



European Monitoring Centre
for Drugs and Drug Addiction



2014 NATIONAL REPORT (2013 data) TO THE
EMCDDA
by the Reitox National Focal Point

FRANCE

New Developments, Trends

Reitox

Supervision

François Beck

Coordination and editorial

Aurélie Lermenier-Jeannet

Contribution to the chapters

Chapter 1: Carine Mutatayi, Ivana Obradovic

Chapter 2: Marie-Line Tovar, Éric Janssen

Chapter 3: Carine Mutatayi

Chapter 4: Eric Janssen, Agnès Cadet-Taïrou

Chapter 5: Tanja Bastianic, Anne-Claire Brisacier, Christophe Palle

Chapter 6: Anne-Claire Brisacier, Agnès Cadet-Taïrou

Chapter 7: Anne-Claire Brisacier, Agnès Cadet-Taïrou

Chapter 8: Aurélie Lermenier-Jeannet

Chapter 9: Ivana Obradovic

Chapter 10: Michel Gandilhon, Magali Martinez, Agnès Cadet-Taïrou

Proofreading (French version)

Julie-Émilie Adès, François Beck, Aurélie Lermenier-Jeannet, Christophe Palle (OFDT)

Stéphane Bahrami, Christian Ben Lakhdar, Henri Bergeron, Olivier Cottencin, Emmanuelle Godeau, Fabien Jobard, Serge Karsenty, Nacer Lalam and Marie-José Parent (OFDT Scientific Committee)

Danièle Jourdain Menninger, president of the Interministerial Mission for Combating Drugs and Addictive Behaviours, and all the project managers of the MILDECA

Proofreading (English version)

Anne de l'Eprevier, Julie-Émilie Adès

Documentation

Isabelle Michot

Legal references

Anne de l'Eprevier

Table of contents

SUMMARIES	6
PART A. NEW DEVELOPMENT AND TRENDS.....	9
1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS	9
1.1. <i>Introduction</i>	9
1.2. <i>Legal framework</i>	17
1.2.1. Laws, regulations, directives or guidelines in the field of drug issues (demand and supply).....	18
1.2.2. Laws implementation.....	18
1.3. <i>National action plan, strategy, evaluation and coordination</i>	21
1.3.1. National action plan and/or strategy.....	21
1.3.2. Implementation and evaluation of national action plan and/or strategy.....	23
1.3.3. Other drug policy developments	23
1.3.4. Coordination arrangements	24
1.4. <i>Economic analysis</i>	25
1.4.1. Public expenditures	25
1.4.2. Revenues.....	26
2. DRUG USE IN THE GENERAL POPULATION AND SPECIFIC TARGETED-GROUPS.....	27
2.1. <i>Introduction</i>	27
2.2. <i>Drug use in the general population</i>	29
2.3. <i>Drug use in the school and youth population</i>	30
2.4. <i>Drug use among targeted groups / settings at national and local level</i>	32
3. PREVENTION.....	33
3.1. <i>Introduction</i>	33
3.2. <i>Environmental prevention</i>	36
3.2.1. Alcohol and tobacco policies.....	36
3.2.2. Other social and normative changes.....	39
3.3. <i>Universal prevention</i>	40
3.3.1. School settings	41
3.3.2. Family settings	41
3.3.3. Community.....	42
3.3.4. Workplace	42
3.4. <i>Selective prevention in at-risk groups and settings</i>	42
3.4.1. At-risk groups	42
3.4.2. At-risk families	42
3.4.3. Recreational settings.....	43
3.5. <i>Indicated prevention</i>	43
3.6. <i>National and local media campaigns</i>	43
4. HIGH RISK DRUG USE (HRDU).....	44
4.1. <i>Introduction</i>	44
4.2. <i>Prevalence of and trends in HRDU</i>	44
4.2.1. Estimates of high risk drug use prevalence	44
4.2.2. Other sources of information on prevalence of HRDU	45
4.2.3. HRDU trends	45
4.3. <i>Characteristics of high risk drug users</i>	45
4.3.1. Main patterns of polydrug use among the main groups of high risk drug users	45
4.3.2. Data and studies of characteristics of high risk drug users other than the treatment demand data reported in chapter 5.....	46

5.	DRUG-RELATED TREATMENT: TREATMENT DEMAND AND TREATMENT AVAILABILITY	48
5.1.	<i>Introduction</i>	48
5.2.	<i>General description, availability and quality assurance</i>	48
5.2.1.	Strategy and Policy.....	48
5.2.2.	Treatment and management systems	49
5.3.	<i>Access to treatment</i>	54
5.3.1.	Characteristics of treated patients (TDI data included)	55
5.3.2.	Trends of treated population and treatment provision	59
6.	HEALTH CORRELATES AND CONSEQUENCES	61
6.1.	<i>Introduction</i>	61
6.2.	<i>Drug related infectious diseases</i>	63
6.2.1.	HIV/AIDS and viral hepatitis	63
6.2.2.	Sexually transmitted infections and tuberculosis.....	66
6.2.3.	Other infectious morbidity	66
6.2.4.	Behavioural data	67
6.3.	<i>Other drug-related health correlates and consequences</i>	68
6.3.1.	Non-fatal overdoses and drug-related emergencies.....	68
6.3.2.	Psychiatric comorbidities	68
6.4.	<i>Drug related deaths and mortality of drug users</i>	68
6.4.1.	Drug-induced deaths (overdoses/poisonings).....	68
6.4.2.	Mortality and causes of death among drug users (mortality cohort study).....	70
6.4.3.	Specific causes of mortality indirectly related to drug use	71
7.	RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES	72
7.1.	<i>Introduction</i>	72
7.2.	<i>Prevention of drug-related emergencies and reduction of drug-related deaths</i>	77
7.3.	<i>Prevention and treatment of drug-related infectious diseases</i>	77
7.4.	<i>Responses to other health correlates among drug users</i>	83
8.	SOCIAL CORRELATES AND SOCIAL REINTEGRATION	84
8.1.	<i>Introduction</i>	84
8.2.	<i>Social exclusion and drug use</i>	84
8.2.1.	Social exclusion among drug users	85
8.2.2.	Drug use among socially excluded groups	87
8.3.	<i>Social reintegration</i>	87
8.3.1.	Housing	88
8.3.2.	Education and training	88
8.3.3.	Employment.....	89
9.	DRUG-RELATED CRIME, PREVENTION OF DRUG-RELATED CRIME AND PRISON	91
9.1.	<i>Introduction</i>	91
9.2.	<i>Drug-related crime</i>	95
9.3.	<i>Drug law offences</i>	95
9.4.	<i>Other drug-related crime</i>	96
9.5.	<i>Prevention of drug-related crime</i>	97
9.6.	<i>Interventions in the criminal justice system</i>	97
9.7.	<i>Drug use and problem drug use in prisons</i>	97
9.8.	<i>Responses to drug-related health issues in prisons</i>	98
9.8.1.	Drug treatment (including number of inmates receiving opioid substitution treatment).....	98
9.8.2.	Prevention and reduction of drug-related harm	98
9.8.3.	Prevention, treatment and care of infectious diseases.....	99
9.8.4.	Prevention of overdose-risk upon prison release.....	99
9.9.	<i>Reintegration of drug users after release from prison</i>	100

10. DRUG MARKETS.....	101
10.1. <i>Introduction</i>	101
10.2. <i>Supply to and within the country</i>	104
10.2.1. Drugs origin: national production versus imported.....	104
10.2.2. Trafficking patterns, national and international drug flows, routes, <i>modi operandi</i> and organisation of domestic drug markets	105
10.3. <i>Seizures</i>	110
10.3.1. Quantities and numbers of seizures of all illicit drugs.....	110
10.3.2. Quantities and numbers of seizures of precursor used in the manufacture of illicit drugs	111
10.3.3. Number of drug production sites dismantled, description of production methods and illicit drugs manufactured.....	111
10.4. <i>Availability</i>	111
10.4.1. Perceived availability of drugs, exposure, access to drugs	111
10.4.2. Price of illicit drugs at retail level and wholesale level	115
New psychoactive substances (NPS)	117
10.4.3. Purity / potency of illicit drugs.....	117
10.4.4. Composition of illicit drugs and drug tablets (including cutting agent).....	118
PART B. BIBLIOGRAPHY.....	119
ALPHABETIC LIST OF BIBLIOGRAPHIC REFERENCES	119
ALPHABETIC LIST OF RELEVANT DATABASES AVAILABLE ON INTERNET	128
ALPHABETIC LIST OF RELEVANT INTERNET ADDRESSES	130
ANNEXES	131
APPENDIX I – LIST OF TABLES.....	131
APPENDIX II – LIST OF FIGURES.....	133
APPENDIX III – LIST OF FULL REFERENCES OF LAWS IN ORIGINAL LANGUAGE	134
APPENDIX IV – LIST OF ABBREVIATIONS.....	140
APPENDIX V - LIST OF SOURCES	148

Summaries

1. Drug policy: legislation, strategies and economic analysis

The 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours, presented in September 2013, has three major priorities: basing public action on observation, research and evaluation, considering the most exposed populations (young people, women and marginal populations) and reinforcing public security, order and health on a national and international level. In January 2014, this plan was completed with an action plan outlining 131 actions to be undertaken from 2013 to 2015 and an evaluation of certain measures for achieving the plan's strategic objectives (prevention and communication, anti-trafficking, law enforcement, research and coordination of national and international public actions).

Replacing the term "drug addiction" with "addictive behaviours" both in the title of the plan and the Interministerial Mission (which is now known as the MILDECA) responsible for implementing the plan is indicative of the government's desire to widen the scope of intervention to include all addictions.

Three legislative items can be highlighted: for the first time, a cannabis-based medication (Sativex[®]) was authorised in France; methoxetamine, a new psychoactive substance (NPS), was classified as a narcotic, and the Council of State (*Conseil d'Etat*) issued a negative opinion on the draft governmental decree regarding lower risk drug consumption rooms. Experimentation with such drug consumption rooms has nevertheless been announced as part of a draft public health law.

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

The latest data on the prevalence of use in the general population are from 2010-2011 (INPES 2010 Health Barometer for adults, HBSC 2010, ESPAD 2011 and ESCAPAD 2011 for adolescents). Regardless of the age bracket, cannabis is by far the most frequently used substance. Problem use, which is identified using the Cannabis Abuse Screening Test (CAST), is only estimated in adolescents 17 years of age: in 2011, of those who had engaged in last year cannabis use, 18% had a high risk of problem use, and the majority of this population were boys.

With regard to the perceived risks of drugs, half of French people consider cannabis dangerous from the first time it is used; over eight in ten believe this for cocaine and heroin. Moreover, 70% of the population believe that smoking cannabis leads people to use more dangerous substances.

3. Prevention

Alcohol and tobacco prevention policies largely employ an environmental strategy established by lawmakers. In 2013, the main lever for prevention was taxation, with fairly positive results in terms of curtailing tobacco and beer sales.

There are many areas targeted by the Government Plan for Combating Drugs and Addictive Behaviours, such as developing prevention in schools and at the workplace, raising awareness among key people in neighbourhoods sensitive to addictive behaviours and supporting families in difficulty, etc. For many, the conceptual and initial implementation work is in progress. Against this background, the Interministerial Commission for the Prevention of Addictive Behaviours was launched in February 2014. Its purpose is to promote prevention policy based on promising, evaluated programmes.

In 2013, media campaigns conducted in the addiction field pertained only to tobacco (first in May and then in October with a youth-targeting campaign) and alcohol (in November).

4. High risk drug use (HRDU)

France does not have an estimate of the number of high risk drug users, according to the EMCDDA definition, but the last evaluation of the number of problem users, performed in 2011, estimated the number of people in question to be 275,000 to 360,000 (7 to 9 per 1,000 inhabitants). This means that, compared with other European Union member states, France has an average number of problem users. There are no statistics on the number of adult at-risk cannabis users; there are only figures on 17 year-olds.

The characteristics of high-risk drug users and their use are mainly revealed in studies conducted on people frequenting harm reduction facilities. This population is mainly male (80%) and over the age of 35 (54%). They are very socially vulnerable and mainly consume alcohol and cannabis, but also use opioids, cocaine and benzodiazepines.

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

In 2012, over 149,000 people were reimbursed for opioid substitution treatment, predominantly buprenorphine (71%), even though the proportion represented by methadone is on the rise. This trend may become more prominent since, as part of the governmental plan, there is a strategy being deployed to expand the conditions under which methadone can be prescribed and dispensed, particularly in light of the findings of an experimentation conducted in a primary care setting (*Méthaville*).

The latest usable data on requests for treatment date back to 2012. Treatments for cannabis use tended to drop while those for opioids increased. In terms of patient sociodemographic profile, the mean age has increased from 28 in 2005 to 31 years in 2013. The proportion of people living in stable housing also trended upwards.

6. Health correlates and consequences

In 2012, only 1.2% of people determined to be HIV-positive were contaminated through intravenous drug use and the number of new AIDS cases among injecting drug users continued to fall (5.9% versus 7.7% in 2011). Moreover, the prevalence of HIV infection in drug users snorting or injecting at least once in their lifetime was 10% in 2011 (stable versus 2004). This figure reached 44% for HCV infection (versus 60% seven years prior).

The number of lethal overdoses in 2011 dropped (249 among 15-49 year olds), but for methodological reasons, this figure should be interpreted with care. The causal role played by substitution treatments, and methadone in particular, in these deaths rose (60% versus 54% in 2010). The mortality cohort study included 1,134 individuals, and for 970 (or 86%) of these subjects, the vital status was found again in July 2013. For men, the standardised mortality ratio was 5.2. For women, it was much higher (20.8).

7. Responses to health correlates and consequences

Preventing drug use-related infectious diseases relies on a harm reduction policy and an encouragement to undergo screening for HIV, HBV and HCV, as well as HBV vaccination. Recommendations for treating HBV- and HCV-infected individuals and the utility of rapid diagnostic tests for HCV, published in early 2014, have promoted the continuation and strengthening of actions conducted in this area.

Furthermore, drug-related health surveillance and alert measures exist in France, and an evaluation of injection kits has been performed in accordance with recommendations made public in 2014. These recommendations aimed to modify the contents of these kits (for example, by replacing alcohol with chlorhexidine, providing an ascorbic acid packet and a small container with a premounted handle, and adding 2 cm³ syringes in addition to 1 cm³ syringes, etc.).

8. Social correlates and social reintegration

The population seen in CSAPAs (National treatment and prevention centre for addiction) and CAARUDs (Support centre for the reduction of drug-related harms), centres that provide social support to drug users in France, is generally in a more unstable situation (e.g., unemployed, sporadic income, temporary housing, homeless) than the rest of the French population. However, the situation of this population does not seem to be worsening. Nevertheless, it is still difficult to identify the actions and programmes undertaken by these structures to promote the integration and reintegration of these people.

The 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours reaffirmed the intention, already expressed in the previous plan, to provide comprehensive treatment to improve the chances of success, especially by improving dialogue between specialised treatment structures and more general social housing centres.

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

In 2013, 208,325 drug-related offences were recorded by law enforcement services, representing a 17% increase in the last five years. In more than eight in ten cases, these offences were related to use, primarily cannabis use. If all convictions are considered, the 53,113 for drug-related offences represented 9% of the total in 2012, and nearly 60% of these were for simple use.

Issues pertaining to inmates released from prison remain complex, especially regarding the discontinuation of treatment for OST users or HIV-/HCV-infected users. To avoid this, counselling programmes were established on an experimental basis in social and medico-social structures. The evaluation conducted by the OFDT in 2012 on these counselling programmes revealed the difficulty encountered in achieving treatment objectives within a population with an accumulation of significant social issues.

10. Drug markets

Three points emerge from the observation of the "traditional" drug market: the increase in herbal cannabis share is being confirmed, cocaine trafficking in the French Antilles is intensifying and heroin purity is on the rise. In 2013, quantities of seized drugs rose in general compared with 2012, and especially quantities of seized cannabis (and seeds in particular). The retail prices are fairly stable and purity seems to be increasing.

The New Psychoactive Substances (NPS) phenomenon is still very dynamic, with 36 new substances identified in 2013, most of which were cannabinoids. The TREND and SINTES schemes, mainly through the European I-TREND project, revealed the progressive expansion of NPS accessibility, as well as their use, to specific user subgroups. However, this was nothing compared to what was seen with the use of traditional substances, and this expansion is mainly seen in the digital market (except for methoxetamine, which is also seen on the "real" market).

Part A. New Development and Trends

1. Drug policy: legislation, strategies and economic analysis

1.1. Introduction

Definitions

The term "drug user" refers to a person who uses narcotic substances. The legal authorities often consider the possession of small quantities of narcotics, as well as cannabis cultivation for the purposes of personal use, in the same category as drug use.

Any drug-related offence may result in arrest (by the police, the *gendarmerie* or the customs department) and will be referred to the judicial services. Offences are examined on a case-by-case basis by the public prosecutor who, based on the principle of the *opportunité des poursuites* (appropriateness of proceedings), decides to take legal action against the offender, to simply close the case or to propose other measures as an alternative to prosecution. This principle enables individual situation-appropriate interventions to take place by making punishments fit the crimes and appropriate to recidivism. It also explains why court practices differ, since local penal policies have territorial differences.

Data sources

The main sources used are the *Code pénal* (Penal Code), *Code de la route* (Traffic Code), *Code de la santé publique* (Public Health Code), *Code de l'action sociale et des familles* (Social Action and Family Code) and *Code du sport* (Sports Code), as well as official documents on public expenditure.

Background information

Two types of legislation govern drugs in France. The use, possession and supply of legal drugs (such as alcohol and tobacco) are regulated, but not forbidden. On the other hand, illegal drugs classified as narcotics¹ (heroin, cocaine, cannabis and hallucinogens, for example) are subject to a ban that is chiefly enshrined in the law of 31 December, 1970², the provisions of which have been incorporated into the Penal Code and the Public Health Code. Current regulations make it illegal to use or deal in any substance or plant listed as a narcotic (regardless of the substance). A user is considered both an offender and someone who is sick.

The Public Health Code stipulates that drug users may have free, anonymous access to addiction treatment. This is the result of the adoption of the 1970 French law on narcotics that created specialised treatment measures including structures that are today called CSAPAs (National Treatment and Prevention Centre for Addiction) and CTs (Therapeutic Communities).

¹ The list of narcotic substances covered by the law is detailed in a legislative order from the Ministry of Health, following a proposal from the Director General of the French National Agency of Medicine and Health Product Safety (ANSM, formerly the AFSSAPS), in conformity with international regulations.

² Loi n°70-1320 du 31 décembre 1970 relative aux mesures sanitaires de lutte contre la toxicomanie et à la répression du trafic et de l'usage illicite des substances vénéneuses. JORF du 3 janvier 1971

Access to HIV³ and hepatitis screening centres that are affiliated with health establishments (CDAGs⁴ and CIDDISTs⁵) is also completely free of charge.

Hepatitis B vaccination and viral hepatitis screening are free of charge and anonymous⁶ when they are performed in a CSAPA (art. L.3411-4 of the Public Health Code). Since the circular of 9 November 2009⁷, drug users are also entitled to receive hepatitis B vaccinations in CDAGs.

People being treated in a CDAG or CIDDIST are not required to reveal their identity. Since the adoption of the HPST law of July 2009⁸ (art. 108, codified in the Public Health Code, art. L.3121-2 and L.3121-2-1), if therapeutically necessary, a CDAG or CIDDIST physician may lift anonymity provided that the express, informed and voluntary consent of the patient is obtained. The purpose of this provision⁹ is to improve the support given to people to procure health treatment. Moreover, if expressly requested, drug users who spontaneously go to a dispensary or health establishment may remain anonymous from the moment they are admitted (art. L.3414-1 of the Public Health Code).

To maintain the confidentiality of personal and medical information, health professionals are required to comply with medical and professional confidentiality.

Drug users without income or with low income, like any person residing in France with limited means, are entitled to free primary health care and hospital care. Since 1999, drug users are also entitled to coverage under France's CMU universal medical coverage scheme. The person seeking health care pays the medical expenses out of pocket and requests reimbursement. Moreover, there is free supplemental health care coverage, which exempts the person seeking health care from having to advance health care expenses. Foreign nationals without papers in France may request the *Aide médicale d'état* (AME) State Medical Assistance provided to foreigners without health coverage.

Narcotics use

Under the terms of article L.3421-1 (formerly art. L.628) of the Public Health Code, the illegal use of substances listed as narcotics constitutes an offence subject to one year's imprisonment and a fine of €3,750. However, the Public Health Code authorises a public prosecutor to suspend proceedings against a drug user if said user agrees to undergo treatment.

³ Circulaire DGS/PGE/1C n°85 du 20 janvier 1988, relative à la mise en place d'un dispositif de dépistage anonyme et gratuit du virus de l'immunodéficience humaine. BO Santé n°88-28 bis, Fascicule spécial : l'infection par le virus de l'immunodéficience humaine, 1988. (NOR ASEP8810054C)

⁴ Anonymous free screening centres

⁵ Information screening, diagnosis (and treatment) centres on sexually transmitted diseases.

⁶ Loi n°2007-1786 du 19 décembre 2007 de financement de la Sécurité sociale pour 2008. JORF n°296 du 21 décembre 2007. (NOR BCFX0766311L), art. 72.

⁷ Circulaire DGS/MC2 n°2009-349 du 9 novembre 2009 relative à la mise en œuvre de l'action II-1,3 du plan national de lutte contre les hépatites B et C 2009-2012 ayant pour objectif de permettre aux usagers de drogues de bénéficier d'un service de proximité assurant gratuitement le dépistage de ces hépatites et, le cas échéant, d'une vaccination contre l'hépatite B. BO Santé, Protection sociale et Solidarités n°12 du 15 janvier 2010. (NOR SASP0927192C)

⁸ Loi n°2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires. JORF n°167 du 22 juillet 2009. (NOR SASX0822640L)

⁹ 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. JORF n°166 du 21 juillet 2010. (NOR SASP1007832A)

The "delinquency prevention law" of 5 March 2007¹⁰ provided for a wider range of law enforcement measures that could be taken against drug users. It introduced a new penalty: a mandatory, awareness-building training course on the dangers of drug and alcohol use (€450 maximum, the amount of a third class contravention). Introduced by means of article L 131-35-1 of the Penal Code and by articles R131-46 and R131-47 of the Penal Code in application of the decree of 26 September 2007¹¹, the aim of this measure is to make offenders fully aware of the danger and harm generated by the use of narcotic substances, as well as the social impact of such behaviour. The awareness-building training course may be proposed by the authorities as an alternative to prosecution and to fixed penalty notice. An obligation to complete the awareness training course may also be included in the criminal ruling as an additional sentence. It applies to all adults and to minors over the age of 13¹².

This 5 March 2007 law expands the scope of court-ordered drug treatment measures, which now can be ordered at any stage of criminal proceedings: originally conceived as an alternative to prosecution (resulting in a suspension of the legal process), court-ordered treatments can now be ordered as a sentence enforcement measure, including for persons who have committed an offence related to alcohol consumption.

Narcotics use and road safety

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

The law of 3 February 2003¹³ introduced a new offence punishing any driver whose blood test revealed the presence of narcotics. Drivers can be imprisoned for up to two years and be fined up to €4,500. These sentences can be increased to three years' imprisonment and a fine of €9,000 (as well as a three-year driving licence suspension) if alcohol is consumed in conjunction with the use of illegal substances. Driving after using narcotics constitutes aggravating circumstances in the event of bodily harm or a fatal accident: the penalties can run up to a €100,000 fine and seven years' imprisonment (in the event of involuntary manslaughter). These sanctions are harsher for public transport personnel.

The laws of 12 June 2003¹⁴ and 5 March 2007 widened the range of possible additional sanctions to include driving licence suspension or revocation for three years or more, community service, and a mandatory (at the offender's own expense) awareness course on road safety or awareness course on the dangers of drug and alcohol use.

¹⁰ Loi n°2007-0297 du 5 mars 2007 relative à la prévention de la délinquance. JORF n°56 du 7 mars 2007. (INTX0600091L)

¹¹ Décret n°2007-1388 du 26 septembre 2007 pris pour l'application de la 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. JORF n°225 du 28 septembre 2007. (NOR JUSD0755654D)

¹² Circulaire CRIM 08-11/G4 du 9 mai 2008 relative à la lutte contre la toxicomanie et les dépendances. BO Justice n°2008/3 du 30 juin 2008 (NOR JUSD0811637C)

¹³ Loi n°2003-087 du 3 février 2003 relative à la conduite sous l'influence de substances ou plantes classées comme stupéfiants. JORF du 4 février 2003. (NOR JUSX0205970L)

¹⁴ Loi n°2003-495 du 12 juin 2003 renforçant la lutte contre la violence routière. JORF n°135 du 13 juin 2003. (NOR EQUX0200012L)

Since the adoption of the French homeland security performance planning act¹⁵ (the so-called LOPPSI 2 law) and its application circular¹⁶ of 28 March 2011, drug use screening is now mandatory for people involved in traffic accidents, whether fatal or not, and the vehicle is automatically confiscated in the event of a subsequent alcohol- or narcotics-related traffic offence. Moreover, this 28 March 2011 circular makes it possible for public prosecutors to request random narcotics controls on all drivers present at a given time and location (art. L.235-2 of the Traffic Code, amended by LOPPSI article 83). These roadside narcotics screening tests can be performed on urine (since 2003) or saliva (since 2008)¹⁷. The tests can detect the recent use of four illegal drug families (cannabis, cocaine, opioids and amphetamines). The detection thresholds are stipulated in a decree dated 5 September 2001¹⁸.

In the event of a positive screening result (or an inability to perform screening), the driver's licence is immediately suspended and a mandatory blood test is performed by a physician to confirm whether or not narcotics are present. Since cannabis can be detected in the urine for several weeks after use¹⁹, a positive blood test is the only way to indicate with certainty if a screened person used narcotics within four hours prior to getting behind the wheel. Since narcotics use is illegal, even simple traces are enough to convict a person of driving while using narcotics.

A refusal to undergo screening is punishable by the same penalties as driving under the influence of alcohol or after narcotics use: a €4,500 fine, two years' imprisonment and the additional sanctions provided for by the law: licence suspension or revocation, awareness-building training course, etc.

Since the decree of 29 February 2012²⁰, people convicted of driving after using narcotics, in addition to likely paying a fine and legal costs for appearing in criminal court (€90), must pay €210 for the toxicology analyses.

Narcotics use in professional environments

The law steps up 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) who commit drug use offences. They now risk a five-year prison sentence and a total fine of up to €75,000. Public transport company employees committing drug use offences while on duty are also subject to these penalties, in addition to further sanctions prohibiting them from carrying out their

¹⁵ Loi n°2011-267 du 14 mars 2011 d'orientation et de programmation pour la performance de la sécurité intérieure. JORF n°62 du 15 mars 2011. (NOR IOCX0903274L)

¹⁶ Circulaire du 28 mars 2011 de la LOPPSI en ce qui concerne l'amélioration de la sécurité routière. BO Intérieur n°2011-03 du 31 mars 2011. (NOR IOCD1108865C)

¹⁷ The laboratory screening tests currently available have two major drawbacks: they do a poor job of indicating how much time has elapsed since last use (sensitivity) and they are subject to "false negatives" and "false positives" (reliability).

¹⁸ The cannabis detection threshold, for example, is 50 nanograms of the active substance (THC) per ml of urine and 1 nanogram per ml of blood, according to the decree of 5 September 2001 establishing the procedures for narcotics screening and analyses on drivers involved in a fatal traffic accident. (Arrêté du 5 septembre 2001 fixant les modalités du 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. JORF n°216 du 18 septembre 2001. (NOR MESP0123164A))

¹⁹ The mean durations for detection in urine and blood that are established by law are available on the Drogues info service website (<http://www.drogues-info-service.fr/?Tableau-des-durees-de-positivite>).

²⁰ Arrêté du 29 février 2012 fixant le montant de l'augmentation du droit fixe de procédure dû en cas de condamnation pour conduite après usage de stupéfiants. JORF n°58 du 8 mars 2012. (NOR JUSD1205700A)

professional activities in the future and (where applicable) requiring them to undergo, at their own expense, an awareness-building training course on the dangers of drug and alcohol use. The 20 July 2011 law²¹ (article L.4622-2 of the Labour Code), applicable since 1st July 2012, establishes the operating procedures for occupational health services, stipulating that occupational physicians are to provide advice to employers, workers and their representatives on the measures needed to prevent drug use and alcohol consumption at the workplace (see chapter 3).

Drug-trafficking

Anti-drug trafficking law enforcement has changed since the late 1980s. Aggravating circumstances are considered to exist when a drug trafficking incident involves minors or takes place in an educational, teaching or administrative establishment. Current legislation therefore stipulates distinct penalties for different trafficking-related offence types: minimum penalties sanction dealing and selling drugs for personal use (an offence created by the law of 17 January 1986²²). Maximum penalties can include life imprisonment and a fine of €7.5 million (law of 16 December 1992²³) for certain laundering operations (as defined in the law of 31 December 1987²⁴ and categorised as a criminal offence by the laws of 23 December 1988²⁵, 12 July 1990²⁶ and 13 May 1996²⁷).

Following the introduction of the law of 17 January 1986, the immediate hearing procedure can be used in proceedings against small-scale dealers. This law made it possible to immediately judge user-dealers following their arrest, much in the same way as the instigators of organised crime networks. The legal provisions pertaining to anti-money laundering measures that have been in effect since the 1990s subsequently enable drug traffickers to be pursued based on their outward signs of wealth. As result, the fact that an individual "is unable to account for resources corresponding to his or her lifestyle when in frequent contact with a drug user or trafficker ", is considered an offence under the terms of the law of 13 May 1996, which makes "living off the proceeds of drugs" illegal.

The law of 9 March 2004²⁸ allows for reductions in the sentences handed down to offenders for offences ranging from drug dealing to all forms of trafficking if, "by having informed the administrative or legal authorities, the offender has made it possible to put an end to the offence and possibly identify other guilty parties". This possibility for "penitents" to avoid a sentence for trafficking is a new feature in the French penal process.

²¹ Loi n°2011-867 du 20 juillet 2011 relative à l'organisation de la médecine du travail. JORF n°170 du 24 juillet 2011. (NOR ETSX1104600L)

²² Loi n°86-76 du 17 janvier 1986 portant diverses dispositions d'ordre social. JORF du 18 janvier 1986

²³ Loi n°92-1336 du 16 décembre 1992 relative à l'entrée en vigueur du nouveau Code pénal et à la modification de certaines dispositions de droit pénal et de procédure pénale rendue nécessaire par cette entrée en vigueur. JORF n°298 du 23 décembre 1992. (NOR JUSX9200040L)

²⁴ Loi n°87-1157 du 31 décembre 1987 relative à la lutte contre le trafic de stupéfiants et modifiant certaines dispositions du Code pénal. JORF n°3 du 5 janvier 1988. (NOR JUSX8700015L)

²⁵ Loi n°88-1149 du 23 décembre 1988 : Loi de finances pour 1989. JORF du 28 décembre 1988. (NOR ECOX8800121L)

²⁶ Loi n°90-614 du 12 juillet 1990 relative à la participation des organismes financiers à la lutte contre le blanchiment des capitaux provenant du trafic des stupéfiants. JORF n°162 du 14 juillet 1990. (NOR ECOX9000077L)

²⁷ Loi n°96-392 du 13 mai 1996 relative à la lutte contre le blanchiment et le trafic des stupéfiants et à la coopération internationale en matière de saisie et de confiscation des produits du crime. JORF n°112 du 14 mai 1996. (NOR JUSX9400059L)

²⁸ Loi n°2004-204 du 9 mars 2004 portant adaptation de la justice aux évolutions de la criminalité. JORF n°59 du 10 mars 2004. (NOR JUSX0300028L)

The "delinquency prevention" law of 5 March 2007²⁹ provides for more severe penalties in the event of "directly inciting a minor to transport, possess, propose or sell narcotics" (up to 10 years imprisonment and a fine of €300,000). The penalties for certain offences committed under the influence of a narcotic substance or in a state of drunkenness have also been made more severe. Moreover, legislation provides for new investigative measures (including investigations based on the use of new Information and Communication Technologies or undercover purchases).

Finally, the law of 9 July 2010 (the so-called "Warsmann law"³⁰) established a new penal procedure enabling assets of suspects to be seized to ensure that they are confiscated if the suspects are eventually found to be guilty.

Trafficking of drug precursors

The production and sale of chemical precursors that may be used to extract drugs or manufacture synthetic substances have been controlled in France since the introduction of the law of 19 June 1996³¹. This law is part of the framework of current European regulations on the misuse of raw materials commonly used in the chemicals industry to supply narcotics trafficking networks. The law classifies controlled chemical substances into three categories established by decree. The law also requires companies involved in producing, selling or transporting controlled chemical substances to be authorised by the Ministry of Industry to do so³². The French National Mission for the Control of Chemical Precursors (MNCPC) is responsible for granting and renewing such approvals.

Opioid substitution treatments

Opioid substitution treatments (OSTs) were introduced in France in the 1990s. The marketing authorisation for methadone, granted in March 1995³³, was followed a few months later by that of high-dose buprenorphine (HDB) in July of that same year³⁴. Subutex® (buprenorphine) has been on the market since February 1996. Generics have been on the market since 2006. Considered to be safer than methadone (and as such, not classified as a narcotic), since its launch, buprenorphine could be prescribed by any physician: this flexible prescription system (methadone was reserved for specialised centres only - at least for the initial treatment phase) led to a major surge in buprenorphine substitution prescriptions, which today account for approximately 80% of all substitution drugs reimbursed by the National Health Insurance Fund (*Assurance maladie*). As a result, a second "doorway" to substitution through health

²⁹ Loi n°2007-0297 du 5 mars 2007 relative à la prévention de la délinquance. JORF n°56 du 7 mars 2007. (INTX0600091L)

³⁰ Loi n°2010-768 du 9 juillet 2010 visant à faciliter la saisie et la confiscation en matière pénale. JORF n°158 du 10 juillet 2010. (NOR JUSX0912931L)

³¹ Loi n°96-542 du 19 juin 1996 relative au contrôle de la fabrication et du commerce de certaines substances susceptibles d'être utilisées pour la fabrication illicite de stupéfiants ou de substances psychotropes. JORF n°142 du 20 juin 1996. (NOR INDX9500023L)

³² Décret n°96-1061 du 5 décembre 1996 relatif au contrôle de la fabrication et du commerce de certaines substances susceptibles d'être utilisées pour la fabrication illicite de stupéfiants ou de substances psychotropes. JORF n°287 du 10 décembre 1996. (NOR INDD9600699D)

³³ Circulaire DGS/SP3/95 n°29 du 31 mars 1995 relative au traitement de substitution pour les toxicomanes dépendants aux opiacés et Avis d'octroi d'autorisations de mise sur le marché de spécialités pharmaceutiques : AMM du 21 mars 1995 pour le chlorhydrate de méthadone, 5, 10 et 20mg, sirop en récipient unidose. JORF du 28 juin 1995. (NOR SANM9501657V)

³⁴ Avis d'octroi d'autorisations de mise sur le marché de spécialités pharmaceutiques : AMM du 31 juillet 1995 pour le Subutex à 0,4 mg, 2 mg et 8 mg, comprimé sublingual. JORF du 27 octobre 1995. (NOR SANM9502981V)

establishments was opened with the circular of 30 January 2002³⁵ which made it possible for any doctor practising in a health establishment to initiate methadone substitution treatment.

Since 1993, a series of official texts and circulars have been published to fight against the misuse of substitution treatments in France. Moreover, in 2004, the French National Health Insurance Fund for Salaried Workers (CNAMTS) instituted a control strategy, which had a significant effect on OST misuse (see chapter 5). In April 2008³⁶, the health authorities also decided to reinforce the conditions for prescribing and dispensing buprenorphine. To obtain reimbursement, patients are now required to provide their doctor with the name of the pharmacist who will dispense the medication. Since this 1 April 2008 legislative order, not only is it mandatory to inscribe the name of the dispensing pharmacist on a prescription, but it is also necessary to establish a treatment protocol in the event of misuse. Moreover, the French National Agency for Medicine and Health Product Safety (ANSM, formerly the AFSSAPS) has established a risk management plan for each buprenorphine product on the market.

The legal framework for harm reduction measures

The harm reduction policy aimed at drug users is the responsibility of the state (article L3121-3 of the Public Health Code modified by article 71 of the law of 13 August 2004³⁷). The policy aims to prevent transmission of infection, fatal overdoses linked to intravenous drug use and the social and psychological harm caused by drug addiction. The law of 9 August 2004³⁸, which created CAARUDs (Support Centres for the Reduction of Drug-related Harms), stipulates that along with numerous other schemes and measures, these low-threshold structures should be used to further enforce the harm reduction policy (article L3121-5 of the Public Health Code). Thus, CAARUDs admit individuals and groups³⁹ and provide drug users with customised advice and information, support in obtaining access to treatment (which includes assistance with hygiene and access to first aid care), referrals to specialised or general treatment systems, encouragement to undergo screening for transmissible infections, support in exercising their rights, access to housing and professional integration or rehabilitation, provision of infection prevention equipment, and local resources outside the centre with a view to establishing contact with users. CAARUDs also perform "social mediation" to ensure satisfactory integration into the neighbourhood and to avoid the kind of nuisances typically associated with drug use. Their coordination with other organisations has been stipulated in a circular⁴⁰.

³⁵ Circulaire n°2002-57 DGS/DHOS du 30 janvier 2002 relative à la prescription de méthadone par les médecins exerçant en établissement de santé, dans le cadre de l'initialisation d'un traitement de substitution pour les toxicomanes dépendants majeurs aux opiacés. BO Santé n°2002/8 du 18 février 2002. (NOR MESP0230029C)

³⁶ Arrêté du 1^{er} avril 2008 relatif à la liste de soins ou traitements susceptibles de faire l'objet de mésusage, d'un usage détourné ou abusif, pris en application de l'article L.162-4-2 du Code de la sécurité sociale. JORF n°83 du 8 avril 2008. (NOR SJSP0808150A)

³⁷ Loi n°2004-809 du 13 août 2004 relative aux libertés et responsabilités locales. JORF n°190 du 17 août 2004. (NOR INTX0300078L)

³⁸ Loi n°2004-806 du 9 août 2004 relative à la politique de santé publique. JORF n°185 du 11 août 2004. (NOR SANX0300055L)

³⁹ Article R.3121-33-1 modified by Décret n°2005-1606 du 19 décembre 2005 relatif aux missions des centres d'accueil et d'accompagnement à la réduction des risques pour usagers de drogues et modifiant le Code de la santé publique. JORF n°297 du 22 décembre 2005. (NOR SANP0524015D)

⁴⁰ Circulaire n°2006-01 DGS/S6B/DSS/1A/DGAS/5C 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. BO Santé n°2006/2 du 15 mars 2006. (NOR SANP0630016C)

Since May 1987⁴¹, the unrestricted sale of syringes is authorised in retail pharmacies, in-house pharmacies located within health establishments and establishments dealing exclusively in medical-surgical and dental equipment or that have a specialised department for such sales. Since March 1995⁴², syringes may be issued free of charge by any not-for-profit association carrying out AIDS prevention or harm reduction measures among drug users and meeting the requirements described in a legislative order issued by the Ministry of Health (article D.3121-27 of the Public Health Code). The dispensing of syringes and needles to minors is only authorised upon presentation of a prescription (art. D.3121-28 of the Public Health Code). However, neither pharmacies nor associations are legally required to ask users for proof of their identity or age since the 1987 suspension of the provisions of the 1972 decree.

A national harm reduction standard for drug users was prepared (art. D. 3121-33 of the Public Health Code) and approved via the decree of 14 April 2005⁴³. 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 incitement to use drugs during their work.

Orientations of the national anti-drug strategy

The first interministerial anti-drug action plan dates back to 1983. The government plan, which spans 2013-2017 (MILDT 2013), was prepared by the French Interministerial Mission for the Fight against Drugs and Drug Addiction (MILDT) in coordination with the involved ministries. The MILDT also coordinates and listens to the advice of its network of drug addiction project managers (working under prefects), associations, local elected officials, local authorities and professional and community partners. This governmental plan was made public in September 2013 after its presentation before an interministerial commission chaired by the Prime Minister. This plan is complemented by an intermediary action plan that was adopted in January 2014 and sets forth concrete measures to support the governmental strategy until the end of 2015. A second plan will follow for the 2016-2017 period.

In March 2014, the coordinating body for the fight against drugs and drug addiction, initially known as the French Interministerial Mission for the Fight against Drugs and Drug Addiction (MILDT), became the **French Interministerial Mission for Combating Drugs and Addictive Behaviours (MILDECA)**.

Public expenditures and budgets

Public expenditures in the fight against drugs and drug addictions mainly fall within the scope of the budgets of the government and National Health Insurance Fund (*Assurance maladie*). The government's budget includes expenses for implementing public policy within the scope of law

⁴¹ Décret n°87-328 du 13 mai 1987 portant suspension des dispositions du décret n°72-200 du 13 mars 1972. JORF du 16 mai 1987. (NOR ASEM8700689D) ; Décret n°88-894 du 24 août 1988 portant suspension des dispositions du décret n°72-200 du 13 mars 1972. JORF du 27 août 1988. (NOR SPSM8801069D) and 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. JORF du 12 août 1989. (NOR SPSM8901501D)

⁴² Décret n°95-255 du 7 mars 1995 modifiant le décret n°72-200 du 13 mars 1972 réglementant le commerce et l'importation des seringues et des aiguilles destinées aux injections parentérales, en vue de lutter contre l'extension de la toxicomanie. JORF n°58 du 9 mars 1995. (NOR SPSP9500414D)

⁴³ Décret n°2005-0347 du 14 avril 2005 approuvant le référentiel national des actions de réduction des risques en direction des usagers de drogue et complétant le Code de la santé publique. JORF n°88 du 15 avril 2005. (NOR SANP0521129D)

enforcement and anti-trafficking as well as international cooperation, training, observation, research, communication, information and prevention (particularly in school settings). The majority of these health expenditures (primary care and hospital physicians) are covered by social security funds. Some of these expenditures are related to treatments for illnesses that were caused by drug use, but for which assessments are only based on estimates. According to the last available study (Kopp *et al.* 2006), the social cost of illegal drugs in 2005 represented approximately €2.8 billion, of which €732 million were spent on treating diseases related to the use of these substances.

Since the promulgation of the Constitutional by-law on budget acts (the LOLF) of 2001⁴⁴, the funds allocated by the government to central administration and decentralised services are presented on a per-programme basis. The resources available for the alcohol, tobacco and illegal drugs policy are found within about thirty programmes that mainly involve the ministries of foreign affairs, culture, defence, economics, national education, higher education and research, the interior, justice, health and labour. The expenditures that are part of these different programmes are allocated to one of five drug public policy areas: prevention of use, law enforcement and anti-trafficking measures, intensification and diversification of health treatment, research promotion, and finally, international actions. Since 2008, the government's budget for the fight against drugs has been presented in a transversal policy document (DPT) on drugs and drug addiction. The creation of this budgetary document, which follows government spending on an annual basis, is coordinated by the MILDECA. The resources used by local authorities (especially regions, departments and municipalities) to prevent and fight against drug use cannot be directly identified.

The amounts attributed by the National Health Insurance Fund (*Assurance maladie*) to preventing and treating addictions go towards reimbursing OSTs as well as funding specialised structures (CSAPAs, CAARUDs and CTs).

Public expenditure on the drug prevention policy, treatment, and drug supply curtailment measures has been the subject of numerous studies in France (Ben Lakhdar 2007; Díaz Gómez 2012; Kopp *et al.* 2000; Kopp *et al.* 2004; Kopp *et al.* 2006; Kopp *et al.* 1998).

1.2. Legal framework

This section focuses only on the legislation related to illegal drugs, chemical precursors or poisonous substances intended for human medicines, in compliance with the scope of observation of the EMCDDA. The legislation related to legal psychoactive substances, doping and gambling addiction – areas also covered by the government strategy against addictive behaviours – are therefore not described here.

Here, the legislative provisions adopted in France from July 2013 to July 2014 are presented, in line with the information provided by the preceding report (covering the period from June 2012 to June 2013). Over the observation period, relatively few new pieces of legislation have been added to the existing French legal arsenal against illegal drugs or poisonous substances.

⁴⁴ Loi organique n°2001-692 du 1er août 2001 relative aux lois de finances. JORF n°177 du 2 août 2001. (NOR ECOX0104681L)

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

Reinforcement of the prevention framework

According to the **law of 8 July 2013**⁴⁵ on the radical reform of the national education system, modifying the French Education Code, the promotion of health among students has become one of the missions of the French education system as a foundation for success and reducing health care inequalities. It is based on prevention and information actions, as well as on monitoring student medical care. Their objectives are, in part, to screen for problems that may hinder learning and to endow students with more responsibility regarding health risks "mainly to prevent and reduce addictive behaviour and psychological suffering". According to this legislation, health promotion in schools might include:

- early detection of health problems or treatment deficiencies that may interfere with education
- counselling, support and customised follow-up measures for students
- participation in epidemiological surveillance by collecting and making use of statistical data.

This integration of health promotion into educational missions is likely to incite more participation by school establishments in preventing addictive behaviours.

Sativex® Marketing authorisation

Following the 5 June 2013 decree⁴⁶ authorising the use of cannabis-containing medications (and not only the use of the active ingredient as before), the ANSM was able to evaluate the marketing authorisation (MA) dossier for the Sativex® oromucosal mouth spray (GW Pharmaceuticals) and on 8 January 2014, granted an MA for this medication only for the treatment of muscle spasms for Multiple Sclerosis sufferers⁴⁷. Until this date, only Marinol® (dronabinol) could be prescribed in France, and only within the scope of a temporary authorisation for use (ATU), which is a highly specialised procedure.

1.2.2. Laws implementation

The decrees, circulars and legislative orders adopted between July 2013 and July 2014 for the enforcement of existing laws are detailed hereinafter.

Pharmacovigilance and withdrawing medications from the market

By decree of 31 December 2012, the ANSM became responsible for collecting and processing reports on medications suspected of being falsified and of having quality defects (article R.5312-1 of the Public Health Code).

⁴⁵ Loi n°2013-595 du 8 juillet 2013 d'orientation et de programmation pour la refondation de l'école de la République. JORF n°157 du 9 juillet 2013. (NOR MENX1241105L)

⁴⁶ Décret n°2013-473 du 5 juin 2013 modifiant en ce qui concerne les spécialités pharmaceutiques les dispositions de l'article R. 5132-86 du code de la santé publique relatives à l'interdiction d'opérations portant sur le cannabis ou ses dérivés. JORF n°130 du 7 juin 2013. (NOR AFSP1308402D)

⁴⁷ Like in other European countries, where it is already authorised.

The **decree of 16 October 2013**⁴⁸ reinforced the role of the ANSM. Transposing the directive of 2012/26/EU of the European Parliament and the Council of 25 October 2012 instituting an EU Community-wide code for medications for human use, the decree established that, based on concerns regarding pharmacovigilance activities, the director of the ANSM can initiate the European Union emergency procedure:

- by deciding to suspend, withdraw or withhold the renewal of a marketing authorisation (MA) to protect public health, by waiting until a definitive decision is taken in application of the European Union (EU) arbitration procedure
- by informing the European Commission, the European Medicines Agency and the other EU Member states of any new contraindication or dosage variation deemed necessary to report
- by prohibiting the dispensing of a medication or a substance with a MA and by informing the competent EU authorities and the Member states of the reasons for this measure, and by providing all relevant scientific information at hand.

