



European Monitoring Centre  
for Drugs and Drug Addiction



2015 NATIONAL REPORT (2014 data)  
TO THE EMCDDA  
by the Reitox National Focal Point

FRANCE

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# WB 1.1 Drug policy

*France*

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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.
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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.

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## T0. Summary

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

- National profile

The current overarching general principles of French drug policy were stated in a mission letter on 17 October 2012. The Government stated its vision for the actions to be taken in this policy area as being of a global and integrated nature, entrusting responsibility for their implementation to the chairperson of the Interministerial Mission for Combating Drugs and Addictive Behaviours (MILDECA). The MILDECA reports to the Prime Minister and is in charge of developing the national strategies and actions plans and coordinating their implementation. France's Government Plan for Combating Drugs and Addictive Behaviours 2013–17 was endorsed by the Interministerial Committee chaired by the Prime Minister on 19 September 2013. Its approach is a comprehensive and global one towards illicit and licit drugs (narcotics, alcohol, tobacco, psychotropic medicines and new synthetic products) and other forms of addictive behaviours (gambling, gaming, doping). The 2013–17 strategy is structured around three main priorities:

1. To base public action on observation, research and evaluation.
2. To take the most vulnerable populations into consideration to reduce risks and health and social harm.
3. To reinforce safety, tranquillity and public health, both locally and internationally, by fighting drug trafficking and all forms of criminality related to psychoactive substance use.

The 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours also emphasises the need for developing "evaluative" research, preferably in connection with the academic world in order to obtain reliable, independent and useful results for the public authorities to improve the effectiveness of public action. Hence, an external evaluation of this plan, based on a qualitative analysis of four measures of the 2013-2015 Action Plan, will be conducted by a team from the *Sciences Po* institution. In addition, the evaluation of the degree to which the objectives of the plan have been achieved was entrusted to the OFDT.

In 2013 total drug-related expenditure represented 0.1% of gross domestic product (GDP) (approximately €2 billion), with 58% of the total for demand reduction initiatives, 39% for supply reduction activities and 2% allocated for crossed activities (research, training, observation, evaluation, coordination and international cooperation).

- New developments

The main recent development in illicit drug policy since last report has concerned the "Projet de loi de modernisation du système de santé" which proposes new prevention and harm reduction measures intended to drug users, in particular the "drug consumption rooms" and the open sale of HIV self-testing kits (see T3.3 in Harms and harm reduction workbook).

## T1. National profile

### T1.1 National drugs strategies

The purpose of this section is to:

- Summarise the main characteristics of your national drug strategy(ies). Where there is no national strategy, and regional strategies take the place of a national strategy, please summarise the characteristics of these.

Please structure your answers around the following questions.

T1.1.1 Please summarise your current national drugs strategy document.

Information relevant to this answer includes:

- time frame,
- responsible ministries,
- overview of its main principles, priorities, objectives and actions,
- its structure (i.e. pillars and cross-cutting themes),
- the main substances and addictions

The current overarching general principles of French drug policy were stated in a mission letter on 17 October 2012 [[Mission statement of 17 October 2012 from the Prime Minister to Ms Jourdain-Menninger, president of the MILDT](#)]. The Government stated its vision for the actions to be taken in this policy area as being of a global and integrated nature, entrusting responsibility for their implementation to the chairperson of the Interministerial Mission for Combating Drugs and Addictive Behaviours (MILDECA). The MILDECA reports to the Prime Minister and is in charge of developing the national strategies and actions plans and coordinating their implementation. France's Government Plan for Combating Drugs and Addictive Behaviours 2013–17 (MILDT 2013) was endorsed by the Interministerial Committee chaired by the Prime Minister on 19 September 2013. It takes a comprehensive and global approach towards illicit and licit drugs (narcotics, alcohol, tobacco, psychotropic medicines and new synthetic products) and other forms of addictive behaviours (gambling, gaming, doping).

The current strategy is built on an understanding of addictions as multidimensional problems that emerge from the interaction of complex factors, including the biological, psychological, family, socio-economic and environmental status and contexts of individuals. The 2013–17 strategy is based around three main priorities:

1. To base public action on observation, research and evaluation.
2. To take the most vulnerable populations into consideration to reduce risks and health and social harm.
3. To reinforce safety, tranquillity and public health, both locally and internationally, by fighting drug trafficking and all forms of criminality related to psychoactive substance use.

These priorities are addressed across five areas of action, or pillars, that structure the Actions Plan: (i) prevention, care and risk reduction; (ii) stepping up the fight against trafficking; (iii) improving the application of the law; (iv) basing policies for combating drugs and addictive behaviours on research and training; (v) reinforcing coordination at national and international levels. Through these domains of activity, the new strategy addresses, to differing extents, illicit drug use, alcohol, tobacco, psychotropic medications and other addictive behaviours (doping, gambling, gaming). The Government also adopted a more detailed Actions Plan in 2013 (MILDT 2014) that covers the first period of implementation of the national strategy (2013–15).



This first Actions Plan set specific objectives and actions over this period, allocated budget, identified key stakeholders, and detailed the planned timeline and expected outcomes for delivering the strategy. The MILDECA will elaborate the 2016-2017 Actions Plan by the end of 2015.

*T1.1.3 **Optional.** Please provide any additional information you feel is important to understand the governance of drug issues within your country.*

## T1.2 Evaluation of national drugs strategies

The purpose of this section is to

- Summarise any formal evaluation carried out of your most recent national drug strategy.

Where no formal evaluation exists, please summarise any available progress or final reviews. Please structure your answers around the following questions.

T1.2.1 List the titles of the most recent evaluations of national drugs strategies and supporting action plans.

The external evaluation of the 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours is based on a qualitative analysis of four measures of the 2013-2015 Action Plan (see T1.2.2):

- Action 5 "Student liaison officers"
- Action 68 "Easy money"
- Action 22 "Roll-out of the CJC campaign"
- Action 55 "FAS programme trial"

In addition, the evaluation of the degree to which the objectives of the government plan have been achieved (internal evaluation of effectiveness) was entrusted to the OFDT.

T1.2.2 Please summarise the results of the latest evaluation.

Information relevant to this answer includes:

- who carried out the evaluation,
- the objectives,
- methods,
- main findings
- recommendations

The 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours notably emphasises the need for developing "evaluative" research, preferably in connection with the academic world in order to obtain reliable, independent and useful results for the public authorities to improve the effectiveness of public action (Measure 4.1.3.3 of the Action Plan). This government plan recommends evaluation, by a research team specialising in public policy evaluation, of several schemes or symbolic actions in different areas of public action in terms of combating drugs and addictive behaviours (Measure 5.1.3).

In this context, the MILDECA entrusted the evaluation of four priority measures concerning both licit (tobacco and alcohol) and illicit drugs, to the Laboratory for Interdisciplinary Evaluation of Public Policies (LIEPP, *Sciences Po*). The objective of this research is to contribute to evaluating the role of the MILDECA as a protagonist in coordinating and acting as an impetus for implementing these actions. This evaluation should allow the contributors to make adjustments during implementation of the schemes.

The four actions chosen and the methodology for the evaluation are described in detail below:

Action 5 "Student liaison officers": the student liaison officers mainly intervene during recreational events and universal preventive actions on campus or in student halls of residence. This evaluation will be supported by a comparative analysis of the place and role of the prevention of addictive behaviours in the universities which have implemented the scheme compared to universities which have not yet tried it. This will, moreover, make it possible to measure the links between student liaison officers and other prevention stakeholders in the same region. A qualitative analysis of the impact of student liaison officer training in prevention on their approach to intervention is also planned.

Action 68 "Easy money": this action aims to elicit exchanges on the problem of narcotic trafficking with a view to developing representations and reducing the appeal of trafficking. This evaluation should analyse the conditions for implementing this trial in the southern districts of Marseille, particularly the links between the organisations involved in the programme and the coordination measures set in place: how to present the roles of these protagonists, schools, colleges, young offender establishments? Does the programme meet the expectations expressed by its sponsors and direct beneficiaries? On a wider scale, this will involve analysing the way in which this programme is integrated into the local policy on combating drugs and addictive behaviours.

Action 22 "Roll-out of the CJC campaign": this action plan recommends strengthening communication on Youth Addiction Outpatient Clinics (CJC) notably aimed at parents and family members of the populations targeted by these schemes. As regards the CJC campaign, the MILDECA thus finances its roll-out on the Web and also endeavours to broadly mobilise institutional stakeholders liable to act as effective liaisons with families, the target of the campaign. For this purpose, a partnership will be created with the National Family Allowance Fund (CNAF). Evaluation of this action should make it possible to analyse the conditions for implementing the chosen communication strategy for this campaign. The evaluation will endeavour to analyse the respective roles of national and local stakeholders in implementing this communication strategy.

Action 55 "FAS programme trial": the proposed action is to trial a programme integrated on a regional scale aiming to consolidate the prevention and management of disorders related to foetal alcohol syndrome (FAS). This evaluation should describe and analyse the changes in project content over the same period, the conditions for implementing this trial and, in particular, the links between the stakeholders mobilised by different aspects of the programme. This evaluation will analyse the implementation of the programme in view of its different components: prevention, screening and management among adults and children, training of front-line professionals and school and judicial stakeholders, creation of a management process for women and children.

The field of study for the first phase of the evaluation (actions 5 and 68) was initiated in March 2015. The results and conclusions of this research will be presented to the MILDECA by the

end of 2015. Evaluation of the second phase (actions 22 and 55) is planned at the end of the first phase of the research.

The evaluation process entrusted to the OFDT involves monitoring performance indicators which endeavour to translate the progress made along the lines of the government objectives during the course of the 2013-2017 plan. This monitoring of performance indicators comprises comparable, relevant indicators. It is associated with a synopsis to give the MILDECA and authorities useful lines of reflection with a view to drawing up the next action plan. This synopsis will be presented as part of the "Standing Committee on the Fight Against Drug Addiction" chaired and periodically convened by the MILDECA (see T1.3).

## T1.3 Drug policy coordination

The purpose of this section is to

- Provide a brief summary of the coordination structure involved in drug policy in your country
- Describe the main characteristics of each coordination body

Please structure your answers around the following questions.

T1.3.1 Please describe the different coordination bodies involved in drug policy in your country indicating their role, hierarchical relationships, and the ministries they are attached to. If available, please include a summary table or graphic.

An Interministerial Committee on Drugs prepares government decisions in all domains related to the drug problem. It is also responsible for approving the national strategies and actions plans on drugs and addictions. The Committee is under the authority of the Prime Minister and is composed of ministers and state secretaries.

The MILDECA is tasked with the organisation and coordination of France's policies against drugs and addictive behaviours. Reporting to the Prime Minister, it focuses on a range of areas, including prevention, treatment, harm reduction, reintegration, traffic, law enforcement and research, monitoring and training for those involved in demand or supply reduction activities. The MILDECA also prepares, coordinates and partly implements the decisions of the Interministerial Committee, and developed the Government Plan for Combating Drugs and Addictive Behaviours 2013–17 at the Prime Minister's request. Throughout France and its territories there is also a network of one hundred MILDECA territorial representatives (*chefs de projet*) who are responsible for providing leadership and implementing the drug policy. Twenty-two of them are responsible for coordinating the MILDECA drug-policy at regional level.

Decree of 11 March 2014 [[Décret n°2014-322 du 11 mars 2014 relatif à la mission interministérielle de lutte contre les drogues et les conduites addictives](#)] confirms the MILDECA's field of activity, enlarging its mandate to addictive behaviours (tobacco, alcohol and addiction without substances). It refers to MILDECA coordination competencies in the field of supply and demand reduction and mentions its international action.

## T1.4 Drug related public expenditure

The purpose of this section is to

- Outline what is known about the main areas of drug related public expenditure in your country.

Please structure your answers around the following questions.

T1.4.1 Please comment on the availability of data on drug-related expenditure and if possible provide a brief summary of recent estimates.

The total drug-related social costs were estimated on two occasions, for 1996 and 2003 (Kopp and Fenoglio 2004; Kopp and Fenoglio 2006). A new estimate of the social costs of drugs in France was released in September 2015 (Kopp 2015): for the year 2010, this cost would amount to €8.7 billion for illicit drugs. Two other studies have focused on drug-related public expenditure (Ben Lakhdar 2007; Díaz Gómez 2012; Díaz Gómez 2013). Since 2008 the total expenditure of the central government is presented annually in a budgetary document submitted to the Parliament (Service du Premier ministre 2015). The French social security system funds also treatment for drug users. Information gathered from these sources shows that estimate of drug related public expenditure accounted for €1.29 billion in 2008, €1.47 billion in 2009 and €1.50 billion in 2010 (Díaz Gómez 2013). This estimate amounts for €2.03 billion in 2013.

In 2013 total drug-related expenditure represented 0.1% of gross domestic product (GDP) (approximately €2 billion), with 58% of the total for demand reduction initiatives, 39% for supply reduction activities and 2% allocated for crossed activities (research, training, observation, evaluation, coordination and international cooperation).

The 2013–15 Actions Plan has an associated budget. It provides an extra planned budget of €59 million for the period 2013-15. The allocation by type of action shows that most of the planned spending is allocated to treatment (62% over the period 2013–15), followed by prevention and communication (15%), international cooperation (9%), research, training and observation (9%) and anti-trafficking and law enforcement actions (5% of the total).

*T1.4.2 **Optional.** Please provide a breakdown of estimates of drug related public expenditure. If possible, please use table IV to break the information down according to COFOG classification (or Reuters classification) of expenditure by Labelled, Unlabelled and Total expenditures. Where not possible please enter the classifications relevant in your country, with an explanation.*

Drug related expenditure is estimated at €2.03 billion for 2013. This estimate relays on total funds spent in 2013 by the French Government and the social security system for providing public services and implementing drug-related activities to deal with the drug problem.

The bulk of drug-related expenditure is not identified as such in the public accountability documents ('unlabelled') and must be estimated. Since 2008, each Ministry provides an estimate indicating the budget to be allocated to the prevention of and fight against drugs. Much of the public health expenditure is covered by the social security system. Because of the methodological difficulties, only the labelled expenditure of the social security system is included in the estimate below. It includes expenditure for funding the specialized agencies providing treatment and harm reduction services and implementing prevention, recovery and social reintegration's activities (CAARUD, CSAPA and TC). It also covers reimbursement figures for the substitution treatments to drug users and extra budget for public hospitals under the impulse of the "Plan de prise en charge et de prévention des addictions" (2007-2011).

Table IV. Breakdown of drug related public expenditure.

Expenditure	Year	COFOG classification	National accounting classification	Trace (Labelled, Unlabelled)	Comments
18 560 487	2013	07.5 - R&D Health	172	Unlabelled	In €
250 000	2013	09.4 - Tertiary Education	142	Unlabelled	In €
4 312 744	2013	09.1 - Pre-primary and primary education	140	Unlabelled	In €
113 252 701	2013	09.2 - Secondary Education	141	Unlabelled	In €
10 314 160	2013	09.2 - Secondary Education	143	Unlabelled	In €
147 348 411	2013	09.2 - Secondary Education	230	Unlabelled	In €
184 650	2013	09.4 - Tertiary Education	163	Unlabelled	In €
232 505 471	2013	07.4 - Public Health services	204	Unlabelled	In €
8 000 000	2013	07.4 - Public Health services	219	Unlabelled	In €
935 542	2013	03.4 - Prisons	107	Unlabelled	In €
1 737 437	2013	03.3 - Law courts	182	Unlabelled	In €
7 050 000	2013	10.4 - Family and Children	304	Unlabelled	In €
379 000 000	2013	07.4 - Public Health services	Security social Budget	Labelled	In €
68 977 167	2013	0.7.1 - Medical products, appliances and equipment	Security social Budget	Labelled	In €
203 000 000	2013	07.3 - Hospital services	Security social Budget	Labelled	In €
109 564 423	2013	03.3 - Law courts	166	Labelled	In €
236 290 851	2013	03.1 - Police services	176	Labelled	In €
199 211 266	2013	02.2 - Civil defence	152	Labelled	In €
5 470 000	2013	09.8 - Education n.e.c.	207	Labelled	In €
239 000 000	2013	03.6 - Public order and safety n.e.c.	302	Labelled	In €
15 616 000	2013	02.2 - Civil defence	178	Labelled	In €
558 986	2013	09.8 - Education n.e.c.	147	Labelled	In €
6 310 000	2013	01.3 - General services	209	Labelled	In €
559 407	2013	01.3 - General services	105	Labelled	In €
19 973 000	2013	01.3 - General services	129	Labelled	In €
653 566	2013	01.3 - General services	307	Labelled	In €

## T2. Trends. Not applicable for this workbook.

## T3. New developments

The purpose of this section is to provide information on any notable or topical developments observed in drug policy 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.

T3.1 Please report on any notable new or topical developments observed in drug policy in your country since your last report.

The main recent development in illicit drug policy since the last report has concerned the “*Projet de loi de modernisation du système de santé*” which proposes new prevention and harm reduction measures intended to drug users, in particular the “drug consumption rooms” and the open sale of HIV self-testing kits (see T3 in the Legal framework workbook).

## T4. Additional information

The purpose of this section is to provide additional information important to drug policy in your country that has not been provided elsewhere.

*T4.1 Optional. Please describe any additional important sources of information, specific studies or data on drug policy. Where possible, please provide references and/or links.*

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*T4.2 Optional. Please describe any other important aspect of drug policy or public expenditure that has not been covered in the specific questions above. This may be additional information or new areas of specific importance for your country*

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## 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.

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

T5.1 Are there any evaluations planned, e.g. annual progress reviews, mid-term, or final evaluations of current national strategy? If yes, please specify the type of evaluation is planned.

YES	1 / External evaluation of four key actions of the current national strategy 2 / Annual progress review
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T5.2 Have you provided EUROSTAT with an estimate of the contribution of the illicit drug market to the National Accounts?

NO	
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## 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.

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

### Sources

- MILDT (2014). Plan gouvernemental de lutte contre les drogues et les conduites addictives. Plan d'actions 2013-2015. MILDT, Paris.
- Services du Premier ministre (2015) Document de Politique Transversale “Politique de lutte contre les drogues et les toxicomanies”, Projet de Loi de Finances pour 2015. Paris.

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

No study or survey used.

## Bibliography

- 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)]. In: Costes, J.M. (Ed.) 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.
- 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.
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- 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.
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- MILDT (2014). Plan gouvernemental de lutte contre les drogues et les conduites addictives. Plan d'actions 2013-2015. MILDT, Paris.
- Service du Premier ministre (2015). Document de Politique Transversale “Politique de lutte contre les drogues et les toxicomanies”, Projet de loi de finances pour 2015. Paris.

# WB 1.2 Legal Framework

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## T0. Summary

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

- National profile

Use or possession of illicit drugs is a criminal offence in France. An offender charged with personal use faces a maximum prison sentence of one year and a fine of up to €3,750, though prosecution may be waived or a simplified procedure of a fine of up to €1,875 can be ordered in minor cases. The possible sentence increases to five years and a fine of €7,500 if endangering transport or if the offence is committed by a public servant on duty. Users in simple cases may receive a caution, but this should usually be accompanied by a request for a compulsory drug awareness course, introduced in March 2007, for which the non-addicted offender may have to pay up to €450. Addicts would continue to receive the therapeutic injunction directing them to treatment. The application of educational and health measures is prioritised for simple drug-law crimes and for minors. Drug supply is punishable with imprisonment of up to 10 years, or up to life in prison if offences are particularly serious, and a fine of up to €7.5 million.

The law itself does not distinguish between possession for personal use or for trafficking, nor by type of substance. However, the prosecutor will opt for a charge relating to use or trafficking that is based on the quantity of the drug found and the context of the case.

Convictions handed down for drug-related offences represent 9% of all convictions recorded in criminal records, i.e. 56,700 convictions. These offences are broken down as follows: illegal use (59%), possession, acquisition (23%), commerce-transport (12%); import-export, dealing and selling, aiding and abetting account for the last 6%.

- Trends

The framework for French policy on combating illicit drugs is set forth in the 1970 French law on narcotics. It has not been modified since; however, with a constant legislative framework, the orientations of the policy on combating drug addiction have led to the creation of a systematic penal response to the use of narcotics.

During the 2000s, the number of proceedings for simple use increased dramatically; the response to this rapid increase in arrests was the growing recourse to both alternative measures to prosecution and court convictions.

- New developments

In 2014, a single legislative text relating to drugs was adopted by the *Assemblée Nationale* and the Senate. This legislation dated 15 August 2014 offers new provisions aiming to increase the effectiveness of penal sanctions by highlighting the goal of tailoring sentences to individual offenders (recourse to sentence adjustment) according to the circumstances of the offence, together with the character of the offender and their financial, family and social situation. A decree published in October 2015 and implementing this law, allows the use of penal transaction for petty offenses (offenses punishable by a maximum of one year's imprisonment), such as simple use of narcotics. Furthermore, the *Assemblée Nationale* and the Senate passed a health bill, that has yet to be definitively adopted, including several measures on the issue of addictions, particularly the prevention of addictive behaviours (Article 8a) and harm reduction (Articles 7-9). It assigns a major role to prevention (particularly among young people), affirms the need to define an ambitious HCV screening strategy and lays down the framework for trialling drug consumption rooms (DCR).

## T1. National profile

### T1.1 Legal framework

The purpose of this section is to:

- Summarise the basic penalties and other responses to the offences of use, possession for personal use, supply (including production) of illicit drugs.

Please structure your answers around the following questions.

T1.1.1 Please describe the characteristics of drug legislation and national guidelines for implementation within your country (are offences criminal; what is the range of possible penalties; are there alternatives to punishment)?

Use or possession of illicit drugs is a criminal offence in France. An offender charged with personal use faces a maximum prison sentence of one year and a fine of up to €3,750, though prosecution may be waived or a simplified procedure of a fine of up to €1,875 can be ordered in minor cases. The possible sentence increases to five years and a fine of €7,500 if endangering transport or if the offence is committed by a public servant on duty. A Directive of 9 May 2008 [[Circulaire CRIM 08-11/G4 relative à la lutte contre la toxicomanie et les dépendances](#)] defined a new 'rapid and graduated' policy. Users in simple cases may receive a caution, but this should usually be accompanied by a request for a compulsory drug awareness course, introduced in March 2007, for which the non-addicted offender may have to pay up to €450 [[Loi n°2007-297 du 5 mars 2007 relative à la prévention de la délinquance](#)]. Addicts would continue to receive the therapeutic injunction directing them to treatment. Users in aggravating circumstances, such as recidivists, might be imprisoned. In 2012 a Directive establishing a criminal policy strategy for drug crimes reiterated that, when sentencing, courts should take account of factors suggesting a simple use or drug addiction, the principle of proportionality with respect to the seriousness of the alleged offence, calls for systematic penal responses and increasingly effective judicial measures [[Circulaire CRIM 2012-6/G4 du 16 février 2012 relative à l'amélioration du traitement judiciaire de l'usage de stupéfiants](#)]. The application of educational and health measures is prioritised for simple drug-law crimes and for minors.

Drug supply is punishable with imprisonment of up to 10 years, or up to life in prison if offences are particularly serious, and a fine of up to €7.5 million.

T1.1.2 How do the penalties vary by drug / quantity / addiction?

The law itself does not distinguish between possession for personal use or for trafficking, nor by type of substance. However, the prosecutor will opt for a charge relating to use or trafficking that is based on the quantity of the drug found and the context of the case. Based on the principle of the appropriateness of proceedings, s/he may decide to take legal action against the offender, to simply close the case or to propose other measures as an alternative to prosecution.

T1.1.3 What, if any, legislation within your country is designed to control New Psychoactive Substances (NPS)?

In France, the mission for vigilance and detection of potentially hazardous substances is entrusted to the (French) National Agency for Medicines and Health Products Safety (ANSM). The Ministry of Health is responsible for placing these substances under restriction, and decides on whether to classify them in the list of narcotics. This decision is taken after

evaluation of the pharmacological properties, psychoactive effects and potential of these substances for abuse and addiction. Moreover, the Head Pharmacist delegated to the Customs Department can classify an NPS-containing product as a “functional drug” according to Article L.5111-1 of the Public Health Code. This legislation allows then Customs to seize non-classified substances.

In response to the incessant emergence of these new substances on the market, France made a decision, in July 2012, to have recourse to a "generic" classification which extends prohibition to a group of substances belonging to the same category and no longer to a single product. This decree of 27 July 2012 [[Arrêté modifiant les arrêtés du 22 février 1990 fixant la liste des substances classées comme stupéfiants et la liste des substances psychotropes](#)] prohibits all chemical classes derived from cathinone, which have already been identified. In 2015, the health authorities classified ethylphenidate [[Arrêté du 17 mars 2015 modifiant l'arrêté du 22 février 1990 fixant la liste des substances classées comme stupéfiants](#)] and synthetic cannabinoids, which represent the NPS class most frequently identified in Europe [[Arrêté du 19 mai 2015 modifiant l'arrêté du 22 février 1990 fixant la liste des substances classées comme stupéfiants](#)].

*T1.1.4 **Optional.** If available provide information in a separate paragraph on other topics relevant to the understanding of the legal framework for responding to drugs in your country, such as: drug driving, workplace regulations, drug testing, precursor control, organised crime legislation relevant to drug trafficking, issues focused on minors. Regulatory aspects of treatment and harm reduction are also of interest.*

The law of 3 February 2003 introduced a new offence punishing any driver whose blood test revealed the presence of narcotics [[Loi n°2003-87 relative à la conduite sous l'influence de substances ou plantes classées comme stupéfiants](#)]. 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 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 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 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.

## T1.2 Implementation of the law

The purpose of this section is to

- Summarise any available data on the implementation of legislation.
- Provide any additional contextual information that is helpful to understand how legislation is implemented in your country.

Please structure your answers around the following questions.

T.1.2.1 Is data available on actual sentencing practice related to drug legislation?

Please provide a summary and a link to the original information or state if no information is available.

In 2013, convictions handed down for drug-related offences represent 9% of all convictions recorded in criminal records, i.e. 56,700 convictions (Ministère de la justice *et al.* 2014). These offences are broken down as follows: illegal use (59%), possession, acquisition (23%), commerce-transport (12%), import-export (2%), dealing and selling (4%), aiding and abetting, which may comprise incitement to use and facilitation of use (34 cases) and other (141 cases). Prison sentences without remission, or partial sentence suspension concern nearly 27% of convictions for drug-related offences.

Other than for sentences handed down by the courts, criminal records also list lighter procedures such as fixed penalty notices. In 2013, one out of ten offences for narcotic use were handled by the State prosecutor in the context of a fixed penalty notice. Close to 8,800 fixed penalty notices for drug-related offences were implemented in 2013, nearly all of which (98%) for illegal narcotic use. Alternative sentences were more widely used than fines, 5,000 versus nearly 3,800.

T.1.2.2 Is data available on actual sentencing practice related to legislation designed to control NPS? Please provide a summary and a link to the original information or state if no information is available.

Actual court practices on the penal response to NPS cannot be documented at present. They may have recourse to the article on inciting use, but no detailed statistics according to type of substances are available.

Furthermore, when suspect goods are detected by the law enforcement services, in order to remove it from the market, the substance may be assimilated to a "medication by function". The judge may challenge the proceedings or decide to authorise the inquiry and pursue legal proceedings.

*T1.2.3 Optional. If possible, discuss why implementation might differ from the text of laws (e.g. political instructions, resource levels, policy priorities).*

## T2. Trends

The purpose of this section is to

- provide a commentary on the context and possible explanations of trends in legislation and the implementation of the legislation within your country.

Please structure your answers around the following questions.

T2.1 Please comment on any changes in penalties and definitions of core offences (offences of use, possession for personal use, supply (including production) of illicit drugs) in the legal framework since 2000. If possible discuss the possible reasons for change (e.g. political philosophy, changes in the drug situation, public debate, policy evaluation).

The framework of the French policy for combating illicit drugs is set forth in the 1970 French law on narcotics [[Loi n°70-1320 relative aux mesures sanitaires de lutte contre la toxicomanie et à la répression du trafic et de l'usage illicite des substances vénéneuses](#)]. It has not been modified since 1970; with a constant legislative framework, the orientations of the penal policy for combating drug use have been redefined on several occasions, leading to the creation of a systematic penal response to the use of narcotics (see T1.1.1).

The law of 9 March 2004 [[Loi n°2004-204 portant adaptation de la justice aux évolutions de la criminalité](#)] 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.

The "delinquency prevention law" of 5 March 2007 [[Loi n°2007-297 relative à la prévention de la délinquance](#)] provided for a wider range of law enforcement measures that could be taken against drug users. It introduced a new penalty: a mandatory awareness course on the dangers of drug and alcohol use (€450 maximum, the amount of a third class contravention). Its aim 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 drug awareness course may be proposed by the authorities as an alternative to prosecution and to fixed penalty notice. An obligation to complete the drug awareness 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 13.

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. The application circular issued by the Ministry of Justice on 16 February 2012 [[Circulaire CRIM 2012-6/G4 relative à l'amélioration du traitement judiciaire de l'usage de stupéfiants](#)] invites the legal authorities to systematically envisage a drug treatment order when circumstances reveal that the suspect needs treatment. The "delinquency prevention law" also 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).

Finally, the law of 9 July 2010 (the so-called "Warsmann law") 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 [[Loi n°2010-768 visant à faciliter la saisie et la confiscation en matière pénale](#)].

T2.2 Please comment on how the implementation of the law has changed since 2000. If possible discuss the possible reasons for change (e.g. new guidelines, availability of alternatives to punishment)

In the past 15 years, the number of proceedings for simple use has more than doubled, increasing from 76,700 to 176,700 persons taken to court between 2000 and 2014. In 2010, (since 2010 national statistics no longer provide details of arrests for each substance), 90% concerned simple cannabis use, 5% heroin use and 3% cocaine use.

In response to this rapid increase in arrests, alternatives to prosecutions (drug warning, referral to a health and social centre, drug treatment order, etc.) have been systematically applied (see T2.1). Although infrequent at the end of the 1990s, they now represent 70% of referrals ordered by prosecutors as disciplinary action against narcotics use. Furthermore, the penal response to these cases of use is characterised by the increasingly frequent recourse to court convictions during the 2000s. Although the number of annual convictions remained below 5,000 in the 1990s, these increased seven-fold between 2000 and 2012 (24,100 convictions for a single drug use offence). The proportion of convictions for drug use only, to the exclusion of any other offences, reached 45% in 2012: this was three times lower in 2000 (15%).



As regards trafficking, the number of proceedings increased 1.6-fold, from 7,350 to 12,000 persons taken to court between 2000 and 2014. Import-export offences give rise to sentences increasingly involving prison sentences: the proportion of prison sentences or partially suspended sentences increased from 65% to 78% between 2000 and 2010. However, the proportion of prison sentences or partial suspended sentences ordered for the supply and sale of narcotics as the main offence has decreased (47% in 2000, 34% in 2010) in favour of totally suspended sentences (increasing from 38% to 49% over the same period) and, marginally, alternative sentences or educational penalties (13% in 2010).

### T3. New developments

The purpose of this section is to provide information on any notable or topical developments observed in legislation, the implementation of legislation, evaluation, and the political position on drug legislations **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.

T3.1 What, if any, laws have changed in the last year?

Please use the following table to structure your answer, providing the title of the law, a hyperlink if available and a short summary of the change and explanatory comments.

In 2014, a single legislative text relating to drugs was adopted by the *Assemblée Nationale* and the Senate. This legislation offers new provisions aiming to increase the effectiveness of penal sanctions [[Loi n°2014-896 du 15 août 2014 relative à l'individualisation des peines et renforçant l'efficacité des sanctions pénales](#)]. This new law reaffirms the legislator's desire to tailor sentences to the circumstances of the offence, together with the character of offenders, and their financial, family and social situation. This highlights the ambition to increase recourse to sentence adjustment measures, except in the event of major contraindications (severity of the offence and character of the offender). A decree published in October 2015 and implementing this law [[Décret n°2015-1272 du 13 octobre 2015 pris pour l'application des articles 41-1-1 du code de procédure pénale et L. 132-10-1 du code de la sécurité intérieure](#)], allows the use of penal transaction for petty offenses (offenses punishable by a maximum of one year's imprisonment), such as simple use of narcotics. This provision allows law enforcement services to offer, after agreement of the prosecutor, a fine payable immediately that suspend the judicial process. Moreover, the law of August 2014 affirms the role of the Ministry of Justice, in collaboration with the other authorities contributing to this mission (State services, local authorities, associations, etc.), notably through "agreements on objectives", to facilitate access to the health and social management of convicts.

In terms of screening for infection, Article 47 of the law of 22 December 2014 [[Loi n°2014-1554 de financement de la sécurité sociale pour 2015](#)] announces the merging of anonymous free screening centres (CDAG) for HIV and hepatitis with information screening and diagnosis centres on sexually transmitted diseases (CIDDIST). As from the 1 January 2016, these facilities will merge with a view to creating free information, screening and diagnosis centres



(CeGIDD) on human immunodeficiency virus infection, viral hepatitis and sexually transmitted infections (see T3.2 for the implementing texts).

Furthermore, other research and parliamentary debates took place in 2014 (and continued in 2015). More precisely, in April 2015, the *Assemblée Nationale* passed a health bill (311 to 241 votes), the main orientations of which were presented by the government for the first time in June 2014. This bill falls within the scope of the prolongation of the national health strategy initiated in 2013. It comprises 57 articles in total. Several measures concern the issue of addictions, particularly the prevention of addictive behaviours (Article 8a) and harm reduction (Articles 7-9). The bill was transferred to the Senate on 15 April 2015 (<http://www.senat.fr/leg/pjl14-406.html> [accessed 30/07/2015]) and should be examined in September.

The bill prioritises prevention in order to provide better protection for young people against the consequences of drug use. Another major concern is the populations furthest removed from the health system, particularly injecting drug users. The text passed by the *Assemblée Nationale* thus affirms the need to define an ambitious strategy for generalised screening for hepatitis C. In this context, it also authorises pharmacy sales of rapid diagnostic tests (RDT). Furthermore, the bill defines a framework for trialling drug consumption rooms (DCR), allowing users and professionals working in these facilities to be legally protected. Lastly, this text introduces a final paragraph in Article 8 in order to safeguard the French part of the European “Early Warning System” (the SINTES scheme: National Detection System of Drugs and Toxic Substances).

T3.2 What, if any, changes have occurred in the implementation of the law in the last year? Please provide the link to any relevant reports or information.

The new texts which have been added to the French regulatory collection focused on pharmacovigilance and the restriction of potentially poisonous substances.

In terms of medications classified as narcotics, the decree of 13 October 2014 modifies the prescribing conditions for methadone in capsule form: only the oral form (syrup) will continue to be subject to limited prescription for 7 days or 14 days; the capsule form may henceforth be prescribed for a maximum period of 28 days [[Arrêté 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](#)].

In 2015, the health authorities banned ethylphenidate and synthetic cannabinoids by including them on the list of substances classified as narcotics (see T1.1.3).

The creation of free information, screening and diagnosis centres (CeGIDD) on human immunodeficiency virus infection, viral hepatitis and sexually transmitted infections announced by the law of 22 December 2014 was enforced by the publication of a decree stipulating the conditions for accreditation and funding of these facilities [[Décret n°2015-796 du 1er juillet 2015](#)] and by a decree describing in detail the specifications and content of the accreditation application dossier [[Arrêté du 1er juillet 2015](#)].

T3.3 Has there been an evaluation of the law in the last year, or other indications as to its effects? Please specify and provide links to the original report.

No recent evaluation of the law in France.

**T3.4 Optional.** Summarise any major political discussions in the last year relating to legislation or its implementation that you feel is important in understanding the current legal framework within your country.

The regulatory document subjected to amendments / Initial version of the text	The amended regulatory document / Current version of the text		
Title. Hyperlink	Title. Hyperlink	Summary of change	Comments
<a href="#">Loi n°2014-896 du 15 août 2014 relative à l'individualisation des peines et renforçant l'efficacité des sanctions pénales</a>		Tailoring sentences (according to the circumstances of the offence and personal situation) and increasing recourse to sentence adjustments.	

