquête nationale 2006 réalisée auprès des « usagers » des Centres d'accueil et d'accompagnement à la réduction des risques. 48.

Toufik, A., Escots, S. and A, C.T. (2010). La transformation des usages de drogues liées à la diffusion des traitements de substitution aux opiacés. Costes, J.M., Les usages de drogues en France depuis, 1999. OFDT

Toufik, A., Legleye, S. and Gandilhon, M. (2007). Approvisionnement et prix. In: COSTES, J. M. (Ed.) Cannabis, données essentielles. OFDT, St Denis.

Tournier, P.-V. (2002). Prisons d'Europe, inflation carcérale et surpeuplement. CESDIP, Paris.

Tournier, P.-V. (2010). L'état des prisons françaises. Pouvoirs 2010/4 (n° 135) 93-108.

Tuteleers, P. and Hebberecht, P. (1998). Drug related cross-border trafic patterns. European forum for urban safety.

Uriely, N. and Belhassen, Y. (2006). Drugs and risk-taking in tourism. Annals of Tourism Research 33 (2) 339-359.

Vaillant, D., Raimbourg, D. and Lepetit, A. (2011). Rapport du groupe de travail parlementaire de députés SRC : Légalisation contrôlée du cannabis. Assemblée nationale, Paris.

Vaissade, L. and Legleye, S. (2009). Capture-recapture estimates of the local prevalence of problem drug use in six French cities. European Journal of Public Health 19 (1) 32-37.

Vasseur, V. (2000). Médecin-chef à la prison de la Santé. Le Cherche Midi éditeur, Paris.

Verger, P., Rotily, M., Prudhomme, J. and Bird, S. (2003). High mortality rates among inmates during the year following their discharge from a French prison. Journal of Forensic Science vol. 48 (n° 3).

Weinberger, D. (2011). Réseaux criminels et cannabis indoor en Europe : maintenant la France ? Drogues, enjeux internationaux (1).

Yeni, P., et al., (2008). Prise en charge médicale des personnes infectées par le VIH. Recommandations du groupe d'experts. Flammarion, Paris.

B - Alphabetic list of relevant databases available on Internet

Bdsp. Banque de données en santé publique:
http://www.bdsp.ehesp.fr/Base/QbeA.asp.

Ireb (Institut de recherches scientifiques sur les boissons). Base de données bibliographiques:
http://www.ireb.com/html/form_fr.htm.

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.

Ofdt. ILIAD - Indicateurs locaux pour l'information sur les addictions:
http://www.ofdt.fr/ofdtdev/live/donneesloc/indic.html.

Ofdt. Répertoire des sources statistiques:
http://www.ofdt.fr/ofdtdev/live/donneesnat/sources.html.

Ofdt. Séries statistiques:
http://www.ofdt.fr/ofdtdev/live/donneesnat/series.html.

Ofdt. SIMCCA. Système d'information mensuel sur les consultations cannabis:
http://www.ofdt.fr/ofdtdev/live/donneesnat/simcca.html.

C - Alphabetic list of relevant Internet adresses

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 (Autosupport 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

