WB 3.4 Harms and Harm Reduction

France

The EMCDDA is investigating how the submission of the workbooks could be made easier through the use of technology. In the first instance, a pilot using templates in Word with defined fields to distinguish the answers to questions is being tried. The outcome of the pilot will be to evaluate the usefulness of this tool and establish the parameters of any future IT project.

Templates have been constructed for the workbooks being completed this year. The templates for the pre-filled workbooks were piloted in the EMCDDA.

1. The principle is that a template is produced for each workbook, and one version of this is provided to each country, in some instances pre-filled.

2. Answers to the questions should be entered into the "fields" in the template. The fields have been named with the question number (e.g. T.2.1). It will be possible to extract the contents of the fields using the field names.

3. Fields are usually displayed within a border, and indicated by "Click here to enter text" Fields have been set up so that they cannot be deleted (their contents can be deleted). They grow in size automatically.

4. The completed template/workbook represents the working document between the NFP and the EMCDDA. Comments can be used to enhance the dialogue between the EMCDDA and the NFP. Track changes are implemented to develop a commonly understood text and to avoid duplication of work.

Workbook Harms and Harm Reduction Contents

T0. Summary

Please provide an abstract of this workbook (target: 500 words) under the following headings:

- National profile

249 fatal overdoses were recorded in 2011 among 15-49 year-olds. A mortality cohort study included 1,134 individuals, and for 970 (or 86%) of these subjects, the vital status was checked in July 2013. For men, the standardised mortality ratio was 5.2. For women, it was much higher (20.8).

In 2013, people infected through intravenous drug use represented only 1.1% of new cases of HIV infection. Furthermore, the biological prevalence of HIV among drug users having injected at least once in their life was 13.3% in 2011, while the biological prevalence of HCV in this population reached 63.8%. The seroprevalence of AgHB (which indicates chronic hepatitis B virus infection) was 2.1% among male drug users surveyed in Paris during the period from 2011 to 2013.

Harm reduction measures are mainly based on the distribution of single-use injection equipment and on opioid substitution treatments. Preventing infectious diseases also relies on encouragement to undergo screening for HIV, HBV and HCV, as well as HBV vaccination.

- Trends

The number of fatal overdoses decreased since 2011 after a growing trend from 2003 to 2010. The proportion of methadone-related deaths declined and the proportion of heroin-related deaths increased between 2012 and 2013.

The prevalence of HCV declined, while remaining at a very high level among injecting drug users, although the prevalence of HIV among this population remained stable, at a much lower level, between 2004 and 2011.

The number of new seropositive cases together with the number of new drug-related AIDS cases remained stable from 2008 to 2013.

- New developments

Recommendations for treating HBV- and HCV-infected individuals and the utility of rapid diagnostic tests for HCV, issued in early 2014, have promoted the continuation and strengthening of actions conducted in this area. In 2014, 14,000 individuals infected with chronic hepatitis C thus received treatment with new direct-acting antivirals. Furthermore, an evaluation of injection kits was conducted, followed by recommendations published in 2014, with a view to modifying their contents.

Trialling of drug consumption rooms (DCR) is part of the health system reform bill adopted by the *Assemblée Nationale* in April 2015 and then by the Senate in September 2015. Three cities have volunteered to test these DCRs: Paris, Bordeaux and Strasbourg. Their opening is not expected before the second half of 2016 because the law has to be formally adopted and renovation work has to be done to implement these rooms.

As regards the implementation of a naloxone distribution programme in France, in February 2015, the Commission on narcotics and psychotropic substances voted in favour of the nasal route of administration for naloxone by drug users and third parties. Priority users are newly released inmates together with users after opioid withdrawal.

T1. National profile

T1.1 Drug-related deaths

The purpose of this section is to:

- Provide a commentary on the numbers of drug-induced deaths, i.e. monitoring of fatal overdoses
- Provide a commentary, if information is available, on mortality among drug users, i.e. findings from cohort studies
- Provide contextual information to the numerical data submitted through ST5/ST6 and ST18

Please structure your answers around the following questions

T1.1.1 Please comment on the numbers of overdose deaths provided to the EMCDDA in ST5/ST6. Please comment on the numbers of cases and breakdown by age, gender and intentionality.