## T4. Additional information

The purpose of this section is to provide additional information important to understanding drug legislation in your country that has not been provided elsewhere.

Please structure your answers around the following questions.

**T4.1 Optional.** Please describe any additional important sources of information, specific studies or data on the legal framework. Where possible, please provide references and/or links.

**T4.2 Optional.** Please describe any other important aspect of the legal framework that has not been covered in the questions above. This may be additional information or new areas of specific importance for your country (e.g. money laundering, tobacco, alcohol legislation, new/changing organisations/structures, regulations related medical or industrial cannabis, and regulatory framework of opioid substitution treatment).

## T5. Notes and queries

This section should 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.

**T5.1** Have there been any recent developments in the debate on cannabis legislation?

YES	A parliamentary report on the evaluation of the fight against illicit drug use (Le Dain <i>et al.</i> 2014) proposed to transform cannabis-use offense into a third class contravention (a maximum fine of €450). One of the two rapporteurs even recommended to legalise use in the private
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	<p>setting for adults, and to establish a regulated supply of the product under the control of the State.</p> <p>On 2 April 2015, the ecologist group presented a legislative draft authorising the controlled use of cannabis, which was not adopted. The need for discussion on all types of addiction in order to define a global prevention policy was the central point of the debates (<a href="http://www.senat.fr/leg/pp113-317.html">http://www.senat.fr/leg/pp113-317.html</a> [accessed 20/10/2015]).</p> <p>In the framework of the draft law on health currently under discussion, the Senate approved an amendment proposing to punish the first drug use by a third class contravention. The draft law will be further discussed in Parliament.</p> <p>Recent publications on the legal status of cannabis include the report of the French think tank Terra Nova (Ben Lakhdar <i>et al.</i> 2014).</p>
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## 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.

T.6.1 Please list notable sources for the information provided above.

The information discussed herein is based on permanent monitoring of legislation and data relative to the activity of law enforcement services (police and *Gendarmerie*) and the justice system.

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

No studies or surveys used here.

## Bibliography

Ben Lakhdar, C., Kopp, P. and Perez, R. (2014). Cannabis : Réguler le marché pour sortir de l'impasse. Terra Nova, Paris.

Le Dain, A.Y., Marcangeli, L. and Comité d'évaluation et de contrôle des politiques publiques (2014). Rapport d'information [...] sur l'évaluation de la lutte contre l'usage de substances illicites. Assemblée nationale, Paris.

Ministère de la justice, Timbart, O. and Busch, F. (2014). Les condamnations. Année 2013. Ministère de la Justice, Paris.

# WB 2 Drugs

*France*

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## **2015 National report (2014 data) to the EMCDDA by the French Reitox National Focal Point**

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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.

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## T0. Summary of the Drugs workbook

The purpose of this section is to:

- Provide a summary of the information provided in this workbook.
- Provide a top-level overview of drugs more commonly reported within your country and note important new developments

Provide a description of important surveys and studies that concern more than one drug, either individually or in combination (polydrug use).

Please structure your answers around the following questions.

T0.1.1 Please, comment on the following:

- a) The main illicit drugs used in your country and their relative importance. (Please make reference to surveys, treatment and other data as appropriate.)
- b) New developments in the drug market, such as changes in availability, the emergence of new drugs and changes in patterns of use
- c) Any relevant surveys or studies that concern more than one drug, either individually or as polydrug use.

### **The main illicit drugs and polydrug use**

Cannabis is still by far the most widely used illicit substance, both among teenagers and the adult population, with 17 million people having already tried it (i.e. 41% of 15 to 64 year-olds). The overall proportion of recent users (in the last month) is 6.6%, and regular use (at least 10 times per month) concerns nearly 1.5 million people in France.

Among last year users aged 18 to 64 years, according to the 2014 INPES Health Barometer Survey, the proportion of those at high risk of problem cannabis use is 21%, i.e. 2.2% of the French population aged 18 to 64 years. Cannabis is also the most frequently reported substance mentioned as the principal reason for entering drug treatment (CSAPA). As far as synthetic cannabinoids are concerned, 1.7% of adults aged 18 to 64 state that they have already used such substances. Their use levels are similar to heroin or amphetamines.

Cannabis use has been on the rise since the beginning of the 2010s, regardless of age group and frequency of use: this rise is part of a context of a marked increase in cannabis supply in France, particularly home cultivation and local production of herbal cannabis, while the cannabis resin market is still very dynamic.

The use of cocaine, the second most frequently used illicit substance, is far below that of cannabis and concerns approximately one tenth the number of people. However, the proportion of lifetime cocaine users aged 18 to 64 has increased four-fold in two decades (from 1.2% in 1995 to 5.6% in 2014). This statistic includes those who have used cocaine at least once in their life (lifetime users) or at least once in the last year. This variation indicates the wider diffusion of a substance once limited to well-off categories, and affecting all social groups in recent years. The levels of lifetime use for synthetic drugs such as MDMA/ecstasy and amphetamines are 4.3% and 2.3%, respectively. The proportion of current MDMA/ecstasy users increased significantly between 2010 and 2014 (from 0.3% to 0.9%), thus reaching a peak since the last decade.

The prevalence of lifetime use of heroin is 1.5% in the entire 18 to 64 year-old population and current use seems very rare (0.2% of those surveyed).

*T0.1.2 **Optional.** Please comment on the use, problem/high risk use, notable changes in patterns of use, and any interaction or association with the use of controlled substances (illicit drug use) for the following substances:*

- a) Alcohol*
- b) Tobacco*
- c) Misuse of prescription drugs*

### **The use of illicit drugs with alcohol, tobacco and prescription drugs**

In the INPES Health Barometer (adult population), like in the OFDT ESCAPAD survey (17 year-olds), polydrug use is discussed through regular use of at least two of three substances, alcohol, tobacco and cannabis, without being able to determine whether this involves concomitant use. In 2014, this type of practice is still uncommon since it only concerns 9.0% of the adult population. It reaches a peak among 18 to 25 year-olds, who are one of the age groups with the highest tobacco and cannabis use (13.2%). Regular polydrug use of three substances is rare since this concerns 1.8% of males and 0.3% of females aged 18 to 64.

In 2014, regular polydrug use of alcohol, tobacco or cannabis concerns 12.8% of 17-year old teenagers. Cumulative regular tobacco and cannabis use is more widespread (5.0%) than in 2010, slightly ahead of cumulative regular tobacco and alcohol use (4.5%). Cumulative regular use of the three substances concerns 3.0% of 17 year-olds.

Between 2011 and 2014, regular polydrug use rose by 2.9 points. This concentration of regular use has become more pronounced among young girls, with polydrug use practically increasing by half relative to 2011, from 5.8% to 8.4%.

Regarding the public received in Youth Addiction Outpatient Clinics (CJC), outpatients seeking help for cannabis use were also tobacco users (80% of daily smokers) and subject to frequent or massive alcohol consumption. Thus, one outpatient out of five stated drinking alcohol often to get drunk, especially among young adults (19% of minors, 26% of 18-25 year olds, 16% over 25 years). About 10% of these "cannabis outpatients" are regular drinkers. Almost half (48%) declared at least one heavy episodic drinking (HED) in the last month, 21% repeated HED (at least 3 in the month) and 4% regular HED (at least 10 in the month) (Obradovic 2015).



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## SECTION A. CANNABIS

### T1. National profile

#### T1.1 Prevalence and trends

The purpose of this section is to:

- Provide an overview of the use of cannabis within your country
- Provide a commentary on the numerical data submitted through ST1, ST2, ST7, TDI and ST30
- Synthetic cannabinoids, are reported here due to their close link with Cannabis

Please structure your answers around the following questions.

T1.1.1 General population. Please comment on the prevalence and trends of cannabis use in the general population.

Focus on last year and last month prevalence and any important demographic breakdowns where available (e.g. young adults 15-34, gender). Include any contextual information important in interpreting trends.

#### **Cannabis use in the general population**

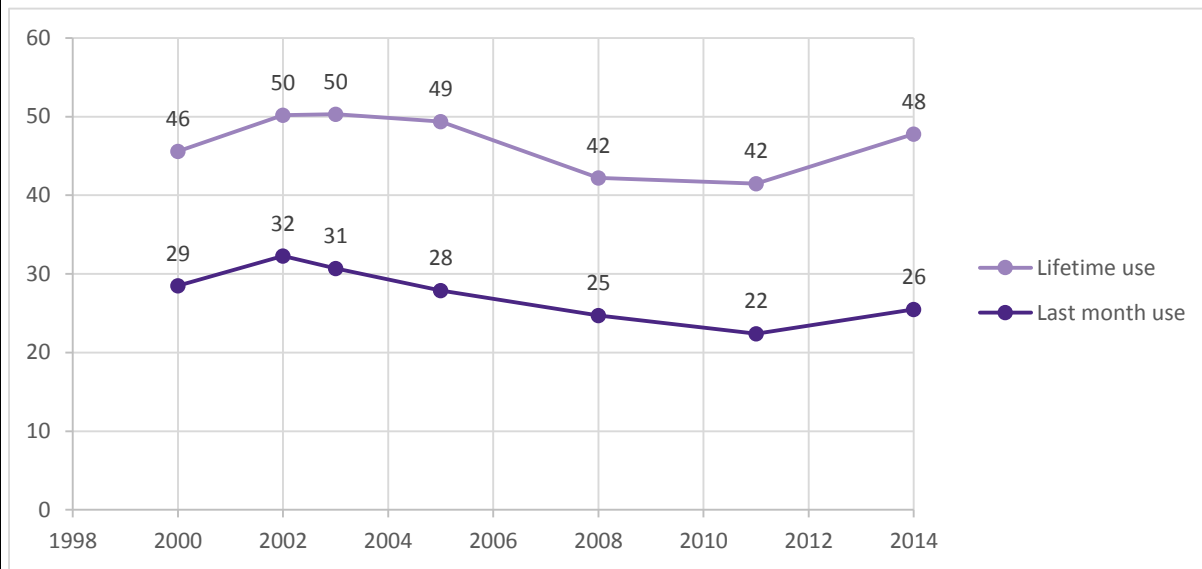
Cannabis is still by far the most widely used illicit substance in France. In 2014, 41% of adults aged 15 to 64 years are estimated to have tried it during their lifetime. More men than women had engaged in lifetime use (49% compared with 33%). Last year use (current use) concerns 11% of 15 to 64 year-olds (15% of males and 7% of females), whereas the overall proportion of recent users (in the last month) is 7% (Beck *et al.* 2015a).

Lifetime cannabis use peaks between age 25 and 34 years (59%) in men (69%) and women (49%). Current cannabis use mainly affects younger age groups (27% for 15 to 24 year-olds, 31% of boys and 23% of girls), and then decreases with age to only 2% of 55 to 64 year-olds. 19% and 13% of males and females, respectively, aged 15 to 24 are recent cannabis users.

Out of all 15 to 64 year-olds, lifetime cannabis use increased from 32% to 41% between 2010 and 2014, more markedly prolonging the trend observed since the 1990s. This rise is mainly driven by a stock effect; however, current use has also shown a significant increase, from 8.4% to 11%, like recent use (from 4.6% to 6.6%), this being observed for all age groups. Among women, this rise is mainly driven by the population aged under 40 years, whereas, among man, it distinctly remains between 35- and 55-year-olds.

In 2014, 48% of 17-year olds have tried cannabis (Spilka *et al.* 2015) with an increase over the 2011-2014 period, as for recent use (see Figure I). Boys appear to use more cannabis than girls. They are 29% to report use in the last 30 days compared to 22% of girls.

**Figure I: Lifetime and last month use (recent use) of cannabis among 17 year-olds from 2000 to 2014**



Source: ESCAPAD

**T1.1.2 Schools and other sub-populations.** Please comment on prevalence and trends of cannabis use in school populations and any other important populations where data is available. Focus on life time prevalence estimates and any important demographic breakdowns where available (e.g gender). Include any contextual information important in interpreting trends.

### **Cannabis use in schools and other sub-populations**

The results of the latest HBSC and ESPAD surveys (both conducted in school settings) are consistent with the ESCAPAD survey in terms of the particular use of cannabis among young people in France. Cannabis stands out as the illicit substance most widely used between the ages of 11 and 16 years, particularly among boys. In terms of lifetime cannabis use, in the 2010 HBSC survey, 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 (Spilka *et al.* 2012).

In 2011, almost two out of five young people (39%) born in 1995 (aged 16) have used cannabis at least once during their lifetime (Hibell *et al.* 2012). This represents an increase compared with the 2007 ESPAD survey (30%).

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%, in 2006, non-significant change). Cannabis is used by 24% of 16 year-olds representing a significant increase compared with 2007 (15%).

**T1.1.3 Optional.** Looking across the information available on cannabis in your country, please provide an overall commentary on the data, focusing on the consistency of trends between data sources (Suggested title: Commentary on Cannabis Use.)

## T1.2 Patterns, treatment and problem/high risk use

Please structure your answers around the following question.

**T1.2.1 Optional.** Please provide a summary of any important surveys/studies reporting on patterns of cannabis use or cannabis use in specific settings. Information relevant to this answer may include, types of product, perceived risk and availability, mode of administration (including mixing with tobacco and use of paraphernalia).

### Recent surveys/studies on cannabis use

The vast majority of the public received in Youth Addiction Outpatient Clinics (CJC) came for psychoactive use (95%) and for 80% of the outpatients, the substance motivating attendance was cannabis alone (Obradovic 2015). Reasons for use largely stated by these users were focused on "the search for pleasure and conviviality" (60%) and even more so among young outpatients with an occasional use. The "pleasure" motivation very often comes with one or several other reasons. This reason is much less common, however, among daily users, who report twice as often other self-therapeutic reasons, which are smoking cannabis to "control anxiety and stress" or "better sleep" (nearly 60% of them). These self-therapeutic intentions are also over-represented in women. Reasons for use appear well correlated to age, sex, frequency of use but also to intensity of consumption: 45% of self-therapeutic uses are associated with the consumption of at least 5 joints a typical day of consumption (against 31% of use motivated by search of conviviality).

T 1.2.2 Please comment on demand reduction activities specific to cannabis use.

Please structure your response around

1. Treatment and help seeking (core data TDI - cross-reference with the Treatment workbook)
2. Availability of specific treatment or harm-reduction programmes targeting Cannabis users (cross-reference with the Treatment workbook)
3. **Optional.** Any other demand reduction activities (prevention or other) specific for Cannabis users (cross-reference with the Prevention workbook)

### Treatment and help seeking

See T1.3 and T2 in Treatment workbook.

### Availability of specific treatment or harm-reduction programmes targeting cannabis users

See T1.4.1 in Treatment workbook and T1.2.4 in Prevention workbook

Despite not being specialised in cannabis use, Youth Addiction Outpatient Clinics (CJC) in fact provide counselling for predominantly cannabis users (Obradovic 2015), given the recruitment of these facilities, geared towards teenagers and young adults. The 2014 survey conducted in the CJC estimated the number of young cannabis users admitted to these facilities at 18,000.

**T1.2.3 Optional.** Please comment on information available on dependent/problem/high risk cannabis use and health problems as well as harms related to cannabis use.

Information relevant to this answer includes:

- accident and emergency room attendance, helplines
- studies and other data, e.g. road side testing
- studies/estimates of dependent/intensive or problem/high risk use

### High-risk cannabis use

The Cannabis Abuse Screening Test (CAST) is a scale used to screen 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)<sup>1</sup> (Legleye *et al.* 2015). Conducted for the first time in 2002 as part of the ESCAPAD survey (Beck and Legleye 2008), its current version was first adopted in 2006 (Legleye *et al.* 2007). The time scale adopted is that of the year preceding the survey.

In 2014, 38.2% of 17 year-olds used cannabis in the last year, 41.1% among boys and 35.3% among girls. Among these last year users (n=9,311), 8,544 (92.0%) completed the CAST (Spilka *et al.* 2015). One in four boys who smoked cannabis in the last year is at high risk of problem use or cannabis addiction (25.7% vs. 17.3% for girls). In total, 21.9% of young last year cannabis users are at high-risk of problem use, i.e. a prevalence of 8.4% in the surveyed population of 17 year-olds. This proportion seems to be on the rise compared to 2011 when 17.8% of last year users were at high risk (22.8% for boys vs. 12.8% for girls).

Although the number of current users among 14-18 year olds has risen, the proportion of those at high risk of problem cannabis use seems stable, at 21% between 2010 and 2014, which represents 2.2% of 18 to 64 year-olds in 2014 (Beck *et al.* 2015a).

The potential health impact of the rise in the purity of cannabis circulating in France (see T1.1.5 in Drug market and crime workbook) has not been well documented yet. However in 2013, the TREND scheme reported on cases of cannabis psychosis. Also, approximately 30 deaths related to acute cardiovascular toxicity due to cannabis were reported in 2013 (ANSM 2015).

<sup>1</sup> 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.

*T1.2.4 Optional. Please comment on any information available on the use, consequences of use, and demand reduction related to synthetic cannabinoids. Where appropriate, please provide references or links to original sources or studies*

### Synthetic cannabinoids

In the general adult population, in the 2014 INPES Health Barometer Survey, 1.7% of 18-64 year-olds claimed to have already smoked a synthetic cannabinoid. It represents 4% of lifetime cannabis users and 17% of current cannabis users. This level of use is similar to that observed for heroin or amphetamines. Lifetime users of synthetic cannabinoids are predominantly men (2.3% vs. 1.2% of women), aged under 35 (4.0% of 18-34 year-olds vs. 0.6% of 35-64 year-olds). More than one in two (53%) have already experimented with at least one illegal substance other than cannabis and one in three (34%) have used at least two such substances (Beck *et al.* 2015a).

Among 17 year-olds, interviewed as part of the 2014 ESCAPAD survey, 1.7% claimed to have already used a substance which "imitates the effects of a drug, such as synthetic cannabis, mephedrone, methoxetamine or another substance". Only 0.7% specified the substance involved, mainly a synthetic cannabinoid, usually referring to a brand name rather than the name of a molecule (Spilka *et al.* 2015).

As for the other NPS, the wide variety of products, due to a very dynamic supply market, does not necessarily translate into the observed levels of use. Out of the 607 individuals interviewed as part of the I-TREND online survey, 61% claimed to have used one or more NPS. Of these, 9% stated that the last substance used was a synthetic cannabinoid. This figure is very close to the percentages observed for cathinones and arylcyclohexylamines (approximately 10% each), and considerably below phenethylamines (28%). Furthermore, 76% of NSP users also used cannabis in the last 30 days.

The research carried out in the context of the I-TREND project shows that out of the 902 Internet discussions studied, 50 concern synthetic cannabinoids. These are split between 16 substances. 5F-AKB-48 in the e-liquid form is the cannabinoid most discussed on forums with 650 to 700 views per day between July 2014 and January 2015 (the most active period). The e-liquid form is equivalent to the cartridges used for e-cigarettes, which then become “e-joints”. Over the first few months of 2015, there was a marked increase in discussions relating to MBMD-CHMICA, AB-FUBINACA and 5F-PB-22.

Furthermore, and according to several sources (SINTES, poison control and toxicovigilance centres, etc.) synthetic cannabinoids are seen predominantly in a “commercial” form (ie presented in a non-powder form such as cannabis resin, herbal cannabis, capsule and e-liquid). Users thus have a substance which is “ready to use”, which implies that, unlike a powder, the constituent molecule(s) and dosage strength are unknown. This may indicate diffusion of synthetic cannabinoids to a population less familiar with NPS.

Out of the 5 analyses conducted as part of the SINTES scheme in 2014, two included JWH-122 5 Fluoropentyl (cannabis resin and herbal cannabis), another 5F-AKB-48 (in e-liquid form) and the last two JWH-073 and 081 (herbal cannabis form).

All known health incidents must be validated by the health authorities responsible for reporting:

- A health incident involving the intoxication of 8 individuals and the arrest of the drug dealer occurred at the beginning of 2015. Analyses on the substances, in the form of plant debris, identified AB-FUBINACA and MDMB-CHMICA. These molecules have been identified in several acute intoxications or deaths in European countries.
- Aside from this specific case, 7 health incidents (3 *via* the SINTES scheme and 4 *via* poison control and toxicovigilance centres (Le Roux *et al.* 2015)), including one death, were reported to the OFDT. In one case, the substance used was also 5F-AKB-48 in herbal cannabis form.

Health care (acute intoxication) would rather seem to concern NPS polydrug users, whether synthetic cannabinoids alone or with other substances, and prescription drug users.

## **T2. Trends. Not relevant in this section. Included above.**

## **T3. New developments**

The purpose of this section is to provide information on any notable or topical developments observed in Cannabis use and availability 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 question.

T3.1 Please report on any notable new or topical developments observed in Cannabis use and cannabis related problems in your country since your last report.  
(Suggested title: New Developments in the Use of Cannabis.)

#### **New developments in the use of cannabis**

An increasing prevalence can be observed for last month use (recent use) of cannabis among 17 year-olds (25.5% in 2014 *versus* 22% in 2011). Among 15-64 year-olds, lifetime cannabis use has increased (driven by a stock effect), markedly prolonging the trend observed since the 1990s. Current use (last year use) has also increased significantly, from 8.4% to 11%, like recent use (from 4.6% to 6.6%), irrespective of age group (Beck *et al.* 2015a).

This rise falls within the context of a marked increase in cannabis supply in France (Cadet-Tairou *et al.* 2014b): home cultivation and local herbal cannabis production advance and at the same time, the cannabis resin market is still very dynamic (with a high level of seizures) This change is related to the average potency of cannabis resin that has tripled in ten years to reach 20.7%, whereas the potency of herbal cannabis is now 13%, the highest in 15 years.

## **T4. Additional information**

The purpose of this section is to provide additional information important to Cannabis use and availability in your country that has not been provided elsewhere.

Please structure your answers around the following questions.

T.4.1 **Optional.** Please describe any additional important sources of information, specific studies or data on Cannabis use. Where possible, please provide references and/or links.  
(Suggested title: Additional Sources of Information.)

T.4.2 **Optional.** Please describe any other important aspect of Cannabis use that has not been covered in the specific questions above. This may be additional information or new areas of specific importance for your country.  
(Suggested title: Further Aspects of Cannabis Use.)

## **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.

No current question.



## 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.

T.6.1 Please list notable sources for the information provided above.

### Sources

2010 and 2014 INPES Health Barometer Survey (adults)  
2011 and 2014 ESCAPAD surveys (young people)  
2007 and 2011 ESPAD surveys  
2006 and 2010 HBSC surveys  
CJC 2014 survey: survey in Youth Addiction Outpatient Clinics  
SINTES scheme: National Detection System of Drugs and Toxic Substances  
I-TREND project / Forum monitoring scheme (TREND)  
TREND scheme: Emerging Trends and New Drugs  
Seizures and checks performed on postal freight or during police cases

T.6.2 Where studies or surveys have been used please list them and where appropriate describe the methodology?

### Methodology

#### 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 15,700 individuals aged 15 to 75 years took part in the 2010 edition. Conducted from December 2013 to May 2014, this survey was the most recent in a series of six, entitled "Adult health barometers", conducted in 1992, 1993, 1995, 2000, 2005 and 2010. 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.

#### ESCAPAD: Survey on Health and Use on National Defence and Citizenship Day

*French Monitoring Centre for Drugs and Drug Addiction (OFDT) and the National Service Directorate 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 2014, 26,351 individuals were surveyed in national armed services centres in mainland France and in overseas French departments during a week in March. 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 / 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.

**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.

**CJC 2014 survey: Survey in Youth Addiction Outpatient Clinics**

*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

2014 is the third year (after 2005 and 2007) of the survey on clients of youth addiction outpatient clinics (CJC), a scheme created in 2005 to offer counselling for young psychoactive substance users. The 2014 survey is based on the responses by professionals having seen the patients or their families between 24 March and 30 June 2014. It covers mainland France and French overseas departments. Out of 260 facilities managing a CJC activity in mainland France and the DOM recorded in 2014, 212 responded to the survey, i.e., a response rate of 82%.

The questionnaire comprises four parts: circumstances and reasons for consulting, user sociodemographic characteristics, substances used and evaluation of cannabis dependence by the Cannabis Abuse Screening Test, and decision made at the end of the appointment. Out of the 5,421 questionnaires collected, corresponding to the number of appointments held during the survey period, 5,407 were considered fit to describe consulting activity. After eliminating questionnaires not stating gender or age, the final user base included 4,958 individuals.



## **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 one of the 4 forensic laboratories working in partnership with OFDT.
- 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.

## **I-TREND project**

*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

<http://www.i-trend.eu/>

The I-TREND project comprises 5 interlinked activities. The focus of the project is to draw up a list of substances, known as the "top list", which is documented via all of the activities. Three activities are partly presented herein:

- Analysis of online discussions and quantitative monitoring of the number of views per discussion.

Three French-speaking forums were selected for the I-TREND project. All discussions on NPS, created or updated after 1 January 2013 were included. A monthly record of the number of views was compiled. Discussions on the most widely discussed substances were selected for a qualitative analysis.

- Internet purchases of substances.

The "top list" was used according to the snapshot methodology: the names of the substances associated with the term "buy" generated search queries. All online sales sites appearing in the first 100 results were recorded. Those shown to be the most popular based on several pre-defined criteria were selected for use as test sites for purchasing substances in the "top list" and for analysis in terms of marketing strategy.

- I-TREND online survey.

The survey conducted as part of the I-TREND project aimed to collect information on the profiles and purchasing habits of NPS users. It does not aim to be representative and it is possible that its promotional strategy led to a recruitment mainly based on informed NPS user population.

### **TREND scheme: 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

### **Seizures and checks performed on postal freight or during police cases**

Six-monthly progress report drawn up by the (French) National Forensic Science Institute (INPS) and the Joint Laboratories Department (SCL) with the OFDT for EWS-REITOX.

Two points should be taken into consideration when interpreting these figures:

- Seizures or checks on postal freight do not mean that the parcels were destined for France.
- These figures represent partial visibility of the circuit, rather than trafficking.

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## SECTION B. STIMULANTS

### T1. National profile

#### T1.1 Prevalence and trends

The purpose of this section is to

- Provide an overview of the use of stimulant drugs within your country.
- Provide an indication of the relative importance of the different stimulant drugs within your country.
- Synthetic cathinones are included here due to their close link with the traditional stimulants.
- Provide a commentary on the numerical data submitted through ST1, ST2, ST30 and, if relevant, ST7

**Note:** Please focus on the stimulant drug(s) which are more prevalent in your country.

Please structure your answers around the following questions.

T1.1.1 Relative availability and use. Different stimulant drugs are important in individual countries. Please comment, based on supply reduction data, research and survey information, on the relative availability and use of stimulant drugs within your country (e.g. amphetamine, methamphetamine, cocaine, ecstasy, synthetic cathinones)

#### **The relative importance of different stimulant drugs**

In 2014, cocaine is still the most commonly used illicit stimulant drug among 18-64 year-olds, with 5.4% lifetime users, indicating diffusion of the substance to all population categories in recent years. MDMA/ecstasy is the second most common stimulant with a lifetime prevalence of 4.2%, ahead of amphetamines (2.2%).

Last year use concerns considerably fewer individuals, with 1.1% for cocaine, 0.9% for MDMA/ecstasy (although only 0.3% in 2010, in 2014 it reached its highest level for a decade) and 0.3% for amphetamines. Of people aged 18-to-64, 0.6% tried crack (freebase cocaine) within their life in 2014 and 0.1% have used it in the last year (Beck *et al.* 2015b). These uses are mainly located in Paris and the French Antilles.

MDMA/ecstasy (in its powder or crystal form or as tablets) is sought for in the party scene and by relatively young people. The diversity of cocaine users is larger, with extremely contrasting social profiles. In a context of economic impoverishment, amphetamine use can be an alternative to cocaine deemed too expensive by some consumers.

For the following questions, include the stimulant drugs that are important for your country.

T1.1.2 General population. Please comment on the prevalence and trends of stimulant use in the general population.

Focus on last year and last month prevalence and any important demographic breakdowns where available (e.g. young adults 15-34, gender). Include any contextual information important in interpreting trends.

### Stimulant use in the general population

In 2014, cocaine is still the most commonly used illicit stimulant drug among 18-64 year-olds, with 5.4% lifetime users, ahead of MDMA/ecstasy (4.2%) and amphetamines (2.2%). Last year use concerns considerably fewer individuals, with 1.1% for cocaine, 0.9% for MDMA/ecstasy and 0.3% for amphetamines (Beck *et al.* 2015a).

Levels of lifetime use of these substances are continuously growing among the adult population due to a stock phenomenon and to the diffusion of these substances outside of specific populations (attending the party scene in particular). Although last year use for cocaine remained stable between 2010 and 2014, this tripled for MDMA/ecstasy over the same period, from 0.3% to 0.9%.

Stimulant use is higher among 15-34 year-olds, than among over 35 year-olds, with 2.4% last year use for cocaine, 2.3% for MDMA/ecstasy and 0.7% for amphetamines. Men have been shown to be users more frequently than women, irrespective of substance. Hence, among 15-64 year-olds, 1.5% of men report last year use for cocaine and 1.2% for MDMA/ecstasy, compared to 0.7% and 0.6%, respectively, among women.

It is estimated that among 17 year-olds, MDMA/ecstasy is the stimulant with the highest levels of lifetime use (3.8%), ahead of cocaine (3.2%) and amphetamines (2.8%). This strong increase in MDMA/ecstasy lifetime use reflects the trends in the adult population. Furthermore, boys have higher levels of lifetime use for amphetamines and MDMA/ecstasy than girls (Spilka *et al.* 2015).

T1.1.3 Schools and other sub-populations. Please comment on prevalence and trends of stimulant use in school populations and any other important populations where data is available. For schools data focus on life time prevalence estimates and any important demographic breakdowns where available (e.g. gender). Include any contextual information important in interpreting trends

### Stimulant use in schools and other sub-populations

In 2012, 51% of CAARUD (low-threshold structures) clients reported stimulants use in the month prior to the survey and 44% reported cocaine use. Among them, 6 out of 10 use also or only cocaine in base form (crack or freebase). Freebase cocaine use increased since the 2008 survey. Amphetamine recent use among CAARUD clients is 8% (a significant rise) and MDMA/ecstasy use is stable at 12% (Cadet-Taïrou *et al.* 2015).

*T1.1.4 Optional. Looking across the information available on stimulants in your country, please provide an overall commentary on the data, focusing on the consistency of trends between data sources. (Suggested title: Commentary on Stimulant Use.)*

*T.1.1.5 Optional. Please comment on any associations or interactions in use and trends in specific stimulants. (Suggested title: Interactions in the Use of Different Stimulants.)*

## T1.2 Patterns, treatment and problem/high risk use

Please structure your answers around the following question.

T1.2.1 Injecting. Please comment on rates and trends in injecting and smoking as routes of administration. (cross-reference with Harms and Harm reduction workbook).

### Injecting and other routes of administration

Among CAARUD clients having used cocaine in the month prior to the 2012 ENa-CAARUD survey, 53% used injection; these represent 33% among recent amphetamine users and 22% among MDMA/ecstasy users (Cadet-Taïrou *et al.* 2015).

Also about cocaine, the TREND scheme report of a shift from snorting to injecting in semi-integrated cocaine users in a more fragile economic situation.

According to the TREND scheme, MDMA/ecstasy in powder or crystal form is mainly ingested "*en parachute*" (rolled in a sheet of cigarette rolling paper and then swallowed) in repeated doses throughout an evening or mixed with drinks. Some snort it despite the irritation it can cause to the nasal mucosa. There has also been an observed rise in the inhalation of the vapours produced by heating MDMA ("chasing the dragon") (Cadet-Taïrou *et al.* 2014c).

T1.2.2 Infectious diseases. Please comment on rates and trends in infectious diseases among stimulant users (cross-reference with Harms and Harm reduction workbook). (Suggested title: Infectious Diseases.)

T1.2.3 **Optional.** *Patterns of use. Please provide a summary of any available information (surveys, studies, routine data collection) reporting on patterns of stimulant use, stimulant use in specific settings, and the most common patterns of stimulant use with other drugs, i.e. polydrug use.* (Suggested title: Patterns of Use.)

T 1.2.4 Treatment. Please comment on the treatment and help seeking of stimulant users  
Please structure your response around

1. Treatment and help seeking (core data TDI - cross-reference with the Treatment workbook)
2. Availability of specific treatment or harm-reduction programmes targeting stimulant users (cross-reference with the Treatment workbook)
3. **Optional.** *Any other demand reduction activities (prevention or other) specific for stimulant users (cross-reference with the Prevention workbook)*

(Suggested title: Treatment for Stimulants.)

### Treatment and help seeking

See T1.3 and T2 in Treatment workbook.

### Availability of specific treatment or harm-reduction programmes targeting stimulant users

There are no national "programmes" exclusively or specifically targeting stimulant users in France.

**T1.2.5 Optional.** *Problem/high risk use. Please comment on information available on dependent/problem/high risk stimulant use and health problems as well as harms related to stimulant use. Information relevant to this answer includes:*

- accident and emergency room attendance, helplines
- studies and other data, e.g. road side testing
- studies/estimates of dependent/intensive or problem/high risk use

(Suggested title: High Risk Stimulant Use.)

**T1.2.6 Optional.** *Please comment on any information available on the use, consequences of use, and demand reduction related to synthetic cathinones. Where appropriate, please provide references or links to original sources or studies*

### **Synthetic Cathinones**

No data based on general population surveys are available on cathinone use and their wide variety and very dynamic supply market, does not necessarily translate into the observed levels of use. Among the 607 individuals taking part in the I-TREND online survey, 61% claimed to have already used one or more NPS, and 11% stated that the last substance used was a cathinone. Over the last 12 months, 20% claimed to have taken 4-MMC, 17% methylone, 12% 4-MEC, 9% 3-MMC and 6% MDPV.

The research carried out in the context of the I-TREND project shows that out of the 902 Internet discussions monitored, 106 focus on cathinones by name. As far as generating discussion is concerned, this category ranks number 2 after phenethylamines. These are split between 16 substances. 3-MMC is by far the most widely discussed and, in particular, the most viewed molecule (750 views per day on average). In contrast to other countries, activity surrounding mephedrone is very low (50 views per day on average). The 3 most frequently monitored cathinones other than 3-MMC are 4-MEC, Bk-2C-B and MDPV (60 to 115 views per day on average). MDPV is primarily discussed concerning its negative effects, but still has a high audience.

In 2014, the number of health reports and data collection continued to increase, with greater visibility, as it was the case for synthetic cannabinoids.

Out of the 21 analyses performed as part of the SINTES scheme in 2014, ten involved 3-MMC (one of which was sold under the brand name "Topaz"), four concerned 4-MEC (one of which was mixed with pentedrone under the name "*la Bleue*" or "4-P"), three pertained to molecules similar to pyrovalerone (1 alpha-PBP and 2 alpha-PVP) and two involved methylone (including one hospital admission). In 2015, only four data collection campaigns were analysed.

Seven reports were notified to the OFDT in 2014 and early 2015 (including 3 deaths): five concerned 4-MEC (in combination with several other substances), one identified 4-MMC (detected during a road accident), and the last involved Bk-2C-B.

Regarding the consumption of cathinones, two specific at risk-subgroups (polydrug NSP users and prescription drug users) were identified. Today, within these specific populations,

new users are discovering cathinones reflecting the gradual spread of these substances in these subgroups:

- People partaking in sexual practices related to substance use. Known as a "slammer" for those who inject, this user profile has been identified several years ago (see national reports for previous years); however, several deaths related to this practice were reported to the OFDT by the police departments in 2014-2015. This increase might be linked to the diffusion of cathinones in a sexual context and/or to a poor harm reduction culture among this population.