The text stipulates that the ANSM publish each year, on its website, the list of medications for which a MA was refused, withdrawn or suspended, or whose dispensing was prohibited, or that was recalled from the market in France and the European Union.

Prevention of drug use at the workplace

The **decree of 1st July 2014**⁴⁹ now explicitly enables employers to limit or prohibit the consumption of alcohol at the workplace by means of internal rules and regulations or in a memorandum in order to protect the health and physical or mental safety of their employees.

Stepping up prevention regarding driving under the influence of narcotics

The **legislative order of 19 November 2013**⁵⁰ adds three Pacific overseas territories (New Caledonia, French Polynesia and Wallis-and-Futuna) to the scope of the provisions established by the order of 5 September 2001⁵¹ for the screening of narcotics use and for the analyses and testing provided in the Traffic Code. In the event of bodily injury or a fatal accident, urine or saliva is tested for the presence of substances indicating the use of four families of narcotics - cannabinoids, amphetamines, cocaine and opioids. For a fatal accident (in which the consequences are immediately fatal), laboratory testing is conducted on a blood sample in order to determine the levels of the aforementioned substances. The screening of blood for psychoactive medicines affecting the ability to drive a motor vehicle can be performed at the request of the driver.

⁴⁸ Décret n°2013-923 du 16 octobre 2013 pris pour la transposition de la directive 2012/26/UE du 25 octobre 2012 modifiant en ce qui concerne la pharmacovigilance la directive 2001/83/CE instituant un code communautaire relatif aux médicaments à usage humain. JORF n°243 du 18 octobre 2013. (NOR AFSP1320840D)

⁴⁹ Décret n°2014-754 du 1^{er} juillet 2014 modifiant l'article R. 4228-20 du code du travail. JORF n°152 du 3 juillet 2014. (NOR ETST1404770D)

⁵⁰ Arrêté du 19 novembre 2013 complétant l'arrêté du 5 septembre 2001 fixant les modalités du dépistage des substances témoignant de l'usage de stupéfiants et des analyses et examens prévus par le code de la route. JORF n°292 du 17 décembre 2013. (NOR AFSP1320472A)

⁵¹ Arrêté du 5 septembre 2001 fixant les modalités du 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. JORF n°216 du 18 septembre 2001. (NOR MESP0123164A)

Public authority risk assessments and vigilance on the appearance of new and potentially dangerous substances

In France, the mission to assess the risks related to medicinal substances is mainly the task of the ANSM. When a case is being examined and requires an additional opinion, the ANSM refers to its consultative Commission, which, since February 2013, is comprised exclusively of independent experts selected for their knowledge in the areas of narcotics, psychotropics and pharmacodependence⁵² rather than their institutional affiliation.

Within the scope of their mission to perform vigilance on potentially dangerous substances since 2012, the French Ministry of Social Affairs and Health, along with the ANSM, revised the lists (I and II) of poisonous substances and medications classified as narcotics or subject to narcotics regulations. As a reminder, list I indexes poisonous substances intended for treatment or prevention and considered dangerous, and list II corresponds to substances deemed potentially dangerous. The amendments that were made in 2013 and in the first half of 2014 are listed hereinafter.

Injectable epinephrine, which is listed as a narcotic, can now be dispensed on pharmacist's order for professional use by a nurse (**order of 23 December 2013**⁵³).

Methoxetamine has been added to appendix IV of the list of substances classified as narcotics (**order of 5 August 2013**⁵⁴), as was "5-IT or 5-(2-aminopropyl) indole" (**order of 22 July 2013**⁵⁵).

The following, in all their forms, are classified as list I poisonous substances:

- medications containing a maximal dose per unit of 50 milligrams of opium powder titrated to 10% morphine, 25 milligrams of opium extract titrated to 20% morphine or 50 milligrams of poppy extract titrated to 1% morphine, which are henceforth no longer list II substances (**order of 6 February 2014**⁵⁶)
- avanafil, enzalutamide, lipegfilgrastim, lomitapide, ponatinib and vismodegib (**order of 16 December 2013**⁵⁷), cobicistat and elvitegravir (**order of 23 September 2013**⁵⁸), bosutinib, lixisenatide, nalmefene, ocriplasmin and pertuzumab (**order of 30 July 2013**⁵⁹)

⁵² Décision n°2013-18 DG du 1er février 2013 portant création d'une commission des stupéfiants et psychotropes à l'Agence nationale de sécurité du médicament et des produits de santé. JORF n°34 du 9 février 2013. (NOR AFSP1300036S)

⁵³ Arrêté du 23 décembre 2013 fixant la liste des médicaments prévue au dernier alinéa de l'article R. 5132-6 du code de la santé publique. JORF n°300 du 27 décembre 2013. (NOR AFSP1330194A)

⁵⁴ Arrêté du 05 août 2013 modifiant l'arrêté du 22 février 1990 fixant la liste des substances classées comme stupéfiants. JORF n°184 du 9 août 2013. (NOR AFSP1320886A)

⁵⁵ Arrêté du 22 juillet 2013 modifiant l'arrêté du 22 février 1990 fixant la liste des substances classées comme stupéfiants. JORF n°172 du 26 juillet 2013. (NOR AFSP1319276A)

⁵⁶ Arrêté du 06 février 2014 portant classement sur la liste des substances vénéneuses. JORF n°38 du 14 février 2014. (NOR AFSP1403314A)

⁵⁷ Arrêté du 16 décembre 2013 portant classement sur la liste des substances vénéneuses. JORF n°296 du 21 décembre 2013. (NOR AFSP1331018A)

⁵⁸ Arrêté du 23 septembre 2013 portant classement sur la liste des substances vénéneuses. JORF n°229 du 2 octobre 2013. (NOR AFSP1323991A)

⁵⁹ Arrêté du 30 juillet 2013 portant classement sur la liste des substances vénéneuses. JORF n°185 du 10 août 2013. (NOR AFSP1320366A)

The following substances have been added to poisonous substances list II:

- medications containing pseudoephedrine not associated with other active substances in a given dosage unit (**order of 6 February 2014**⁶⁰)
- esomeprazole, indicated for gastro-oesophageal reflux and for which the 20 mg dosage is not subject to medical prescription (**order of 11 October 2013**⁶¹).

1.3. National action plan, strategy, evaluation and coordination

1.3.1. National action plan and/or strategy

Government Plan 2013-2017

On 19 September 2013, during the Interministerial Committee, the Prime Minister adopted the *Plan gouvernemental de lutte contre les drogues et les conduites addictives 2013-2017*. An English version (2013-2017 Government Plan for Combating Drugs and Addictive Behaviours) of this plan is also available, and soon, a Spanish version of this plan will be available as well (MILDT 2013). In the title, the term "addictive behaviours" replaces "drug addiction". This change is indicative of the government's desire to expand its scope of intervention to include all addictions, i.e., any activity associated with a risk of addiction or characterising addiction, whether or not related to legal or illegal psychoactive substances. This evolution is also evidenced by the change in the name of the body in charge of government strategy, which in March 2014, became the French Interministerial Mission for Combating Drugs and Addictive Behaviours (MILDECA, formerly the MILDT).

This five-year government plan for combating drugs and addictive behaviours proposes a longer-term perspective than previous plans, and aims to promote the conditions necessary to consolidate experiences and provide consistent responses. The plan is based on three major priorities:

- basing public action on observation, research and evaluation: by gaining a better understanding of addictive behaviours, by supporting research on new medical treatments, by implementing innovative therapeutic strategies and social science research, and by making research a decision-making tool;
- considering the most exposed populations to reduce risks as well as health and social harm: by preventing, delaying and limiting use among young people, by improving treatment and support for female drug users, by bringing measures closer to marginal populations (whether physically marginal or socially marginal) and by preventing addiction in the workplace;
- reinforcing public security, order and health on a national and international level by fighting trafficking and all forms of criminality related to psychoactive substance use: by promoting the social acceptability of users as well as treatment and harm reduction measures (especially through social mediation actions), by improving coordination between the legal system and the health care system, by fighting local and international trafficking, and by considering emerging trafficking phenomena.

⁶⁰ Arrêté du 06 février 2014 portant classement sur la liste des substances vénéneuses. JORF n°38 du 14 février 2014. (NOR AFSP1403317A)

⁶¹ Arrêté du 11 octobre 2013 modifiant l'arrêté du 22 février 1990 portant exonération à la réglementation des substances vénéneuses destinées à la médecine humaine. JORF n°247 du 23 octobre 2013. (NOR AFSP1325658A)

This plan sets forth public action priorities: youth, women and precarious populations, many of whom rarely ask for treatment. Subsequently, it aims to improve accessibility to support measures and develop early detection. To fight local and international trafficking, the plan advocates an integrated, responsive approach so that policies can be adapted in real time to the challenges represented by ever-changing criminal networks. Strengthening operational intelligence, adapting investigatory techniques and resources and sharing expertise are key elements of the plan.

2013-2015 Action plan

In January 2014, MILDECA published its first 2013-2015 Action plan within the framework of the government's five-year strategy (MILDT 2014). Based on five areas of public response (prevention and communication, anti-trafficking, law enforcement, research and public action coordination), the action plan outlines 131 actions intended to make the 16 strategies of the governmental plan operational. For each action, the Action plan describes supervisory bodies and partners, the timetable and the expected effects. The breakdown of actions into those that reduce demand, those that reduce supply and those that do both is presented in Table 1.1.

Table 1.1: Breakdown of actions by strategy covered in the 2013-2015 "Drugs" Action plan

Strategies	Number of actions targeted
Prevention and communication	61
1.1 Prevention and communication	23
1.2 Support and treatment	22
1.3 Reduction of health risks and social harm	14
1.4 Actions specifically for Overseas Departments and Territories	2
Anti-trafficking	18
2.1 Preventing trafficking	6
2.2 Acting on different types of trafficking by adapting the degree of public response	5
2.3 Preventing trafficking by reinforcing anti-money laundering measures and an asset-based approach to legal investigations	2
2.4 Acting with respect to major emerging production and supply trends	3
2.5 Promoting targeted anti-narcotics trafficking in Overseas Departments and Territories	2
Law enforcement	19
3.1 Using the law to protect populations	11
3.2 Fighting criminality resulting directly or indirectly from excessive alcohol use and narcotics use	4
3.3 Acting against doping and medication misuse	4
Research	28
4.1 Supporting research and observation	4
4.2 Harmonising the content of initial and continuing training through a common base of knowledge and skills	24
Coordination of national and international actions	11
5.1 Reinforcing the efficiency of central and territorial governance	2
5.2 Reinforcing France's action on both European and International levels	9

Source: MILDECA

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

In order to improve the governance of the public anti-drug and anti-addictive behaviour policy, the new governmental plan describes the need for scientifically validated data that can be used to devise more effective, sounder public policy. With this in mind, the plan provides for a midpoint assessment of a few innovative actions or measures pertaining to the plan's strategic objectives, and more specifically, actions and measures targeting youth, women and precarious populations.

The assessment, which is conducted by independent researchers, should enable its content to be taken into consideration with the drafting of the second governmental strategy action plan.

Following a request for applications tendered by the MILDECA in March 2014, a team of academic researchers specialising in political science is currently being selected.

1.3.3. Other drug policy developments

Frameworks in addition to those that come directly from the government drug strategy are likely to influence public drug response. These documents are briefly mentioned here.

2014-2019 Cancer plan

The 2014-2019 Cancer plan (Ministère des Affaires sociales et de la Santé *et al.* 2014) provided for a National Tobacco Smoking Reduction Programme (PNRT) based on a few key principles: dissuading new tobacco users, facilitating quitting and conducting a consistent pricing policy. As a reminder, tobacco is one of the legal drugs targeted by the French anti-addictive behaviour strategy (see chapter 3).

Multi-annual plan against poverty and for social integration

The multi-annual plan against poverty and for social integration, which was established for the period running from 2013-2017, was adopted on 21 January 2013 by the Interministerial committee to combat social exclusion (CILE) (Premier ministre 2013). This plan makes fighting against health care inequalities in public health law a priority, and focuses special attention on certain areas, such as addiction treatment. The Plan recommends studying the feasibility of permanent addiction services in penal establishments to ensure better treatment and follow-up care.

Health care treatment for inmates 2010-2014

The 2010-2014 "health/prison" strategic actions plan on health policy for inmates (Ministère de la santé et des sports *et al.* 2010) reiterates the principles of treatment, both physical and psychiatric, for inmates. The interministerial circular of 30 October 2012⁶² suggested a framework agreement for field workers to ensure that inmates exercise their social welfare rights.

⁶² Circulaire n°2012-373 interministérielle DGOS/DSR/DGS/DGCS/DSS/DAP/DPJJ du 30 octobre 2012 relative à la publication du guide méthodologique sur la prise en charge sanitaire des personnes placées sous main de justice. BO Santé, Protection sociale et Solidarité n°11 du 15 décembre 2012. (NOR AFSH1238354C)

Drug consumption room experiment

On 8 October 2013, the Council of State⁶³ reviewed a draft decree covering an experiment with drug consumption rooms and issued a negative opinion regarding opening such a facility, reasoning that the current legal framework, which was established by the law of 1970, did not authorise such measures and thus would first need to be amended.

Following this opinion, a civil association submitted a request to the Administrative Court of Paris on 14 October 2013 to suspend the government's decision for drug consumption rooms' experimentation. The Judge in Chambers overruled the request of the plaintiffs in an order issued on 31 October 2013⁶⁴, challenging the seriousness and immediacy of the public health effects, and therefore, the urgent nature of the suspension.

In order to ensure that it is a legal measure, the experiment is subject to its inclusion in the forthcoming public health law⁶⁵.

1.3.4. Coordination arrangements

An interministerial committee, which in 2014 became the "Interministerial committee for Combatting Drugs and Addictive Behaviours", prepares governmental decisions on both national and international levels. The MILDECA presides over this committee and prepares meetings to ensure the coordination of the governmental action. It relies on its network of project managers to adapt the governmental plan's policy on a local level.

National interministerial coordination

The **decree of 11 March 2014**⁶⁶ stipulates the scope of the interministerial mission, amending articles R.3411-11 to R.3411-13 of the Public Health Code. It ratifies the widening of the scope of expertise of the interministerial mission and committee to include all psychoactive substances, including legal ones (alcohol, tobacco, psychotropic medications) and non-substance related addictions, by replacing the term "drug addiction" with "addictive behaviours" in their titles. The French Interministerial Mission for the Fight against Drugs and Drug Addiction (MILDT) subsequently becomes the French Interministerial Mission for Combating Drugs and Addictive Behaviours (MILDECA).

Moreover, this decree explicitly mentions the MILDECA's expertise in limiting supply and reducing demand, making anti-trafficking measures and international action areas in which mission coordination is fully exercised.

⁶³ The Council of State (*Conseil d'Etat*) advises the government in matters of drafting laws, orders and certain decrees, and is the highest administration jurisdiction in France.

⁶⁴ Ordonnance du juge des référés du 31 octobre 2013 relative à la demande de l'association Parents contre la drogue d'ordonner la suspension de la décision du Premier ministre du 5 février 2013 d'ouvrir "une salle de shoot expérimentale à Paris", Tribunal administratif de Paris, 31 octobre 2013, n°1314533/9

⁶⁵ The key elements of this national health strategy, which should be reviewed by the French *Assemblée Nationale* in early 2015, were presented in June 2014. Regarding addictive behaviours, prevention among young people will be reinforced (particularly thanks to national tobacco reduction programme (PNRT) measures), harm reduction and the use of rapid diagnostic tests (RDTs) will be developed in prison settings, and a legal framework for drug consumption rooms' experimentation will be set forth.

⁶⁶ Décret n°2014-322 du 11 mars 2014 relatif à la mission interministérielle de lutte contre les drogues et les conduites addictives. JORF n°61 du 13 mars 2014. (NOR PRMX1402311D)

Territorial interministerial coordination

Departmental and regional project managers adapt governmental anti-drug and addiction behaviour prevention strategies to local needs by ensuring consistency in actions to limit supply and reduce demand (circular of 14 February 2013⁶⁷). They receive a grant to be used solely for drug use prevention and make mutual actions that can be modelled (i.e., transferable) a priority, especially in terms of training, communication and tool development. The amount of this grant is determined for each region based on objective criteria (number of departments, size of population of young people, most frequent uses by young people and narcotics legislation offences). They must work in coordination with the missions of regional health agencies (ARS) and education authorities to share credits.

An evaluation of this policy on a territorial level was conducted by three major, general inspectorates of social affairs, administration and legal services (the IGAS, IGA and IGSJ respectively). Their purpose in doing so was to take stock of the conditions needed to optimise the organisation of territorial partners and of the supervision by project managers. The inspection report was submitted in March 2014. These recommendations are still being reviewed.

1.4. Economic analysis

This section describes the information available on expenditures and revenues related to the French anti-drug strategy, although a true economic analysis is not provided per se.

1.4.1. Public expenditures

The first action plan established for the 2013-2015 period within the scope of the new Government plan for combating drugs and addictive behaviours has been granted a budget of €58.8 million for its implementation. One quarter (24%) of this budget is granted by the MILDECA. Half must be provisioned by those ministries involved in the fight against drugs (in addition to the funds they dedicate to their regular actions in the area). The remainder is provided through the Social Security budget act (see tables 1.2 and 1.3).

Table 1.2: Breakdown by source of the allocated Action plan 2013-2015 budget (in €)

Source	Amount
MILDECA	14,220,000
Ministries	28,673,000
Social Security	15,950,000
Total	58,843,000

Source: MILDECA

⁶⁷ Circulaire n°2013-75 du 14 février 2013 relative à l'organisation du réseau territorial de la MILDT

Table 1.3: Breakdown by action type of the allocated Action plan 2013-2015 budget (in €)

Action type	Amount	Share
Prevention	8,711,300	15%
Support and treatment	36,210,000	62%
Anti-trafficking	3,056,000	5%
Law enforcement	260,000	0.4%
Research and observation	4,298,000	7%
Training	987,700	2%
International action	5,580,000	9%
Total	58,843,000	100%

Source: MILDECA

1.4.2. Revenues

The "Narcotics" support fund, which is the result of the proceeds from the sale of assets confiscated as part of criminal narcotics proceedings, is overseen by the MILDECA⁶⁸. Ninety percent (90%) of the revenues paid into this fund are distributed to the ministries responsible for combating trafficking and enforcing the law, to fund the procurement of equipment and operations. The remaining 10% are used by MILDECA to fund prevention actions, and especially local prevention efforts.

This fund represents an additional, but unpredictable, resource. It is characterised by significant fluctuations due not only to the volumes seized but also to the sentences finally handed down: according to the AGRASC (Agency for the recovery and management of seized and confiscated assets) less than 20% of seized assets end up being definitively confiscated (Cohen 2013).

Other than the exceptionally high levels this fund achieved in 2010 and 2011 (due to the finalisation of old cases and some exceptional seizures), the revenues of the support fund fall in a bracket of €8 to €10 million per year from 2008 to 2012. In 2013, the amount was €11 million.

⁶⁸ Décret n°1995-322 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. JORF n°71 du 24 mars 1995. (NOR BUDB9560005D) and 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. JORF n°226 du 28 septembre 1995. (NOR SANG9502738A)

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

2.1. Introduction

One of the OFDT's tasks is to monitor legal and illegal drug use and to keep track of trends on a national scale. Since 1997, it has contributed to the implementation of quantitative surveys on drug use among samples and/or subsamples representative of the French population aged from 11 to 75. Repeated regularly, these surveys enable changes in substance use behaviour to be monitored. This involves:

- quantifying the levels of use of the different substances;
- describing the diversity of this use (specifically, distinguishing levels of use: recent, regular, daily, etc.);
- measuring relationships with other factors;
- observing trends;
- performing regional or even departmental mapping;
- measuring representations, perceptions and opinions about psychoactive substances.

Surveys of the general population first and foremost provide information about drug use and the most widely consumed drugs. The surveys also enable to quantify drug use in socially integrated populations. They are not suitable for identifying at-risk drug use and illegal drug addictions (with the exception of cannabis, which is widely used).

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

The survey system

The foundation of the survey system consists of five regular surveys of the general population, conducted on adults or adolescents, via two data gathering methods: telephone interview and self-completed paper questionnaire. The first method applies to adults and young people aged 15 and over. Two surveys use this method: the first is the illicit drug consumption survey, which is incorporated into the Health Barometer (see appendix V-Health barometer). It has been conducted every five years by the INPES since 1995. It asks 15 to 75 year-olds (15 to 85 year-olds in 2010) about their behaviour and attitudes towards health. The second is the Survey on representations, opinions and perceptions regarding psychoactive drugs (EROPP, see appendix V-EROPP) conducted by the OFDT on 15 to 75 year-olds.

These surveys do not allow the different practices to be viewed from all angles. Hence surveys arose for adolescents, who are at an age when young people typically experiment with psychoactive substances and sometimes enter into a more regular drug use. The OFDT carries out three surveys among this population using the most suitable collection method, a self-completed paper questionnaire. The OFDT supports the “drugs” section of the Health Behaviour in School-aged Children (HBSC, see appendix V-HBSC) survey carried out in school settings in 41 countries or regions on pupils aged 11, 13 and 15 years. The European School Survey on Alcohol and Other Drugs (ESPAD, see appendix V-ESPAD) enables the use of 15 to 16 year-olds students to be observed in 36 countries. To overcome the limitations of surveys in school

settings (e.g., lack of school drop-outs, an underestimation of absenteeism), the OFDT has implemented a survey on health and use of 17 year-olds (ESCAPAD, see appendix V-ESCAPAD) carried out on National defence and citizenship day (JDC). All those called, present on certain given days, complete a questionnaire on site about their health, drug and alcohol use.

These three surveys of the adolescent population enable the development of drug use, and particularly regular cannabis use, to be observed throughout adolescence, i.e., between the ages of 11 and 17 years.

Framework data

General population surveys give an idea of the number of users (see table 2.1). However, they are framework data and not exact estimations.

Of the illicit drugs, cannabis is by far the most frequently used substance, with an estimated 13.4 million lifetime users (i.e., people who have used cannabis at least once during their life). Close to one million people regularly use cannabis in France. The use of cocaine, the second most frequently used illicit substance, is well below that of cannabis and concerns approximately one tenth the number of people. This statistic includes those who have used cocaine at least once in their life (lifetime users) or at least once in the past year.

Table 2.1: Estimation of the number of psychoactive substance users in mainland France among 11 to 75 year-olds in 2011

	Illicit substances				Licit substances	
	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
including last year users*	3.8 M	400,000	150,000	//	41.3 M	15.8 M
including regular users*	1.2 M	//	//	//	8.8 M	13.4 M
including daily users	550,000	//	//	//	5.0 M	13.4 M

Sources: Health Barometer 2010 (INPES), ESCAPAD 2011 (OFDT), ESPAD 2011 (OFDT), HBSC 2010 (medical department of the Toulouse education system - INSERM U1027)

// : 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 substance in the population)
- **Last year use:** use at least once during the previous year; for tobacco, this includes people who report that they smoke, even if only occasionally
- **Regular use:** consumption of alcohol at least three times per week, daily tobacco use, and consumption of cannabis at least 10 times per month or at least 120 times during the previous year.

N.B. In France, the number of individuals aged 11-75 years in 2011 was approximately 49.7 million

A margin for error exists even if it seems reasonable in this framework data. For example, taking the confidence interval into account, 13.4 million lifetime cannabis users indicates that the number of lifetime users probably ranges from 13 to 14 million.

2.2. Drug use in the general population

Stabilisation in the levels of cannabis use among 15 to 64 year-olds

Cannabis is by far the most widely used illicit substance in France. In 2010, among individuals aged 15 to 64 years, around a third (32.1%) admitted to having used cannabis during their lifetime. More men than women had engaged in lifetime use (39.5% compared with 25%). Among 15-64 year-olds, 8.4% have used cannabis over the last 12 months (11.9% of men and 5.1% of women), whereas the overall proportion of users during the month is 4.6%.

Although lifetime use rose from 28.8% to 32.1% for all age brackets between 2005 and 2010 (see table 2.2), cannabis use remains stable. The slight increase observed is mechanical, linked to a “stock” effect of former generations of smokers.

Significant increase in lifetime cocaine use

With 1.5 million lifetime users aged 11 to 75 (i.e. 3% of the general population) and 400,000 last year users, cocaine ranks second among the most widely consumed illicit substances, 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 during the past year (see table 2.2).

The proportion of 15 to 64 year-olds who have used cocaine at least once 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 Health Barometer surveys. Use in the last year almost doubled between 2005 and 2010, from 0.5% to 0.9% (see table 2.2). This is a statistically significant increase.

Increase in the use of heroin, amphetamines and poppers and decrease in the use of ecstasy

The use of other drugs remains marginal across the entire 15 to 64 year-old population. Nevertheless, some substances have undergone more widespread use since 2005.

Following a stable period between 2000 and 2005, lifetime use and last year use rose significantly in 2010. The prevalence of heroin lifetime use went from 0.8% in 2005 to 1.2% in 2010 among 15 to 64 year-olds.

Lifetime use of hallucinogenic mushrooms has increased slightly in both genders whereas last year use has remained stable. The levels of lifetime amphetamine use increased from 2000 to 2010, going from 1.3% to 1.7%. Current use of ecstasy is on the decline. Users are not only shifting to the powder (or capsule) and crystal forms of MDMA, but they are also switching to amphetamines, cocaine or other synthetic stimulants.

Poppers (whose legal status has changed in recent years) represent the psychoactive substance with the most frequent levels of lifetime use after alcohol, tobacco and cannabis: 5.2% of 15 to 64 year-olds state having tried poppers; they were 3.7% in 2005 (Beck *et al.* 2011).

Table 2.2: Changes in lifetime and last year use (current use) of psychotropic substances among 15 to 64 year-olds from 2005 to 2010 (expressed as a %)

	Experimentation			Current use		
	2005	2010	2005 vs 2010	2005	2010	2005 vs 2010
Cannabis	28,8	32,1	↗	8,3	8,4	→
Poppers	3,8	5,2	↗	0,6	0,9	↗
Cocaine	2,4	3,6	↗	0,5	0,9	↗
Hallucinogenic mushrooms	2,6	3,1	↗	0,3	0,2	→
Ecstasy/MDMA	2,0	2,5	→	0,5	0,3	↘
Glues and solvents	1,7	1,9	→	0,1	0,4	↗
LSD	1,5	1,7	→	0,1	0,2	→
Amphetamines	1,3	1,7	↗	0,1	0,2	↗
Heroin	0,8	1,2	↗	0,1	0,2	↗

Source: Health Barometer 2010 (INPES, processed by OFDT)

Perceptions of the risks related to drug use

In 2013, a large majority of French people aged 15 to 75 considered that cocaine and heroin are dangerous from the first time they are used (90% and 85% respectively). These numbers had not notably changed since 2008 (see table 2.3). For cannabis, the level of perceived danger is less, and is on the decline compared with 2008 levels (54% versus 62%). This perception varies with age and is strongly related to proximity to the substance. Subsequently, people who have already used cannabis tend to state higher danger thresholds, and compared with non-users, are twice as many to think that people can live normal lives if they regularly use cannabis (39% versus 17% respectively). Moreover, 70% of French people state that they agree with the statement, "smoking cannabis leads people to use more dangerous substances" (Tovar *et al.* 2013).

Table 2.3: Changes in perceptions of danger levels for different drugs from 2002 to 2013 (in %)

	Heroin			Cocaine			Cannabis		
	2002	2008	2013	2002	2008	2013	2002	2008	2013
Dangerous from first use	87	92	90	82	88	85	51	62	54
Dangerous even when used occasionally	6	4	4	8	6	7	12	13	15
Dangerous only when used on a daily basis	6	4	6	8	6	8	33	25	30
It is never dangerous	0	0	0	0	0	0	3	1	1

Source: EROPP 2002, 2008, 2013 (OFDT)

2.3. Drug use in the school and youth population

The results of the latest HBSC, ESPAD (both of these are conducted in school settings) and ESCAPAD surveys are consistent in terms of the particular use of cannabis among adolescents in France. Cannabis stands out as the illicit substance most widely used between the ages of 11 and 17 years, particularly among boys. In terms of lifetime cannabis use, in 2010 it was extremely rare among 11 year-olds. It was found in 6.4% of 13 year-olds (representing an increase compared with 2006 figures (4.8%) and stabilised at 28.0% among 15 year-olds.

Almost two out of five young people (39%) born in 1995 (aged 16 in 2011) have used cannabis at least once during their lifetime. This represents an increase compared with the last measurement recorded in the 2007 ESPAD survey (30%). Among 17 year-olds, in 2011 41.5% of them had used cannabis at least once in their life, with a stable trend for the 2008-2011 period.

Reported use of cannabis over the last 30 days has proved to be marginal among adolescents under the age of 15. Cannabis use is stabilising among 15 year-olds (12.5% vs. 14.4%, in 2006, non significant change). Cannabis is used by 24.0% of 16 year-olds representing a significant increase compared with 2007 (15.0%), and cannabis use is decreasing slightly in 17 year-olds (22.4% vs. 24.7% in 2008).

Lifetime use of other illicit or misused drugs remains rare. Solvents and inhaled substances are the most common substances subject to lifetime use by schooled 15 year-olds. These are followed by cocaine, crack and amphetamines, “medicines for getting high”, with heroin and LSD rounding off the picture.

Adolescents 16 years of age have also stabilised their use of other illicit drugs. There are no significant changes to report regarding lifetime use of these substances.

Adolescents 17 years of age were the largest population to use illicit products at least once in their lifetime and test other substances: poppers, (9.0%) inhaled substances (5.5%), hallucinogenic mushrooms (3.5%) cocaine (3.0%), amphetamines (2.4%) and ecstasy (1.9%). Lifetime use of GHB, crack and heroin were especially low (less than 1.0%). The spread of all of these substances fell overall between 2008 and 2011.

At-risk cannabis use in adolescents under the age of 17

The Cannabis Abuse Screening Test (CAST) is a scale that is used to screen for problem cannabis use; each of the six items on the scale describes specific contexts of use (e.g., use alone or in the morning) or problems encountered within the scope of cannabis use (memory disturbances, failed attempts to quit, violence-related issues or accidents)⁶⁹ (Legleye *et al.* 2013). Conducted for the first time in 2002 as part of the ESCAPAD survey (Beck *et al.* 2008), its current version was first considered the definitive version in 2006 (Legleye *et al.* 2007). The time scale adopted is that of the year preceding the survey.

In 2011, among adolescents 17 years of age who had engaged in last year use of cannabis and who completed the test (28% of the ESCAPAD 2011 sample), one in ten stated having fairly often or very often smoked cannabis alone. The same proportion of young last year users stated having smoked in the morning or that friend or member of their family had suggested that they limit their use (see table 2.4). The three other items, which explicitly mention problems related to cannabis use, are much less frequently reported. The responses are positive for far fewer girls than boys, except for the memory disturbances, which are mentioned by 5% of users, regardless of whether they are male or female.

⁶⁹ To calculate a score, the responses are coded on a scale of 0 to 4. The total score obtained (which can range from 0 to 24) indicates whether or not the questioned users are at risk. A score of less than 3 indicates no addiction risk. A score of 3 or less than 7 indicates low addiction risk, and a score of 7 or above indicates high addiction risk.

Table 2.4: Percentage of 17-year-old respondents answering "fairly often" or "very often" to various CAST questions in 2011 (%)

	Boys	Girls	Boys + Girls
You smoked cannabis when you were alone	13.4	6.0*	10.2
You smoked cannabis before midday	12.7	6.2*	9.9
Your friends or members of your family said you should limit your cannabis use	12.0	6.7*	9.7
You tried to reduce or stop your cannabis use, without success	6.7	4.4*	5.7
You have experienced memory problems when smoking cannabis	4.9	5.0	4.9
You have had problems related to cannabis use	5.9	3.4*	4.8

Source: ESCAPAD 2011 OFDT

*: statistically significant difference between girls and boys ($p < 0.001$)

In 2011, of the 17-year-olds who had engaged in last year cannabis use, 18% were at high risk of problem use (score ≥ 7) and more boys than girls (x 1.8) had clearly higher at-risk use (see table 2.5). When extrapolated to the entire 17-year-old population in 2011, one in 20 is allegedly addicted to cannabis.

Table 2.5: CAST score among 17-year-old cannabis users in 2011 (%)

	0]0; 3[[3; 7[≥ 7
Boys	29.0	24.0	24.3	22.8
Girls	41.7	27.4	18.1	12.8
Boys + Girls	34.5	25.5	21.6	18.4

Source: ESCAPAD 2011 OFDT

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

/

3. Prevention

3.1. Introduction

Main points and references

In France, the scope of the drug use prevention policy has been expanded to include legal psychoactive substances (such as alcohol, tobacco and psychotropic drugs). The main principles of the policy are to prevent people from experimenting with drugs in the first place, or at least to delay experimentation, and to prevent or limit misuse. In school settings, the general intervention framework focuses on preventing addictive behaviour, which more generally falls within the province of health education.

The National institute for prevention and health education (INPES) distributes information on scientifically-validated prevention methods (Bantuelle *et al.* 2008). These documents are still to be used for information purposes only: there is no specific drug use prevention protocol for prevention actors, public servants or associative workers to follow.

Since there is no suitable observation system, there is little review of the implementation of these principles and of best practices. However, certain ideas seem to have been more widely adopted, such as an understanding of the limitations of a purely informative approach and the relevance of developing psychosocial skills, an interactive approach and the preventive role played by parents.

The general context and key players

The public authorities implement drug use prevention initiatives, but can delegate this task to associations when a local approach is more appropriate.

In school settings

The campaigns are mainly on universal prevention and are primarily conducted in secondary schools, where the education community is widely involved in coordination and execution.

Starting with the new 2014-2015 school year, and with support from Health and Citizenship Educational Committees (CESC), education teams will systematically integrate addictive behaviour prevention efforts into the programme for their school and establishment. The CESC, which is chaired by the head teacher of the establishment, brings together the educational community and competent external partners. The CESC supports secondary school addictive behaviour prevention policy and actions. Local administrative authorities provide head teachers with recommendations based on ministerial guidelines.

There are three main categories of professionals who work with young people: 1. educational, social and health personnel, 2. personnel from associations that specialise in prevention or health education, and 3. specially-trained law enforcement officers (FRAD, PFAD)⁷⁰.

⁷⁰ FRAD: *Formateurs relais anti-drogue* (drug prevention educators of the French *gendarmerie nationale*); PFAD: *Policiers formateurs anti-drogue* (drug prevention educators of the French police force).

Since 2006, preventing addictive behaviour has been given a new foothold in the basic missions of the French education system through defining the “*socle commun de connaissances et de compétences*” (“common base of knowledge and skills”). This common base encompasses all of the knowledge, skills, values and attitudes that every student must master by the end of mandatory schooling for their life as future citizens⁷¹. Of these, “social and civic skills” and “independence and initiative skills” figure among the individual and social skills that form part of the life skills (Botvin *et al.* 2002) likely to be employed by students when confronted with drugs.

Agricultural secondary and higher education establishments are also relatively free to determine their level of commitment to prevention, but they are strongly encouraged by their supervisory ministry (the Ministry of agriculture) to invest in such efforts. Since 2001, professionals of agricultural education have enjoyed access to the Adolescent health education, counselling and development network (RESEDA), which encourages dialogue, training and the distribution of drug prevention resources, and extends invitations to tender in the field of health education and prevention.

Actions intended for students of establishments of higher education are organised by the S[I]UMPPS, or [inter]university preventive medicine and health promotion services. Student associations and complementary student health insurance companies also participate in this area.

In the workplace

At the workplace, preventing alcohol, drug or psychotropic medication use is partially regulated by the Labour Code and Public Health Code (see chapter 1). The extent to which occupational policies are implemented in companies to prevent the risks related to drug and alcohol use varies. Sometimes, they are limited to specific provisions of a company's internal rules and procedures, but they can also be part of a comprehensive company harm prevention policy that engages personnel representative bodies as part of the legal obligation to ensure employee safety and protect employee health. Preventing drug and alcohol use at the workplace is now clearly one of the roles of an occupational physician (according to the 20 July 2011 law⁷² that has been applicable since 1st July 2012).

At-risk populations

Prevention targeting “at risk” populations (referred to as “selective prevention”) or users (“indicated prevention”) is handled mainly by specialised associations or by law enforcement services, particularly in neighbourhoods (outside of the school environment) or as part of a legal response. Youth Addiction Outpatient Clinics (CJCs)⁷³ and drug awareness courses exist for these young users (see chapter 9).

⁷¹ Décret n°2006-830 du 11 juillet 2006 relatif au socle commun de connaissances et de compétences et modifiant le Code de l'éducation. JORF n°160 du 12 juillet 2006. (NOR MENE0601554D)

⁷² Loi n°2011-867 du 20 juillet 2011 relative à l'organisation de la médecine du travail. JORF n°170 du 24 juillet 2011. (NOR ETSX1104600L)

⁷³ The purpose of CJCs is to provide information and customised advice to young users and their families, and to support them in their attempts to stop drug use or to obtain longer-term management, if necessary by referring them to other specialised services. A national CJC information campaign targeting young people will be conducted in the autumn of 2014. The aim of this campaign is to promote these support measures.

National campaigns

For the last decade or so, public authority media campaigns on drugs were launched by relevant ministries, the INPES and MILDECA. These entities worked together on certain campaigns. The nature of the drug prevention messages, the substances mentioned (depending on whether a global or another approach has been adopted) and the priority target populations (young people, parents, the general population, professionals) vary with governmental positions. The media used to deploy these activities are just as diverse and include, with increasing frequency, the Internet and social networks. The budget allocated to such activities can vary from campaign to campaign. These campaigns are usually subject to pre- and, sometimes, post-assessment tests (population, memorisation, approval).

Observation and data

There are no national systems in place to observe prevention actions in all of the main, active sectors of the area. The experimental RELIONPREDIL survey (see appendix V-RELIONPREDIL) coordinated by the OFDT from 2006 to 2011 will no longer be conducted due to the low response rate among educational establishments.

In summary, responses to prevention efforts in France come from key institutional players and the description of field actions is based on incomplete feedback.

The legislative framework

Since 2004⁷⁴, French secondary schools have been required to provide at least one annual session per uniform age group to disseminate information on "the consequences of drug use on health, and particularly the neuropsychological and behavioural effects of cannabis".

A major legislative framework regulates tobacco and alcohol advertising, accessibility and use in public places, as well as the taxation on these drugs, the purpose of which is to limit consumption.

National and local coordination and financing

The policies for preventing legal and illegal drug use are established by long-term government plans, coordinated by the MILDECA, and then adapted locally by MILDECA project managers (see chapter 1). These can be mirrored by or enhanced with programmes or national plans from various ministries (of National education or Health in particular).

Since 1995, sales of assets seized during drug-trafficking repression efforts have been turned over to the MILDECA-managed Narcotics support fund. The majority (90%) of the support fund is used for anti-trafficking purposes, while the remaining 10% is earmarked for prevention actions. The French National Health Insurance Fund system (*Assurance maladie*) also subsidises prevention actions through the French National Fund for Prevention, Education and Health Information (FNPEIS). Various cross-territorial local 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

⁷⁴ Loi n°2004-806 du 9 août 2004 relative à la politique de santé publique. JORF n°185 du 11 août 2004. (NOR SANX0300055L)

for education and urban planning (based on socioeconomic, housing quality and educational indicators) makes it possible to channel additional resources into underprivileged populations.

Measures designed to support decision-makers and professionals

The INPES has the task of assessing and developing preventive measures and implementing national programmes (particularly media campaigns). On its website, it provides a set of drug use prevention tools, the quality of which has been validated⁷⁵.

In February 2014, in compliance with what is set forth in the Government plan for combating drugs and addictive behaviours 2013-2017 (MILDT 2013), MILDECA implemented the Interministerial Commission for the Prevention of Addictive Behaviours (CIPCA). The purpose of this commission is to promote and disseminate a new prevention policy based on data and scientific models as well as on programmes that have proven to be effective.

L'UNIRÉS, which is the health education network for French universities, offers training to health educators. The UNIRÉS designs and provides training tools, such as Profédus, which was developed for the University Institute for Teacher Training (IUFM, which has become a network of schools of higher learning on professorship and education, or ESPEs) and the INPES, as well as a platform for distance initial or continuing education.

Federated organisations⁷⁶ represent associations that specialise in public debate. These organisations support professional dialogue and implement training, conference cycles and think tanks on drug demand reduction.

Finally, regionally, local associational structures can help people working in prevention by providing methodological project development advice.

3.2. Environmental prevention

3.2.1. Alcohol and tobacco policies

The various components of alcohol- and tobacco-related environmental prevention policy are set forth in the 2013 national report (Mutatayi 2013). Historically, they are extensively regulated, mainly through the 10 January 1991⁷⁷ anti-tobacco and anti-alcohol law, the so-called "Loi Évin", which was amended by the decree of 29 May 1992⁷⁸ and then the law of 21 July 2009⁷⁹, the so-called "Loi HPST", to be integrated into the French Public Health Code.

⁷⁵ http://www.inpes.sante.fr/CFESBases/catalogue/rech_doc.asp [last accessed 20/10/2014]

⁷⁶ FNES: *Fédération nationale d'éducation et de promotion de la santé* (National federation for health education); Fédération addiction: www.federationaddiction.fr; FFA: *Fédération française d'addictologie* (French federation of addictology): www.addictologie.org; CRIPS: *Centres régionaux d'information et de prévention du sida* (Regional AIDS information and prevention centres): www.lecrips.net/reseau.htm

⁷⁷ Loi n°1991-32 du 10 janvier 1991 relative à la lutte contre le tabagisme et l'alcoolisme. JORF n°10 du 12 janvier 1991. (NOR SPSX9000097L)

⁷⁸ Décret n°1992-478 du 29 mai 1992 fixant les conditions d'application de l'interdiction de fumer dans les lieux affectés à un usage collectif et modifiant le code de la santé publique. JORF n°125 du 30 mai 1992. (NOR SANP9201055D)

⁷⁹ Loi n°2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires. JORF n°167 du 22 juillet 2009. (NOR SASX0822640L)

Today, whether referring to tobacco or alcohol, French law:

- prohibits smoking in public places;
- regulates the composition of tobacco products;
- prohibits the sale or free distribution to minors of tobacco products, including papers and filters, as well as of alcoholic beverages;
- prohibits the sale or free distribution of unlimited alcoholic beverages for commercial purposes (open bars), except during traditional festivals or authorised tastings;
- prohibits encouraging minors to habitually consume alcohol, or to consume alcohol to excess or drunkenness;
- prohibits offering alcoholic beverages at temporarily reduced prices (happy hour) without also offering, for the same duration, non-alcoholic beverages at reduced prices;
- regulates advertising, taxation and sales of these substances (alcohol and tobacco).

Taxation

The taxation rate changes that occurred in 2014, as well as sales data, are provided here.

Alcohol

The tax scheme applied in France to alcohols and alcoholic beverages complies with European Community legislation. Taxation varies with the five beverage categories: wines, beers, other fermented beverages (such as cider), intermediary products (such as fortified wine) and other alcohols (mainly spirits).

Alcoholic beverage taxation includes excise taxes and value added tax (VAT). Besides, some alcoholic beverages are subject to taxation that has a public health objective: this is the case for alcopops, which are additionally taxed (€11 per decilitre of pure alcohol) and beverages containing over 18° of alcohol by volume, for which a social security contribution is applied.

These excise taxes and social security contributions contribute funding to the health insurance and retirement branches of the agricultural workers social security scheme. Through ministerial legislative order, duties on alcoholic beverages are raised every year in proportion to the rate of growth of the consumer price index (excluding tobacco products) for the year before last.

The tax revenue collected on wine consumption represented 4% of the total revenue versus approximately 80% for the more heavily-taxed spirits (Palle 2013). At the end of 2013, one litre of pure alcohol consumed as spirits was taxed €22.3, consumed as beer was taxed €7.3 and consumed as wine was taxed €0.37. After a 160% increase (i.e. €0.5 more per 25 cl glass of 4.5° alcohol by volume) on 1st January 2013, 2014 saw a catch-up increase in beer taxation of 2%, equivalent to that attributed to other types of alcoholic beverages (see table 3.1).

Table 3.1: Taxation of alcoholic beverages from 2011 to 2014

		2011	2012	2013	2014
Excise duties	Alcohols (spirits)	€1,514.47/hlpa*	€1,660/hlpa*	€1,689.05/hlpa*	€1,718.61/hlpa*
	Non-sparkling wines		€3.60/hl	€3.66/hl	€3.72/hl
	Beers with < 2.8% alcohol by volume	€1.36/degree/hl	€1.38/degree/hl	€3.60/degree/hl	€3.66/degree/hl
	Beers with > 2.8% alcohol by volume**	€2.71/degree/hl	€2.75/degree/hl	€7.20/degree/hl	€7.33/degree/hl
Social security contributions (≥ 18% alcohol by volume since 2012)	Alcohols (spirits)	€1.6/l (≥ 25°)	€33/hlpa*	€42.33/hlpa*	€51.82/hlpa*

* hlpa: hectolitre of pure alcohol

** except for "small breweries" that are legally and economically independent and do not produce under licence.

Sources:

Arrêté du 15 décembre 2012 fixant pour l'année 2013 le tarif des droits d'accises sur les alcools et les boissons alcooliques prévus aux articles 402 bis, 403 et 438 du Code général des impôts ainsi que le tarif des contributions prévues aux articles 520 B et 520 C du Code général des impôts. JORF n°299 du 23 décembre 2012. (NOR BUDD1242585A)

Arrêté du 29 décembre 2013 fixant pour 2014 le tarif des droits d'accises sur les alcools et les boissons alcooliques prévus aux articles 317, 402 bis, 403, 438 et 520 A du code général des impôts, le tarif des contributions prévues aux articles 1613 ter et 1613 quater du code général des impôts ainsi que le tarif de la cotisation prévue à l'article L. 245-9 du code de la sécurité sociale. JORF n°303 du 30 décembre 2013 (NOR: BUDD1331542A)

N.B. Article 403.1.2 of the French General Tax Code, which sets the level of taxation applicable to alcoholic beverages, incorporates other categories of alcohol; only the most prevalent of these categories in France are laid out here.

In 2013, the per habitant consumption of alcohol (in litres pure alcohol equivalents) continued its 50-year decline, due mainly to the decrease in quantities of wine drunk, without any relationship to an unchanged, marginal taxation. The quantity of beer drunk decreased markedly in 2013, seemingly in response to the increase in excise taxes earlier that same year.

Tobacco

Tobacco is excluded from the list of products included in the consumer price index. This exclusion has enabled regular price increases to take place on tobacco products for the purpose of restricting tobacco use. As a result of the State's distribution monopoly, for each tobacco product, a retail price (expressed per 1,000 units or 1,000 grams) is set for the entire French territory. This price is established by decree and is necessarily higher than the sum of the cost price and all taxes. The mechanisms for applying taxes to manufactured tobacco are explained in the circular of 12 February 2014⁸⁰.