Overdose deaths

In 2012, 264 fatal overdoses were recorded in the National registry of causes of death (INSERM'S CépiDC department). The majority of these deaths (70%) occurred in males. The number of deaths is still underestimated as some overdose deaths are classified as "unknown cause". In contrast, morphine overdose deaths occurring mainly among over 50-year-olds in palliative care, whether accidental or suicidal, might wrongly be included in the fatal drug overdose statistics. Emphasis should be placed on fatal overdose among 15-49 year-olds in order to overcome this bias. There were 195 deaths in this age group in 2012.

T1.1.2 If information is available, please comment on the substances involved in the overdose cases. If detailed toxicology is reported to the EMCDDA, please comment and elaborate on these findings. If detailed toxicology is not reported, please explain why and comment on available information.

Toxicology of overdose deaths

The DRAMES (Drug and substance abuse-related deaths) information system is not exhaustive by nature and provides information on the substances involved in deaths linked with psychoactive substance abuse. In 2013, methadone was involved (alone or in combination) in 39% of deaths and heroin in 19% of cases. Cannabis was implicated in a larger number of deaths than cocaine (11% *versus* 9%) (ANSM 2015). Reports of cannabis-related deaths is becoming increasingly important due to the raising awareness of experts towards the cardiovascular toxicity of cannabis (infarction, stroke).

Table: Breakdown of fatal overdoses by substance(s) involved*, alone or in combination**, from 2010 to 2013

	2010		2011		2012		2013	
	n	%	n	%	n	%	n	%
Methadone	88	36	121	43	140	45	112	39
Buprenorphine	44	18	40	14	47	15	45	16

Other opioids (non-OST)	23	9	39	14	36	12	33	12
Heroin	82	33	54	19	47	15	57	20
Cocaine	25	10	30	11	36	12	25	9
Other illegal substances	8	3	16	6	31	10	47	16
- of which cannabis	na	na	7	3	15	5	31	11
- of which amphetamines/MDMA	7	3	9	3	15	5	14	5
Others (poppers, medications, etc.)	6	2	8	2	9	3	43	15
TOTAL	247		280		310		285	
Number of participating toxicological experts	31		36		41		32	

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.
na: non applicable

NB: among the deaths occurring in 2013 in the "other illegal substances" category, 2 deaths were directly caused by NPS (one case involving GHB and another case methoxetamine).
The proportion for the "other" category increased between 2012 and 2013 due to a methodological change (inclusion of cases involving psychoactive medicines in combination).

*T1.1.3 **Optional.** Please comment on the overall and cause specific mortality rates observed through cohort studies among drug users.*
If detailed results from the cohorts are available and reported in ST18, please comment considering age and gender breakdown where appropriate. If detailed findings are available and not reported in ST18 (e.g. reference to published paper without direct access to the raw data) please comment on the available information.

Mortality cohort studies

Between September 2009 and December 2011, a mortality cohort study (see methodology below) 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 time 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 2011. 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 below) (Lopez *et al.* 2004). However, given the size of the confidence intervals and their overlap, they cannot be determined as statistically significant.

Due to the lower mortality among women aged 20 to 45 in the general population (compared to men), which is not the case among DU, SMR is markedly higher among women than in men (always observed in mortality cohorts among drug users).

Table: 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 metropolitan France (aged 15 to 75 years only): 2010.

*T1.1.4 **Optional**. Please provide any additional information you feel is important to understand drug related deaths within your country.*
(Suggested title: Additional information on drug-related deaths)

T1.2 Drug related acute emergencies

The purpose of this section is to:
- Provide a commentary on the numbers of drug-related acute emergencies

Please structure your answers around the following questions.

T1.2.1 Is information on drug-related acute emergencies available in your country?
If yes, please provide the definition of drug-related acute emergencies used and, if available, an overview of the monitoring system in place.
(Suggested title: Drug-related acute emergencies)

No information on drug-related acute emergencies is available in France.

T1.2.2 If information is available, please provide a commentary on the numbers of drug-related acute emergencies by main illicit substances, e.g. cannabis, heroin/ other opioids, cocaine, amphetamine type stimulants, new psychoactive substances.
Where appropriate please provide links to the original reports and studies.
(Suggested title: Toxicology of drug-related acute emergencies)

No information on drug-related acute emergencies available in France.