- Polydrug users receiving medicinal treatment, possibly indicating a psychiatric problem. This profile corresponds to a relatively well-integrated population (in the sense that these individuals do not live on the street and benefit from a stable environment). They do not necessarily attend healthcare facilities, but have access to primary care. This trend is also observed in reports related to synthetic cannabinoid and NPS users in general. However it is impossible to quantify these subgroups.

## **T2. Trends. Not relevant in this section. Included above**

## **T3. New developments**

The purpose of this section is to provide information on any notable or topical developments observed in stimulants use and availability 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 question.

T3.1 Please report on any notable new developments observed in stimulant use and related problems in your country since your last report.

### **New developments in the use of stimulants**

Levels of lifetime use of stimulants are continuously growing among the adult population due to a stock phenomenon and to the diffusion of these substances outside of specific populations. Although last year use for cocaine remained stable between 2010 and 2014, it tripled for MDMA/ecstasy over the same period, from 0.3% to 0.9% (Beck *et al.* 2015a). It is its highest level among 18-25 year olds (3.8%).

This new cycle of widespread MDMA/ecstasy use is seen less among older generations of party goers and more among new party going generations. In younger users it is very frequently accompanied by a total underestimation of the risks related to use. MDMA/ecstasy almost never has the image of a drug. This is cause for worry in a context where the number of potential lifetime users is widening due to the distribution of the techno party scene (Cadet-Taïrou *et al.* 2014c).

## T4. Additional information

The purpose of this section is to provide additional information important to stimulants use in your country that has not been provided elsewhere.

Please structure your answers around the following questions.

**T4.1 Optional.** Please describe any additional important sources of information, specific studies or data on stimulants use. Where possible, please provide references and/or links.  
(Suggested title: Additional Sources of Information.)

**T4.2 Optional.** Please describe any other important aspect of stimulants use that has not been covered in the specific questions above. This may be additional information or new areas of specific importance for your country.

(Suggested title: Further Aspects of Stimulant Use.)

## 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.

No current question.

## 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.

**T.6.1** Please list notable sources for the information provided above.

### Sources

2010 and 2014 INPES Health Barometer Survey (adults)  
2011 and 2014 ESCAPAD surveys (young people)  
2007 and 2011 ESPAD surveys  
2006 and 2010 HBSC surveys  
TREND scheme: Emerging Trends and New Drugs  
SINTES scheme: National Detection System of Drugs and Toxic Substances  
I-TREND project/Forum monitoring scheme (TREND)  
ENa-CAARUD survey

**T.6.2** Where studies or surveys have been used please list them and where appropriate describe the methodology?



## **Methodology**

### **Health Barometer**

*French National Institute for Prevention and Health Education (INPES)*

See T6.2 in Cannabis section

### **ESCAPAD: Survey on Health and Use on National Defence and Citizenship Day**

*French Monitoring Centre for Drugs and Drug Addiction (OFDT) and the National Service Directorate of the Ministry of Defence*

See T6.2 in Cannabis section

### **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 / General secretariat of Catholic Education / INSERM U669 / INPES*

See T6.2 in Cannabis section

### **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 National Institute for Prevention and Health Education (INPES)*

See T6.2 in Cannabis section

### **TREND scheme: Emerging Trends and New Drugs**

*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

See T6.2 in Cannabis section

### **SINTES: National Detection System of Drugs and Toxic Substances**

*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

See T6.2 in Cannabis section

### **I-TREND Project**

*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

See T6.2 in Cannabis section

### **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 in 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.

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## SECTION C. HEROIN AND OTHER OPIOIDS

### T1. National profile

#### T1.1 Prevalence and trends

The purpose of this section is to

- Provide an overview of the use of opioids within your country
- Provide a commentary on the numerical data submitted through ST7, TDI, ST24.

Please structure your answers around the following questions.

**T1.1.1 Relative availability and use.** Different opioids are important in individual countries. Please comment, based on supply reduction data, research and available estimates, on the relative availability and use of heroin as opposed to other opioids within your country.

##### **The relative importance of different opioid drugs**

In 2014, among the general population aged 18 to 64, heroin use was relatively limited, with 1.5% lifetime use and 0.1% last year use, stable between 2010 and 2014. Young adults aged 15-34 more frequently tend to be users, with 0.3% last year users. No difference is observed between men and women (Beck *et al.* 2015a).

Heroin is more available than in the beginning of the 2010s and its average purity tends to increase.

Regarding opiate medications, the majority of patients used buprenorphine for therapeutic purposes, although a small proportion misused it for their own use or dealt it like an illicit drug. The methadone syrup form has been misused as an occasional “spare supply” between users helping each other out. The capsule form is also used for these purposes.

Also, the fairly low or even non-existent average purity of heroin circulating in France, from 2011 through part of 2013, clearly stimulated misuse of morphine sulphate (Cadet-Taïrou and Gandilhon 2014a).

**T1.1.2 Indirect estimates.** Please comment on estimates of prevalence and trends of heroin and other opioid use from studies using indirect methods (e.g. multiplier methods, capture-recapture). Where possible, comment on any important demographic information (e.g. age, gender). Include any contextual information important in interpreting trends.

##### **Estimates of opioid use**

In 2013, it was estimated that the number of problem users reached 279,000 individuals – (95% CI: 201,000-400,000), i.e. a prevalence of 0.69% of 15-64 year-olds (0.49%-0.98%). This estimate is higher than that obtained by the police multiplier method using police data in 2011 (222,000 individuals) and lower than the estimate based on treatment data (299,000). Most of problem users were opioid users, i.e. 220,000 individuals (95% CI: 185,000-320,000), with a prevalence of 0.54% (0.45%-0.79%), including 130,000 heroin users (95% CI: 90,000-196,000), i.e. a prevalence of 0.33 (0.22%-0.49%). The large confidence intervals indicate the uncertainty inherent in the data collection instruments together with the statistical methods applied.

The estimate of the number of heroin users should be placed in perspective with data on opioid substitution treatment (OST) provided by the Social Security: in 2011, 160,000 people were reimbursed for OST. Concomitant heroin and OST use in the last month is a common practice affecting two-thirds of patients, according to TDI data.

*T1.1.3 **Optional.** Looking across the information available on heroin and other opioids in your country, please provide an overall commentary on the data, focusing on the consistency of trends between data sources.*

(Suggested title: Commentary on Opioid Use.)

The TREND scheme acknowledged the marked expansion of morphine sulphate demand and use, outside of the strict therapeutic setting. Primarily in the centre and south of France, this trend seems to be a "response" by active drug users to the degradation in the quality of heroin observed until 2013 (Cadet-Taïrou *et al.* 2014c).

## **T1.2 Patterns, treatment and problem/high risk use**

Please structure your answers around the following question.

**T1.2.1 Injecting.** Please comment on rates and trends in injecting among heroin and other opioid users (cross-reference with Harms and Harm reduction workbook).

### **Injecting and other routes of administration**

Among CAARUD clients having used heroin in the month prior to the 2012 ENa-CAARUD survey, 51% reported injection. The proportion of those having injected was 84% among recent sulphate morphine users and 54% among buprenorphine users (Cadet-Taïrou *et al.* 2015). Recent methadone and codeine users predominantly (more than 95%) favoured the oral route.

**T1.2.2 Infectious diseases.** Please comment on rates and trends in infectious diseases among heroin and other opioid users (cross-reference with Harms and Harm reduction workbook). (Suggested title: Infectious Diseases.)

### **Infectious Diseases**

See T1.3.1 in Harms and harm reduction workbook.

*T1.2.3 **Optional.** Patterns of use. Please provide a summary of any available information (surveys, studies of sub-populations such as arrestees, and settings such as harm reduction facilities, cohort studies and routine data collection) reporting on patterns of opioid use, opioid use in specific settings, and the most common patterns of opioid use with other drugs, i.e. polydrug use.*

(Suggested title: Patterns of Use.)

T 1.2.4 Treatment. Please comment on the treatment and help seeking of heroin and other opioid users. Please structure your response around

1. Treatment and help seeking (core data TDI - cross-reference with the Treatment workbook)
2. Availability of specific treatment or harm-reduction programmes targeting heroin and other opioid users (cross-reference with the Treatment workbook)

3. **Optional.** Any other demand reduction activities (prevention or other) specific for heroin and other opioid users (cross-reference with the Prevention workbook)

(Suggested title: Treatment for Heroin and Other Opioids.)

### **Treatment and help seeking**

See T1.3 and T2 in Treatment workbook

### **Availability of specific treatment or harm-reduction programmes targeting heroin and other opioid users**

Apart from buprenorphine and methadone prescription treatments, there are no national "programmes" exclusively or specifically targeting opioid users in France. However, in France, national treatment and prevention centres for addiction (CSAPA) and harm reduction centres (CAARUD) are mainly structured around the problems inherent in treating heroin and opioid users who originally represented the vast majority of users seeking assistance at these centres.

## **T2. Trends. Not relevant in this section. Included above.**

## **T3. New developments**

The purpose of this section is to provide information on any notable or topical developments observed in the use and availability of heroin and other opioids 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 question.

T3.1 Please report on any notable new or topical developments observed in opioids use in your country since your last report, including any information on harms and health problems. (Suggested title: New Developments in the Use of Heroin and Other Opioids.)

No new developments.

## T4. Additional information

The purpose of this section is to provide additional information important to the use and availability of heroin and other opioids in your country that has not been provided elsewhere.

Please structure your answers around the following questions.

**T4.1 Optional.** Please describe any additional important sources of information, specific studies or data on opioids use. Where possible, please provide references and/or links.  
(Suggested title: Additional Sources of Information.)

**T.4.2 Optional.** Please describe any other important aspect of opioids use that has not been covered in the specific questions above. This may be additional information or new areas of specific importance for your country.  
(Suggested title: Further Aspects of Heroin and Opioid Use.)

## 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.

No current question

## 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

2010 and 2014 INPES Health Barometer Survey  
ENa-CAARUD survey  
TREND scheme: Emerging Trends and New Drugs  
Estimate of the number of problem drug users

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

### Methodology

#### Health Barometer

French National Institute for Prevention and Health Education (INPES)  
See T6.2 in Cannabis section.

**ENa-CAARUD: National survey of low-threshold structures (CAARUDs)**

*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

See T6.2 in Stimulants section.

**TREND scheme: Emerging Trends and New Drugs**

*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

See T6.2 in Cannabis section

**Estimate of the number of problem drug users**

*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

The number of problem drug users was estimated by applying a capture-recapture method with a unique information source. It is based on data collected by the common data collection or compendium on addictions and treatments (RECAP) as part of the key indicator for treatment demand indicators (TDI), a method advocated by the EMCDDA.

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## SECTION D. NEW PSYCHOACTIVE SUBSTANCES (NPS) AND OTHER DRUGS NOT COVERED ABOVE

### T1. New Psychoactive Substances (NPS), other new or novel drugs, and less common drugs

The purpose of this section is to:

- Provide an opportunity to report on new psychoactive substances, other new or novel drugs or and drugs which are important for your country, but are not covered elsewhere.
- Other new or novel drugs and less common drugs are included here to allow reporting on drugs beyond a strict definition of NPS. These drugs may be new or important to your country, but not covered elsewhere.
- Synthetic Cannabinoids are reported with Cannabis. Synthetic Cathinones are reported with Stimulants.

*T1.1.1 **Optional.** Please comment on any supply or demand side data that provides information on the availability, prevalence and/or trends in NPS use in your country. Where possible please refer to individual substances or classes of substance.*

#### **Prevalence and trends in NPS use**

According to the TREND scheme, ketamine is increasingly visible on both the alternative party scene and in urban settings (marginalised users), due to the improved image of a substance that elicits less and less fear. All substances similar to ketamine (such as methoxetamine), continue to show signs of diffusion. It may be a substance sold as "substitute" or a NPS sold under its real name (Cadet-Taïrou *et al.* 2014c).

An increasingly significant proportion of type 25-x-NBOMe phenethylamines is observed and other substances with psychedelic effects (indolalkylamines and arylalkylamines) are extending too. Several reports (including one death) related to these latter types of substances were recorded in 2013-2014.

In French Polynesia, the seizure of several arylalkylamines (5 and 6 APB and MAPB) lead to their classification as poisonous substances [[Arrêté n°428 CM du 16 avril 2015 portant modification de l'arrêté n°626 CM du 14 avril 2014 fixant la liste des substances vénéneuses destinées à la médecine et les listes des exonérations au classement des substances vénéneuses en médecine humaine et vétérinaire](#)], a provision which is not applicable in mainland France. The availability of these substances is increasing on the drug market and especially among groups attending alternative party scene events.

Ethylphenidate, discussed in specialist forums since late 2011, has only become visible more recently via other monitoring sources. The National Narcotics and Psychotropic Substances Commission stated that "*four spontaneous reports were recorded in France in 2013 and 2014, including one case of death. [...] Ethylphenidate was present in three cases [...]*", leading to classification thereof by the decree of 17 March 2015 [[Arrêté modifiant l'arrêté du 22 février 1990 fixant la liste des substances classées comme stupéfiants](#)] (ANSM 2014).

**T1.1.2 Optional.** Please comment on any information available on health or other problems associated with the use of NPS substances (e.g. targeted surveys, data on treatment entry, emergency room presentations, mortality, and any specific demand reduction activities).

### **Harms related to NPS use**

Toxicovigilance and pharmacovigilance are gradually intensifying; however, the findings described below should still be interpreted with caution.

In 2013, 20 health reports relating to NPS other than synthetic cannabinoids or cathinones were reported to the OFDT. The DRAMES (Drug and Substance Abuse-related Deaths) survey established 11 direct deaths involving NPS. Only one of these strictly concerned a new psychoactive substance, methoxetamine, which had caused more than a dozen acute intoxications in previous years. The other 10 cases were related to products long known to be the subject of misuse and/or medications (GHB, tramadol, venlafaxine, alprazolam, zopiclone, pregabalin), usually in combination with other substances. The health network also reported two indirect deaths respectively related to 25C-NBOMe and ketamine, and intoxication involving diphenidine.

Two health reports, including one case of acute intoxication, concern a type x-NBOMe molecule. The remainder are split between arylalkylamines (6-APB, 6-APDB), a phenethylamine (5-MEO-DALT) and 2-CT-4 (Ferec *et al.* 2014).

In 2014, 12 reports relating to NPS other than synthetic cannabinoids or cathinones were submitted to the OFDT. Four originated from forensic professionals (2 road accidents respectively related to methoxetamine and 4-MMC, and 2 acute intoxications respectively involving phenethylamine and DOC). The ANSM<sup>1</sup> toxicovigilance network reported a death involving an x-APB. The scientific literature instanced 6 cases related to diverse NPS and 2 intentional intoxications with diclazepam and pregabalin respectively (Bretaudieu Deguigne *et al.* 2015; Dumestre-Toulet *et al.* 2015; Ferec *et al.* 2015; Langrand *et al.* 2015; El Balkhi *et al.* 2015; Grossenbacher *et al.* 2015).

As already mentioned above, those experiencing acute intoxication appear to be polydrug users or individuals receiving medicinal treatment, probably in a context of psychiatric care.

<sup>1</sup>. National Agency for Medicines and Health Products Safety

**T1.1.3 Optional.** Please comment on patterns of use, trends in prevalence and health or other problems associated with use of drugs not covered elsewhere, but relevant to your country's drug situation (e.g. LSD, magic mushrooms, ketamine, GHB, benzodiazepines, some painkiller drugs, etc.). Consider data from both supply and demand side sources (e.g. seizures, treatment surveys, studies, emergency room presentations mortality data etc.) and provide any relevant contextual information.

(Suggested title: Prevalence, Trends and Harms related to Other Drug Use.)

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## T2. Trends. Not relevant in this section. Included above.

## T3. New developments

The purpose of this section is to provide information on any notable or topical developments observed in the drug epidemiological situation of 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 question.

T3.1 Please report on any notable new developments observed in use of NPS or other new, novel or uncommon drugs in your country since your last report.

### New developments in the use of NPS and other drugs

The visibility of "commercial" substances, i.e. presented in highly marketed packaging or in a non-powder form (resin, herbal cannabis, e-liquid, etc.) is one of the most striking features of 2014, regardless of the substances. This could reflect an increasing availability and a wider audience, with users who are less informed in terms of NPS.

## T4. Additional information

The purpose of this section is to provide additional information important to drug use and availability in your country that has not been provided elsewhere.

Please structure your answers around the following question.

*T.4.1 **Optional**. Please describe any additional important sources of information, specific studies or data on NPS. Where possible, please provide references and/or links.  
(Suggested title: Additional Sources of Information.)*

*T.4.2 **Optional**. Please describe any other important aspect of other drugs that has not been covered in the specific questions above. This may be additional information or new areas of specific importance for your country. Where possible, please provide references and/or links.  
(Suggested title: Further Aspects of NPS and Other Drug Use.)*

## 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.

No current question

## 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.

T.6.1 Please list notable sources for the information provided above.

### Sources

SINTES scheme: National Detection System of Drugs and Toxic Substances  
I-TREND project / Forum monitoring scheme (TREND)  
Seizures and checks performed on postal freight or during police cases  
DRAMES Survey

T.6.2 Where studies or surveys have been used please list them and where appropriate describe the methodology?

### Methodology

#### **SINTES: National Detection System of Drugs and Toxic Substances**

*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

See T6.2 in Cannabis section

#### **I-TREND Project**

*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

See T6.2 in Cannabis section

#### **Seizures and checks performed on postal freight or during police cases**

*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

See T6.2 in Cannabis section

#### **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-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.

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# WB 3.1 Prevention

*France*

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## **2015 National report (2014 data) to the EMCDDA by the French Reitox National Focal Point**

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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.

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## T0. Summary

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

- National profile

Drug use prevention policy in France is coordinated at central level by the Interministerial Mission for Combating Drugs and Addictive Behaviours (MILDECA). The Ministries of National Education, Agriculture (responsible for agricultural education), Health and Interior are the other main central stakeholders in this field. Since 1999, the French prevention policy embraces all psychoactive substances, both illicit and licit (alcohol, tobacco and psychotropic medicines), and other forms of addiction (gambling, gaming, doping). General goals are not only to prevent first use or delay it, but also to curb use or abuse of these products.

The use of existing guidelines on drug prevention in school settings is strongly encouraged, but is not compulsory. The main focus of the school-based prevention activities, within the area of health education, is to develop students' individual and social skills to resist drug use.

The MILDECA territorial representatives ("*chefs de projet*") coordinate the implementation of the national prevention priorities at the local level (regions, cities). These ones and the independent Regional Health Authorities (ARS) allocate decentralised credits for prevention activities, while the French national health insurance system also provides funding for prevention.

There is no prevention monitoring system in France and therefore information about the scope and coverage of prevention activities remains limited.

- Environmental strategies on alcohol and tobacco use are well developed and have substantial political support.

- At local level, prevention activities are implemented by a large number of professionals. They are mostly universal prevention activities carried out in secondary schools, with school communities involved in commissioning, planning and sometimes in implementing activities. In most cases, external interveners (NGO staff and/or specialised law enforcement officers) address pupils.

- Selective and indicated prevention is mainly the responsibility of specialised NGOs. About 300 Youth Addiction Outpatient Clinics (CJC) deliver 'early intervention' towards young users and their families throughout France.

- Community-based prevention is carried out in youth counselling centres. Prevention in the workplace covers both licit and illicit drug use and is primarily in the remit of occupational physicians. Implementation varies across companies/services, according to their sizes (scarcer in small/medium companies) and the lines of business. Formally, it also engages human resources and staff representatives, as part of the legal obligation to ensure and preserve employee safety and health, but the latter have timidly taken hold of this issues so far. Still, psychoactive substance uses are quite taboo in the work world. For some years, jurisprudence has laid the ground for the recognition of screening as a legal mean of control. Screening is implemented in some companies/services. But public authorities advocate that, to be effective in a preventive purpose, screening needs to be integrated in comprehensive in-house prevention policies, including training, awareness-raising, counselling and support towards treatment.

- National media campaigns to prevent alcohol, tobacco or illicit drugs are regularly issued by the National Institute for Prevention and Health Education (INPES).



- Trends

Over the 2010's, there has been a growing concern among practitioners and decision makers to enhance quality in the delivered prevention programmes and services. The creation of the Interministerial Commission for the Prevention of Addictive Behaviours (CIPCA), in 2014, is a symbolic sign of this awareness-raising. The strengthening of quality in addictive behaviours prevention through the promotion of evidence-based methods and the professionalization of practitioners results from a quadruple juncture: (i) the evolution of both levels et patterns of use, especially among adolescents; (ii) the improvement of knowledge on harms related to early consumption; (iii) the easier access to substances and synthetic drugs through Internet; (iv) the growing awareness of the gaps and ineffectiveness of a policy that is solely focused on the ban of any drug use so as to prevent addictive behaviours and the related risks.

If young people are definitely the core target public of prevention policies, the two last Government plans (2008-2011, 2013-2017) have clearly set forth priorities towards specific segments of this public, such as youth in deprived neighbourhoods or in contact with the judicial system, or female publics.

Over the last ten years, the most salient engagement of French public authorities in drug prevention is the support provided for the development of the Outpatient Clinics for Young Users, so-called CJC's ("*Consultations jeunes consommateurs*"). These CJC's are the main indicated prevention system in France.

The institutional support for the development of prevention in the workplace is getting important.

- New developments

In the current Government strategy, priority has been given to drug prevention directed to: young people, especially those in contact with a juvenile court system; pregnant women and female drug-users; and people that are remote from the care system, whether geographically or socially. The new Government plan requires the reinforcement of the Outpatient Clinics for Young Users (CJC's), in particular through professional training.

The year 2015 is a favourable context to the development of addictive behaviour prevention: (i) the issue of addictive behaviours is introduced for the first time in the forthcoming National Plan for Health at Work, as a risk to be addressed in priority; (ii) drug prevention is being officially assigned to the remit of drug treatment centres (CSAPA), within the framework of the preliminary discussions of the forthcoming law on the modernisation of the health system.

In the workplace, priority is granted to the development of collective drug prevention in all workplaces, whether public or private, and in relation to any drug, whether illicit or not, including misused psychotropic medicines. In 2015, a national training scheme on early detection and brief intervention (EDBI) is being developed by the MILDECA in order to enhance its implementation by occupational physicians. The study of the relation between working conditions and working organization and psychoactive substance use is also a prevention-oriented stake as it is intended to favour protective work environments for employees' health.

Specific impetus is put on the promotion of quality in prevention, especially through budding governmental initiative to develop evaluation endeavour among practitioners as well as local funders. Monitoring and evaluation are clearly identified as priorities in the 2013–17 Government plan, at operational and public policy levels.

Many prevention measures have been developed with a double approach of crime prevention and addictive behaviour prevention. These use classical psychological patterns based on self-help, self-expression or information provision.

## T1. National profile

### T1.1 Policy and organization

The purpose of this section is to:

- Provide an overview of how prevention is addressed in your national drug strategy or other relevant drug policy document
- Describe the organisation and structure responsible for developing and implementing prevention interventions in your country
- Provide contextual information useful to understand the data submitted through SQ25 and SQ26.

Please structure your answers around the following questions.

T1.1.1 Please summarise the main prevention-related objectives of your national drug strategy or other key drug policy document (Cross-reference with the Policy workbook).

The main principles of the prevention policy are to prevent people from experimenting with drugs in the first place, or at least to delay first use, and to prevent or limit misuse or addictive behaviours whether they are related to drugs or not (Internet, video games, gambling, etc.). The school-based universal prevention remains the preponderant field of development for drug prevention.

In school settings, the general intervention framework focuses on preventing addictive behaviour, which more generally falls within the province of health education.

T1.1.2 Please describe the organisational structure responsible for the development and implementation of prevention interventions. Information relevant to this answer includes:

- responsible institutional bodies
- organizations delivering different types of interventions
- coordination between the different actors involved (education, health, youth, criminal justice)

#### *Responsible institutional bodies engaged in coordination and funding*

The policies for preventing legal and illegal drug use are established by long-term Government plans, coordinated by the Interministerial Mission for Combating Drugs and Addictive Behaviours (MILDECA), and then adapted locally by its territorial representatives (the so-called “*chefs de projet*”, see Drug policy workbook, part T1.3.1). The latter allocate decentralised credits for local drug prevention actions. These governmental priorities can be mirrored by or enhanced with national programmes from various ministries (of National education or Health in particular) or regional plans (e.g. from Regional Health Authorities - ARS).

The National Institute for Prevention and Health Education (INPES) assesses and develops preventive measures, especially national media campaigns. On its website, drug use prevention tools are provided, the quality of which has been validated ([http://www.inpes.sante.fr/CFESBases/catalogue/rech\\_doc.asp](http://www.inpes.sante.fr/CFESBases/catalogue/rech_doc.asp) [last accessed 29/07/2015]).

Regional health authorities (ARS) define regional public health programmes which generally provide for lines of actions to curb health issues whether related to licit (alcohol, tobacco) or illicit drugs. The ARSs can be additional sources of drug prevention granting.

In secondary schools, including those of agricultural education, headmasters are relatively free to determine their level of commitment to prevention, even though they are strongly

encouraged by their supervisory administrations (at regional and/or central levels) to invest in such efforts. Local administrative authorities provide head teachers with recommendations based on ministerial guidelines.

#### *Organisations delivering interventions*

Public services have the remit of implementing drug use prevention initiatives, but prevention programmes can be delegated to associations when a local approach is more appropriate.

Since 2006, preventing addictive behaviour has been given a new foothold in the basic missions of the French education system through the “common base of knowledge and skills” (*“socle commun de connaissances et de compétences”*) which encompasses all of the knowledge, skills, values and attitudes that every pupil must master by the end of mandatory schooling. Consequently, the educational, social and health school staffs are quite involved in coordinating prevention or even implementing prevention towards pupils, although external practitioners from prevention or health education NGOs and specially-trained law enforcement officers (FRAD and PFAD, respectively from *gendarmerie* or police) are most often entrusted to implement prevention actions.

Actions intended for students in higher education are organised by (Inter)University Preventive Medicine and Health Promotion Services (S[*I*]UMPPS). Student associations and complementary student health insurance companies also participate in this area.

#### **T1.1.3 Optional.** Please provide a commentary on the funding system underlying prevention interventions.

Information relevant to this answer includes:

- alcohol and gambling taxes, confiscated assets
- quality criteria linked to funding

Since 1995, sales of assets seized through drug-trafficking repression have been turned over to the Narcotics support fund, under the MILDECA management. Most of the amount (90%) is used for anti-trafficking purposes, while the remaining 10% are earmarked for prevention actions and endow the grants delegated to the MILDECA territorial representatives to fund local prevention activities.

In addition to these local MILDECA allotments, local grantings for drug prevention can also be allocated according to regional or sub-regional priorities by the independent Regional Health Authorities (ARS). Various cross-territorial local programmes (concerning health, social exclusion, public safety and/or urban policy) also make it possible to redistribute public credits for drug use prevention. Furthermore, the identification of priority areas for education and urban planning (based on socioeconomic, housing quality and educational indicators) makes it possible to channel additional resources into underprivileged populations.

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) and so do -although more sporadically- Mutual health insurance organisations.

Some calls for tenders – co-organised by public health institutions (French Institute for Public Health Research (IReSP), French National Cancer Institute (INCa)...) and central administrations (MILDECA, Health ministry ...) – allow financing prevention experimentations, translational or interventional studies (see Research workbook).

## T1.2 Prevention interventions

The purpose of this section is to provide an overview of prevention interventions in your country.

Please structure your answers around the following questions.

T1.2.1 Please provide an overview of Environmental prevention interventions and policies. Information relevant to this answer includes:

- alcohol and tobacco policies/initiatives
- delinquency and crime prevention strategies
- environmental restructuring, e.g. of neighbourhoods

### Environmental prevention interventions and policies

#### *Alcohol and tobacco policies/initiatives*

Alcohol and tobacco products are historically extensively regulated, as for their use patterns, manufacture, trading / sale and promotion, mainly through 1991-1992 regulations (by the so-called "Loi Évin" [[Loi n°91-32 du 10 janvier 1991 relative à la lutte contre le tabagisme et l'alcoolisme](#)] and its related Decree of 1992 [[Décret n°92-478 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](#)]) and a 2009 law (the so-called "Loi HPST" [[Loi n°2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires](#)]). These legal provisions are integrated into the French Public Health Code.

Today, French law referring to tobacco or alcohol:

- prohibits smoking in public places;
- regulates the composition of tobacco products;
- prohibits the sale or free distribution to minors of alcoholic beverages and tobacco products (including papers and filters);
- 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).

From 2014 onwards, a new provision in Labour Code authorizes the employer to regulate and even ban the consumption of alcoholic beverages in the workplace if employees' health and safety are at stake (formerly, jurisprudence sometimes made personal freedoms prevail over health and safety concerns).

Over the last 6 years, whereas restrictions on tobacco and alcohol use have been reinforced towards young people, there have been several measures to lessen the legislation on tobacco or alcohol promotion. In 2009, the French legislator ruled that Internet-based advertising on alcohol was authorized provided it was "neither intrusive nor interstitial". So online advertising has to use only classical Internet formats (like banners or "skyscrapers"). The law for the

growth, activity and equality of economic opportunities (so-called “*Loi Macron*”), discussed during the first 2015 semester, initially integrated a provision destined to relax legislation on alcohol promotion but this provision was censured in August 6<sup>th</sup>, 2015, by the Constitutional Council which considered it as uncorrelated to the general subject of the law. This provision would have meant that references relating to a region of production, a place name, a reference or a geographical indication, a rural land, a route, a production area, a know-how, an history or cultural heritage, gastronomy and landscape associated with an alcoholic beverage or with an identification of quality or origin would not be considered anymore as illegal advertising. It would have strongly hardened legal proceedings against alcohol beverage advertising.

The tax scheme applied in France to alcoholic beverages complies with the minimal taxation level determined by the Council of Europe [[Council Directive 92/83/EEC of 19 October 1992 on the harmonisation of the structures of excise duties on alcohol and alcoholic beverages](#) and [Council Directive 92/84/EEC of 19 October 1992 on the approximation of the rates of excise duty on alcohol and alcoholic beverages](#)]. The total amount generated through excise duties and social contributions on alcohol goes to finance the healthcare and ageing branches of the social security scheme of farmers. Duties on alcohol are annually revalued by ministerial decree in a ratio equal to the growth rate of the Consumer Price Index, excluding tobacco, recorded the penultimate year.

Tobacco is excluded from the list of products included in the Consumer Price Index. This exclusion has enabled regular price increases on tobacco products to occur for the purpose of restricting tobacco use. From 2014, according to the National Tobacco Smoking Reduction Programme (PNRT, adopted in September 2014) (Ministères des affaires sociales de la santé et des droits des femmes 2014), the Ministry of Health assists the Ministry of Budget in the homologation of tobacco prices.

#### *Delinquency and crime prevention strategies*

Over the last years, delinquency and crime prevention strategy has been implemented towards addicted/drug user offenders, with a concern for better collaboration and communication between judicial and medico-social stakeholders. In accordance with this strategy, the MILDECA funds many local projects each year, such as prison staff training in the management of addiction issues, detection and support of addicted people; and detainees’ awareness raising on addictions.

It has also resulted in specific actions such as the following examples:

- The “Bobigny city project” has been recently introduced by the MILDECA and Ministry of Justice in the Bobigny Court. It is an experimental programme aimed at preventing recidivism among drug users who have been convicted in a court of the Paris region. This programme associates judges, probation officers and medico-social workers. It consists in proposing a deferred sentence to any addicted person convicted for minor offences as an alternative to prison. If accepted, this alternative implies that the offender engaged into the programme is bind to take part in various activities (theatre, writing workshop, sports, psychological and probation interviews, drug treatment-oriented motivational interviews...) coordinated by a multidisciplinary team involving probation officers and addiction treatment practitioners (from CSAPAs, i.e. addiction treatment centres). Any serious lack of attendance may be reported to Court. The implementation evaluation of the “Bobigny project” is on-going and its efficiency will be assessed at its term.

- Some Recidivism Prevention Programmes (RPP) linked to addiction issues are funded thanks to MILDECA credits at local level. Basically, these RPPs are self-help groups of convicted offenders, accompanied by probation officers and addiction treatment practitioners. Participants collectively talk about and reflect on the offences they committed, their negative consequences on victims and society, the keys in their hands to avoid further offences. This dialogue can stress on addictions issues. In any case, RPPs must be lead in addition to more “classical” approaches like individual psychological and probation interviews.
- Video prevention messages on illegal drug use and trafficking have been produced and broadcasted on internal video networks, in some prisons. They complete the information disseminated to inmates about psychotropic medicines misuse and diversion.

Other preventive measures directed to offenders have been developed and are described below in section T1.2.4 as their primarily aim is more focused on preventing addiction rather than recidivism. These measures are off-premise consultations provided by Youth Outpatient Clinics (CJC) in judicial youth protection services.

T1.2.2 Please comment on Universal prevention interventions as reported to the EMCDDA in SQ25 or complement with information on new initiatives (activities/programmes currently implemented) or interventions (including their contents and outcomes).  
Comment, if applicable, on the relevance (i.e. number, money spent) of mass media campaigns

## **Universal prevention interventions**

### *Schools*

Universal prevention is directed primarily towards secondary students. The reflection and work on the prevention actions planned within the scope of the governmental strategy started in 2013 (MILDT 2013). With regards to school settings, the actions listed hereinafter have been developed in the 2014-2015 period (MILDT 2014):

- a contest has been directed to 400 high school students (*Lycées*, equivalent to sixth-form college in the UK or high school in the USA) for them to write drug prevention messages addressing peers. Pupils were assessed against the conformity of the message produced in respect to the governmental prevention priorities, the propensity of the message to foster psychosocial skills and the quality of the communication support (action 4, 2014-2015);
- over 2012-2016, life skills prevention programmes are experimented in the first four years of French secondary school. In universities, peer-led prevention experiences are supported and aimed to identify addictive behaviours among students and initiate treatment (action 5, 2013-2015);
- road safety actions have been implemented in schools to raise awareness about the dangers of driving under the influence of alcohol or drugs, targeting the young driving licence applicants (action 6, 2013-2017). No precise data on implementation is available.

Further prevention events with educational teams from different kinds of teaching establishments should be organised from 2016 (under next Actions Plan) or are being monitored (data available next year).



According to provisions given by the law of 8 July 2013 on the revision of the national education system [[Loi n°2013-595 du 8 juillet 2013 'orientation et de programmation pour la refondation de l'école de la République](#)], these actions are part of a global approach to educational, social and health policy for students facing the risk of addictive behaviours. The on-going reflection lead by Ministry of Education on the “school climate” (in particular under the aegis of the ministerial delegation for preventing and combating violences at school) considers the need of not breaking up responses developed for preventing risk behaviours (drug use, violence, bullying, unsafe sexuality, etc.).

#### *Higher education students*

Actions directed to higher education students are organised by (Inter)University Preventive Medicine and Health Promotion Services, student associations or complementary health insurance companies. They mainly consist in: (i) self-evaluation of drug use as a mean to refer users or abusers towards help services; (ii) risk reduction measures (designated sober driver, preferential/discounted price for non-alcoholic beverages, chill-out spaces, etc...); (iii) peer-based information during parties; (iv) guidelines for organising students parties, providing event organisers with useful advice to help them ensure party goes safety and comply with current legal requirements on alcohol use and on public events.

#### *Families*

The Government plan for combating drugs and addictive behaviours 2013-2017 (MILDT 2013) foresees entrusting the national addiction help-line (ADALIS, Drugs and Alcohol Addiction Information Service) with implementing a parenting support help line and an “Addiction info service” web portal. From 2014 and over 2015, the protocol of such a deployment has been developed. The opening of the help-line is planned for 2016. The operational work to create the general addiction web portal will be engaged in 2016, after the migration of the help-line on gambling to the wider hosting platform of the INPES (the INPES is the supporting structure of ADALIS and the owner of the technical tools). Nevertheless, the electronic directory on specialised drug treatment services, managed by the ADALIS national addiction help-line, needs more visibility.