Appendices

Appendix I - List of tables, graphs and maps

List of graphs

List of maps

Appendix II - List of full references of laws in original language

LOIS

Appendix III - List of abbreviations

AAH	Adult disability allowance
AFSSAPS	French health products safety agency
AGRASC	Agency for managing and recovering seized and confiscated assets
AMELI	National file of the National Health Insurance
AMM	Marketing authorisation
ANAES	National agency for health accreditation and evaluation
ANITeA	National association of drug abuse and addictology workers
ANPAA	National Association for the prevention of alcoholism and addiction
ANRS	National AIDS research agency
ARS	Health regional agency
ASIP	Agency for shared information systems
ASUD	Drug users' self-support association
BEP	Vocational diploma
BHD	High dosage buprenorphine (HDB)
CAARUD	Harm reduction support centres for drug users
CAMPS	Early Medico social Services Centres
CAP	Vocational training certificate
CAST	Cannabis abuse screening test
CCAA	Outpatient Alcoholism Treatment Centres
CCNE	National ethics advisory commitee
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
CHSCT	Committees on hygiene, safety and working conditions
CIDDIST	Information, screening and diagnosis centre on sexually transmitted deseases
CIFAD	Interministerial training centre for the fight against drugs
CIM	International classification of diseases (ICD)
CIRDD	Centres for information and resources on drugs and dependencies
CJC	Clinics for young users
CJN	National police (criminal) records
CLS	Local security contracts
CMU	Universal health cover
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
CPT	Commitee for the prevention of torture
CRIPS	Regional AIDS information and prevention centre
CSAPA	Addictology treatment, support and prevention centres
CSST	Specialised centres for drug addicts
CT	Therapeutic community
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)
DGCS	General directorate for social cohesion
DGS	General Health department (Ministry of health and Welfare)
DH	Hospitals directorate (Ministry for Health and Welfare)
DHOS	Directorate of hospital care and treatment organisation
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
DPJJ	Directorate for the youth protection service
DPT	Transverse policy document
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 Psychoactive 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	National Drug-Related Offence's Record (OCRTIS, Ministry of Interior)
FNES	National Federation of Health Education Committees
FNPEIS	French national fund for prevention, education and health information

FRAD	Anti-drug shift trainers (Gendarmerie)
GECA	Group of Studies on Pregnancy and Addictions
GIP	Public interest group
HAS	National authority for health
HBSC	Health behaviour in school-aged children
HDB	high dose buprenorphine
HCSP	National committee for public health
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 Institute for Public Health Surveillance
IST	Sexually transmitted infections
IT	Treatment order
IUFM	University institutes for teacher training
IVG	Termination of pregnancy
JAP	Judge responsible for the execution of sentences
JAPD	Day of defence preparation
JDC	Defence and citizenship day
JO	Journal Officiel
LFI	Governmental budgetary law
LFSS	Social security funding law
LOLF	Organic Law Pertaining to Finance Laws
LSQ	French Daily Security Act
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
NGO	Non-governmental organisation
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
ONDAM	National objective for health insurance expenditure
OPPIDUM	Monitoring of illegal psychoactive substances or those that are used for purposes other than medicinal (CEIP)
OR	Odd ratio
OST	Opioid substitution treatment
PA	person-year
PACA	Provence-Alpes-Côte d'Azur
PAEJ	Youth reception and counselling centre
PES	Syringe exchange programme
PFAD	Anti drug trainer / police officer
POPHEC	First hepatitis C prison's observatory
PRAPS	Programmes for access to preventive measures and health care for people in vulnerable situations
PRS	Regional health programmes
PRSP	Regional Public Health Programmes
REAPP	Parental counselling and support networks
RECAP	Common data collection on addictions and treatments
RDR	Risk and harm reduction (policy)

RESEDA	Health education, counselling and adolescent development network
RMI	Minimum income
RSM	Standardised mortality ratio
SAM	Road Safety epidemiological survey on narcotics and fatal road accidents
SFA	French Society of Alcohology
SIAMOIS	System of information on the accessibility of injection equipment and substitution products (InVs)
SINTES	National Detection System of Drugs and Toxic Substances (OFDT)
SMPR	Regional hospital medical/psychological services
SPIP	Prison service for integration and probation
TDI	Treatment demand indicator
THC	Tetrahydrocannabinol
TRACFIN	Money laundering service of the French Ministry of Finance
TREND	Emerging Trends and New Dugs (OFDT)
UCSA	Counselling/treatment hospital 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
WHO	World health organisation

Appendix IV – List of sources

A - Baromètre santé (Health Barometer)

French Institute for Health Promotion and Health Education (INPES)

This is a five-yearly telephone survey of a representative sample of the population living in France. The first edition was conducted in 1992. This survey examines smoking, alcohol, medical drug and illegal drug use and much other behaviour which influence health (use of care, depression, screening practices, vaccination habits, sports, violent behaviour, sexuality, etc.).