The taxation of tobacco products includes 16.7% VAT⁸¹ and consumption taxes, which are broken down into a specific, set rate per 1,000 units or 1,000 grams, and an amount proportionate to the accredited retail selling price (European Commission DG TAXUD 2014). For cigarettes, this proportionate amount is 64.7% for mainland France.

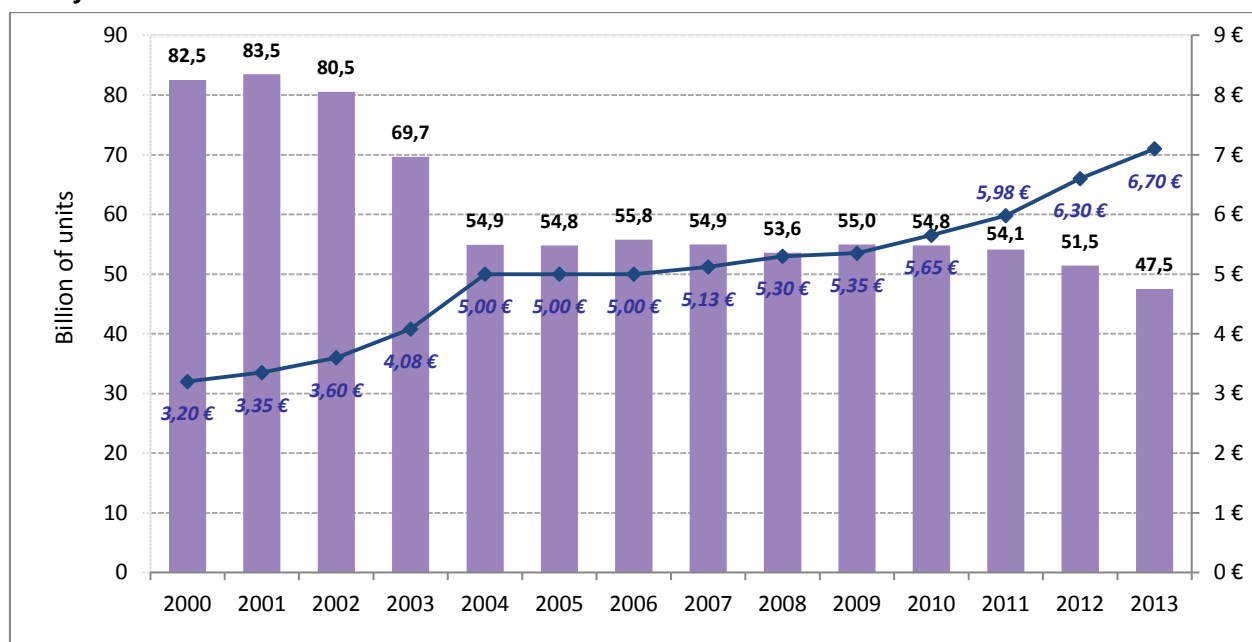
⁸⁰ Circulaire du 12 février 2014 relative à la fiscalité applicable aux tabacs manufacturés. (NOR BUDD1404184C)

⁸¹ Since 1st January 2014, French VAT increased to 20%: the 16.7% corresponds to a VAT of 20% divided by (1+20%).

Cigarettes sold in France are among the most expensive in Europe (Lermenier 2013). Since 2003, tobacco has experienced several price hikes of varying intensity; the price of the most popular brand reached €6.70 on average for 2013 (see figure 3.1). On 1st January 2014, following the July 2013 increase and the revaluation of VAT, the average weighted price of a pack of 20 cigarettes was €6.43 (versus €6.03 in January 2013).

In 2013, mainland France experienced a 6.2% decreased in tobacco sales compared with 2012, down to 58,309 tonnes, under the 60 million tonne mark for the first time in decades (Lermenier 2014). The sales of cigarettes, lion's share (approximately 80% of the market), clearly fell down 7.6% (see figure 3.1). With the exception of rolling tobacco, the sales of other types of tobacco (cigars, cigarillos, snuffs and chewing tobacco) also fell, by 5.6% overall. The increase in cigarette prices seems to stimulate, in part, a shift towards rolling tobacco, which in 2013 reached record sales volumes (over 8,700 tonnes) and market share (15% versus 13.7% in 2012). However, sales are an imperfect tool for measuring real use, due to purchases made outside of the official tobacconist network, such as in French border countries where prices are lower.

Figure 3.1: Cigarette sales (in billions of units) and annual average price per pack of the most widely sold brand from 2000 to 2013



Source: Logista France / DGDDI (French customs)

3.2.2. Other social and normative changes

National tobacco smoking reduction programme

On 4 February 2014, the third National Cancer Plan (2014-2019), with its €1.5 billion in funding, was announced by the French President (Ministère des Affaires sociales et de la Santé *et al.* 2014). Its key objective is to reduce the prevalence of tobacco smoking by one third. To do this, a National Tobacco Smoking Reduction Programme (PNRT) must be established. It will be based on four key strategic measures: dissuading new tobacco users, especially among young people, facilitating quitting by reinforcing smoking cessation assistance, reinforcing the tobacco

pricing policy as a public health tool and involving tobacco retailers in preparing for the impact of the decrease in prevalence of smokers.

Violence prevention and school environments

In 2012, the Ministry of National education developed several measures for preventing violence in school settings. Correlations between these measures and drug prevention efforts may be pursued.

3.3. Universal prevention

The new directions of the addictive behaviours prevention policy are set forth in the government's 2013-2017 plan, which was adopted in September 2013 and completed with a plan of actions to be achieved by 2015 (see chapter 1) (MILDT 2013; MILDT 2014). The actions are based mainly on a series of consultations with key national stakeholders and the conclusions of a panel of experts on adolescent addictive behaviours coordinated by the National Institute for Health and Medical Research (INSERM) (INSERM 2014).

For the majority of the planned actions, 2013 was a transitional year in which think-tanks and partnerships were initiated. These actions should be achieved and, for some, the initial results should be seen in 2014.

In terms of prevention, the collective expert report on adolescent addictive behaviours described several areas for thoughtful future research on the targets of prevention, its analytical frameworks, its action frameworks and those involved (INSERM 2014). The expert report also recommends approaches to strengthening the local coordination of those working at the local level on prevention and treatment in order to:

- support the observation and evaluation of prevention actions to underpin the deployment of validated prevention actions and strategies and the proposal of intervention guidelines to educational establishments and local authorities. It is reiterated that there is no centralised system for cataloguing actions, which are rarely evaluated or documented.
- accompany those involved locally (institutions and private establishments) in implementing validated prevention programmes, especially by organising collaboration between researchers and those involved in prevention through programme assessment
- develop local expertise through training
- study the feasibility in France of programmes acknowledged as being effective in other countries
- adapt actions to ages and life skills development
- opt for multidimensional approaches involving all relevant stakeholders
- implement a commission to evaluate prevention programmes.

In line with these guidelines, in 2014 the CIPCA was formed to promote and disseminate a new prevention policy based on data and scientific models as well as on programmes that have proven to be effective. Overseen by MILDECA, the CIPCA is comprised of representatives of ministerial departments and scientific institutions involved in drug and addictive behaviour

prevention. Given this, from May to September 2014, the CIPCA is organising a first request for candidatures in order to proceed with an evaluation by academic teams of selected prevention programmes. This initiative will enable a national registry of effective prevention interventions to be created. On 23 June 2014, a national day of events enabled this new approach to be inaugurated among professionals to promote evidence-based evaluation and methods.

3.3.1. School settings

Thought and efforts based on actions programmed within the scope of the new governmental prevention strategy in school settings started in 2013. These actions, listed hereinafter, will be implemented in part during the 2014-2015 school year:

- the organisation of a contest for *Lycée* students (equivalent to sixth-form college in the UK or high school in the USA) to write a prevention message and organise an information day for the start of the school year (action 4, 2014-2015)
- the organisation of prevention events with educational teams from different teaching establishments, experimentation with prevention programmes in the first four years of French secondary school by focusing on the development of life skills, as well as prevention programmes in universities that may help identify addictive behaviours and initiate treatment (action 5, 2013-2015)
- the implementation of actions to raise awareness about road safety and the dangers related to use in school settings, and for students who are aiming for a driving licence (action 6, 2013-2017)
- the development of actions and peer prevention programmes (school activities, after-school activities, sporting events and festivals) (action 10, 2013-2015).

These actions are part of a global approach to educational, social and health policy for students facing the risks of addictive behaviours based on the positions set forth in the 8 July 2013 law on the radical reform of the national education system⁸² (see chapter 1).

The Ministry's review of the school environment, and in particular within the scope of the ministerial delegation responsible for the prevention and combating of violence in school settings, aims to prevent disparities in the actions for preventing at-risk behaviour (such as drug involvement, violence, intimidation/harassment and sexuality).

3.3.2. Family settings

The Government plan for combating drugs and addictive behaviours 2013-2017 (MILDT 2013) foresees entrusting the national addiction hotline, ADALIS (Drugs and Alcohol Addiction Information Service) with implementing a parenting support line and an "Addiction info service" portal. Moreover, the electronic directory of the specialised ADALIS-managed treatment programme needs to increase its visibility.

⁸² Loi n°2013-595 du 8 juillet 2013 d'orientation et de programmation pour la refondation de l'école de la République. JORF n°157 du 9 juillet 2013. (NOR MENX1241105L)

3.3.3. Community

The 2013-2017 Government plan aims to implement and assess specific strategies to adapt prevention actions to populations that are remote from support measures. It intends to develop peer prevention programmes (through school activities, after-school activities, sporting events and festivals).

3.3.4. Workplace

In line with Government plan for combating drugs and addictive behaviours 2013-2017, the Labour Code (article R.4228-20) was recently amended⁸³ to explicitly authorise employers to limit or prohibit the consumption of alcohol at the workplace (see chapter 1). A circular intended for regional directorates of businesses, competition, consumption, labour and employment (DIRECCTE) will specify the administrative implications and practices of this revision.

In addition, the 2013-2015 action plan (MILDT 2014) stipulates experimentation with pilot actions within the departments of the Prime Minister and Ministries with at-risk positions. In order to disseminate knowledge in the world of work, new “*Assises nationales de la prévention au travail*” (National workplace prevention conferences) (last edition was in 2010) will be organised.

3.4. Selective prevention in at-risk groups and settings

3.4.1. At-risk groups

According to the 2013-2015 action plans, the addictive behaviours theme should be incorporated into the prevention actions developed within the scope of the city policy, notably as part of the “*Ateliers santé ville*” framework (City health workshops, which serve as interfaces between local elected officials, government health policy representatives and local residents). This is in order to best adapt public health projects to local needs in sensitive urban areas (ZUS). This momentum requires raising addictive behaviour awareness among professionals of the “*Politique de la ville*” (City policy) network. To support these action plans, a system of global positioning for specialised structures in priority areas has also been planned.

Best practices for the Judicial youth protection service (PJJ) will be drafted to help prevent the massive heavy episodic drinking and narcotics trafficking involvement seen in minors in the juvenile court system.

3.4.2. At-risk families

MILDECA intends to support the experimental implementation of the PANJO⁸⁴ programme (Promotion of health and attachment of newborns and young parents), developed by the INPES

⁸³ Décret n°2014-754 du 1er juillet 2014 modifiant l'article R. 4228-20 du code du travail. JORF n°152 du 3 juillet 2014. (NOR ETST1404770D)

⁸⁴ The purpose of this programme is to enhance home visits by the motherhood and child care services (PMI) to promote health in vulnerable families by offering extended follow-up, from the prenatal period to the child's sixth month of life, or for households expressing need, up to the child's twelfth month of life.

to provide early parenting intervention for fragile parents who have trouble gaining access to support and health measures, or who distrust health professionals.

3.4.3. Recreational settings

/

3.5. Indicated prevention

The 2013-2017 plan sets forth specific prevention objectives for inmates. New subsequent offence prevention programmes that take into consideration the issue of addiction will need to be implemented. In the longer term, internal video broadcasts of messages on preventing illegal substance use and trafficking should be developed in penal establishments.

3.6. National and local media campaigns

The 2013 national media campaigns in the field of psychoactive substances mainly focused on tobacco and alcohol use. Although these two substances do not fall within the EMCDDA's scope, some additional information on these campaigns is provided hereinafter.

Traditionally, an INPES campaign is launched at the occasion of World No Tobacco Day. So, on 31 May 2013, the “We all have a good reason to stop smoking. To get help, call Tabac info service at 39 89” campaign was conducted once again⁸⁵. This campaign incorporates a message that is broadcast for a month on television and general public websites, as well as a display campaign (7 posters for 7 reasons to stop smoking).

In October 2013, a specific campaign geared towards adolescents was conducted by the INPES to denounce what are seen as positive values associated with smoking: independence, freedom, pleasure and social acceptance. The tag line was, “If you’re free, why choose addiction?”. This campaign incorporated a television broadcast and an interactive experience inviting 14 to 18 year-olds to go to a dedicated mini site and rise to the challenge of self-evaluating their addiction.

In November 2013, a public INPES anti-alcohol campaign entitled, “Yes, you can say no” used two television ads to focus on how to refuse alcoholic beverages. Two brochures, “Alcohol, what do you know about it?”, one adapted for overseas territories⁸⁶ and the other for mainland France⁸⁷, were reissued with the contact information of a new Alcohol info service on the back cover.

⁸⁵ 39 89 is the abbreviated telephone number for the French Tobacco Information Service telephone helpline

⁸⁶ <http://www.inpes.sante.fr/CFESBases/catalogue/detaildoc.asp?numfiche=1381> [last accessed 20/10/2014]

⁸⁷ <http://www.inpes.sante.fr/CFESBases/catalogue/detaildoc.asp?numfiche=1123> [last accessed 20/10/2014]

4. High Risk Drug Use (HRDU)

4.1. Introduction

Since the mid-90s, France has been recording national estimates of the number of problem drug users (PDU), a category that includes regular users of opioids, cocaine or amphetamines and injecting drug users, regardless of the substance they use. Therefore, this definition is a little different from that of “High-risk drug use” recently adopted by the EMCDDA (Thanki *et al.* 2013), and for which no estimate or survey has been performed or conducted⁸⁸. In contrast, the generalisation of the Cannabis Abuse Screening Test (CAST) since 2006 in France (Beck *et al.* 2008) provides an opportunity to include cannabis addiction risk, especially among the adolescent population (see chapter 2).

The latest estimate of the number of PDUs performed by the OFDT (NEMO study, see appendix V-NEMO) was for 2011 and follows the estimates performed in 1995, 1999 and 2006.

The last two estimates were produced using three methods recommended by the EMCDDA and applicable to the French situation: a multiplier method using treatment data – in this case the sale of opioid substitution medications (buprenorphine and methadone), a multiplier method based on arrest data provided by the police and *gendarmerie*, and finally, a multivariate method based on indirect indicators of problem drug use and local estimates of prevalence calculated using the capture/recapture technique. All of the national estimates obtained are in fact based on the results of local prevalence estimates using the capture-recapture method for the following six French cities: Lille, Lyon, Marseille, Metz, Rennes and Toulouse (Cadet-Tairou *et al.* 2010; Janssen *et al.* 2013; Vaissade *et al.* 2009).

In France, where difficulties are encountered in identifying some drug users who slip through the administrative information system net due to their desire for anonymity, prevalence studies must rely on an actual census performed at the local level by professionals working within specialised structures. These censuses are not compatible with long rounds of questioning, the priority being to establish all the facts. This is why it is impossible to describe problem drug users in detail using data from prevalence studies. The characteristics of these users are presented in section 4.3 of this chapter and are described using the results of the ENa-CAARUD survey (see appendix V-ENa-CAARUD) conducted among drug users attending harm reduction facilities.

4.2. Prevalence of and trends in HRDU

4.2.1. Estimates of high risk drug use prevalence

The number of PDUs estimated at national level varies with the method employed, and ranges from 222,000 (multiplier applied to arrest data method) to 340,000 (multivariate indicator method), which corresponds to a prevalence of 5.5 per thousand and 8.4 per thousand, respectively (see table 4.1). The multiplier method applied to treatment data gives an intermediate prevalence of 7.5 per thousand. In 2006, the range of values adopted at national level, i.e., 210,000 to 250,000 users, corresponded to the overlap zone of the confidence

⁸⁸ France is foreseen to comply with the EMCDDA's definition by performing before long an estimate of the number of high-risk users, including problem cannabis users.

intervals calculated for each estimation method. Adopting the same principle for the 2011 data led to the exclusion of the multiplier method applied to arrests (whose confidence interval did not match up with that of the two other methods at all). The only estimate retained was based on treatment data and the “multivariate indicator” estimate. A rather large range in values was thus obtained, namely 275,000 to 360,000 problem drug users. The upper and lower prevalence limits associated with these estimates are 7 per thousand and 9 per thousand. This result places France in the average in terms of European Union ranking.

Table 4.1: Estimate of the number of problem drug users in metropolitan France in 2011

Estimation method	2011 Estimate	95% CI	2006 Estimate	95% CI
Treatment multiplier	299,000	238,000-360,000	272,000	209,000-367,000
Arrest multiplier	222,000	176,000-267,000	187,000	144,000-253,000
Multivariate indicator	340,000	275,000-410,000	264,000	189,000-338,000

Source: NEMO (OFDT)

The data on high-risk cannabis use generated by the Cannabis Abuse Screening Test are presented in chapter 2 and only pertain to the adolescent population.

4.2.2. Other sources of information on prevalence of HRDU

There are no other information sources available in France on high-risk drug use.

4.2.3. HRDU trends

Overall, the three PDU estimation methods reveal a marked rise in the prevalence of problem drug use since the 2006 estimates. However, given the broad confidence intervals, it is difficult to confirm any increases.

4.3. Characteristics of high risk drug users

From a quantitative viewpoint, the data used to describe those users most heavily involved in drug use is obtained from the surveys carried out in the CAARUD low-threshold structures (Support Centre for the Reduction of Drug-related Harms). The drug users seen in CAARUDs tend to still be more focused on managing their drug addiction than on receiving treatment, even though a certain proportion of them are followed-up by a CSAPA (National treatment and prevention centre for addiction). However, this data is insufficient when it comes to describing all non-recreational drug users as a whole.

4.3.1. Main patterns of polydrug use among the main groups of high risk drug users

The substances most frequently consumed by those users who responded to the survey in 2012 were still cannabis and alcohol (see table 4.2). Approximately one-third (30.8%) of the users encountered in 2012 had taken heroin in the last month, but the most widely consumed opioid was still buprenorphine (37.1%). The use of cocaine in its hydrochloride (powder) form or in the form of freebase concerns more than one out of three drug users seen by the CAARUDs (36.1%).

The use of MDMA, amphetamines and hallucinogenic drugs among CAARUD-frequenting drug users is chiefly accounted for by those users who also frequent the techno party scene (with the exception of certain natural hallucinogens).

Table 4.2: Prevalence of drug use in the last month (in %) among drug users seen in CAARUDs in 2012

	Recent users (used in the last month)
Cannabis	72.8
Alcohol	65.5
Buprenorphine	37.1
Heroin	30.8
Methadone	27.0
Morphine sulphate	17.2
Powder / freebase cocaine	36.1
Crack	17.5
Amphetamines	12.8
Ecstasy	12.3
Methylphenidate (Ritalin®)	1.9
Benzodiazepines	30.5
Hallucinogenic plants and mushrooms	7.5
LSD	7.2
Ketamine	8.6

Source: ENa-CAARUD 2012 (OFDT)

N.B. Last month use of opioid substitution medications (buprenorphine and methadone), morphine sulphates, Ritalin® and benzodiazepines indicates use within and beyond the scope of a medical prescription.

4.3.2. Data and studies of characteristics of high risk drug users other than the treatment demand data reported in chapter 5

This is still a predominantly male population group (80.5%). The percentage accounted for by women tends to be higher among the youngest users. Women represented 34.8% of users under the age of 25 and 42.5% of users under the age of 20. The proportion represented by users over the age of 45 increased from 9.6% in 2006 to 19.4% in 2012, since many users continue to frequent CAARUDs as they get older (see table 4.3). In 2012, drug users visiting harm reduction facilities displayed a high degree of social vulnerability (see chapter 8) (Cadet-Taïrou *et al.* 2014a; Janssen *et al.* 2013; Saïd *et al.* in press).

Table 4.3: Breakdown of CAARUD clients by age class (in %) from 2006 to 2012

	2006	2008	2010	2012
Under 25 years of age	17.9	18.2	14.0	11.6
From 25 to 34	36.3	33.0	32.2	34.3
Over 34 years of age	45.7	48.8	53.8	54.1

Source: ENa-CAARUD (OFDT)

The routes of administration used for psychoactive substances are diversifying. In 2012, 64% of CAARUD clients had injected at least once during their lives, and 46.1% had injected in the last month. Other routes of administration (inhalation and snorting) are on the rise, and are being adopted as additional routes of administration for users already using a certain route or routes (see table 4.4). An increase in the number of heroin users who snort (51.6% vs. 47.7% in 2010) and who smoke (31.6% vs. 28.9% in 2010) was also observed, backing up the qualitative data collected through the TREND scheme (see appendix V-TREND). This phenomenon, which is fairly widespread on the alternative party scene, is also used by disadvantaged urban users, for whom the inhalation route of administration has become an alternative to injection in the last few years.

Table 4.4: Routes of administration for drugs used in the last month by drug users seen in CAARUDs in 2012

	N	Injection (%)	Oral (%)	Snorting (%)	Inhalation / smoking (%)
Morphine sulphate	497	84.3	15.9	10.1	1.1
Heroin	887	51	0.8	51.6	31.6
Cocaine	1,040	52.8	0.6	46.9	32.9
Buprenorphine	1,071	54.2	45.9	25.9	5.1
Ketamine	247	31.9	5.7	75.1	0.9
Amphetamines	369	32.7	31.8	62.5	3.6
Ecstasy	356	21.8	70.6	34.8	11.1
Codeine	193	5.9	92.4	3.5	2.4
Benzodiazepines	879	5.4	95.8	3.4	0.5
LSD	208	0	97.3	2.7	1.1
Crack	504	4.2	0.2	2.9	98.9
Methadone	778	2.4	98.1	1.3	0.1
Hallucinogenic plants	217	0	91.7	1.6	13.5
Alcohol	1,889	0.3	99.9	0	0
Cannabis	2,098	0.1	3.1	0.4	98.7

Source: ENa-CAARUD 2012 (OFDT)

N.B. Several routes of administration may be used by a user for a given drug. Consequently, the total percentage per drug may exceed 100%.

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

5.1. Introduction

Definitions

A system for recording treatment demands in compliance with the European protocol (Common Data Collection on Addictions and Treatments or “RECAP”, see appendix V-RECAP) was introduced in France in 2005 in specialised centres dealing with drug users. These centres, previously known as CSSTs (Specialised care centres for drug users) were renamed National treatment and prevention centres for Addiction (CSAPAs) in 2010. This term now also covers institutions that provide support for people with illegal drug and alcohol problems, or with a non-substance addiction. In accordance with the European protocol, only those persons for whom illegal drugs or psychotropics medicines pose the main problem will be discussed here.

A patient is a drug user having been seen at least once in the year during a face-to-face interview in a treatment centre. A new patient is a drug user seen for the first time by a centre or returning after a loss of contact of at least six months. A first-time treatment entrant is a drug user who has never before been monitored by a CSAPA professional for his/her addiction problems.

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.

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

Virtually all structures today manage their patient files using specialised software. A feature included within the software makes it possible to extract RECAP data on patients seen in the last year in an anonymous file in a predefined format. The data, which is sent to the OFDT, is then verified and merged to render it exploitable.

5.2. General description, availability and quality assurance

5.2.1. Strategy and Policy

Background information

The care and treatment policy concerning users of illegal drugs can be characterised by several major phases in France. Before the 70s, illegal drug users were mostly treated in psychiatric hospitals.

The first major turning point dates back to the adoption of the 1970 French law on narcotics⁸⁹. This law stipulated that any drug user could obtain anonymous, free treatment to wean themselves off drugs completely. The adoption of this law prompted the development of specialist outpatient centres and residential centres, the latter of which house drug users after withdrawal.

The second major milestone was brought about by the rise of the AIDS epidemic. The authorities only adopted opioid substitution treatments (OST) and harm reduction measures in the early 90s, which was rather late compared with other countries.

In France, it was decided to quickly make high-dose buprenorphine (HDB) substitution treatments widely available. Any practising physician was authorised to prescribe them (see chapter 1). As a result, general practitioners began to play an increasingly important role in treating 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 the epidemic) raised the question of treating drug users for their somatic and/or addiction problems. Following the example of the measures adopted for the treatment of alcoholism, hospital liaison teams were established for drug users. Their role was to promote treatment in health care departments and prevent patients being admitted for this type of problem from leaving the hospital without a diagnosis and addiction treatment plan.

As in most developed countries, the policy for treating drug users in France is based on specialised treatment and harm reduction facilities, as well as on general practitioners and hospitals. Above and beyond the effects of publicity, this policy is based in practice on a relatively stable combination of the various sectors and resources available.

5.2.2. Treatment and management systems

There are two schemes available for dispensing treatments to illegal drug users: the specialised addiction treatment system (in socio-medical establishments) and the general healthcare system (hospitals and general practitioners).

The specialised system

These centres, which were created in application of the 1970 French law on narcotics, are now present in nearly all French departments.

These centres were originally government-funded, and since 1st January 2003, they have been funded by the national health insurance system as medical-social establishments (except when such centres are associated with hospitals). These centres provide medical, social and educational services as well as social rehabilitation, among other things. A circular dated 28 February 2008⁹⁰ describes the missions of the CSAPA. CSAPAs are responsible for admitting, informing and ensuring the psychological, medical and social assessment and onward referral of all person presenting with any substance related or non-substance related addiction. CSAPAs

⁸⁹ Loi n°70-1320 du 31 décembre 1970 relative aux mesures sanitaires de lutte contre la toxicomanie et à la répression du trafic et de l'usage illicite des substances vénéneuses. JORF du 3 janvier 1971

⁹⁰ Circulaire n°2008-79 DGS/MC2 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. BO Santé, Protection sociale et Solidarité n°3 du 15 avril 2008. (NOR SJSP0830130C)

also ensure medical, psychological and socio-educational treatment and provide harm reduction measures. CSAPA can specialise in treating addictions to illegal drugs or to alcohol.

CSAPAs either provide outpatient services, or provide individual or group inpatient services, or provide both. In 2013, 419 CSAPAs provided outpatient care, but of these, only 200 or so mainly treated illegal drug users. The rest were mostly frequented by people mainly affected by alcohol problems.

The different services and missions provided by or undertaken by CSAPAs are detailed in the 2013 national report (Bastianic *et al.* 2013).

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 90s, there has been a focus on improving how patients suffering from addiction problems are admitted into the general healthcare system (hospitals and general practitioners).

Hospitals

Hospital addiction treatment is organised into an addiction network involving different components. The aim of these components is to enable anyone with addictive behaviour to gain access to nearby, stepwise general treatment and, if necessary, access to a specialised technical platform. This network has three distinct levels, the details of which are indicated in the 2013 national report (Bastianic *et al.* 2013).

General practitioners

General practitioners today play a key role in France when it comes to prescribing opioid substitution treatments (Beck *et al.* 2013).

They are often the first to intervene when patients start to use illegal drugs. Public authorities plan on introducing initial and continuing training for general practitioners to enable them to spot illegal drug users and familiarise them with the therapeutic solutions best suited to their situation. A hundred or so general practitioners have addiction medicine degrees (certification, university degree or continuing education certificates in addiction medicine). Furthermore, there were 76 addiction health networks in 2013 covering 30% of the territory. These networks are funded by Regional health agencies (ARS) through Regional intervention funds (FIR). The main purpose of these networks is to coordinate the private sector and hospital sector. Their development arose through the 2007-2011 plan for the treatment and addiction prevention (Ministère de la santé et des solidarités 2006), the objectives of which had been more ambitious. In reality, 254 networks were to be created in addition to the 46 that existed in 2006. This was to ensure that addiction networks would reach 200,000 inhabitants each.

Availability and diversity of treatment

Withdrawal

Withdrawal can take place in an outpatient setting, with the patient followed up in a CSAPA, or in a hospital addiction unit as an outpatient or an inpatient. Today, hospital inpatient withdrawal from illegal drugs is infrequent in France. In the past, opioid users, who were often hospitalised to go through withdrawal, now are mainly treated with opioid substitution medications since

hospitalisation is only required in the presence of psychiatric or somatic comorbidities (or at the request of the drug users).

Opioid substitution treatments (OSTs)

After first being marketed in 1995⁹¹, HDB very quickly became the leading treatment for opioid dependency in France. Since 2006, Subutex® is no longer the only product available. After encountering many obstacles, generics have appeared on the market. Schering-Plough, which distributed Subutex® until 2010, was ordered in 2013 by the Competition Authority to pay a €15 million fine for obstructing the arrival of generics on the market in 2006⁹². In 2014, six HDB generics were launched by Arrow, Biogaran, EG, Mylan, Sandoz and Teva. Their penetration rate, which has been steadily rising in the last five years, reached 35% in 2013 (Assurance Maladie). Within the scope of a substitution protocol, generics are prescribed at mean daily doses of approximately 2 mg less than the reference drugs, according to the results of the 2012 OPPIDUM survey (see appendix V-OPPIDUM) (CEIP *et al.* 2013).

In January 2012, Suboxone® (a combination of HDB and an opioid antagonist, naloxone) was launched in a sublingual tablet administration form. The purpose of this combination is to prevent HDB misuse, because HDB also causes withdrawal symptoms when used by the injection route.

According to data from the National public health insurance centre (CNAMTS) collected from a general sample of patients receiving buprenorphine OST (Brisacier *et al.* 2014), in 2012, 149,000 people were reimbursed for an OST dispensed in a retail pharmacy, with buprenorphine being dispensed to a clear majority of people (71% of the total) (this is a French phenomenon). Moreover, 20,000 patients received methadone dispensed at a CSAPA in 2010⁹³ (Palle *et al.* 2013).

The role of methadone nevertheless continues to increase in compliance with the consensus Conference recommendations on substitution treatments (FFA *et al.* 2005). The 2008 granting of the marketing authorisation for methadone capsules contributed to this increase. In 2012, 47,000 people were reimbursed for methadone. The syrup form is still predominant, although it is being prescribed less and less frequently. The syrup form is exclusively prescribed to 53% of the people who were reimbursed for methadone, while the capsule form was exclusively prescribed to 33% of the people who were reimbursed for methadone. Finally, 15% of those reimbursed for methadone were reimbursed for both the syrup and the capsule form (Brisacier *et al.* 2013). According to sales data, in 2013 the syrup form represented 55% of the methadone sold (by weight) and the capsule form 45%. Moreover, 82% of the quantities were dispensed in retail pharmacies, while 18% were in CSAPAs or hospitals (data provided by Bouchara). Figure 5.1 presents the use of HDB (including Suboxone®) and methadone in France. These data, which are based on sales figures, are provided by the Group for the Production and Elaboration of Statistics (GERS), based on an assumed mean daily dose of 8 mg for HDB (including Suboxone®) and 60 mg for methadone. HDB generics (introduced in France in 2006), and then Suboxone® generics (introduced in France in 2012) offset the decrease in Subutex® use observed since 2006. In 2013, the quantities of HDB sold (by weight) were as follows: Subutex®

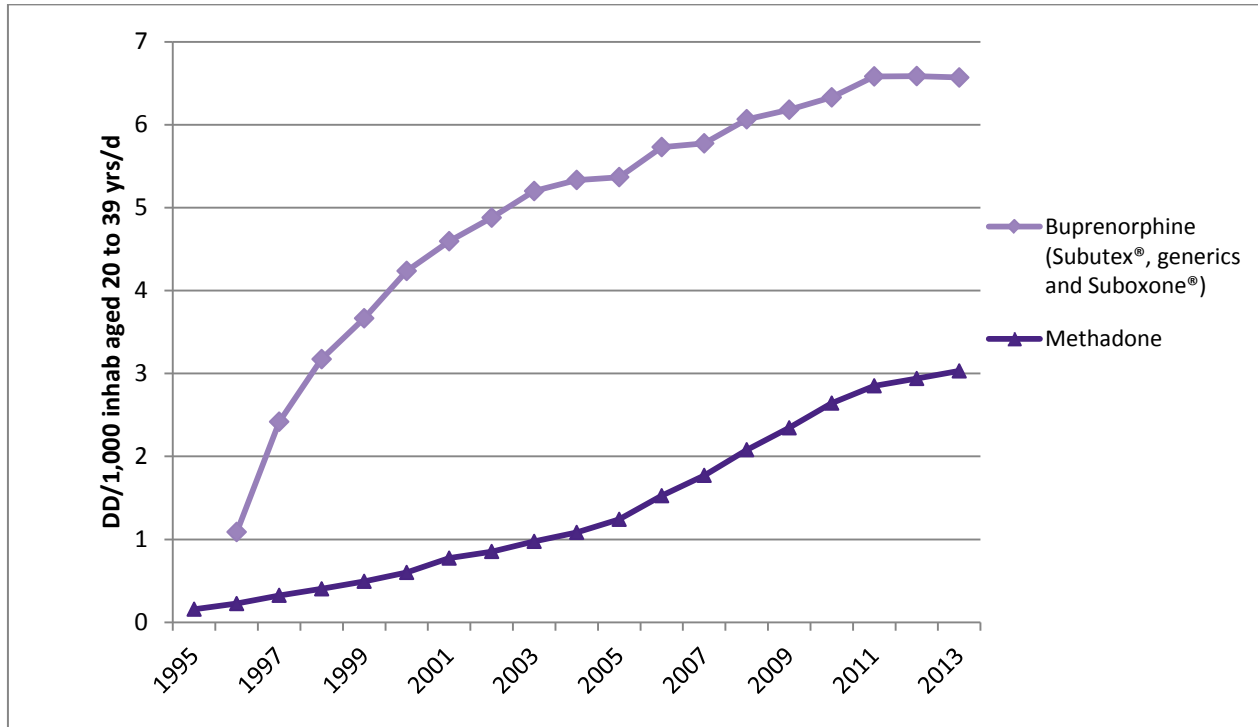
⁹¹ Avis d'octroi d'autorisations de mise sur le marché de spécialités pharmaceutiques : AMM du 31 juillet 1995 pour le Subutex à 0,4 mg, 2 mg et 8 mg, comprimé sublingual. JORF du 27 octobre 1995. (NOR SANM9502981V)

⁹² Décision n°13-D-21 du 18 décembre 2013 relative à des pratiques mises en œuvre sur le marché français de la buprénorphine haut dosage commercialisée en ville. Autorité de la concurrence (2013)

⁹³ Today, methadone treatment must be initiated by physicians working in a CSAPA or a hospital.

73%, generics 24% and Suboxone® 3% (versus 1% in 2012). In total, HDB use continued its upward trend in 2013. Methadone use is also rising, albeit more slowly than from 2006 to 2011.

Figure 5.1: Opioid substitution treatments: use of buprenorphine and methadone from 1995 to 2013 in terms of daily dose/1,000 inhabitants aged 20 to 39 years/day (Subutex® and 8 mg generics, Suboxone® 8 mg, methadone® 60 mg)



Source: SIAMOIS (InVS), Bouchara, Medic'AM (CNAMTS)

In addition, these opioid substitution medications reimbursement or sales data do not take misuse into consideration. Fewer patients are actually receiving OST, although it is still difficult to give a precise figure, since the line between patients following treatment and those receiving HDB prescriptions, but who cannot be considered as following treatment, is unclear.

Following the Methaville study (Lions *et al.* 2014; Roux *et al.* 2014), the methadone prescription and dispensing conditions may be modified. Methaville is a pragmatic study that was conducted from 2009 to 2012 by the INSERM, ANRS and ORS PACA. The objectives of the study were to determine the feasibility and acceptability among physicians and patients of initial methadone prescription in a primary care setting, and to observe whether or not the primary efficacy endpoints (abstinence from non-prescription opioids, treatment commitment and retention, treatment satisfaction) are inferior to induction of treatment in a specialised centre. Methaville was conducted at 10 sites in France on 221 randomised patients (155 in primary care settings, 66 in a CSAPA). Of these patients, 162 were followed (129 and 33 respectively). This study demonstrates that initial prescriptions in a primary care setting offer results that are comparable to the current situation with respect to abstinence from non-prescription opioids, committing to treatment and remaining in treatment. Initial prescriptions in a primary care setting are well-accepted by willing patients and trained physicians who work in a network. No overdoses were reported. Following this study, the OST group established by the National Health Directorate (DGS) issued proposals to ensure the extension of the experimental measures and their

accessibility. Three conditions seem to be crucial for authorising general practitioners to be the initial prescribers of methadone: (1) the need for special training and dialogue on practices; (2) physician certification (with again three conditions: the certification is voluntary, training-based and leads to registration); and (3) collaboration between stakeholders and pharmacist involvement, with mandatory supervised dispensing when treatment is initiated. The purpose of extending the experimentation is to target simplified, secure access to methadone in rural or semi-rural areas, to decrease the number of treatments initiated without medical supervision or by unauthorised physicians, to reduce HDB misuse and at-risk practices, and finally, to decrease the waiting period for a methadone prescription. On 20 March 2014, the ANSM's Commission on narcotics and psychotropic substances issued a favourable opinion on allowing certain certified general practitioners to write initial methadone prescriptions. The Commission was also favourable to prolonging the maximal prescription duration for the methadone capsule form to 28 days (versus the current 14 days) (ANSM 2014). After this recommendation, a legislative order from 13 October 2014⁹⁴ excluded methadone in capsule form from the list of narcotics which prescriptions must be renewed every 14 or 7 days. Thus, stabilised patients are therefore allowed, if their physician agrees so, to receive their prescription every 28 days.

Morphine (generally sustained-release morphine sulphate capsules) is used for substitution purposes in thousands of patients who mainly inject it. However, there is neither a legal prescription framework nor any benefit/risk assessment for the drug as substitution treatment.

Interrupting an opioid substitution treatment

To date, there is no reliable, regularly updated source of information on the number of persons who stop taking OST in the various systems (specialist or generalist). It should be noted that many French addiction specialists and specialised psychiatrists are reluctant to fully withdraw substitution treatment too suddenly given the potential risk of relapse and overdose that may ensue. Unlike retention in treatment, discontinuing substitution treatment did not appear as a key objective in the 2004 consensus conference. However, many patients request discontinuation of their substitution treatment, leading health professionals to rethink their practices to determine strategies, indications and procedures that favourable to this kind of discontinuation (Dugarin *et al.* 2013; Hautefeuille 2013).

Buprenorphine misuse and trafficking

Some of the buprenorphine prescribed is misused and is not taken as part of a treatment programme. This proportion has diminished since the implementation of the French National Health Insurance Fund's 2004 strategy to control opioid substitution treatments⁹⁵. One of the main indicators for buprenorphine misuse (average daily dose higher than 32 mg/d⁹⁶) fell by two-thirds between 2002 and 2007 (Canarelli *et al.* 2009). Since then, this indicator has remained stable (2.2% in 2012) (Brisacier *et al.* 2014). Moreover, 73% of patients receiving buprenorphine

⁹⁴ Arrêté du 13 octobre 2014 modifiant l'arrêté du 20 septembre 1999 modifié fixant la liste des médicaments classés comme stupéfiants dont la durée maximale de prescription est réduite à quatorze jours ou à sept jours. JORF n°241 du 17 octobre 2014. (NOR AFSP1424228A)

⁹⁵ The French national insurance organisation (CNAMTS) controls introduced since 2004 primarily aim to identify dealers ("patients" as well as a few doctors and pharmacists) through reimbursement data. These controls red flag users who have at least five different prescribers or dispensing pharmacies, or who are being given a mean dose of more than 32 mg.

⁹⁶ The HDB maintenance dose is 8 mg per day with a maximal daily dose of 16 mg. A mean daily dose of greater than 32 mg is a very suspicious indicator of HDB trafficking or dealing.

are receiving regular treatment⁹⁷ and therefore are integrated into a therapeutic process. People who are not regularly receiving these treatments are not necessarily cut off from any treatment strategy, just as users taking this medication as part of a treatment plan are not necessarily exempt from certain forms of misuse (INSERM 2012).

According to the results of the OPPIDUM survey conducted in 2012 (CEIP *et al.* 2013), 10% of users undergoing substitution treatment and being seen in a therapeutic setting had injected buprenorphine. Of these users, 10% had snorted and a tiny proportion had inhaled. In 2012, of people seen in CAARUDs, 54% of buprenorphine users reported having injected in the last month, i.e., more than the oral route (46%). Of these, 26% stated having snorted, and 5% having inhaled. Buprenorphine was the most frequently injected substance for 8% of CAARUD clients who had injected at least once in their lives (Cadet-Taïrou 2012).

Two population groups in particular tended to use buprenorphine as a drug: the first group is comprised of the most disadvantaged drug users, of whom 90% are homeless males and some are illegal aliens who tend to consume medications and alcohol; the second group is wandering young people, most of whom are polydrug users (INSERM 2012).

Methadone misuse and risks

The monitoring of methadone addictovigilance and toxicovigilance (ANSM 2014), which is the responsibility of the CAPTV (Poison control and toxicovigilance centre) and the CEIP (Centre for evaluation and information on pharmacodependence) of Marseille, identified five risks: paediatric poisoning, death, attempting to snort or inject, occasional intake and intake by naive subjects (i.e., first time users). Over the five and a half years of monitoring, there were 79 reports of paediatric poisoning (27 with the capsule dosage form, 52 with the syrup dosage form), 288 cases of misuse and 19 cases of death by overdose directly related to methadone in naive subjects. The severity of the paediatric poisoning cases are often limited thanks to rapid parental response. An informational campaign targeting parents was launched.

Substitution treatment in prison settings

The proportion of inmates receiving OST was estimated in 2010 to be 7.9%, or approximately 5,000 people, of whom 68.5% were taking buprenorphine (see chapter 9). The proportion is significantly higher in the female prison population (DGS 2011).

5.3. Access to treatment

Total number of patients receiving treatment

In France, only people seen in CSAPAs provide data compatible with the EMCDDA protocol for recording treatment requests. This data collection is not exhaustive, since approximately one quarter of CSAPAs did not provide data in 2013. In addition, TDI (treatment demand indicator) data are only on new patients, people who are starting or restarting a treatment in a centre, which excludes all people who were already followed in the last year without interruption in a given centre. It is therefore necessary to use other sources to provide a quantitative assessment

⁹⁷ Patients taking regular HDB treatment are subjects who let at least 35 days go by between prescription refills, or who sometimes wait longer (36-45 days) on at most three occasions. The maximum duration for which prescriptions are legally valid is 28 days.

of the total number of people seeking aid from professionals because of their problems with illegal drug use.

Moreover, CSAPAs are required to provide the administrative authorities with an annual activity report containing certain information about people admitted during the previous year (see appendix V-CSAPA Activity reports). 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 104,000 the number of people who were seen in the outpatient CSAPA in 2010⁹⁸ for a problem with illegal drugs. Compared to this figure, the number of people housed in a residential treatment centre appeared to be very low, a bit fewer than 2,000 people, some of whom had already been counted among those already seen in an outpatient CSAPA. In fact, these centres send a large number of patients to residential centres where they are then housed. The number of people seen for a problem with illegal drugs in 2010 in prison CSAPAs can be estimated at 5,700.

The only national data available for primary care is for people receiving substitution treatment. In 2010, approximately 150,000 people were reimbursed for their substitution treatment by social security organisations. Some of these people may also have been monitored jointly or subsequently by a CSAPA during the year.

National data obtained from the Medicalised Information System Programme (PMSI) specify the number of hospital admissions in the departments of medicine, surgery and obstetrics with a primary diagnosis of behavioural disorders related to the use of psychoactive substances excluding alcohol and tobacco (ICD-10 diagnosis: F11 to F16, F18 and F19). There were approximately 7,700 hospitalisations in 2013, of which more than 2,000 involved opioid users, nearly 2,000 involved sedative and hypnotic users, approximately 1,400 involved cannabis users and almost 1,600 involved polydrug users. It should be noted that these data do not include visits to emergency departments or people seen in outpatient hospital addiction units. Overlaps may exist between hospitalised patients and those seen in specialist centres or a primary care setting.

5.3.1. Characteristics of treated patients (TDI data included)

Patients seen in outpatient centres

In 2013, approximately 160 outpatient CSAPAs, or nearly three-quarters of CSAPAs mainly seeing illegal drug users, took part in the RECAP survey. The data shown below pertain to over 45,000 patients (referred to as “new patients”) who started a new episode of treatment in one of these centres in the last year.

Due to the changes in the TDI protocol, significant software updates have been made since 2012. Consequently, 2013 data on substances used are incorrect and are not included in the following analysis, which is based on the 2012 results. The 2013 figures will be used solely to describe the sociodemographic characteristics of users.

⁹⁸ Last available figures at the time of drafting this report

Those patients receiving treatment for the first time in their life (referred to as “first-time treatment entrants”) accounted for 31%⁹⁹ of all new patients seen in 2013, and this percentage was lower in women (26% vs. 32% men). The other patients (the remaining 69%) had previously been monitored for an addiction problem but were about to start a new treatment in a CSAPA. Caution must be exercised when considering the percentage of first-time treatment entrants in relation to the overall number of patients since information relating to the existence of earlier treatments was unknown in 24% of cases.

Socio-demographic characteristics of patients

In 2013, nearly four in five (81%) new patients were men. Their average age was 31 years (31.9 for women versus 30.9 for men). This mean age actually results from the mixing of two subpopulations, users for whom cannabis is the most problematic substance on one hand, with a mean age between 25 and 26, and users for whom opioids or cocaine is the most problematic substance, with a mean age of around 34.

First-time treatment entrants tended to be much younger (see table 5.1). Their mean age was 26.1.

Table 5.1: Breakdown of patients by age group (in %), in 2013

Age	New patients (N=45,841)	First-time treatment entrants (N=10,940)
< 20 years of age	15.7	31.5
20-24 years old	16.8	23.6
25-29 years old	17.7	16.3
30-34 years old	15.7	10.9
35-39 years old	11.5	7.1
40-44 years old	9.9	4.6
45-49 years old	6.5	2.9
50 years old and over	5.8	3.1
Total	100.0	100.0

Source: RECAP 2013 (OFDT)

New patients generally approach treatment centres on their own initiative (35%) or following a referral order from the court system or law enforcement (29%) (see table 5.2). Far fewer women were referred by the courts or law enforcement than men (12% vs. 33% respectively). Of first-time treatment entrants, nearly half (44%) were referred in this way. Most of the people referred to a treatment centre by a court of law or law enforcement services were cannabis users.

⁹⁹ Unless stipulated otherwise, all percentages are calculated based on the totals excluding missing responses and “I don't know” responses.

Table 5.2: Breakdown of patients by treatment origin (in %) in 2013

Origin of the treatment	New patients (N=37,863)	First-time treatment entrants (N=10,105)
Patient's own initiative	35.2	24.0
Family or friends	8.8	10.6
Other specialised centres for drug users	5.7	1.8
General practitioners	6.0	3.7
Hospital or other medical establishment	6.2	4.3
Social services	4.1	4.4
Police, courts or court-ordered treatment	29.3	43.9
Other	4.8	7.2
Total	100.0	100.0

Source: RECAP 2013 (OFDT)

New patients usually live with their parents or alone (35% and 27% respectively) (see table 5.3) and most often live in stable housing situations (78%) (see table 5.4). The situation for women differed from that of men: women lived alone with their child 10 times more often than men (11% vs. 1%), and more often with a partner (18% vs. 10% for men). In contrast, they much less frequently lived with their parents (25% vs. 38% for men). Due to the higher proportion of younger people in this group, first-time treatment entrants were less likely to live alone and more likely (49%) to live with their parents.