#### *Communities*

The 2013-2017 Government plan aims to implement and assess specific strategies to adapt prevention actions to populations that are not easily reached by help services. It intends to develop peer prevention programmes (through school activities, after-school activities, sporting events and festivals). These measures are postponed to the next Actions Plan 2016-2017. The government strategy aims at developing the training of educators at recreational centres to help them implement awareness-raising actions on addictive behaviours and risky sexual practices among children and teenagers. This measure will be developed under the next Actions Plan.

#### *Workplace*

In line with Government plan for combating drugs and addictive behaviours 2013-2017, the Labour Code (article R.4228-20) was amended in 2014 [[Décret n°2014-754 du 1<sup>er</sup> juillet 2014 modifiant l'article R. 4228-20 du code du travail](#)] to explicitly authorise employers to limit or prohibit the consumption of alcohol at the workplace. Regional directorates of businesses, competition, consumption, labour and employment (DIRECCTE) will be informed about the administrative and practical implications of this revision, by means of circular.

In order to disseminate knowledge on and give an impetus to workplace drug prevention, a national conference on preventing addictive behaviours in the workplace is planned for October 22, 2015 (the previous one was in 2010). Under the aegis of the MILDECA, an organisational committee, set up in April 2015, gathers competent Health or Labour directorates and institutions to develop the programme of this event (under development in July 2015). The aim is to assemble a large audience of 500 work world stakeholders, from public or private sectors, business leaders, human resource managers, occupational physicians, prevention practitioners, syndicates as well as public health professionals. The conference should provide these stakeholders with (new) keys helping them overcome preconceptions and taboos about drug prevention, and to give an impetus to prevention especially collective prevention.

The forthcoming occupational Health Plan 2015-2019 acknowledges the prevention of addictive behaviours as a factor promoting workers' health that needs to be implemented in close interaction with public health stakeholders.

The national strategy includes specific prevention objectives toward professional branches more at risk for psychoactive substance misuse or addiction. As an example, specific communication tools (specific website) and prevention media campaign targeted at sea farers are under development.

The 2013-2015 Actions Plan also foresees to include compulsory prevention training for tobacconists, dealing with rights duties related to the sale of tobacco products, prevention and protection of minors, on the model of what is done for bar owners (article L. 3332-1-1 of Public Health code). In June 2015, public authorities discussed about the concrete implementation patterns of such a training module on health for tobacconists, that could be implemented after the law on the modernisation of the health system is adopted (the draft law is currently in reading in Parliament).

T1.2.3 Please comment on Selective prevention interventions as reported to the EMCDDA in SQ26 or complement with information on new initiatives (activities/programmes currently implemented) or interventions (including their contents and outcomes).

### **Selective prevention interventions**

Selective prevention is mainly implemented by specialised associations or law enforcement services, particularly in neighbourhoods (outside of the school environment).

#### *Deprived neighbourhoods*

According to the 2013-2015 Actions Plan, the addictive behaviours theme should be incorporated into the prevention actions developed within the scope of the city policy, in particular through City-Health workshops ("*Ateliers santé-ville*", which serve as interfaces between local elected officials, health authorities and local residents) and various organisations working in integration, education, mediation for youth in deprived neighbourhoods, local social services, youth counselling centres, and other organisations involved in urban policies. In 2014, 600 000 euros from urban policy funds were allocated to addictive behaviour prevention actions (twice the amount planned by governmental plan).

Improving training of "Urban policy" professionals on addictive behaviours is planned for 2016: in this framework, the MILDECA will deliver an attestation of training on prevention. In 2015, upon request from MILDECA, the "Urban policy" directorate has implemented an interactive mapping that allows spotting medico-social addiction structures in the defined priority districts



in order to better refer young people to addiction specialised professionals and to develop prevention. This mapping is now accessible from the "Urban policy" Directorate website (<http://sig.ville.gouv.fr/Cartographie/1193>). There is still a need for analysing whether the existing services meet the population's needs, especially among young people, and a need for promoting partnerships between Youth Addiction Outpatient Clinics (CJC) and the City-Health workshops (see above paragraph).

#### *Publics under judicial youth protection*

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.

#### *At-risk families*

The MILDECA supports the experimental implementation of the PANJO programme (Promotion of health and attachment between newborns and young parents), an early parenting support programme developed by the INPES<sup>1</sup>.

The PANJO nurses-oriented tools have been pre-tested in three departments (*Rhône, Loire-Atlantique, Hauts de Seine*) and reviewed in Spring 2015. The second phase of development could start during Winter 2015-16. Its implementation will be coordinated and funded by the INPES and entrusted to a NGO ("*Agence des nouvelles interventions sociales et de santé*") which will be the interlocutor of the local authorities.

With support from the MILDECA, several experiences of Multidimensional Family Therapy (MDFT) have been tested out as pilot stage in different places, including some judicial youth protection services. The next step is now for the MILDECA to collect MDFT first results before any extension of this approach into CJsCs.

<sup>1</sup> It is based on international experiments (e.g., CAPEDP study on Parenting Skills and Attachment in Infants: Reducing Mental Health Risks and Promoting Resiliency) and the long experience of the French Mother and Child Health services (PMI). The purpose of this programme is to enhance home visits by the motherhood and child care services to promote health in vulnerable families by offering extended follow-up, from the prenatal period until the child's sixth month of life, or beyond for households in need, up to the child's twelfth month of life. So PANJO aims at providing fragile parents with early parenting intervention and helping them better access to support and health services. The target-public is more particularly (future) parents who have social difficulties, drug-related troubles or who distrust health institutions

([http://www.inpes.sante.fr/CFESBases/equilibre/numeros/91/parentalite\\_accompagner\\_les\\_familles.asp](http://www.inpes.sante.fr/CFESBases/equilibre/numeros/91/parentalite_accompagner_les_familles.asp) [last accessed 29/07/2015]).

T1.2.4 Please provide an overview of Indicated prevention interventions (activities/programmes currently implemented).

Information relevant to this answer includes:

- interventions for children at risk with individually attributable risk factors e.g. children with Attention Deficit (Hyperactivity) Disorder, children with externalising or internalising disorders, low-responders to alcohol, etc.

#### **Indicated prevention interventions**

As for selective prevention, indicated prevention is mainly delivered by specialised associations or law enforcement services, often as part of a legal response.

#### *Young users*

Young users can be directed to Youth Addiction Outpatient Clinics (CJC) and drug awareness courses. The purpose of CJsCs is to provide young users and their families with information and customised advice, to support them in attempting to stop taking drug or to have longer-

term care, if necessary by referring them to other specialised services. In 2014, 30,000 young people have been to the 540 consultation points throughout France (mainland and overseas), in the 260 CJC premises or in “advanced” consultations i.e. outside the main premises (e.g., in schools) (Obradovic 2015). Clients are aged 20.1 in average and predominantly males (81%). As for their recruitment, 15% have come to consult voluntarily (spontaneously) whereas 40% have been referred by the judicial system, vs 21% by their family, 9% by schools (by school health professionals, school consultation points or by school authorities within the framework of a sanction). In the last few years, the number of referrals of drug users by the judicial system to CJsCs (and to health structures in general) has been on the rise.

#### *Users among law offenders and delinquents*

Over the last years, several cases of collaboration have been experienced to develop partnership between judicial youth protection services and CJsCs, either instigated by the MILDECA (for example: the “advanced” CJsCs) or decided locally. An on-going study commissioned by the MILDECA is assessing the cost of such a partnership, and thus the funding required to carry on what has been initiated.

The 2013-2017 strategy sets forth specific prevention objectives for offenders. New programmes for the prevention of drug-related subsequent offence have been initiated (see section T1.2.1).

**T1.2.5 Optional.** Please provide any additional information you feel is important to understand prevention activities within your country.

A national media campaign on CJC (Youth Addiction Outpatient Clinics) was launched in January 2015 (from January 12 to February 8) with the aim of making these services better known by the general public (young people, parents, relatives) as a location where it is possible to talk about drugs and take stock before evolving in addiction. The campaign stages the gap of perceptions between a young person and his/her relatives about his/her drug or video game consumption. By means of posters, web, radio and TV spots, the campaign has focused on cannabis, video games and alcohol, and illustrated the expertise of the CJC staff in restoring the dialogue on the basis of each other's concern (<http://inpes.sante.fr/30000/actus2015/002-cjc.asp>).

## **T1.3 Quality assurance of prevention interventions**

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

Note: cross-reference with the Best Practice Workbook.

Please structure your answers around the following question.

**T1.3.1 Optional.** Please provide an overview of the main prevention quality assurance standards, guidelines and targets within your country.

In February 2014, in compliance with the Government plan 2013-2017, the MILDECA has set up 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 evidence and scientific models as well as on programmes that have proven to be effective. Chaired by the MILDECA, the CIPCA gathers ministerial departments and scientific institutions involved in drug and addictive behaviours prevention. In 2014, the CIPCA

conducted a first call for tenders so as to select prevention programmes with a view to organise their scientific evaluation thereof over 2015-2016. This initiative will contribute to build a national registry of effective prevention interventions. Information on these initiatives and, more generally, on quality and evidence-based approaches is disseminated through annual national information. During the second national day, on June 29, 2015, the European Drug Prevention Quality Standards (EDPQS) project and tools were introduced to participants. France, represented by OFDT, participated to the EDPQS phase 2 project in 2013-2015. Further reflection on the most relevant ways to adapt, disseminate and support the use of these standards should be lead, in the first instance between OFDT and MILDECA, in order to propose operational programme selection tool for territorial MILDECA representatives.

## T2. Trends

The purpose of this section is to provide a commentary on the context and possible explanations of trends in prevention within your country.

Please structure your answers around the following questions.

T2.1 Please comment on the main changes in prevention interventions in the last 10 years and if possible discuss the possible reasons for change.  
For example, changes in demography, in patterns of drug use, in policy and methodology, in target groups or in types of interventions.

See sub-section "Trends" in "T0. Summary"

## T3. New developments

The purpose of this section is to provide information on any notable or topical developments observed in prevention **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.

T3.1 Please report on any notable new or innovative developments observed in prevention in your country since your last report.

See sub-section "New developments" in "T0. Summary"

## T4. Additional information

The purpose of this section is to provide additional information important to prevention in your country that has not been provided elsewhere.

Please structure your answers around the following questions.

**T4.1 Optional.** Please describe any additional important sources of information, specific studies or data on prevention. Where possible, please provide references and/or links.

**T4.2 Optional.** Please describe any other important aspect of prevention that has not been covered in the specific questions above. This may be additional information or new areas of specific importance for your country.

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## 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.

T5.1 Have there been recent relevant changes in tobacco and alcohol policies?

YES	<p><b>Tobacco</b></p> <p>The French National Tobacco Smoking Reduction Programme (PNRT) 2014-2019 defines several preventive measures in compliance with the European directive of April 3, 2014 [<a href="#">Directive 2014/40/EU of the European parliament and of the Council 4 on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products and repealing Directive 2001/37/EC</a>]:</p> <ul style="list-style-type: none"> <li>(i) make tobacco products less attractive, in particular by establishing neutral packages and forbidding advertising in points-of-sale and attractive aromas (supposedly to facilitate the onset of smoking in young people)</li> <li>(ii) strengthen the respect for the smoking ban in public places</li> <li>(iii) forbid to smoke in cars in the presence of a child under the age of 12 and establish free-smoking children playgrounds. Therefore, municipal police will be authorised to enforce the ban on sale to minors and ban on smoking in public settings.</li> </ul> <p>The forthcoming law for Public Health modernization will consolidate these measures, notably, according to the project of law: (i) by extending to 18 the car occupants' age under which smoking in car is forbidden and (ii) by requiring tobacco manufacturers, importers or distributors as well as representative companies or organisations to address a detailed report on their expenditure in advertising, propaganda and promotion activities carried out in France, including lobbying.</p>
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Yes/No answers required. If yes please provide brief additional information.

T5.2 Has there been recent research on aetiology and/or effectiveness of prevention interventions?

NO	
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## 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.

T.6.1 Please list notable sources for the information provided above.

The report is mostly based on information reviewed by OFDT in collaboration with MILDECA representatives.

T.6.2 Where studies or surveys have been used please list them and where appropriate describe the methodology?

### Methodology

#### **CJC survey: Survey in youth addiction outpatient clinics**

*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

2014 is the third year (after 2005 and 2007) of the survey on clients of youth addiction outpatient clinics (CJC), a scheme created in 2005 to offer counselling for young psychoactive substance users. The 2014 survey is based on the responses by professionals having seen the patients or their families between 24 March and 30 June 2014. It covers metropolitan France and French overseas departments. Out of 260 facilities managing a CJC activity in metropolitan France and the DOM recorded in 2014, 212 responded to the survey, i.e., a response rate of 82%.

The questionnaire comprises four parts: circumstances and reasons for consulting, user sociodemographic characteristics, substances used and evaluation of cannabis dependence by the Cannabis Abuse Screening Test, and decision made at the end of the appointment.

Out of the 5,421 questionnaires collected, corresponding to the number of appointments held during the survey period, 5,407 were considered fit to describe consulting activity. After eliminating questionnaires not stating gender or age, the final user base included 4,958 individuals.

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MILDT (2013). Government plan for combating drugs and addictive behaviours 2013-2017. MILDT, Paris.

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Obradovic, I. (2015). Dix ans d'activité des « consultations jeunes consommateurs ». Tendances. OFDT, 101.

## WB 3.2 Treatment

*France*

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## **2015 National report (2014 data) to the EMCDDA by the French Reitox National Focal Point**

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**Coordination and editorial:** Aurélie Lermenier-Jeannet and Anne de l'Eprevier

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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.

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## T0. Summary

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

- National profile

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). Approximately 104,000 individuals were received in outpatient CSAPA (specialised addiction treatment centres) in 2010 for problems with illegal drugs or diverted psychotropic medications.

A large proportion of new patients are treated for cannabis problems (58%). This was already the case in previous years; however, the inclusion of all illegal drug users treated in former alcoholism treatment centres in TDI data as from 2013 further reinforced the weight of cannabis.

OST is mainly prescribed in a primary care setting by general practitioners, and is usually dispensed in community pharmacies. In 2014, 147,000 people received opioid substitution treatment: 99,000 were prescribed buprenorphine (Subutex® or generics), 49,000 methadone and 6,500 buprenorphine in combination with naloxone (Suboxone®). Moreover, 20,000 patients received methadone dispensed at a CSAPA in 2010.

In terms of outpatient treatment provision, the public authorities developed specific healthcare for young users by creating youth addiction outpatients clinics (CJC) in 2004. Presently, approximately 540 clinics have opened. Although no national "programmes" intended for other target groups exist, some CSAPA have specialised in healthcare adapted to specific populations (women with children, offenders, etc.).

- Trends

Among those overseen for the first time in the specialised addiction treatment structure, the proportion of cannabis users is tending to increase whereas the proportion of opioid users is on the decline. In 2014, this population, with an average age of 26 since 2007, comprises nearly 70% cannabis users and slightly over 10% opioid users.

As regards all treatment entrants, the distribution according to substances seems fairly stable up to 2012, with a slight downward trend in the percentage of cannabis users up to 2010. In 2013, the proportion of cannabis users increased considerably, whereas the proportion of opioid users showed a symmetrical decline.

- New developments

The maximum prescribing duration for methadone capsules is now 28 days as opposed to 14 in the past. However, the syrup form maintains a maximum prescribing duration of 14 days. Despite the debate on initial prescribing of methadone in a primary care setting, the results of the Méthaville study showed that this prescribing method was no less effective than the current method (exclusively by physicians at a CSAPA or hospital), paving the way to trialling this method.

## T1. National profile

### T1.1 Policies and coordination

The purpose of this section is to:

- describe the main treatment priorities as outlined in your national drug strategy or similar key policy documents
- provide an overview of the co-ordinating/governance structure of drug treatment within your country

Please structure your answers around the following questions.

T1.1.1 What are the main treatment-related objectives of the national drug strategy?

#### **Main treatment priorities in the national drug strategy**

As regards treatment, the 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours (MILDT 2013) comprises two main themes, split into objectives:

- I) Adapt frontline and specialised health care delivery:
  - Reinforce the skills of professionals in contact with young people (particularly Youth Addiction Outpatient Clinics (CJC), by developing early intervention).
  - Reinforce the skills of healthcare professionals and the position of general practitioners (training in brief intervention and motivational interviewing).
  - Extend interventions of specialised healthcare schemes (expand the missions of national treatment and prevention centres for addiction (CSAPA) and support centres for the reduction of drug-related harms (CAARUD) to prevention, professional integration, and family support; develop addiction liaison and treatment teams (ELSA) in healthcare establishments).
  - Increase geographical and social accessibility.
- II) Adapt therapeutic strategies
  - Support and offer multidimensional family therapy (training of several CJC spread over the territory).
  - Deploy an integrated approach to psychiatric and somatic comorbidities
  - Support research on new treatments for addictive behaviours and addiction
  - Improve the quality of care for patients receiving opioid substitution treatment (OST) and make it more accessible (new treatment procedures, such as initial prescription of methadone in a primary care setting; prison setting).
  - Propose distance support services

T1.1.2 Who is coordinating drug treatment and implementing these objectives?

#### **Governance and coordination of drug treatment implementation**

See T1 in the "Drug policy" workbook

**T1.1.3 Optional.** Please provide any additional information you feel is important to understand the governance of treatment within your country.  
(Suggested title: Further aspects of drug treatment governance.)

## T1.2 Organisation and provision of drug treatment

The purpose of this section is to:

- Describe the organisational structures and bodies that actually provide treatment within your country
- Describe the provision of treatment on the basis of Outpatient and Inpatient, using the categories and data listed in the following tables. Drug treatment that does not fit within this structure may be included in the optional section
- Provide a commentary on the numerical data submitted through ST24

Please structure your answers around the following questions.

### Outpatient network

**T1.2.1** Using the structure and data provided in table I please provide an overview of the main bodies/organisations providing Outpatient treatment within your country and comment on their relative importance.

#### Outpatient drug treatment system – Main providers

There are two schemes available for dispensing treatments to illegal drug users (DU): the specialised addiction treatment system (in socio-medical establishments) and the general healthcare system (hospitals and general practitioners). Only those individuals overseen by the professionals mentioned in Table I will be described herein.

##### *The specialised scheme*

Until 2004, illegal drug users were only overseen at specialised care centres for drug users (CSST). Outpatient alcoholism treatment centres (CCAA) only received individuals with alcohol problems. After this date, both categories of centres adopted the same name, national treatment and prevention centres for addiction (CSAPA), and in 2008 were assigned the joint task of treating all individuals with an addiction problem, irrespective of the substance, nonetheless with the possibility of retaining their previous specialisation. Until 2010-2011, the latter maintained a strong presence and the number of illegal drug users (DU) admitted in the former CCAA has remained negligible. CSAPA which had previously been outpatient alcoholism treatment centres were not therefore taken into account in TDI data. However, the gradual increase in the number of DU receiving treatment in former CCAA now means that it is no longer appropriate to make a distinction between CSAPA based on their history. All CSAPA have been included in TDI data since 2013, even though some centres only oversee a minority of DU, and sometimes none. This change explains the sudden increase in the number of CSAPA registered for this year.

CSAPA mainly have association status, and a minority of centres are administered by hospitals.

CSAPA in a prison setting, few in number, focus their activities on incarcerated drug users. However, their activity only represents part of addiction health care delivery in a prison setting. On the one hand, addiction health care is delivered by general hospital or mental health

establishments which provide health care in a prison setting. However, no information system exists able to measure this activity. On the other hand, the public authorities wished to set in place, as from 2011, a reference CSAPA for each of the 187 prisons in France. These CSAPA are responsible for intervening in custody to ensure continuity of care. A financial budget has been planned to allow each reference CSAPA to dedicate an additional part-time social worker to intervention alongside incarcerated drug users or those having recently left prison.

In France, the activity of the CAARUD (low-threshold structures) is not perceived as falling within the scope of treatment: the information relating to this type of facility are detailed in the "Harms and harm reduction" workbook.

#### *The general scheme*

The activity of office-based general practitioners with regard to treatment of drug use is described via the INPES Health Barometer general practitioner survey, conducted on a sample of practitioners. In 2009, two thirds of general practitioners (about 40 000) 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) and 12% (about 7 000) received at least 5 user per month. This substantial level of activity alongside opioid-dependent drug users is mainly related to the prescription of opioid substitution treatment (OST). Appointments related to cannabis concern considerably fewer physicians: nearly 3,000 claim to have seen at least 5 patients per month related to cannabis use. Lastly, approximately one in five physicians (13,000) saw at least one patient in the course of the year for problem stimulant use. No information is available on the treatment of drug users by office-based psychiatrists.

Illegal drug users may also be treated in an outpatient setting at numerous addiction medicine clinics created in general hospitals and psychiatric clinics. In 2010, approximately 480 hospital addiction medicine clinics were registered (Palle *et al.* 2012). This figure refers both to clinics open for a few hours a week and those which operate every working day. Patients are mainly seen for alcohol problems; however all clinics may treat illegal drug users.

**T1.2.2 Optional.** Please provide any additional information you feel is important to understand the availability of Outpatient treatment within your country.

(Suggested title: Further aspects of outpatient drug treatment provision.)

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Table I. Network of outpatient treatment facilities (total number of units)

	<b>Total number of units</b>	National Definition (Characteristics/Types of centre included within your country)
Specialised drug treatment centres	410	Facilities of a medical-social nature authorised and funded by the Social Security scheme, the activity of which completely focuses on the treatment of individuals addicted to illegal drugs, alcohol and tobacco or with a behavioural addiction (gambling, cyberaddiction). These facilities are known as national treatment and prevention centres for addiction (CSAPA).
Low-threshold agencies	160	Facilities of a medical-social nature authorised and funded by the Social Security scheme, whose role is to contribute to harm reduction among drug users: unconditional counselling, personalised information and guidance, support for

		access to care and social rights, provision of equipment for prevention of infectious diseases, external interventions to meet drug users and social mediation actions. These facilities are known as support centres for the reduction of drug-related harms (CAARUD) and do not fall within the scope of treatment data in France.
General/ Mental health care	30,000	Estimated number of general practitioners having claimed to have seen at least one opioid client in the past month.
Prisons	15	Facilities authorised and funded by the Social Security scheme, the activity of which completely focuses on the treatment of incarcerated individuals addicted to illegal drugs, alcohol and tobacco or with a behavioural addiction (gambling, cyberaddiction). These facilities are known as national treatment and prevention centres for addiction (CSAPA) in a prison setting.
Other outpatient units		
Other outpatient units		

Source: Standard Table 24.

T.1.2.3 Using the structure and data provided in table II please provide an overview of the utilisation of the outpatient treatment system within your country and comment on the clients served.

### Outpatient drug treatment system – Client utilisation

According to the data provided in the CSAPA activity reports, the approximate number of individuals admitted in outpatient CSAPA is 104,000<sup>1</sup> in 2010<sup>2</sup> for problem use of illegal drugs or misappropriated psychoactive medicines.

The number of DU seen by general practitioners (147,000) is estimated based on the reimbursements for prescription of OST.

CSAPA in a prison setting treat 5,000 to 6,000 patients over the year. These figures only represent undoubtedly a relatively small proportion of all incarcerated drug users receiving addiction medicine delivered by the CSAPA. Treatment is indeed often provided also by CSAPA whose activity is not only in prison settings (outpatient CSAPA) and by general or mental health hospitals intervening in prisons. A more in-depth evaluation of these figures should be available for the next report.

<sup>1</sup> These figures take into account a 3% proportion of double entries of declared data, a percentage evaluated based on the last capture-recapture study conducted in a few French towns.

<sup>2</sup> The number of individuals seen in the CSAPA has not been updated since 2010 due to the delays in submission of activity reports to the OFDT. This update is, however, currently in progress and should most likely lead to a markedly higher estimate for 2014.

**T1.2.4 Optional.** Please provide any additional information you feel is important to understand the utilisation of Outpatient treatment within your country

(Suggested title: Further aspects of outpatient drug treatment utilisation.)

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**T1.2.5 Optional.** Please provide any additional information on treatment providers and its utilisation not covered above.  
(Suggested title: Further aspects of outpatient drug treatment provision and utilisation.)

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Table II. Total outpatient treatment provision (number of clients)

	Total number of clients	National Definition (Characteristics)
Specialised drug treatment centres	104,000	Drug users having been seen at least once in the year as part of a meeting in person with a healthcare professional employed at a CSAPA in the context of structured treatment.
Low-threshold agencies	60,000	Drug users seen at least once at a CAARUD or seen externally by a team from the CAARUD. In France, drug users seen at a CAARUD are not considered as receiving treatment.
General/ Mental health care	147,000	Individuals having benefited from reimbursement further to prescription of opioid substitution treatment.
Prisons	5,700	Drug users having been seen at least once in the year as part of a meeting in person with a healthcare professional employed at a prison CSAPA in the context of structured treatment.
Other outpatient units		
Other outpatient units		

Source: Standard Table 24

## Inpatient network

**T1.2.6** Using the structure and data provided in table III please provide an overview of the main bodies/organisations providing Inpatient treatment within your country and comment on their relative importance.

### Inpatient drug treatment system – Main providers

As for an outpatient setting, residential treatment may have a role in the context of a CSAPA or public, general or specialised psychiatric hospital.

#### *Residential care in CSAPA*

CSAPA with housing offer different types of services. The most important in terms of the number of patients concerned, corresponds to collective housing in the context of residential treatment centres (CTR). These centres were historically create to receive drug users after withdrawal for stays over a few months, allowing them to readjust to life without drugs. Since OST became more widespread in the 1990s, these institutions are also open to individuals receiving this type of treatment. 37 CTR currently exist. In addition to these institutions, 8 experimental therapeutic communities (CTE), created in the 2000s, also exist. CTE should in principle be changed to CSAPA, but have not yet officially been awarded this status<sup>1</sup>. All CTR and CTE are administered as associations. It can also be observed that CTE have a considerably higher number of spaces compared to CTR (30 vs. 10 on average). CSAPA with

housing, as well as those in an outpatient setting, may offer housing services in residential therapeutic apartments (ATR), for stays of not more than two years. In 2011, there were 64 CSAPA with spaces in ATR. Lastly, one more type of service exists: short stays which meet the requirements of emergency housing for homeless drug users or transitional housing (notably for newly released inmates). In 2011, there were 8 CSAPA offering this kind of service.

#### *Residential care in hospitals*

Further to the 2007-2011 Plan for addiction treatment and prevention (Ministère de la santé et des solidarités 2006), the resources available for residential treatment of addiction were considerably increased. In 2010, there were 391 hospitals in France, practically all public, equipped with hospital beds for withdrawal and 113 offering aftercare activities including addiction medicine (Palle *et al.* 2012). These services cover all types of addiction (notably alcohol), hence it is difficult to identify those which are actually open to drug users.

<sup>1</sup> CTE are not therefore subject to the same obligations as CSAPA regarding activity reports and the RECAP scheme (which does not therefore include their data).

**T1.2.7 Optional.** Please provide any additional information you feel is important to understand the availability of Inpatient treatment within your country.

(Suggested title: Further aspects of inpatient drug treatment provision.)

Table III. Network of inpatient treatment facilities (total number of units)

	Total number of units	National Definition (Characteristics/Types of centre included within your country)
Hospital-based residential drug treatment	na	
Residential drug treatment (non-hospital based)	37	Residential treatment centres are facilities which combined collective housing and treatment. It carries out the same missions and services as in an outpatient setting. It offers support for customised treatment.  It is aimed at individuals, including those on OST, who need a structured framework together with temporary distancing, a break from their usual environment. It offers a variety of approaches: medical and psychological treatment, support, socialisation (activities and community life, but with a different approach to the therapeutic community), and socioprofessional reintegration.
Therapeutic communities	8	Therapeutic communities are housing facilities which target users dependent on one or more psychoactive substances, aiming for a goal of abstinence, with the specific feature of placing the group at the heart of the therapeutic and social integration project.
Prisons		



Other inpatient units	68	Housing in therapeutic apartments allows individuals followed up in the context of medical, psychosocial and educational care (outpatient follow-up) to regain their autonomy and re-establish their social relationships (e.g., by sharing daily tasks in the apartment) and professional relationships (searching for training, employment, etc.). This type of housing aims to prolong and reinforce the therapeutic action undertaken. It particularly aims at individuals receiving major treatment (OST, HCV, HIV).
Other inpatient units	8	<p>Short stays, in emergency or transitional facilities, are intended for counselling over short periods (less than three months), during which the user's health and social situation is assessed and medical, psychosocial and educational care proposed.</p> <p>This should enable a break and/or transition period (initiation of OST, awaiting withdrawal, newly released inmates, etc.) which is conducive to initiating a treatment process.</p> <p>Short-stay housing may be collective (such as in a residence) or individual (hotel stays).</p>

na: not available

**Source:** Standard Table 24

T1.2.8 Using the structure and data provided in table IV please provide an overview of the utilisation of the inpatient treatment system within your country and comment on the clients served.

### **Inpatient drug treatment system – Client utilisation**

Based on the CTR and ATR activity reports, the number of individuals housed by these two schemes may be estimated at 1,400 and 1,000 drug users respectively in 2010<sup>1</sup>. The number of individuals housed in CTE should also be taken into account. The precise figure is not currently known, but should lie between 300 and 400 individuals in 2014. The parallels with drug users seen in outpatient CSAPA are undoubtedly fairly broad: a large proportion of the individuals received are, in fact, referred by an outpatient CSAPA.

<sup>1</sup> The number of individuals seen in the CSAPA has not been updated since 2010 due to the delays in submission of activity reports to the OFDT.

*T1.2.9 **Optional.** Please provide any additional information you feel is important to understand the utilisation of Inpatient treatment within your country.*

(Suggested title: Further aspects of inpatient drug treatment utilisation.)

*T1.2.10 **Optional.** Please provide any additional information on types of treatment providers and its utilisation not covered above.*

(Suggested title: Further aspects of inpatient drug treatment provision and utilisation.)



Table IV. Total inpatient treatment provision (number of clients)

	Total number of clients	National Definition (Characteristics)
Hospital-based residential drug treatment	na	
Residential drug treatment (non-hospital based)	1,400	Individuals housed in residential treatment centres
Therapeutic communities	na	Individuals housed in experimental therapeutic communities
Prisons		
Other inpatient units	1,000	Individuals housed in residential therapeutic apartments
Other inpatient units	na	

na: not available

**Source:** Standard Table 24

### T1.3 Key data

The purpose of this section is to provide a commentary on the key estimates related to the topic.

Please structure your answers around the following questions.

T1.3.1 Please comment and provide any available contextual information necessary to interpret the pie chart (figure I) of primary drug of entrants into treatment and main national drug-related treatment figures (table v). In particular, is the distribution of primary drug representative of all treatment entrants?

#### **Summary table of key treatment related data and proportion of treatment demands by primary drug**

The TDI data coverage rate may be estimated at approximately 70% for CSAPA in an outpatient setting. The rate is lower for CSAPA with housing, but they have very little weight in terms of the number of users. Centres which did not provide data do not seem to display common characteristics which would distinguish them from those having submitted data. Drug users at centres contributing to the TDI may therefore be considered as representative of all patients seen at CSAPA in an outpatient setting.

The proportion of new patients treated for cannabis problems seems particularly high (58%) in 2014. This was already the case in previous years; however, the inclusion of all drug users treated in former CCAA in TDI data as from 2013 further reinforced the weight of cannabis (see T1.2.1).

Opioid users represent the second largest group in France. However, individuals for whom stimulants are described as the primary drug only represent a small proportion of new patients. Cocaine appears much more frequently as the secondary drug among individuals describing an opioid as the primary drug.

The total number of individuals on treatment is only known for CSAPA. It is not currently possible to determine the number of individuals admitted in hospitals, or the proportion of patients seen by a primary care practitioner having also been treated at a CSAPA in the last year.

*T1.3.2 **Optional.** If possible, please provide any available information on the distribution of primary drug in the total population in treatment.*

(Suggested title: distribution of primary drug in the total population in treatment.)

*T1.3.3 **Optional.** Please comment on the availability, validity and completeness of the estimates in Table V below.*

(Suggested title: Further methodological comments on the Key Treatment-related data.)

*T1.3.4 **Optional.** Describe the characteristics of clients in treatment, such as patterns of use, problems, demographics, and social profile and comment on any important changes in these characteristics. If possible, describe these characteristics of all clients in treatment. If not, comment on available information such as treatment entrants (TDI ST34).*

(Suggested title: Characteristics of clients in treatment.)

*T1.3.5 **Optional.** Please provide any additional top level statistics relevant to the understanding of treatment in your country.*

(Suggested title: Further top level treatment-related statistics.)

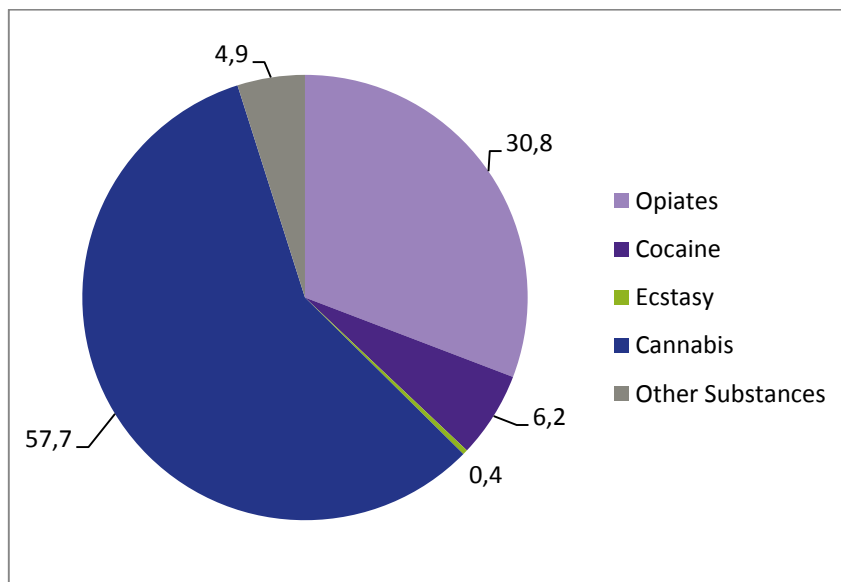
Table V: Summary table - Clients in treatment

	Number of clients
<b>Total clients in treatment</b>	na
<b>Total OST clients</b>	167,000
<b>Total All clients entering treatment</b>	70,000

na: not available

**Source:** ST24 and TDI

Figure I. Proportion of treatment demands by primary drug



Source: TDI

## T1.4 Treatment modalities

The purpose of this section is to:

- Comment on the treatment services that are provided within Outpatient and Inpatient settings in your country, with reference to the categories and data reported in SQ27 part 1 where possible. provide an overview of Opioid Substitution Treatment (OST) in your country

Please structure your answers around the following questions.

### Outpatient and Inpatient services

T1.4.1 Please comment on the types of outpatient drug treatment services available in your country and the scale of provision, as reported to the EMCDDA in SQ27 part 1.

(Suggested title: Outpatient drug treatment services)

#### Outpatient drug treatment services

In terms of outpatient treatment provision, other than measures relating to OST (widely available), the public authorities have primarily attempted to develop counselling and treatment specific to young users (for whom addiction problems are even more often intertwined with adolescent problems and their associated psychological difficulties), by particularly targeting adolescents and young adults who use cannabis. Created in 2004 [[Circulaire DGS/DHOS/DGAS n°2004-464 du 23 septembre 2004 relative à la mise en place de consultations destinées aux jeunes consommateurs de cannabis et autres substances psychoactives et leur famille](#)], slightly more than half of youth addiction outpatient clinics (CJC) are administered by a CSAPA, and the remainder by hospitals. Approximately 540 clinics are currently in operation (Obradovic 2015). Their opening hours can vary (sometimes half a day each week, sometimes every working day). Numerous CJC have opened advanced clinics in schools or different youth facilities. This resource is available throughout France, and may be perceived to have a high level of accessibility. A best practices guide intended for

professionals operating in the context of CJC, issued by the professional body for those working in the field of addiction medicine (Fédération addiction 2012), was published in 2012.