T1.3 Drug related infectious diseases

The purpose of this section is to:
- Provide a commentary on the prevalence, notifications and outbreaks of the main drug-related infectious diseases among drug users, i.e. HIV, HBV and HCV infections in your country
- Provide contextual information to the numerical data submitted through ST9 including prevalence and behavioural data (e.g. sharing syringes)
- Provide a commentary, if information is available, on the prevalence/outbreaks of other drug related infectious diseases, e.g. STIs, TB, anthrax, hepatitis A

Please structure your answers around the following questions.

T1.3.1 Please comment on the prevalence among drug users and on notifications of the main drug related infectious diseases (HIV, HBV, HCV) provided to the EMCDDA.

Main drug-related infectious diseases among drug users – HIV, HBV, HCV

Data based on biological samples
In 2011, the biological prevalence of HIV was 10% among drug users and increased to 13% among those having injected at least once in their lives. The biological prevalence of HCV was 44% among drug users and 64% among those having injected at least once in their lives, according to the Coquelicot survey (DREES 2015; Jauffret-Roustide *et al.* 2013b).

Among the 647 male drug users (injecting and/or snorting at least once in their lives) surveyed in Paris between 2011 and 2013 as part of the Coquelicot study, 15 were AgHB carriers, indicating chronic hepatitis B virus infection, which corresponds to a seroprevalence of 2.1% (Sauvage *et al.* 2015).

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 (low-threshold structures). In 2012, the majority of drug users stated having undergone one of these screening tests at least once (91% underwent HIV screening and 87% underwent HCV screening).
Among drug users having injected at least once in their lives and having carried out a test, 6.2% claimed to be HIV seropositive and 33% HCV seropositive in 2012 (Cadet-Taïrou *et al.* 2015).
These reported data are likely to underestimate actual prevalence, especially for HCV.

Notifications of drug-related infectious diseases

In 2013, 66 (95% CI: [40-92]) injecting drug users (IDU) were newly diagnosed as HIV seropositive, i.e. 1.1% of all newly diagnosed cases. This involved men in 77% of cases, 4% aged under 25 and 21% aged 50 or over. Half (53%) were born abroad, mainly in Eastern and Central Europe. The proportion of HCV co-infection reached 79% (Cazein *et al.* 2015).
The number of new AIDS cases related to IDU was estimated at 92 in 2013, i.e. 7.6% of all cases.
Lastly, 92 AIDS deaths occurred among IDU, i.e. 35.4% of all AIDS deaths.

T1.3.3 **Optional**. *Please comment on any information on prevalence of HIV, HBV, HCV among drug users from other sources. Where appropriate please provide links to the original studies. (Suggested title: Prevalence data of drug-related infectious diseases outside the routine monitoring)*

T1.3.4 **Optional** *Please comment on available behavioural data (e.g. sharing, slamming…) Where appropriate please provide links to the original studies.*

Drug-related infectious diseases - behavioural data

Whilst most drug users are now familiar with the concept of not sharing syringes, this is not the case for other injecting paraphernalia. Of recent injecting drug users seen in CAARUDs (low-threshold structures) 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 below). 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" (since there are no syringe exchange programmes in prison, other objects, such as pens, can be used to inject) during their imprisonment (Cadet-Taïrou *et al.* 2015).

Table: 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	Total 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%
injecting paraphernalia (except syringes and needles)	19.7%	29.8%	21.6%
At least one item (including syringes and needles)	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, and are not really familiar with harm reduction techniques. Among drug users under the age of 30, 53% were last month injectors versus 33% of drug users over the age of 30 (Jauffret-Roustide *et al.* 2013b).

T1.4 Other drug-related health harms

The purpose of this section is to provide information on any other relevant drug related health harms.

Please structure your answers around the following question.

Other drug-related health harms

In 2012, 34.8% of CAARUD clients had been hospitalised at least once in the last year (Cadet-Taïrou *et al.* 2015).

Non-fatal overdoses
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%).

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 level (out of the 34.8%, or 854 users, who reported having been hospitalised in the last year) (Cadet-Taïrou *et al.* 2015).

T1.5 Harm reduction interventions

The purpose of this section is to
- Provide an overview of how harm reduction is addressed in your national drug strategy or other relevant drug policy document
- Describe the organisation and structure of harm reduction services in your country
- Comment on the harm reduction provision (activities/programmes currently implemented)
- Provide contextual information useful to understand the data submitted through SQ23/ST10.

Please structure your answers around the following questions.