The survey is conducted by the French Institute for Health Promotion and Health Education (INPES) in partnership with the "Caisse nationale de l'assurance maladie des travailleurs salaries", the Ministry of Employment and Solidarity, the French Monitoring Centre for Drugs and Drug Addiction (OFDT), the "Fédération nationale de la mutualité française", the "Haut comité de la santé publique", the Interministerial Mission for the Fight against Drugs and Drug Addiction (MILDT) and the National Federation of Regional Health Monitoring Centres (FNORS).

B - CJN: National Crime Register

Sub-directorate for statistics, studies and documentation (SDSED) of the Ministry of Justice.

Information on sentences has been obtained from 1984 through the study of the National Crime Register. This information describes the different offences for which sentences have been handed down by judges, the type of procedure, nature of the sentence, duration or sum concerned and the specific characteristics of the people sentenced (age, sex and nationality).

As sentences may be handed down for several offences, the concept of the main offence, which in principle is the most serious, is useful (the offences may also be listed in the order given in the report, although a consistency check is carried out depending on the magnitude of the sentence). This is the most commonly used concept in Ministry of Justice statistics. Other counting units can be used to refine the analysis. In the case of narcotics use, for example, sentences for use as an associated offence (for example, the commonest associations and corresponding sentences) or for use alone.

Sentenced persons and the sentences themselves must not be mixed up. A person sentenced twice in a given year is counted twice in the sentencing statistics.

In accordance with the Penal Code, cannabis is not distinguished from other narcotics in these data.

C – HIV and HCV prevalence survey in drug users (Coquelicot-2004)

Conducted by: The National Institute for Public Health Surveillance (InVS).

This study combines an epidemiological arm (combined with self-sampling of capillary blood onto "dry spot") intended to measure the prevalence of HIV and HCV infection in drug users and a socio-anthropological arm to understand determining factors in risk-taking.

D – Deaths involving abuse of medicines and substances (DRAMES)

The French Health Products Safety Agency (AFASSAPS) and the Marseilles Drug Dependency Information/Evaluation Centres (CEIP).

This study uses a continuous collection method and was set up in order to obtain the most exhaustive data possible on deaths occurring from use of psychoactive substances in the context of drug abuse or addiction.

This enables:

- substances involved in psychoactive substance abuse deaths, regardless of whether they are medical drugs or otherwise, to be identified;
- quantitative data (blood measurements) to be collected about the substances responsible;
- a more detailed estimate of the number of drug-related deaths in France by reducing under-notification of some deaths due to toxic effects, particularly those occurring in a medico-legal situation and therefore not declared to the Health Authorities for legal confidentiality reasons.

E – Health behaviour in School-aged Children (HBSC) survey

University of Edinburgh for the HSBC network and for France by the medical department of the Toulouse regional education authority: a quantitative survey in 11-, 13- and 15-year-old school pupils being educated in mainland France.

This is intended to:

- Understand attitudes, behaviours and opinions of young people about their use of psychoactive substances (particularly alcohol and tobacco, but also illegal drugs), their health and lifestyles;
- measure changes in behaviour and these lifestyles over time;
- carry out international comparisons

F – National survey in centres for accommodation and assistance with the reduction of risks for drug users (CAARUD) (ENa-CAARUD)

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

Biennial quantitative survey of users received/seen by the CAARUD.

The aims of this survey are:

- to provide monitoring indicators for the number and characteristics of drug users;
- to adapt the responses of professionals and public authorities to the needs and expectations of this population of people in difficulty;
- to monitor trends in terms of use and help identify new trends

G – Survey among drug users attending low threshold services (Prelud)

French Monitoring Centre for Drugs and Drug Addiction.

This annual quantitative survey from 2000 to 2003, and then biennial or triennial thereafter, is designed to obtain knowledge about and monitor users of psychoactive substances and their practices.