As regards other target groups mentioned in the SQ27P1 questionnaire, no national "programmes" comparable to the resources set in place for young users currently exist. However, some CSAPA are committed and specialise in the specific treatment of different populations, such as individuals presenting psychiatric comorbidities, for whom specific protocols have been set in place. Nonetheless, no specific information is available on this subject. The issue relating to the treatment of pregnant women or new mothers has also long been a concern of the public authorities as well as healthcare professionals working in the field of addiction medicine. The 2008-2011 Government action plan against drugs and drug addiction (MILDT 2008) aimed to encourage projects along these lines. Further to a call for tenders, approximately forty projects have been funded, all contributed by CSAPA (Mutatayi 2014). Two residential treatment centres, located in two different regions (Aquitaine and Île-de-France), are entirely or highly specialised in the treatment of this type of population. The 2013-2017 plan also provides for the creation of two residential schemes for women with children, and two teams for the early detection and treatment of parents/children. In a hospital setting, addiction liaison and treatment teams (ELSA) also regularly work with maternity units, either directly with patients or to train personnel.

In the context of early referral into treatment ordered by the public prosecutor's office or courts (see "Legal framework" workbook) further to a drug-related offence, health care delivery is available for this type of population. However, it is undoubtedly not always adapted to the needs of the population concerned, particularly newly released inmates, for whom housing is an acute problem. To prevent breaks in care and "cold releases"<sup>1</sup>, 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. In two years (2009-2010), seven programmes targeting newly released inmates were thus funded (4 projects of rapid access, short-stay units and 3 projects of early CSAPA consultations in social housing and rehabilitation centres) and then assessed by the OFDT (Obradovic 2014). The public authorities recently promoted the implementation of an experimental programme for the prevention of subsequent offences and an alternative to imprisonment among drug users having committed criminal acts related to their addiction, within the jurisdiction of a Paris court<sup>2</sup>. This experimental programme (the "Bobigny city project") was initiated in March 2015. The objective is to invite approximately fifty multiple offenders to follow an intensive treatment programme (five hours of activities and treatment per day, five days a week, for a year) rather than returning to prison (see "Prevention" workbook).

Numerous CSAPA also face the situation of counselling homeless drug users. Although some have specialised in counselling this population, their number is not sufficient. A programme called "*Un chez soi d'abord*" (inspired by the north-American *Housing first* program) is currently being trialled in four French towns (Paris, Lille, Marseille and Toulouse). It is not specifically aimed at drug users but homeless individuals suffering from major psychiatric disorders, a population which partly covers drug users without fixed abode. Recruited individuals are offered access to ordinary housing in return for intensive health and social support. This support is provided by teams bringing together both health professionals (psychiatrists, addiction specialists, general practitioners, nurses) and social workers, housing specialists or even individuals having experienced life on the streets or mental illness.

In the absence of a systematic survey on the development of specific counselling for the population listed in the SQ27P1 questionnaire, it was not possible to obtain information on counselling for seniors, sex workers or the LGBT community.

There is undoubtedly a need to develop specific programmes for these populations; however, the treatment of pregnant women or women with children, as well as individuals suffering from psychiatric problems or arrested for a drug-related offence, represents some of the situations which all CSAPA should be able to face. Training of CSAPA personnel and the development of specific "programmes" are most likely ways in which this goal can be achieved.

As a general rule, appointments with psychologists or psychiatrists are fairly widely available in CSAPA in an outpatient setting. The availability of the other types of services mentioned in the SQ27P1 is not known.

<sup>1</sup> Releases from prison without any therapeutic follow-up.

<sup>2</sup> The project run by the Bobigny courts is inspired by those existing in Canada (Montreal, Vancouver) which are based on an all-round approach to the individual and reinforced collaboration between the different protagonists of the programme, particularly in the health and judicial fields. Individuals with a complex psychiatric profile cannot be included in this programme. The trial planned for two years should enable 40 to 50 individuals to be included in this programme.

*T1.4.2 **Optional.** Please provide any additional information on services available in Outpatient settings that are important within your country.*

(Suggested title: Further aspect of available outpatient treatment services)

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T1.4.3 Please comment on the types of inpatient drug treatment services available in your country and the scale of provision, as reported to the EMCDDA in SQ27part 1.

### **Inpatient drug treatment services**

As a general rule, OST and appointments with psychologists or psychiatrists are fairly widely available in France in hospital addiction medicine departments, residential treatment centres, experimental therapeutic communities and residential therapeutic apartments. The availability of the other types of services mentioned in the SQ27P1 is not known.

*T1.4.4 **Optional.** Please provide any additional information on services available in Inpatient settings that are important within your country.*

(Suggested title: Further aspect of available inpatient treatment services)

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*T1.4.5 **Optional.** Please provide any available information or data on treatment outcomes and recovery from problem drug use.*

(Suggested title: treatment outcomes and recovery from problem drug use)

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**T1.4.6 Optional.** Please provide any available information on the availability of social reintegration services (employment/housing/education) for people in drug treatment and other relevant drug using populations. (Suggested title: Social reintegration services (employment/housing/education) for people in drug treatment and other relevant populations)

## Opioid substitution treatment (OST)

**T1.4.7** Please provide an overview of the main providers/organisations providing OST within your country and comment on their relative importance. (Suggested title: Main providers/organisations providing Opioid substitution treatment)

### **Main providers/organisations providing opioid substitution treatment**

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

OST is mainly prescribed in a primary care setting by general practitioners, and is usually dispensed in community pharmacies.

The organisation of access to OST is based on two different prescription frameworks, one for methadone, and the other for buprenorphine. Methadone, classed as a narcotic, has a more stringent prescription framework than buprenorphine (with or without naloxone). The latter is a list I<sup>1</sup> drug, but is regulated by narcotics prescription and dispensing rules. This difference is related to the lesser danger involved with buprenorphine (a partial opioid receptor agonist) compared with methadone (a pure agonist), since buprenorphine's ceiling effect limits the depressant, and particularly cardiopulmonary depressant, effects.

Methadone treatment must be initiated by physicians working in a CSAPA or a hospital (or in a prison health unit). Primary care physicians may provide follow-up care once patients have been stabilised. Trialling of initial methadone prescriptions in a primary care setting is part of the 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours. The methadone capsule form, which is more discreet than the large-volume syrup bottles and does not contain sugar or ethanol, is not intended for treatment initiation. It can be prescribed to patients taking the syrup form once they have been stabilised. Initial methadone capsule prescriptions can only be written by CSAPA or hospital physicians specialised in treating drug users.

Any physician can initiate buprenorphine treatment. The maximum duration of prescription is 14 days for methadone, while it is 28 days for buprenorphine. Both of these treatments are subject to controlled prescriptions.

Although the percentage of physicians prescribing OST has not significantly changed since 2003 (9 of 10), the prescription structure has. More than one-third of these general practitioners prescribing an OST now prescribe methadone, while the percentage prescribing buprenorphine is diminishing (from 84.5% in 2003 to 77% in 2009).

<sup>1</sup> Medications dispensed only on medical prescription are included on list I (for those presenting high risks), list II (for those perceived as less hazardous) or on the narcotics list. Narcotics carry the risk of addiction with their use and are subject to controlled prescriptions.

T1.4.8 Please comment on the number of clients receiving OST within your country and the main medications used.

### ***Number of clients in OST***

After first being marketed in 1995, buprenorphine very quickly became the leading treatment for opioid dependency in France. Since 2006, Subutex® is no longer the only product available. A number of generics have arrived on the market, six in 2015, marketed by Arrow, Biogaran, EG, Mylan, Sandoz and Teva. In January 2012, Suboxone® (a combination of buprenorphine and an opioid antagonist, naloxone) was launched in a sublingual tablet administration form. The purpose of this combination is to prevent buprenorphine misuse, by provoking withdrawal symptoms when used by the injection route.

According to data from the French national public health insurance centre (CNAM-TS) collected from the EGB database, 147,000 individuals were reimbursed for OST in a primary care setting in 2014. The number of OST beneficiaries, which had increased continuously since it was first introduced, has started to decline slightly since 2013 (150,000 beneficiaries *versus* 152,000 beneficiaries in 2012), related to a decline in the number of buprenorphine beneficiaries. More specifically, in 2014, 99,000 individuals were prescribed buprenorphine (Subutex® or generics), 49,000 methadone and 6,500 buprenorphine in combination with naloxone (Suboxone®). Buprenorphine, representing 69% overall, still clearly predominates. Moreover, 20,000 patients received methadone dispensed at a CSAPA in 2010 (Palle and Rattanatray 2013).

Morphine sulphate (generally sustained-release 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). 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***

The line between patients following treatment and those receiving buprenorphine prescriptions, but who cannot be considered as following treatment, is unclear. Some of the buprenorphine prescribed is misused and is not taken as part of a treatment programme (see T1.1.1 in workbook Drugs). This proportion has diminished since the implementation of the French National Health Insurance Fund's 2004 strategy to control opioid substitution treatments<sup>1</sup>. One of the main indicators for buprenorphine misuse (average daily dose higher than 32 mg/d<sup>2</sup>) fell by two-thirds between 2002 and 2007 (Canarelli and Coquelin 2009). Since then, this indicator has remained stable (2.2% in 2012) (Brisacier and Collin 2014). Moreover, 73% of patients receiving buprenorphine are receiving regular treatment<sup>3</sup> 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 and ANSM 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 ENa-CAARUD survey, 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 2014a), 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 six years of monitoring, there were 87 reports of paediatric poisoning (31 with the capsule dosage form, 56 with the syrup dosage form), causing 5 deaths, and 325 cases of misuse (illegal procurement, diversion of the route of administration by injecting or snorting, occasional use or overdose). 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 Prison workbook). The proportion is significantly higher in the female prison population (DGS 2011).

<sup>1</sup> 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.

<sup>2</sup> The buprenorphine 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 buprenorphine trafficking or dealing.

<sup>3</sup> Patients taking regular buprenorphine 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.

**T1.4.9 Optional.** Describe the characteristics of clients in opioid substitution treatment, such as demographics (in particular age breakdowns), social profile and comment on any important changes in these characteristics. (Suggested title: Characteristics of clients in OST)

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**T1.4.10 Optional.** Please provide any additional information on the organisation, access, and availability of OST. (Suggested title: Further aspect on organisation, access and availability of OST)

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## T1.5 Quality assurance of drug treatment services

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

Please structure your answers around the following question.

**T1.5.1 Optional.** Please provide an overview of the main treatment quality assurance standards, guidelines and targets within your country.

### Quality assurance in drug treatment

In 2014, the medico-social system for the treatment 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 system, of its correct positioning and interaction with other protagonists in the prevention, health care, social and medico-social fields"* (Hesse and Duhamel 2014).

The latest national recommendations on therapeutic strategies for opioid-dependent individuals date back to the 2004 consensus conference (FFA and ANAES 2005).

A guide on OST in a prison setting, published in 2013 (Ministère des affaires sociales et de la santé and MILDT 2013), describes in detail the legal and regulatory framework for OST (in France in general and in a prison setting) and gives recommendations for best practices in terms of treatment.

## T2. Trends

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

T2.1 Please comment on the possible explanations of long term trends (10 years - or earliest data available) in the following treatment data:

- New treatment entrants (figure II),
- All treatment entrants (figure III),
- OST clients (figure IV).

For example, patterns of drug use, referral practices, policy changes and methodological changes.

### Long term trends in numbers of clients entering treatment and in OST

#### *New treatment entrants*

The proportion of cannabis users is increasing among individuals entering treatment for the first time in their lives (Figure II) whereas the proportion of opioid users is declining. In 2014, this population of individuals entering treatment for the first time, with an average age of 26 since 2007, comprises nearly 70% cannabis users and slightly over 10% opioid users. The downward trend in opioid users in 2014 could be related to the higher percentage of users without information on substances. In 2014, data on substances were deleted in order to avoid falsifying the results for ten or so CSAPA for which it was unclear as to whether their software had been updated further to changes in the European protocol. Furthermore, it should be borne in mind that the question relating to the existence of previous treatments is only completed for two-thirds of users included in TDI data.

The percentages for cocaine users and "other substance" users, at a fairly low level, remained relatively stable over the period. The proportions of amphetamine and ecstasy users are so low that changes do not require comment.

The developments observed in 2012 contrast with the trends over the entire period. Disruptions related to the changeover to the new European protocol for recording treatment demands may be apparent since 2012 and trends may not be an accurate reflection of reality.

#### *All treatment entrants*

As regards all treatment entrants (Figure III), the distribution according to substances seems fairly stable up to 2012, with a slight downward trend in the percentage of cannabis users up to 2010. The proportion of cannabis users increased considerably in 2013, whereas the proportion of opioid users showed a symmetrical decline. These developments are perhaps amplified due to all drug users (predominantly cannabis users) seen at the former CCAA being included as from 2013 (see T1.2.1). Inclusion of these centres resulted in an increase in numbers between 2012 and 2013 by 9,000 users, including 5,600 cannabis users. This therefore accounts for a large proportion of the overall increase (+ 9,000 cannabis users) but not the whole increase. Excluding these centres, the proportion of cannabis users has risen from 34% in 2012 to 40% in 2013.

The proportion of opioid users remained fairly stable between 2009 and 2012, and only declined from 2013, due to the large increase in the number of cannabis users. The decline observed in 2014 is the result of a drop in numbers which appears to be related to a slight reduction in the number of CSAPA responding in 2014 and the deliberate deletion of data on substances in ten or so CSAPA.

The proportion of non-respondents on substances was about 20% up to 2012, with, however, a slight trend towards an increase. The decline in 2013 is once again explained by the inclusion of the former CCAA in TDI data. The resulting increase in numbers (+ 9,000) was only accompanied by a very small rise in non-respondents on substances. For all former CCAA, non-respondents on substances correspond, in the large majority of cases, to users for whom alcohol is the primary substance which should not be included in TDI data. All non-respondents on substances among individuals received at former CCAA were therefore excluded from the data analysis. The possible presence of these alcohol users among non-respondents at former CCAA was not detected during the 2013 data analysis. The numbers of non-respondents, hence the overall numbers, were partly overestimated (by approximately 10%) in the 2013 TDI data. Those used herein were recalculated after excluding the non-respondents on substances at former CCAA. The large increase in overall numbers without an increase in non-respondents on substances is mechanically expressed by a decrease in the percentage of non-respondents.

Despite the various disruptions in determining the TDI indicator, the rise in the proportion of cannabis users may be explained both by the increase in cannabis use in France among adolescents and young adults between 2010-2011 and 2014 and by the public authorities' investment to increase treatment provision for young cannabis users (see T1.2 in workbook Drugs).

#### *OST clients*

Since 2010, the number of OST beneficiaries has been estimated based on National Health Insurance Fund reimbursement data (Figure IV). This had previously been estimated based on sales data for opioid substitution medications (OSM). In order to maintain the long-term developments, Figure V shows the available data on OSM use since 1995.

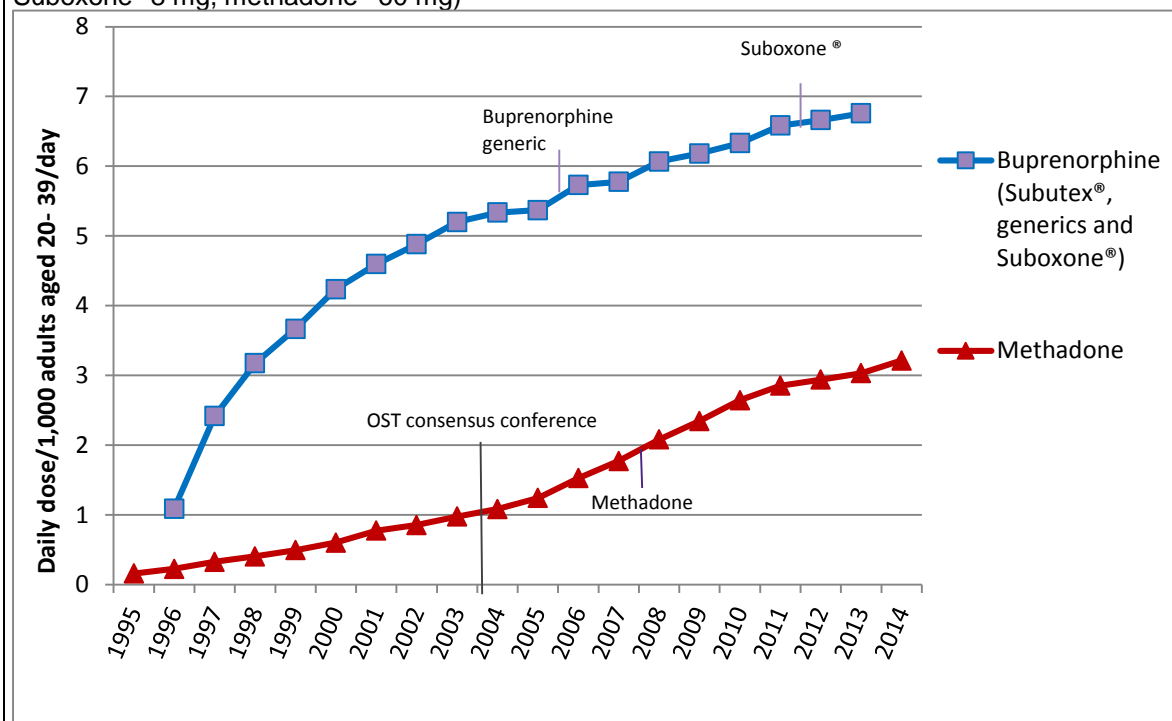
In 2013 and 2014, the number of OST beneficiaries showed a slight decline, for the first time since OSMs were introduced (Figure IV). However, this trend is not significant. Sales data

for OSM are conflicting to a certain extent, with growth continuing in 2013 (overall data for 2014 are not yet available).

The proportion of methadone 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. Among the 49,000 individuals having received reimbursement for methadone in 2014, for the first time, the syrup form no longer predominates, even though it is still widely prescribed (exclusively to 42% of beneficiaries of reimbursement for methadone *versus* 47% for the capsule form). Furthermore, 11% of beneficiaries were reimbursed for both forms (EGB data, CNAM-TS). According to sales data, in 2014, the syrup form represented 48% (*versus* 55% in 2013) of the methadone sold (by weight) and the capsule form 52% (*versus* 45% in 2013). Moreover, 78% of the quantities were dispensed in retail pharmacies, while 22% were in CSAPAs or hospitals (Bouchara data).

Figure V presents the use of buprenorphine (including Suboxone®) and methadone in France since 1995. These data are based on sales figures, according to an assumed prescribed mean daily dose of 8 mg for buprenorphine (including Suboxone®) and 60 mg for methadone. Buprenorphine generics (introduced in France in 2006), and then Suboxone® (introduced in 2012) offset the decrease in Subutex® use observed since 2006. In 2013, the quantities of buprenorphine sold (by weight) were as follows: Subutex® 73%, generics 24% and Suboxone® 3% (*versus* 1% in 2012). The penetration rate of generics, 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 (CEIP *et al.* 2013).

Figure V: Opioid substitution treatments: use of buprenorphine and methadone from 1995 to 2014 in terms of daily dose/1,000 inhabitants aged 20 to 39 years/day (Subutex® and generics 8 mg, Suboxone® 8 mg, methadone® 60 mg)

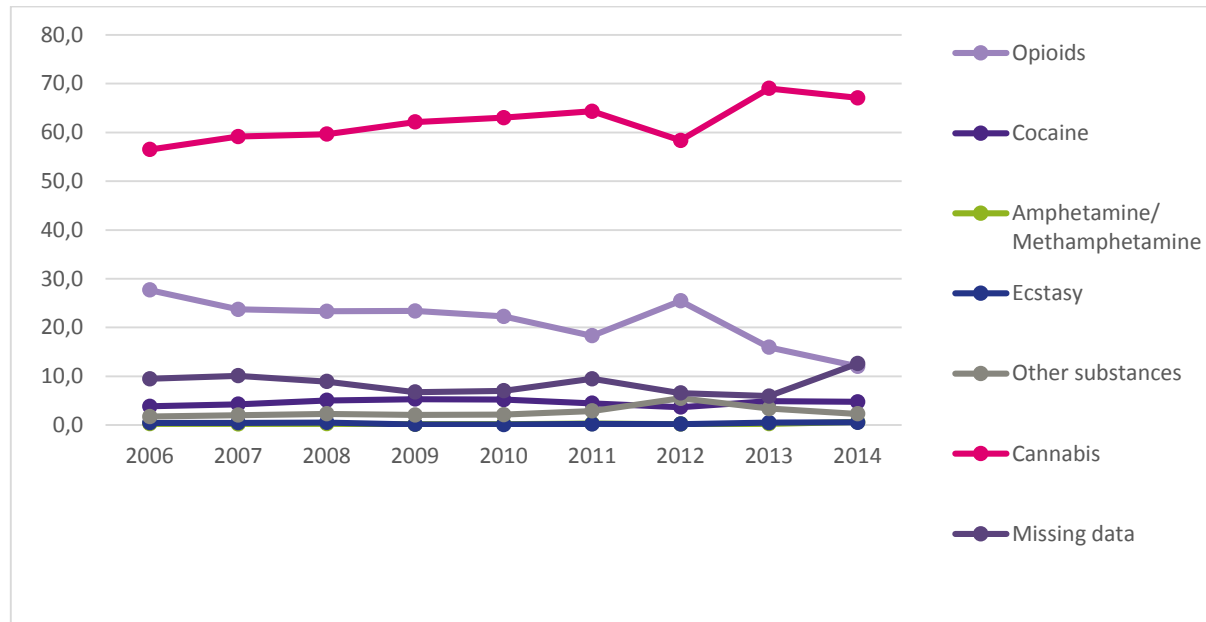


Source: SIAMOIS (InVS), Bouchara, Medic'AM (CNAM-TS)

N.B. Sales data on buprenorphine are not yet available for 2014

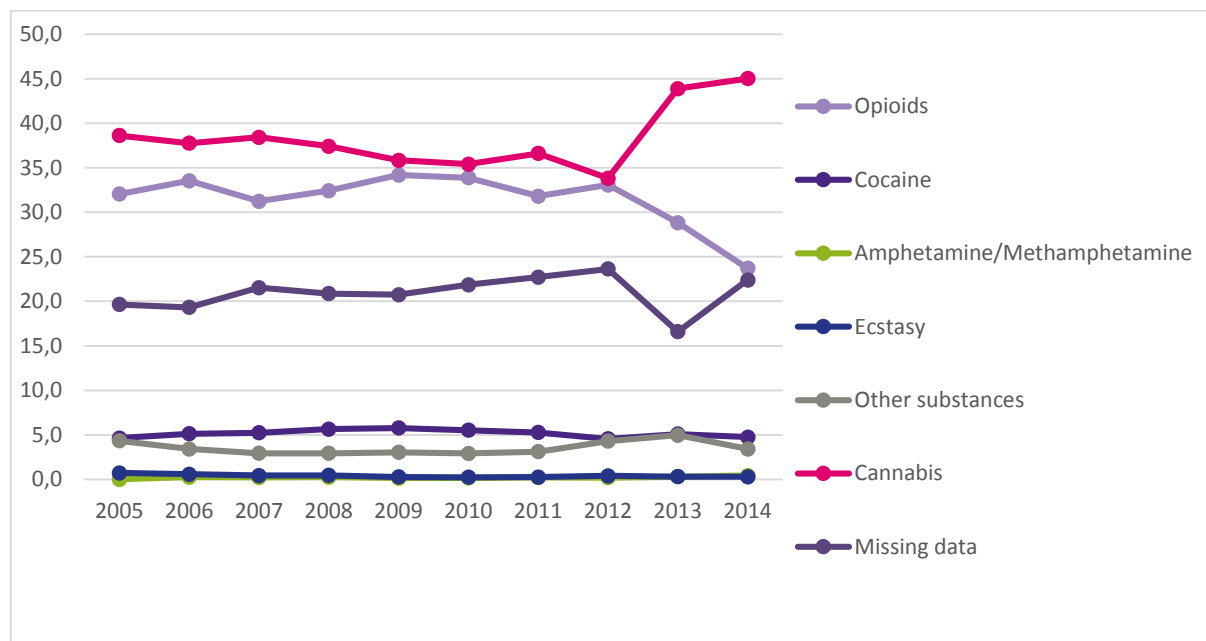
**T2.2 Optional.** Please comment on the possible explanations of long term trends and short term trends in any other treatment data that you consider important.  
(Suggested title: Additional trends in drug treatment)

Figure II. Trends in numbers of first-time clients entering treatment, by primary drug, 2006-2014



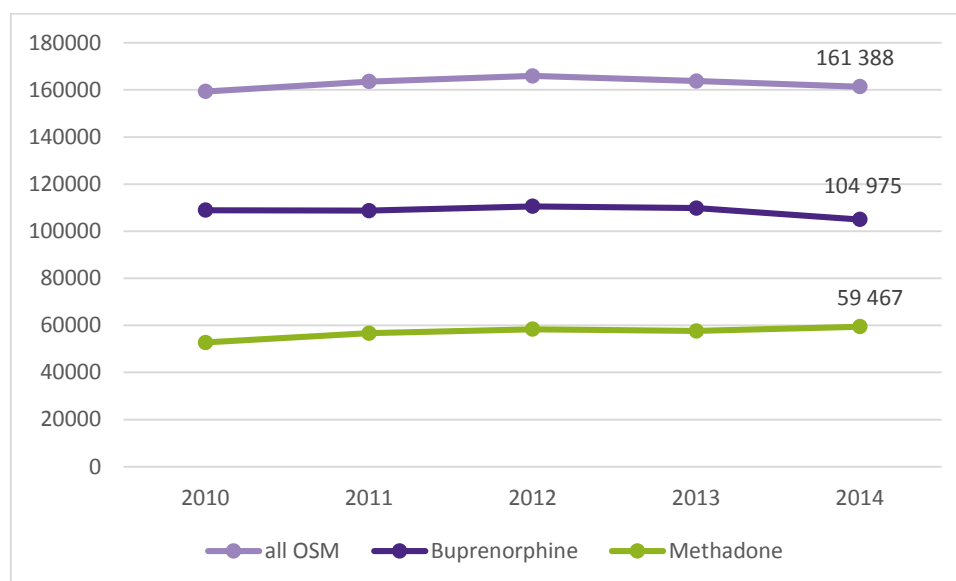
Source: TDI

Figure III. Trends in numbers of all clients entering treatment, by primary drug, 2005-2014



Source: TDI

Figure IV. Trends in numbers of clients in opioid substitution treatment, 2010-2014



Source: ST 24

### T3. New developments

The purpose of this section is to provide information on any notable or topical developments observed in drug treatment 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.

T3.1 Please report on any notable new or topical developments observed in drug treatment in your country since your last report.

#### New developments

The prescribing conditions for methadone in capsule form were modified by decree in October 2014 [[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](#)]. The maximum prescribing duration for this form is now 28 days as opposed to 14 in the past. However, the syrup form maintains a maximum prescribing duration of 14 days.

Treatment with methadone can only be initiated in France by a physician practising at a CSAPA or in a hospital (see T1.4.7). However, this restriction has been the subject of debate and the public authorities have questioned the advantages and disadvantages of allowing treatment with methadone to be initiated by primary care practitioners. The results of the *Méthaville* study published in November 2014 in PLoS One (Carrieri *et al.* 2014) support those in favour of extending initiation of methadone treatment to a primary care setting. In this randomised study, opioid-dependent individuals wishing to receive methadone treatment were randomly divided into two groups: in the first group (155 individuals), treatment was initiated by a primary care practitioner and, in the second group (66 individuals), initiation took place at

a CSAPA. Comparison between the two groups after a year showed similar results for the two groups regarding opioid abstinence and adherence to treatment, and better satisfaction among patients treated in a primary care setting. However, the study authors emphasise the fact that this result is determined by the willingness of primary care practitioners, through access to specific training on methadone prescribing and collaboration with a CSAPA and a reference pharmacist. The 2013-2017 plan for combating drugs and addictive behaviours provides for the trialling of initial prescription of methadone in a primary care setting; however, this has not yet begun.

Further to a survey conducted by the Nantes CEIP in 2013, which had shown that misuse by injecting buprenorphine (particularly generics) could cause necrotic skin lesions, the formulation of buprenorphine generics was modified at the end of 2014. The withdrawn excipients are colloidal silica, amide and magnesium stearate (ANSM 2014b).

As regards treatment, the experimental programme for the medico-judicial management of offenders suffering from alcohol or drug addiction, already described in part T1.4.1 and in the Prevention workbook, may also be mentioned.

## T4. Additional information

The purpose of this section is to provide additional information important to drug policy in your country that has not been provided elsewhere.

Please structure your answers around the following questions.

**T4.1 Optional.** Please describe any additional important sources of information, specific studies or data on drug treatment. Where possible, please provide references and/or links.  
(Suggested title: Additional Sources of Information.)

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**T4.2 Optional.** Please describe any other important aspect of drug treatment that has not been covered in the specific questions above. This may be additional information or new areas of specific importance for your country. (Suggested title: Further Aspects of Drug Treatment.)

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## 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.

**T5.1** Is there any monitoring in place and data available on the misuse of opioid substitution medications?

YES	<ul style="list-style-type: none"> <li>Monitoring of indicators for diversion (targeting individuals dispensed more than 32 mg buprenorphine per day, together with users having at least 5 prescribers or 5 pharmacies dispensing treatment) in the OSM reimbursement databases of the National Health Insurance Fund.</li> </ul>
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	<ul style="list-style-type: none"> <li>• Qualitative monitoring via the TREND scheme (OFDT) in 7 cities which track the availability and prices of OSM on the black market together with patterns of use.</li> <li>• ENa-CAARUD surveys (OFDT): route of administration of buprenorphine by CAARUD clients.</li> <li>• Oppidum survey (ANSM): route of administration of buprenorphine by CSAPA or CAARUD clients.</li> </ul>
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T5.2 Is internet-based treatment available in your country?

NO	
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T5.3 Has your country developed any specific treatments for NPS users?

NO	
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## 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.

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

### Sources

CSAPA activity reports  
EGB: General sample of French persons with social security coverage  
ENa-CAARUD: National survey of CAARUDs' clients  
CJC 2014 survey: Survey in Youth Addiction Outpatient Clinics  
OPPIDUM: Observation of illegal drugs and misuse of psychotropic medications  
RECAP: Common data collection on addictions and treatments  
TREND: Emerging Trends and New Drugs

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

### Methodology

#### **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%.

**EGB: Échantillon généraliste des bénéficiaires [General sample of French persons with social security coverage]**

*National public health insurance centre-Employed workers (CNAM-TS)*

The population being dispensed an OSM in the primary care setting was studied using data from the French National Health Insurance Fund's "EGB" general population sample from 2012. The EGB is a permanent representative sample of the population protected by the general health insurance scheme (excluding students and civil servants), the agricultural worker health insurance scheme (MSA) and the health insurance scheme for self-employed people (RSI). It comprises 1/97<sup>th</sup> of the list of Social Security numbers, grouping more than 600,000 beneficiaries in 2012. The database resulting from this sample contains some sociodemographic data and all reimbursed health services and treatments (medical consultations, medications and laboratory work, etc.). There are also medical data on treatment under the French ALD (long-term illness) scheme as well as hospital data from the Programme of Medicalisation of Information Systems (PMSI) covering medicine, surgery and obstetrics. The CNAM-TS has made the EGB available to several health agencies, including the ANSM and OFDT. The 2011 and 2012 data were extracted by the ANSM, and the 2013 and 2014 data by the OFDT.

**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.

**CJC 2014 survey: Survey in Youth Addiction Outpatient Clinics**

*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

2014 is the third year (after 2005 and 2007) of the survey on clients of youth addiction outpatient clinics (CJC), a scheme created in 2005 to offer counselling for young psychoactive substance users. The 2014 survey is based on the responses by professionals having seen the patients or their families between 24 March and 30 June 2014. It covers metropolitan France and French overseas departments. Out of 260 facilities administering a CJC activity in metropolitan France and the DOM recorded in 2014, 212 responded to the survey, i.e., a response rate of 82%.

The questionnaire comprises four parts: circumstances and reasons for consulting, user sociodemographic characteristics, substances used and evaluation of cannabis dependence by the Cannabis Abuse Screening Test, and decision made at the end of the appointment.

Out of the 5,421 questionnaires collected, corresponding to the number of appointments held during the survey period, 5,407 were considered fit to describe consulting activity. After



eliminating questionnaires not stating gender or age, the final user base included 4,958 individuals.

### **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 2012, 140 centres (or 4,765 patients) took part in the survey. The majority of patients had been seen in outpatient CSAPAs, but some had been seen in prison-based hospital healthcare units (UCSA) and CAARUDs).

### **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.

### **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.

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## WB 3.3 Best practice

*France*

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## **2015 National report (2014 data) to the EMCDDA by the French Reitox National Focal Point**

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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.

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## T0. Summary

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

- National profile

In France, quality assurance in Drug Demand Reduction (prevention, risk reduction, treatment and rehabilitation) builds on specific advocacy, guidelines or trainings from professional societies or organisations or public health institutions but it is not strongly institutionally structured nor imposed. As for risk reduction and treatment, different guidelines exist (on (i) Opiate Substitution Treatment, (ii) Early intervention and risk/harm reduction for crack or free base users, (iii) Clinics for young drug users and (iv) Treatment of cocaine users). However their implementation is not compulsory: there is no formal prerequisite of fulfilling guidelines to get support or subsidies. The compliance to these guidelines is not as a label. The addiction treatment services (so-called CSAPA) are marginally impacted by the existing accreditation and certification processes directed to health establishments.

In drug prevention, the National Institute for Prevention and Health Education (INPES) distributes information on evidence-based prevention methods. However, there is no specific drug use prevention protocol for prevention providers, public servants or associative workers to follow.

In the 2010's, although many resource services in prevention engineering have collapsed at local level, there is a noticeable willing at national level to enhance quality in the programmes and services delivered, especially in prevention. The creation of the Interministerial Commission for the Prevention of Addictive Behaviours (CIPCA), in 2014, is part of it.

- New developments

A growing though still limited number of prevention organisations get involved in implementing international evidence-based programmes in local French contexts. In the recent years, the concern about good practices and evidence-based practices has got higher. This general climate is incentivized by both a political impetus (repeated references to evidence-based approaches in governmental strategies) and professional inspiration. In 2014-2015, particular endeavours in quality assurance were focused on improving the training supply on addiction topics, especially for health professionals or future ones.

## T1. National profile

### T1.1 Policies and coordination

The purpose of this section is to:

- Provide a brief summary of quality assurance-related objectives, if any, within your national drug strategy

Please structure your answers around the following questions.

T1.1.1 Please summarise the main quality assurance-related objectives of your national drug strategy or other key drug policy document.

The Government Plan for Combating Drugs and Addictive Behaviours 2013–17 (MILDT 2013) was adopted on 19 September 2013. The responsibility for its implementation is entrusted to the Interministerial Mission for the Fight Against Drugs and Addictive Behaviours (MILDECA) which reports to the Prime Minister. This 2013–17 strategy is based around three main priorities:

- To base public action on observation, research and evaluation.
- To take the most vulnerable populations into consideration to reduce risks and health and social harm.
- To reinforce safety, tranquillity and public health, both locally and internationally, by fighting drug trafficking and all forms of criminality related to psychoactive substance use.

These priorities are addressed across the five areas of action that structure the anti-drug strategy, among which one is directly related to research evidence-based approach and skill improvement training Actions Plan: (i) prevention, care and risk reduction; (ii) stepping up the fight against trafficking; (iii) improving the application of the law; (iv) **basing policies for combating drugs and addictive behaviours on research and training**; (v) reinforcing coordination at national and international levels.