T1.5.1 Please summarise the main harm reduction-related objectives of you national drug strategy or other key drug policy document (cross-reference with the Policy workbook)

Drug policy and main harm reduction objectives

The harm reduction policy is the responsibility of the state (article L3121-3 of the Public Health Code modified by article 71 of the law of 13 August 2004 [Loi n°2004-809 relative aux libertés et responsabilités locales]). 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 2004 [Loi n°2004-806 relative à la politique de santé publique], 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).

Since May 1987, 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 1995, 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 1987.
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 2005 [Décret n°2005-347 approuvant le référentiel national des actions de réduction des risques en direction des usagers de drogue et complétant le code de la santé publique]. 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.

The 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours (MILDT 2013) aims to open up new avenues in the field of harm reduction (HR):
- by promoting the acceptability of HR measures
- by extending the field of HR to all problem substances
- by developing population-based approaches (aimed at the most precarious users, young people, pregnant women)
- by reinforcing accessibility and safeguarding the provision of HR measures
- by trialling innovative actions, such as drug consumption rooms.

T1.5.2 Please describe the structure of harm reduction service organisation in your country, including comment on its relationship to the treatment service provision system and the extent to which these are integrated or operate separately. Where possible, please refer to the EMCDDA drug treatment system map (see Treatment workbook) to identify the range of treatment providers that are also delivering harm reduction services.

Organisation of Harm reduction services

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 offer. The following indicators are useful to assess the actual coverage of the systems in place.

Level of involvement and location of pharmacy professionals
Nearly half (48%) of the retail pharmacies surveyed in 2010 by the ANSM stated having provided information on the prevention of infectious diseases to drug users, and 40% confirmed having syringe retrieval systems (Lapeyre-Mestre and Boeuf-Cazou 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*®[1] and *Stéricup*®[2] units.

Level of professional involvement in primary care
Health care delivery, concerning OST, is largely based on primary care practitioners (see "Treatment" workbook).

National coverage of medical-social harm reduction systems
In 2015, medico-social harm reduction facilities (CAARUD and CSAPA) covered the majority of the French territory: only eight departments (out of a total of 101) do not have a CAARUD, and all departments have CSAPA.

CAARUD harm reduction activities
154 CAARUDs were registered in 2014 throughout France, versus 135 in 2010. These are medico-social establishments funded by the French social security system. The main actions are providing assistance with hygiene and first aid care, offering health education promotion activities (mainly by distributing prevention materials (Cadet-Taïrou and Brisacier 2013)), 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 and Dambélé 2014).
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
Apart from CAARUDs, other structures such as non-CAARUD associations and communities also distribute injection equipment via dispensing machines and provide drug users with prevention kits such as the *Stéribox*® kit or *Kit*+[3]. 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).

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.* 2014). Other associations carrying out harm reduction measures are not included in the medical-social system. These are mainly humanitarian, community health or specialised associations that are not CAARUD-certified. Many of them work on the party scene.

[1] 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, edema, phlebitis). For single-use only, this sterile filter aims to prevent injection equipment reuse or sharing.

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

[3] 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.

T1.5.3 Please comment on the types of harm reduction services available in your country and the scale of provision, as reported to the EMCDDA in SQ23/ST10. Please structure your answer to include services targeting drug overdose and other deaths, emergencies and drug related infectious diseases. For a list of relevant interventions see http://www.emcdda.europa.eu/publications/ecdc-emcdda-guidance and http://www.emcdda.europa.eu/scientific-studies/2012/preventing-overdoses.

Harm reduction services

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" (inhaling the vapours produced by heating the substance placed on aluminium foil). 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 injection (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 foreseen in the 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours (MILDT 2013). This experimentation is now part of the health system reform bill adopted by the *Assemblée Nationale* in April 2015 and then by the Senate in September 2015. Three cities have volunteered to test these DCRs: Paris, Bordeaux and Strasbourg. Their opening is not expected before the second half of 2016 because the law has to be formally adopted and renovation work has to be done to implement these rooms.

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). In 2011 there were 344 CDAGs in France in addition to about a hundred CDAG units operating in prisons. As from 1 January 2016, these facilities will merge with information, screening and diagnosis centres on sexually transmitted diseases (CIDDIST) to create free information, screening and diagnosis centres on human immunodeficiency virus infection, viral hepatitis and sexually transmitted infections (CeGIDD) [Arrêté du 1er juillet 2015 relatif aux centres gratuits d'information, de dépistage et de diagnostic (CeGIDD) des infections par les virus de l'immunodéficience humaine et des hépatites virales et des infections sexuellement transmissibles]. This merger aims to improve visibility and accessibility of the scheme for prevention and screening of HIV, hepatitis B and C and sexually transmitted infections for users. This service will remain free of charge; however, management may be anonymous or not, according to the user's choice when consulting.