Table 5.3: Breakdown of patients by living status (with whom) (in %), in 2013.

Living status (with whom)	New patients (N=37,314)	First-time treatment entrants (N=10,394)
Alone	27.4	20.9
With parents	35.2	48.5
Alone with child	3.2	2.2
With partner but without child(ren)	11.6	9.5
With partner and child(ren)	12.3	10.2
With friends	3.5	2.7
Other	6.8	6.1
Total	100.0	100.0

Source: RECAP 2013 (OFDT)

Table 5.4: Breakdown of patients by type of dwelling (in %), in 2013

Type of dwelling	New patients (N=39,691)	First-time treatment entrants (N=10,707)
Stable housing	78.4	84.8
Unstable housing	19.1	13.5
Institutional housing	2.5	1.7
Total	100.0	100.0

Source: RECAP 2013 (OFDT)

Economically inactive people (retired, at home, disabled) and unemployed people account for 46% of new patients (see table 5.5). Slightly more than a quarter had regular employment and 16% were still high school or post-high school students. The percentage of economically inactive patients was clearly higher among women than men (26% vs. 22%). Because they tend to be younger, there were more students among first-time treatment entrants than among new patients.

Table 5.5: Breakdown of patients by professional situation (in %), in 2013

Professional situation	New patients (N=37,357)	First-time treatment entrants (N=10,293)
Regular employment	25.2	24.1
Student (high school or post-high school)	15.6	25.2
Economically inactive	23.2	18.9
Unemployed	23.0	18.8
Other	13.0	13.1
Total	100.0	100.0

Source: RECAP 2013 (OFDT)

Six in ten patients stated having reached secondary school level, 5% had not gotten past primary school level and 35% indicated that they had post-secondary school level (A-level/High School Diploma). A much higher percentage of women had a post-secondary level of education (47% vs. 32%). The breakdown of educational level remained unchanged for first-time treatment entrants.

Drug use

As previously indicated, due to inconsistencies in 2013 data on substances used (following changes in the software used in CSAPAs), the analysis is based on 2012 results, which are presented in the 2013 national report (Bastianic *et al.* 2013).

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 all CSAPAs. The influence of the characteristics of these patients on those of all patients was negligible. In 2013, 23 residential centres provided RECAP data on nearly 1,000 patients.

Nearly all of the patients admitted to these residential centres had already been helped by a healthcare professional for their addiction. It was rare for the patients themselves to request treatment directly from these centres. In the majority of cases, the patients were referred, at least the first time, by other treatment centres. 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.

Patients seen in residential centres were on average older than those seen as outpatients (34.2 years of age vs. 31 years of age respectively). In general, these centres tend to treat patients with the most serious addiction problems who are also often experiencing the most social exclusion.

Compared with those patients seen on an outpatient basis, the even higher percentage of patients who were living alone (40%), who had unstable housing conditions (35%) or who were unemployed or economically inactive (35% and 28% respectively) indicates the higher level of social exclusion of this population.

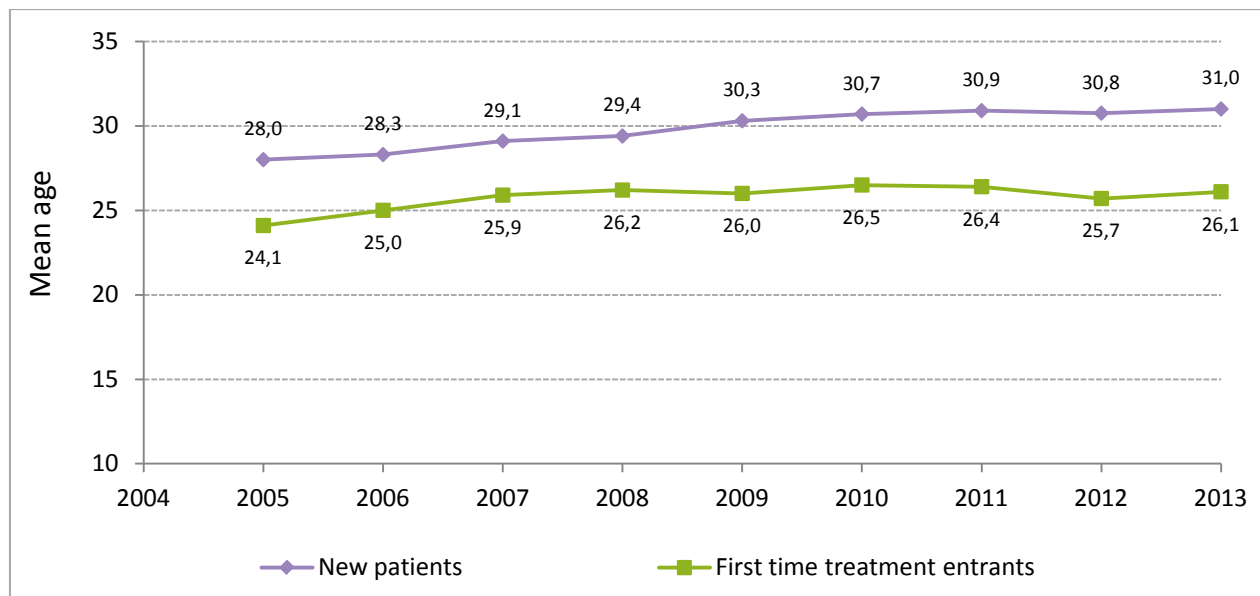
5.3.2. Trends of treated population and treatment provision

Patient data that are TDI-compatible have only been available in France since 2005. Major changes in the numbers of patients treated in residential centres, in addition to the highly variable response rates, make it difficult to interpret changes. Consequently, only trends relating to patients seen on an outpatient basis will be considered in this section.

Data for the 2005-2013 period are now available. The first two years (2005 and 2006), however, correspond to a phase during which data collection was being implemented, and there was a rather low participation rate for the period in question (less than 50% in 2005, slightly more than 50% in 2006). The changes observed over these first two years must therefore be interpreted with caution. Over the next seven years, the mean level of centre participation in the survey was two-thirds, but the centres responding were not always the same. This situation can cause fluctuations in data levels, which do not necessarily reflect changes in the patients' situation. Attention should therefore only be paid to major trends that remain constant over several years.

Mean patient age has risen steadily since 2005, except for in 2012, from 28 years to nearly 31 years, in 2013 (see figure 5.2).

Figure 5.2: Changes in the mean age of new patients and first-time treatment entrants managed in CSAPAs, 2005 - 2013



Source: RECAP (OFDT)

This ageing is essentially due to an approximate 10-point decrease in the proportion of 15 to 24 year-olds and a near doubling in the proportion of 40 year-olds and over, from almost 11% in 2005 to over 22% in 2013. The decrease from 2007 to 2013 was mainly seen in 20 to 24 year-olds. From 2012 to 2013, the breakdown per age bracket remained fairly stable (see table 5.6).

In terms of first-time treatment entrants, their mean age has remained quite stable since 2008, and after a slight decrease in 2012, returned to the levels seen in previous years.

Table 5.6: Breakdown of all new patients by age group (in %), evolution 2005 - 2013

Age bracket	2005 (N=20,989)	2006 (N=31,674)	2007 (N=41,205)	2008 (N=44,631)	2009 (N=44,339)	2010 (N=45,247)	2011 (N=45,247)	2012 (N=44,960)	2013 (N=45,841)
>20	16.6	15.6	12.6	12.7	12.6	11.5	13.5	15.5	15.7
20-24	24.8	25.2	24.7	23.3	20.4	19.6	18.6	17.7	16.8
25-29	19.0	19.4	21.2	21.4	20.2	20.5	19.1	18.3	17.7
30-34	16.6	15.4	14.9	14.6	14.8	15.9	15.7	15.7	15.7
35-39	12.3	12.3	12.5	12.7	13.4	13.0	11.8	11.3	11.5
40-44	6.8	7.1	8.4	8.4	9.3	9.7	10.0	9.6	9.9
45-49	2.5	3.2	3.5	4.2	5.4	5.4	6.1	6.3	6.5
>50	1.4	2.0	2.3	2.9	4.0	4.4	5.2	5.6	6.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: RECAP (OFDT)

The fact that older people are being seen in the centres has repercussions on certain patient characteristics. Thus, in line with the decrease in the number of 15 to 24 year-olds, the percentage of people living with their parents is constantly declining, falling from 42% to approximately 35%. In contrast, the number of people living alone increased from 25% to 27%. For reasons also associated with changes in breakdown by age group, numbers of high school and post-high school students are slightly decreasing, falling from 17% in 2005 to 16% in 2013.

Moreover, the proportion of people with stable housing conditions increased slightly from 75% in 2005 to 78% in 2013. It is difficult to know whether or not this change also results from the increase in mean age or if it is related to other factors.

The 2013 data on the distribution of patients by primary drug are not sufficiently reliable to be integrated into this report: the results recorded from 2007 to 2012 are detailed in last year's national report (Bastianic *et al.* 2013), revealing a downward trend for cannabis and an upward trend for opioids.

6. Health correlates and consequences

6.1. Introduction

Drug use can be the direct cause of viral infections (HIV/AIDS and hepatitis), other injection-related infectious pathologies and even substance-related disorders, especially overdoses. Other problems, like tuberculosis, are related to unstable living conditions, a risk-laden lifestyle (sexually transmitted infections¹⁰⁰) or the psychiatric and somatic comorbidities that often accompany drug use. Deaths also occur and are recorded and categorised based on a number of information gathering systems in France.

HIV/AIDS and viral hepatitis (Hepatitis B and C)

Infectious diseases account for most of the somatic morbidity observed. Estimates of prevalence levels among drug users were based on data collected within the scope of various surveys:

- The reported prevalence of HIV, HBV and HCV: since 2005 (Palle *et al.* 2007), these prevalence numbers have been supplied by the RECAP scheme (see appendix V-RECAP) of patients seen in CSAPAs¹⁰¹ and by surveys of patients seen in low-threshold structures (CAARUDs¹⁰²), particularly the PRELUD (see appendix V-PRELUD) and ENa-CAARUD (see appendix V-ENa-CAARUD) surveys.
- The biological prevalence of HIV and HCV, determined using blood samples, were collected from the Coquelicot survey (see appendix V-Coquelicot) (Jauffret-Roustide *et al.* 2006) conducted in 2004 and 2011.
- The biological prevalence of HIV and HCV, determined using saliva samples, were collected from CAARUD clients as part of the BioPRELUD¹⁰³ study conducted by the OFDT in 2006 in five cities, among voluntary users. The data helped summarise current psychoactive substance use and practices in a population with a high prevalence of drug use.
- Estimates of the national incidence of AIDS, HIV infection and acute hepatitis B infection were also performed. AIDS case and AIDS death reporting, which has existed since the early 80s, has been mandatory since 1986. A new anonymous reporting measure implemented in 2003 following a circular¹⁰⁴ issued by the National Health Directorate (DGS) made HIV-infection reporting obligatory as well. This system is accompanied by HIV virological monitoring (see appendix V-HIV/AIDS Monitoring System). Reporting of acute hepatitis B infection has been required since 2004 (see appendix V-Acute hepatitis B Monitoring System).

¹⁰⁰ In addition to intravenous drug use, at-risk sexual behaviours among injecting drug users increase the risk of sexually transmitted infections.

¹⁰¹ National treatment and prevention centres for addiction

¹⁰² Support Centres for the Reduction of Drug-related Harms

¹⁰³ The BioPRELUD survey represents the biological portion of the larger PRELUD study, which was conducted among CAARUD clients in nine cities (including the five BioPRELUD cities) in 2006. The HIV and HCV prevalence data collected within the scope of the PRELUD study were reported.

¹⁰⁴ Circulaire n°2003-60 DGS/SD5C/SD6A du 10 février 2003 relative à la mise en œuvre du nouveau dispositif de notification anonymisée des maladies infectieuses à déclaration obligatoire. BO Santé, Protection sociale et Solidarité n°2003-12 du 17 au 23 Mars 2003. (NOR SANP0330122C)

Sexually transmitted infections and tuberculosis

There is no specific French information system that provides details on the reported or biological prevalence of tuberculosis or of sexually transmitted infections, other than HIV infection, among drug users.

Other infectious diseases

There is no French specific information system that records the reported or biological prevalence of other infectious diseases among drug users.

Behavioural data

In France, quantitative information (ENa-CAARUD and Coquelicot study data), qualitative information from the TREND scheme (see appendix V-TREND) and the qualitative section of the Coquelicot survey, provide details on the perceived health status of drug users and their at-risk behaviours (Cadet-Taïrou *et al.* 2013c; Jauffret-Roustide *et al.* 2006; Saïd *et al.* in press).

Psychiatric comorbidities

There is no specific French information system that provides details on the prevalence of psychiatric illness among drug users.

Somatic comorbidities

There is no specific French information system that provides details on the prevalence of somatic comorbidities among drug users.

Drug-related deaths

In France, there are currently two sources that list fatal overdoses:

- The national statistics on the medical causes of death (CepiDc-INSERM – see appendix V-National registry of causes of death). Since 1968, this registry has been listing information from death certificates on all deaths in the past year. Fatal overdoses are those for which the death certificate mentions codes from the International Classification of Diseases (ICD-10) that are on the list of codes (selection B¹⁰⁵) established by the EMCDDA. Without going into further detail here, this is a group of codes mentioning the use of an illegal substance or certain medications. Some fatal overdoses are nevertheless coded under “deaths with poorly defined causes” and therefore are not registered. Furthermore, the substances responsible for death are poorly detailed in this source, since the most frequently seen wording is that of polydrug use without any further specifications. These data only become available two years after they are recorded.
- The system known as DRAMES (Drug and Substance Abuse-related Deaths – see appendix V-DRAMES). This information system records deaths that involved legal proceedings and a request for a toxicology analysis and/or autopsy. Volunteer

¹⁰⁵ Common definition of fatal overdoses for all European countries: <http://www.emcdda.europa.eu/publications/methods/drld-overview> [Last accessed 20/10/2014]

toxicological analysts report these cases throughout the French territory. Forty-one experts who performed toxicological analyses within a forensic scope participated in the 2012 edition of the survey. Analyses are performed upon the request of the public prosecutor's office. The definition of overdose used is very similar to the definition accepted by the EMCDDA (illegal substances and opioid substitution treatments). Contrary to the preceding source, DRAMES is not exhaustive. First of all, DRAMES does not cover all toxicology laboratories, and secondly, the system only lists deaths for which the judicial system requested a toxicological analysis, and such requests are not systematic. Therefore, DRAMES data are mainly useful in determining a breakdown of fatal overdoses according to the substance that caused them.

The number of AIDS deaths related to intravenous drug use can be estimated using the national HIV/AIDS monitoring database coordinated by the French Institute for Public Health Surveillance (InVS).

6.2. Drug related infectious diseases

6.2.1. HIV/AIDS and viral hepatitis

Monitoring system for HIV infection and new AIDS cases

Since HIV reporting became mandatory in 2003, the estimated number of new HIV patients¹⁰⁶ was 67,953 on 31 December 2012¹⁰⁷, and 6,372 of these occurred in 2012 (95% CI: [5,974-6,770]). After significantly decreasing from 2004 to 2008, the number of new HIV cases discovered per year has stabilised at approximately 6,000.

In 2012, people infected through intravenous drug use represented no more than 1.2% of these new cases of HIV infection (77 on 6,372). The most frequent contamination route is heterosexual intercourse (56% of cases) followed by homosexual intercourse between men (42%) (Cazein *et al.* 2014). The recommendations (generalised screening and repeated screening among exposed populations) of the 2010-2014 French national HIV-AIDS and STI plan (Ministère de la santé et des sports 2010) were followed by a moderate rise in screening activity, which slowed down the following year. In 2008, the incidence of HIV among injecting drug users was estimated at 86 per 100,000 person-years (Le Vu *et al.* 2010).

The number of new AIDS cases among injecting drug users has been steadily declining since the mid 90s: they represented one quarter of people diagnosed with AIDS at that time, but only represented 5.9% in 2012 (see table 6.1) (Cazein *et al.* 2014).

¹⁰⁶ People who discovered that they were HIV positive prior to 2003 and those who do not know their serological status do not appear in these figures. However, the contamination date might have occurred long before the date HIV positivity is discovered.

¹⁰⁷ Data corrected for reporting delays, under-reporting and missing data.

Table 6.1: Total number of new AIDS cases, number of new AIDS cases among injecting drug users (IDUs) and proportion of IDUs per year of diagnosis from 2001 to 2012

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
IDUs	405	333	286	285	221	189	174	160	109	117	118	88
Total new AIDS cases	2,343	2,361	2,186	2,092	2,053	1,830	1,752	1,757	1,598	1,622	1,546	1,507
IDU proportion (%)	17.3	14.1	13.1	13.6	10.8	10.3	9.9	9.1	6.8	7.2	7.7	5.9

Source: Mandatory HIV/AIDS reporting system (InVS)

N.B. Data from 31 December 2012 corrected due to reporting delays and under-reporting.

Hepatitis B monitoring system

The number of acute hepatitis B cases reported between 2003 and 2012 was 1,311; of these, 39 cases (5% of the 881 for whom at-risk exposure was documented) were related to drug use. The annual number of reported new cases has halved since 2006, dropping from 185 to 92 in 2012. This decrease may not reflect reality, given the limited exhaustiveness of the reporting, estimated at 25% in 2005 and between 9% and 15% in 2010 (InVS 2014c).

Survey of the prevalence of HIV, HCV and HBV among drug users

The latest prevalence data based on biological samples are from 2011 (Coquelicot data). They are not strictly comparable to those established in 2004, since 2011 introduced the concept of the agglomeration to replace cities, and added two departments. Furthermore, recruitment through general practitioners was abandoned.

Data based on biological samples

In 2011, the HIV positivity in drug users who have snorted or injected at least once in their life was 10%. This prevalence was higher in older generations: only 0.6% (95% CI: [0.09-4.3]) of drug users under the age of 30 were infected.

Among these snorting and/or injecting users, the HCV positivity was 44%. In users under the age of 30, HCV seroprevalence was 9% (95% CI: [5-15]) (Jauffret-Roustide *et al.* 2013).

Marseille stands out due to its high HIV and HCV seroprevalence rates, while those observed in Lille and Bordeaux are the lowest (see table 6.2). This is explained by the older drug-using population and the “traditionally” higher rates of injection in Marseille.

Although the 2004 and 2011 editions of the Coquelicot survey are not strictly comparable, the HIV seroprevalence rate seems to be stable while the HCV seroprevalence rate dropped (from 60% to 44% between the two editions).

Table 6.2: Estimated prevalence of HIV and HCV infection from blood samples of lifetime injecting or snorting drug users in the Coquelicot survey by urban centre or department, in 2011

	HIV N=1,418		HCV N=1,418	
	% infected	95% CI	% infected	95% CI
Bordeaux	4	1-14	24	13-40
Lille	0		28	20-37
Marseille	17	11-25	56	48-63
Paris	10	7-14	44	39-50
Seine-Saint-Denis	18	9-32	52	40-63
Seine-et-Marne	2	0.2-10	32	16-53
Strasbourg	3	0.8-14	47	35-60
All sites	10	7-12	44	39-48

Source: Coquelicot (InVS)

The 2011 data on injecting drug users are not yet available; in 2004, in this population, the seroprevalence of HCV infection was 73.8%, while that of HIV infection was 11.3%. A significant proportion of users (27%) erroneously believed that they were HCV negative (Jauffret-Roustide *et al.* 2009).

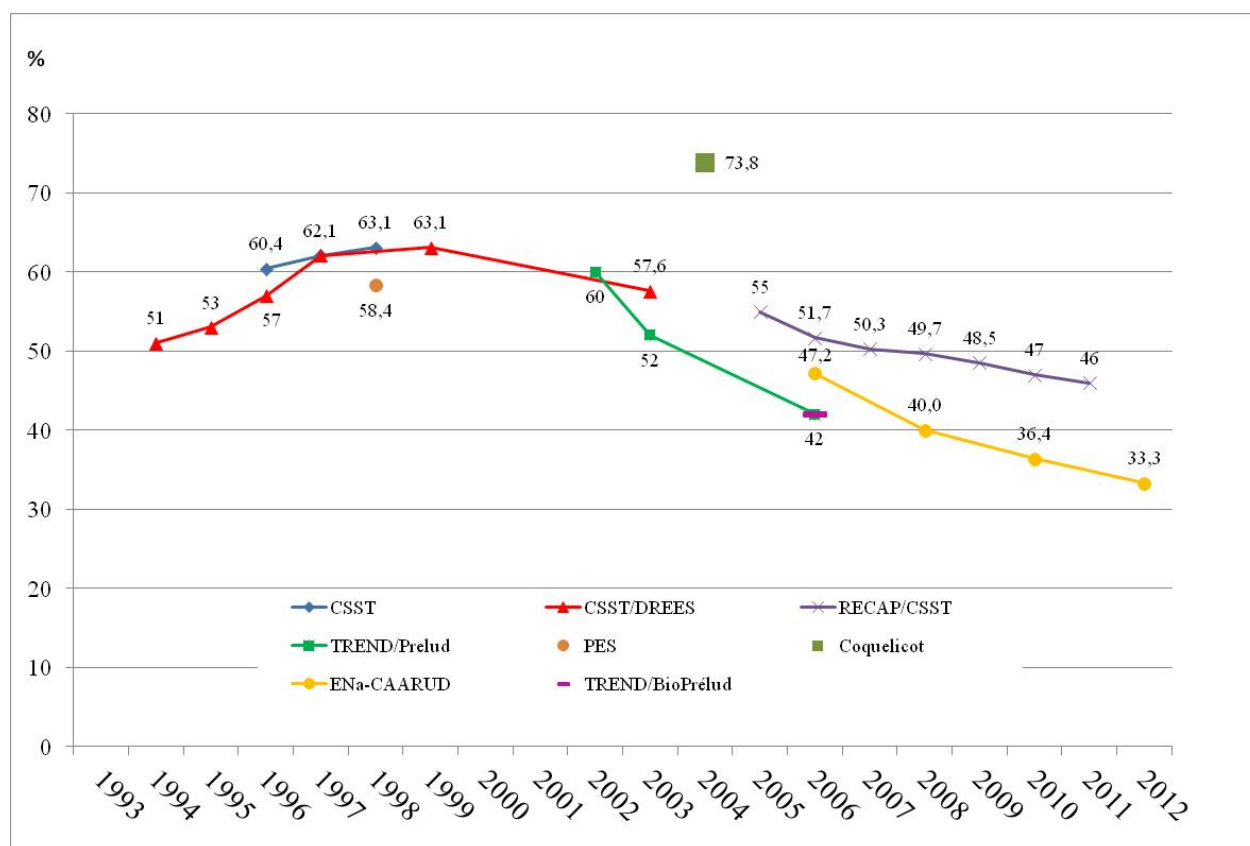
Reported data

The ENa-CAARUD survey, which was conducted for the fourth time in 2012, questioned 2,905 users seen over the course of a week in 139 CAARUDs. In 2012, the majority of drug users stated having undergone one of these screening tests at least once (91.1% underwent HIV screening and 86.7% underwent HCV screening).

For HIV as for HCV, since the early 2000s there has been a decline in the reported prevalence of these infections in injecting drug users (see figure 6.1). This trend can be explained by different factors: the impact of the different public health measures taken in France (and harm reduction measures in particular), greater accessibility to treatment, greater access to screening and changes in drug use practices (and a drop in injection in particular (Brisacier *et al.* 2013; Cadet-Taïrou 2012; Saïd *et al.* in press).

Nevertheless, although HIV prevalence among injecting drug users in 2012 was most probably 10%, HCV prevalence reached levels that are still very high.

Figure 6.1: Change in the prevalence of hepatitis C virus infection among injecting drug users in France from 1993 to 2012



Sources:

Residential CSSTs: IDUs in residential treatment centres, reported prevalence

DREES: IDUs treated in CSST specialised treatment centres for drug users, reported prevalence

RECAP: IDUs treated in CSAPA specialised treatment centres, reported prevalence

TREND/PRELUD: IDUs seen in low-threshold structures (CAARUDs), reported prevalence

PES: IDUs using an SEP (Syringe exchange programme), reported prevalence

Coquelicot: IDUs, biological data

ENa-CAARUDs: IDUs seen in low-threshold structures (CAARUDs), reported prevalence

TREND/BioPRELUD: IDUs seen in low-threshold structures (CAARUDs), biological data

N.B. injecting drug user (IDU) means a person who has injected at least once in their life

6.2.2. Sexually transmitted infections and tuberculosis

There is no specific French information system that provides information on the reported or laboratory prevalence of tuberculosis or of sexually transmissible infections among drug users.

6.2.3. Other infectious morbidity

Different diseases, particularly infectious ones, may occur with the injection of HDB or other substances. Table 6.3 presents some of these consequences seen among CAARUD clients in 2006.

Table 6.3: Consequences of injection reported by clients of low-threshold drug treatment services in 2006

Injection during the previous month	HDB (n=239)	Other substance(s) (n=232)	Total (n=471)
Injection difficulties	68%*	56%	62%
Skin abscesses	36%*	22%	29%
Venous obstruction, thrombosis, phlebitis	46%*	29%	38%
Swollen hands or forearms	43%*	30%	37%
Swollen feet or legs	16%	12%	14%
“Poussières” ¹⁰⁸	31%	24%	27%

Source: PRELUD 2006 (OFDT)

* significant difference with a <1% risk for error between the percentages among HDB and other substances injectors

6.2.4. Behavioural data

Whilst most drug users have adopted the concept of not sharing syringes, this does not apply to other ancillary injection equipment. Of recent injecting drug users seen in CAARUDs in 2012, 8.3% state having shared their syringe in the last month, but one out of five (21.6%) shared at least one other piece of equipment (see table 6.4). Moreover, 7.6% of CAARUD clients who had been incarcerated that year stated that they had injected, 38.4% stated that they had snorted and 1.4% stated that they had shared a “syringe”¹⁰⁹ during their imprisonment (Saïd *et al.* in press).

Table 6.4: Prevalence of injection materials shared among CAARUD clients who had injected in the last 30 days, in 2012

	Men N = 1,061	Women N = 248	Boys + Girls N = 1,309
Syringes	7.5%	11.6%	8.3%
Water for preparation	13.9%	22.0%	15.4%
Water for rinsing	6.3%	11.3%	7.2%
Spoons, containers	13.4%	22.1%	15.0%
Cotton/Filters	10.3%	18.9%	11.9%
Ancillary equipment (except syringes)	19.7%	29.8%	21.6%
At least one item (including syringes)	20.7%	30.8%	22.6%

Source: ENa-CAARUD 2012 (OFDT)

The 2011 Coquelicot survey demonstrates that young drug users more frequently inject than older users, but are not really familiar with harm reduction techniques. Among drug users under the age of 30 years, 53% were last month injectors versus 33% of drug users over the age of 30 (Jauffret-Roustide *et al.* 2013).

¹⁰⁸ “Poussières” is a French term employed by drug users to refer to a sudden fever with aches, headaches and chills following an injection. Its intensity may vary. It generally results from bacterial contamination of the blood or septicemia. In English, it is often referred to as “cotton fever”.

¹⁰⁹ Since there are no syringe exchange programmes in prison, other objects (such as pens) can be used to inject.

6.3. Other drug-related health correlates and consequences

In 2012, 34.8% of CAARUD clients had been hospitalised at least once in the last year (Saïd *et al.* in press).

6.3.1. Non-fatal overdoses and drug-related emergencies

The only data currently available on a regular basis are those of the ENa-CAARUD survey of users frequenting CAARUDs.

In 2012, 6.5% of these CAARUD clients stated having experienced a non-fatal overdose (loss of consciousness after taking of one or more substances) in the 12 months preceding the survey. Alcohol was the drug most often responsible for these overdoses (19.7%), followed by benzodiazepines (15.0%), cocaine (13.9%) and heroin (13.3%).

6.3.2. Psychiatric comorbidities

In 2012, 7.0% of users stated having been hospitalised in the last 12 months for psychological problems not related to withdrawal. Subsequently, nearly one out of five hospitalisations that had occurred in the last 12 months were for this reason. Hospitalisations for withdrawal were more or less at the same level¹¹⁰ (Saïd *et al.* in press).

6.4. Drug related deaths and mortality of drug users

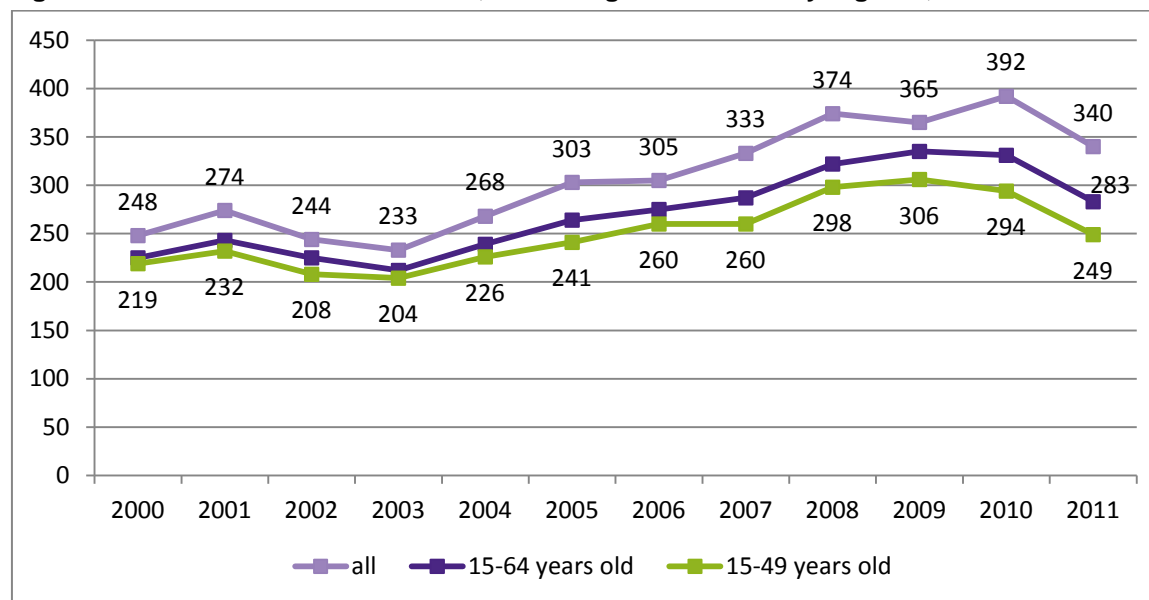
6.4.1. Drug-induced deaths (overdoses/poisonings)

Data from the mortality register reveal a constant decrease in the number of fatal overdoses in 2011 after a period of increase from 2003 to 2010. If we limit the age range to 15 to 49 year-olds – the largest drug-user age group – the number of fatal overdoses decreased dramatically with 249 deaths in 2011 after increasing from 2000 to 2008 and stabilising at approximately 300 from 2008 to 2010 (see figure 6.2). However, this decrease should be interpreted with caution since there were changes in coding rules in 2011¹¹¹.

¹¹⁰ Out of the 34.8%, or 854 users, who reported having been hospitalised in the last year.

¹¹¹ Codes F10 to F19 (Mental and behavioural disorders due to psychoactive substance use: F11 for opioids, F12 for cannabis, F14 for cocaine, F15 for other stimulants, F16 for hallucinogens, F19 for multiple drugs or other psychoactive substances) may no longer be used as primary causes and are replaced by X41, X42, X61, and so on depending on the substance and the context. Consequently, fatal methadone or HDB overdose, formerly coded F11.0, are now coded X42.

Figure 6.2: Fatal overdoses in France, according to the mortality register, from 2000 to 2011



N.B. The fatal overdoses recorded here correspond to selection B of the EMCDDA (which groups all deaths for which the initial cause was mental and behavioural disorders due to opioids, cannabis, cocaine, stimulants, hallucinogens and multiple substance use, accidental narcotic and psychodysleptic poisoning, self-harm by poisoning with these substances and poisoning for which the intention was undetermined).

France does not consider the following deaths, despite belonging to selection B: deaths in combination with codes T40 and T43.6 (poisoning by narcotics, psychodysleptics and psychostimulants), by accidental poisoning with antiepileptics, sedatives, hypnotics, antiparkinsonians or psychotropics (X41), intentional self-harm with these substances (X61) and those for which the intention was undetermined (Y11). This lack of consideration is related to the fact that T codes are rarely used in France.

Source: CépiDc (INSERM)

DRAMES provides information on the substances that are the main cause of fatal overdoses. In 2012, opioid substitution medications were the primary cause of 60% of all deaths. Heroin was the primary cause in 15% of deaths, other non-opioid substitution medications in 12% of deaths and cocaine in 12% of deaths (ANSM 2014). The percentage of opioid substitution medications-induced deaths rose from 53% to 60% from 2010 to 2012, while that of heroin declined, from 33% to 15%. The proportion represented by other illegal substances rose during this period while more deaths occurred due to amphetamines (5%) and cannabis (5%). Death by myocardial infarction or stroke related to cannabis only began to be considered recently, and inconsistently among laboratories, which could lead to bias. Hence, the increase in the proportion of deaths involving cannabis is undoubtedly related to this situation (see table 6.5). In 25% of fatal overdoses, several substances were involved.

The qualitative data of the TREND scheme elucidates possible explanations for the increasing proportion of deaths involving opioid substitution medications. Firstly, the black market for methadone is gradually growing as it becomes more accessible as a treatment. However, methadone is far from being as available on the black market as buprenorphine, and is as much a source of self-substitution treatment for opioid users than a drug (Cadet-Tairou *et al.* 2013b; Cadet-Tairou *et al.* 2013c; Gandilhon *et al.* 2010).

Table 6.5: Breakdown of fatal overdoses by substance(s) involved*, alone or in combination, from 2010 to 2012**

	2010		2011		2012	
	n	%	n	%	n	%
Methadone	88	36	121	43	140	45
Buprenorphine	44	18	40	14	47	15
Other opioids (non-OST)	23	9	39	14	36	12
Heroin	82	33	54	19	47	15
Cocaine	25	10	30	11	36	12
Other illegal substances	8	3	16	6	31	10
Others (poppers, medications, etc.)	6	2	8	3	4	1
TOTAL	247		280		310	
Number of participating toxicological experts	31		36		41	

Source: DRAMES (ANSM)

* Only deaths directly caused by drug use are mentioned.

** Several substances can be involved in a death when no predominant substance has been determined.

N.B. Of the 31 fatal overdoses that occurred in 2012 in the “other illegal substances” category, 15 deaths were directly caused by cannabis, 15 by amphetamines and 1 by GHB.

6.4.2. Mortality and causes of death among drug users (mortality cohort study)

Between September 2009 and December 2011, the mortality cohort study enrolled 1,134 individuals, the majority seen in CSAPAs and a few in CAARUDs. In July 2013, the vital status was determined for 970 of them (or 86% of the enrolled subjects). The mean age at the moment of inclusion was 35.3 years, and 77% were men. In this cohort, there were 37 deaths registered (26 men and 11 women). The mean age of death was 42.6 years. The causes are currently available for 17 deaths that occurred in 2010 and 2011¹¹². They are broken down as follows: 2 medication poisonings, 2 sudden deaths, 2 gastrointestinal bleeds, 2 lung cancers, 1 liver cancer, 1 alcohol-induced coma, 1 fatal overdose (without mention of the causal substance), 1 road accident, 1 asthma attack and 4 deaths of unknown cause.

For men, the standardised mortality ratio (SMR) is similar to that observed in the mortality cohort of people arrested for heroin, cocaine or crack use from 1992 to 2001 (SMR 5.2 – 95% CI: [4.9-5.5]). For women, the SMR is much higher than observed in the 90s cohort (SMR 9.5 – 95% CI: [8.0-11.3]) (see table 6.6) (Lopez *et al.* 2004). However, given the size of the confidence intervals and their overlap, they cannot be determined as statistically significant.

¹¹² Due to the delay in transmitting mortality data, causes of death in 2012 and 2013 will only be known in July 2014 and July 2015 respectively.

Table 6.6: Gross annual mortality rate and SMR in the 2009-2013 mortality cohort, by gender

	N	Number of person-years	Annual gross mortality rate per 1,000 person-years	SMR	95% CI
Women	220	659	16.7	20.8*	10.4-37.3
Men	750	2,290	11.3	5.2*	3.4-7.7
Total	970	2,949	12.6	6.7*	4.7-9.3

Source: Mortality cohort (OFDT)

Interpretation: women seen in CSAPAs or CAARUDs have a 20.8 times higher risk of mortality than women of the same age in the general French population, and this risk is statistically significant (*: $p < 0,001$).

Reference year for gross mortality rates of the general population of mainland France (aged 15 to 75 years only): 2010.

6.4.3. Specific causes of mortality indirectly related to drug use

With 60 deaths of injecting drug users with AIDS in 2012, the decrease that began in the 90s thanks to the introduction of triple therapy in 1996 continued slowly, and in parallel to a net decrease in HIV prevalence. Since the beginning of the epidemic, and still in 2012, one quarter of all AIDS deaths occur in injecting drug users (InVS 2014b).

There is still no source in France that provides information on other causes of death indirectly related to drug use (e.g., death by accident, suicide, hepatitis C).

7. Responses to health correlates and consequences

7.1. Introduction

Response measures to drug user health problems over the last two decades have largely been focused on and structured around infectious diseases transmissible by injection (HIV and hepatitis) (Bello *et al.* 2010). For this reason, the oldest and best structured actions pertain above all to fighting these diseases. There are three levels of prevention¹¹³: primary prevention with all measures taken to prevent use from generating complications, secondary prevention with an encouragement to undergo screening and early treatment, and finally, tertiary prevention, which aims at improving access to treatments and their follow-up for users. Other pathologies related to drug use, psychiatric and somatic comorbidities or acute incidents have not been the subject of specific treatment protocols or guidelines until now.

With the exception of substitution treatments, changes in the supply and health care delivery as well as harm reduction measures have not been closely monitored in France until recently due to the difficulty in gaining access to data. However, a number of indicators exist, making it possible to monitor the geographical coverage of specialised services for drug users. Two surveys conducted by the French National Institute for Prevention and Health Education (INPES) on a sample of pharmacists and physicians make it possible to measure the number of health professionals contributing to harm reduction measures or treatments: the INPES *Baromètre santé pharmaciens* (pharmacists' health barometer) and the *Baromètre santé médecins généralistes* (general practitioners' health barometer) (see appendix V-Health Barometer-General Practitioners).

Prevention of drug-related medical emergencies and deaths

Up until 2008-2009, no national policy or specific measures existed in France concerning the reduction of serious, acute pathologies and deaths related to drug use. Access to substitution treatments and harm reduction measures (access to sterile injection equipment through pharmacies, syringe exchange programmes, addiction centres and access to health care and social entitlements in so-called “low threshold” structures) offer a number of indirect means of preventing death related to opioid use. The increasingly widespread use and misuse of buprenorphine (which causes relatively few overdoses) instead of heroin is considered one of the reasons behind the fall in the number of overdoses recorded between 1994 and 2003 in France.

The health warning system related to the use of psychoactive substances was launched in 2006 and is now operational and gradually coming on stream.

Nationally, this includes the DGS (the addictions office and the alert management unit), the InVS, the ANSM, the OFDT and the MILDECA (formerly the MILDT) as well as the local networks of each of these institutions (hospitals, physicians, specialised treatment centres, regional monitoring units, low threshold services and pharmacists) and their international

¹¹³ The conceptualisation of the field of prevention is changing with a dissemination of the concepts of universal prevention, selective prevention and indicated prevention (see chapter 3). However, the classification used here proves to be still relevant for describing actions in relation to the various stages of the pathological process.

networks (such as the Early Warning System and the European Centre for Disease Prevention and Control).

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

- warning signs related to 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;
- warning signs related to substances: circulating, seized or already-used psychoactive substances or a combination of substances of an unusual or dangerous nature likely to pose a lethal threat or entail serious health consequences (due to the presence of specific additives, the level of purity, the extent to which the substance or use patterns is new).

Following an analysis of the signs in question, the response can range from simple monitoring to a health alert concerning the toxicity of certain circulating substances or a formal reminder of the dangers of certain “at risk” practices (Lahaie *et al.* 2009).

Monitoring

Apart from the non-specific result indicators described in chapter 6 (the number of overdoses, the percentage of users seen in CAARUDs stating that they have experienced a non-fatal overdose during the last year), the tools for monitoring these actions have not yet been defined. Currently, the alert management 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 of drug-related infectious diseases

The prevention of drug-related infectious diseases initially targeted only HIV until the 1999-2002 period, when the first national hepatitis C strategic plan was adopted. The prevention measures of this plan chiefly concerned drug users, who account for the vast majority of new cases in France. This plan contained measures for 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 “*Programme national hépatite B et C*” (National hepatitis B and C strategic plan) incorporated measures to fight hepatitis B. The latest plan (2009-2012) (DGS 2009) was based on the same issues, but more generally identified “at-risk” groups to better reach them. Prevention also targeted the most vulnerable and precarious individuals in society, and migrant populations in particular. The plan further stipulated working on preventing experimentation with intravenous drug use. The plan also covered possible contamination by the nasal or inhalation routes, whereas up until now the French prevention measures had scarcely considered this. The 2009-2012 national viral hepatitis B and C strategic plan was evaluated by the High Council for Public Health (HCSP) in 2013 (HCSP 2013). The HCSP does not recommend drawing up a new national plan because there is a lack of clear strategy, of consistency in the measures and in clearly identified and allocated financial resources. However, the HCSP does recommend making hepatitis a priority in the future national healthcare strategy.

In 2014, a recommendation report on the treatment of people infected with hepatitis B or C was drafted under the supervision of the National AIDS and viral hepatitis Research Agency (ANRS)

and the French Association for the Study of the Liver (AFEF) at the request of the Ministry of Social Affairs and Health (Dhumeaux *et al.* 2014). This report suggests re-initiating hepatitis B and C prevention, to incorporate an organised approach to the phases of patient treatment and to support efforts towards equal access to screening and care.

The prevention measures used in France are of three types:

1) The harm reduction policy

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

- distributing and recovering sterile, single-use injection equipment. Syringes and injection kits are sold without restriction in pharmacies (without a prescription since 1987). Injection kits are also distributed by or exchanged within harm reduction facilities (CAARUDs), national treatment and prevention centres for addiction (CSAPAs) and automatic distribution machines. For several years now, the availability of prevention material has gradually been extended to administration routes other than injection, with the distribution of snort kits and basing kits for crack smokers and the distribution of special foils for users who “chase the dragon”¹¹⁴. Finally, distributing condoms (and encouraging their use) also helps reduce HIV virus contamination.
- The circulation of information on drug-related risks and the promotion of health education.
- The distribution of opioid substitution treatments (OSTs) since 1995, which initially aims to reduce intravenous drug use (preventing the first injection and/or encouraging users to give up the injecting route) by reducing heroin use, but also by encouraging access to treatment by providing a common objective for both physicians and drug users. This makes it possible to develop a strong therapeutic relationship between them.
- Experimentation in a lower risk drug consumption room was part of the 2013-2017 Government plan for combating drugs and addictive behaviours (MILDT 2013). A draft decree legally allowing this type of experimentation was submitted in October 2013 to the Council of State, which in turn recommended that the government incorporate this measure into legislation to provide a legal framework for it (see chapter 1).

The implementation of the harm reduction policy is based essentially on retail pharmacies (for the sale of injection equipment and participation in syringe exchange programmes), on specialised medical-social systems (CAARUDs and CSAPAs), and non medical-social systems offered by associations. These associations mainly intervene on the party scene and in municipal syringe distribution machine programmes. Treatment access points also contribute to reducing risks, either directly (by providing information and equipment) or indirectly (through substitution treatments). General practitioners and pharmacists also contribute to harm reduction measures by prescribing and dispensing buprenorphine.

¹¹⁴ “Chasing the dragon” consists of inhaling the vapours produced by heating (with a cigarette lighter) the substance placed on aluminium foil. The active substance enters the bloodstream through the pulmonary alveoli, which are highly permeable to gas, and not via the nasal mucosa, like in sniffing. This route of administration increases both the intensity and the rapidity of onset of the effects.

2) Encouragement to undergo screening for HIV, HCV and HBV infections and the ease of access to this screening

The screening programme is chiefly carried out in anonymous free screening centres (known as CDAGs) (see chapter 1). 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 measures or treatment centres that organise the on-site collection of samples for screening purposes. CSAPAs also provide screening free of charge. Finally, access to screening is also possible via the traditional care system. However, whereas the cost of screening for HIV and HCV infections is 100% covered by the French national health insurance scheme, the screening for chronic HBV markers is only reimbursed at a rate of 65%.

The recommendation report on the treatment of people infected with hepatitis B or C (Dhumeaux *et al.* 2014) suggests targeted screening according to currently accepted risk factors and expanding such screening to include men aged 18 to 60 and to pregnant woman as of their first prenatal examination. It recommends fully reimbursing the HBV screening test (which combines AgHB, anti-HB antibody and anti-HBc antibody screening) and encourages developing rapid diagnostic tests (RDTs) for hepatitis B and C viral infections, especially for populations that do not frequent traditional health care structures.

3) Encouragement to undergo vaccination against hepatitis B

The hepatitis B vaccine is provided free of charge by CDAGs and CSAPAs. This vaccine is 65% reimbursed by the National Health Insurance Fund (*Assurance maladie*) as part of a general care system.

The 2014 recommendation report (Dhumeaux *et al.* 2014) endorses 100% reimbursement of hepatitis B vaccination by the National Health Insurance Fund, continued efforts to vaccinate newborns and ensure the vaccination of adolescents, and better access to vaccination by persons at risk of contracting hepatitis B.

Monitoring

Data allowing the quantities of injection equipment delivered to drug users to be monitored was collected by the OFDT in 2008. The OFDT collects these data from:

- the sale of syringes by *Becton Dickinson* to pharmacies;
- sales of Stéribox^{®115} to pharmacies (system of information on the accessibility of injection equipment and substitution products, see appendix V-SIAMOIS);
- the information system based on standardised annual reports produced by CAARUDs (see Appendix V-ASA-CAARUD);
- evaluations produced by various associations distributing syringes.

¹¹⁵ Prevention kits contain two 1-ml syringes, one vial of sterile water, one alcohol wipe, one condom with a prevention mention, two containers ("cookers") and two sterile filters.

The information system based on these CAARUD activity reports also makes it possible to monitor activities aimed at preventing infectious diseases (number of condoms distributed, mean annual number of acts pertaining to screening for viral disease or hepatitis B vaccination per CAARUD client).

The monitoring of the policy to provide access to screening is chiefly based on the ENa-CAARUD survey (see appendix V-ENa-CAARUD) among CAARUD clients every two years. The percentage of users having already undergone screening for HIV or HCV is now very high (above 85%). What is important is that this screening needs to be repeated. Therefore, the OFDT also monitors the percentage of users for whom the most recent negative result dates back less than six months.