The Government Plan sets several objectives out in relation to quality assurance impetus. Under the prevention and care pillar, the strategy clearly specifies the aim of:

- **“Promoting Evidence-Based Preventive Strategies”**, especially through the creation of an Interministerial Commission for the Prevention of Addictive Behaviours (CIPCA)
- **“Improving the Quality of Healthcare for Patients receiving Opiate Substitution Treatment and Increasing the Accessibility”**.

Thereof:

- By trialling and assessing new therapeutic methods and initial methadone prescription in urban community medicine, in particular, in order to avoid misuse and promote appropriate healthcare.
- By increasing the accessibility of these treatments, in particular through greater mobility of the programmes (methadone bus).
- By bringing the recommendation of the French national agency for the safety of medicines and health products (Agence nationale de sécurité du médicament et des produits de santé - ANSM) into general application with regard to the daily dispensing of opiate substitution treatment in pharmacies for patients receiving care within the urban community.



- By reducing drug interactions through the creation of a functional liaison between urban pharmacies and CSAPAs for patients receiving care within these facilities.
- By putting therapeutic education protocols in place, in liaison with the regional health agencies (ARS), for patients taking these medicines.
- By a more systematic use of screening tests in urban medical practices, in accordance with ANSM recommendations. These tests, the results of which are interpreted by doctors during consultations with patients, do not constitute a surveillance tool. They are used in a spirit of mutual trust: patients thus feel that they are backed up and supported by therapists and healthcare providers on jointly fixed therapeutic objectives.
- By promoting the practices recommended in the guide for opiate substitution treatment in the prison environment.” (see also T1.4.1 in Prison workbook).

A whole piece of the governmental strategy develops avenues to **Base Policies for Combating Drugs and Addictive Behaviours upon Research and Training**. In this registry, some specific goals are:

- To “**Improve the Interface Between Researchers and Decision-Makers**”, thereby: (i) to promote the production of scientific results that are directly useful for public policy decisions; (ii) to develop preventive research; (iii) to develop evaluative research.
- To reinforce initial training with regard to addictive behaviours directed to medical students, or professionals working in school, university and criminal justice environments. Endeavours in this field should address professionals with different profiles, i.e. prevention stakeholders, but practitioners also engaged in early detection and intervention, in risk reduction or in tackling trafficking.

## T1.2 Organisation and functioning of best practice promotion

The purpose of this section is to describe the organization of best practice promotion in your country

Please structure your answers around the following questions.

T1.2.1 What are the national organizations/institutions promoting quality assurance of drug demand reduction interventions and their function?

Please provide a brief description of each body and their relationship.

The MILDECA is responsible for the achievement of the goals defined in the French Government Drug strategy towards more quality assurance.

The specific objective of “Promoting Evidence-Based Preventive Strategies” is specifically in the remit of the Interministerial Commission for the Prevention of Addictive Behaviours (CIPCA). The CIPCA must promote preventive programmes, in accordance with European and international recommendations. The EDPQS materials (European Drug Prevention Quality Standards) should be discussed within this commission to study their transferability to the French context. This commission is chaired by the MILDECA and will be part of an original procedure for the selection of existing or innovative programmes, with a view to organising and funding the scientific external evaluation thereof. The OFDT and the INPES take part to this Commission, for scientific advocacy. The MILDECA and its regional network will promote scientifically validated programmes corresponding to national priorities.

In the prevention field, the INPES distributes information on scientifically-validated prevention methods, e.g. of the French adaptation of the Preffi 2 guidelines (developed by the NIGZ Centre for Knowledge and Quality Management). The Preffi is a quality assurance instrument for health promotion (implementation and evaluation of effectiveness). These documents are still to be used for information purposes only: there is no specific drug use prevention protocol for prevention providers, public servants or associative workers to follow.

The French National Authority for Health (*Haute autorité de santé* - HAS) is an independent scientific public authority that aims at contributing to regulate the quality of the health system. It has a specific remit of developing guidance and disseminating evidence-based information among health professionals. For instance, the HAS has developed a web section on tools for early detection and brief intervention with regards to alcohol, cannabis and tobacco uses in adults ([http://www.has-sante.fr/portail/jcms/c\\_1795221/fr/outil-daide-au-reperage-precoc-et-intervention-breve-alcool-cannabis-tabac-chez-ladulte](http://www.has-sante.fr/portail/jcms/c_1795221/fr/outil-daide-au-reperage-precoc-et-intervention-breve-alcool-cannabis-tabac-chez-ladulte)).

T1.2.2 Do you have any accreditation systems for intervention providers in drug demand reduction? If yes, please provide a brief description.

The French National Authority for Health (HAS: [http://www.has-sante.fr/portail/jcms/c\\_1249588/fr/accueil-2012](http://www.has-sante.fr/portail/jcms/c_1249588/fr/accueil-2012)) is an independent public body, with financial autonomy, set up in August 2004, which aims at improving the quality of patient care and guaranteeing equity within the healthcare system. Its activities range from (i) assessment of drugs, (ii) medical devices and procedures, (iii) publication of guidelines, (iv) certification of healthcare establishments and (v) accreditation of practitioners.

The certification process of health establishments is structured around two main areas, i.e. the establishment management and the patient management, as formalised in the 2014 Manual on certification of healthcare establishments (Haute autorité de santé (HAS) 2014). However the addiction treatment services (so-called CSAPA) are marginally impacted by these processes:

- The accreditation procedures are applied to high-risk medical or surgery specialities, which are not the ones generally engaged in addiction treatment.
- The certification process has little inference as to addiction issues:
  - (i) Certificated establishments have to define an integrated programme on the management of quality and safety of care, which includes “addictovigilance” as part of their warning system for the earliest detection of any unusual health events and for the response to health alert.
  - (ii) With regards to the patient management, the only criterion related to addiction issues is directed to the establishments that address inmates. These establishments/services must develop adapted therapies taking into account the higher iatrogenic and suicidal risk related to the frequent poly-use of addictive substances among inmates.

T1.2.3 Do you have specific education systems for professionals working in the field of demand reduction? If yes, please provide a brief description.

Information relevant to this answer includes:

- specific academic curricula,
- specific continued education/specialization courses

Specific continued education is provided to drug specialised law enforcement officers who are likely to provide for prevention interventions on topics like drugs, alcohol or violence, in various settings (mainly schools, but also occupational settings, common touristic sites...). These interveners are FRAD (national *Gendarmerie*) or PFAD (from national Police). They are assigned to local units or services throughout France and there is a variation of their involvement and experience in drug prevention: in general, prevention interventions are a limited part of their activities, though some of them work full time in this field. For both groups (FRAD and PFAD), updating skill courses can be undertaken on a voluntary basis, according to a 2 or 4 year cycle. The PFAD (initial or continuous) training education is managed by a national centre (the National Institute for the Training of the National Police, INFPN). The four-week training of the PFAD is based on multidisciplinary sessions in respect to the current scientific knowledge. It includes interventions from a psychologist, health and health promotion professionals, epidemiologist on topics like the psychological development of teenagers, health promotion principles. During this training, the trainees can practice conducting a prevention session towards adults (school staff, teenagers' parents...) or adolescents. Each exercise gives rise to a complete collective debriefing by the trainer and the psychologist, in terms of both content and form. The FRAD system training will be progressively integrated to the PFAD one and entrusted to the INFPN.

Continuous education on addiction issues is mainly implemented by professional societies, according to an annual programming.

As per the current French National plan 2013 -2017, a range of objectives address the reinforcement of professional skills through training, in the general aim of "Coordinating the Content of Initial and Continuing Training on the Basis of Common Core Knowledge and Skills". The two core objectives under this general aim are: "Reinforcing Initial Training with Regard to Addictive Behaviours" and "Encouraging the Sharing of Professional Cultures Through Continuing Training". Some of the initiatives related to these objectives have begun to be implemented, especially in respect to the first one, as shown below.

As per the objective of **"Reinforcing Initial Training with Regard to Addictive Behaviours"**, planned actions and progress are reported in the table below:

Specific component/action stated by the governmental plan	Progress in implementation
(i) Creating an inter-university Master's Degree in addiction research open to practicing medical students and other health professionals. In this respect, the expertise of the Federative Organisation for Research in the study and Treatment of Addictions (SFRA) can be called upon insofar as necessary.	In 2014, a specialization of Master's degree in addictology was created in the Master's degree of Public health of the Paris 7 University, opening the way for the implementation of an interdisciplinary Master's degree in addictology for the year 2016-2017, within the framework of the future Action plan 2016-2017.
(ii) Consolidating the teaching concerning the study and treatment of addictions introduced in the 2007-2011 addictions plan, for medical studies at Bachelor, Master and PhD levels.	Professional societies for addictology, University professors and hospital practitioners (PU-PH), the Department of Research and Higher education and the MILDECA are considering how to develop an inter-university Master's Degree in

	addiction research. This reflection is part of the agenda of the reform of the post-graduate medical studies (3rd cycle) which has to end up in the 2016 and 2017 academic years.
(iii) Extending teaching on addictions, which is currently provided to medical students, to health professionals, social workers, occupational therapists and psychomotor therapists as a whole.	<p>Since the reform of health studies in 2010, a Common first year of health studies (so-called PACES in French) has been instituted for medical, odontological, pharmaceutical and maieutics disciplines (law of July 7th, 2009 [<a href="#">Loi n°2009-833 portant création d'une première année commune aux études de santé et facilitant la réorientation des étudiants</a>]).</p> <p>This PACES integrates a training in addictology within the framework of the credit "Health, society, humanity" (Ministerial Order of October 28<sup>th</sup>, 2009 [<a href="#">Arrêté relatif à la première année commune aux études de santé</a>]). A few faculties have opened the PACES to students in occupational therapy or physiotherapy. The introduction of such a module of addictology in the PACES allows any future healthcare practitioners to be introduced to the issue of addictions and to the principles of the addictology. From 2011 till 2014, the addictology has been integrated into the curricula of the first and second cycles of the medical studies.</p>

As per the objective of “**Encouraging the Sharing of Professional Cultures Through Continuing Training**”, planned actions and progress are reported in the table below:

Specific component/action stated by the governmental plan	Progress in implementation
<ul style="list-style-type: none"> <li>Organising a training module for all providers involved in prevention, who have not had the benefit of such training and are in contact with young people. Such interministerial training in addiction prevention, based upon a body of common knowledge, should lead to the award of a national certificate.</li> </ul>	<p>In 2014 and 2015, four regional inter-institutional and inter-professional continuous training courses on preventing addictive behaviours were experimentally directed to social and educational professionals (education, social, childhood, adolescence areas). The aim was to assess the transferable components of such trainings in territories willing to develop such initiatives. A similar training course is planned to be implemented by the end of 2015, in a fifth region.</p> <p>In 2016, the implementation process of such trainings will be refined on the basis of these experiences, with a view of dissemination from 2017.</p>

<ul style="list-style-type: none"> <li>• Creating specific training in prevention and treatment of the negative consequences of drug use in the world of festive events, for both health and security professionals, young people (student associations) and partners involved in the organisation of events (professionals of nightlife establishments, organisers of evening events, managers of temporary bars etc.).</li> </ul>	Not implemented yet: task under the next action plan 2016-2017
<ul style="list-style-type: none"> <li>• Developing early detection and intervention training programmes. These training programmes will be aimed at health, education, social work and criminal justice professionals, in contact with priority groups and, more specifically, with young people and pregnant women.</li> </ul>	With the circular of July 19th, 2013 [ <a href="#">Circulaire DGOS/RH4 n°2013-295 sur les orientations en matière de développement des compétences des personnels des établissements mentionnés à l'article 2 de la loi n°86-33 du 9 janvier 1986 portant dispositions statutaires relatives à la fonction publique hospitalière</a> ], the early detection and brief intervention of addictive behaviours, more particularly towards young people, becomes in 2014 a priority for the public hospitals staffs' skills development.
<ul style="list-style-type: none"> <li>• Trialling common training programmes in the field of risk-reduction, built on the basis of concrete situations rooted in the territories, for members of the police forces, justice system and health services, in partnership with associations working for risk-reduction.</li> </ul>	Not implemented yet: task under the next action plan 2016-2017
<ul style="list-style-type: none"> <li>• Continuing to adapt the training of providers in the criminal justice system to changes in trafficking and, in particular, to combating the supply of drugs via the Internet and the practice of seizing and confiscating criminal assets, as well as the detection of chemical precursor diversion networks.</li> </ul>	Not implemented yet: task under the next action plan 2016-2017
<p>Furthermore, since 2013, the MILDECA has financially supported the training of change agent among students to intervene in preventing addictive behaviours so as to strengthen peer-led prevention within higher education settings. From September 2015, 24 universities will implement a system of peer change agent (students), versus 12 universities in 2013).</p>	

## T2. Trends. Not applicable for this workbook

### T3. New developments

The purpose of this section is to provide information on any notable or topical developments observed in best practice promotion 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 question.

T.3.1 Please comment on any notable new or topical developments observed in best practice promotion in your country (eg. new standards/guidelines/protocols developed). Please note that the information here should complement or add to the information submitted through Structured Questionnaire 27P2 which monitors the implementation of quality assurance systems by collecting information on Guidelines and Standards available in the country.

No new developments.

### T4. Additional information

The purpose of this section is to provide additional information important to best practice promotion in your country that has not been provided elsewhere.

Please structure your answers around the following questions.

*T.4.1 **Optional**. Please describe any additional important sources of information, specific studies or data on best practice promotion. Where possible, please provide references and/or links.*

*T.4.2 **Optional**. Please describe any other important aspect of best practice promotion that has not been covered in the specific questions above. This may be additional information or new areas of specific importance for your country*

### 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.

No current questions.

### 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.

T.6.1 Please list notable sources for the information provided above.

## Sources

About the EDPQS materials:

- <http://prevention-standards.eu/standards/>
- <http://www.ofdt.fr/europe-et-international/projets-internationaux/edpqs/#3>

About the CIPCA:

<http://www.drogues.gouv.fr/site-professionnel/prevention/cipca/index.html>

About the French National Authority for Health (HAS) guidance for early detection and brief intervention in adults: [http://www.has-sante.fr/portail/jcms/c\\_1795221/fr/outil-daide-au-reperage-precoc-et-intervention-breve-alcool-cannabis-tabac-chez-ladulte](http://www.has-sante.fr/portail/jcms/c_1795221/fr/outil-daide-au-reperage-precoc-et-intervention-breve-alcool-cannabis-tabac-chez-ladulte)

T.6.2 Where studies or surveys have been used please list them and where appropriate describe the methodology?

No study reference. Data collected through direct interviews or specific investigation.

## Bibliography

Haute autorité de santé (HAS) (2014). Manuel de certification des établissements de santé. HAS, Saint-Denis.

MILDT (2013). Government plan for combating drugs and addictive behaviours 2013-2017. MILDT, Paris.

## WB 3.4 Harms and Harm Reduction

*France*

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## **2015 National report (2014 data) to the EMCDDA by the French Reitox National Focal Point**

**Supervision:** François Beck

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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.

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## 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.

**T1.2.3 Optional.** Please provide a commentary on any additional information you feel is important to understand drug-related acute emergencies data within your country.  
(Suggested title: Additional information on drug-related acute emergencies)

## 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.

**T1.3.2 Optional** Please comment on notification data (e.g. notification of new HIV and AIDS cases among drug users)  
Short descriptions of outbreaks/clusters, specific surveys or other relevant data can be reported here.

### 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).



**T.1.3.5 Optional.** Please provide, if information is available, a comment on the prevalence of other infectious diseases e.g. STIs, TB among drug users. Where appropriate please provide links to the original studies. (Suggested title: Other drug-related infectious diseases)

**T.1.3.6 Optional.** Please provide any additional information you feel is important to understand patterns and trends in drug related infectious diseases within your country. (Suggested title: Additional information on drug-related infectious diseases)

## 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.

**T.1.4.1 Optional.** Please provide additional information on other drug-related health harms including co-morbidity.

### 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 your 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*<sup>®</sup> units, but only 16% dispense individual syringes, and even fewer (1.2%) dispense *Stérifilt*<sup>®1</sup> and *Stéricup*<sup>®2</sup> 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*<sup>®</sup> kit or *Kit+*<sup>3</sup>. 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.

<sup>1</sup> 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.

<sup>2</sup> A sterile aluminium recipient that diminishes the risks of infection due to the reuse and sharing of injection preparation equipment.

<sup>3</sup> 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<sup>®1</sup> 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<sup>2</sup>, ascorbic acid<sup>3</sup> - 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<sup>4</sup>, 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<sup>4</sup> syringes (to inject medications) in addition to 1 cm<sup>3</sup> 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.

<sup>1</sup> A non-invasive machine that can instantly detect liver fibrosis and assess its degree of advancement.

<sup>2</sup> This type of filter is more effective at trapping impurities than *Stérifilt*® filters.

<sup>3</sup> 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.

<sup>4</sup> Alcohol is less HCV-virucidal than chlorhexidine and causes bleeding at the injection site, which could increase the risk of hepatitis C transmission.

**T1.5.4 Optional.** Where possible, provide any contextual information helpful to understand the estimates provided in ST10 'Syringe availability' and ratings in SQ23 'Prevention and Reduction of Health-Related Harm associated with drug use'.

(Suggested title: Contextual information on routine harm reduction monitoring)

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**T1.5.5 Optional.** Please provide any additional information you feel is important to understand harm reduction activities within your country.

Information on services outside the categories of the 'treatment system map' may be relevant here (e.g. services in pharmacies/dedicated to HIV/AIDS or other drug related infectious diseases testing sites not linked to hospitals, e.g. other types of facilities offering testing of infectious diseases targeting people who use drugs, or drugs/outreach activities not covered above).

### **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.

**T.1.6.1 Optional.** Please provide additional information on any other relevant targeted health interventions for drug-related health harms.

(Suggested title: Targeted interventions for other drug-related health harms)

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## 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<sup>1</sup> along with a better control of the deaths registered under X42 as primary cause in 2012<sup>2</sup>.

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.

<sup>1</sup> 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.

<sup>2</sup> 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  $\geq 2$ ) 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 femme 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.)

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**T.4.2 Optional.** Please use this section to describe any aspect of drug related harms and harm reduction that the NFP value as important that has not been covered in the specific questions above. This may be an elaboration of a component of drug related harms and harm reduction outlined above or a new area of specific importance for your country.

(Suggested title: Further Aspects of Drug-Related Harms and Harm Reduction.)

## 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	<p>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).</p> <p>No national data are available on the use of emergency services related to stimulant use.</p> <p>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 <i>et al.</i> 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.</p>
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## 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<sup>1</sup>) 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.

<sup>1</sup> 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 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 quantify 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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# WB 4 Drug Market and Crime

*France*

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## **2015 National report (2014 data) to the EMCDDA by the French Reitox National Focal Point**

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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.

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## T0. Summary

- National profile

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 strong purchasing power, France is also a country where there are significant levels of use (for some of these substances), making it a strategic market for drug traffickers, from wholesalers to user-dealers. In recent years, the major changes in terms of supply have concerned cannabis, cocaine and MDMA/ecstasy. These changes notably provide insight into why the levels of prevalence for use of these three substances are showing such a significant increase, as supply dynamics are partly able to explain the dynamics of demand.

- Trends

Over the past few years, the cannabis market in France has been in upheaval, like other European countries, with herbal cannabis increasingly competing against cannabis resin produced in Morocco. While the cannabis resin market is still superior, the herbal cannabis market is becoming increasingly dynamic, driven by protagonists sharply contrasting with the usual profiles. Hence, alongside home-grown cannabis growers with a marginal role on the market, herbal cannabis factories have emerged, cultivating hundreds or, indeed, thousands of plants. Among the latter, two types of groups can be distinguished. Vietnamese criminal gangs, long having specialised in this illegal segment, particularly in Britain, who are becoming established in France, drawn by the dynamic market and prospects in terms of profit (Weinberger 2011), and private individuals, *a priori* not connected to the traditional criminal scene, who are turning to large-scale illegal commercial cultivation for the same reasons. A third group is in the process of emerging, also made up of "housing estate" dealers, specialising in the resale of cannabis resin and moving into production more suited to the new reality of demand. These changes in the cannabis market can be seen in seizures by the law enforcement services in France (police, customs, *Gendarmerie*). This reconfiguration of the French market could partly explain the growing tendency for the settling of scores between resin dealers located in "working class" districts, faced with a narrowing market; this trend is exacerbating the well-known competition between rival points of sale.

The second largest illegal market, cocaine, has also been affected by changes in supply. This change does not concern those involved in importing the substance into France, whether traditional organised crime networks (Corsican and North African) or the lower spheres of minor trafficking, or "small-time drug runners" in police jargon. The changes observed supposedly affect major trafficking channels, notably with the increasing role of French overseas departments such as French Guiana and Martinique (Lesser Antilles), both as developing zones and secondary markets, for cocaine produced in Colombia. Furthermore, the port of Le Havre is increasingly serving as a major gateway for cocaine to the French and European market. In 2014, the largest cocaine seizure ever in metropolitan France (1.4 tonnes) took place there. This phenomenon, which started to grow in amplitude from 2011, should be connected with the recent reopening of cocaine routes in the Caribbean headed to the United States and Europe, further to the security crisis in Venezuela which has become a major transit country for Colombian cocaine.

Lastly, the MDMA/ecstasy market has experienced renewed dynamism as before its shortage in 2009. The availability of powder and crystal forms has increased with high purity levels, while the tablet form has been on the rise since 2013, particularly in the recreational setting, with high MDMA/ecstasy potency. Furthermore, dealers' attention to tablet appearance (bright colours, 3D forms, etc.) has boosted their appeal to young users.

- New developments

No new developments.

## T1. National profile

The purpose of this profile is to provide a commentary on the drug supply chain within your country.

### T1.1 Drug market

The purpose of this section is to summarise the basic structure of the drug market in your country. Namely it should provide a commentary on:

- Sources of drugs in your country: international sources of the drug, trafficking routes, domestic production/cultivation
- Information available on the wholesale drug market
- Information available on the retail drug market
- The numerical data submitted through ST11, ST13, ST14, ST15, ST16

**Note:** Please focus on the main/most important drugs in your country.

Please structure your answers around the following questions.

T1.1.1 Please describe any domestic production of drugs within your country by drug. For synthetic drugs please include also processing stages such as tableting operations.

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 2014, 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, whose number is estimated to be 80 000 persons (OFDT 2013), 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 implementing real production units (“cannabis factories”) with up to several thousand plants (Weinberger 2011). Involvement of groups coming from so-called “sensitive” suburban areas that originally were specialised in importing and distributing cannabis resin has emerged.

In 2013, as part of the TREND (Emerging Trends and New Drugs) scheme, based on ethnographic surveys, the Toulouse site reported on amphetamine production in the rural areas of south-west France. This production supposedly involves private individuals rather than professionals, and is said to resemble a form of small-scale amateur production based on the *kitchen lab* model for methamphetamines in the United States.

T1.1.2 Please comment on any available information on the routes of trafficking for drugs imported into your country whether in transit or not.

Information relevant to this answer includes:

- origin
- most recent country prior to your country
- any other information on trafficking routes as well as the mode of transport

### *Cannabis*

The cannabis resin smoked in France comes from Morocco and usually transits through Spain. The herbal cannabis comes mostly from the Netherlands: in 2013, 58% of herbal cannabis for which the origin was known came from this country (OCRTIS data, 2013).

The routes for cannabis resin destined for the European and French market have been changing over the past two years. Hence, dealers taking advantage of the collapse of the state are said to be increasingly using Libya as a transit country, as evidenced by the scale of seizures in the eastern Mediterranean in 2014. In June 2014, this region saw the largest ever ship seizure, with 42 tonnes.

To a more marginal extent, France is seeing the emergence of markets for cannabis resin from Afghanistan and herbal cannabis from Albania, the latter becoming a major producer of this substance in Europe.

### *Cocaine*

The cocaine used in France mainly comes from Colombia, the second largest producer worldwide. It mainly passes through the south via Spain and the north via the Netherlands (Rotterdam) and Belgium (Antwerp). Over the past few years, the port of Le Havre appears to be becoming a major gateway for cocaine to France. In 2014, it was the site of the largest seizure ever in France, amounting to 1.4 tonnes. These changes are explained by the connections between the Antilles port of Fort-de-France and Le Havre in a context where the French West Indies are becoming a major developing zone for cocaine destined for France and Europe (Gandilhon 2014a). The substance leaves Colombia, passes through Venezuela (Weinberger 2013), and reaches Martinique via the Caribbean sea.

### *Heroin*

The heroin used in France mainly comes from Afghanistan and passes *via* the Balkans (Turkey, Greece, Albania). White heroin originating from the Golden Triangle (Thailand, Myanmar and Laos) is also imported; however, this phenomenon is unclear due to its marginal nature.

Over the past few years, some Afghan heroin has been passing through African countries (Chad, Niger, Mali) and reaching the port of Dakar, Senegal, before directly arriving in France. The Netherlands, ahead of Belgium, is the main platform which supplies French dealers.

### *Amphetamines/MDMA/ecstasy*

Synthetic drugs (MDMA/ecstasy, amphetamines) used in France mainly come from the Netherlands, the leading production zone in Western Europe. France is also a transit country for dealers particularly targeting the United Kingdom and Spain.

### *New psychoactive substances (NPS)*

NPS, which circulate on the French market *via* the web, are mainly produced in Asia, particularly in China and India.

T1.1.3 Please comment on any available contextual information on trafficking within your country.

Information relevant to this answer includes:

- range and relative importance of different products
- size of transactions
- smuggling methods
- organisation



The cannabis and cocaine markets are the two biggest illegal drug markets in France, achieving sales of about two billion euros combined (Ben Lakhdar 2012; Ben Lakhdar *et al.* 2007). The wholesale and semi-wholesale levels of these drug markets are controlled by major organised crime networks. In 2014, the police departments highlighted the stranglehold of the North African scene (specialising in cannabis resin) on cocaine trafficking, to the disadvantage of the Corsican-Marseille scene. This can be linked with the fact that a large part of the cocaine targeting the European and French market passes through West and North Africa to be stored in southern Spain where French criminal gangs are well established. Another factor is the increasing demand in France and the multiplicity of the social circles of cocaine users. Over the past few years, networks located in certain neighbourhoods with a high proportion of social housing and specialised in cannabis resin, are targeting working-class groups.

Alongside these "large" networks exist a myriad of small trafficking channels run by user-dealers, directly supplied by the Netherlands and Belgium.

The law enforcement services have observed an increase in postal cocaine trafficking originating from French overseas departments such as Guiana and the French West Indies (Guadeloupe and Martinique).

The heroin market in France is controlled by Turkish and Albanian organised crime networks. Reflecting the situation with cocaine, user-dealer micro-networks, supplied by the Netherlands and Belgium, play an important role in explaining the availability of the substance in France.

T1.1.4 Please comment on available information on the wholesale drug and precursor market.

Information relevant to this answer includes:

- range and relative importance of different products
- size of transactions
- common prices
- product transformation
- adulteration
- the nature and organisation of buyers, sellers and intermediaries

As France is not a zone in which the production of synthetic drugs takes place, problems related to chemical precursors are marginal (Gandilhon 2014b). In 2014, 5 seizures of phenylacetone (precursor of methamphetamine) were reported, amounting to a total of 2 kilos.

Regarding the issue of wholesale markets, the most important point is the control of the cocaine market by organised crime networks which import cannabis resin (OCRTIS data).

In 2014, the median price per kilogram of cocaine reached 35,000 euros (€), i.e. a €5,000 increase compared to previous years. Furthermore, a wholesale cocaine market also exists, notably in the French West Indies, where dealers obtain supplies at prices ranging from €6,000 to €9,000 per kilogram.

The price per kilo of cannabis resin was about €2,200, compared to approximately €15,000 for heroin.

T1.1.5 Please briefly comment on available information on the retail drug market.

Information relevant to this answer includes:

- nature and organisation of buyers, sellers and intermediaries
- range and relative importance of different products
- size of transactions
- common prices
- purity of products
- market locations and settings

Two main types of organisations control the retail market for illegal drugs:

- 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.

In 2013-2014, as regards the retail market for the main illegal drugs, the ethnographic data collected by the TREND scheme report changes in dealer practices, in their attempt to offset problems arising from the impoverishment of an incessantly growing number of users belonging to the middle classes. These developments are particularly apparent due to the availability of increasingly fractionated doses, irrespective of substance, to be sold at more accessible prices, in a context in which the price of the main illegal substances (cannabis, cocaine, ecstasy and heroin) is tending to increase after years of decline. Cocaine hydrochloride, the use of which among many users is associated with a certain form of social “success”, has been particularly affected by the development of this form of discount or low cost market. This is even more so the case after years of regular decline in the average price – this has more than halved in 20 years, from €150 a gram in the early 1990s to €60 in 2010 –, it is now rising significantly and is becoming increasingly unaffordable, even among more or less well-off populations. Consequently, fractionation of doses (0.1, 0.2 or 0.5 grams) is increasingly reported by the TREND scheme. This trend is affecting both the alternative scene (free parties, raves) and the commercial dance-event setting (clubs, discotheques). This phenomenon is also observed for substances such as MDMA/ecstasy crystal, which has experienced certain popularity in recent years, despite a relatively high price, particularly among young users in the recreational scene. Hence, this substance is often sold by dealers, who themselves are often users, in “parachute” form (rolled in a sheet of cigarette rolling paper and then swallowed), containing small quantities, the price of which does not exceed €10.

#### *Cannabis*

According to law enforcement (OCRTIS 2013), the median price for herbal cannabis in 2014 was approximately €8.50 per gram and ranged from €7.50 to €10 per gram (see table below). This price was up compared with previous years (€6.50 in 2009, €7 in 2010, €7.50 in 2011 and €8 in 2012). This rise in price may reflect the fact that an increasing percentage of users appear to display a marked preference for what they perceive as “high-quality” substances. The median price of cannabis resin increased from €6 in 2013 to €6.50 in 2014. Average cannabis resin potency tripled in ten years, to reach 21% in 2014, whereas that of herbal cannabis, at 13%, is at its highest in 15 years (STUPS® file data).

#### *Heroin*

According to the OCRTIS, like in 2013, the 2014 median price for a gram of brown heroin was approximately €35, down more than 10% compared with 2010. Brown heroin samples seized by the police are 15% pure on average, which confirms the rise in purity levels reported since 2012 (STUPS® file data). This phenomenon can be explained by the fact that heroin shortage is over, as observed in other European countries.

#### *Cocaine*

The price per gram of cocaine hydrochloride was €65 in 2014. It remained stable compared with 2013, the year in which there was a rise in the previously stable price observed over the last five years (€60).

The average purity of samples seized in the street (< 10 g) corresponds to 41% (43% in 2013), after having stabilised between 30 and 35% in the previous 10 years.

**Table: Change in median drug prices (in euros) since 2000**

	TREND*				OCRTIS**		
	2000	...	2012	2013	2012	2013	2014
Heroin	59		43	47	35	35	35
Cocaine	84		71	77	60	65	65
Ecstasy (tablets)	15		10	8	7.5	7.5	8.5
Cannabis resin	na		7	7	6	6	6.5
Herbal cannabis	na		10	10	8	8.5	8.5
Amphetamines	15		14	14	na	na	na
LSD (blotter)	8.5		10	10	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 and LSD.

\*\*: 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, the 2014 price of a tablet of ecstasy was €8.50, 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.

In 2013, the price per gram of MDMA/ecstasy in crystal form was about €55. Since 2010, there has been a regular downward trend in prices.

For the past three years, although the average potency of MDMA/ecstasy has remained stable (36% in 2014), tablet mass has increased, and, consequently, so has the quantity of MDMA/ecstasy. Tablets contain 120 mg of MDMA/ecstasy on average (some tablets contain more than 200) compared to 50 to 60 mg in the 2000s (Néfau *et al.* 2014).

The average purity level measured in MDMA/ecstasy crystal seizures is 65%.

### *New psychoactive substances (NPS)*

In 2014, there were 1,243 seizures or checks<sup>1</sup> (*versus* 1,076 in 2013) related to 131 different NPS<sup>2</sup>: a third concerned NPS not classified as narcotics or psychotropic molecules. Most of them were cathinones, ahead of phenethylamines, which outstripped synthetic cannabinoids (classified in early 2015 – see T1.1.3 in the Legal Framework workbook) for the first time in 2014 (see figure below).

As in 2013, the molecules most frequently found in seizures were three cathinones (3-MMC, methylone, 4-MEC) and a phenethylamine (4-FA).

Cathinones are mainly supplied in powder form<sup>3</sup> (75%). Chloromethcathinone (1,200 kg for 2 cases), alpha-PVP (56 kg for 14 cases) and mephedrone (31 kg for 7 cases) were the

molecules with the highest representation in terms of weight<sup>4</sup>. However, all cases representing more than 1 kg had a destination other than France.

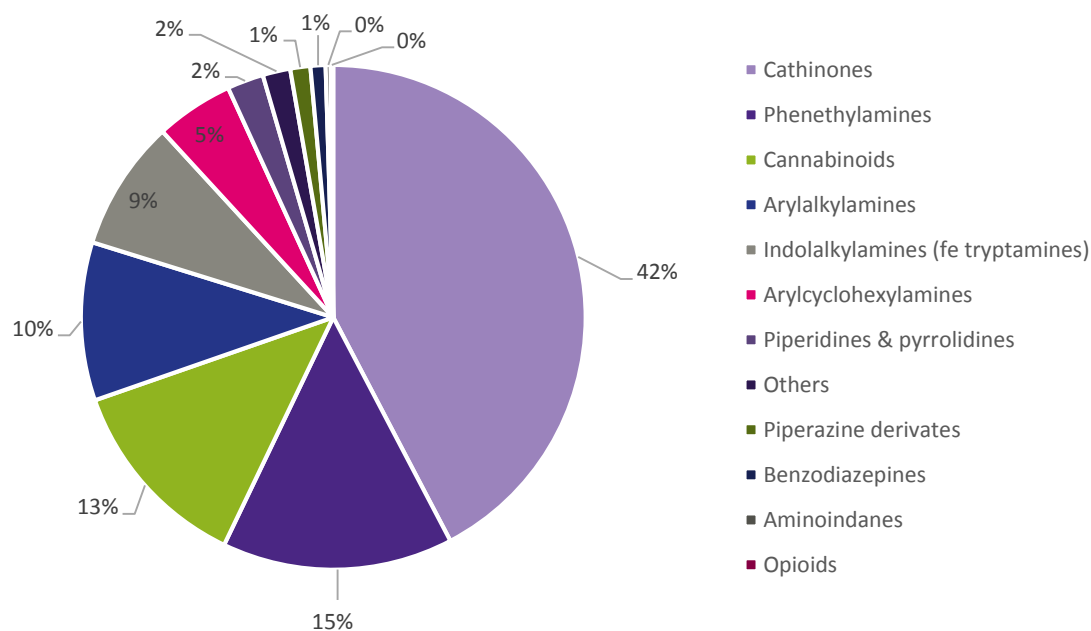
In 2014, alpha-PVP had greater visibility. Although alpha-PVP use to be a secondary substance associated with other cathinones, it has been identified on numerous occasions as being sold on its own via street trafficking, in south-west France, as a substitute (not disclosed by the drug dealer) for conventional stimulants. Despite its supply on the actual market, the molecule has a very limited presence on websites and forums monitored by I-TREND. NPS users do not search for it.

It has been the subject of 15 seizures by the French law enforcement services (customs and police):

- 13 seizures of small quantities destined for French users;
- 1 seizure amounting to 1 kg from persons in transit through France;
- 1 seizure amounting to 50 kg (two parcels) destined for Spain on 16 December 2014 (originating from China).

Unlike cathinones, phenethylamines are supplied in various forms: liquids, tablets and blotters represent 65% of reported seizures and checks. The powder form (19%) mainly corresponds to large seizures of 2C-I (104 kg)<sup>5</sup>.