The population studied consists of users attending low threshold facilities that provide support to drug users: harm reduction centres (shops, needle exchanges, etc.), so called “low-threshold” services, including “low threshold” methadone distribution centres. It should be pointed out that the people interviewed are not necessarily representative of users attending these centres as participation in the survey is voluntary.

H – Prison entrants health survey

Directorate for Research, Studies, Evaluation and Statistics (DREES) (Ministry of Health and Solidarity)

The prison entrants health survey was conducted for the first time in 1997 in all prisons and in the prison quarters of penal establishments. It collects information about risk factors for the health of entrants from the admission medical visit and diseases recorded on admission, identified in particular by treatments being taken. Declared use of psychoactive substances includes daily smoking, excessive alcohol consumption (>5 glasses per day) and “prolonged regular use during the 12 months before imprisonment” of illegal drugs, including cannabis.

I – Survey on the care of drug addicts in the medical-social system (in a given month)

Directorate for research, studies, evaluation and statistics (DREES, formerly CESI, Ministry for Health and Solidarity)

This survey was created at the beginning of the 1980s in order to monitor the number and characteristics of drug users seen in the addictology centres (mostly the specialised centres for drug addicts – CSST), health establishments (general public or specialist psychiatry public hospitals and some private psychiatric hospitals) and some social establishments handling prevention, referral or housing activities for drug users.

This survey was conducted, always in the month of November*, from 1989 to 1997, and then in November 1999 and 2003 (the date of the last edition).

All of the patients seen that month are interviewed: illegal drug users or people misusing psychotropic medical drugs. Overlapping (double counting) between the centres cannot be ruled out, but is likely to be limited given the relatively short observation period.

J - EROPP: Survey on Representations, Opinions, and Perceptions Regarding Psychoactive Drugs

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

This survey measures opinions and perceptions of the population about drugs and the related public actions. The people surveyed are also asked about their use.

The first survey was conducted in 1999 and was a telephone survey based on a quota sample (by sex, age, occupation of the household reference person, region and category of conurbation) in people between 15 and 75 years old representative of the population in mainland France.

K - ESCAPAD: Survey on Health and Use on Call-Up and Preparation for Defence Day

French Monitoring Centre for Drugs and Drug Addiction (OFDT) in collaboration with the National Service Directorate (DSN)

The ESCAPAD survey is conducted every tree years by OFDT in partnership with the National Service Directorate (DSN) and is carried out during the National Defence and Citizenship Day (JDC) which has replaced national service in France. Once a year, the young people participating in a Defence Preparation Day session fill out an anonymous self-completed questionnaire administered throughout the country about their use of legal or illegal psychoactive substances and their health and lifestyle.

The adolescents questioned are mostly 17 years old, French nationals and most are still in secondary education, although some have already entered the world of work, are apprenticed or in higher education.

L - ESPAD: European School Survey Project on Alcohol and Other Drugs

National institute for health and medical research-(INSERM, U472)/French Monitoring Centre for Drugs and Drug Addiction (OFDT)/Ministry for Youth, National Education and Research (MJENR)

This is a school survey on use, attitudes and opinions on drugs. ESPAD is conducted every four years at the same time and is used to monitor French and European trends in drug use. Pupils are selected randomly from classes after stratification.

M - FNAILS: National Drug-Related Offence's Record

Central Office for the Repression of Narcotics Trafficking (OCRTIS)

All procedures relating to narcotics legislation offences, conducted by the local police services and gendarmerie (including the overseas départements) are recorded in FNAILS, except for offences recorded by customs and not resulting in the writing of a statement.

FNAILS contains information about arrests (classified as simple use, use/dealing, local trafficking, international trafficking) and seizures. The substance listed is the "dominant drug", i.e. the substance mostly used by the user or which is held in the largest amount by the trafficker. When this rule cannot be used, the "hardest" substance is recorded.