A number of indicators are not available on a sufficiently regular basis, such as the percentage of HCV- or HIV-infected drug users who are unaware that they are infected. The Coquelicot survey (see appendix V-Coquelicot) found in 2004 that a large proportion (27%) of HCV-infected drug users were unaware that they were infected (Jauffret-Roustide *et al.* 2006). Similarly, drug users' knowledge of their hepatitis B serological status (vaccinated, contaminated, cured or otherwise) was assessed in 2006 with the PRELUD survey (see appendix V-PRELUD) without being subsequently repeated (Cadet-Taïrou *et al.* 2008).

Treatment of drug-related infectious diseases

Finally, facilitating access to treatment for infected persons is the main purpose of “treatment” measures, but it is also a public health measure for those users who are not yet infected.

Ministerial measures introduced in December 2005 created “a coordinated treatment process for hepatitis C” organised around hospital reference units. The purpose of this was to improve liaison between primary care and specialised medical services as well as to enhance the quality of treatment offered to patients and their overall quality of life. A “physician’s” guide to hepatitis C was produced by the French National Authority for Health (HAS) in 2006 (HAS 2006).

The 2014 recommendation report (Dhumeaux *et al.* 2014) endorsed the concept of giving drug users with chronic hepatitis C infection treatment priority, regardless of their fibrosis score. New anti-HCV antiviral treatments are now available in France under temporary authorisations for use (ATU), which means that these treatments can be used, even though the Marketing Authorisation has not yet been granted, on patients experiencing failure with another treatment and patients with severe disease.

Prevention of infectious diseases has also been planned for drug users in prison. Access to HIV and hepatitis screening was a pillar of the 2010-2014 “health/prison” strategic actions plan on health policy for inmates (Ministère de la santé et des sports *et al.* 2010) (see chapter 1).

Responses to other health-related consequences of drug use

Other health-related consequences of drug use have not given rise to any specific responses in France. Specialised centres for drug users and harm reduction structures facilitate access to care, some of which can be administered on-site (such as skin treatments and dental care). The activities carried out by the CAARUDs in this particular field can be measured. Furthermore, drug users also utilise the general healthcare system for treatment (emergency departments, hospitals, private practitioners).

For economically disadvantaged populations, access to healthcare is made possible through Universal Medical Coverage (CMU) and foreign nationals without papers can benefit from State Medical Assistance (AME) if they request it (see chapter 1). 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 (5.6% in 2012) have no social cover whatsoever (Saïd *et al.* in press).

Treating psychiatric comorbidities in French drug users remains a largely unresolved problem in France. Indeed, although addiction medicine is not lacking in psychiatrists, and although some psychiatric hospitals have developed drug addiction treatment activities over recent years, these initiatives remain few and far between and insufficient to cover needs. Physicians treating drug addicts experience major difficulties in finding suitable treatment establishments for those requiring residential and often particularly complex treatments.

There are no French indicators for monitoring the treatment of psychiatric comorbidities.

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

In 2010, the health warning system for psychoactive substance use improved its organisation by promoting and inciting coordination among stakeholders likely to receive, process and respond to alerts¹¹⁶ on a regional level: Regional health agencies (ARS), Centres for evaluation and information on pharmacodependence (CEIP) of the ANSM network and OFDT TREND/SINTES sites, if need be. The purpose of these measures is also to inform potential targets (e.g., CAAARUDs, CSAPAs, networks of physicians specialised in drug addiction, user associations and hospital emergency departments, etc.).

Subsequently, on 6 November 2013, the SINTES scheme (see appendix V-SINTES) uploaded a memorandum on MDMA (composition and appearance) (Dispositif SINTES 2013), and on 31 July 2014, updated its “Catalogue of new psychoactive substances identified in France since 2000” (Lahaie *et al.* 2014).

7.3. Prevention and treatment of drug-related infectious diseases

Accessibility to harm reduction measures, structures and professionals

In order to guarantee widespread access for drug users to harm reduction measures, the health authorities have promoted local services based primarily on pharmacies, primary care 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 coverage of the systems in place.

¹¹⁶ A signal is likely to be linked to a phenomenon warranting management. It should be evaluated and possibly investigated.

Level of involvement and location of pharmacy professionals.

Another national survey of retail pharmacies was carried out in 2010 by the ANSM. Nearly half (48%) of the retail pharmacies surveyed stated having provided information on the prevention of infectious diseases to drug users, and 40% confirmed having syringe retrieval systems (Lapeyre-Mestre *et al.* 2011). Of the pharmacies surveyed, 79% see at least one patient per month being treated with opioid substitution treatment, 78% dispense *Stéribox*[®] units, but only 16% dispense individual syringes, and even fewer (1.2%) dispense *Stérifilt*^{®117} and *Stéricup*^{®118} units.

Level of professional involvement in primary care

In 2009, two thirds of general practitioners saw at least one opioid-addicted drug user in the last year (Gautier 2011). The proportion of those receiving at least one user per month substantially increased to almost 50% (compared to one-third in 2003). Hence, physicians saw an average of 1.8 opioid-addicted drug users per month, which was stable compared with the number they saw in 2003 (1.6). However, the physicians who saw at least one opioid-addicted patient per month saw 3.6 per month, which was significantly lower than in 2003 (4.6).

Although the percentage of physicians prescribing substitution treatment has not significantly changed since 2003, the prescription structure has. More than one-third of these general practitioners prescribing an opioid substitution treatment (the profile of which is described in the 2013 national report (Cadet-Taïrou *et al.* 2013a)) now prescribe methadone, while the percentage prescribing buprenorphine is diminishing (see table 7.1).

Table 7.1: Change in involvement of general practitioners in harm reduction between 1999 and 2009

	1998/1999	2003	2009
Proportion of general practitioners seeing at least one drug user (of opioids) per month	35%	34%	49%*
Of which:			
Proportion of general practitioners prescribing an OST	78.9%	90.3%*	87.2%
Buprenorphine	71.9%	84.5%*	76.9%*
Methadone	12.6%	26.0%*	37.7%*
Other	13.5%	7.4%*	14.9%

Source: *Baromètre santé médecins généralistes (Health barometer, General practitioners) (INPES)*

*: significant difference $p < 0.001$ compared with the previous edition

National coverage of medical-social harm reduction systems

In 2003, medico-social harm reduction facilities (CAARUD and CSAPA) covered the majority of the French territory: only eight departments (out of a total of one hundred or so) do not have a CAARUD, and all departments have CSAPA.

¹¹⁷ A filter that removes impurities from a drug preparation for injection, thereby limiting the risk of the vascular and infectious complications related to injection (e.g., abscesses, oedema, phlebitis). For single-use only, this sterile filter aims to prevent injection equipment reuse or sharing.

¹¹⁸ A sterile aluminium recipient that diminishes the risks of infection due to the reuse and sharing of injection preparation equipment.

CAARUD harm reduction activities

In 2013, 159 CAARUDs existed throughout France, versus 135 in 2010. These are medico-social establishments funded by the French social security system. They operate in various places according to diverse methods. The main actions are providing assistance with hygiene and first aid care, offering health education promotion activities (mainly by distributing prevention materials (Cadet-Taïrou *et al.* 2013a)), helping people get access to social services, following-up on administrative and legal procedures and seeking out emergency housing. Providing assistance in gaining access to OSTs is one of the CAARUD's primary missions: 79% of them report implementing these actions (Cadet-Taïrou *et al.* 2014a).

The role of CSAPAs in harm reduction, which has been one of their missions for the past few years, cannot be quantified in the absence of data.

Actual scope of dispensing machines and operational status

CAARUDs are not the only structures to distribute injection equipment via dispensing machines. Other operators, non-CAARUD associations and communities, for the most part, also provide drug users with prevention kits such as the *Stéribox*[®] kit or *Kit+*¹¹⁹ via this method. These distribution machines make a substantial contribution to ensuring the accessibility of injection equipment, not only from a quantitative point of view (they distributed just under 10% of all syringes sold or distributed in France) but also in terms of the service they provide (anonymity and around-the-clock access). Furthermore, these dispensing devices enable them to reach a different population from that of other programmes. In 2010, there were 283 automatic prevention kit distributors, 201 syringe exchange devices (return one used syringe for a token) and 70 syringe retrieval devices (collecting used syringes with no token in exchange) in 56 departments. These devices distributed over 1.1 million syringes (nearly half by CAARUDs) and retrieved nearly 500,000 used syringes. However, the system is fragile since one quarter of the dispensers and one third of the exchange devices were in a bad state of repair (Duplessy 2012).

Availability of injection 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 injecting drug users (81,000 recent injecting 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, indicates a rather high accessibility to syringes in France for injecting drug users.

Since 2008, no complete estimate of the number of syringes distributed or sold could be performed. However, there are some data available for 2010 and 2011 (see table 7.2).

¹¹⁹ The kits or prevention kits are intended to limit the risks of transmitting infectious diseases among injecting drug users. These kits comprise 2 syringes, 2 alcohol wipes, 2 bottles of sterile water, 2 sterile aluminium containers (to replace spoons), a cotton filter, a dry wipe (to dab the injection site after administration), 1 condom, instructions for use and general prevention messages.

Table 7.2: Number of syringes dispensed by pharmacies or distributed by CAARUDs and dispensing machines from 2008 to 2011

Number of syringes sold or distributed (millions)			
	2008	2010	2011
Pharmacy: single syringes	4.3	na	na
Pharmacy: <i>Stéribox</i> [®]	5.2	4.7	4.5
CAARUD: single syringes handed over directly to drug users	2.3	2.6	na
CAARUD: prevention kits handed over directly to drug users	1.0	0.9	na
CAARUD: pharmacy syringe exchange programmes	na	0.6	na
CAARUD automatic dispensing machines	0.4	0.5	na
Non-CAARUD automatic dispensing machines	0.6	0.6	0.6
Total (excluding single syringes sold in pharmacies)	9.5	10	
Total (including single syringes sold in pharmacies)	13.8		

Sources: *Siamois (InVS)*, *Becton Dickinson*, *ASA-CAARUD (OFDT)* and *Safe association*

na: not available

In 2011, the Safe association began experimenting with an alternative equipment access programme through the postal service. Users call or write the association, which assesses their use and needs and ensures that users are followed by a professional. The syringe exchange programme via the post sends customised drug use equipment free of charge. They also deliver a prevention message and refer users to a CAARUD or CSAPA when desired or possible. In 2012, this syringe exchange programme had 140 active drug users in its new patient intakes and had delivered 53,000 syringes. The reasons why these users employ this method are structural (geographic distance, poorly-adapted hours of operation, need for specific material – wheel filters¹²⁰, ascorbic acid¹²¹ - that are not available in CAARUDs) or personal (desire for anonymity, difficulty to acknowledge in CSAPAs that he/she injects his/her opioid substitution treatment) (De Postis 2013).

Within the scope of the Coquelicot 2011 survey, an assessment of harm reduction tools (injection kits) was performed, followed by recommendations to update the content of these kits (InVS 2014a). The proposals were:

- to replace the alcohol wipes, which are often incorrectly employed (i.e., post-injection) by a chlorhexidine wipe¹²², which is more effective against HCV
- add a new sterile field as well as a new container with a premounted handle (to avoid extra handling when attaching the handle)
- integrate membrane filters, which are more effective at reducing bacterial and fungal contamination

¹²⁰ This type of filter is more effective at trapping impurities than *Stérifilt*[®] filters.

¹²¹ To dissolve heroin or crack, users often add an acidic solution, such as lemon juice or vinegar, to the preparation. These solutions are not adapted to this use and are not sterile. To reduce the risks related to this practice, sterile citric acid packaged into small packets of powder are made available to users needing it.

¹²² Alcohol is less HCV-virucidal than chlorhexidine and causes bleeding at the injection site, which could increase the risk of hepatitis C transmission.

- add a packet of ascorbic acid
- offer a kit with 2 cm³ syringes (to inject medications) in addition to 1 cm³ syringes
- increase the size of the dry wipe
- review and clarify the harm reduction messages

Harm reduction on the party scene

In 2010, nearly 6 out of every 10 CAARUDs had a team that worked on the party scene (Cadet-Taïrou *et al.* 2014a). Other associations carrying out harm reduction measures are not included in the medical-social system. These are mainly certain humanitarian, community health or specialised associations that are not CAARUD-certified. Many of them work on the party scene.

Preventing first-time injection

The contexts and circumstances surrounding the initial injection of psychoactive substances were examined in the “*Priminject*” survey conducted from October 2010 to March 2011 by the INPES. The mean age at first injection increased, which was related to a prolonged duration of drug use prior to first injection and experimentation with more diverse substances (Cadet-Taïrou *et al.* 2013a; Guichard *et al.* 2013).

Given this context, the adaptation of the English “Break the cycle” programme provides an additional tool to the range of harm reduction measures (Guichard 2012). The objective is to work on the attitudes of injecting drug users towards initiating injection, on the ability of more experienced injectors to refuse requests for help from younger drug users and on the familiarity of drug users with less risky injection techniques.

Harm reduction Awareness

The TREND scheme reveals that groups of users who make little or no use of CAARUD services appear to have little knowledge of harm reduction measures. This is especially true for errant young people as well as “socially integrated” users, young people from working class neighbourhoods and younger drug users of the party scene (Cadet-Taïrou *et al.* 2010).

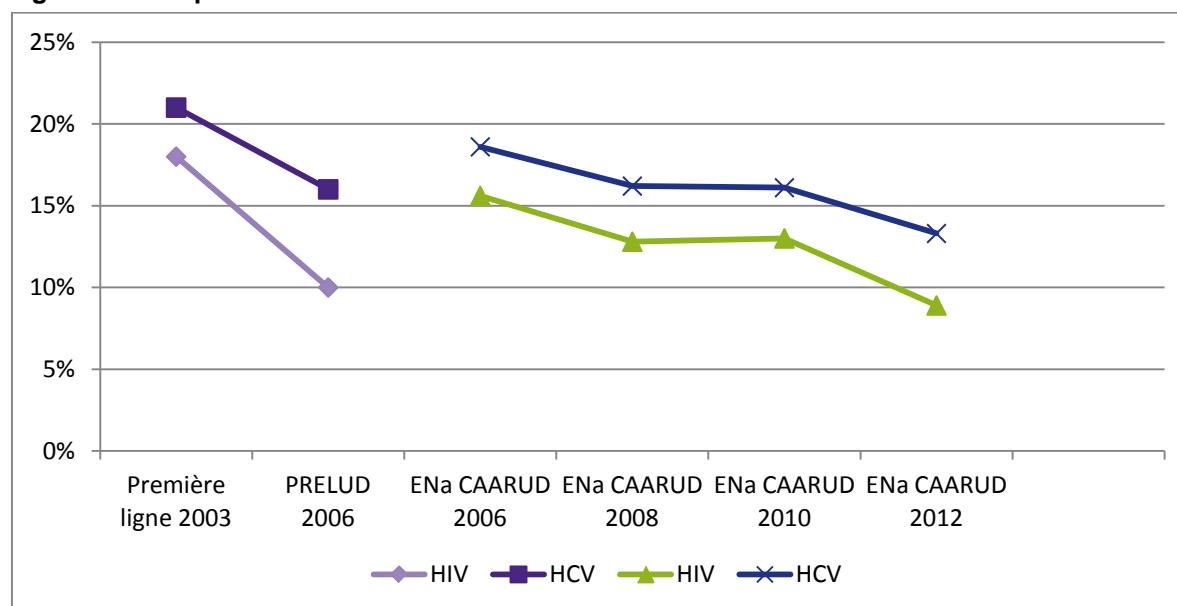
Activity and screening rates for drug users in France

In 2010, of the approximately 60,000 drug users seen as patients intakes, the CAARUDs organised almost 16,000 HBV, HCV and HIV infection screening tests and hepatitis B vaccinations.

Screening rates for drug users in France

The ENa-CAARUD survey showed that the vast majority of drug users frequenting low threshold structures in 2012 had already been screened for HIV and HCV infection (see chapter 6). The proportion of CAARUD clients who have never been screened first declined, and then remained stable from 2008 to 2010, before declining once again in 2012 (see figure 7.1).

Figure 7.1: Proportion of CAARUD clients who have never been screened for HIV or HCV



Sources : Première ligne 2003 (OFDT), PRELUD 2006 (OFDT), ENa-CAARUD (OFDT)

However, if risky behaviours are persistent, these screening tests rapidly become obsolete. In more than half of the people who had a negative result, the result was at least six months old (see table 7.3). This proportion has been on the decline since 2008 for HIV (59.0% to 51.5% from 2008 to 2012) and for HCV (56.9% to 53.0%).

Table 7.3: HIV and HCV infection screening test of CAARUD clients, in 2012

	HIV		HCV	
	Population	%	Population	%
Had the test	2,890	91.1%	2,862	86.7%
Did not have the test	256	8.9%	381	13.3%
Of those with a negative response*, date of last test				
Less than 6 months ago	1,069	48.4%	756	47.0%
6 months to one year ago	528	23.9%	389	24.2%
More than one year ago	610	27.6%	463	28.8%

Source: ENa-CAARUD 2012 (OFDT)

* Stated results

In 2004, the Coquelicot survey, conducted in 5 French cities estimate the proportion of HIV positive users unaware of their positivity to be 2%. This proportion jumped to 27% for HCV (the estimate for the 2011 edition is not yet available). Another study conducted from the “*pôles de référence pour l’hépatite C*” (hepatitis C reference areas) information system, which processes 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). This proportion fell between 2001 and 2007 from 42.7% to 33.4% of the total patient group (regardless of the source of the infection). The proportion of injecting drug users did not change significantly (for men, 39.6% in 2001 compared with 35.5% in 2007 and for women, 15.9% compared with 12.7%). It can be

concluded that late screening is falling among drug users in the same way as in all other patients.

A evaluation of hepatitis B self-reporting by drug users performed in 2012 in the ENa-CAARUD study revealed that users had poor knowledge of their status (Saïd *et al.* in press).

Many CAARUD patients underwent Fibroscan^{®123} exams to assess the level of hepatic fibrosis and, if necessary, enable drug users to be referred for more extensive testing. At the request of the National health directorate (DGS), in May 2014 the National authority for health (HAS) issued recommendations on the utility of rapid diagnostic tests (RDTs) for HCV in the hepatitis C screening strategy (HAS 2014). Given their performance and advantages (simple to use, quick results, acceptable, no initial venous sample needed, can be used in a remote setting), the HAS positions RDTs as an additional screening tool that could be of interest for drug users in particular. HCV RDTs could be used in CSAPAs and CAARUDs by health care or non-medical professionals provided that the latter group has first followed training (for both HIV and HCV). In the event of a positive result, systematic confirmation is required using immunoenzymatic testing (third generation Elisa) on venous samples. However, it is imperative to firstly put in place a treatment network downstream to facilitate access to patients who have been screened positive and to coordinate all stakeholders and health professionals involved in the hepatitis C treatment process.

Access to treatment

Data obtained in 2012 from CAARUD clients show that the majority of users who were aware of being HIV-infected were being followed up medically since 85.8% had had at least one medical consultation for their infection during the year. Only 73.2% were prescribed treatment for the infection.

This same survey showed that two-thirds (64.2%) of people interviewed who had said that they had tested positive for hepatitis C had had at least one medical consultation for their infection in the 12 months before the survey. Slightly over one third (36.2%) were or had been prescribed treatment for this infection.

7.4. Responses to other health correlates among drug users

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

Of the drug users seen at CAARUD centres in 2012, only 5.6% had no medical coverage. More than half (59.2%) had CMU or AME medical coverage and 11.5% had all their costs paid due to a Long duration disease (ALD) (Saïd *et al.* in press).

The provision of treatment and access to care ¹²⁴ together represented the fourth leading activity of CAARUDs in 2010 after social-integration, harm reduction and hygiene promotion measures (Cadet-Taïrou *et al.* 2014a).

¹²³ A non-invasive machine that can instantly detect liver fibrosis and assess its degree of advancement.

¹²⁴ In CAARUDs, the most frequently-provided treatments are nursing care, general medical care, psychological/psychiatric treatment, OST treatment, HBV/HCV/AIDS treatment and dental care.

8. Social correlates and social reintegration

8.1. Introduction

Drug users often encounter difficulties in social integration, professional rehabilitation and relationships. All these problems (unemployment, housing problems, social isolation and criminality) can be grouped together under the term “social harm”. These problems are often analysed as being the consequence of taking psychoactive substances. The relationship between social harm and psychoactive substance use is, however, far from one-sided, and social difficulties can create a situation conducive to the development and continuation of drug use. It is also important to be wary of exaggerated viewpoints that link all drug use to social exclusion.

Social integration problems for drug users are described based on the results of surveys carried out among drug users visiting National treatment and prevention centres for addiction (CSAPA) and Support Centre for the Reduction of Drug-related Harms (CAARUD).

In order to deal with problems of poverty and social exclusion, the French public authorities are introducing a large number of social policies that focus primarily on health issues, employment, training and housing, but these policies cannot be discussed in detail in this report. Drug users can benefit from these policies in the same way as the general population in France.

Active Solidarity Benefit (RSA¹²⁵) ensures minimum income for people without work and provides additional income for people who have very low wages. In 2013, approximately 2.3 million people were receiving RSA benefits.

In 2000, France also established Universal Medical Coverage (CMU) for anyone residing in France who does not have any other coverage, and CMU-C, a free complementary medical insurance coverage. State Medical Assistance (AME) was instituted at the same time. AME entitles illegal aliens residing in France to health coverage (see chapter 1).

Thus, in theory, drug users can benefit from numerous programmes introduced for the general French population. In practice, the most marginalised drug users often find themselves unable to assert their rights, and procedures become too complex for them. Thus, one of the missions of the CSAPAs and CAARUDs, the latter especially, is to help these people assert their rights. More generally, they issue information and perform social assessments, providing guidance to people and their families in addition to social and educational assistance, which includes access to social entitlements and help with integration and reintegration.

8.2. Social exclusion and drug use

The social situation of problem drug users in France is mainly reported through the specialised addiction information systems that glean information from the RECAP survey (see appendix V-RECAP) of patients seen in CSAPAs as outpatients or residents and the ENa-CAARUD survey (see appendix V-ENa-CAARUD) in CAARUDs.

¹²⁵ Loi n°2008-1249 du 1er décembre 2008 généralisant le revenu de solidarité active et réformant les politiques d’insertion. JORF n°281 du 3 décembre 2008. (NOR PRMX0818589L)

Every year, the OFDT TREND scheme (see appendix V-TREND) provides information on changes in substance use, types of substances in circulation, routes of administration, relevant populations and contexts. The social situations of users can be discussed within this framework, which also sheds light on specific populations (wandering young or street youths, migrants and women).

8.2.1. Social exclusion among drug users

Users seen in CSAPAs

The indicators available to describe the social situation of people seen in CSAPAs in 2008, 2010 and 2012 are presented in table 8.1. These indicators illustrate the significant portion of treated people who are in precarious situations. A distinction was made between persons being treated for cannabis use and those being treated for “opioids, cocaine, alcohol and other drugs” given the marked difference in the characteristics of these two sub-groups (especially in terms of age and number of substances used).

Table 8.1: Social instability of people treated in CSAPAs in 2008, 2010 and 2012

	Cannabis users			Users of “opioids, cocaine and other drugs”		
	2008	2010	2012	2008	2010	2012
Unstable housing ¹²⁶	11.8%	11.9%	13.2%	20.0%	19.3%	19.6%
Homeless	2.0%	2.1%	1.5%	6.5%	6.1%	6.2%
Unstable occupational status ¹²⁷	47.1%	50.3%	46.9%	68.0%	66.2%	65.7%
Unstable financial resources ¹²⁸	34.0%	35.2%	38.4%	54.4%	55.5%	55.5%

Source: RECAP 2008, 2010 and 2012 (OFDT)

Users of the “cannabis” group as well as users of the “opioids, cocaine and other drugs” group have had a relatively stable situation in the last few years.

Users seen in CAARUDs

Drug users seen in CAARUDs are even more vulnerable. These people are usually not undergoing active treatment or have withdrawn from the care system. In addition to their mission of counselling patients, CAARUDs develop a number of “services” to reach out to the most marginalised drug user populations and those furthest away from health and social services. These services include outreach teams, mobile units, squats and prison visits and interventions on the party scene (night clubs, concerts, teknivals).

A “socioeconomic instability” variable¹²⁹ was designed to categorise individuals based on their degree of precariousness: low, moderate or high. This classification has been adapted to the

¹²⁶ Temporary or institutional residence and inmates.

¹²⁷ Intermittent paid activities, unemployed persons and other non-workers.

¹²⁸ Unemployment benefits, social welfare (RSA, AAH) and other resources (including people without income).

¹²⁹ The classification is based on calculating a score (from 0 to 6) obtained by adding the scores of the responses of the following three variables: a) Health coverage: 1- affiliated to a social security scheme with complementary coverage 2 - affiliated to a social

population being seen in CAARUDs, since this population is in an extremely precarious situation compared with the general population. Subsequently, three-quarters (76.2%) of CAARUD clients lived in a situation of moderate to high instability in 2012 (see table 8.2) (Cadet-Tairou *et al.* 2014a; Dambélé *et al.* 2013).

Table 8.2: Instability of CAARUD clients from 2008 to 2012

	2008	2010	2012
Low instability	20.0%	25.7%	23.8%
Moderate instability	47.3%	46.5%	43.0%
High instability	32.6%	27.8%	33.2%

Source: ENa-CAARUD 2008, 2010 and 2012 (OFDT, DGS)

Interpretation: 27.8% of users presented with high instability in 2010 versus 33.2% in 2012.

The vast majority (87%) of users seen in the CAARUDs in 2012 had national health insurance coverage. More than half of CAARUD clients had national health coverage through the CMU scheme (63.8% in 2012). Nearly one in eight (13.2%) had 100% medical coverage¹³⁰ due to a Long duration disease (ALD). A bit over one third of users (34.6%) had complementary health coverage. For both cases, the numbers had more than doubled compared with 2008 figures.

The source of income for CAARUD clients was characterised from 2008 to 2012 by an increase in the percentage receiving social welfare and from 2010 to 2012 by a decrease in employment income (see table 8.3).

Table 8.3: Origin of income for CAARUD clients from 2008 to 2012

	2008	2010	2012
Work-related income	17.8%	22.0%	16.5%
Employment income (including retirement/disability pensions)	13.4%	13.6%	13%
Unemployment benefits	8.4%	9.5%	8.3%
Social welfare / Income from a third party	52.8%	56.0%	56.6%
Active Solidarity Benefit (RSA)	35.2%	40.7%	42.7%
Disability living allowance	13.9%	16.6%	16.1%
Other social benefits	2.6%	1.5%	3.5%
Funds from a third party	1.1%	1.7%	1.7%
Other income	25.4%	22.0%	26.8%
Illegal or unofficial resources*	5.4%	8.2%	9.2%
No income (not even from begging)	20.0%	17.5%	18.1%

Source: ENa-CAARUD 2008, 2010 and 2012 (OFDT, DGS)

* Prostitution, dealing, theft and undeclared work are included in this category.

N.B. In 2010 and 2012, the total number of items within each category was greater than the weight of this category because two methods were accepted. This was not the case in 2008. Conversely, the total of the percentages of the three main categories was equal to 100%; individuals belonging to two categories were selectively classified in the less unstable of the two.

security scheme (including people with CMU) without complementary coverage 3- no medical coverage or people with AME coverage b) Housing: 1- long-term (independent or long-term with relatives), 2- in an institution or lodging temporarily with relatives, 3- homeless or squatting c) Origin of income: 1- employment income or unemployment benefits, 2- social welfare or funds from third parties, 3- other income (illegal or unofficial) or no income. Score of 0 to 2: low instability; 3-4: moderate instability; 5-6: high instability.

¹³⁰ Only those healthcare expenditures related to the illness in question are 100% covered.

Finally, in 2012, 46.8% of users seen in CAARUDs lived in temporary housing. The proportion of those living on the street and in squats was 15.2% and 11.9% respectively (Saïd *et al.* in press). Moreover, 5% of users live in an institution on a long-term basis and 10.8% live on a temporary basis¹³¹.

8.2.2. Drug use among socially excluded groups

Of people involved in prostitution who took part in the ProSanté 2010-2011 survey (see appendix V-ProSanté), 17% stated having engaged in last year cannabis use (37% of men and 14% of women) and 11% in last year cocaine use (21% and 8% respectively). Heroin and misused medications were used in the last year by 4% of the people surveyed. Women used less than men and transgender people, and use of psychoactive substances was very rare among Chinese or sub-Saharan African women. Other than for cannabis, there was no correlation between time spent in prostitution and the use of psychoactive substances.

However, it is difficult to determine whether this use is directly related to the prostitution or more generally to the often unstable living conditions of the people in question. Some of them may use drugs to help them “get over their fears and the violence they undergo every day [...]”, others engage in prostitution to pay for their drugs (FNARS *et al.* 2013).

8.3. Social reintegration

Social support for drug users in France is mainly provided by specialist CSAPA and CAARUD structures through their own targeted projects and programmes or acting as relays towards the general healthcare system. Psychologists and social workers who work in “microstructures” in general practitioner offices also provide follow-up support.

CAARUD annual activity reports (see appendix V-ASA-CAARUD) provide information on the number and type of actions undertaken by these structures. Rehabilitation measures, such as access to entitlements, housing, training or employment, are developed. However, these only represent a small part of these structures’ total activity, which is primarily centred on first line intervention (providing “shelter”, food and basic hygiene), harm reduction measures and nursing or general medical care. In 2010, only 10% of the activities of these structures pertained to providing access to administrative and social entitlements. Of these entitlement-related actions, 23.6% pertained to housing measures. Activities pertaining to job-seeking, job-keeping and training only represented 10.4% of all entitlement-related actions (Cadet-Taïrou *et al.* 2014a).

Apart from the CAARUD activity reports, there are no tools available to precisely trace the measures undertaken to address the various aspects of social integration for people being treated. The CSAPA activity reports contain very little information on this theme and no description of actions and programmes being undertaken in this area. The only data available pertain to integration-related measures undertaken that have succeeded: regarding housing, 73% of the measures undertaken succeeded, whereas only 38% of the employment-related measures and half of training-related measures succeeded (Palle *et al.* 2013).

¹³¹ The survey was conducted in the winter - a time period during which great efforts are made to provide temporary solutions to homeless people.

8.3.1. Housing

The main options available for drug users with housing problems are **social housing**, **emergency housing**, **integration housing** and **residential treatment**.

Social housing in France essentially comprises “HLM” housing (low-rent social housing). However, the waits to get such housing can be from several months to several years, depending on the region since the number of available housing units is far lower than 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.

Some structures (CSAPAs mainly) are developing services to facilitate access to individual housing, however there is no information system that can assess the frequency and volume of these programmes.

Specialised structures may make use of **emergency housing** (described in detail in the 2013 annual report (Dambélé *et al.* 2013)) which accepts lodgers unconditionally (i.e., without discrimination), but only for a limited duration. Emergency housing centres tend to admit “stabilised” people who do not present any behavioural disorders. This may tend to exclude a number of drug users.

Integration housing is selective in terms of its residents and offers longer-term counselling and integration measures. A team of professionals is present at all times.

Finally, several specialist **residential treatment** centres dedicated specifically to people receiving treatment are available in France. All of these establishments, the list of which is detailed in the preceding report (Dambélé *et al.* 2013), are managed by CSAPAs.

The preceding governmental drug plan (2008-2011) wanted to promote partnerships and interaction between specialised structures and “general” social housing structures, which gave rise to funding for 30 projects over the period. Since, according to professionals in the field, supply remained insufficient, the 2013-2017 Government plan for combating drugs and addictive behaviours (MILDT 2013) reaffirmed this intention to improve exchanges between these types of structures. It mainly encourages “experimental partnerships between those involved in housing integration and those involved in addiction”: moreover, it is one of the objectives defined in the 2013-2015 Action plan (MILDT 2014). It also focuses on promoting assistance to obtain “long-term housing by relying on the use of tools recommended by the multi-annual plan against poverty and for social integration” (see chapter 1). In general, the 2013-2014 plan reiterates the importance of comprehensive management to improve treatment success.

8.3.2. Education and training

People undergoing treatment in CSAPAs do not have any specific programmes or measures for training or for basic education available to them. Like the general population, and particularly those looking for work, they can however rely on public and private occupational training organisations.

An identical situation exists for vocational skills training. The relevant measures are incorporated into the employment policy, the main operator is the National agency for employment (*Pôle emploi*). Referrals and funding for training are part of its missions. There is no specific training dedicated to vulnerable populations. However, three priority populations have been identified:

people who have been out of work for an extended period of time, young people and immigrants (and immigrant women in particular).

The 2013-2017 government plan for combating drugs and addictive behaviours also aimed to “facilitate the admission of minors in the most difficulty into specific residential CSAPAs” with a “project including paediatric psychiatric treatment and strengthened job placement measures”.

8.3.3. Employment

Although it may be assumed that employers are reluctant to employ such people, there are no particular administrative barriers (screening or discriminatory medical situations) in France to gaining access to employment on the “open job market” for people receiving treatment¹³².

Moreover, in France, an “intermediary job market” has been implemented that covers various measures targeting young people and adults encountering difficulties in entering the job market or needing special social support.

Some specialist structures have developed their own occupational integration schemes or promote reorientation pathways and cooperation¹³³ given the difficulties encountered in assisting their “beneficiaries” in finding employment (Maguet *et al.* 2009). In 2011, an inventory of these measures was performed as part of the “*Pratiques en réseaux et insertion par l’emploi d’usagers de drogues*” (Networking and job placement for drug users)¹³⁴ project. The report published on this work (Calderon *et al.* 2011) detailed some of these occupational integration initiatives and formulated recommendations (Dambélé *et al.* 2012).

The 2013-2017 plan aims to have Youth Addiction Outpatient Clinics (CJCs) and CSAPAs offer “social and professional integration” and, reciprocally, attempt to make it possible for users identified as being in difficulty, by integration professionals, to be referred to specialised structures.

Such an experiment was conducted in the mid 2000s for five years in Brittany by the CSAPA Douar Nevez de Ploëmel and the local mission (departmental structure whose purpose was to help young people in difficulty in their social and professional integration). It involved implementing a CJC within this structure since the people working there often observed psychoactive substance use, which hindered integration for these young people. This involved offering, several hours a week, individual meetings with the CSAPA psychologist for young people in difficulty who had been identified by local mission counsellors. In addition, an agreement was signed with an accomodation centre and referrals to general practitioners and psychological medical centres were established to provide comprehensive management for youths in difficulty (Couteron *et al.* 2013).

¹³² However, for certain public servant jobs or “sensitive” positions (security jobs, working with young children) employers may require a candidate to prove that they do not have a criminal record.

¹³³ Professional activities should be dissociated from integration/employment-seeking activities, but offer an initial experience that can lead to traditional employment.

¹³⁴ The purpose of this project, which was launched in 2009 and incorporated four other European countries (Portugal, Italy, Greece and Lithuania) was to create a network of French and European measures to enable the sharing of professional practices and public policies and promote the occupational rehabilitation of drug users.

Since the results of this experiment were positive, the CSAPA and the local mission made this a long-term partnership, which became a sustainable measure and continued to foster exchanges, especially with multidisciplinary training on integration tools and addictions.

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

9.1. Introduction

Definitions

According to French law, anyone who uses and/or possesses substances classified as narcotics runs the risk of imprisonment (with or without a suspended sentence) and a fine. Ever since the law of 5 March 2007¹³⁵, persons arrested for possessing and using narcotics may be sentenced to undergo an awareness courses on the dangers of drug and alcohol use. This measure aims at occasional, non-addicted narcotics users in an attempt to dissuade them from reverting to drug use by making them aware of the consequences of their use. Simple drug users may therefore face arrest and possible conviction, which may lead to imprisonment (see chapter 1).

According to penal procedure, any arrest must be submitted to the Public prosecutor, who can close the case, order an alternative to prosecution (e.g., warning, fixed penalty notice or court-ordered treatment measure) or prosecute through simplified sentencing where the defendant is not obliged to be present (criminal ruling) or before the court. In the latter case, the offender who has been arrested is seen by a judge, who may hand down a sentence: a fine, an alternative to imprisonment or imprisonment (with or without a suspended sentence). The significant increase in arrests for narcotics use in France has been accompanied by the handing down of more systematic alternatives to prosecution by the courts.

As of 1st January 2013, France had 190 prison establishments (Direction de l'administration pénitentiaire 2013) with a total operational capacity of 56,992. These establishments include:

- 98 remand centres and 41 remand wings (located in penitentiaries) holding pre-trial detainees (remand inmates), inmates with less than one year of their sentence left and newly convicted inmates awaiting transfer to another prison setting (detention centre or high security prison);
- 85 prisons for convicted inmates (with several wings), i.e.:
 - 43 penitentiaries including at least two wings for inmates of a different detention status (remand centre, detention centre and/or high security);
 - 25 detention centres and 37 detention centre wings holding those convicted adults with the best prospects for reintegration. Their detention programme is chiefly aimed at “re-socialising” inmates;
 - 6 high security prisons and 5 high security wings;
 - 11 semi-custodial centres and 10 semi-custodial wings housing convicted offenders who have been referred there by a judge responsible for the execution of sentences with an outside placement without monitoring or an open prison regime, and 7 resettlement prison wings, which are located in penitentiaries;

¹³⁵ Loi n°2007-0297 du 5 mars 2007 relative à la prévention de la délinquance. JORF n°56 du 7 mars 2007. (INTX0600091L)

- 6 penal establishments for minors, which are provided for in the French law of September 2002 on the orientation and programming of the justice system¹³⁶. The first of these was opened in mid-2008.

Data collection tools

Police statistics on drug-related offences from the police or court system have the advantage of being regular, sufficiently historical and easily accessible. However, these data may be subject to breaks in the statistical series when there is an organisational change within ministries responsible for following the annual indicators. Hence, for example, the source of data being used since 1968 to document arrests for drug-related offences, the OSIRIS database (see appendix V-OSIRIS) of the OCRTIS (Ministry of the Interior), has not been able to collect data from the *gendarmerie* since 2011. Since then it only contains the activity of the police and ignores a large proportion of arrests, particularly those in rural areas (which fall within the scope of the *gendarmerie*).

To obtain series of long-term statistics, since 2010 it has been necessary to resort to the *État 4001* (see appendix V-État 4001) classification, which does not take into consideration customs data, but does include police and *gendarmerie* data. Likewise, within the Ministry of Justice, the overhaul of the penal procedure information system (known as Cassiopée) over the last few years led to, in 2012 and 2013, an interruption in the flow of data from the “*Nouvelle chaîne pénale*” information centre. Starting in 2014, this information system should be generalised to all 161 active district courts (*tribunaux de grande instance*). However, these data will not provide a complete view of how offences are processed, from arrest through to conviction and sentence enforcement. There are several reasons for this. Firstly, there is no method of identification to enable suspects to be followed during the trial process; secondly, the court system and law enforcement use different identification systems; thirdly, it is difficult to isolate the penal response offered to each drug-related offence since one conviction can sanction several offences.

Over and above these regular activity indicators, the French framework for the production of knowledge on drug-related crimes also includes data specifically collected in the prison setting:

- Institutional surveys: initiated, designed and deployed by the governing authorities (e.g., the Ministry of Health or the Ministry of Justice), the results are published by these authorities. They often comprise follow-up analyses of existing data (e.g., health forms for new inmates, the number of opioid substitution treatments (OSTs), prescribed in prison settings, data derived from prison CSAPA activity reports). The samples involved are large and seek to be as representative as possible of the prison population. These surveys are conducted at irregular intervals, as is the survey on the health of new inmates, conducted in 1997 (Ministry of Employment, Work and Social Cohesion) and in 2003 (Ministry of Solidarity, Health and Family). The other surveys include the survey on the mental health and psychiatric follow-up of inmates seen in regional medico-psychological hospital services (Coldefy *et al.* 2002). These surveys provide data for analysing the profile of new inmates (use of psychoactive substances,

¹³⁶ Loi n°2002-1138 du 9 septembre 2002 d'orientation et de programmation pour la justice. JORF du 10 septembre 2002. (NOR JUSX0200117L)

OSTs, risk factors and observed pathologies). This data is recorded during the initial medical examination when inmates arrive at a penitentiary remand centre or remand wing.

Likewise, the DGS-DHOS survey (from 1999 to 2004) on substitution treatments in prison settings or those conducted “on a given day” by the DHOS (Directorate for Hospitalisation and Organisation of Care) among detainees known by prison medical teams to be infected by HIV or hepatitis C, enables data to be collected. These “substitution” and “HIV-HCV” surveys have been grouped together within the PREVACAR (*PREVA*lences *en milieu CARcéral* – prevalence in prison settings) survey (see appendix V-PREVACAR), now jointly designed and implemented by the National Health Directorate or DGS (sponsor) and the Institute for Public Health Surveillance or InVS (scientific co-ordination).

- Epidemiological surveys: often backed by research institutes: for example, the INSERM (Falissard *et al.* 2006; Lukasiewicz *et al.* 2007; Rotily *et al.* 1997; Vernay-Vaisse *et al.* 1997) or the InVS (Chemlal *et al.* 2012; Chiron *et al.* 2013; Jauffret-Roustide *et al.* 2006). These are local or national and are also based on pre-existing data.
- Qualitative sociological research and studies: based on qualitative interviews with small samples, these surveys seek to describe user profiles and document their drug addiction and imprisonment histories. These data are collected outside the period of imprisonment (after release).
- Studies conducted on the practices of treatment professionals working in prison settings: quantitative or qualitative studies, such as the PRI²DE survey (research and intervention programme to prevent infection among inmates, see appendix V-PRI²DE) conducted by the French National AIDS and Viral Hepatitis Research Agency (ANRS) (Michel *et al.* 2011b; Michel *et al.* 2011a). They allow the viewpoints and experience of professionals to be known.
- Official reports: motivated by legal or regulatory changes, by current 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 (Mission d'information sur les toxicomanies *et al.* 2011).
- Non-gouvernemental organisation publications: in terms of content, they are similar to official reports (observations and recommendations) but they have a more flexible format. More rarely, they may be based on a collection of data (OIP (Observatoire International des Prisons) 2005).

To these sources should be added a number of more general documents concerning prisons, primarily sociological or demographic works that elucidate the general context of the prison environment. Additionally, we should mention the use of various articles and documents that are often summaries of other works.

Background information

Criminality and drug use

The numerous surveys conducted on the relationship between criminality and drug use have shown that drug users are more frequently responsible for offences, the number of which tend to

increase as the frequency of psychotropic substance use increases, even though there is debate as to whether criminality leads to drug use or vice-versa. The link observed between drug use in young people and problem behaviour (e.g., “acquisitive” criminality, absenteeism and expulsion from school, involvement in fights or acts of vandalism) has been well-established (Barré *et al.* 2001).

Drug use in prison

Drug users frequently end up being incarcerated: of those who receive specialised treatment¹³⁷, the proportion who are ex-inmates varies from 43% to 61%¹³⁸. At the same time, drug use, which may both be a cause¹³⁹ and a consequence of imprisonment, is widespread in prison settings.

Drugs use is relatively well studied in France because it gives rise to many detention issues (e.g., trafficking, at-risk behaviour, OST prescription, special withdrawal management and detoxification). Studies conducted about a dozen years ago by the DREES demonstrated that one third of new inmates stated prolonged, regular use of illegal drugs in the year prior to entering prison: cannabis (29.8%), cocaine and crack (7.7%), opioids (6.5%), misused medications (5.4%), other substances (LSD, ecstasy, glues, solvents: 4.0%) (Mouquet 2005). Nearly 11% of inmates stating that they used illegal drugs on a regular basis used multiple substances prior to their imprisonment. 10% of inmates were addicted: this proportion increased to 40% of inmates who had been incarcerated for less than six months (Falissard *et al.* 2006). However, it remains difficult to precisely quantify this phenomenon since it is difficult to interpret the conditions of admission to the prison setting.

Imprisonment rarely means discontinuing use: all substances smoked, snorted, injected or swallowed prior to imprisonment continue to be used (albeit in reduced proportions) during imprisonment (Rotily 2000). Furthermore, there is an observed transfer of use from illegal drugs (which are less available) to medicines (Stankoff *et al.* 2000). Finally, an unspecified proportion of inmates begin using illegal substances or misused opioid substitution medications during their imprisonment.

Regardless of whether initiated or continued in prison, narcotics use can seriously affect the health of the inmates by generating serious abscesses, accidents when combining medicines and other substances, severe and longer cravings, and the onset or worsening of psychological or psychiatric disorders (Obradovic *et al.* 2011). Moreover, detainees constitute a population group with numerous, cumulative risk factors considering the health and social consequences of drug use. The low levels of access to care for this population group, and more fundamentally, the unstable and marginal situations often faced before incarceration (including a lack of stable housing or social security coverage) all contribute to explaining the prevalence of “at risk” use behaviour among new inmates.

¹³⁷ Users of opioids, cocaine and other illegal substances (not including cannabis) seen in CSAPAs, CAARUDS and by general practitioners who prescribe OST or via syringe exchange programmes, etc.

¹³⁸ According to the RECAP survey conducted in 2012 (see appendix V-RECAP), 48% of drug users seen in a CSAPA for a problem involving the use of an illegal drug other than cannabis had already been incarcerated: three out of every five had even been incarcerated several times. (http://www.ofdt.fr/ofdtdev/live/donneesnat/recap_fr.html). The 2004 Coquelicot survey (see appendix V-Coquelicot) revealed that 61% of drug users who had snorted or injected drugs at least once in their lives had already been imprisoned (Jauffret-Roustide *et al.* 2006).

¹³⁹ An estimated 15% of incarcerations and one third of detentions in remand centres are related to a drug-related offence (Coldefy *et al.* 2002).

The prevalence of injection is high in prisons, even though the number of injecting drug users seems to be declining among new inmates. This concerned, in the year preceding imprisonment, 6.2% of new inmates in 1997 (Mouquet *et al.* 1999); this figure was only 2.6% in 2003 (Mouquet 2005). According to studies, between 60 and 80% of inmates stop injecting during their imprisonment (Stankoff *et al.* 2000). The remaining 20 to 40% who carry on injecting tend to reduce the frequency of their injections but increase the quantities injected. They also tend to be more often HIV- and/or HCV-infected, with a high risk of contamination from shared equipment, unprotected sex and tattooing (Rotily *et al.* 1998). 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 shown by the data of the Coquelicot survey (2004).

As a result, inmates have greater rates of infectious disease than the general population (DGS 2011; DHOS 2004; Sanchez 2006): in 2011, the HIV prevalence was 2% and the HCV prevalence was 4.8% (Chemlal *et al.* 2012; Godin-Blandeau *et al.* 2014).

9.2. Drug-related crime

France does not have a specific data collection system or survey scheme for amassing information on drug use-related crime other than as part of the survey conducted by the Centre for Sociological Research on Law and Criminal Justice Institutions (CESDIP) fifteen years ago (Aubusson de Cavarlay *et al.* 1995).

9.3. Drug law offences

Arrests for drug-related offences

According to the most recent figures available from the Ministry of the interior in 2013, there were 208,325 observed drug-related offences recorded by the police, *gendarmerie* and customs services, representing an increase of 17% over the last five years. In more than eight in ten cases, these offences were related to use, primarily cannabis use.

The last arrest data available date back to 2010, when 157,341 arrests for a drug-related offence were recorded, and of these, 135,447 (86%) were for simple use.