**Figure: Proportion of different categories in checks and seizures of NPS in France in 2014**



Source: SCL and STUPS<sup>®</sup> national database

Cathinones thus represent the main category (14 in 2014 *versus* 4 in 2013) whereas until then they were lower than synthetic cannabinoids (which showed 13 new molecules in 2014 as in 2013). Lastly, phenethylamines remained stable in 2013 (9 in 2014 *versus* 8 in 2013).

As regards synthetic cannabinoids, the supply remains split into two categories: commercial supply with commercial packaging copying conventional cannabis forms (herbal or resin) and more specialist supply, in powder form, exclusively with chemical names. These two types of supply have their own distribution channels and also aim at different user profiles.

There is no street trafficking. Unlike previous years, synthetic cannabinoids with commercial packaging have disappeared from postal freight and yet are observed in use practices.

Online purchases carried out in the context of I-TREND showed that even if the product is displayed on the website in commercial packaging, it is delivered in simple plastic or metallic bags: for the past few months, only the appearance of the substance enables commercial supply to be distinguished from specialist supply.

As cannabis is the most widely used illegal substance in France, synthetic cannabinoids may be more experimented than other NPS, due to the expected similarity of the effects. However, substances reported as being tried by lifetime users (in general population surveys) hardly correspond to those preferred by more informed users. In forums, even the most "popular" substances among seasoned users (JWH018, AM-2201, UR-144 and 5F-AKB-48) ultimately have a negative image in comparison with natural cannabis.

2014 as a whole and early 2015 showed strong forum activity on synthetic cannabinoids in e-liquid form. Furthermore, between April 2013 and May 2014, 21 seizures, concerning 12 synthetic cannabinoids, in the context of simple use or local trafficking, took place in Mayotte and in La Réunion (Roussel *et al.* 2015). Drug-dealers had access to cannabinoids in powder form, which they were repackaging in cigarettes, an unusual presentation for synthetic cannabinoids.

Among rarer NSP categories, a single molecule is often predominantly found in seizures and checks. Thus, 85% of the tryptamine seizures correspond solely to DMT (for a total of 7 molecules identified). Also, benzodiazepine analysis (beyond their categorisation as NSP) correspond to etizolam (a molecule considered as a NPS and not marketed in France) in 83% of cases (for a total of 6 molecules identified). Benzodiazepines represent a small number of seizures (1% to 2.5% of seizures and checks), but are higher in terms of the number of tablets (3,042) than cathinones (2,839) and phenethylamines (2,275), the NPS groups most frequently observed in this form.

<sup>1</sup> When a molecule is not classified as a narcotic, this involves a check and not a seizure.

<sup>2</sup> The data presented concern synthetic substances and exclude plants or extracts perceived as NPS. If these were taken into account, they would exceed synthetic substances in qualitative terms, notably given the extent of khat circulation between the Netherlands and the United Kingdom. Other than khat, other plants catalogued as NPS and identified in France in the context of trafficking are harmine, kratom and ibogaine.

<sup>3</sup> Out of the total number of seizures and checks, 45% are not quantified (by weight or by volume). However, it is highly likely that these cases primarily involve very small quantities.

<sup>4</sup> The quantities are not stated for 10% of seizures or checks related to cathinones.

<sup>5</sup> The quantities are not stated for 15% of seizures or checks related to phenethylamines.

## T1.2 Drug related crime

The purpose of this section is to provide a commentary on the context and possible explanations of drug law offences within your country.

Please structure your answers around the following questions.

T1.2.1 Please comment on drug law offences data.

Please structure your response around supply data (if possible distinguish between trafficking, cultivation/production, wholesale/ retail, and other supply offences) and possession/use data.

Since 2010, national statistics no longer provide details of arrests according to substance. Roughly 140,000 arrests were recorded in 2010 for narcotic use, 90% concerned simple cannabis use, 5% heroin use and 3% cocaine use. Eight out of ten arrests for drug-related offences involved the use of illegal narcotics (all substances combined). In 2014, arrests related to use, slightly higher (3.7%) than in 2013, were still the number one offence (83%) reaching 176,700 cases. Law enforcement services (police and *gendarmerie*) recorded 32,500 cases of use-dealing and trafficking-resale without narcotic use, not including arrests for use only.

In 2013, convictions handed down for drug-related offences represent 9% of all convictions recorded in criminal records, i.e. 56,700 convictions (Ministère de la justice *et al.* 2014). These offences are broken down as follows: illegal use (59%), possession, acquisition (23%), commerce-transport (12%), import-export (2%), dealing and selling (4%), aiding and abetting, which may comprise incitement to use and facilitation of use (34 cases) and other (141 cases). Prison sentences without remission or partial sentence suspension concern nearly 27% of convictions for drug-related offences. Other than for sentences handed down by the courts, criminal records also list lighter procedures such as fixed penalty notices. In 2013, one out of ten offences for narcotic use was handled by the State prosecutor in the context of a fixed penalty notice. Nearly 8,800 fixed penalty notices for drug-related offences were implemented in 2013, nearly all of which (98%) for illegal narcotic use. Alternative sentences were more widely used than fines, 5,000 versus nearly 3,800.

**T1.2.2 Optional.** *If possible summarise any available data on drug related crime outside of drug law offences (i.e. possession/supply), e.g. money laundering, crimes undertaken under the influence of drugs (e.g. driving under the influence of drugs) or as a result of the use of drugs, crimes committed to fund drug use, crimes between drug market actors (e.g. violent crime, including homicide).*

Driving under the influence of narcotics has been an offence in France since 2003. These prosecutions only represent 3% of all offences stated in criminal records (8% of road safety offences), but are constantly on the increase (5,200 in 2007, 11,200 in 2009 and 21,800 in 2013). To compare, convictions relating to driving under the influence of alcohol account for 48% of road safety offences and 21% of all offences. Overall, 137,400 records for driving under the influence of alcohol were registered in 2013

## T1.3 Drug supply reduction activities

The purpose of this section is to summarise the drug law enforcement activities for drug supply reduction.

Please structure your answers around the following questions.

T1.3.1 Please comment on drug supply reduction activities within you country.

Please structure your response in terms of

- a) the key priorities of supply reduction
- b) areas of activity of supply reduction
- c) organisational structures/co-ordinating bodies

*Please note that information on specialist drug law enforcement (eg. drug squads) is part of a separate focused data collection.*

The 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours includes a line of action for stepping up measures against trafficking, with the following objectives:

- Acting at pre-trafficking stages: notably by strengthening international cooperation and capabilities for control, and by sharing information;
- Adapting the public response to the scale of narcotic trafficking: trafficking involving minors, trafficking at local level in "priority safety zones" (PSZ), in the prison setting, and trafficking on an international scale;
- Reinforcing anti-money laundering measures and an asset-based approach to legal investigations;
- Acting on major emerging trends in terms of production and supply: step up measures against cannabis growing, contraband tobacco, synthetic drugs and diversion of chemical precursors;
- Promoting targeted anti-narcotics trafficking action overseas

As regards operational aspects, given the nature of the drugs market in France, law enforcement services focus on dismantling criminal organisations which import cannabis resin and cocaine. This priority objective was reaffirmed by the French Prime Minister, Manuel Valls, during his visit to Marseille in February 2015 due to the established presence and control of certain areas of France by trafficking organisations, particularly in social housing neighbourhoods. One of France's main priorities is to cut off international cannabis and cocaine trafficking routes in the Mediterranean and Caribbean sea. To do so, France has joined international cooperation organisations, such as the MAOC-N (*Maritime Analysis and Operation Center for Narcotics*) and CECLAD-M (Mediterranean anti-drug coordination centre). As regards the Caribbean sea, in 2014 the French government created the "Caribbean" branch of the OCRTIS, which has been set up in Fort-de-France. Like its metropolitan counterpart, this is an interministerial organisation, made up of representatives from the *gendarmerie*, the French Navy, customs and police, together with liaising officers from three foreign countries (Great Britain, United States and Spain). This branch notably works with other anti-trafficking organisations, such as the JIATF-S (*Joint Inter-Agency Task Force South*), based in Key West, Florida, a North American interministerial anti-trafficking entity which covers the Caribbean sea, the West Pacific and a large part of the Atlantic. Given the essentially sea-based nature of trafficking, the French Navy is the major operational armed branch for operations out at sea.

The other line of action against drug trafficking is the seizure and confiscation of criminal assets accumulated by dealers. In 2010, France therefore created an Agency for the Recovery and Management of Seized and Confiscated Assets (AGRASC).

## T2. Trends

The purpose of this section is to provide a commentary on the context and possible explanations of trends in drug markets and crime within your country.

Please structure your answers around the following questions.

T2.1 For the most important drugs in your country, please comment on the possible explanations of short term trends (5 years) in the following aspects of the drug market:

- seizures (by weight bin if possible)
- price (wholesale and retail if possible)
- purity (wholesale and retail if possible)

Examples: changes in police practices, patterns of drug use, interruptions to the supply of drugs or the emergence of substitutes or alternatives.

### *Cannabis*

Like in the rest of Europe, the cannabis market in France is undergoing a major upheaval. This is notably expressed by the increased production of herbal cannabis on French soil, driven by private individuals or organised crime networks. Although, in 2014, cannabis seizures (herbal cannabis and cannabis resin) were at their lowest since 2007, these overall data mask conflicting developments: major drop in resin seizures and record herbal cannabis seizures, reaching more than 10 tonnes. Moreover, the growing importance of the herbal cannabis market in France is corroborated by the scale of plant confiscations, with 158,000 being seized in France in 2014, the highest level ever to have been observed. The nearly 50% decline in cannabis resin seizures could be explained to a lesser extent by the reported drop in production in Morocco (Chouvy and Afsahi 2014) than by the emergence of new trafficking routes, including transit via Libya, and new techniques, mainly from Spain, involving more discreet, fragmented convoys of resin (*go slow vs. go fast*). The other key event is the very strong growth in THC levels in cannabis resin and herbal cannabis, which is explained by the cultivation of hybrid cannabis varieties, in both Europe and Morocco.

### *Cocaine*

The cocaine market, driven by regularly growing demand over the past twenty or so years, is highly dynamic. After years of remaining stable, retail prices have been rising over the past three years. The two key events in recent years are the stranglehold of organised crime networks which import cannabis resin onto this market, and the diversification of cocaine routes with the emergence of the French West Indies as a developing zone and secondary wholesale market.

### *Heroin*

The heroin market is relatively limited given the small number of users. However, it is still present, notably sustained by dynamic cross-border small-time drug runners. The "quality" of the substance in circulation in France is somewhat poor, which causes certain users to switch to opioid medications such as morphine sulphates (Cadet-Taïrou and Gandilhon 2014a) and/or buprenorphine (Subutex®). Heroin seizures have once again reached high levels, despite regularly declining since 2010. The relative shortages in Western Europe, in 2011 and 2012, due to the dismantling of major trafficking organisations, now appear to be in the past.

### *Synthetic drugs*

The synthetic drugs market is still dominated by MDMA/ecstasy. However, major changes have been observed with the development of the "crystal" form which is popular among younger generations. Furthermore, after years of decline, the use of tablets, driven by substances with higher dosage strengths, is making a significant comeback in the recreational setting. Ecstasy tablet seizures are at their highest in six years, which attests to the dynamic nature of the market, although this form faces competition from MDMA/ecstasy in powder or crystal form.

The ethnographic observations in the context of the TREND scheme reveal greater availability of amphetamines (speed) in the alternative recreational setting, which can be explained by an effect of the recession affecting the country since 2008. Some users are giving up cocaine, considered too expensive and with its price rising, in favour of amphetamines which, in this context, represent the cocaine of the poor (Cadet-Taïrou *et al.* 2014b).



**Table: Quantities of drugs seized (in kilograms), from 2008 to 2014 and changes from 2013 to 2014 (in %)**

Drugs seized	2010	2011	2012	2013	2014	Change from 2013 to 2014
Cannabis: resin	52,795	55,641	51,118	70,918	36,917	- 47.9
Cannabis: herbal	4,564	5,450	3,270	4,758	10,073	+ 111.7
Cannabis: seeds	22	na	13	25	na	na
Cannabis: plants	54,728	73,572	131,307	141,374	158,592	+ 12.2
Heroin	1,087	883	701	570	990	+ 73.7
Cocaine	4,125	10,834	5,602	5,612	6,876	+ 22.5
Crack	14	13	14	7	19	+ 172
Amphetamines	176	601	279	474	260	- 45.1
Ecstasy (tablets)	663,595	1,510,500	156,337	414,800	940,389	+ 126.7
LSD (blotter)	28,411	3,136	4,135	58,344	2,390	- 95.9
Ketamine	14	0.1	7.2	14.6	na	na

Source: OSIRIS (OCRTIS)

na: not available

**T2.2 Optional.** For the most important drugs in your country, please comment on the possible explanations of long term trends (greater than 5 years) in the following aspects of the drug market:

- seizures (by weight bin if possible)
- price (wholesale and retail if possible)
- purity (wholesale and retail if possible)

Examples: changes in police practices, patterns of drug use, interruptions to the supply of drugs or the emergence of substitutes or alternatives.

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**T2.3 Optional.** Please comment on the possible explanations of long term trends and short term trends in any other drug market data that you consider important.

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**T2.4** Please comment on the possible explanations of short term trends in the following drug law offences data:

- supply (if possible distinguish between trafficking, cultivation/production, wholesale, retail, and other supply offences)
- possession/use

Ex.: changes in law enforcement practices, government priorities, patterns of drug use, sources of drugs.

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**T2.5 Optional.** Please comment on the possible explanations of long term trends in the following drug law offences data:

- supply (if possible distinguish between trafficking, cultivation/production, wholesale, retail, and other supply offences)

- possession/use  
Ex.: changes in law enforcement practices, government priorities, patterns of drug use, sources of drugs.

**T2.6 Optional.** Please comment on the possible explanations of long term trends and short term trends in any other drug related crime data that you consider important.

**T2.7** Please indicate notable trends or important developments in the organisation, coordination and implementation of drug supply reduction activities in your country over the past 5 years.

### T3. New developments

The purpose of this section is to provide information on any notable or topical developments observed in drug market and crime **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.

**T3.1** Please report on any notable new or topical developments observed in the drug market and crime in your country since your last report.

Although production laboratories (only processing and packaging sites) had no longer been observed in France since 1996 (Colombié *et al.* 1999), some signs - which have yet to be confirmed – and practically pure collected substances (MDMA/ecstasy and heroin) suggest the presence of these laboratories in France. These would be the result of user-dealer micro-networks which aim to control the content of the substance rather than to make large profits. At the same time, monitoring of discussions on the Internet as part of the I-TREND project shows that topics on the home-production of synthetic drugs was the second most widely consulted topic on forums in the first semester of 2015, after e-liquids containing synthetic cannabinoids.

### T4. Additional information

The purpose of this section is to provide additional information important to drug market and crime in your country that has not been provided elsewhere.

Please structure your answers around the following questions.

**T4.1 Optional.** Please describe any additional important sources of information, specific studies or data on drug market and crime. Where possible, please provide references and/or links.

**T4.2 Optional.** Please describe any other important aspect of drug market and crime that has not been covered in the specific questions above. This may be additional information or new areas of specific importance for your country.

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## 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.

T5.1 Within each country there may be specific seizures or other law enforcement activities that are considered important, e.g. a drug new to the country, a new method of concealment, a new trafficking route, or an example of successful law enforcement action. Does the National Focal Point have access to descriptions of such activities? If so, please describe.

"YES" or "NO"?	
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## 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

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 substances, 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.

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 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 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.

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

## Methodology

### 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/ecstasy (tablets, powder, crystal) and cocaine (for which the prices were collected in both urban areas and on the party scene).

### **SINTES: National Detection System of Drugs and Toxic Substances**

*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

The SINTES scheme is based on collecting samples of illegal and legal substances directly from drug users. The products collected are forwarded to one of the 4 forensic laboratories working in partnership with OFDT, to determine 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. The SINTES questionnaire has three sections:

- The *observation* section provides an annual overview of the composition of a particular illegal substance. The SINTES observation scheme relies primarily on the French TREND network.
- 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. 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.

**TREND scheme: 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

**STUPS® national database**

*French National Forensic Science Institute (INPS)*

Created in 1986, the French National Register of Drug Seizures (FNDS) initially focused on heroin analyses; from 1990, cocaine samples were also studied, before being extended to all drugs, as part of the STUPS® (harmonised narcotics processing system) database, initiated in 1999.

Five national forensic science institutes (Lille, Paris, Lyon, Marseille, Toulouse) and the Forensic Sciences Institute of the French *Gendarmerie* (FSIFG) add their analyses to this database, accompanied by photos, logos, etc. in order to identify the substances in circulation.

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# WB 5.1 Prison

*France*

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## **2015 National report (2014 data) to the EMCDDA by the French Reitox National Focal Point**

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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.



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## T0. Summary

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

- National profile

As of 1<sup>st</sup> January 2014, France had 191 prison establishments with a total operational capacity of 57,516. With 67,075 inmates, there are 117 inmates for every 100 beds in France. Studies conducted about a dozen years ago demonstrated that one third of new inmates stated prolonged, regular use of illegal drugs in the year prior to entering prison. 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, but the total number of problem drug users (PDU) in prison settings is not quantified in France. The prevalence of injection is high in prisons: in the year preceding imprisonment, 2.6% of new inmates were concerned in 2003. Inmates have greater rates 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), while prevalences of HCV are from 4.2% to 6.9% (four to five times higher). Since 1994, the Ministry of Health is responsible for health in prisons and the treatment of addiction in prison settings is based on a three-tiered system: prison-based hospital healthcare units (UCSAs), which are responsible for monitoring the physical health of inmates, Regional Medico-Psychological Hospital Services (SMPRs) established in each of the 26 French regions handle the mental health aspects of drug addicts in establishments where no local units exist, and finally, "local addiction units" have been established in the 16 largest establishments in France (and cover approximately a quarter of the incarcerated population). Furthermore, a reference national treatment and prevention centre for addiction (CSAPA) is appointed for each prison so as to offer support for inmates with addiction problems. Drug-related prison health is mentioned in the 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours, which sets forth specific prevention objectives for inmates, and in the 2010-2014 "health/prison" strategic actions plan on health policy for inmates. To guarantee the application of harm reduction measures, two main ways of preventing the spread of infectious diseases have been implemented in prison settings since 1996. First, inmates receiving OST must not only be able to continue their treatment in prison, but should also be able to initiate treatment if they wish. In addition to substitution, prison establishments offer prevention and decontamination tools for fighting against HIV and hepatitis's.

- New developments

The 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours (MILDT 2013) comprises several measures specific to inmate populations currently being implemented. Among other measures, this includes the diffusion of messages on prevention by video and the development (with a view to prevention) of support groups on addictive behaviours, the improvement in the management of individuals presenting addictive behaviours, and increased regular monitoring of inmate health data.

Furthermore, the bill on the reform of the health system (known as the health act, which has yet to be adopted by the Senate) provides for the application of harm reduction measures to inmates and the reinforcement of reference CSAPAs in the largest prisons.

## T1. National profile

### T1.1 Organization

The purpose of this section is to:

- Describe the organisation of prisons and the prison population.

Please structure your answers around the following question.

**T1.1.1 Optional.** Please provide a short overview of prison services in your country: relevant topics here could include: number of prisons, capacity, & differing inmate profile (type offence, gender, age).

Please note that SPACE statistics, which provide the statistics on the prison population in Europe (<http://www3.unil.ch/wpmu/space/space-i/annual-reports/>), will be used to complement this information.

As of 1<sup>st</sup> January 2014, France had 191 prison establishments (Sous-direction de la statistique et des études 2014) with a total operational capacity of 57,516. These establishments include:

- 99 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;
- 6 penal establishments for minors, which are provided for in the French law of September 2002 on the orientation and programming of the justice system [[Loi n°2002-1138 d'orientation et de programmation pour la justice](#)]. The first of these was opened in mid-2008.
- 1 national public health establishment (thus falling within the scope of the Ministry of Health), open to inmates (defendants and convicted inmates) presenting somatic and/or psychiatric disorders.

The prison population in France consists of nearly 80% convicted inmates, with 14% present due to a drug-related offence (DLO); the mean age is approximately 34.5 years, and almost exclusively concerns males (96%) (Direction de l'administration pénitentiaire (DAP) 2014). With 67,075 inmates as of 1st January 2014 for 57,516 operational beds, there are 117 inmates for every 100 beds in France.

## T1.2 Drug use and related problems among prisoners

The purpose of this section is to provide a commentary on the:

- Prevalence of drug use and the related problems among prisoners
- Numerical data submitted in the relevant parts of ST 12, ST 9, TDI

Please structure your answers around the following questions.

T1.2.1 Please comment on any recent studies that provide information on prevalence of drug use (please specify substance covered and provide links if available). Structure your answer under the headings:

- Drug use prior to imprisonment
- Drug use inside prison

### *Drug use prior to imprisonment*

Studies conducted about a dozen years ago by the DREES (Directorate for research, studies, assessment and statistics of the Ministry of Health) on drug use among inmates 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.

### *Drug use inside prison*

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.

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

T1.2.2 Please comment on any studies that estimate drug-related problems among the prison population. If information is available please structure your answer under the following headings

- Drug related problems – on admission and within the prison population
- Risk behaviour and health consequences (please make specific reference to any available information on data on drug related infectious diseases among the prison population)

### *Drug related problems*

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 drug 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.

#### *Risk behaviour and health consequences*

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.

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): 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; Remy 2004; Semaille *et al.* 2013)). 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%).

## **T1.3 Drug-related health responses in prisons**

The purpose of this section is to:

- Provide an overview of how drug-related health responses in prison are addressed in your national drug strategy or other relevant drug/prison policy document
- Describe the organisation and structure of drug-related health responses in prison in your country
- Comment on the provision of drug-related health services (activities/programmes currently implemented)
- Provide contextual information useful to understand the data submitted through ST24/ST10

Please structure your answers around the following questions.

T1.3.1 Is drug-related prison health explicitly mentioned in a policy or strategy document at national level? (Relevant here are any: drug-specific health strategy for prisons; as well as the national drug or prison strategy documents).

The 2010-2014 “health/prison” strategic actions plan on health policy for inmates (Ministère de la santé et des sports and Ministère de la justice et des libertés 2010) stipulates acting on inmates' health determinants (practices exposing them to a risk for infection) and making screening programmes available for inmates. It provides for the establishment of suitable harm reduction measures that can be applied in prisons to remedy the shortcomings observed in France: these measures include distributing bleach with instructions for use, providing access to condoms, taking into consideration the infection risk of certain behaviours (e.g., snorting, tattooing, injections), providing access to sterile drug-use related harm reduction equipment, providing access to Fibroscan<sup>®1</sup> testing in prison, improving prevention measures (inviting professional tattoo artists to prisons) and screening (developing screening during incarceration). Furthermore, a reference national treatment and prevention centre for addiction (CSAPA) is appointed for each prison so as to offer support for inmates with addiction problems. The strategies of this plan are to improve treatment and bolster the objectives of the 2009-2012 national viral hepatitis strategic plan (DGS 2009), which defines a general framework for actions in prison settings, limiting itself to encouraging new inmates to undergo screening for hepatitis and assessing the Health/Justice memorandum of 9 August 2001. The 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours (MILDT 2013) sets forth specific health objectives for inmates (see T3.1).

<sup>1</sup> A non-invasive machine that can instantly detect liver fibrosis and assess its degree of advancement.

T1.3.2 Please describe the structure of drug-related prison health responses in your country. Information relevant to this answer includes: ministry in charge; coordinating and implementing bodies/organizations; relationship to the system for community-based drug service provision.

Since the law of 18 January 1994 [[Loi n°94-43 relative à la santé publique et à la protection sociale](#)], which transferred the responsibility for health in prisons from the Ministry of Justice to the Ministry of Health, the treatment of addiction in prison settings is based on a three-tiered system: prison-based hospital healthcare units (UCSAs), which are responsible for monitoring the physical health of inmates, Regional Medico-Psychological Hospital Services (SMPRs) established in each of the 26 French regions handle the mental health aspects of drug addicts in establishments where no local units exist, and finally, since 1987, “local addiction units” have been established in the 16 largest establishments in France (and cover approximately a quarter of the incarcerated population). This general scheme is also accompanied by another, set up on an experimental basis: UPSs, or care units for prison leavers, exist in 7 establishments.

At the same time, the legal framework of the prison harm reduction scheme also offers various possibilities for providing access to care for drug addicted inmates since the circular of 5 December 1996 [[Circulaire DGS/DH/DAP n°96-739 relative à la lutte contre l'infection par le virus de l'immunodéficience humaine \(VIH\) en milieu pénitentiaire : prévention, dépistage, prise en charge sanitaire, préparation à la sortie et formation des personnels](#)]:

- Screening for HIV and hepatitis is theoretically offered upon arrival (CDAG - Anonymous Free Screening Centre) but is not systematic for hepatitis C (POPHEC - First hepatitis C prison's observatory - data)



- Prophylactic measures (hygiene measures and the provision of post-exposure treatments for both staff and inmates)
- Availability of condoms with lubricant (theoretically accessible via UCSAs)
- Access to OSTs and the availability of bleach to disinfect equipment in contact with blood (injection, tattooing and body piercing equipment).

T1.3.3 Please comment on the types of drug-related health responses available in prisons in your country and if possible the scale of provision in terms of coverage and capacity. Information relevant to this answer could include: assessment of drug use and related problems at admission; availability of treatment (psychosocial / counselling / pharmacological-assisted), harm reduction interventions (including syringe distribution), overdose prevention training and naloxone (in prison or on release), testing, vaccination and treatment of infectious diseases & referral processes to external services on release.

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.

To guarantee the application of harm reduction measures, now embodied in legislation [[Loi n°2004-806 du 9 août 2004 relative à la politique de santé publique](#)]<sup>1</sup>, two main ways of preventing the spread of infectious diseases have been implemented in prison settings since 1996. The 5 December 1996 circular [[see above](#)] first and foremost stipulates access to OST in prison: inmates receiving OST must not only be able to continue their treatment in prison, but should also be able to initiate treatment if they wish, and especially HDB therapy. Since 2002, methadone OST can also be initiated. There is no medicalised heroin programme in prison, unlike outside of prisons. However, in practice, not all penal establishments offer generalised access to all available treatments (Michel *et al.* 2011). In 2010, a few establishments only offered one type of treatment: HDB only was offered in four establishments and methadone only in four others. Continuity of OST care upon release is only ensured by half of the establishments (55%), and 38% of the establishments stated that they did not have a formalised procedure. Based on the more recent PREVACAR (Chemlal *et al.* 2012; DGS 2011) and PRI<sup>2</sup>DE (Michel *et al.* 2011) 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.

In addition to substitution, prison establishments offer prevention and decontamination tools for fighting against HIV: in accordance with the recommendations of the Gentilini report (Gentilini and Tcheriatchoukine 1996), periodically distributing bleach in set quantities and concentrations became generalised in prison in order to clean any equipment that comes into contact with blood (such as injection, tattooing and piercing equipment). Distributing bleach chlorometrically titrated to 12° has occurred systematically since the Health-Justice circular of 5 December 1996 [[see above](#)] and since the Health/Justice memorandum dated 9 August

2001 [Note interministérielle MILDT/DGS/DHOS/DAP n°474 relative à l'amélioration de la prise en charge sanitaire et sociale des personnes détenues présentant une dépendance aux produits licites ou illicites ou ayant une consommation abusive], prison administrations have been encouraging health personnel to inform inmates on how to use bleach as a product to disinfect injection equipment. The legal measures implemented by the 5 December 1996 circular to fight against the spread of HIV also stipulate making NF-compliant condoms available free of charge with lubricants (theoretically obtainable through prison-based hospital healthcare units): inmates can keep these items on their person or in their cell. Access to prophylactic antiretroviral therapy after accidental exposure to blood is also available for health and prison staff as well as for inmates. Subsequently, for injecting drug users, the only current way to protect themselves against AIDS, other than through post-exposure antiretroviral prophylaxis and access to condoms and lubricants in the event of sexual relations, is to disinfect syringes with bleach. These measures for cleaning injection equipment with bleach have been proven acceptable in eliminating HIV: however, it has been established that these measures are not sufficiently effective in combating the hepatitis C virus (Crofts 1994). 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). Outside of the prison setting, messages on disinfecting with bleach have furthermore been largely abandoned in favour of messages on refraining from reusing injection equipment ("À chaque injection, du matériel neuf"/"New equipment for each injection").

In contrast to the situation outside prisons, support for drug users is limited in the prison setting (counselling, peer education, primary health care) and access to sterile injection equipment (alcohol wipes, bottles of sterile water, sterile containers "cookers", sterile syringes), which has been authorised in the general population since 1989, is absent from all prison settings.

France does not offer syringe exchange programmes in prisons. This was considered a "premature" initiative by the Health-Justice mission of 2000 before becoming the subject of new recommendations within the scope of the INSERM collective expert evaluation conducted in 2010 (INSERM 2010). There was also no specific programme in prisons to provide information on how contamination occurs through injection practices.

<sup>1</sup> This law proposes an official definition of the harm reduction policy ("the policy of harm reduction for drug users aims to prevent the transmission of infection, death by intravenous drug overdose and the social and psychological harm related to abuse of drugs classified as narcotics", art. L. 3121-4) and places the responsibility for defining this policy with the French government (art. L. 3121-3).

**T1.3.4** Please comment any contextual information helpful to understand the estimates of opioid substitution treatment clients in prison provided in ST24.

The prevalence of individuals receiving OST is estimated based on a cross-disciplinary study on a random sample. Hence, there may be a number of double entries for individuals having been in prison and having been followed up by a CSAPA/general practitioner for their treatment at release (and vice versa). This particularly concerns reporting data from healthcare units which have endeavoured to comply with best practices, overestimating the proportion of individuals receiving OST.

**T1.3.5 Optional.** Please provide any additional information important for understanding the extent and nature of drug-related health responses implemented in prisons in your country.



## T1.4 Quality assurance of drug-related health prison responses

The purpose of this section is to provide information on quality system and any drug-related health prison standards and guidelines.

Note: cross-reference with the Best Practice Workbook.

Please structure your answers around the following question.

**T1.4.1 Optional.** Please provide an overview of the main treatment quality assurance standards, guidelines and targets within your country.

A first guide to the health care treatment of inmates was distributed in 1994 to prison system health workers. This guide was updated for the first time in 2005 (Ministère de la santé et de la protection sociale and Ministère de la justice 2004). The interministerial circular of 30 October 2012 [[Circulaire interministérielle DGOS/DSR/DGS/DGCS/DSS/DAP/DPJJ n°2012-373 relative à la publication du guide méthodologique sur la prise en charge sanitaire des personnes placées sous main de justice](#)] updated this guide (*Guide méthodologique relatif à la prise en charge sanitaire des personnes détenues*: Methodological guide on the health care of detainees (Ministère de la justice and Ministère des affaires sociales et de la santé 2012)). In its outline, the guide reiterates the current principles of the treatment offered to inmates and persons in detention, both physical and psychiatric, in compliance with the 2010-2014 “health/prison” strategic actions plan” (Ministère de la santé et des sports *et al.* 2010). 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 guide 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. Furthermore, the guide offers a framework agreement for field workers to ensure that inmates take advantage of their social rights. Other framework documents are also enclosed within the guide, such as useful references on treating minors.

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 and MILDT 2013) recommends daily supervised methadone dispensing, including on weekends and on holidays, to prevent overdose risk. But this recommendation seems difficult to systematically apply given the lack of health personnel described by professionals working in prison settings.

## T2. Trends. Not applicable for this workbook

## T3. New developments

The purpose of this section is to provide information on any notable or topical developments observed in drug-related issues in prisons 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 question.

T3.1 Please report on any notable new or topical developments in drug-related issues in prisons in your country since your last report.

Several measures specific to inmate populations in the 2013-2017 governmental plan (MILDT 2013) are currently being implemented, notably:

- The use of videos to diffuse messages on prevention in a prison setting.
- The development of support groups on addictive behaviours with a view to prevention.
- Improvement in the organisation of the management of individuals presenting addictive behaviours in a prison setting, by reinforcing intervention by hospital liaison teams specialising in addiction medicine (ELSA). This involves offering management in a prison setting in which addiction clinics are not available, and where specialist follow-on management cannot be provided by a CSAPA.
- The promotion of practices recommended in the Guide to Opioid Substitution Treatments in prison settings.
- Reinforcement of regular monitoring of inmate health data in the context of a health-justice partnership working group, coordinated by MILDECA.
- Installation of anti-projectile systems (nets, videosurveillance), millimetre wave scanners and training of personnel in the use of these systems.

Furthermore, from a legislative perspective, Article 8 of the bill on health system reform (known as the health act) provides for the application of harm reduction measures to inmates (including the possibility of trialling needle and syringe exchange programmes in prisons), according to conditions adapted to the prison setting. There are also plans to reinforce the reference CSAPAs (each prison has a reference CSAPA which liaises between the prison and the external environment) in the largest prisons. This bill was adopted by the Assemblée Nationale in April 2015, and has yet to be debated by the Senate before being definitively adopted. Once the law has been promulgated, a decree is expected to be drafted in the Council of State, stipulating the conditions for application of these measures.

## T4. Additional information

The purpose of this section is to provide additional information important to drug use among prisoners, its correlates and drug-related health responses in prisons in your country that has not been provided elsewhere.

Please structure your answers around the following questions.

**T4.1 Optional.** Please describe any additional important sources of information, studies or data on drug use or drug problems among prisoners' particular interest studies on psychiatric comorbidity and post-release mortality. Where possible, please provide references and/or links.

The Toulouse University (Université de Toulouse-Jean Jaurès) is currently conducting the study "Backgrounds and addictive paths of incarcerated individuals and inmates" (*Parcours de vie et trajectoire addictive chez les personnes incarcérées et placées sous main de justice*), with funding from MILDECA.

**T4.2 Optional.** Please comment on any other important aspect of this topic that has not been covered in the questions above but is important for your country.

## 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.

No current question

## 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.

- Series of inmate statistics (1980-2014). Ministry of Justice. (see bibliography)
- Collective expert report on infectious harm reduction measures (2010). INSERM (see bibliography)
- Health survey on new prison inmates (1997, 1999, 2003). DREES.
- PREVACAR survey (2010). DGS.
- ANRS-PRI<sup>2</sup>DE inventory (2009). ANRS

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

### Methodology

#### Health survey on new prison inmates

*French Directorate for Research, Studies, Assessment and Statistics (DREES) of the Ministry of Health*

This survey was conducted for the first time in 1997 in all remand centres and remand wings within prison settings. The last survey was conducted in 2003. It collects information during the admission medical visit about risk factors for the health of entrants as well as observed pathologies, which are mainly identified from ongoing treatments. Declared use of psychoactive substances included daily smoking, excessive alcohol consumption (more than 5 glasses per day) and “prolonged regular use during the 12 months before imprisonment” of illegal drugs.

#### 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 1<sup>st</sup> July 2010.

### **PRI2DE: Research and intervention programme to prevent infection among inmates**

*French National AIDS and hepatitis research agency (ANRS)*

This 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.

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## WB 5.2 Research

*France*

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## **2015 National report (2014 data) to the EMCDDA by the French Reitox National Focal Point**

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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 Research Contents

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## T0. Summary

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

- National profile

### **National profile**

In France, the Ministry of National Education, Higher Education and Research (MENESR) designs, coordinates and implements national policy on research and innovation. Two primary academic organisations, the National Centre for Scientific Research (CNRS) and the National Institute for Health and Medical Research (INSERM), cover a wide range of research areas, from neurosciences, through public health and clinical research to social sciences. The French National Focal Point (OFDT) is the main body involved in drug-related data collection, studies and network development. It collaborates extensively with national and European drug-related research teams. Dissemination of data and research results are also part of its mandate, together with publishing in national and international scientific journals, and promoting the use of research results in practice and policymaking. The Interministerial Mission for the Fight Against Drugs and Addictive Behaviours (MILDECA) is the central structure responsible to the Prime Minister for coordinating governmental action in the drugs field. Part of its role is to promote and fund drug-related research. In line with the Government Plan for Combating Drugs and Addictive Behaviours 2013–17 (MILDT 2013), the MILDECA supports calls for proposals and extended collaboration with research organisations/universities and with the French Research Agency (ANR). It also promotes clinical research networks and dissemination initiatives towards the scientific community and policymakers. The Ministry of Research together with the MILDECA also supports the ERANID research network, which includes major academic research centres (INSERM, CNRS) and the national monitoring centre for drugs and drug addiction (OFDT).