Since 2006, FNAILS has been administered through an IT application called OSIRIS (Statistical information and research tool for drug-related offences) which automatically incorporates information from the customs and gendarmerie.

N - FND: National Prisoners' Register

Prison Service (DAP), Ministry of Justice

Since 1993, statistics on sentences served have been produced from the National Prisoners' Register (FND). This record identifies prison flows for the year, i.e. the number of people entering and leaving prison establishments between 1st January and 31st December in the year, for each offence. The difference between incoming and outgoing prisoners is used to determine the number of people in the prison establishments on a given date.

A new version of FND has been in preparation since 2003. Unlike the previous version, it takes account of all offences resulting in the sentence for each imprisonment, whereas only the main offence was used previously (see CJN). The offences are also described in more detail. Narcotics offences are now broken down into use, sale, possession, trafficking, aiding and abetting use, inciting use and unspecified narcotics offences compared to only four categories previously (use, sale, trafficking, other narcotics offence). A slippage of data from the former "trafficking" category to the "possession" category has been reported.

In accordance with the Penal Code, cannabis is not distinguished in these data from the other narcotics.

O – Monitoring of illegal psychoactive substances or those that are used for purposes other than medicinal (OPPIDUM)

Network of Drug Dependency Information/Evaluation Centres (CEIP) and French Health Products Safety Agency (AFSSAPS).

OPPIDUM is an annual, national pharmaco-epidemiological study conducted in October each year. It is coordinated by the CEIP network which is responsible for recruiting centres which manage patients with drug abuse or addiction problems or who are receiving opiate substitution treatment. It has been conducted since 1990 in the PACA region and since 1995 nationally. Its objectives are to:

- monitor the use of psychoactive substances by people with drug addiction;
- describe the specific characteristics of the people concerned;
- assess the potential of pharmaceutical products for abuse and addiction.

P – CSST Activity Reports: Use of activity reports from Drug Addiction Treatment Centres

Directorate General for Health (DGS)/French Monitoring Centre for Drugs and Drug Addiction (OFDT)

Since 1998, the Drug Addiction Treatment Centres (CSST) have completed an annual standard activity report which is sent to the Departmental Directorate of Health and Social Affairs (DDASS). These reports are then sent to the DGS which processes them with the assistance of the OFDT. The aim of this data collection exercise is to monitor the activity of the centres and the number and characteristics of the patients received. Epidemiological data are not recorded patient by patient but for all people received in the centre.

A common activity report to the CSST and the Outpatient Alcoholism Treatment Centres (CCAA) was introduced from 2004.

Q - RECAP: Common data collection on addictions and treatments

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

This system was set up in 2005 and continually collects information about patients in the outpatient specialist drug addiction and alcohol treatment centres. Annual results are sent in April of the following year to OFDT which analyses them.

The data collected relate to patients, their current management and treatments taken, uses (substances used and medicines taken as part of the care) and their health.

Cannabis users described through RECAP are those for whom cannabis is the substance used during the previous 30 days which, in the opinion of the care team, currently poses the greatest problem to the patient and led the person to seek care.

This system is replacing the DREES month spot survey

R - SINTES: National Detection System of Drugs and Toxic Substances

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

The SINTES system is intended to document the toxicological composition of illegal substances in circulation in France. The information incorporated in this system come from two sources:

- communication of toxicology test results performed on seizures by the law enforcement services' laboratories (Institut national de police scientifique, Institut de recherche criminelle de la gendarmerie nationale and customs laboratories) to OFDT;

- investigations conducted by OFDT based on samples of substances obtained directly from users. These collections are governed by a strict regulatory framework and obtained by specifically trained survey workers.

In its initial version of 1999, the system only examined synthetic substances. From 2006 onwards its scope has been extended to cover all illegal substances.