Reasons for arrests

Simple use is by far the number one reason for drug-related offence arrests. In 2013, the number of people accused by police services for simple use was four times higher than for all other drug-related offences (170,337 versus 36,948 for use-dealing, trafficking-dealing without use and other drug-related offences).

Substances involved in drug-related offences

Since the details of police accusations by substance are absent from the statistics, the last data available date back to 2010 (OCRTIS). These demonstrate that more than nine in ten arrests for use involved users of cannabis, the number one involved substance. Lagging far behind were heroin and cocaine (5.4% and 3.5% respectively of these arrests).

Data from the Ministry of Justice: convictions

The conviction data presented here only represent a part of the penal response to narcotics use cases, since the majority of sanctions are handed down prior to referral to the court system, usually as an alternative to prosecution by the Public prosecutor.

Given the general context of an increase in court convictions for crimes and offences, the penal response has become harsher for certain types of offences, such as drug-related offences (over 50,000 convictions per year, of which nearly 60% are for use, and mainly cannabis use). The sentences handed down for drug-related offences (as the main or ancillary offence) represented 9% of all convictions for an offence, or 53,113 convictions in 2012 (French national criminal record, see appendix V-CJN). These offences are broken down as follows: use (31,475, or 59%), possession-acquisition (11,424, or 22%), commerce-transport (6,935 or 13%), import-export (1,130 or 2%), dealing and selling (1,983 or 4%), aiding and abetting, which may comprise incitement to use and facilitate use (166, or less than 1%). Prison sentences, some partially suspended, are handed down in 11% of the convictions for illegal drug use.

Data from the Ministry of Justice: imprisonment

In 2010, over 11,500 people, or 14% of people entering the prison system, were incarcerated for a drug-related offence. The proportion of offences for use was approximately 5% of all imprisonments (whereas this figure was 2.5% five years prior).

9.4. Other drug-related crime

Narcotics checks

Since the driving after narcotics use offence was created in 2003, the number of tests performed subsequent to a fatal accident has remained stable: 4,000 to 5,000 (except in 2005, when these figures were exceeded). Despite the law, narcotics screening is not systematic in fatal accidents, although it is used in the majority of bodily injury cases (Obradovic 2013).

Of the some 4,600 narcotics tests performed each year following a fatal accident, approximately 11% turn out to be positive (Road Traffic-related Offences Record, see appendix V-Road Traffic-related Offences Record). The percentage of people testing positive following a fatal traffic accident has been consistently falling since 2008 (-15%), in contrast with the trend observed in the years preceding the adoption of the law (Obradovic 2013).

The 455 fatal accidents involving at least one driver controlled positive for narcotics in the year 2011 led to the death of 499 people. These deaths represented 13% of all traffic fatalities, versus 31% for alcohol. These percentages cannot be combined. Since the simultaneous use of alcohol and narcotics is not assessed as part of traffic control statistics, it is difficult to identify the number of fatal traffic accidents related solely to alcohol or narcotics¹⁴⁰. However, thanks to the road safety epidemiological survey on narcotics and fatal road accidents (SAM), we do know that combining alcohol and cannabis use increases the risk of causing fatal traffic accidents by a factor of 14 (Laumon *et al.* 2005).

¹⁴⁰ Moreover, screening statistics do not distinguish the types of narcotics found.

Convictions handed down

The judicial response to narcotics use while driving has steadily increased (from 735 convictions in 2004, the first year in which the law was applied, to 16,000 in 2011). After a marked upward trend until 2009, the trend slowed down. However, convictions for driving after narcotics use now exceed those for excessive speeding or all offences in which the driver attempts to circumvent police controls (e.g., hit-and-run, refusal to undergo testing). They usually involve a fine, and imprisonment with or without a suspended sentence represents less than 10% of convictions. In addition, driving after drug use is often associated with driving while under the influence of alcohol. Finally, the subsequent offence rate for driving after narcotics use has been continually rising, and is currently at 7.3% (Obradovic 2013).

9.5. Prevention of drug-related crime

According to the terms of the 1970 French law on narcotics, the French criminal justice system provides several court-ordered treatment options for drug users to help prevent criminality and subsequent offences related to this behaviour. These treatment measures can be ordered by the Public prosecutor (case dismissal after referral to a treatment or social structure, drug treatment order) or by the judge (e.g., bail conditional upon court ordered treatment). The number of referrals of drug users to health structures has been on the rise in the last few years, especially referrals to Youth Addiction Outpatient Clinics (CJC), which have existed since 2004 (Obradovic *et al.* 2013).

9.6. Interventions in the criminal justice system

Like for other offences, people found guilty of a drug-related offence by a criminal court may receive alternative sentencing, thus avoiding imprisonment. These alternatives to imprisonment may take various forms: community service, '*jours-amendes*' penalties (day-fines, literally, corresponding to the number of days in prison paid off by fines)¹⁴¹ or other types of sanctions. Although the national data on this topic are fragmented, they show a rise in the numbers and proportions of these measures applied to simple drug users.

9.7. Drug use and problem drug use in prisons

The total number of problem drug users (PDU) in prison settings is not quantified in France.

Illegal drug market in prison

Although it is known that illegal drugs are available in French prisons, it is difficult to define the magnitude of the problem. The sparse official information available on the subject goes back to 1996: 75% of French penal establishments were subject to drug trafficking. In 80% of cases, the illegal substance seized was cannabis, a prescription drugs was confiscated in 6% of cases, and heroin or another drug in the rest (Senon *et al.* 2004). Nearly twenty years later, some elements indicate that the situation has not changed much. Cannabis remains the most widely trafficked illicit substance within French prisons, and trafficking of buprenorphine, sedatives and cocaine hydrochloride is also increasing.

¹⁴¹ The convicted offender in question must pay the amount of a fine of Y Euros over X days; if the offender does not pay the fine or does not pay it in full, they shall be incarcerated for the period corresponding to the amount that was not paid.

9.8. Responses to drug-related health issues in prisons

The regulatory framework for the organisation of treatment in French prisons authorises OST to be initiated and renewed just as they are outside of prison settings. However, in practice, not all penal establishment offer generalised access to all available treatments (Michel *et al.* 2011b; Obradovic and Gandilhon 2013).

Offering inmates customised treatment is rendered twice as difficult given French prison overpopulation and inmate conditions. With 66,572 inmates as of 1st January 2013 for 56,992 operational beds, there are 116 inmates for every 100 beds in France. However, all inmates must have a medical visit when they enter prison. This visit, which was reorganised in 2012 as an “admission examination”, is performed by prison-based hospital healthcare units (formerly known as UCSAs), which can screen for infectious diseases.

The principle of harm reduction (with respect to drug use), although within a legal framework¹⁴², is still difficult to apply in practice in penal establishments, as described in the same section of chapter 9 of the 2013 national report (Obradovic and Gandilhon 2013).

9.8.1. Drug treatment (including number of inmates receiving opioid substitution treatment)

Based on the more recent PREVACAR (Chemlal *et al.* 2012; DGS 2011) and PRI²DE (Michel *et al.* 2011b) surveys, 8% to 9% of detainees, or 5,000 individuals, receive OST. The prevalence of OST use is highest in women and in remand centres. The predominance of buprenorphine seems marked, even though the proportion of methadone among OSTs tends to rise (Obradovic and Gandilhon 2013).

The *Guide des traitements de substitution aux opiacés en milieu carcéral* (guide to opioid substitution treatments in prison settings) (Ministère des affaires sociales et de la santé *et al.* 2013) recommends, daily supervised methadone dispensing, including on weekends and on holidays, to prevent overdose risk. This recommendation seems difficult to systematically apply given the lack of health personnel described by professionals working in prison settings.

9.8.2. Prevention and reduction of drug-related harm

Harm reduction strategies are directed towards reducing harm, in many cases by altering behaviour associated with drug use and drug effects (acquisition, drug use, and withdrawal). Several strategic documents (MILDT 2008-2011 and then 2013-2017 governmental plans on drugs (MILDT 2008; MILDT 2013), 2010-2014 “health/prison” strategic actions plan on health policy for inmates (Ministère de la santé et des sports *et al.* 2010)) discuss the public problems encountered in the three levels of drug-related harm (harm related to drug acquisition, harm related to use and harm related to withdrawal (Obradovic and Gandilhon 2013).

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 (INSERM 2010).

¹⁴² Loi n°2004-806 du 9 août 2004 relative à la politique de santé publique. JORF n°185 du 11 août 2004. (NOR SANX0300055L)

9.8.3. Prevention, treatment and care of infectious diseases

Inmates have a higher rate of infectious disease than the general population: although declining, HIV infection prevalences vary, depending on the source, from 0.6% to 2.0% (three to four times the prevalence in the general population (InVS 2009)), while prevalences of HCV are from 4.2% to 6.9% (four to five times higher (DHOS 2004; Meffre 2006); PREVACAR 2010, DGS-InVS (Chiron *et al.* 2013; Semaille *et al.* 2013); POPHEC (Remy 2004). In people receiving opioid substitution treatment, these prevalences are even higher, both for HIV (3.6%) and HCV (26.3%), since drug use is the most frequent contamination route (70%).

To prevent the health problems and the spread of drug use-related infectious disease, both of which are aggravated by the prison overpopulation problem, newly-arrived inmates are screened to determine their drug use-related health problems. Upon their arrival in prison, all inmates are offered a medical visit provided by a prison-based hospital healthcare unit. The screening includes, along with tuberculosis testing, a voluntary, free HIV test and, more recently, screening for hepatitis C as well as a hepatitis B vaccination. The PREVACAR survey conducted in 2010 (DGS 2011) showed increasingly higher rates of infectious disease screening in the last decade.

9.8.4. Prevention of overdose-risk upon prison release

Release from prison is linked to a high risk of relapse, which is sometimes fatal, for inmates with a history of opioid addiction (Harding-Pink 1990; Marzo *et al.* 2009; Seaman *et al.* 1998). The risk of fatal overdose in former inmates was more than 120 times that of the general population (Prudhomme *et al.* 2001; Verger *et al.* 2003). The “Prudhomme” study also established a particularly high rate of fatal overdose among newly-released inmates under the age of 55.

The *Guide méthodologique relatif à la prise en charge sanitaire des personnes détenues* (Ministère de la justice *et al.* 2012) (Methodological guide on the health care of detainees) specifies that the modalities for release need to be planned sufficiently early, before the definitive release date. However, in practice, the tools of the current system are often insufficient: in addition to the problems accessing care during imprisonment (especially due to overpopulation), there are difficulties finding housing and continuity of care following release, especially in remand centres.

To prevent breaks in care and “cold releases”¹⁴³, as part of the 2008-2011 governmental plan on drugs, the public authorities implemented experimental, rapid access, short-stay admission programmes in social and medical-social structures (with housing) for newly released inmates. These programmes are linked to the hospital upon which the prison depends. In two years (2009-2010), two types of programmes targeting newly released inmates were thus funded and then assessed by the OFDT (Obradovic 2014), demonstrating the existence of a real need.

The first programme involved opening four group residential units, each with approximately 10 beds, for newly-released prisoners with addiction problems: 225 people were admitted to medical-social structures immediately after their release from prison, meaning all available spots were filled. The mean stay in these residential units was approximately 2.5 months (71 days), with extensive differences from structure to structure (from 39 to 109 days). The majority of those admitted to these short-stay units were people who had just been released from prison

¹⁴³ Releases from prison without any therapeutic follow-up.

(55%), while 37% had had a resettlement and 8% were on leave and therefore admitted within the scope of preparation for release. This population has great need for social and treatment support: of the people admitted, 65% lived on the streets or in unstable housing conditions before being incarcerated, 53% lived on social benefits and 33% had no social coverage. Moreover, more than one third (35%) of people admitted to these residential units stated being HIV-, HBV- and/or HCV-positive. The majority were users of multiple psychoactive substances (nearly all smoked cigarettes, over 50% drank excessively, 62% used cocaine or crack and 32% used opioids) and the majority (54%) were taking OST when they were admitted to the unit.

The second type of programme intended for newly-released inmates was early CSAPA consultations in social housing and rehabilitation centres (CHRS), and especially residential integration centres (AHI). These structures admit people having trouble with their alcohol or illegal drug use upon release from prison. Implemented from 2009 to 2011 in three regions, these early CSAPA consultations in AHI centres admitted 70 people, the majority of whom had just been released from prison (80%), while 20% had been granted resettlement. For nearly two thirds (65%) of these people, the follow-up lasted more than two months. In contrast, nearly one quarter (25%) underwent short follow-up. People with precarious lifestyles predominate among people with addiction problems. Over one quarter (27%) live on the street or in unstable housing conditions and 37% receive social benefits. Half of all people receiving early CSAPA consultations in AHIs were regular opioid users (heroin, morphine, opium), and the majority (61%) stated being under opioid substitution treatment when they entered the programme, and were often polydrug users. Nearly 7% stated being HIV-, HBV- and/or HCV-positive.

9.9. Reintegration of drug users after release from prison

The OFDT evaluation of housing programmes for released prisoners revealed that the objective of social integration, or even professional placement, seemed difficult to achieve in a population that, for the most part, had never worked and had significant social issues. Professionals emphasise the difficulty in taking action in the absence of social entitlements when released from prison, which is worsened by the difficulties encountered when searching for a follow-up structure after the residential admission stay. The follow-up provided when discharged (by downstream structures) is therefore deemed insufficient by all short-stay residential structures. All professionals surveyed pleaded for more focus on treatment through measures intended for released prisoners with addiction problems (Obradovic 2014).

10. Drug markets

10.1. Introduction

Understanding the market for illegal drugs requires assessing the *availability* and *accessibility* of a given substance, the changes in the quantities seized and the changes in street price.

Monitoring drug supplies also means tracking the composition (purity and cutting agents) of the substances in circulation.

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 “perceived” to the extent that it is determined by “sentinels” devoted to observing what is obtainable.

Accessibility refers to the degree of effort required by an average user with the necessary financial resources to obtain the substance they are seeking. A substance actually may well be available but not particularly accessible. There are several degrees of accessibility and they can be measured based on factors such as the time needed to gain access to the substance, the location (public/private) of the sourcing, the time (night or day) of procurement and the type of supply network involved.

The main source of information in this area is provided by the ongoing Emerging Trends and New Drugs survey (see appendix V-TREND), which, since 1999, has been providing chiefly qualitative information (accessibility, availability and price) on users and the various stakeholders in the fields of prevention, treatment and law enforcement.

The substance analysis scheme referred to as the National Detection System of Drugs and Toxic Substances (see appendix V-SINTES), an integral part of the TREND survey, provides information on the circulation of rare and emerging substances.

General population surveys on the perceived accessibility, supply and availability of various illegal substances can also provide us with information on the most widely available substances.

Seizures and the structure of trafficking activities

It is difficult to distinguish between the quantities of drugs intended for the French market and those that are only in transit. France is a transit country particularly for substances destined for the Netherlands, Belgium, the United Kingdom, Italy and beyond. Trafficking in France must therefore be assessed based on the substances encountered, since countries of acquisition and destination vary depending on the substance in question.

In France, there are three main types of supply networks for illegal substances:

- Networks linked to major criminal organisations are often encountered at the “wholesale” or “semi-wholesale” sale stage.
- “Retailer” networks are based on a strict organisational structure (manager/dealer/tout/lookout).
- “Micro-networks” include user-dealers.

The main source of information is data from law enforcement services (police, customs and *gendarmerie*), which are centralised on an annual basis by the Central Office for the Repression of Drug-related Offences (OCRTIS). This report indicates, among other things, the quantities of illegal drugs seized in France, the prices and any information on the structure of the trafficking networks.

Additionally, the TREND scheme provides qualitative information on methods for gaining access to substances and on micro-trafficking.

Online sales of new psychoactive substances¹⁴⁴, whether classified in France or not, gives rise to different forms of traffic. Their documentation requires additional information sources to contribute. The Customs Joint laboratories department (SCL) and the French National Forensic Science Institute (INPS) are the main bodies collecting information on the number of seizures, the quantities seized, and the identification of the substances seized.

Prices

Two resources make it possible to collect unit sale prices of illegal substances:

- A periodic OCRTIS survey based on data collected at 69 sites throughout metropolitan France records the median semi-wholesale and retail prices of certain illegal substances (heroin, cocaine, cannabis and ecstasy).
- The TREND network, based on qualitative questionnaires completed by CAARUD low threshold structures and staff operating in the techno/party scene on each site involved in the scheme. For each substance under consideration (whether illegal drugs or misused legal medications), the retail price and an estimate of the lowest price, the highest price and the usual price are requested. In 2011, at the request of the MILDECA (ex MILDT), the collection of information on prices was reinforced by data collected from the seven TREND sites every six months (every year since 2012). The illegal substances in question were cannabis (herbal, resin), heroin, MDMA (tablets, powder, crystal) and cocaine (for which the prices were collected in both urban areas and on the party scene).

Substance composition and purity

The composition of a product refers to all of the substances present in a sample of that product. The purity, or potency, represents the percentage of the psychoactive substance found in the product. Product samples also include cutting agents or 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 needed of a substance to identify it in a sample. The quantification threshold is the minimum quantity needed of a substance to determine its dosage in a sample.

¹⁴⁴ New psychoactive substances, according to the EMCDDA's definition, include new psychoactive substances (NPS) as well as other substances, such as khat, GHB, ketamine, and hallucinogenic plants and mushrooms (e.g., psilocybes, Salvia, Datura) or even misused prescription drugs. In France, the definition of new psychoactive substances is more restrictive than the EMCDDA's.

Two further information sources are used by the OFDT to document the composition of substances in circulation:

- Analyses are performed on substances seized by law enforcement services. These data are supplied by law enforcement laboratories and are grouped together in the report from the OCRTIS.
- Analyses are also performed on drug user data collected as part of the OFDT's SINTES system.

Analyses of seizures

Analyses of seizures by law enforcement laboratories provide the main source of information on the composition of illegal substances in France. The OCRTIS provides a summary of all of the data on the composition of illegal substances seized and analysed by all French law enforcement services (customs, police and *gendarmerie*) during the year for the whole country. The data represents the results of analyses of seizures without regard for the volume of each seizure, with the exception of cocaine, for which a distinction is made between airport seizures and street seizures.

The content of the main psychoactive substance is determined; with few exceptions, the other substances in the product are simply identified.

The exchange of information between the Early Warning System (EWS) – the EMCDDA's European alert system – and SINTES – the EWS's national correspondent – also helps identify new molecules.

Finally, SINTES is also in contact with the laboratories of law enforcement services through an agreement that officially establishes and authorises an exchange of information on substances in circulation. Following a specific request from the OFDT, these entities provide information on the nature and composition of substances that have been recently seized or that attract special attention from the OFDT and/or the EMCDDA.

The SINTES scheme

The SINTES scheme is based on collecting samples of illegal and legal substances directly from drug users. The products collected are forwarded to a toxicological analysis laboratory, which determines their composition. At the same time, drug users are asked to complete a questionnaire on the context of use for the substance and its purchase price. This makes it possible to directly correlate the price and purity of a given substance. SINTES has three sections:

- The *observation* section provides an annual overview of the composition of a particular illegal substance¹⁴⁵. Conducted since 2006, this section could not be conducted in 2013 for budgetary reasons. The SINTES observation scheme relies primarily on the French TREND network. "Collectors" are selected and trained according to their networks and skills by the regional coordinator under the

¹⁴⁵ Cocaine in 2006, heroin in 2007-2008, synthetic substances in 2009, heroin again in 2011, and cannabis (herbal and resin) in 2012.

responsibility of the OFDT, which then provide collectors with their collector card. In total, the network has approximately 90 collectors. Each year, about 350 to 450 samples of the substance being studied are collected from as many different users. This is consequently the main focus of the SINTES scheme: obtaining details on the composition of a given substance on a national basis for a given year.

- The *monitoring* section comes under the health alert system. It is based on the TREND network sites as well as sites outside of this network that have signed agreements. In 2013, the SINTES network welcomed three new sites. Outside of the network, any professional working with drug users may ask the OFDT for authorisation to collect an illegal substance as long as this substance has generated undesirable and unusual effects in users or if it is new in some way. The annual number of samples collected is generally between 60 and 100. The contributions made in this section are limited exclusively to the identification of newly circulating molecules and up-to-date information on the composition of certain substances at a given moment and in a given location.
- Since 2010, SINTES has been exploiting the Internet to monitor for new psychoactive substances (NPS) and document them. In April 2013, the official launch of the European I-TREND project coordinated by the OFDT helped to design and implement tools for observing new psychoactive substances sold on the Web and their use.

All pharmacologically active substances are identified provided that they are included in the laboratory database. However, only the main psychoactive substances undergo content analyses, unless requested otherwise.

10.2. Supply to and within the country

10.2.1. Drugs origin: national production versus imported

Herbal cannabis is the only illegal substance for which production is seen in France. Although herbal cannabis has mainly been cultivated by individuals at home and on a very small scale, the situation has begun to change. Starting in 2011, “cannabis factories” began to appear. These factories are overseen by organised crime and use the investment of individual people in commercial cultivation.

All of these phenomena were confirmed in 2013, providing a fairly precise overview of the French herbal cannabis supply. In terms of production, the main players can be classified as follows:

- Small growers who produce for themselves or for their immediate circle.
- Individuals getting involved in relatively large-scale commercial herbal cannabis production (several dozen plants)
- Criminal groups installing real production units (“cannabis factories”) with up to several thousand plants. The new phenomenon is the emerging involvement of groups coming from so-called “sensitive” suburban areas that originally were specialised in importing and distributing cannabis resin.

There are also significant herbal cannabis networks supplying themselves especially in the Netherlands. In 2013, 58% of herbal cannabis for which the origin was known came from the

Netherlands (OCRTIS data, 2013). These networks include highly organised structures and smaller user-dealer networks.

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

Cannabis

The cannabis resin smoked in France comes from Morocco and usually transits through Spain. It is imported by well-organised cross-border criminal networks that are often established in housing estates located on the periphery of major French cities, where the networks are in close proximity with the country of production. The cannabis resin trafficking network in France is comprised of three major types of dealers:

- The first type is comprised of wholesalers in southern Spain or Morocco. These traffickers can import cannabis resin by the tonne. According to certain law-enforcement services, there are approximately sixty such groups using about one thousand people in total.
- There are also intermediaries (semi-wholesalers), who regularly transport cannabis resin from Spain or the Netherlands to France. These are very structured groups that primarily import a single type of substance, although they may also import other illegal substances (cocaine, heroin).
- Finally, we observe local traffickers who oversee a network of dealers in charge of selling the substances in a given territory.

Today, the cannabis resin market seems to be less dynamic and less profitable. There are several reasons for this. On the one hand, there is increasingly stiff competition from cannabis grown in France and elsewhere in Europe. On the other hand, law-enforcement efforts by the police, customs and *gendarmerie* oblige traffickers to have multiple storage areas thereby fragmenting their deliveries. This automatically leads to an increase in prices and a decline in profitability.

In 2013, large quantities of cannabis resin seized in the Mediterranean on boats coming from Libya and Egypt represented the diversification of major resin traffic routes.

Heroin

The trend towards increasing heroin availability on the French market is encouraged both by a renewed dynamism of supply over the last decade in Afghanistan, the source country for 90% of the heroin consumed in France, and by higher demand in recent years (Cadet-Taïrou *et al.* 2012).

The rise in opium and heroin production (Chouvy 2013) has encouraged the installation of criminal organisations (particularly Turkish and Albanian) that import heroin through the

Balkans¹⁴⁶ onto French soil. There are two major circuits for this importation, and they are described in the relevant section of the 2013 national report (Gandilhon *et al.* 2013b).

Alongside these networks, which are controlled by organised crime, there are what the police refer to as *secondary* networks, i.e. small-scale organisations chiefly comprised of user-dealers. They obtain heroin in countries bordering France, such as Belgium and the Netherlands. These two countries are the customary storage sites for heroin arriving via the Balkan route (OCRTIS 2009).

High dose buprenorphine (HDB)

Ever since its 1996 commercial launch, the high-dose buprenorphine (HDB) prescribed for opioid substitution treatment (OST) has been the subject of trafficking on the urban black market, and often targets extremely marginalised drug users (Toufik *et al.* 2010). This trafficking is organised by two types of groups.

- The first type, which displays a certain degree of organisation, obtains major quantities of tablets available for sale on the black market by falsifying prescriptions and obtaining multiple prescriptions from people not dependent on opioids.
- The second type is chiefly comprised of users receiving OST themselves, and carry out small-scale dealing in the products.

Morphine sulphates

Morphine sulphates (Skenan[®]LP, Moscontin[®]) are a class of opioid medications indicated in the treatment of intense pain and/or pain uncontrolled by other analgesics. They are sometimes prescribed within the scope of opioid addiction treatment. In 2012 and 2013, TREND sites, except for the Lille site, reported the development of a black market for these medications. The purpose of this black market was to meet growing demand (Cadet-Taïrou *et al.* 2014b). Since 2000, this market has been growing, due mainly to the decrease in purity in heroin in France in 2010 and 2011 (Cadet-Taïrou *et al.* 2013c). Allegedly, users turned to morphine sulphates, which has a better image than Subutex[®]. When the black market is limited, it is generally due to users who engage in small-scale dealing. Some of them are being treated through a protocol, which enables them to sell some of their substance, either because they succeeded in receiving a prescription that covers more than what they need, or because they are diminishing their use. These practices appear to be increasingly rare in areas where there are few, well-controlled prescriptions. Bordeaux also has small-time dealers who supply a certain group or area, such as a squat.

A portion of the users also obtain multiple prescriptions and supply the black market by consulting several physicians. These users include, once again, certain users following a protocol (Rennes). Like for HDB, obtaining multiple prescriptions can involve procuring prescriptions outside of the department or region either to avoid being identified or when access appears to be “saturated”¹⁴⁷ or when the relationship of trust with the prescriber is broken.

¹⁴⁶ According to the UNODC, 80% of Afghan heroin intended for the European market transited through the Balkans (UNODC 2012).

¹⁴⁷ Too much demand with respect to the number of prescribing physicians.

Finally, in Bordeaux, there appears to be a network overseen by people from Eastern Europe and the Caucasus organising traffic bound for their countries of origin¹⁴⁸. This traffic represents the lion's share of misused substance.

Methadone

For several years now, the "syrup" oral form has been subject to misuse in the same way it was in preceding years. In other words, for the most part, it was used for "spare supply" between users helping each other out, or by very small-scale traffickers who never go beyond the micro level, even though they are increasingly visible each year. In 2013, certain TREND sites (Rennes, Lille, Bordeaux, Toulouse and Paris) reported that methadone capsules were circulating outside of their therapeutic framework. However, like for the syrup form, it seems that the capsules are not part of organised trafficking, but rather serve as supply for "temporary fixes" among users.

Cocaine

Today, there are three major types of cocaine distribution networks in France:

- networks related to organised crime in France and elsewhere; these networks specialise in wholesale.
- so-called "housing estate" networks, which are established in neighbourhoods located at the periphery of major cities; these networks deal either in wholesale or in retail sales.
- user-dealers of varying reach.

This cocaine trafficking system had not changed much by 2013. However, law enforcement services focus on the increasing role played by the French Antilles (Guadeloupe, Martinique) and French Guiana both as areas dispatching cocaine to mainland France and, more broadly, to Europe and the secondary wholesale market. According to the OCRTIS, the French Antilles and the Dominican Republic are playing increasingly strategic roles in the trafficking of cocaine destined for Europe. The cocaine mainly comes from the coasts of Venezuela, a country that, in the last few years, has become "*a new epicentre for regional and global cocaine trafficking*" (Weinberger 2013). Since 2004, the year in which the "Caribbean" unit of the OCRTIS¹⁴⁹ was created, nearly thirty tonnes of cocaine have been seized, while 73 organisations were dismantled and 1,000 people placed in police custody. In mainland France, the extent of the trafficking was illustrated in 2013 by one of the biggest seizures in history, i.e., over 500 kg of cocaine were intercepted at Le Havre in cargo coming from Fort-de-France.

Antilles-Metropolitan air trafficking occurs mainly through mules transporting the substance either *in corpore*¹⁵⁰ or in luggage. These mules can be recruited by French criminal organisations set up in Metropolitan France. For the last few years, with the increasing involvement by gangs from neighbourhoods surrounding main cities in cocaine trafficking, this phenomenon continues to develop. In general, the people chosen are young women, who are

¹⁴⁸ According to the National Health Insurance Fund (*Assurance maladie*) and prison workers

¹⁴⁹ The OCRTIS Antilles unit is responsible for coordinating the work of the police, *gendarmerie*, customs, French Navy and maritime *gendarmerie*.

¹⁵⁰ Smugglers, or "mules" can ingest up to one kilogram of cocaine.

paid €1,000 to €3,000 to carry “small” quantities (3 to 5 kg) (Colombani 2010). The benefit of an Antilles-based wholesale market is in the prices, which are much lower than in Metropolitan France. In Metropolitan France, the wholesale price per kilogram of cocaine amounts in average to €30,000, and it can drop to as low as €10,000 in the French Antilles. With this lower price, profits can be generated that can easily cover the cost of a plane ticket¹⁵¹ and a “week of holidays”. Trading cannabis against cocaine also occurs, at a ratio of 2 to 1¹⁵².

Ecstasy/MDMA

In 2013, most of the supply found on the French market came through small-scale networks that sourced abroad (from Belgium, the Netherlands or Germany) and less commonly through Eastern Europe’s organised crime networks.

Moreover, it would seem that, in response to the increase in demand, a more organised MDMA (powder) supply network is being established. For example, law enforcement services in Paris and Rennes are observing an emergence of professionalised, organised networks that are sourcing from the Netherlands and Belgium.

New psychoactive substances (NPS)

Since the discreet arrival of new psychoactive substances in France in 2008 (Lahaie *et al.* 2013), 97 new substances have been identified by toxicological analyses laboratories, and 36 of these were identified in 2013 alone. Since 2010, the rate of identification of new substances has increased, with three new substances analysed every month (one per month in 2012). In 2013, cannabinoids were what was most frequently identified (31 from 2008 to 2013, and 13 in 2013 alone) but for the first time, the number of phenethylamines¹⁵³ identified in the year exceeded the number of cathinones (seven versus four), making equal numbers of substances identified from both families from 2008 to 2013 (19 in each family). Molecules belonging to new chemical classes are appearing: mainly arylcyclohexylamines¹⁵⁴ (similar to ketamine, like methoxetamine) and arylalkylamines¹⁵⁵.

The role of the various NPS on the online market is observed through sales sites and user forums. On the Internet¹⁵⁶, being classified as a narcotic (especially in many countries) and opinions expressed by users on forums can affect the availability of an NPS. The substances eliciting the most interest tend to be stimulants.

Few NPSs sold on the online market or referenced in Europe are observed on the “real” market by TREND and SINTES schemes. They continue to be sold as imitations of traditional

¹⁵¹ In Metropolitan France, one kilogram of cocaine purchased for €30,000 and cut to 50% can generate an average profit of €90,000 based on a per-gram price of €60. Purchasing that same kilogram in the Antilles can generate an average profit of €10,000.

¹⁵² For geographic reasons, the French cannabis market, which relies on the distance from Morocco, the second largest worldwide producer, is dominated by herbal cannabis. However, there is demand for cannabis resin, which can be sold at much higher prices than herbal cannabis.

¹⁵³ Phenethylamines have stimulant, empathogenic and more or less hallucinogenic properties. They are derived from a model of molecules representing this family, namely MDMA, amphetamines or 2C-B.

¹⁵⁴ Arylcyclohexylamines are both hallucinogenic psychotropes and dissociatives (i.e., leading to a feeling of dissociation between the body and the mind).

¹⁵⁵ Arylalkylamines have effects similar to those of phenethylamines (hallucinogenic, stimulant, empathogenic). The best known of these molecules are 6-APB, bromo-dragonfly or 2C-B-Fly.

¹⁵⁶ Internet here means the Internet to which general search engines have access.

substances or directly under the name of the substance they are intended to copy (MDMA, amphetamines), or even carry more whimsical names (Vortex, RTI-111). More rarely, certain substances are sold under the name of their molecule.

On the alternative party scene, there are more NPS substances with hallucinogenic effects (arylcyclohexylamines, phenethylamines and tryptamines), some of which have already been identified¹⁵⁷ through TREND and SINTES schemes, but not identified as NPS. These substances seem to be becoming more widespread. On the commercial party scene, stimulant-like NPS substances (MPA, ethylphenidate) seem to be increasingly present.

Methoxetamine supply continues to stand out on the online market and on the “real” market due to its long existence, and despite its classification in August 2013¹⁵⁸. It is the NPS group that has had the most success in spreading beyond groups of users that frequent dedicated forums (Kmetonyova *et al.* in press; Gandilhon *et al.* 2014; Cadet-Taïrou *et al.* 2013c).

At the same time, seizures of illegal NPSs indicate that molecules, different to those that elicit interest among internet users, are in circulation. Subsequently, 59% of these seizures contained one of the three following substances: methylone, x-MEC and 4-FA. Between 2012 and 2013, the number of 4-FA seizures increased 100-fold. Simultaneously, and since 2009, there have been practically no other reports in France for this molecule¹⁵⁹. In 2013, there were seizures of small quantities intended for end users. This difference begs the question of which data are most representative of the market. It is possible that customs services tend to verify a certain type of package or letters in which they can identify the sender, if said sender is very active in NPS.

Until now, online purchases were only for the personal use of NPS users. The development of a commercial resale market using substances bought online had not yet been clearly identified, but appears to be more marked now, especially on the party scene.

Moreover, the year 2013 was characterised by the initial discovery in France of an NPS packaging laboratory (Ladroue *et al.* 2013). In this case, an online sales site offered a loyal customer the opportunity to become an intermediary. This strategy was reported by active users on specialised forums.

Khat

Due to the changes in trafficking routes for this substance, following its classification as a narcotic in the Netherlands, seizures of khat increased in terms of number and volume in 2013, while in France there were no significant signs of increased use¹⁶⁰.

¹⁵⁷ 2C-B was first identified by SINTES in 2001.

¹⁵⁸ Arrêté du 05 août 2013 modifiant l'arrêté du 22 février 1990 fixant la liste des substances classées comme stupéfiants. JORF n°184 du 9 août 2013. (NOR AFSP1320886A)

¹⁵⁹ 4-FA (4-fluoroamphetamine), also known as 4-FMP, was first identified in Europe in February 2009. At the time (and now still), there were very few signs of use on French soil, but over 600 seizures took place of quantities often reaching a kilogram or more.

¹⁶⁰ There are rare community practices (sub-Saharan African) identified mainly in eastern France but not acknowledged by warnings from health or legal reports.

10.3. Seizures

10.3.1. Quantities and numbers of seizures of all illicit drugs

Given France's geographic position at the heart of Western Europe, it is a transit area for the main illegal substances (cannabis, cocaine, heroin and synthetic drugs) produced worldwide. Like many developed countries, where the population has high purchasing power, France is also a country where there are high levels of use, making it a strategic market for drug traffickers.

Cannabis

Cannabis resin and herbal cannabis seizures rose sharply in 2013 (see table 10.1). For resin, the increase reversed the downward trend being observed since 2009. This phenomenon can be explained by the large maritime seizures that took place on the Mediterranean.

Seizures of cannabis plants rose to unprecedented levels. This is due to the development of herbal cannabis cultivation in France.

Heroin

Heroin seizures in 2013 reached 570 kg, declining sharply and confirming the trend that has been observed over the last few years (see table 10.1). The fragmenting of heroin trafficking, which is now dispersed among many minor structures that distribute smaller quantities of substance, may explain the contrast between a steady decrease in seizures and the certain availability of the substance in France.

Table 10.1: Quantities of drugs seized (in kilograms), from 2008 to 2013 and changes from 2012 to 2013 (in %)

Drugs seized	2008	2009	2010	2011	2012	2013	Change from 2012 to 2013
Cannabis: resin	71,075	56,073	52,795	55,641	51,118	70,918	+ 38.7
Cannabis: herbal	3,422	3,495	4,564	5,450	3,270	4,758	+ 45.5
Cannabis: seeds	30	45	22	na	13	25	+ 92,3
Cannabis: plants	37,441	56,453	54,728	73,572	131,307	141,374	+ 7.6
Heroin	1,117	970	1,087	883	701	570	- 18.6
Cocaine	8,214	5,211	4,125	10,834	5,602	5,612	+ 0.17
Crack	12	12	14	13	14	7	- 50,3
Amphetamines	10	564	176	601	279	474	- 69,9
Ecstasy (tablets)	342,923	106,597	663,595	1,510,500	156,337	414,800	+ 165.3
LSD (blotter)	90,021	10,209	28,411	3,136	4,135	58,344	+ 1,310
Ketamine	65	3	14	0.1	7.2	14.6	+ 102.7

Source: OSIRIS (OCRTIS)
na: not available

Cocaine

Cocaine seizures in 2013 were stable compared with 2012 (see table 10.1). These results are considered average with respect to seizures observed since the early 2000s, which were around 5 tonnes (Gandilhon 2012).

Crack seizures declined in 2013, but given their erratic and random nature, no clear trends could be identified.

Ecstasy and LSD

In 2013, ecstasy tablet seizures increased dramatically against a background in which the quantities have varied from year to year for the last ten years or so. These variations result from the very random nature of seizures and interceptions as a part of the trafficked drugs are only in transit. The phenomenon is exactly the same for LSD.

New psychoactive substances (NPS)

From 2008 to 2013, the number of NPS seizures rose dramatically from 21 to 1,076 (customs and police seizures). Of these seizures, 649 pertained to a substance or a combination of substances for which at least one was classified as a narcotic (59%) and 427 (41%) were unregulated psychoactive substances.

Until 2012, the majority of NPSs were seized in envelopes with small quantities of several substances being sent to the end user. Since early 2013, there have been increasing numbers of packages (weighing from 500 g to 5 kg) containing one single substance, meaning that the purchases are probably being made for the purposes of trafficking. Being circulated in this format may indicate increasing activity being generated on the *deep web*¹⁶¹.

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

There is no data on seizures of precursor chemicals because France is currently not (or is only marginally) an illegal drug-producing country .

10.3.3. Number of drug production sites dismantled, description of production methods and illicit drugs manufactured

There were no production laboratories dismantled in France in 2013.

10.4. Availability

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

Cannabis

¹⁶¹ Sites not referenced by search engines.

Due to well-established French drug networks, which import the substance either directly from Morocco or indirectly from Spain, cannabis resin was still widely available in 2013¹⁶² regardless of the fluctuations that can arise on certain local markets.

Furthermore, in France and the rest of the European continent, users are becoming increasingly enthusiastic about herbal cannabis, which seems to be ever more available locally. In contrast with countries like the United Kingdom or the Netherlands, this herbal cannabis is cultivated mainly by small growers. In the overwhelming majority of cases, these small-scale growers aim to supply their own personal use. However, several facts demonstrate that this dispersed herbal cannabis supply continues to undergo changes, with an increasing number of indoor commercial sites run by individuals and the involvement, confirmed in 2013, of certain, mainly Asian crime networks in intensive cannabis production (Weinberger 2011).

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 black market. It only circulates through highly specific channels, such as 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.

With the exception of Marseille, in 2013 heroin was still available in the territories within the scope of TREND observation sites in France. However, in certain sites, like Bordeaux or Rennes, the poor substance quality incites users to switch to medications, such as morphine sulphate.

For the OCRTIS, in 2013, the availability of heroin was on the rise, especially in areas close to the Netherlands and Spain, which are areas in which heroin destined for Western Europe is stored. In the more enclosed areas of the centre and West of France, availability and accessibility remain high due to supply that is structured between professional networks and/or user-dealers.

Cocaine

In 2013, the overall availability of cocaine hydrochloride remained high at all TREND sites. The observation was the same for the OCRTIS, which reported that “*the availability of cocaine was high or fairly high throughout much of France*”, with the exception of rural departments in the centre of the country. It is in the major urban areas of Lille, Paris, Lyon and Marseille that the substance is most readily available (OCRTIS 2013).

Crack/freebase cocaine

In contrast, the availability of crack (cocaine sold in its base form and in very small quantities to a primarily unstable clientèle) remains characteristic of northeastern portions of Greater Paris and adjacent municipalities, the Antilles and French Guyana. The micro-markets that sporadically crop up in provincial cities are very short-lived (Gandilhon *et al.* 2013a).

¹⁶² Perceived cannabis accessibility was also high among young people: half of the 16 year-old high school/sixth-form college students surveyed during ESPAD 2011 believe this substance to be easy or fairly easy to access (Spilka *et al.* 2013).

For the last five years or so, the Paris market has undergone major changes. On the one hand, the dominant dealer profile, that of the West African “modou”¹⁶³, has changed as a new profile of dealers from the “housing estates” of Northern Paris has appeared. These new dealers are specialised in cannabis resin trafficking (Gandilhon *et al.* 2013a). This phenomenon became visible in 2008 and was characterised by territorial disputes, which resulted in the partial eviction of the market’s traditional dealers. This is part of the more general development of the drug market, increasingly characterised by cocaine and cannabis resin associated with points of sale in the suburbs of northern Paris or the close suburb of Seine-Saint-Denis. Similarly, points of crack sale are still seen in the hallways of buildings in the 19th and 20th *arrondissements* of Paris, similar to the cannabis resin model. Ethnographic observations reveal very rigorous organisation with a well-known division of labour of production in Seine-Saint-Denis: dealers, lookouts and touts. The new trend is not only seen in the dealing organisation, but also with the clientèle, which comes from more socially stable environments. This confirms the existence of new demand for freebase cocaine from users who no longer consider freebase cocaine and crack cocaine as fundamentally different. In 2014, the Paris police force dismantled a crack point of sale operating in a housing estate of the 19th *arrondissement*.

Is a provincial freebase cocaine market emerging?

Contrary to the fears expressed when the substance first arrived in Paris, the crack market model never really expanded outside of the city. Of course, in the 2000s, small crack markets in which the substance was sold as is appeared at certain TREND sites (like recently in Toulouse and Marseille), but the phenomenon was short-lived. Ethnographic observations demonstrated that this expansion was mainly the consequence of crack user-dealers travelling from Paris or French overseas departments. These limited dealing scenes never really generated a real clientèle, and probably suffered due to crack’s negative reputation.

However, in the last two years, we have been witnessing, at certain sites, like Bordeaux, Marseille and Toulouse, the cropping up of small freebase cocaine markets run by user-dealers, cocaine users or freebase cocaine users. Unlike the Parisian crack market, this is “artisanal” freebase cocaine. It seems to meet demand from users who enjoy using freebase cocaine and, it is thought, either do not know how to make it themselves or do not necessarily have the resources to buy the cocaine necessary to make freebase cocaine (since a proportion of this clientèle is represented by marginalised polydrug users or users in dire financial situations due to their drug use getting out of hand).

In Toulouse, users who frequent these deal sites speak of “freebase cocaine” or even “crack” when referring to the substance. A sign that may indicate that they are realising that freebase cocaine and crack cocaine really are, toxicologically speaking, one and the same. The phenomenon is identical in Marseille and Bordeaux, which in 2013 reported “crack” sales in certain neighbourhoods.

Ecstasy and amphetamines

To correctly understand the current ecstasy market and supply, a distinction needs to be made between the drug’s different forms: tablets, capsules, powder and crystal.

¹⁶³ This term comes from the West African Wolof language, and means “small-scale merchant”.

For several years now, the MDMA powdered 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”. It is also reputed to have higher purity than the tablets. Given its relatively high price, it is only used by a special subpopulation of party goers (those who frequent discothèques and nightclubs).

While the reputation of the tablet form suffered among users during the 2000s (Girard *et al.* 2010), 2013 saw the arrival of tablets with higher weights and purity, as well as three-dimensional forms (triangles, hearts and ghosts, to name a few). These new items have renewed interest in the tablet forms.

Amphetamine (speed) supply is still dynamic, and targets a well-identified segment of users who view speed as a cheap alternative to cocaine because it is available in powdered form and is snorted, but at a lesser price. The substance is mainly available at alternative environments of the techno party setting, but is also developing in night clubs and discothèques, taking advantage of the loss of interest many users have for ecstasy tablets.

New psychoactive substances (NPS)

NPS accessibility differs with the population using them and the site of use. For this type of substance, the concept of accessibility includes practical access as well as the ability to understand the diversity of the supply and to control use (doses to take, expected effects).

Accessibility is maximal for a core of experienced, nearly specialised users who know the chemical classes, names and specific effects of the molecules in the substances. Beyond specialised forums, these users are not very visible to the observation networks. In the alternative party scene, an initial circle of users is also experienced with this culture and procures directly on the Internet.

The accessibility continues to expand on the party scene, but the further we move out of this initial circle, the less experienced the users are with the pharmacology of the substances. They seek less information and purchase less often on the web (instead turning to dealers). They use trade names or the names of the substances they are supposed to imitate (they are sometimes incapable of identifying what they are using).

The prices, which are lower than those of traditional substances, seem to alter purchase behaviour. The socioeconomically integrated population seen in clubs makes a positive connection between purity and intensity of effects. On the alternative party scene, users have a different interpretation: the low price evokes a poor quality substance, and therefore “fraud”. They also seem to be wary of the potency of the substances.

Accessibility rose in 2013, also among traditional user profiles (OST patients, opioid-centred polydrug users). Two situations stand out:

- More integrated users who are often ex-heroin addicts on OST and have housing are seeking these new substances that they purchase directly online. Access to these substances may incite drug users who had stopped to use again.
- More precarious users, who buy from dealers: their NPS use remains minimal compared with that of “traditional drugs”, especially since these substances are often considered of lower quality than those they are meant to replace.

There was no observed spread of NPS, particularly those bearing trade names, to a younger population generally distanced from the world of drugs (minors, students).

Hallucinogens

The market for hallucinogens is divided into two submarkets: one for synthetic substances such as LSD or ketamine and the other for natural substances 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 that depends greatly on the law enforcement activities in the countries that produce this substance, such as Belgium or the Netherlands. In 2013, LSD seems to have been mainly available at *free parties* and teknivals, where the drug appears to be actively sought by a fringe group of consumers comprised of young thrill seekers.

Since 2009, ketamine has had an increasingly important place within the range of substances used on the alternative party scene, due mainly to an image that has greatly evolved over the last few years. This drug for experienced users, with effects that are radically different from the party mindset ("dissociation" versus "community"), has undergone a change in status, make it an "exhilarating", "fun" substance for a portion of users. This change in image promotes the development of use, even though this does not change its image as a common substance among many users. In 2012-2013, although certain sites reported an increase in ketamine availability (Bordeaux, Toulouse), others simply mention that its availability remains at a high level (Rennes, Lille), while others emphasise the erratic nature of the substance's presence and the inability of supply to meet demand (Paris, Metz, Marseille). Nearly all TREND sites report cyclic availability, in which periods of high ketamine availability alternate with phases of shortage.

Ketamine is mainly available at alternative party events, except for those taking place in Bordeaux and Toulouse (and to a lesser extent, Metz), where it is accessible, albeit irregularly, in the urban setting.

In 2012 and 2013, all TREND sites observed a more varied profile of ketamine users. However, the process is not identical everywhere. At certain sites, like in Paris and Rennes, the spread did not progress beyond the original scene, i.e., the alternative party scene. At other sites, the use expanded to include the more traditional party scene (commercial and private). In Toulouse, Bordeaux and, to a lesser extent, Metz, the use of ketamine spread to non party-going populations.