View '[Drug-related research](#)' for additional information.

- New development

### **New developments**

In 2013, within the framework of the ERANID project, the OFDT carried out a study on French drug-related research policy priorities, funding mechanisms and recent projects (2010-2013). Compared to previous similar studies carried out for the European Commission (EC), the results show a strengthening of French research activities. In addition, in 2014, CNRS carried out a study on Research priorities on illicit drug and social science among stakeholders (researchers, institutional representatives, harm reduction professionals and caregivers). Most of the research projects identified over the period focus on aspects related to the patterns of use, treatment responses, the determinants and consequences of drugs uses. Other issues receive less or little attention over the period considered. This is particularly the case of drug supply issues and law enforcement responses. Most of the projects provide epidemiological analyses, medical sciences are mobilised to a lesser extent and, except sociology, nearly none social sciences analyses is provided.

The majority of research projects are collaborative. However, the partnership remains at a national level. Still, the involvement of French organizations in EC funded projects progressed.

Although drug research priorities are not formally made explicit by the authorities, the French policy documents raise strong concerns which are addressed by a number of research projects identified. This is particularly the case regarding the epidemiology of drug use, treatment responses and the consequences of drug use. Also, specific approaches supported by the authorities such as neurosciences are mobilized by a number of projects. More knowledge is expected regarding prevention responses and supply reduction. The authorities express as well their interest for the genetics of addiction which is little addressed by researchers. By contrast, current research projects give special attention to areas that are not particularly emphasized in the policy documents such as the determinants and mechanism of drug use, as well as harm reduction responses.

The main research team of the projects comes from a public body which is an academic centre in a third of the cases. Public funding remains the key enabler of drug-related research and projects are mainly funded through calls for tenders. But, the economic crisis significantly impacted the budgets available and contributed to the vulnerability of many research teams or institutes involved in the drug field.

A study on the research priorities in the field of illicit drugs and social sciences was conducted by the CNRS within the framework of the Eranid project between November 2013 and September 2014. An online questionnaire and focus groups were conducted with 101 stakeholders in France (professionals, researchers, institutional representatives). This study highlighted the need to develop research in the following areas: analysis of public policies, better knowledge of the profiles of drug users and evaluation of interventions in the field. However, studies on the prevalence should to be maintained, but without reinforcement, given the high-quality existing in France for several years on the subject. Similarly, it was noted that too much emphasis had been granted in France in recent years to research on drug dependence treatment in an epidemiological and neurobiological perspective, at the expense of more qualitative research mobilising sociology and anthropology of drug use that deserve be best developed in France.

## T1. Drug-related research<sup>1</sup>

The purpose of this section is to:

- Describe the organization of drug-related research in your country
- Provide a summary of specific resources on drug-related research available in your country
- Update the available information already provided to the EMCDDA (workbook will be pre-filled).

Please structure your answers around the following questions.

T1.1.1 Please update the main drug-related research institutions/associations/bodies (public or private) in your country.

Please provide links, also to pages in English, if available.

- Centre National de la Recherche Scientifique (CNRS):  
<http://www.cnrs.fr/index.php>
- Conservatoire National des Arts et Métiers (CNAM):  
<http://the.cnam.eu/>
- École des Hautes Études en Santé Publique (EHESP):  
<http://www.ehesp.fr/en/>
- École des Hautes Études en Sciences Sociales (EHESS):  
<http://www.ehess.fr/en/ehess>
- Fédération Nationale des Observatoires Régionaux de la Santé (FNORS):  
<http://www.fnors.org/Fnors/Ors/Coord.htm>
- Fondation Nationale des Sciences Politiques (FNSP):  
<http://www.sciencespo.fr/en/home>
- Institut de Prévention et d'Éducation pour la Santé (INPES):  
<http://www.inpes.sante.fr/>
- Institut de Recherche en Santé Publique (GIS-IReSP):  
<http://www.iresp.net/>
- Institut de Recherche pour le Développement (IRD):  
<http://en.ird.fr/ird.fr>
- Institut de Veille Sanitaire (InVS):  
<http://www.invs.sante.fr/en>
- Institut National de la Recherche Agronomique (INRA):  
<http://www.inra.fr/en>
- Institut National de la Santé et de la Recherche Médicale (INSERM):  
<http://english.inserm.fr/>
- Institut National du Cancer (INCa):  
<http://en.e-cancer.fr/>
- Observatoire Français des Drogues et des Toxicomanies (OFDT):  
<http://en.ofdt.fr/>

<sup>1</sup>“Drug-related research involves performing a study on illicit drugs, which may involve a range of disciplines, through the use of scientifically accepted methods and procedures, in order to test a hypothesis or answer a specific question.” (EMCDDA, 2012 Drug-related research in Europe: recent developments and future perspectives)

T1.1.2 Please update the main institutions/associations/bodies/programmes (public or private) funding drug-related research in your country.  
Please provide links, also to pages in English, if available.

- The Ministry of National Education, Higher Education and Research (MENESR: <http://www.education.gouv.fr/>) designs, coordinates and implements national policy on research and innovation. A large scope of research areas ranging from neurosciences, through public health and clinical research to social sciences is mainly covered by two major academic operators: the National Centre for Scientific Research (CNRS) and the National Institute for Health and Medical Research (INSERM).
- The French Research Agency (*Agence Nationale de la Recherche* – ANR: <http://www.agence-nationale-recherche.fr/en/project-based-funding-to-advance-french-research/>) is in charge of programming national research and innovation. The agency establishes the thematic priorities of research and allocates the resources. Every year, the agency launches calls for tenders covering a large spectrum of scientific areas.
- The Interministerial Mission for Combating Drugs and Addictive Behaviours (MILDECA: <http://www.drogues.gouv.fr/english-version/index.html>) is the central structure responsible to the Prime Minister for coordinating governmental action in the drugs field. Part of his role is to promote and fund drug related research. In line with the last Actions Plan 2013–17 (MILDT 2014), the MILDECA supported new annual calls for proposals and extended collaborations with research organizations/universities and with the ANR. It also promoted clinical research networks and dissemination initiatives towards the scientific community and policy makers. The Ministry of Research together with the MILDECA also supported the ERANID research network gathering major academic research centres (INSERM, CNRS) and agencies including the national focal point itself.
- The Ministry of Health (<http://www.sante.gouv.fr/>) funds, in specific years, clinical projects on addiction treatment in hospitals (under the programme “*Programme Hospitalier de Recherche Clinique*” - PHRC). It also funds studies on specific populations of drug users, interventions (prevention, treatment, harm reduction) or legal disposition.
- The National Research Agency on AIDS (*Agence Nationale de Recherche sur le Sida* – ANRS: <http://www.anrs.fr/>) and the Institute for Public Health Surveillance (*Institut de Veille Sanitaire* – InVS: <http://www.invs.sante.fr/>) implement regular surveys and research projects on the links between injecting drug use and infectious diseases (mainly HIV and HCV).
- NGOs and foundations representing practitioners, users and companies (alcohol suppliers, tobacco industry and pharmaceutical laboratories) also regularly fund surveys and research project in these areas.

T1.1.3 Please update the list of the main national scientific journals where drug-related research is published in your country.  
Please provide links, also to pages in English, if available.

Name	Topic	Language(s)	Abstract
Alcoologie et Addictologie <a href="http://www.sfalcoologie.asso.fr/page.php?choix=B3-GB&amp;PHPSESSID=9f11067128dbabb15e27b66f913d0b8b">http://www.sfalcoologie.asso.fr/page.php?choix=B3-GB&amp;PHPSESSID=9f11067128dbabb15e27b66f913d0b8b</a>	Treatment	French, English	English
Archives des Maladies Professionnelles et de l'Environnement <a href="http://www.sciencedirect.com/science/journal/17758785">http://www.sciencedirect.com/science/journal/17758785</a>	Treatment	French	English
Toxicologie Analytique et Clinique (former Annales de Toxicologie Analytique) <a href="http://www.sciencedirect.com/science/journal/23520078">http://www.sciencedirect.com/science/journal/23520078</a>	Toxicology	French, English	English
Bulletin Épidémiologique Hebdomadaire <a href="http://www.invs.sante.fr/Publications-et-outils/BEH-Bulletin-epidemiologique-hebdomadaire">http://www.invs.sante.fr/Publications-et-outils/BEH-Bulletin-epidemiologique-hebdomadaire</a>	Epidemiology and public health	French	English
Le Courrier des Addictions <a href="http://www.edimark.fr/courrier-addictions">http://www.edimark.fr/courrier-addictions</a>	Addiction all topics	French	French
Déviance et Société <a href="http://www.cairn-int.info/revue.php?ID_REVUE=E_DS">http://www.cairn-int.info/revue.php?ID_REVUE=E_DS</a>	Sociology and political science	French	English
L'Encéphale <a href="http://www.sciencedirect.com/science/journal/00137006">http://www.sciencedirect.com/science/journal/00137006</a>	Treatment	French	English
Médecine/sciences <a href="http://www.medecinesciences.org/">http://www.medecinesciences.org/</a>	Health	French	French
Psychotropes, Revue internationale des toxicomanies et des addictions <a href="http://www.cairn.info/revue-psychotropes.htm">http://www.cairn.info/revue-psychotropes.htm</a>	Treatment	French	English
Revue d'Épidémiologie et de Santé Publique <a href="http://www.journals.elsevier.com/revue-depidemiologie-et-de-sante-publique/">http://www.journals.elsevier.com/revue-depidemiologie-et-de-sante-publique/</a>	Epidemiology and public health	French, English	English
Revue Française des Affaires Sociales <a href="http://www.cairn.info/revue-francaise-des-affaires-sociales.htm">http://www.cairn.info/revue-francaise-des-affaires-sociales.htm</a>	Human and social sciences	French	English
Revue Française de Sociologie <a href="http://www.cairn-int.info/revue.php?ID_REVUE=E_RFS">http://www.cairn-int.info/revue.php?ID_REVUE=E_RFS</a>	Sociology	English, French	English
La Santé en Action <a href="http://www.inpes.sante.fr/SLH/default.asp">http://www.inpes.sante.fr/SLH/default.asp</a>	Public Health	French	French
Santé Publique <a href="http://www.sfsp.fr/santepublique/accueil.php">http://www.sfsp.fr/santepublique/accueil.php</a>	Epidemiology and public health	French	English

Sciences Sociales et Santé <a href="http://www.jle.com/en/revues/sante_pub/sss/sommaire.md">http://www.jle.com/en/revues/sante_pub/sss/sommaire.md</a>	Human and social sciences	French, English	English
Sociétés Contemporaines <a href="http://www.pressesdesciencespo.fr/en/revues/societes-contemporaines/">http://www.pressesdesciencespo.fr/en/revues/societes-contemporaines/</a>	Sociology	French	English
Sociologie <a href="http://www.cairn-int.info/revue.php?ID_REVUE=E_SOCIO">http://www.cairn-int.info/revue.php?ID_REVUE=E_SOCIO</a>	Sociology	French	English
Swaps <a href="http://www.pistes.fr/swaps/index.htm">http://www.pistes.fr/swaps/index.htm</a>	Addiction in all fields	French	French
Thérapie <a href="http://www.journal-therapie.org/">http://www.journal-therapie.org/</a>	Treatment	French, English	English

T1.1.4 Please update the list of drug-related research relevant websites/resources you would like us to include in your research country profile.  
Please provide links, also to pages in English, if available.

ERANID (<http://www.eranid.eu/>) is an ERA-NET (European Area Network) cooperation project on illicit drugs funded by the European Commission under the 7th Framework Programme. Within this project, the study 'Comparative analysis of research into illicit drugs across Europe (2010–13)' is carried out by the OFDT. The study consisted in mapping and analysing the situation of drug-related research in the six ERANID participating countries (Belgium, France, Italy, the Netherlands, Portugal, United Kingdom) and at the European Commission level, over the period 2010–13. The results will be published by the European Commission.

## T2. Trends

Not applicable for this workbook.

## T3. New developments

The purpose of this section is to provide information on any notable or topical developments observed in drug-related research 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 question.

T3.1 Please update the list of the main drug-related, recent/on-going (from 2012 on) studies/research projects in your country.

Please provide links, also to pages in English, if available.

Please note that this workbook was pre-filled in, using the information provided through the bibliography of your national report. Some references may not be well translated, or may not correspond to studies/research projects, others may correspond to the same study/research project and others may be missing. Please correct/complete as necessary.

Recent studies used for the 2014 National Report

### **2014 National report bibliography**

Brisacier, A.C. and Collin, C. (2014). Les traitements de substitution aux opiacés : données récentes [Opioid substitution treatments in France: recent data]. Tendances. OFDT, (94).

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. OFDT, (78).

Cadet-Taïrou, A. and Dambélé, S. (2013). Héroïne et autres opiacés. In: OFDT (Ed.) Drogues et addictions, données essentielles. OFDT, Saint-Denis.

Cadet-Taïrou, A. and Dambélé, S. (2014). Les CAARUD en 2010. Analyse des rapports d'activité annuels standardisés ASA-CAARUD [CAARUDs in 2010. Analysis of standardised annual activity reports ASA-CAARUD]. OFDT, Saint-Denis.

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### **Current research projects in France (2010- 2014)**

The following list is not exhaustive. It is based upon a "one shot study" carried out within the framework of the Eranid project (funded by the EC).

Title	Main research institute
Dissection génétique de la fonction du récepteur des glucocorticoïdes dans les effets du stress sur les réponses comportementales aux drogues d'abus [Genetic dissection of the function of the glucocorticoid receptor in chronic stress effects on behavioral responses to drugs of abuse]	INSERM (National Institute for Health and Medical Research)
Analyse quantitative de perception des dommages et bénéfices associés aux substances addictives [Quantitative analysis of the perception of damages and benefits associated to addictive substance use]	INSERM (National Institute for Health and Medical Research)
Consommation de médicaments psychotropes détournés de leur usage par les adolescents et jeunes adultes [Prescription drug misuse among adolescents and young adults]	University of Bordeaux, OFDT
Acceptabilité par les usagers de drogues injectables de deux nouvelles trousse de prévention [Acceptability by injecting drug users of two new harm reduction tools]	OFDT (French monitoring centre for drugs and drug addiction)
Les politiques européennes de lutte contre les drogues [European national drug policies]	Institute of Political Sciences
Le sexe de la répression. Le traitement pénal des femmes usagères et trafiquantes de drogues [Does repression have a gender? Criminal justice for drug-using and drug-trafficking women]	CNRS (National Centre for Scientific Research)
SAGE, Facteurs impliqués dans la consommation de drogues chez les jeunes majeurs en population générale [SAGE, Factors involved in drug use among young adults in the general population]	INSERM (National Institute for Health and Medical Research)
PrimInject : une enquête nationale par internet sur les contextes et les pratiques de la première injection parmi les jeunes usagers de drogues en France [PrimInject: a national internet-based survey on the practices and context of the first injection among young drug users in France]	INPES (French National Institute for Prevention and Health Education)
Économie des drogues et des toxicomanies [Economy of drugs and drug addiction]	Catholic University of Lille
Les traitements de substitution vus par les patients : quels sont les enseignements de leur expérience? [Substitution treatments from the patient's point of view: what can we learn from their experience?]	University of Bordeaux Segalen

Jeunes errants urbains à Bordeaux [Young urban homelessness wandering in Bordeaux (French metropolis)]	University of Bordeaux Segalen
Programme de recherche et intervention pour la réduction du risque infectieux en détention (PRIDE) – acceptation sociale des mesures de réduction des risques [Research programme and intervention to reduce the risk of infection while being in custody (PRIDE) – social acceptability of harm reduction measures]	INSERM (National Institute for Health and Medical Research) – Inserm U669 and Cermes3 (Inserm U988).
Exploitations régionales des données sur les addictions du Baromètre Santé 2010 de l'INPES [ <i>Baromètre santé</i> 2010 in Ile-de-France - Health barometer on addictions in the Paris region in 2010]	INPES (French National Institute for Prevention and Health Education)
Étude de la prévalence des troubles psychiatriques et neurocognitifs au cours du suivi de patients co-infectés par le VIH et le VHC (sous-étude ANRS CO13 HEPAVIH) [Prevalence study of the psychiatric and neurocognitive impairment among monitored HIV and HCV co-infected patients (sub-study A999S CO13 HEPAVIH)]	INSERM (National Institute for Health and Medical Research)
L'héroïne en France. Une histoire sociale et culturelle de la diffusion des usages et des trafics, 1968-2004 [Heroin in France. A social and cultural history of the dissemination of its use and trafficking, 1968-2004]	CNRS (National Centre for Scientific Research)
Intervention précoce, prévention et réduction des risques et des dommages liés à l'usage de cocaïne basée : construire un guide destiné aux professionnels [Early intervention, prevention and risk reduction related to base cocaine use: writing a guide for professionals]	GRVS (Groupe de Recherche sur la Vulnérabilité Sociale)
Évaluation qualitative du dispositif transdisciplinaire de prévention et de prise en charge des conduites addictives de la commune de Valbonne Sophia-Antipolis : un dispositif innovant de proximité à modéliser pour produire une méthodologie transposable [Qualitative evaluation of a transdisciplinary network for preventing and treating addictive behaviours in the Valbonne Sophia-Antipolis French area: an innovative community system to be modelled to achieve a replicable methodology]	GRVS (Groupe de Recherche sur la Vulnérabilité Sociale)
Intérêt du Fibroscan pour l'amélioration de la prise en charge des hépatites B et C au sein des CSAPA : volet qualitatif CSAPASCAN [Contribution of the Fibroscan to the care and treatment of hepatitis B and C within CSAPA (National treatment and prevention centre for addiction): CSAPASCAN qualitative study]	GRVS (Groupe de Recherche sur la Vulnérabilité Sociale)

ABSTINENCE - Déficits émotionnels dans l'abstinence prolongée aux drogues d'abus : mécanismes moléculaires et nouveaux gènes dans le raphe dorsal [ABSTINENCE- Mood disruption in prolonged abstinence from drugs of abuse: molecular mechanisms and gene discovery in the dorsal raphe]	INSERM (National Institute for Health and Medical Research)
Santé et environnement social des élèves [Health and social environment of adolescent school children]	University of Lorraine
ESM : Facteurs associés au craving et à la consommation chez des sujets dépendants aux substances en début de prise en charge. Une étude en vie quotidienne [ESM: Factors associated to craving and drug use in patient who were addicted when starting a treatment. A study based on everyday life]	CNRS (National Centre for Scientific Research)
Thèse : Inégalités de genre et inégalités sociales dans les usages de drogues en France [PhD thesis: Gender inequalities and social inequalities in the use of drugs in France]	INED (Institut National d'Études Démographiques)
PREVDROG-PRO - Usages d'alcool, drogues et médicaments psychotropes au travail [PREVDROG-PRO - Use of alcohol, drugs and psychotropic drugs at work]	CNAM CRTD (Centre de Recherche sur le Travail et le Développement)
Étude du profil psychopathologique et addictologique de patients atteints de maladie de Buerger [Study of psychopathological and addictive profile of patients suffering from Buerger's disease]	CHRU de LILLE
Effets de la stimulation à haute fréquence du noyau subthalamique sur la motivation pour la cocaïne chez le singe [Effects of high frequency stimulation of the subthalamic nucleus on motivation for cocaine in monkeys]	University of Aix-Marseille
Approche transversale du rôle du noyau subthalamique dans la motivation et la dépendance aux drogues : du rat au patient parkinsonien [Transversal approach of the role of the subthalamic nucleus in motivation and drug addiction: from rats to parkinsonian patients]	University of Aix-Marseille
Stimulation cérébrale profonde du noyau subthalamique pour le traitement des troubles du contrôle des impulsions [Subthalamic nucleus deep brain stimulation for the treatment of impulse control disorders]	University of Aix-Marseille

<p>Stimago ANRS - Évaluation de la dose efficace de méthylphénidate dans la dépendance à la cocaïne pour un essai clinique randomisé sur l'efficacité du méthylphénidate</p> <p>[Stimago ANRS (National Research Agency on AIDS) - Evaluation of the effective dose of methylphenidate in cocaine dependence for a randomised controlled trial on the effectiveness of methylphenidate]</p>	INSERM (National Institute for Health and Medical Research) – Inserm U992.
<p>Dépendance aux opioïdes et impact des traitements de substitution</p> <p>[Opioid addiction and impact of the substitution treatments]</p>	CNRS (National Centre for Scientific Research)
<p>Effets respiratoires des substances donnant lieu à abus</p> <p>[Respiratory effects of drugs of abuse]</p>	INSERM (National Institute for Health and Medical Research)
<p>Mémoire neurochimique : quels sont les mécanismes cellulaires et moléculaires à son origine ? Est-ce un facteur de vulnérabilité à la rechute ?</p> <p>[Neurochemical memory: what are the cellular and molecular mechanisms of its origin? Is it a factor of vulnerability to relapse?]</p>	CNRS (National Centre for Scientific Research)
<p>mGluR7 et addiction : régulation des récepteurs et fonctions dans les différentes phases de la dépendance (acquisition, expression, extinction, rechute)</p> <p>[mGluR7 &amp; addiction: regulation of the receptors and functions in the different phases of addiction (acquisition, expression, maintenance, relapse)]</p>	CNRS (National Centre for Scientific Research)
<p>Le trafic de stupéfiants à partir des aérodromes secondaires non surveillés et plateformes de circonstance</p> <p>[Drug trafficking based on unmonitored airfields and improvised landing platforms]</p>	Département "Sécurité" de l'INHESJ (Institut National des Hautes Études de la Sécurité et de la Justice)
<p>ESCAPAD, Enquête sur la santé et les consommations lors de la journée défense et citoyenneté</p> <p>[ESCAPAD, National survey on Health and Use on National Defence and Citizenship Day]</p>	OFDT (French Monitoring Centre on Drugs and Drug Addictions)
<p>EROPP, Enquête sur les représentations, opinions et perceptions sur les psychotropes</p> <p>[EROPP, Survey on Representations, Opinions, and Perceptions Regarding Psychoactive Drugs]</p>	OFDT (French Monitoring Centre on Drugs and Drug Addictions)
<p>Évaluation d'un habitat collectif thérapeutique expérimental pour usagers de cocaïne ou de crack</p> <p>[Evaluation of experimental therapeutic collective housing for cocaine or crack users]</p>	OFDT (French Monitoring Centre on Drugs and Drug Addictions)

ENa-CAARUD, Enquête nationale auprès des usagers des CAARUD [ENa-CAARUD, National survey of low-threshold CAARUDs structures]	OFDT (French Monitoring Centre on Drugs and Drug Addictions)
Evaluation des stages de sensibilisation aux dangers de l'usage de produits stupéfiants [Evaluation of awareness-building training courses on the drug related harms]	OFDT (French Monitoring Centre on Drugs and Drug Addictions)
RELIONPREDIL, Étude expérimentale pour l'observation des actions de prévention liées aux usages de drogues illicites et licites [RELIONPREDIL, Experimental survey for the monitoring of prevention actions related to illicit or licit drugs]	OFDT (French Monitoring Centre on Drugs and Drug Addictions)
Facteurs de variabilité des doses de méthadone nécessaires pour atteindre l'équilibre [Variability factors of the appropriate methadone doses to reach stability]	AP-HP (Assistance publique – Hôpitaux de Paris)
Mécanismes de signalisation intracellulaire responsables des effets des psychostimulants [Intracellular signalling mechanisms implied in the effects of psychostimulants]	INSERM (National Institute for Health and Medical Research)
Étude sur les traitements de substitution aux opiacés [National survey on opiate substitution treatment]	OFDT (French Monitoring Centre on Drugs and Drug Addictions)
Thèse de doctorat d'histoire. La lutte contre la drogue en France (1966-1996) : l'impossible prohibition [PhD thesis in history. The fight against drug in France (1966-1996): the impossible prohibition]	Institut des sciences sociales du politique (ISP), pôle Cachan, UMR C999S 7220
Correction des estimations du taux de décès liés à la drogue en France [Correcting estimates of the rate of drug related death in France]	OFDT (French Monitoring Centre on Drugs and Drug Addictions)
Cohorte mortalité chez les usagers de drogues vus dans les centres spécialisés (CSAPA, CAARUD) [Cohort health and mortality among drug users addressing addiction treatment and low threshold centres]	OFDT (French Monitoring Centre on Drugs and Drug Addictions)
Étude sur l'opportunité et la faisabilité d'un centre d'injection supervisé à Metz [Study on the opportunity and feasibility of a supervised injection facility in Metz city]	ORS Lorraine (Regional Monitoring Centre on Health)
Publics féminins : les approches en matière de prévention et de soins [Evaluation of experimental female-oriented addiction care services]	OFDT (French Monitoring Centre on Drugs and Drug Addictions)



Mesures d'accueil des sortants de prison [Evaluation of fast access and short-term support units for drug addicted prison leavers]	OFDT (French Monitoring Centre on Drugs and Drug Addictions)
Évaluation des consultations pour usagers de cocaïne dans les centres de soins ambulatoires [Evaluation of consultations for cocaine users in out-patient drug addiction treatment centres]	OFDT (French Monitoring Centre on Drugs and Drug Addictions)
Évaluation des communautés thérapeutiques en France. Quelle mise en œuvre pour quels résultats ? [Evaluation of the therapeutic communities in France. Implementation and results]	Phénoménologie et déterminants des comportements appétitifs, addictologie et psychiatrie / Sanpsy C999S USR 3413
Étude qualitative sur l'attrait des Consultation jeunes consommateurs (CJC) [Qualitative study on the attractiveness of the Youth Addiction Outpatient Clinics (CJC)]	OFDT (French Monitoring Centre on Drugs and Drug Addictions)
TREND, Tendances récentes et nouvelles drogues [TREND, Emerging trends and new drugs]	OFDT (French Monitoring Centre on Drugs and Drug Addictions)
Polyconsommations de substances psychoactives chez des femmes enceintes [Polyconsumption of psychoactive substances during pregnancy]	INSERM (National Institute for Health and Medical Research)
CHANGE, sortir des addictions [CHANGE, quitting addiction]	INSERM (National Institute for Health and Medical Research) – Cermes3 (Inserm U988)
Améliorer le repérage des conduites addictives par les médecins généralistes français [Increasing trends in screening for addictive behaviours among general practitioners in France]	OFDT (French Monitoring Centre on Drugs and Drug Addictions)
Mesure de la prévalence des usages de drogues illicites en population générale [Prevalence estimates of illicit drug use in general population]	OFDT (French Monitoring Centre on Drugs and Drug Addictions)
Sociologie des addictions des jeunes [Sociology of the addictions among the French youth]	INPES (French National Institute for Prevention and Health Education)
Stupéfiants et accidents mortels (projet SAM) [Drugs and fatal road crashes (SAM project)]	IFSTTAR (Institut Français des Sciences et Technologies des Transports, de l'Aménagement et des Réseaux)

Conduite sous l'influence de drogues ou de médicaments (WP2 - épidémiologie): étude de prévalence et étude de responsabilité [Driving under the influence of drugs and medicines (WP2 – Epidemiology): prevalence study and responsibility study]	IFSTTAR (Institut Français des Sciences et Technologies des Transports, de l'Aménagement et des Réseaux)
Genre et addictions [Gender and addictions]	CNRS (National Centre for Scientific Research)
L'influence du mode de collecte dans les enquêtes sur la mesure des pratiques addictives [The influence of the collection method in the surveys measuring addictive practices]	CNRS (National Centre for Scientific Research)
Déficits cognitifs dans la dépendance aux drogues et troubles mentaux comorbides [Cognitive deficits related to drug addiction and comorbid mental disorders]	Phénoménologie et déterminants des comportements appétitifs, addictologie et psychiatrie / Sanpsy C999S USR 3413
Analyses de patients traités par méthadone et buprénorphine depuis plus de 8 ans [Analyses of patients treated by methadone and buprenorphine for more than 8 years]	Phénoménologie et déterminants des comportements appétitifs, addictologie et psychiatrie / Sanpsy C999S USR 3413
The effect of opiate integrated treatment including methadone and buprenorphine/naloxone (Suboxone®) maintenance treatment for injecting drug users at community in Ho Chi Minh city, Vietnam	Phénoménologie et déterminants des comportements appétitifs, addictologie et psychiatrie / Sanpsy C999S USR 3413
Trajectoires de personnes présentant une addiction aux substances ou une addiction comportementale, en contact avec le dispositif de soins. Caractéristiques médicales, neurobiologiques, sociologiques et psychologiques. Étude prospective multicentrique, multidisciplinaire [Trajectories of peoples presenting a drug addiction or a behavioural addiction and addressing the care system. Medical, neurobiological, sociological and psychological characteristics. A prospective multicentric and multidisciplinary study]	Phénoménologie et déterminants des comportements appétitifs, addictologie et psychiatrie / Sanpsy C999S USR 3413
Enquête sur la consommation de substances parmi les travailleurs se rendant à la Médecine du Travail en Aquitaine [Survey on the consumption of substances among the workers addressing the Occupational medicine in Aquitaine]	Phénoménologie et déterminants des comportements appétitifs, addictologie et psychiatrie / Sanpsy C999S USR 3413

Étude des facteurs cliniques, génétiques et environnementaux associés à la survenue de symptômes psychotiques chez les cocaïnomanes [Study of the clinical, genetic and environmental factors associated to the declaration of psychotic symptoms in cocaine addicts]	AP-HP (Assistance publique – Hôpitaux de Paris)
Les échecs ou réussites du sevrage hospitalier de cocaïne peuvent-ils être prédits ? (QUIT-COC) [QUIT-COC. Can the failure or success of the hospital cocaine withdrawal be predicted?]	AP-HP (Assistance publique – Hôpitaux de Paris)
Acceptabilité sociale des salles de consommation à moindre risque en France [Social acceptability of drug consumption rooms in France]	INSERM (National Institute for Health and Medical Research) – Cermes3 (Inserm U988)
Évaluation d'un outil de réduction des risques lié à l'usage de crack sur la transmission de l'hépatite C [Evaluation of a tool reducing HCV transmission risk for crack users]	INSERM (National Institute for Health and Medical Research) – Cermes3 (Inserm U988)
ANRS - Etude Coquelicot sur la séroprévalence du VIH et de l'hépatite C chez les usagers de drogues, incluant une évaluation des outils de réduction des risques de l'injection [ANRS - Coquelicot Study on HCV, HIV seroprevalence among drug users including evaluation of harm reduction injecting tools]	INSERM (National Institute for Health and Medical Research) – Cermes3 (Inserm U988)
Recherche épidémiologique socio-comportementale et clinique sur les usagers de drogues [Socio-behavioural and clinical epidemiological research on drug users]	INSERM (National Institute for Health and Medical Research)
Recherche sur la mise au point d'un traitement de l'abus de cannabis [Research on the development of a treatment for cannabis abuse]	INSERM (National Institute for Health and Medical Research)
Perception et représentations des risques liés à la consommation d'alcool et de cannabis chez les militaires [Perception and representation of the risks of alcohol and cannabis use among military]	INSERM (National Institute for Health and Medical Research) / CESPA (Centre d'épidémiologie et de santé publique des armées)
Étude Buprénorphine injectable [Study on injected buprenorphine]	INSERM (National Institute for Health and Medical Research) – Inserm U912.
Évaluation d'un programme thérapeutique résidentiel (KAÏROS) [Evaluation of a residential treatment program (KAÏROS)]	Hôpital Maison Blanche

Enquête Virage, violences faites aux femmes [Virage study, violence against women]	INED (Institut National d'Études Démographiques)
Intention du locuteur dans la campagne de prévention contre les drogues et la toxicomanie - impact sur le jeune adulte [Intention of the speaker in the prevention campaign against drugs and drug addiction - impact on young adults]	EHESS (Ecole des Hautes Études en Sciences Sociales) - doctorat
Modifications en mémoire autobiographique chez les consommateurs réguliers de cannabis [Study of autobiographical memory in adult cannabis users]	University of Montpellier
COCADDICT. Addiction à la cocaïne : une étude translationnelle pour identifier et caractériser les réseaux neuronaux dysfonctionnels [COCADDICT. Cocaine addiction: a translational study to identify and characterize dysfunctional neuronal networks]	ANR (French Research Agency)
Étude Argent de la drogue [Study on the drug money]	INHESJ (Institut National des Hautes Études de la Sécurité et de la Justice)
Le crack dans le centre historique de Sao Paulo. Traitement d'un problème public en contexte de rénovation urbaine [Crack in the historical centre of Sao Paulo. Addressing a public problem in a context of urban renovation]	CNRS (National Centre for Scientific Research) - doctorat
Projet Purdrog. Pratiques d'usage-revente de drogues dans six groupes de jeunes : analyse d'un phénomène ignoré et stratégies pour la prévention [Purdrog project. Practice of drug use and resale among six groups of young people: analysis of an ignored phenomenon and strategies for prevention]	University of Bordeaux
Usagers de drogues : une nouvelle stratégie pour réduire les risques infectieux [Drug users: a new strategy to reduce infectious risks]	INSERM (National Institute for Health and Medical Research)
Prévenir le VHC chez les usagers de drogues : l'expérience de l'essai ANRS Méthaville [Reducing HCV among drug users: learnings from the Méthaville ANRS trial]	INSERM (National Institute for Health and Medical Research) Inserm U912
Évaluation d'un dispositif de lutte contre la récidive [Evaluation of a measure deterring recidivism]	CNRS (National Centre for Scientific Research)
Parcours de vie et trajectoire addictive chez les personnes incarcérées et placées sous main de justice [Life paths and trajectories among addicted prisoners incarcerated and in custody]	University of Toulouse

SOCIALRISK_MH : Déterminants sociaux des trajectoires de santé mentale depuis la petite enfance [SOCIALRISK_MH: Social determinants of mental health trajectories from early childhood]	INSERM (National Institute for Health and Medical Research)
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## T4. Additional information

The purpose of this section is to provide additional information important to drug-related research in your country that has not been provided elsewhere.

Please structure your answers around the following questions.

*T4.1 **Optional.** Please describe any additional important sources of information, specific studies or data on drug-related research. Where possible, please provide references and/or links.*

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*T4.2 **Optional.** Please describe any other important aspect of drug-related research that has not been covered in the specific questions above. This may be additional information, a reference to an organisation in your country that monitors national drug-related research, the availability of a bibliography of recent studies or new areas of specific importance for your country.*

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## 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.

No current questions.

## 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.

Please note that this workbook was pre-filled in using the information provided through the bibliography of your national report. If you used other sources while reviewing/correcting it, please list them here

**Source**

Milhet, M., Díaz-Gómez, C. and Mutatayi, C. (in press). Comparative analysis of research into illicit drugs across Europe (2010-2013). European Commission, Brussels.

T.6.2 Where studies or surveys have been used please list them and where appropriate describe the methodology

The source mentioned in T.6.1 is based on a study carried out within the framework of the ERANID project funded by the European Union under the 7th Framework Programme. The study consisted in mapping and analysing the situation of the drug-related research in the six ERANID participating countries (Belgium, France, Italy, Netherlands, Portugal, and United-Kingdom) and at the European Commission (EC) level over the period 2010-2013. Drug-related research projects were identified through an online survey carried out between June and September 2013 amongst research organisations, teams and researchers within the six ERANID participating countries. Data collected through the online survey have been complemented with documentary research and additional investigations on relevant websites. The EC data were collected on the basis of documentary research, contacts with Directorate Generals' (DG) officers involved in the EC funding programmes and the consultation of relevant websites (CORDIS, REA, EAHC..., EMCDDA, websites of the EC funded projects identified....).