Users can visit CDAGs, 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 Fund (*Assurance maladie*), the screening for chronic HBV markers is only reimbursed at a rate of 65%.

Many CAARUD patients underwent Fibroscan®[1] 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.

HCV RDTs are not currently available in CAARUDs because of an administrative ban following a decision of the State Council of April 2015 due to the opposition of the National Union of biologists physicians regarding the availability of RDTs outside of the exercise of medical biology.

Self-screening tests for HIV-infection screenings are available in pharmacies since September 2015. These tests do not replace other screening devices, they complement the measures available to meet specific needs.

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.

From the different information sources, it may be estimated 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 is only 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.

Furthermore, these dispensing devices enable them to reach a different population from that of other programmes. In 2015, there were 287 automatic prevention kit distributors in 54 departments. These devices distributed 936,000 syringes (nearly half by CAARUDs) in 2013. 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 (Safe association data).

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 requested or possible. In 2014, this syringe exchange programme had 300 active drug users in its patient intakes and had delivered 177,000 syringes. The reasons why these users employ this method are structural (geographic distance, poorly-adapted hours of operation, need for specific material – wheel filters[2], ascorbic acid[3] - 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; Duplessy and Pourchon 2015).

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 (Jauffret-Roustide *et al.* 2013a). The proposals were:
- to replace the alcohol wipes, which are often incorrectly employed (i.e., post-injection) by a chlorhexidine wipe[4], which is more effective against HCV and which allows to wash hands
- add a new sterile field as well as a new container with a premounted handle (to avoid extra handling when attaching the handle)
- integrate wheel filters, which are more effective at reducing bacterial and fungal contamination
- offer a kit with 2 cm[4] syringes (to inject medications) in addition to 1 cm^3 syringes
- increase the size of the dry wipe
- review and clarify the harm reduction messages
- remove the condom included in the kits and prefer a large distribution (on demand) in harm reduction services.
- not to include ascorbic acid within kits but to dispense on demand.

[1] A non-invasive machine that can instantly detect liver fibrosis and assess its degree of advancement.
[2] This type of filter is more effective at trapping impurities than *Stérifilt®* filters.
[3] 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.
[4] Alcohol is less HCV-virucidal than chlorhexidine and causes bleeding at the injection site, which could increase the risk of hepatitis C transmission.

Additional information on harm reduction activities

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 (National Institute for Prevention and Health Education). Mean age at first injection increased, due to a prolonged duration of drug use prior to first injection and experimentation with more diverse substances (Cadet-Taïrou *et al.* 2013; 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.

From June 2015 to February 2016, seven CAARUD located in Île-de-France, Marseille, Bordeaux and Metz will be trialling this intervention known in French as *"Change le programme"*. An intervention guide has been created. It describes in detail the successive sequences forming the basis of the approximately forty minute face-to-face interview. The intervention explores two themes: awareness by injecting drug users of their influence on non-injectors, and thoughts on their position and attitude in terms of initiating others, with a view to reducing initiation practices (Fournier *et al.* 2014; Balteau *et al.* 2014).

T1.6 Targeted interventions for other drug-related health harms

The purpose of this section is to provide information on any other relevant targeted responses to drug-related health harms.
Please structure your answers around the following question.

T1.7 Quality assurance of harm reduction services

The purpose of this section is to provide information on quality system and any national harm reduction standards and guidelines.

Note: cross-reference with the Best Practice Workbook.

Please structure your answers around the following question.

*T.1.7.1 **Optional**. Please provide an overview of the main harm reduction quality assurance standards, guidelines and targets within your country.*

Quality assurance for harm reduction services

In 2014, the medico-social system for the management of addictive behaviours was evaluated by the Interministerial Audit and Evaluation Office for Social and Health, Employment and Labour Policies (IGAS). In its conclusions, the IGAS confirmed the missions of the CAARUD and CSAPA and stated that *"the organisation and operation of these establishments meet the needs of the highly specific populations who turn to them"*. However, it recommends more stringent evaluation of *"the efficacy of the scheme, of its correct positioning and interaction with other protagonists in the prevention, health care, social and medico-social fields"* (Hesse and Duhamel 2014).