S – Road offences and testing statistics

Road safety sections (Bureau des usagers de la route et de la réglementation des véhicules - Sous-direction de la circulation et de la sécurité routières - Direction des libertés publiques et des affaires juridiques - Ministry for the Interior and National Works)

Since 2004, the Road Safety Section's publication combines statistics on tests performed by the local police services and gendarmerie and offence statistics (offences and infringements) of the Highway Code recorded by these services. These data are communicated monthly to the Ministry and are published nationally.

Information is given on speeding offences, driving without a licence, blood alcohol and, since 2004, the use of narcotics. For narcotics use, the number of screening tests and positive tests is described depending on the circumstances of testing (fatal accidents, body or material injury, offences, suspected use of narcotics without accident or offence). Positivity rates should be interpreted with considerable caution as, in view of the particularly high positive test rates, it is

likely that the screening and detailed result testing are not carried out at random but target the drivers who are most likely to test positive for narcotics.

The annual total of the different narcotics offences is also listed: driving a vehicle after using substances or plants classified as narcotics, driving a vehicle after using substances and under the influence of alcohol and refusal of the driver to have tests or investigations performed to determine whether he/she was driving after using narcotics.

In accordance with the Penal Code, cannabis is not distinguished in these data from the other narcotics.

T – AIDS surveillance system in France

This data collection system has been run continuously since 1982 by the InVS. It has the following objectives:

- to provide epidemiological surveillance on AIDS;
- to measure the incidence of the disease;
- to measure the impact of access of seropositive people to testing;
- to measure the impact of primary prophylaxis prevention actions;
- to measure the impact of therapeutic management before the AIDS stage;
- to measure AIDS-related mortality.

U - TREND: Emerging Trends and New Drugs

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

The aim of the TREND system, which has been established since 1999, is to provide information about illegal drug uses and users and on related emerging phenomena. These cover either new phenomena or existing ones which have not yet been detected by the other observation systems.

The observations are conducted in two social settings chosen by the high likelihood of finding new or not as yet observed phenomena, even if these do not alone affect the entire reality of drug use in France:

- the urban settings defined by TREND cover mostly low threshold services (“Drop ins” and Needle Exchange Programme) and open scenes (streets, squat, etc.). Most of the people met and observed in these settings are problem users of illegal drugs living in particularly precarious conditions;
- the techno party settings which describe places where events are organised around this music. These include the so-called “alternative” techno setting (free-party, teknivals, etc.) and also clubs, discothèques and private parties for their "techno" events.

The system is based on a data set analysed by local coordinators who produce site reports which are then put into a national perspective:

- qualitative continuous collection instruments coordinated by OFDT and run by a network of local coordinating entities (Bordeaux, Lille, Lyon, Marseille, Metz, Paris, Rennes and Toulouse) with a joint information collection and analysis strategy;

- the SINTES system, an observation system geared towards detecting and analysing the toxicological composition of illegal substances;

- recurring quantitative surveys, particularly with low threshold services clients;

- use of results from partner information systems (particularly ESCAPAD, EROPP, FNAILS);

- and quantitative or qualitative subject-based investigations to provide more in-depth information on the subject.

V – National analysis of CAARUD activity reports. ASA-CAARUD

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

This annual study of standardised activity reports from the Reception and harm reduction support centres for drug users (CAARUD) is the second instrument of a set of epidemiological data collection mechanisms, the first of which was the national survey in Reception and harm reduction support centres for drug users (ENa-CAARUD), which concentrated more specifically on people seen in these centres.

ASA-CAARUD provides information about the type of activities developed and services available to clients.

W – Collection of local indicators for the national observation of prevention activities concerning legal and illegal drugs (ReLION)

French Monitoring Centre for Drugs and Drug Addiction (OFDT); Drug and Addiction Information and Resource Centres (CIRDD)

This is a qualitative, biennial survey intended to:

- document the main features of local prevention actions on legal and illegal drug use (alcohol, tobacco, psychotropic medical drugs, cannabis, ecstasy, doping substances, etc.);

- It identifies changes in prevention practices at different national levels though simple identifiers used in the field – for whom, from whom, when and how.