10.4.2. Price of illicit drugs at retail level and wholesale level

Cannabis

According to OCRTIS (OCRTIS 2013), the median price for herbal cannabis in 2013 was approximately €8.5 per gram and ranged from €7 to €10 per gram (see table 10.2). This price was up compared with previous years (€6.50 in 2009, €7 in 2010, €7.50 in 2011 and €8 in 2012). This increase in herbal cannabis price is explained by the fact that an increasing percentage of users appear to display a marked preference for "high-quality" substances.

The wholesale price, as determined by the police, was €4,000 per kg – the highest ever observed in France.

The median price of cannabis resin has remained stable. In 2013, it was €6 per gram. The wholesale price of cannabis resin for the same year was €2,250 per kilogram.

Heroin

According to the OCRTIS, like in 2012, the 2013 median price for a gram of brown heroin was approximately €35, down more than 10% compared with 2010. The wholesale price for brown heroin was approximately €10,000 per kilogram.

Misuse of substitution medications

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, was around €4 in 2013. The price of a 60 ml vial of methadone ranges from €5 to approximately €20, depending on the location.

Cocaine

The price per gram of cocaine hydrochloride was €65 in 2013. It remained stable compared with 2012, the year in which there was a rise in the previously stable price observed over the last five years (€60).

The wholesale price, which also remained stable, was €30,000 per kilogram.

Table 10.2: Change in median drug prices (in Euros) since 2000

	TREND*				OCRTIS**		
	2000	...	2011	2012	2011	2012	2013
Heroin	59		40	41	40	35	35
Cocaine	84		68	76	60	65	65
Ecstasy (tablets)	15		7	10	6	7.5	7.5
Cannabis resin	na		5.4	7	5	6	6
Herbal cannabis	na		8	10	7.5	8	8.5
Amphetamines	15		15.5	na	na	na	na
LSD (blotter)	8.5		10	na	na	na	na
HDB (Subutex [®] /8mg)	6.3		4.8	na	na	na	na

Source:

*: Half-yearly TREND (OFDT) price analysis for heroin, cocaine, ecstasy tablets, cannabis resin and herbal cannabis; TREND ethnographic observations for amphetamines, LSD and buprenorphine.

** : Baromètre prix OCRTIS (OCRTIS Price barometer)

na: not available

Ecstasy

It is necessary to indicate the galenic form in which the substance is sold: tablets, powder or crystal.

According to the OCRTIS, like in 2012, the 2013 price of a tablet of ecstasy was €7.50, indicating a relative increase compared with previous years. However, this retail price does not fully reflect the reality of the retail market since users tend to buy several dozen tablets at a time to lower the unit price. By doing so, consumers can lower the unit price of a tablet to €2.50.

New psychoactive substances (NPS)

The resale price on the “real” market remained higher than the online prices, generating higher profits for dealers. The prices can be more competitive than those of “traditional” drugs, or they may be higher, since the dealer can play on the purity or novelty of the substance.

10.4.3. Purity / potency of illicit drugs

The elements described hereinafter on the purity of various substances only pertain to substances sold retail, and not to substances seized by customs as they enter French territory.

Cannabis

The increase in mean THC potency seen since the 2000s continued in 2013. THC levels in resins increased once more, from 16% in 2012 to 17% in 2013, doubling over a 10-year period. This was due primarily to the increase in the circulation of high-dose resins (>15%) and the concomitant decrease in the circulation of low-dose resins (< 2%). The maximum THC content observed in resin was 40% in 2013 (INPS (Institut national de police scientifique) 2013).

The THC potency in herbal cannabis also rose from 10% on average in 2012 to 13% in 2013. This trend can also be explained by an increase in high-dose (>15%) herbal cannabis.

Heroin

After a net decrease in the mean content of a gram of heroin sold on the street between 2010 and 2012, law enforcement data clearly demonstrate a sharp increase. In 2013, the mean content of a street gram, which had dropped to 7% in 2012, rose to 11%.

Cocaine

In 2013, cocaine potency in seized street samples (i.e., weighing under 10 g) tended to increase. The majority of samples had a potency of 20% to 30%, versus 10% to 20% in 2012.

Ecstasy

The mean potency of MDMA powder, the form that is becoming increasingly present on the French market, experienced a slight decrease and stabilised around 60%. Nevertheless, this is still a high level compared with previous years (55% in 2011 and 47% in 2009). The situation is similar for tablets. In 2013, the mean potency stabilised at a high level (33% versus 35% in 2012) compared with previous years (23% in 2011 versus 21% in 2009).

In both customs seizures and through the SINTES scheme, there was an observed sharp increase in tablet mass. The percentage of MDMA in their composition was still 40% to 50%, but due to the increase in mass, a tablet dose in 2013 had a higher content than in previous years. Hence, the mean content of customs seizures was generally 60 to 80 mg per tablet; it rose to

145 mg in the second half of 2013. The mean MDMA dose per ecstasy tablet in SINTES analyses increased from 50 to 60 mg in the 2000s to 100 mg since 2012.

The MDMA concentration in tablets nevertheless remained lower than the concentration in the powder or crystal form (60-70% in 2012).

New psychoactive substances (NPS)

The diversity of NPS, the cost of reference standards and their expiry dates do not enable customs and police analytical laboratories to systematically have such standards. These substances are therefore rarely quantified. The analytical documents tend to demonstrate the presence of nearly pure substances. Cross checking data from the SINTES scheme system with quantified substances confirms that their contents are often high.

10.4.4. Composition of illicit drugs and drug tablets (including cutting agent)

Heroin

The substances most frequently used to cut heroin are the paracetamol/caffeine combination. Other psychoactive caffeine-related substances (lidocaine, dextromethorphan and diazepam) are also used.

Cocaine

When cocaine arrives in France it has already been cut using substances such as levamisole, hydroxyzine and caffeine. At this stage, its mean purity (in 2013) reach 63%, which is twice the potency of the cocaine sold in the street. This percentage has been stable for three years. This imported cocaine is then re-cut with the same or different substances such as phenacetin or lidocaine, and sugars (mannitol, lactose, inositol and glucose) before being resold on the street.

Levamisole (an antiparasitic) still remains the most frequently found adulterant (present in more than three quarters of samples, although its potency is low (mean of 10% of the total volume of a sample). The second most frequently encountered adulterant is caffeine, and the third is phenacetin.

New psychoactive substances (NPS)

NPS seizures continue to demonstrate either unique substances or mixtures of psychoactive substances. NPSs almost never contain cutting agents, pharmacologically active or otherwise.

Part B. Bibliography

Alphabetic list of bibliographic references

- ANSM (2014). Compte rendu de la séance n°6 du 20 mars 2014 de la Commission des stupéfiants et psychotropes. ANSM, Saint-Denis.
- Assurance Maladie (2013). Medic'AM 2008-2012 [online]. Available: <http://www.ameli.fr/l-assurance-maladie/statistiques-et-publications/donnees-statistiques/medicament/medic-am-2008-2012.php> [accessed 28/07/2014].
- Aubusson de Cavarlay, B., Hure, M.S., Aillet, V. and Barré, M.D. (1995). Arrestations, classements, défèrements, jugements : suivi d'une cohorte d'affaires pénales de la police à la justice. CESDIP, Guyancourt.
- Bantuelle, M. and Demeulemeester, R. (2008). Référentiel de bonnes pratiques. Comportements à risque et santé : agir en milieu scolaire. Programmes et stratégies efficaces. INPES, Saint-Denis.
- Barré, M.C., Pottier, M.L. and Delaitre, S. (2001). Toxicomanie, police, justice : trajectoires pénales. OFDT, Paris.
- Bastianic, T., Palle, C., Brisacier, A.C. and Cadet-Taïrou, A. (2013). Drug-related treatment: Treatment demand and treatment availability (chapter 5). 2013 National report (2012 data) to the EMCDDA by the Reitox National Focal Point France. New development, trends and in-depth information on selected issues. OFDT, Saint-Denis.
- Beck, F. and Legleye, S. (2008). Measuring cannabis related problems and dependence at the population level. In: Rödnér Sznitman, S., Olsson, B. & Room, R. (Eds.) A Cannabis reader: global issues and local experiences. Office for Official Publications of the European Communities, Luxembourg.
- Beck, F., Guignard, R., Richard, J.B., Tovar, M.L. and Spilka, S. (2011). Les niveaux d'usage des drogues en France en 2010. Exploitation des données du Baromètre santé 2010 relatives aux pratiques d'usage de substances psychoactives en population adulte [Levels of drug use in France in 2010. An analysis of the *Baromètre santé* 2010 data on psychoactive substances use among the adult population]. Tendances (76) 1-6.
- Beck, F., Guignard, R., Gautier, A., Palle, C. and Obradovic, I. (2013). La prise en charge des usagers d'opiacés par les médecins généralistes : état des lieux et tendances récentes. Revue française des affaires sociales (3) 24-41.
- Bello, P.Y., Cadet-Taïrou, A. and Halfen, S. (2010). L'état de santé des usagers problématiques. In: Costes, J.M. (Ed.) Les usages de drogues illicites en France depuis 1999 vus au travers du dispositif TREND. OFDT.
- Ben Lakhdar, C. (2007). Les dépenses publiques attribuables aux drogues illicites en France en 2005 (thème spécifique 1) [Public expenditures related to illicit drugs in France in 2005 (Selected issue 1)]. 2007 National report (2006 data) to the EMCDDA by the Reitox National Focal Point France. New development, trends and in-depth information on selected issues. OFDT, Saint-Denis.
- Botvin, G.J. and Griffin, K.W. (2002). Life skills training as a primary prevention approach for adolescent drug abuse and other problem behaviors. International Journal of Emergency Mental Health 4 (1) 41-47.

- Brisacier, A.C. and Collin, C. (2013). Données récentes relatives aux traitements de substitution aux opiacés. Analyse des données de remboursement concernant l'échantillon généraliste des bénéficiaires en 2011. OFDT ; ANSM, Saint-Denis.
- Brisacier, A.C. and Collin, C. (2014). Les traitements de substitution aux opiacés en France : données récentes. Tendances (94) 1-6.
- Brouard, C., Delarocque Astagneau, E., Meffre, C., Pioche, C., Silvain, C., Larsen, C. *et al.* (2009). Évolution du dépistage de l'hépatite C en France à partir des systèmes de surveillance Rena-VHC et des pôles de référence, 2000-2007. BEH - Bulletin Epidémiologique Hebdomadaire (20-21) 199-204.
- Cadet-Taïrou, A., Gandilhon, M., Toufik, A. and Evrard, I. (2008). Phénomènes émergents liés aux drogues en 2006. Huitième rapport national du dispositif TREND. OFDT, Saint-Denis.
- Cadet-Taïrou, A., Gandilhon, M., Lahaie, E., Chalumeau, M., Coquelin, A. and Toufik, A. (2010). 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. (2012). Résultats ENa-CAARUD 2010. Profils et pratiques des usagers. OFDT, Saint-Denis.
- Cadet-Taïrou, A., Gandilhon, M. and Lahaie, E. (2012). Phénomènes marquants et émergents en matière de drogues illicites (2010-2011) [Noteworthy phenomena and emerging trends in illegal drugs (2010-2011)]. Tendances (78) 1-6.
- Cadet-Taïrou, A. and Brisacier, A.C. (2013a). Responses to drug-related health correlates and consequences (chapter 7). 2013 National report (2012 data) to the EMCDDA by the Reitox National Focal Point France. New development, trends and in-depth information on selected issues. OFDT, Saint-Denis.
- Cadet-Taïrou, A. and Dambélé, S. (2013b). Héroïne et autres opiacés. In: OFDT (Ed.) Drogues et addictions, données essentielles. OFDT, Saint-Denis.
- Cadet-Taïrou, A. and Gandilhon, M. (2013c). Marchés, produits, usagers : les tendances récentes (2011-2012). Observations au plan national du dispositif TREND en matière de psychotropes illicites ou détournés de leur usage [Markets, products, users: recent trends (2011-2012). French summary report on the TREND scheme's observations on illegal or misused psychotropic drugs]. Tendances (86) 1-8.
- Cadet-Taïrou, A. and Dambélé, S. (2014a). Les CAARUD en 2010. Analyse des rapports d'activité annuels standardisés ASA-CAARUD. OFDT, Saint-Denis.
- Cadet-Taïrou, A. and Gandilhon, M. (2014b). L'usage de sulfate de morphine par les usagers de drogues en France : tendances récentes (2012-2013). Note 2014-9 (10 juillet 2014) du dispositif TREND de l'OFDT à destination de l'ANSM. OFDT, Saint-Denis.
- Calderon, C., Lagomanzini, P., Maguet, O., Menneret, F., Drogues et Société, CIRDD Rhône-Alpes *et al.* (2011). Insertion sociale et par l'emploi des usagers de drogues. Recommandations pour un accompagnement individuel et collectif. CIRDD Rhône-Alpes, Lyon.
- 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 [Recent information on opioid substitution treatments. Initial results of a reimbursement data analysis on more than 4,500 patients in 2006 and 2007]. Tendances (65) 1-6.

- Cazein, F., Lot, F., Pillonel, J., Le Strat, Y., Sommen, C., Pinget, R. *et al.* (2014). Découvertes de séropositivité VIH et sida - France 2003-2012. BEH - Bulletin Epidémiologique Hebdomadaire (33-34) 154-162.
- CEIP and ANSM (2013). OPPIDUM (Observation des Produits psychotropes Illicites ou Détournés de leur Utilisation Médicamenteuse). Résultats de l'enquête 24 - octobre 2012. Agence nationale de sécurité du médicament et des produits de santé (ANSM), Saint-Denis.
- Chemlal, K., Bouscaillou, J., Jauffret-Roustide, M., Semaille, C., Barbier, C., Michon, C. *et al.* (2012). Offre de soins en milieu carcéral en France : infection par le VIH et les hépatites. Enquête Prévacar, 2010. BEH - Bulletin Epidémiologique Hebdomadaire (10-11) 131-134.
- Chiron, E., Jauffret-Roustide, M., Le Strat, Y., Chemlal, K., Valantin, M.A., Serre, P. *et al.* (2013). Prévalence de l'infection par le VIH et le virus de l'hépatite C chez les personnes détenues en France. Résultats de l'enquête Prévacar 2010. BEH - Bulletin Epidémiologique Hebdomadaire (35-36) 445-450.
- Chouvy, P.A. (2013). L'opium Afghan : 20 ans de suprématie mondiale. Drogues, enjeux internationaux (5) 1-5.
- Cohen, L. (2013). Projet de loi de finances pour 2014 - Tome II. Direction de l'action du Gouvernement : Mission interministérielle de lutte contre la drogue et la toxicomanie (MILDT). Avis n°159 (2013-2014) fait au nom de la commission des affaires sociales, déposé le 21 novembre 2013. Sénat, Paris.
- Coldefy, M., Faure, P. and Prieto, N. (2002). La santé mentale et le suivi psychiatrique des détenus accueillis par les services médico-psychologiques régionaux. Etudes et résultats (181) 1-12.
- Colombani, J.M. (2010). Les routes de la cocaïne. Swaps (58) 12-13.
- 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. OFDT, Saint-Denis.
- Couteron, J.P. and Picard, E. (2013). Une consultation jeunes consommateurs en mission locale. Alcoologie et Addictologie 35 (4) 335-339.
- Dambélé, S. and Cadet-Taïrou, A. (2012). Social correlates and social reintegration (chapter 8). 2012 National report (2011 data) to the EMCDDA by the Reitox National Focal Point France. New development, trends and in-depth information on selected issues. OFDT, Saint-Denis.
- Dambélé, S. and Cadet-Taïrou, A. (2013). Social correlates and social reintegration (chapter 8). 2013 National report (2012 data) to the EMCDDA by the Reitox National Focal Point France. New development, trends and in-depth information on selected issues. OFDT, Saint-Denis.
- De Postis, R. (2013). Safe, le programme d'échange de seringues postal : un vrai besoin. Le Courrier des Addictions 15 (4) 22-25.
- DGS (2009). Plan national de lutte contre les hépatites B et C 2009-2012. Ministère de la santé et des sports, Paris.
- DGS (2011). Enquête Prévacar - Volet offre de soins - VIH, hépatites et traitements de substitution en milieu carcéral. DGS, Paris.

- 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, Paris.
- Dhumeaux, D., ANRS and Association française pour l'étude du foie (AFEF) (2014). Prise en charge des personnes infectées par le virus de l'hépatite B ou de l'hépatite C. Rapport de recommandations 2014. EDP Sciences, Les Ulis.
- Díaz Gómez, C. (2012). Tendances récentes des dépenses publiques relatives aux réponses apportées aux drogues (thème spécifique 2) [Recent trends in drug-related public expenditure and drug-related services in France (Selected issue 2)]. In: Pousset, M. (Ed.) 2012 National report (2011 data) to the EMCDDA by the Reitox National Focal Point France. New development, trends and in-depth information on selected issues. OFDT, Saint-Denis.
- Direction de l'administration pénitentiaire (2013). Les chiffres clés de l'administration pénitentiaire au 1er janvier 2013. Ministère de la Justice, Paris.
- Dispositif SINTES (2013). MDMA (poudre et comprimé) : composition et aspect. Note SINTES n°2013-03 du 6 novembre 2013. OFDT, Saint-Denis.
- Dugarin, J., Dupuy, G. and Nominé, P. (2013). Arrêter la méthadone, pour quoi faire ? Psychotropes 19 (2) 9-22.
- Duplessy, C. (2012). Résultats de l'enquête nationale sur le dispositif d'automates d'échange de seringues. Enquête menée en 2011 sur les résultats de l'année 2010. Safe, Paris.
- European Commission DG TAXUD (2014). Excise duty tables - Part III: Manufactured tobacco. European Commission, Brussels.
- Falissard, B., Loze, J.-Y., Gasquet, I., Duburc, A., de Beaurepaire, C., Fagnani, F. *et al.* (2006). Prevalence of mental disorders in French prisons for men. BMC Psychiatry 6 (33).
- FFA and ANAES (2005). Conférence de consensus, Lyon, 23-24 juin 2004. Stratégies thérapeutiques pour les personnes dépendantes des opiacés : place des traitements de substitution. Textes des recommandations. ANAES, Saint-Denis.
- FNARS and InVS (2013). Étude ProSanté 2010-2011. Étude sur l'état de santé, l'accès aux soins et l'accès aux droits des personnes en situation de prostitution rencontrées dans des structures sociales et médicales. Institut de veille sanitaire, Saint-Maurice.
- Gandilhon, M., Cadet-Taïrou, A., Lahaie, E. and Chalumeau, M. (2010). Drogues illicites : les observations du dispositif TREND en 2009 [Illegal drugs: the 2009 observations of the TREND system]. Tendances (73) 1-6.
- Gandilhon, M. (2012). Les trafics de cocaïne en France. In: Pousset, M. (Ed.) Cocaïne, données essentielles. OFDT, Saint-Denis.
- Gandilhon, M., Cadet-Taïrou, A. and Lahaie, E. (2013a). La cocaïne basée en France métropolitaine : évolutions récentes [Freebase cocaine in mainland France: recent trends]. Tendances (90) 1-4.
- Gandilhon, M., Lahaie, E. and Martinez, M. (2013b). Drug markets (chapter 10). 2013 National report (2012 data) to the EMCDDA by the Reitox National Focal Point France. New development, trends and in-depth information on selected issues. OFDT, Saint-Denis.
- Gandilhon, M., Cadet-Taïrou, A. and Martinez, M. (2014). L'usage de kétamine en France : tendances récentes (2012-2013). OFDT, Saint-Denis.

- Gautier, A. (2011). Baromètre santé médecins généralistes 2009. Inpes, Saint-Denis.
- Girard, G. and Boscher, G. (2010). L'ecstasy, de l'engouement à la "ringardisation". In: Costes, J.M. (Ed.) Les usages de drogues illicites en France depuis 1999 vus au travers du dispositif TREND. OFDT, Saint-Denis.
- Godin-Blandeau, E., Verdot, C. and Develay, A.E. (2014). État des connaissances sur la santé des personnes détenues en France et à l'étranger [State of knowledge on prison health in France and abroad]. Institut de veille sanitaire (InVS), Saint-Maurice.
- Guichard, A. (2012). Adaptation du programme Break the cycle au contexte français. Protocole. INPES, Saint-Denis.
- Guichard, A., Guignard, R., Michels, D., Beck, F., Arwidson, P., Lert, F. *et al.* (2013). Changing patterns of first injection across key periods of the French Harm Reduction Policy: PrimInject, a cross sectional analysis. Drug and Alcohol Dependence 133 (1) 254-261.
- Harding-Pink, D. (1990). Mortality following release from prison. Medicine, Science, and the Law 30 (1) 12-16.
- HAS (2006). Hépatite chronique C. Guide - Affection de longue durée. Haute Autorité de santé, Saint-Denis.
- HAS (2014). Place des tests rapides d'orientation diagnostique (TROD) dans la stratégie de dépistage de l'hépatite C. Recommandation en santé publique. Haute Autorité de santé, Saint-Denis.
- Hautefeuille, M. (2013). Arrêter la substitution [Editorial]. Psychotropes 19 (2) 5-8.
- HCSP (2013). Evaluation du Plan national de lutte contre les hépatites B et C 2009-2012. Haut Conseil de la santé publique, Paris.
- INPS (Institut national de police scientifique) (2013). Données issues de fichiers STUPS 2012.
- INSERM (2010). Réduction des risques infectieux chez les usagers de drogues. INSERM, Paris.
- INSERM (2012). Médicaments psychotropes : consommations et pharmacodépendances. INSERM, Paris.
- INSERM (2014). Conduites addictives chez les adolescents : usages, prévention et accompagnement. INSERM, Paris.
- InVS (2009). Surveillance du VIH/Sida en France. Données du 30 septembre 2009. InVS, Saint-Maurice.
- InVS (2014a). L'enquête Coquelicot 2010-2011 [online]. Available: http://www.invs.sante.fr/Dossiers-thematiques/Populations-et-sante/Usagers-de-drogues/Infections-virales-et-pratiques-a-risques-chez-les-usagers-de-drogues#coquelicot_2010 [accessed 12/06/2014].
- InVS (2014b). Infection à VIH et sida [online]. Available: <http://www.invs.sante.fr/Dossiers-thematiques/Maladies-infectieuses/VIH-sida-IST/Infection-a-VIH-et-sida> [accessed 12/06/2014].
- InVS (2014c). Hépatite B aiguë [online]. Available: <http://www.invs.sante.fr/Dossiers-thematiques/Maladies-infectieuses/Hepatitis-virales/Hepatitis-B> [accessed 29/07/2014].
- Janssen, E. and Bastianic, T. (2013). Usage problématique de drogues en France : les prévalences en 2011. Estimations locales et extrapolations nationales. OFDT, Saint-Denis.

- 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., Le Strat, Y., Couturier, E., Thierry, D., Rondy, M., Quaglia, M. *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) 1-12.
- Jauffret-Roustide, M., Pillonel, J., Weill-Barillet, L., Léon, L., Le Strat, Y., Brunet, S. *et al.* (2013). Estimation de la séroprévalence du VIH et de l'hépatite C chez les usagers de drogues en France - Premiers résultats de l'enquête ANRS-Coquelicot 2011. BEH - Bulletin Epidémiologique Hebdomadaire (39-40) 504-509.
- Kmetonyova, D., Belackova, V. and Pazitny, M. (in press). I-TREND project. Report on 25I-NBOMe, AH-7921, methoxetamine and MDVP - accessibility online.
- 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. OFDT, Paris.
- Kopp, P. and Fenoglio, P. (2000). Le coût social des drogues licites (alcool et tabac) et illicites en France. OFDT, Paris.
- Kopp, P. and Fenoglio, P. (2004). Coût et bénéfices économiques des drogues. OFDT, Saint-Denis.
- Kopp, P. and Fenoglio, P. (2006). Le coût des traitements et de la mise en œuvre de la loi dans le domaine des drogues. OFDT, Saint-Denis.
- Ladroue, V., Besacier, F. and Hologne, M. (2013). Découverte d'un laboratoire de conditionnement de nouveaux produits de synthèse en France. Annales de Toxicologie Analytique 25 (4) 175-184.
- Lahaie, E. and Cadet-Taïrou, A. (2009). The SINTES monitoring system, OFDT Contribution to the National Alert Unit in France. EMCDDA, Lisbon.
- Lahaie, E., Martinez, M. and Cadet-Taïrou, A. (2013). Nouveaux produits de synthèse et Internet [New psychoactive substances and the Internet: current situations and issues]. Tendances (84) 1-8.
- Lahaie, E., Martinez, M. and Cadet-Taïrou, A. (2014). Nouveaux produits de synthèse identifiés en France depuis 2000. Note d'information SINTES, 7 mars 2014. OFDT, Saint-Denis.
- Lapeyre-Mestre, M. and Boeuf-Cazou, O. (2011). Rôle du pharmacien dans la réduction des risques liés à la toxicomanie. Point de vue des patients sous médicaments de substitution aux opiacés (MSO) et des usagers de drogues. U1027 INSERM - Unité de Pharmacopépidémiologie de Toulouse - AFSSAPS-CEIP.
- Laumon, B., Gadegbeku, B., Martin, J.L., Biecheler, M.B. and The Sam Group (2005). Cannabis intoxication and fatal road crashes in France: population based case-control study. British Medical Journal 331 (7529) 1371-1374.
- Le Vu, S., Le Strat, Y., Barin, F., Pillonel, J., Cazein, F., Bousquet, V. *et al.* (2010). Incidence de l'infection par le VIH en France, 2003-2008. BEH - Bulletin Epidémiologique Hebdomadaire (45-46) 473-476.

- Legleye, S., Karila, L., Beck, F. and Reynaud, M. (2007). Validation of the CAST, a general population cannabis abuse screening test. Journal of Substance Use 12 (4) 233-242.
- Legleye, S., Piontek, D., Kraus, L., Morand, E. and Falissard, B. (2013). A validation of the Cannabis Abuse Screening Test (CAST) using a latent class analysis of the DSM-IV among adolescents. International Journal of Methods in Psychiatric Research 22 (1) 16-26.
- Lermenier, A. (2013). Le marché du tabac. In: OFDT (Ed.) Drogues et addictions, données essentielles. OFDT, Saint-Denis.
- Lermenier, A. (2014). Tableau de bord mensuel des indicateurs tabac : bilan de l'année 2013. Tabagisme et arrêt du tabac en 2013. OFDT, Saint-Denis.
- Lions, C., Carrieri, M.P., Michel, L., Mora, M., Marcellin, F., Morel, A. *et al.* (2014). Predictors of non-prescribed opioid use after one year of methadone treatment: an attributable-risk approach (ANRS-Methaville trial). Drug Alcohol Depend 135 1-8.
- Lopez, D., Martineau, H. and C, P. (2004). Mortalité des personnes interpellées pour usage d'héroïne, de cocaïne ou de crack [Mortality of individuals arrested for heroin, cocaine or crack use]. Tendances (36) 1-4.
- Lukasiewicz, M., Falissard, B., Michel, L., Neveu, X., Reynaud, M. and Gasquet, I. (2007). Prevalence and factors associated with alcohol and drug-related disorders in prison: a French national study. Substance Abuse Treatment, Prevention, and Policy 2 (1) 1-10.
- Maguet, O., Calderon, C., Dorso, V., Menneret, F. and Lagomanzini, P. (2009). Insertion par l'emploi des usagers de drogues. Territoires en réseaux. Commission Européenne, Bruxelles.
- Marzo, J.N., Rotily, M., Meroueh, F., Varastet, M., Hunault, C., Obradovic, I. *et al.* (2009). Maintenance therapy and 3-year outcome of opioid-dependent prisoners: a prospective study in France (2003-06). Addiction 104 (7) 1233-1240.
- Meffre, C. (2006). Prévalence des hépatites B et C en France en 2004. Décembre 2006. InVS, Saint-Maurice.
- 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 11 (400).
- 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. BEH - Bulletin Epidémiologique Hebdomadaire (39) 409-412.
- MILDT (2008). Plan gouvernemental de lutte contre les drogues et les toxicomanies 2008-2011. La Documentation française, Paris.
- MILDT (2013). Government plan for combating drugs and addictive behaviours 2013-2017. MILDT, Paris.
- MILDT (2014). Plan gouvernemental de lutte contre les drogues et les conduites addictives. Plan d'actions 2013-2015. MILDT, Paris.
- Ministère de la justice and Ministère des affaires sociales et de la santé (2012). Prise en charge sanitaire des personnes placées sous main de justice. Guide méthodologique. Ministère de la Justice, Ministère des affaires sociales et de la santé, Paris.

- Ministère de la santé et des solidarités (2006). La prise en charge et la prévention des addictions : plan 2007-2011. Ministère de la santé et des solidarités, Paris.
- Ministère de la santé et des sports (2010). Plan national de lutte contre le VIH/SIDA et les IST 2010-2014. Ministère de la santé et des sports, Paris.
- 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 des affaires sociales et de la santé and MILDT (2013). Guide des traitements de substitution aux opiacés en milieu carcéral.
- Ministère des Affaires sociales et de la Santé and Ministère de l'Enseignement supérieur et de la Recherche (2014). Plan cancer 2014-2019. Guérir et prévenir les cancers : donnons les mêmes chances à tous, partout en France. Paris.
- Mission d'information sur les toxicomanies, Branget, F. and Barbier, G. (2011). Toxicomanies : rejeter la fatalité, renouveler les stratégies. Rapport d'information sur les toxicomanies. Assemblée nationale, Paris.
- Mouquet, M.C., Dumont, M. and Bonnevie, M.C. (1999). La santé des entrants en prison : un cumul de factures de risque. Etudes et résultats (4) 1-10.
- Mouquet, M.C. (2005). La santé des personnes entrées en prison en 2003. Etudes et résultats (386) 1-12.
- Mutatayi, C. (2013). Prevention (chapter 3). 2013 National report (2012 data) to the EMCDDA by the Reitox National Focal Point France. New development, trends and in-depth information on selected issues. OFDT, Saint-Denis.
- Obradovic, I., Bastianic, T., Michel, L. and Jauffret-Roustide, M. (2011). Politique de santé et services de soins concernant les drogues en prison (thème spécifique 1) [Drug-related health policies and services in prison (Selected issue 1)]. In: OFDT (Ed.) 2011 National report (2010 data) to the EMCDDA by the Reitox National Focal Point France. New development, trends and in-depth information on selected issues. OFDT, Saint-Denis.
- Obradovic, I. (2013). La réponse pénale à la conduite sous influence (alcool et stupéfiants). Tendances (91) 1-6.
- Obradovic, I. and Gandhilhon, M. (2013). Drug-related crime, prevention of drug-related crime and prison (chapter 9). 2013 National report (2012 data) to the EMCDDA by the Reitox National Focal Point France. New development, trends and in-depth information on selected issues. OFDT, Saint-Denis.
- Obradovic, I., Le Nézet, O. and Spilka, S. (2013). Jeunes usagers de drogues et demande d'aide. Estimation du public potentiel d'un dispositif d'aide aux jeunes consommateurs. Agora débats/jeunesses (64) 61-76.
- Obradovic, I. (2014). « Mesures d'accueil des sortants de prison ». Synthèse du focus group. OFDT, Saint-Denis.
- OCRTIS (2009). Usage et trafic des produits stupéfiants en France en 2008 - Stups - Osiris. Ministère de l'Intérieur, de l'Outre-Mer et des Collectivités territoriales, Direction Générale de la Police Nationale, Direction Centrale de la Police Judiciaire, OCRTIS, Paris.
- OCRTIS (2013). Les prix des stupéfiants en France. La photographie au 4ème trimestre 2012. OCRTIS, Nanterre.

- OIP (Observatoire International des Prisons) (2005). Les conditions de détention en France. Rapport 2005. La Découverte, Paris.
- 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 [The initial national results of the RECAP survey. Persons treated in the CSSTs and CCAAs in 2005]. Tendances (54) 1-6.
- Palle, C. (2013). Le poids économique de l'alcool. In: OFDT (Ed.) Drogues et addictions, données essentielles. OFDT, Saint-Denis.
- Palle, C. and Rattanatrak, M. (2013). Les centres de soins, d'accompagnement et de prévention en addictologie en 2010. Situation en 2010 et évolutions sur la période 2005-2010. OFDT, Saint-Denis.
- Premier ministre (2013). Plan pluriannuel contre la pauvreté et pour l'inclusion sociale adopté lors du Comité interministériel de lutte contre les exclusions. Paris.
- Prudhomme, J., Ben Diane, M.K. and Rotily, M. (2001). Evaluation des unités pour sortants (UPS). ORS PACA, Marseille.
- Remy, A.J. (2004). Le traitement de l'hépatite en prison est possible avec des résultats satisfaisants : résultats définitifs du premier observatoire prison hépatite C (POPHEC). Gastroentérologie Clinique et Biologique 28 (8-9) 784.
- Rotily, M., Vernay-Vaisse, C. and Bourlière, M. (1997). Three quarters of one French prison population needed immunisation against hepatitis B [Letter]. British Medical Journal 315 (7099) 61.
- Rotily, M., Delorme, C. and Ben Diane, M.K. (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, Marseille.
- Rotily, M. (2000). Stratégies de réduction des risques en milieu carcéral. Rapport de la mission santé-justice. Ministère de la justice ; ORS PACA, Paris.
- Roux, P., Lions, C., Michel, L., Cohen, J., Mora, M., Marcellin, F. *et al.* (2014). Predictors of non-adherence to methadone maintenance treatment in opioid-dependent individuals: implications for clinicians. Current Pharmaceutical Design 20 (25) 4097-4105.
- Saïd, S., Cadet-Taïrou, A. and Martinez, M. (in press). Résultats ENa-CAARUD 2012. Profils et pratiques des usagers. OFDT, Saint-Denis.
- Sanchez, G. (2006). Le traitement du VHC en prison : le foie, une bombe sous les barreaux. Journal du Sida (185) 9-12.
- Seaman, S.R., Brettell, R.P. and Gore, S.M. (1998). Mortality from overdose among injecting drug users recently released from prison: database linkage study. British Medical Journal 316 (7129) 426-428.
- Semaille, C., Le Strat, Y., Chiron, E., Chemlal, K., Valantin, M.A., Serre, P. *et al.* (2013). Prevalence of human immunodeficiency virus and hepatitis C virus among French prison inmates in 2010: a challenge for public health policy. Eurosurveillance 18 (28) art. 20524.
- Senon, J.L., Méry, B. and Lafay, N. (2004). Prison. In: Richard, D., Senon, J.L. & Valleur, M. (Eds.) Dictionnaire des drogues et des dépendances. Larousse, Paris.

- Spilka, S. and Le Nézet, O. (2013). Alcool, tabac et cannabis durant les « années lycée » [Alcohol, tobacco and cannabis use during the « lycée years »]. Tendances (89) 1-8.
- Stankoff, S., Dherot, J., DAP (Direction de l'administration pénitentiaire) and DGS (Direction générale de la santé) (2000). Rapport de la mission santé-justice sur la réduction des risques de transmission du VIH et des hépatites en milieu carcéral. Ministère de la Justice, Paris.
- Thanki, D. and Vicente, J. (2013). PDU (Problem drug use) revision summary. EMCDDA, Lisbon.
- Toufik, A., Escots, S. and Cadet-Taïrou, A. (2010). La transformation des usages de drogues liée à la diffusion des traitements de substitution aux opiacés. In: Costes, J.M. (Ed.) Les usages de drogues illicites en France depuis 1999 vus au travers du dispositif TREND. OFDT, Saint-Denis.
- Tovar, M.L. and Bastianic, T. (2013). Opinions et perceptions sur les drogues. In: OFDT (Ed.) Drogues et addictions, données essentielles. OFDT, Saint-Denis.
- UNODC (2012). World drug report 2011. United Nations, New York.
- 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.
- 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 Sciences 48 (3) 614-616.
- Vernay-Vaisse, C. and Rotily, M. (1997). Epidémiologie des hépatites virales B et C : évaluation d'un programme de dépistage et de vaccination au centre pénitentiaire de Marseille. Revue d'Epidémiologie et de Santé Publique 45 (Suppl.1) S42-S43.
- Weinberger, D. (2011). Réseaux criminels et cannabis indoor en Europe : maintenant la France ? [Criminal networks and indoor cannabis in Europe: has the phenomenon reached France?]. Drogues, enjeux internationaux [Drugs, international challenges] (1) 1-6.
- Weinberger, D. (2013). Le Venezuela : un épïcetre du trafic régional et mondial de cocaïne. Drogues, enjeux internationaux (6) 1-5.

Alphabetic list of relevant databases available on Internet

BDSP (Banque de données en santé publique). Bibliographic database
<http://www.bdsp.ehesp.fr/Base/SearchForm>

IREB (Institut de recherches scientifiques sur les boissons). Bibliographic database
<http://doc.ireb.com/>

OFDT. ODICER – Observation des drogues pour l'information sur les comportements en régions
<http://www.ofdt.fr/ofdtdev/live/donneesloc.html>

OFDT. Répertoire des sources statistiques
<http://www.ofdt.fr/ofdtdev/live/donneesnat/sources.html>

OFDT. Statistical series

<http://www.ofdt.fr/ofdtdev/live/donneesnat/series.html>

Alphabetic list of relevant Internet addresses

AFR (Association française pour la réduction des risques)

<http://a-f-r.org>

ANPAA (Association nationale de prévention en alcoologie et addictologie)

<http://www.anpaa.asso.fr>

ANSM (Agence nationale de sécurité du médicament et des produits de santé)

<http://ansm.sante.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>

Fédération addiction

<http://www.federationaddiction.fr/>

FNORS (Fédération nationale des observatoires régionaux de la santé)

<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>

MILDECA (Mission interministérielle de lutte contre les drogues et les conduites addictives)

<http://www.drogues.gouv.fr>

OFDT

<http://www.ofdt.fr>

SFA (Société française d'alcoologie)

<http://www.sfalcoologie.asso.fr>

Annexes

Appendix I – List of tables

Table 1.1: Breakdown of actions by strategy covered in the 2013-2015 "Drugs" Action plan	22
Table 1.2: Breakdown by source of the allocated Action plan 2013-2015 budget (in €)	25
Table 1.3: Breakdown by action type of the allocated Action plan 2013-2015 budget (in €)	26
Table 2.1: Estimation of the number of psychoactive substance users in mainland France among 11 to 75 year-olds in 2011	28
Table 2.2: Changes in lifetime and last year use (current use) of psychotropic substances among 15 to 64 year-olds from 2005 to 2010 (expressed as a %)	30
Table 2.3: Changes in perceptions of danger levels for different drugs from 2002 to 2013 (in %)	30
Table 2.4: Percentage of 17-year-old respondents answering "fairly often" or "very often" to various CAST questions in 2011 (%)	32
Table 2.5: CAST score among 17-year-old cannabis users in 2011 (%)	32
Table 3.1: Taxation of alcoholic beverages from 2011 to 2014	38
Table 4.1: Estimate of the number of problem drug users in metropolitan France in 2011	45
Table 4.2: Prevalence of drug use in the last month (in %) among drug users seen in CAARUDs in 2012	46
Table 4.3: Breakdown of CAARUD clients by age class (in %) from 2006 to 2012	46
Table 4.4: Routes of administration for drugs used in the last month by drug users seen in CAARUDs in 2012	47
Table 5.1: Breakdown of patients by age group (in %), in 2013	56
Table 5.2: Breakdown of patients by treatment origin (in %) in 2013	57
Table 5.3: Breakdown of patients by living status (with whom) (in %), in 2013	57
Table 5.4: Breakdown of patients by type of dwelling (in %), in 2013	57
Table 5.5: Breakdown of patients by professional situation (in %), in 2013	58
Table 5.6: Breakdown of all new patients by age group (in %), evolution 2005 - 2013	60
Table 6.1: Total number of new AIDS cases, number of new AIDS cases among injecting drug users (IDUs) and proportion of IDUs per year of diagnosis from 2001 to 2012	64

Table 6.2: Estimated prevalence of HIV and HCV infection from blood samples of lifetime injecting or snorting drug users in the Coquelicot survey by urban centre or department, in 2011	65
Table 6.3: Consequences of injection reported by clients of low-threshold drug treatment services in 2006	67
Table 6.4: Prevalence of injection materials shared among CAARUD clients who had injected in the last 30 days, in 2012.....	67
Table 6.5: Breakdown of fatal overdoses by substance(s) involved*, alone or in combination**, from 2010 to 2012	70
Table 6.6: Gross annual mortality rate and SMR in the 2009-2013 mortality cohort, by gender .	71
Table 7.1: Change in involvement of general practitioners in harm reduction between 1999 and 2009	78
Table 7.2: Number of syringes dispensed by pharmacies or distributed by CAARUDs and dispensing machines from 2008 to 2011	80
Table 7.3: HIV and HCV infection screening test of CAARUD clients, in 2012.....	82
Table 8.1: Social instability of people treated in CSAPAs in 2008, 2010 and 2012	85
Table 8.2: Instability of CAARUD clients from 2008 to 2012	86
Table 8.3: Origin of income for CAARUD clients from 2008 to 2012	86
Table 10.1: Quantities of drugs seized (in kilograms), from 2008 to 2013 and changes from 2012 to 2013 (in %)	110
Table 10.2: Change in median drug prices (in Euros) since 2000	116

Appendix II – List of figures

Figure 3.1: Cigarette sales (in billions of units) and annual average price per pack of the most widely sold brand from 2000 to 2013	39
Figure 5.1: Opioid substitution treatments: use of buprenorphine and methadone from 1995 to 2013 in terms of daily dose/1,000 inhabitants aged 20 to 39 years/day (Subutex® and 8 mg generics, Suboxone® 8 mg, methadone® 60 mg)	52
Figure 5.2: Changes in the mean age of new patients and first-time treatment entrants managed in CSAPAs, 2005 - 2013.....	59
Figure 6.1: Change in the prevalence of hepatitis C virus infection among injecting drug users in France from 1993 to 2012	66
Figure 6.2: Fatal overdoses in France, according to the mortality register, from 2000 to 2011...	69
Figure 7.1: Proportion of CAARUD clients who have never been screened for HIV or HCV	82

Appendix III – List of full references of laws in original language

Arrêté du 01 avril 2008 relatif à la liste de soins ou traitements susceptibles de faire l'objet de mésusage, d'un usage détourné ou abusif, pris en application de l'article L.162-4-2 du Code de la sécurité sociale. JORF n°83 du 8 avril 2008. (NOR SJSP0808150A).....	16
Arrêté du 05 août 2013 modifiant l'arrêté du 22 février 1990 fixant la liste des substances classées comme stupéfiants. JORF n°184 du 9 août 2013. (NOR AFSP1320886A).....	23, 116
Arrêté du 05 septembre 2001 fixant les modalités du 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. JORF n°216 du 18 septembre 2001. (NOR MESP0123164A)	13
Arrêté du 06 février 2014 portant classement sur la liste des substances vénéneuses. JORF n°38 du 14 février 2014. (NOR AFSP1403314A)	23
Arrêté du 06 février 2014 portant classement sur la liste des substances vénéneuses. JORF n°38 du 14 février 2014. (NOR AFSP1403317A)	24
Arrêté du 08 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. JORF n°166 du 21 juillet 2010. (NOR SASP1007832A).....	10
Arrêté du 11 octobre 2013 modifiant l'arrêté du 22 février 1990 portant exonération à la réglementation des substances vénéneuses destinées à la médecine humaine. JORF n°247 du 23 octobre 2013. (NOR AFSP1325658A)	24
Arrêté du 13 octobre 2014 modifiant l'arrêté du 20 septembre 1999 modifié fixant la liste des médicaments classés comme stupéfiants dont la durée maximale de prescription est réduite à quatorze jours ou à sept jours. JORF n°241 du 17 octobre 2014. (NOR AFSP1424228A).....	59
Arrêté du 15 décembre 2012 fixant pour l'année 2013 le tarif des droits d'accises sur les alcools et les boissons alcooliques prévus aux articles 402 bis, 403 et 438 du Code général des impôts ainsi que le tarif des contributions prévues aux articles 520 B et 520 C du Code général des impôts. JORF n°299 du 23 décembre 2012. (NOR BUDD1242585A).....	43
Arrêté du 16 décembre 2013 portant classement sur la liste des substances vénéneuses. JORF n°296 du 21 décembre 2013. (NOR AFSP1331018A)	23
Arrêté du 19 novembre 2013 complétant l'arrêté du 5 septembre 2001 fixant les modalités du dépistage des substances témoignant de l'usage de stupéfiants et des analyses et examens prévus par le code de la route. JORF n°292 du 17 décembre 2013. (NOR AFSP1320472A).22	
Arrêté du 22 juillet 2013 modifiant l'arrêté du 22 février 1990 fixant la liste des substances classées comme stupéfiants. JORF n°172 du 26 juillet 2013. (NOR AFSP1319276A).....	23

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. JORF n°226 du 28 septembre 1995. (NOR SANG9502738A)	30
Arrêté du 23 décembre 2013 fixant la liste des médicaments prévue au dernier alinéa de l'article R. 5132-6 du code de la santé publique. JORF n°300 du 27 décembre 2013. (NOR AFSP1330194A).....	23
Arrêté du 23 septembre 2013 portant classement sur la liste des substances vénéneuses. JORF n°229 du 2 octobre 2013. (NOR AFSP1323991A)	23
Arrêté du 29 décembre 2013 fixant pour 2014 le tarif des droits d'accises sur les alcools et les boissons alcooliques prévus aux articles 317, 402 bis, 403, 438 et 520 A du code général des impôts, le tarif des contributions prévues aux articles 1613 ter et 1613 quater du code général des impôts ainsi que le tarif de la cotisation prévue à l'article L. 245-9 du code de la sécurité sociale. JORF n°303 du 30 décembre 2013 (NOR: BUDD1331542A)	43
Arrêté du 29 février 2012 fixant le montant de l'augmentation du droit fixe de procédure dû en cas de condamnation pour conduite après usage de stupéfiants. JORF n°58 du 8 mars 2012. (NOR JUSD1205700A).....	13
Arrêté du 30 juillet 2013 portant classement sur la liste des substances vénéneuses. JORF n°185 du 10 août 2013. (NOR AFSP1320366A)	24
Avis d'octroi d'autorisations de mise sur le marché de spécialités pharmaceutiques : AMM du 21 mars 1995 pour le chlorhydrate de méthadone, 5, 10 et 20mg, sirop en récipient unidose. JORF du 28 juin 1995. (NOR SANM9501657V).....	16
Avis d'octroi d'autorisations de mise sur le marché de spécialités pharmaceutiques : AMM du 31 juillet 1995 pour le Subutex à 0,4 mg, 2 mg et 8 mg, comprimé sublingual. JORF du 27 octobre 1995. (NOR SANM9502981V)	16, 57
Circulaire du 12 février 2014 relative à la fiscalité applicable aux tabacs manufacturés. (NOR BUDD1404184C).....	44
Circulaire du 28 mars 2011 de la LOPPSI en ce qui concerne l'amélioration de la sécurité routière. BO Intérieur n°2011-03 du 31 mars 2011. (NOR IOCD1108865C)	12
Circulaire n°1988-85 DGS/PGE/1C du 20 janvier 1988, relative à la mise en place d'un dispositif de dépistage anonyme et gratuit du virus de l'immunodéficience humaine. BO Santé n°88-28 bis, Fascicule spécial : l'infection par le virus de l'immunodéficience humaine, 1988. (NOR ASEP8810054C)	10
Circulaire n°1995-29 DGS/SP3/95 du 31 mars 1995 relative au traitement de substitution pour les toxicomanes dépendants aux opiacés.....	16
Circulaire n°2002-57 DGS/DHOS du 30 janvier 2002 relative à la prescription de méthadone par les médecins exerçant en établissement de santé, dans le cadre de l'initialisation d'un traitement de substitution pour les toxicomanes dépendants majeurs aux opiacés. BO Santé n°2002/8 du 18 février 2002. (NOR MESP0230029C)	16