The national reference on harm reduction among drug users, appended to the Decree of 14 April 2005 [Décret n°2005-347 approuvant le référentiel national des actions de réduction des risques en direction des usagers de drogue et complétant le code de la santé publique], stipulates the conditions of intervention concerning HR measures, the objectives for distribution of prevention material and the themes covered by the information on drug use-related harm and its prevention. The other points examined in this reference include the diffusion of health alerts, the places of intervention, the type of intervention personnel taking part in HR measures, confidentiality, participation in the monitoring of psychoactive substance use and participation in trialling new preventive strategies or resources.

Other references cover more targeted interventions such as those in the recreational setting (AFR and DGS 2012) or, indeed, early intervention and the use of freebase cocaine and crack (Reynaud-Maurupt 2013).

T2. Trends

The purpose of this section is to provide a commentary on the context and possible explanations of trends in drug related harms and responses data.

Please structure your answers around the following questions.

T2.1 Please comment on the possible explanations of short term (5 years) trends in the following data sets, including any relevant information on changes in specific sub-groups:
    a) drug-induced deaths among adults
    b) prevalence and notifications of infections, e.g.
        i) newly diagnosed HIV cases with drug use as a risk group
        ii) notifications of AIDS cases related to injecting drug use…
    c) drug-related acute emergencies
    d) numbers of syringes distributed to injecting drug users
For example, changes in demography, in prevalence and patterns of drug use, in policy and methodology.

Short term trends in drug-related harms and harm reduction services

Drug-induced deaths among adults
Data from the mortality register reveal a decrease in the number of fatal overdoses in 2011 and 2012 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 195 deaths in 2012 after increasing from 2000 to 2008 and stabilising at approximately 300 from 2008 to 2010. However, this decrease should be interpreted with caution since there were changes in coding rules in 2011[1] along with a better control of the deaths registered under X42 as primary cause in 2012[2].

In 2013, according to the DRAMES information system, the proportion of methadone-related deaths declined (39% *versus* 45% in 2012) after increasing in 2011 and 2012. The proportion of heroin-related deaths rose (19% *versus* 13% in 2012) after falling in 2011 and 2012. The increase in cases of death directly related to cannabis (11% *versus* 5% of cases in 2012) should be interpreted with caution as it could stem from more extensive reporting due to increased awareness among experts of the cardiovascular toxicity of cannabis (ANSM 2015).

Prevalence and notifications of infections
In 2011, the biological prevalence of HCV declined compared to 2004 (63.8% *versus* 73.8%) while remaining stable for HIV (13.3% *versus* 11.3%) among drug users having injected at least once in their lives (DREES 2015).
These trends are identical to the changes in the reported prevalence of HCV and HIV among injecting drug users originating from the RECAP scheme (from 47.7% in 2008 to 43.8% in 2012, stable at nearly 8% for HIV) and the ENa-CAARUD survey (from 40.1% in 2008 to 33.3% in 2012, stable at 6.2 % *versus* 7.7% in 2008 for HIV) (Cadet-Taïrou *et al.* 2015). This decrease in reported seropositivity is particularly marked in under-25s who had injected: it decreased from 22.5% in 2006 to 8.5% in 2010 and 7.6% in 2012 (Cadet-Taïrou *et al.* 2015).

The annual number of newly diagnosed seropositive cases and new AIDS cases among IVDU has remained stable since 2008.

These trends 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, changes in drug use practices and a drop in injection in particular.

[1] 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 buprenorphine overdoses, formerly coded F11.0, are now coded X42.

[2] In 2012, deaths coded X42 (accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens]) as primary cause have been subject to systematic verifications to rule out deaths by morphine overdose in palliative setting and deaths from a pathology that led to the prescription of opiate analgesics. In 2012, deaths coded X42 showed a marked decrease, probably because of fewer deaths being wrongly coded.

*T2.2 **Optional.** Please comment on the possible explanations of long term (greater than 5 years) trends in the following data sets, including any relevant information on changes in specific sub-groups:*
    a) drug-induced deaths among adults
    b) prevalence and notifications of infections e.g.
        i) newly diagnosed HIV cases with drug use as a risk group
        ii) notifications of AIDS cases related to injecting drug use
    c) drug-related acute emergencies
    d) numbers of syringes distributed to injecting drug users
For example, changes in demography, in prevalence and patterns of drug use, in policy and methodology.

Long term trends in drug-related harms and harm reduction services

Prevalence and notifications of infections:
- newly diagnosed HIV cases with drug use as a risk group
The number of newly diagnosed HIV seropositive cases related to injecting drug users fell from 210 to 81 cases between 2003 and 2008.

- notifications of AIDS cases related to injecting drug use
Following a dramatic decline in the number of new AIDS cases related to injecting drug users between 1995 and 1997, notably related to the introduction of tritherapy delaying entry into the symptomatic phase of infection, the rate of this decrease was slower but almost consistent until 2009. This downward trend is also related to the reduction in the number of new cases of HIV infection related to injecting drug users.

*T2.3 **Optional**. Please comment on the possible explanations of long term trends and short term trends in any other drug related harms data that you consider important.*
(Suggested title: Additional information on any other drug related harms data)

T3. New developments

The purpose of this section is to provide information on any notable or topical developments observed in drug related harms and harm reduction in your country **since your last report.**

T1 is used to establish the baseline of the topic in your country. Please focus on any new developments here.

If information on recent notable developments have been included as part of the baseline information for your country, please make reference to that section here. It is not necessary to repeat the information.

Please structure your answers around the following questions.

T.3.1 Please report on any notable new or topical developments observed in drug related deaths in your country since your last report.
(Suggested title: New developments in drug-related deaths)

No new developments.

T.3.2 Please report on any notable new or topical developments observed in drug related infectious diseases in your country since your last report.

> **New developments in drug-related infectious diseases**
>
> In 2014, 14,000 individuals infected with chronic hepatitis C received treatment with new direct-acting antivirals (DAA). At present, 4 new direct-acting antivirals are 100% reimbursed by the National Health Insurance Fund. This concerns sofosbuvir with or without ledipasvir, daclatasvir and simeprevir. The indications for DAA reimbursed by the National Health Insurance Fund are based on the severity of chronic hepatitis, evaluated by the degree of fibrosis (fibrosis score >=2) and/or the existence of HIV co-infection (Ministère des finances et des comptes publics and Ministère des affaires sociales de la santé et des droits de la femmes 2015).
> The French Association for the Study of the Liver issued recommendations on the management of hepatitis C in June 2015 in which it advocates treating all parenteral or nasal drug users in order to reduce the viral reservoir (AFEF 2015).

> T.3.3 Please report on any notable new or topical developments observed in harm reduction interventions in your country since your last report.

> **New developments in harm reduction interventions**
>
> Trialling of drug consumption rooms (DCR), for a maximum period of 6 years, is part of the health system reform bill adopted by the *Assemblée Nationale* in April 2015. This bill should shortly be examined by the Senate. These consumption rooms should be provided by CAARUDs. Individuals in possession of narcotics for personal use and using them in a DCR cannot be prosecuted for illegal use and possession of narcotics. Moreover, professionals working in a DCR cannot be prosecuted for aiding and abetting or facilitating the illegal use of narcotics. Conducted by the National Institute of Health and Medical Research (INSERM), the evaluation of the trial would notably focus on its impact on public health, based on the COSINUS (cohort for the evaluation of drug consumption rooms) drug user cohort, and on the social acceptability of the scheme and the reduction of nuisances in public spaces (Assemblée nationale 2015).
>
> As regards the implementation of a naloxone distribution programme in France, in February 2015, the Commission on narcotics and psychotropic substances voted in favour of the nasal route of administration for naloxone by drug users and third parties. Priority users are newly released inmates together with users after opioid withdrawal. Pending the market launch of a naloxone nasal spray, the Commission also issued a favourable opinion for administration via the injection route so that naloxone can be rapidly made available (ANSM 2015).

T4. Additional information

The purpose of this section is to provide additional information important to drug related harms and harm reduction in your country that has not been provided elsewhere.

Please structure your answers around the following questions.

> T.4.1 *Optional. Please describe any important sources of information, specific studies or data on drug related harms and harm reduction that are not covered as part of the routine monitoring. Where possible, please provide published literature references and/or links.*
> (Suggested title: Additional Sources of Information.)

T5. Notes and queries

The purpose of this section is to highlight areas of specific interest for possible future elaboration. Detailed answers are not required.