Circulaire n°2003-60 DGS/SD5C/SD6A du 10 février 2003 relative à la mise en œuvre du nouveau dispositif de notification anonymisée des maladies infectieuses à déclaration obligatoire. BO Santé, Protection sociale et Solidarité n°2003-12 du 17 au 23 Mars 2003. (NOR SANP0330122C)	68
Circulaire n°2006-01 DGS/S6B/DSS/1A/DGAS/5C 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. BO Santé n°2006/2 du 15 mars 2006. (NOR SANP0630016C)	17
Circulaire n°2008-11/G4 CRIM du 9 mai 2008 relative à la lutte contre la toxicomanie et les dépendances. BO Justice n°2008/3 du 30 juin 2008 (NOR JUSD0811637C)	11
Circulaire n°2008-79 DGS/MC2 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. BO Santé, Protection sociale et Solidarité n°3 du 15 avril 2008. (NOR SJSP0830130C)	55
Circulaire n°2009-349 DGS/MC2 du 9 novembre 2009 relative à la mise en œuvre de l'action II-1,3 du plan national de lutte contre les hépatites B et C 2009-2012 ayant pour objectif de permettre aux usagers de drogues de bénéficier d'un service de proximité assurant gratuitement le dépistage de ces hépatites et, le cas échéant, d'une vaccination contre l'hépatite B. BO Santé, Protection sociale et Solidarités n°12 du 15 janvier 2010. (NOR SASP0927192C)	10
Circulaire n°2012-373 interministérielle DGOS/DSR/DGS/DGCS/DSS/DAP/DPJJ du 30 octobre 2012 relative à la publication du guide méthodologique sur la prise en charge sanitaire des personnes placées sous main de justice. BO Santé, Protection sociale et Solidarité n°11 du 15 décembre 2012. (NOR AFSH1238354C)	27
Circulaire n°2013-75 du 14 février 2013 relative à l'organisation du réseau territorial de la MILDT	28
Décision n°13-D-21 du 18 décembre 2013 relative à des pratiques mises en œuvre sur le marché français de la buprénorphine haut dosage commercialisée en ville. Autorité de la concurrence (2013)	57
Décision n°2013-18 DG du 1er février 2013 portant création d'une commission des stupéfiants et psychotropes à l'Agence nationale de sécurité du médicament et des produits de santé. JORF n°34 du 9 février 2013. (NOR AFSM1300036S)	22
Décret n°1987-328 du 13 mai 1987 portant suspension des dispositions du décret n°72-200 du 13 mars 1972. JORF du 16 mai 1987. (NOR ASEM8700689D)	18
Décret n°1988-894 du 24 août 1988 portant suspension des dispositions du décret n°72-200 du 13 mars 1972. JORF du 27 août 1988. (NOR SPSM8801069D)	18
Décret n°1989-560 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. JORF du 12 août 1989. (NOR SPSM8901501D).....	18
Décret n°1992-478 du 29 mai 1992 fixant les conditions d'application de l'interdiction de fumer dans les lieux affectés à un usage collectif et modifiant le code de la santé publique. JORF n°125 du 30 mai 1992. (NOR SANP9201055D).....	41
Décret n°1995-255 du 7 mars 1995 modifiant le décret n°72-200 du 13 mars 1972 réglementant le commerce et l'importation des seringues et des aiguilles destinées aux injections parentérales, en vue de lutter contre l'extension de la toxicomanie. JORF n°58 du 9 mars 1995. (NOR SPSP9500414D).....	18
Décret n°1995-322 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. JORF n°71 du 24 mars 1995. (NOR BUDB9560005D)	30
Décret n°1996-1061 du 5 décembre 1996 relatif au contrôle de la fabrication et du commerce de certaines substances susceptibles d'être utilisées pour la fabrication illicite de stupéfiants ou de substances psychotropes. JORF n°287 du 10 décembre 1996. (NOR INDD9600699D) ...	15
Décret n°2005-0347 du 14 avril 2005 approuvant le référentiel national des actions de réduction des risques en direction des usagers de drogue et complétant le Code de la santé publique. JORF n°88 du 15 avril 2005. (NOR SANP0521129D).....	18
Décret n°2005-1606 du 19 décembre 2005 relatif aux missions des centres d'accueil et d'accompagnement à la réduction des risques pour usagers de drogues et modifiant le Code de la santé publique. JORF n°297 du 22 décembre 2005. (NOR SANP0524015D)	17
Décret n°2006-830 du 11 juillet 2006 relatif au socle commun de connaissances et de compétences et modifiant le Code de l'éducation. JORF n°160 du 12 juillet 2006. (NOR MENE0601554D).....	38
Décret n°2007-1388 du 26 septembre 2007 pris pour l'application de la 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. JORF n°225 du 28 septembre 2007. (NOR JUSD0755654D).....	11
Décret n°2013-473 du 5 juin 2013 modifiant en ce qui concerne les spécialités pharmaceutiques les dispositions de l'article R. 5132-86 du code de la santé publique relatives à l'interdiction d'opérations portant sur le cannabis ou ses dérivés. JORF n°130 du 7 juin 2013. (NOR AFSP1308402D).....	21
Décret n°2013-923 du 16 octobre 2013 pris pour la transposition de la directive 2012/26/UE du 25 octobre 2012 modifiant en ce qui concerne la pharmacovigilance la directive 2001/83/CE instituant un code communautaire relatif aux médicaments à usage humain. JORF n°243 du 18 octobre 2013. (NOR AFSP1320840D)	21
Décret n°2014-322 du 11 mars 2014 relatif à la mission interministérielle de lutte contre les drogues et les conduites addictives. JORF n°61 du 13 mars 2014. (NOR PRMX1402311D) .	28
Décret n°2014-754 du 1 ^{er} juillet 2014 modifiant l'article R. 4228-20 du code du travail. JORF n°152 du 3 juillet 2014. (NOR ETST1404770D)	22, 47

Loi n°1970-1320 du 31 décembre 1970 relative aux mesures sanitaires de lutte contre la toxicomanie et à la répression du trafic et de l'usage illicite des substances vénéneuses. JORF du 3 janvier 1971	9, 55
Loi n°1986-76 du 17 janvier 1986 portant diverses dispositions d'ordre social. JORF du 18 janvier 1986	14
Loi n°1987-1157 du 31 décembre 1987 relative à la lutte contre le trafic de stupéfiants et modifiant certaines dispositions du Code pénal. JORF n°3 du 5 janvier 1988. (NOR JUSX8700015L)	14
Loi n°1988-1149 du 23 décembre 1988 : Loi de finances pour 1989. JORF du 28 décembre 1988. (NOR ECOX8800121L)	14
Loi n°1990-614 du 12 juillet 1990 relative à la participation des organismes financiers à la lutte contre le blanchiment des capitaux provenant du trafic des stupéfiants. JORF n°162 du 14 juillet 1990. (NOR ECOX9000077L)	14
Loi n°1991-32 du 10 janvier 1991 relative à la lutte contre le tabagisme et l'alcoolisme. JORF n°10 du 12 janvier 1991. (NOR SPSX9000097L)	40
Loi n°1992-1336 du 16 décembre 1992 relative à l'entrée en vigueur du nouveau Code pénal et à la modification de certaines dispositions de droit pénal et de procédure pénale rendue nécessaire par cette entrée en vigueur. JORF n°298 du 23 décembre 1992. (NOR JUSX9200040L)	14
Loi n°1996-392 du 13 mai 1996 relative à la lutte contre le blanchiment et le trafic des stupéfiants et à la coopération internationale en matière de saisie et de confiscation des produits du crime. JORF n°112 du 14 mai 1996. (NOR JUSX9400059L)	14
Loi n°1996-542 du 19 juin 1996 relative au contrôle de la fabrication et du commerce de certaines substances susceptibles d'être utilisées pour la fabrication illicite de stupéfiants ou de substances psychotropes. JORF n°142 du 20 juin 1996. (NOR INDX9500023L)	15
Loi n°2001-692 organique du 1er août 2001 relative aux lois de finances. JORF n°177 du 2 août 2001. (NOR ECOX0104681L)	19
Loi n°2002-1138 du 9 septembre 2002 d'orientation et de programmation pour la justice. JORF du 10 septembre 2002. (NOR JUSX0200117L)	99
Loi n°2003-087 du 3 février 2003 relative à la conduite sous l'influence de substances ou plantes classées comme stupéfiants. JORF du 4 février 2003. (NOR JUSX0205970L)	12
Loi n°2003-495 du 12 juin 2003 renforçant la lutte contre la violence routière. JORF n°135 du 13 juin 2003. (NOR EQUX0200012L)	12
Loi n°2004-204 du 9 mars 2004 portant adaptation de la justice aux évolutions de la criminalité. JORF n°59 du 10 mars 2004. (NOR JUSX0300028L)	15
Loi n°2004-806 du 9 août 2004 relative à la politique de santé publique. JORF n°185 du 11 août 2004. (NOR SANX0300055L)	17, 39, 105

Loi n°2004-809 du 13 août 2004 relative aux libertés et responsabilités locales. JORF n°190 du 17 août 2004. (NOR INTX0300078L).....	17
Loi n°2007-0297 du 5 mars 2007 relative à la prévention de la délinquance. JORF n°56 du 7 mars 2007. (INTX0600091L).....	11, 15, 98
Loi n°2007-1786 du 19 décembre 2007 de financement de la Sécurité sociale pour 2008. JORF n°296 du 21 décembre 2007. (NOR BCFX0766311L).....	10
Loi n°2008-1249 du 1er décembre 2008 généralisant le revenu de solidarité active et réformant les politiques d'insertion. JORF n°281 du 3 décembre 2008. (NOR PRMX0818589L)	91
Loi n°2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires. JORF n°167 du 22 juillet 2009. (NOR SASX0822640L).....	10, 41
Loi n°2010-768 du 9 juillet 2010 visant à faciliter la saisie et la confiscation en matière pénale. JORF n°158 du 10 juillet 2010. (NOR JUSX0912931L)	15
Loi n°2011-267 du 14 mars 2011 d'orientation et de programmation pour la performance de la sécurité intérieure. JORF n°62 du 15 mars 2011. (NOR IOCX0903274L).....	12
Loi n°2011-867 du 20 juillet 2011 relative à l'organisation de la médecine du travail. JORF n°170 du 24 juillet 2011. (NOR ETSX1104600L).....	13, 38
Loi n°2013-595 du 8 juillet 2013 d'orientation et de programmation pour la refondation de l'école de la République. JORF n°157 du 9 juillet 2013. (NOR MENX1241105L).....	20, 47
Ordonnance du juge des référés du 31 octobre 2013 relative à la demande de l'association Parents contre la drogue d'ordonner la suspension de la décision du Premier ministre du 5 février 2013 d'ouvrir "une salle de shoot expérimentale à Paris", Tribunal administratif de Paris, 31 octobre 2013, n°1314533/9.....	27

Appendix IV – List of abbreviations

AAH	Allocation adulte handicapé	Disability Living Allowance
ADALIS	Addictions drogues alcool info service	Drugs and alcohol addiction information service
AFEF	Association française pour l'étude du foie	French Association for the Study of the Liver
AFSSAPS	Agence française de sécurité sanitaire des produits de santé	(French) Agency for the Safety of Health Products (now ANSM)
AGRASC	Agence de gestion et de recouvrement des avoirs saisis et confisqués	Agency for the Recovery and Management of Seized and Confiscated assets
AHI	Accueil hébergement insertion	residential integration centres
AIDS	Acquired Immuned Deficiency Syndrome	
ALD	Affection de longue durée	Long Duration Disease
AME	Aide médicale d'État	State Medical Assistance (for foreigners without medical coverage)
AMM	Autorisation de mise sur le marché	Marketing Authorisation
ANAES	Agence nationale d'accréditation et d'évaluation en santé	(French) National agency for accreditation and evaluation of health care
ANPAA	Association nationale de prévention en alcoologie et addictologie	(French) National association for the prevention of alcoholism and addiction
ANRS	Agence nationale de recherche sur le sida et les hépatites virales	(French) National AIDS and viral hepatitis research agency
ANSM	Agence nationale de sécurité du médicament et des produits de santé	(French) National Agency for Medicines and Health Products Safety
ARS	Agence régionale de santé	Regional Health Agency
ASA-CAARUD	Analyse nationale des rapports d'activités des CAARUD (OFDT)	National analysis of CAARUD activity reports (OFDT) (<i>see list of sources</i>)
ASUD	Association d'auto-support des usagers de drogues	(French) drug users' self-support group
ATU	Autorisation temporaire d'utilisation	Temporary authorisation for use
CAARUD	Centre d'accueil et d'accompagnement à la réduction des risques pour usagers de drogues	Support Centre for the Reduction of Drug-related Harms (low-threshold structures)

CAPTV	Centre antipoison et de toxicovigilance	Poison Control and Toxicovigilance Centre
CAST	Cannabis Abuse Screening Test	
CCAA	Centre de cure ambulatoire en alcoologie	Outpatient alcoholism treatment centre
CDAG	Centre de dépistage anonyme et gratuit	Anonymous Free Screening Centre
CEIP	Centre d'évaluation et d'information sur la pharmacodépendance	Centre for Evaluation and Information on Pharmacodependence
CépiDc	Centre d'épidémiologie sur les causes médicales de décès	Centre for epidemiology of the medical causes of death
CESC	Comité d'éducation à la santé et à la citoyenneté	Health and Citizenship Educational Committee
CESDIP	Centre de recherches sociologiques sur le droit et les institutions pénales	Centre for Sociological Research on Law and Criminal Justice Institutions
CHRS	Centre d'hébergement et de réinsertion sociale	Social Housing and Rehabilitation Centre
CI	Confidence Interval	
CIDDIST	Centre d'information, de dépistage et de diagnostic des infections sexuellement transmissibles	Centre for providing information, screening, diagnosing and treating sexually transmitted diseases
CILE	Comité interministériel de lutte contre l'exclusion	Interministerial committee to combat social exclusion
CIPCA	Commission interministérielle de prévention des conduites addictives	Interministerial Commission for the Prevention of Addictive Behaviours
CIRDD	Centre d'information régional sur les drogues et les dépendances	Regional information centre on drugs and drug addiction
CJC	Consultation jeunes consommateurs	Youth Addiction Outpatient Clinics
CJN	Casier judiciaire national	National Criminal Record
CMU	Couverture maladie universelle	Universal Medical Coverage
CMU-C	Couverture maladie universelle complémentaire	Complementary Medical Insurance Coverage
CNAMTS	Caisse nationale d'assurance maladie des travailleurs salariés	National health insurance fund for salaried workers
CRIPS	Centre régional d'information et de prévention du sida	Regional AIDS Information and Prevention Centre

CSAPA	Centre de soins, d'accompagnement et de prévention en addictologie	National Treatment and Prevention Centre for Addiction
CSP	Code de la santé publique	Public Health Code
CSST	Centre spécialisé de soins pour toxicomanes	Specialised Care Centre for Drug Users
CT	Communauté thérapeutique	Therapeutic Communities
DAP	Direction de l'administration pénitentiaire (ministère de la Justice)	Prisons Administration Directorate (Ministry of Justice)
DCPJ	Direction centrale de la police judiciaire	Central directorate of the judicial police
DGDDI	Direction générale des douanes et droits indirects (ministère de l'Économie et des Finances)	French customs (Ministry of Economy and Finances)
DGS	Direction générale de la santé (ministère chargé de la Santé)	National Health Directorate (Ministry in charge of Health)
DHOS	Direction de l'hospitalisation et de l'organisation des soins (ministère chargé de la Santé)	Directorate for Hospitalisation and Organisation of Care (Ministry in charge of Health)
DIRECCTE	Direction régionale des entreprises, de la concurrence, de la consommation, du travail et de l'emploi	Regional directorate of businesses, competition, consumption, labour and employment
DPT	Document de politique transversale	Transversal Policy Document
DRAMES	Décès en relation avec l'abus de médicaments et de substances (ANSM)	Drug and substance abuse-related deaths (ANSM) (<i>see list of sources</i>)
DREES	Direction de la recherche, des études, de l'évaluation et des statistiques (ministère de la Santé)	(French) Directorate for research, studies, assessment and statistics (Ministry of Health)
ECDC	European Centre for Disease Prevention and Control	
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction	
ENa-CAARUD	Enquête nationale auprès des usagers des CAARUD (OFDT)	National survey of CAARUDs low-threshold structures (OFDT) (<i>see list of sources</i>)
EROPP	Enquête sur les représentations, opinions et perceptions sur les psychotropes (OFDT)	Survey on representations, opinions and perceptions regarding psychoactive drugs
ESCAPAD	Enquête sur la santé et les consommations lors de l'appel de préparation à la défense (OFDT)	Survey on Health and Use on National Defence and Citizenship Day (OFDT) (<i>see list of sources</i>)

ESPAD	European School Survey Project on Alcohol and other Drugs (INSERM - OFDT - MJENR) (see list of sources)	
ESPE	École supérieure du professorat et de l'éducation	a network of schools of higher learning on professorship and education
EU	European Union	
EWS	Early Warning System	
FFA	Fédération française d'addictologie	French Federation of Addictology
FIR	Fonds d'intervention régional	Regional intervention fund
FNARS	Fédération nationale des associations d'accueil et de réinsertion sociale	(French) Federation of Support and Social Rehabilitation Centres
FNES	Fédération nationale d'éducation et de promotion de la santé	(French) National federation for health education
FNORS	Fédération nationale des observatoires régionaux de santé	(French) National federation of regional health observatories
FNPEIS	Fonds national de prévention, d'éducation et d'information sanitaire	(French) National Fund for Prevention, Education and Health Information
FRAD	Formateurs relais antidrogues (gradés de la Gendarmerie nationale)	Anti-drug liaison trainer (of the French Gendarmerie Nationale)
GERS	Groupement pour l'élaboration et la réalisation de statistiques	Group for the Production and Elaboration of Statistics
GHB	Gamma-hydroxybutyrate	
HAS	Haute autorité de santé	(French) National Authority for Health
HBSC	Health Behaviour in School-aged Children	
HBV	Hepatitis B Virus	
HCSP	Haut conseil de la santé publique	High Council for Public Health
HCV	Hepatitis C Virus	
HDB	High-Dose Buprenorphine	
HIV	Human Immune deficiency Virus	
HLM	Habitation à loyer modéré	Low-rent Social Housing
HPST	(Loi) Hôpital, patients, santé, territoires	Hospital, Patients, Health and Territories (French) law of July 21, 2009

HR	Harm reduction	
HRDU	High Risk Drug Use	
ICD	International Classification of Diseases	
IDU	Intravenous Drug Use or Injecting Drug User	
IFSTTAR	Institut français des sciences et technologies des transports, de l'aménagement et des réseaux	French Institute of Science and Technology for Transport, Development and Networks
IGA	Inspection générale de l'administration	General inspectorate of administrative affairs
IGAS	Inspection générale des affaires sociales	The interministerial audit and evaluation office for social and health, employment and labour policies
IGSJ	Inspection générale des services judiciaires	Inspectorate-General of the Judicial Services
INPES	Institut national de prévention et d'éducation pour la santé	(French) National Institute for Prevention and Health Education
INPS	Institut national de police scientifique	(French) National Forensic Science Institute
INSEE	Institut national de la statistique et des études économiques	(French) National Institute for Statistics and Economic Studies
INSERM	Institut national de la santé et de la recherche médicale	(French) National Institute for Health and Medical Research
InVS	Institut de veille sanitaire	(French) Institute for Public Health Surveillance
IUFM	Institut universitaire de formation des maîtres	University institute for teacher training
JDC	Journée défense et citoyenneté	National defence and citizenship day
JORF	Journal officiel de la République française	Official Journal of the French Republic
LOLF	Loi organique relative aux lois de finances	Constitutional bylaw on budget acts
LOPPSI	Loi d'orientation et de programmation pour la performance de la sécurité intérieure	Homeland security performance planning act
LSD	Lysergic Acid Diethylamide	
M€	Million of euros	
MA	Marketing Authorisation	
MDMA	3,4-methylene-dioxymethamphetamine	

MILDECA	Mission interministérielle de lutte contre les drogues et les conduites addictives	(French) Interministerial Mission for Combating Drugs and Addictive Behaviours
MILDT	Mission interministérielle de lutte contre la drogue et la toxicomanie	(French) Interministerial Mission for the Fight against Drugs and Drug Addiction
MNCPC	Mission nationale de contrôle des précurseurs chimiques	(French) National Mission for the Control of Chemical Precursors
NEMO	Nouvelle étude multicentrique sur les estimations locales de la prévalence de l'usage problématique de drogues (OFDT)	New multicentre study on local estimates of problem drug use prevalence (OFDT) (<i>see list of sources</i>)
NPS	New Psychoactive Substance	
OCRTIS	Office central pour la répression du trafic illicite de stupéfiants	Central office for the repression of drug-related offences
OFDT	Observatoire français des drogues et des toxicomanies	French Monitoring Centre for Drugs and Drug Addiction
OIP	Observatoire international des prisons	International observatory on prisons
ONDRP	Observatoire national de la délinquance et des réponses pénales	French National Supervisory Body on Crime and Punishment
OPPIDUM	Observation des produits détournés de leur utilisation médicamenteuse (CEIP)	Observation of illegal drugs and misuse of psychotropic medications (CEIP) (<i>see list of sources</i>)
ORS	Observatoire Régional de la Santé	Regional health observatory
OSIRIS	Outil et système d'informations relatives aux infractions à la législation sur les stupéfiants	Statistical information and research tool for drug-related offences (<i>see list of sources</i>)
OST	Opioid Substitution Treatment	
PACA	Provence-Alpes-Côte d'Azur	a region located south-east of France
PANJO	Promotion de la santé et de l'attachement des nouveau-nés et de leurs jeunes parents	Promotion of health and attachment of newborns and young parents
PDU	Problem Drug User	
PFAD	Policier formateur antidrogue	Anti-drug police trainer
PJJ	Protection judiciaire de la jeunesse	Judicial Youth Protection Service
PMI	Protection maternelle et infantile	Motherhood and child care services
PMSI	Programme de médicalisation des systèmes d'information	Medicalised information system programme

PNRT	Programme national de réduction du tabagisme	National tobacco smoking reduction programme
POPHEC	Premier observatoire en prison de l'hépatite C	First hepatitis C prison's observatory
PRELUD / BioPRELUD	(Enquête) Première ligne usagers de drogues (OFDT)	Survey among drug users seen in harm reduction facilities (OFDT) (<i>see list of sources</i>)
PREVACAR	(Enquête) Prévalences en milieu carcéral (InVS/DGS)	Prevalence in prison settings (DGS/InVS) (<i>see list of sources</i>)
PRI ² DE	Programme de recherche et d'intervention pour la prévention du risque infectieux en détention (ANRS)	Research and intervention programme to prevent infection among inmates
RECAP	Recueil commun sur les addictions et les prises en charge (OFDT)	Common Data Collection on Addictions and Treatments (OFDT) (<i>see list of sources</i>)
RDT	Rapid Diagnostic Test	
RELION-PREDIL	Recueil d'indicateurs pour l'observation nationale des actions de prévention liées aux drogues illicites et licites (OFDT)	Survey for the monitoring of prevention actions related to licit and illicit drugs (OFDT) (<i>see list of sources</i>)
RESEDA	Réseau d'éducation pour la santé, l'écoute et le développement de l'adolescent	Adolescent Health Education, Counselling and Development Network
RNIPP	Répertoire national d'identification des personnes physiques	National Directory for the Identification of Natural Persons
RSA	Revenu de solidarité active	Active Solidarity Benefit
S[I]UMPPS	Service [inter] universitaire de médecine préventive et de promotion de la santé	[Inter]-University Preventive Medicine and Health Promotion Service
SAM	Enquête « Stupéfiants et accidents mortels de la circulation routière » (OFDT/IFSTTAR)	Road safety epidemiological survey on narcotics and fatal road accidents (OFDT/IFSTTAR)
SCL	Service commun des laboratoires	Customs Joint Laboratories Department
SDSE	Sous-direction de la statistique et des études	Sub-Directorate for Statistics and Studies (of the French Ministry of justice)
SEP	Syringe Exchange Programme	
SFA	Société française d'alcoologie	French society of alcoholology
SIAMOIS	Système d'information sur l'accessibilité au matériel officinal d'injection et de substitution (InVs)	System of information on the accessibility of injection equipment and substitution products (InVs) (<i>see list of sources</i>)

SINTES	Système d'identification national des toxiques et des substances (OFDT)	National Detection System of Drugs and Toxic Substances (OFDT) (<i>see list of sources</i>)
SMPR	Services médico-psychologiques régional	Regional Medico-Psychological Hospital Service
SMR	Standardised Mortality Ratio	
STI	Sexually Transmitted Infection	
TDI	Treatment Demand Indicator	
THC	Δ^9 -Tetrahydrocannabinol	
TREND	Tendances récentes et nouvelles drogues (OFDT)	Emerging Trends and New Drugs (OFDT) (<i>see list of sources</i>)
UCSA	Unité de consultation et de soins ambulatoires	Prison-based Hospital Healthcare Unit
UNIRéS	Réseau des universités pour l'éducation à la santé	Health education network for French universities
UNODC	United Nations Office on Drugs and Crime	
VAT	Value Added Tax	
WHO	World Health Organisation	
ZUS	Zones urbaines sensibles	Sensitive urban areas

Appendix V - List of sources

Acute Hepatitis B Monitoring System

French Institute for Public Health Surveillance (InVS)

In March 2003, it became mandatory in France to report acute hepatitis B cases. Like for HIV and AIDS, HBV-positive individuals are anonymised as soon as they are tested in a laboratory. The testing laboratories report all suspected acute hepatitis B cases to the prescribing physician, who, in the event of a past medical history of hepatitis B, makes a report to the inspecting physician of the relevant Regional Health Agency (ARS).

The collected data help describe the epidemiological profile of infected individuals and to estimate the incidence in France and any changes thereof. To do this, the data coming from reports are corrected for under-reporting, this underestimation being assessed at 85-91% in 2010. They also help assess the impact of the prevention policy by quantifying the spread of the hepatitis B virus.

ASA-CAARUD: National analysis of CAARUD activity reports

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

In addition to the ENa-CAARUD study, the OFDT implemented another epidemiological data collection tool in **low-threshold structures (CAARUDs)**: the standardised annual activity report. This report, which is called ASA-CAARUD, provides information about the type of activities developed in these structures.

Each CAARUD provides quantitative and qualitative information on its activity, the users seen and their practices, as well as on the substances being used. The most recent overall analysis was on 118 reports (from a total of 133 CAARUDs, or 89%) in 2010. Despite the differences that exist from one CAARUD to the next, the analyses described the network from a national and regional point of view, the clients admitted and the main interventions carried out by the CAARUDs.

CJN: National Criminal Record

Sub-Directorate for Statistics and Studies (SDSE) of the Ministry of Justice

Information on convictions has been obtained since 1984 through the use of the National Criminal Record. This information describes the different offences for which convictions have been handed down by judges, the type of procedure, the nature and duration of the sentence, and if applicable, the specific characteristics of convicted offenders (age, sex and nationality).

Since people may be convicted for several offences at once, the main offence is what is most frequently used in the statistics of the Ministry of Justice. Other concepts can be used to refine analyses, such as an isolated offence versus an associated offence. Convictions should not be confused with offenders: a person who has been convicted twice will be counted as two convictions, not one.

Coquelicot: a multi-centre, multi-site study on the frequency and determining factors in practices that lead to a high risk of HIV and HCV transmission in drug users

French Institute of Public Health Surveillance (InVS)

The purpose of this study is to measure the prevalence of HIV and HCV infection in drug users through a face-to-face questionnaire and a blood sample taken by the user himself for biological testing. The study focuses on users' perceptions of their health and healthcare, use practices (substances and routes of administration), knowledge of transmission modes for HIV, HCV and HBV, and at-risk practices (e.g., context in which they first used drugs, sharing of equipment, use of condoms).

The first study was conducted in 2004 in five French cities (Lille, Strasbourg, Paris, Marseille and Bordeaux) on 1,500 users who had injected or snorted at least once in their life. In 2011, the sampling changed a bit: it was no longer cities, but urban centres, and two departments (Seine-Saint-Denis and Seine-et-Marne) were added; drug user recruitment focused on specialised services (CSAPAs, CAARUDs, residential structures) not including general medicine. This survey took place between May and July 2011, and questioned 1,568 drug users in 122 structures. The participation rate was 75%. Of these users, 92% agreed to provide a blood sample from their finger.

CSAPA Activity Reports: use of activity reports from National Treatment and Prevention Centres for Addiction (CSAPAs)

National Health Directorate (DGS) / French Monitoring Centre for Drugs and Drug Addiction (OFDT)

Since 1998, CSSTs (Specialised care centres for drug users), and then the CSAPAs that followed them, have been annually completing a standardised activity report and submitting it to their Regional Health Agency (ARS). 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 rather for all people received in the centre. For 2010, the reports from the 348 outpatient CSAPAs and 10 prison-based CSAPAs were analysed. The respective response rates were 83% and 67%.

DRAMES: Drug and Substance Abuse-related Deaths

French National Agency for Medicines and Health Products Safety (ANSM)

Implemented in 2002, this survey uses a continuous method for collecting data in mainland France 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. The survey also aims to describe the circumstances under which the body was discovered, the level of abuse at the moment of death and the results of the autopsy, as well as to identify and quantify the substances involved, through blood testing.

Thirty-six toxicological experts performed forensic analyses for the 2010 edition of the survey. DRAMES includes drug-related deaths (the definition of which is similar to that of the European Monitoring Centre for Drugs and Drug Addiction) for which toxicological analyses were performed by experts who took part in the study.

ENa-CAARUD: National survey of low-threshold structures (CAARUDs)

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

Conducted every two years since 2006 in all CAARUDs (on mainland France and in French overseas departments), this survey determines the number of users seen in these structures, the characteristics of these users and their use patterns. Each user who enters into contact with the structure during the survey undergoes a face-to-face interview with someone working at the structure. The questions asked are on use (frequency, age of experimentation, administration route, equipment-sharing), screening (HIV, HBV and HCV) and social situation (social coverage, housing, level of education, support from friends and family).

The 2012 survey was conducted from 26 November to 7 December: 4,241 completed or "non-responder" questionnaires were conducted in 142 CAARUDs. After eliminating duplicates (299) and "non-responders" (1,037), 2,905 individuals (in 139 CAARUDs) were included in the analysis.

EROPP: Survey on Representations, Opinions, and Perceptions Regarding Psychoactive Drugs

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

The EROPP survey measures the French population's opinions and perceptions pertaining to psychotropic drugs and the related public actions. The 2013 survey was the fourth. The first three were conducted in 1999, 2002 and 2008. This telephone survey was based on a randomly surveyed, representative sample of the French population aged 15 to 75 years. The sample comprised households with a landline telephone (2,200) and people who used mobile phones only (300 individuals). The data were collected between 27 October and 25 December 2012.

The individuals were questioned about their use, their perception of the level of danger to health, their perception of users and public legal and illegal drug policies.

ESCAPAD: Survey on Health and Use on National Defence and Citizenship Day

The French Monitoring Centre for Drugs and Drug Addition (OFDT) and the National Service Directorate (DSN) of the Ministry of Defence

Originally conducted on an annual basis from 2000 to 2003, the ESCAPAD survey has been organised on a triennial basis since 2005. It takes place on the National Defence and Citizenship Day (JDC), which has existed since obligatory military service was eliminated in France. Young people participating in a JDC session fill out an anonymous, self-administered questionnaire about their use of legal or illegal psychoactive substances and their health and lifestyle.

In 2011, 200 national armed services centres in mainland France and in overseas French departments conducted the survey for a week and a half in April. In total, 32,249 individuals were surveyed and 29,143 questionnaires were analysed. These mainly 17-year-old French nationals were still in higher education or in training, for the most part. On a given day, JDC participation is 90%, but the coverage rate is much higher (people can be summoned on different days because participation is quasi-compulsory to be allowed to register later on for examinations such as university diplomas and the driver licence).

ESPAD: European School Survey Project on Alcohol and Other Drugs

French Monitoring Centre for Drugs and Drug Addiction (OFDT) / Ministry of Youth, National Education and Research (MJENR) / General secretariat of Catholic Education / French National Institute for Health and Medical Research (INSERM U669 / French National Institute for Prevention and Health Education (INPES)

This survey was initiated Europe-wide in 1995 by the Swedish council for information on alcohol and other drugs with the support of the Council of Europe. It takes place every four years in school settings and targets students aged 16 years - the age at which mandatory schooling is over in the majority of European countries. Data collection takes place in the second quarter of the year of the survey.

The 2011 survey took place in 36 countries, including France for the fourth consecutive year. There was one common questionnaire that focused on use, attitudes and opinions related to drugs. In France, a total of 2,572 students born in 1995, i.e., 15-16 years of age when the 2011 survey was conducted, answered a self-administered questionnaire in a classroom setting in the presence of a health professional.

État 4001

National Supervisory Body on Crime and Punishment (ONDRP) in partnership with the Central directorate of the judicial police (DCPJ)

État 4001 is the name given to the institutional statistics on observations by the French police and *gendarmerie*, and the Paris police force, i.e., crimes and offences reported for the first time or discovered by these services, as well as elucidated acts, interrogations and accusations. It excludes the majority of fines, traffic offences and offences observed by another institution (e.g., customs, tax authorities, labour inspectorate). The Central directorate of the judicial police collects data and classifies the statistical results.

HBSC: Health Behaviour in School-aged Children survey

University of Edinburgh (CAHRU) for the HBSC network / Medical department of the Toulouse school district - INSERM U1027 for the survey in France / French Monitoring Centre for Drugs and Drug Addiction (OFDT) / French Institute for Prevention and Health Education (INPES)

This is an international survey being conducted every four years since 1982 under the auspices of the European office of the World Health Organisation (WHO). Currently, over 41 countries (including France since 2002) or regions, mainly in Europe, take part and collect standardised information on behaviours that are detrimental to or positive for health in students aged 11, 13 and 15 years. The HBSC survey is self-administered, strictly anonymous and conducted in class under the supervision of a specially trained investigator.

In 2010, 11,754 school-age students from the last year of primary school to the first year of high school were surveyed in public or private establishments in mainland France under contract with the French national education authority. A total of 11,638 questionnaires were analysed.

Health Barometer

French National Institute for Prevention and Health Education (INPES)

The health barometer is a telephone health survey of a representative sample of the population of mainland France: nearly 27,700 individuals aged 15 to 85 years took part in the 2010 edition. Conducted from October 2009 to July 2010, this survey was the most recent in a series of five, entitled, "Adult health barometers", conducted in 1992, 1993, 1995, 2000 and 2005. The survey collects information on various health behaviours and attitudes among French people (such as those pertaining to the use of treatments, depression, vaccination, screening practices, physical activity, violence and sexuality). The survey also broaches the subject of legal and illegal drug use.

Health Barometer - General Practitioners

French National Institute for Prevention and Health Education (INPES)

Since 1992, the INPES has conducted six surveys of general practitioners (1992, 1993/1994, 1994/1995, 1998/1999, 2002/2003 and 2008/2009) and two surveys of retail pharmacists (1998/1999, 2002/2003) using the same methodology developed for the "Health barometer" surveys.

The most recent survey, which was conducted from 6 November 2008 to 31 January 2009, questioned 2,083 general practitioners in private practice, representing one in 30 physicians. These practitioners were questioned on their behaviours, attitudes and opinions regarding their medical practice, and addiction treatment in particular.

HIV/AIDS Monitoring System

French Institute for Public Health Surveillance (InVS)

Since 1986, reporting new AIDS cases has been mandatory. Reporting newly diagnosed HIV infection cases became mandatory in 2003. The HIV data incorporate biological information from laboratories and epidemiological and clinical information from prescribing physicians. Only physicians can report AIDS cases, and such reporting has been anonymised from the very beginning.

Since 2003, approximately 2,500 biologists and 16,000 clinicians have taken part in mandatory HIV and/or AIDS reporting. At the same time, virological monitoring (Elisa test to detect specific antibodies) is performed by the National HIV reference centre. This totally anonymous information is sent to Regional Health Agencies (ARSs) and then to the InVS.

NEMO: National estimate of the number of problem drug user

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

The "capture-recapture" method, which is particularly useful for difficult-to-access populations, provides local estimates of numbers of problem drug users in several cities in France. This method involves cross-checking groups of users surveyed at different observation sites (CSAPAs, CAARUDs, hospitals) to estimate the number of people who are absent. The total number of users encountered and the calculation of the number of those who are absent provides an estimate of the number of problem drug users in each city.

These local prevalence estimates can then be used to perform a national extrapolation. The OFDT subsequently obtains an estimate of the number of problem drug users in France by comparing the number of known drug users treated in the French system to the locally-estimated number.

OPPIDUM: Observation of illegal drugs and misuse of psychotropic medications

Centre for Evaluation and Information on Pharmacodependence (CEIP)

This epidemiological system for monitoring narcotic and psychotropic drug use (illegal or misused substances), through an annual multi-centre study of structures that admit and treat drug users, has existed at national level in France since 1995. Any patient addicted to or abusing psychoactive substances or taking substitution treatment presenting to these structures in the month of October of any given year is included in this study.

The information collected includes the characteristics of individuals and each of the substances used in the last week (description, how it was procured, use, sought effect and signs of addiction). In 2011, 137 centres (or 5,189 patients) took part in the survey. The majority (61%) of patients had been seen in outpatient CSAPAs, but some had been seen in prison-based hospital healthcare units (UCSA) and CAARUDs).

OSIRIS: Statistical information and research tool for drug-related offences

Central office for the Repression of Drug-related Offences (OCRTIS)

All drug-related offence procedures established by the police, *gendarmerie* or customs on French territory (including overseas departments) are registered in the OSIRIS database. It contains information about arrests (classified as simple use, possession, local trafficking, international trafficking) and seizures. However, the least serious cases of narcotics trafficking and those that are settled through a customs transaction are not always registered.

The substance listed is the “dominant drug”, i.e., the substance primarily consumed by the user or the substance held in the largest amount by the dealer. When this rule cannot be used, the “strongest” substance (in this order, heroin, then cocaine, then cannabis) is recorded.

PRELUD: Survey among drug users seen in harm reduction facilities

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

This quantitative survey, conducted annually from 2000 to 2003, and then repeated in 2006, was designed to obtain knowledge about and monitor users of psychoactive substances and their practices. The population studied consists of users attending frontline facilities that provide support to drug users: harm reduction facilities (shops, syringe exchanges) and so called “low-threshold” structures, including “low threshold” methadone distribution centres. People interviewed are not necessarily representative of users attending these centres, as participation in the survey is voluntary.

The BioPRELUD survey represents the biological section of the larger PRELUD survey, which was conducted among CAARUD clients in five cities. The prevalence of HIV and HCV observed is reported (declarative data). BioPRELUD gathered biological data (saliva samples).

PREVACAR: Survey on HIV and HCV prevalence in prison settings

National Health Directorate (DGS) / French Institute for Public Health Surveillance (InVS)

Conducted in June 2010, this survey determined the prevalence of HIV and HCV infection and the proportion of people receiving opioid substitution treatment (OST) in prison settings. The survey also comprises a section on health care delivery in prison settings: screening

organisation and practices, treatment of HIV- and hepatitis-infected individuals, access to OSTs and harm reduction.

For the "prevalence" section, data were collected through an anonymous questionnaire completed by the supervising physician. For the "health care delivery" section, a 35-item questionnaire was sent to all 168 prison-based hospital healthcare units (UCSAs): 145 of them sent them back to the DGS, (86% response rate), representing over 56,000 inmates, or 92% of the incarcerated population, on 1st July 2010.

PRI²DE : Research and intervention programme to prevent infection among inmates

French National AIDS and viral hepatitis research agency

The PRI²DE study was designed to assess infection harm reduction measures to be established in prison settings. It is based on an inventory whose purpose is to reveal the availability and accessibility of infection harm reduction measures officially recommended in French prisons, as well as the inmates' and health care teams' awareness of these measures. To do this, a questionnaire was sent to each UCSA (prison-based hospital healthcare unit) and SMPR (regional medico-psychological hospital services) in November 2009. 66% of the 171 establishments answered the questionnaire, covering 74% of the population incarcerated at the moment of the study.

The questions pertained to, among others, opioid substitution treatments, infection harm reduction measures (e.g., bleach, condoms and lubricants, tattoo and piercing tools or protocols), screening and the transmission of information on HIV, hepatitis and other sexually transmitted diseases, as well as the treatments dispensed following suspected at-risk practices (e.g., abscesses, skin infections). A consultation with a caregiver was then conducted to specify certain, qualitative items.

ProSanté: a study on health status, access to care and access to entitlements for people engaging in prostitution

French Federation of Support and Social Rehabilitation Centres (FNARS) / French Institute of Public Health Surveillance (InVS)

ProSanté was conducted on volunteer women, men and transgender people of at least 18 years of age, encountered in social structures and stating that they were engaging in prostitution. It was conducted between June 2010 and March 2011 in 12 social structures and 15 medical centres in a dozen Metropolitan French cities (mainly Nice and Paris).

The study had two sections: a health and social section coordinated by the FNARS and a medical section coordinated by the InVS. The study was proposed to all people met by a specially trained social worker of the structure. After the person being surveyed gave consent, the data were collected in a face-to-face interview by questionnaire. The questionnaire touched up the person's sociodemographic characteristics (age, gender, country of birth, education, family situation, living conditions, income, social relations) as well as the following themes: prostitution activity, health perceptions, state of health (use of psychoactive substances, psychological health, violence, sexuality and contraception, screening), access to care and access to entitlements (health care coverage, medical treatments).

In total, 251 people took part in the health-social section of the study. Of these, 71 also took part in the medical section of the study.

National registry of causes of death

Centre for epidemiology of the medical causes of death (CépiDc) of the National institute for health and medical research (INSERM)

Since 1968, the INSERM'S CépiDC department has been recording all deaths observed on French territory. The information on the causes of these deaths comes from the death certificate (paper or, since 2007, electronic) completed by the physician recording the death. They are coded by the INSERM following the 10th revision of the International Classification of Diseases (ICD 10). This system enables annual, national statistics on medical causes of death to be established in cooperation with the French National Institute for Statistics and Economic Studies (INSEE), which oversees National Directory for the Identification of Natural Persons (RNIPP) containing all information from birth, marriage and death records.

In some cases, information pertaining to the causes of death that are to undergo forensic investigation is not always submitted to the INSERM. These deaths remain classified as cause unknown, generating an under-representation of certain causes in the statistics (especially violent deaths and fatal overdoses).

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 clients seen in National Treatment and Prevention Centres for Addiction (CSAPAs). In the month of April, each centre sends its results from the prior year to the OFDT, which analyses these results. The data collected relate to patients, their current treatment and treatments taken elsewhere, their uses (substances used and substance for which they came in the first place) and their health. The common core questions help harmonise the data collection on a national level and fulfil the requirements of the European Treatment Demand Indicator (TDI) protocol.

In 2011, approximately 96,000 patients seen in 160 outpatient CSAPAs (75%), 18 residential treatment centres (nearly 50%) and 11 prison based CSAPAs (69%) were included in the survey.

RELIONPREDIL: Survey for the monitoring of prevention actions related to licit and illicit drugs

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

The purpose of this survey is to describe the main characteristics of the actions undertaken to prevent licit and illicit drug use at local level. It does not pertain to training, or to the standing counselling, support and consultation activities of specialised structures. The survey is on actions aimed directly at a subpopulation, the general population or an at-risk group to help prevent new or repeated harmful use practices.

The RELIONPREDIL survey on the actions undertaken between January and December 2010 was conducted in the Rhône-Alpes region from 3 January to 15 March 2011. The 112 responses collected describe a total of 487 actions undertaken in as many different locations. The limited response rate for certain respondent categories, particularly schools and specialised associations, explains why the overall response rate was only 17%.

Road Traffic Violations Record

Directorate of modernisation and territorial action (Sub-directorate of traffic and road safety) of the Ministry of the Interior

This registry records all road traffic-related offences booked by law enforcement services (Police, Paris prefect police, *gendarmerie*) and classified as speed limit offences, specific controls (helmet, seatbelt, red-lights, stop signs) and the results of alcohol and narcotics blood testing on drivers. Each year, a report is written on this information. This report (*Bilan du comportement des usagers de la route*) is made available to the general public on the website of the Ministry of the Interior: <http://www.interieur.gouv.fr/Publications/Statistiques/Securite-routiere/Bilan-du-comportement-des-usagers-de-la-route>.

SIAMOIS: System of information on the accessibility of injection equipment and substitution products

French Institute for Public Health Surveillance (InVS)

This database was designed in 1996 to follow trends in access to the sterile injection material available in pharmacies, and trends in opioid substitution medications. These data are submitted to the InVS by the GERS (Group for the Production and Elaboration of Statistics). They are collected from 509 geographical analysis units that provide regional and departmental information, although information on a lower level is difficult to obtain. This system, along with the national health insurance fund reimbursement data, is used to estimate the number of drug users being treated with opioid substitution medications.

SINTES: National Detection System of Drugs and Toxic Substances

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

The SINTES scheme is intended to document the toxicological composition of illegal substances in circulation in France. The information incorporated in this system comes from two sources:

- the submission to the OFDT of the results of toxicology tests performed on seizures by law enforcement laboratories (French National Forensic Science Institute, Forensic Sciences Institute of the French *gendarmerie* and Customs laboratories)
- investigations conducted by the OFDT on samples of substances obtained directly from users. These collections are governed by a strict regulatory framework and obtained by specifically trained survey workers.

TREND: Emerging Trends and New Drugs

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

The aim of the TREND scheme, which was established in 1999, is to provide information about illegal drug use and users, and on emerging phenomena. Emerging phenomena refer either to new phenomena or to existing phenomena that have not yet been detected by other observation systems. The observations are conducted in two social settings chosen due to the high likelihood of finding new or not as yet observed phenomena, even though these do not necessarily reflect the entire reality of the drug use in France:

- urban areas, as defined by TREND, mainly cover low-threshold structures (CAARUDs) and open sites (street, squats). Most of the people met and observed in these settings are problem users of illegal drugs living in particularly precarious conditions.
- Techno party settings refer to places where events are organised around techno music. These include so-called “alternative” techno settings (free-party, teknivals) and techno events in clubs, discothèques and private parties.

The system is based on data analysed by seven local coordinating sites (Bordeaux, Lille, Marseille, Metz, Paris, Rennes and Toulouse) that produce site reports, which are then extrapolated to a national level:

- continuous qualitative data collection by the local coordination network, which has a common data collection and information strategy
- the SINTES scheme, an observation system geared towards detecting and analysing the toxicological composition of illegal substances
- recurring quantitative surveys, particularly among CAARUD clients (ENa-CAARUD)
- partner information system results
- thematic quantitative and qualitative investigations that aim to gather more information about a particular subject.