Please structure your answers around the following questions.

Yes/No answers required. If yes please provide brief additional information.

T.5.1 Is there any evidence of an increase in acute emergencies or deaths related to stimulants? If yes, please provide links or references to further information if available.

YES	The number of cases of death related to an amphetamine-type stimulants (amphetamine, MDMA, methamphetamine ...) stabilised in 2013 (14 cases, i.e. 5% of all deaths) after increasing between 2010 and 2012 (7 deaths observed in 2010, 9 in 2011 and 15 in 2012). The proportion of cocaine-related deaths was stable between 2010 and 2012, at about 10% (2013 DRAMES survey).
	No national data are available on the use of emergency services related to stimulant use.
	The Poison Control Centre of Angers, France, manages poisoning cases in western France, which includes around 11 million people and around 30,000 calls per year. Phenethylamine poisoning cases reported to the Angers Poison Control Centre, from January, 2007 to December, 2013 were examined (Le Roux *et al.* 2015). The aim of this investigation was to describe the pattern of exposure to all phenethylamines as well as the circumstances under which these poisonings occurred and the consequences. MDMA (38%), amphetamine (18%) and methamphetamine (14%) were the most commonly reported. Synthetic cathinones (10%) and the 2C series (7%) were also found. The most frequently reported symptoms included anxiety and hallucinations (49%), mydriasis and headache (41%), tachycardia (40%) and hypertension (15%). Complications such as seizures (7%), cardiac arrest (5%), toxic myocarditis (1%) and haemorrhagic stroke (1%) were also observed. Of the patients, 77% received hospital care and 12% were admitted to an intensive care unit, 5 deaths occurred and 2 patients presented with neurological sequelae.

T6. Sources and methodology

The purpose of this section is to collect sources for the information provided above, including brief descriptions of studies and their methodology where appropriate.

Please structure your answers around the following questions

T6.1 Please list notable sources for the information provided above.

Sources

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 and Vaissade 2007), these prevalence numbers have been supplied by the RECAP scheme of patients seen in CSAPAs and by surveys of patients seen in low-threshold structures (CAARUDs), particularly ENa-CAARUD surveys.

- The biological prevalence of HIV and HCV, determined using blood samples, were collected from the Coquelicot survey (Jauffret-Roustide *et al.* 2009) conducted in 2004 and 2011.

- 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 circular issued by the National Health Directorate (DGS) made HIV-infection reporting obligatory as well. This system is accompanied by HIV virological monitoring. Reporting of acute hepatitis B infection has been required since 2004.

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). 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 B[1]) 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). This information system records deaths that involved legal proceedings and a request for a toxicology analysis and/or autopsy. Volunteer toxicological analysts report these cases throughout the French territory. 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) but do not include suicidal deaths. 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).
A mortality cohort study among drug users conducted by the OFDT (2009-2015), describes the causes of death, calculates standardised mortality indices (Standardised Mortality Ratio), quantifies the years of life lost and identifies risk factors associated with the occurrence of death.

[1] Common definition of fatal overdoses for all European countries:
http://www.emcdda.europa.eu/publications/methods/drd-overview (Last accessed 20/10/2015)

T6.2 Where studies or surveys have been used please list them and where appropriate describe the methodology.

Methodology

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.

ANRS-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
National Institute for Health and Medical Research (Cermes3-Inserm U988) and 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 areas, 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 of 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.

DRAMES: Drug and Substance Abuse-related Deaths
French National Agency for Medicines and Health Products Safety (ANSM)

Implemented in 2002, this information system 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 system 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 quantity the substances involved, through blood testing.

Thirty-two experts performed toxicological analyses within a forensic scope in the 2013 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.

Mortality cohort study among drug users
French Monitoring Centre for Drugs and Drug Addiction (OFDT)

A cohort of drug users seen in the specialised centres (CSAPA, CAARUD) was incorporated between September 2009 and December 2011 by the OFDT. One thousand individuals were included in 51 volunteers CAARUD and 17 volunteers CSAPA and responded to a questionnaire similar to that of the RECAP scheme. Their vital status was questioned in July 2013 and will be again in December 2015. If appropriate, the causes of death are filled.

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.

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 2013, approximately 175,000 patients seen in 180 outpatient CSAPAs, 18 residential treatment centres and 10 prison based CSAPAs were included in the survey.

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