European Monitoring Centre for Drugs and Drug Addiction

# France

## France Drug Report 2018

This report presents the top-level overview of the drug phenomenon in France, covering drug supply, use and public health problems as well as drug policy and responses. The statistical data reported relate to 2016 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

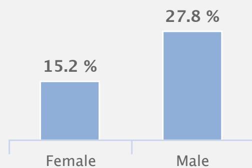
### THE DRUG PROBLEM IN FRANCE AT A GLANCE

**Drug use**

"in young adults (15-34 years) in the last year"

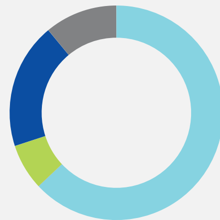
Cannabis

**21.5 %**

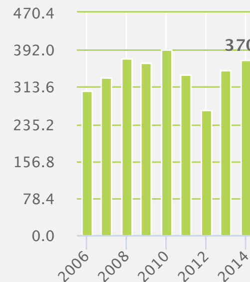



**Treatment entrants**

by primary drug




**Overdose deaths**




**Drug law offences**

**218 731**

**Top 5 drugs seized**

ranked according to quantities measured in kilograms

1. Cannabis resin
2. Herbal cannabis
3. Cocaine
4. Heroin
5. MDMA

**Other drugs**

| | |
|---|---|
| MDMA | **2.3 %** |
| Amphetamines | **0.7 %** |
| Cocaine | **2.4 %** |

**High-risk opioid users**

**230 000**

**(180 000 - 280 000)**

**Opioid substitution treatment clients**

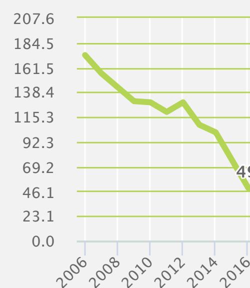
**169 750**

**Syringes distributed**

through specialised programmes

**12 314 781**

**HIV diagnoses attributed to injecting**




Source: ECDC

**Population**

(15-64 years)

**41 853 977**

Source: EUROSTAT Extracted on: 18/03/2018

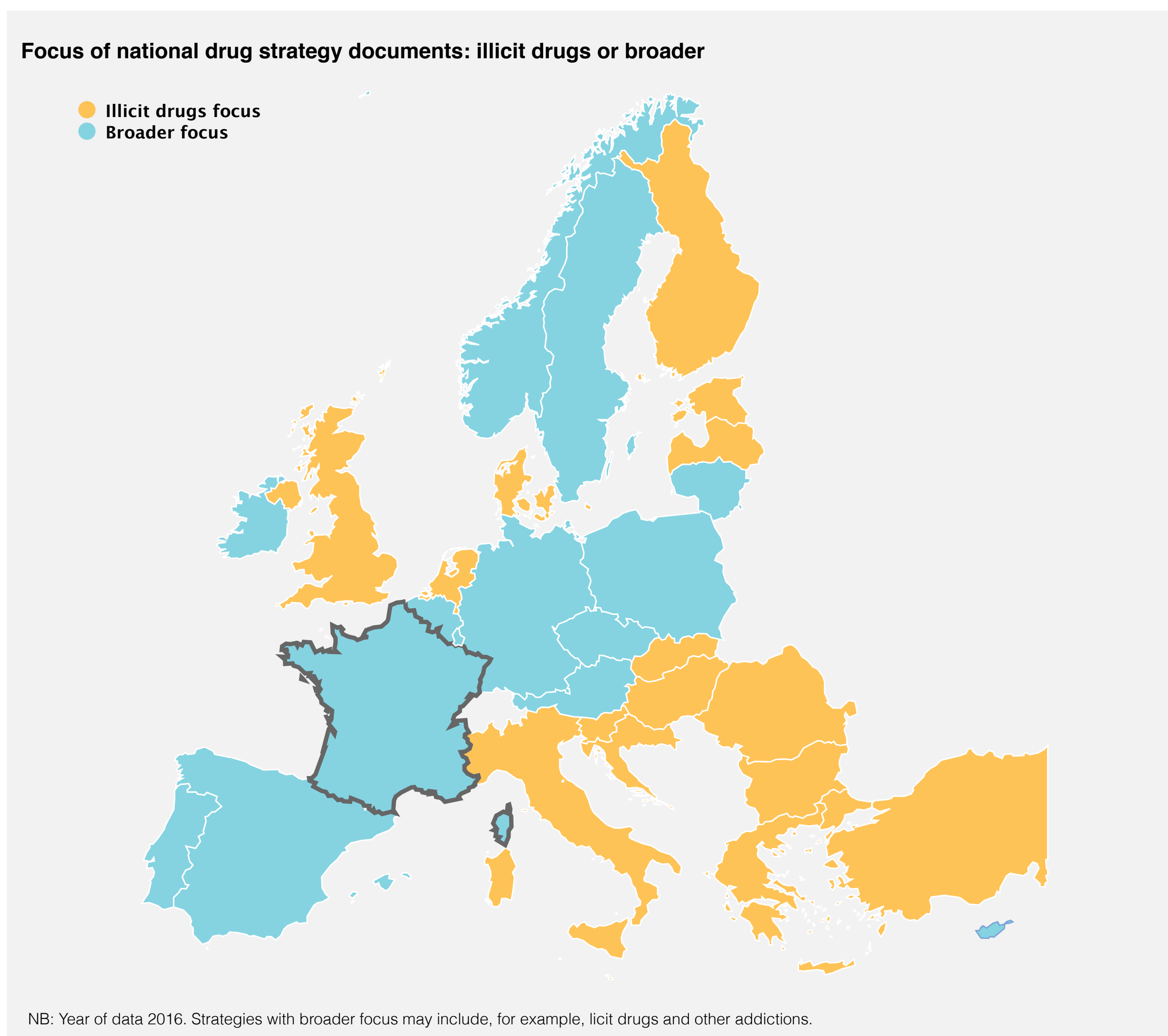
NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or reported numbers through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnosis, drug law o?ences and seizures). Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin.

## National drug strategy and coordination

In France, the Government Plan for Combating Drugs and Addictive Behaviours 2013-17 is the responsibility of the Inter-ministerial Mission for Combating Drugs and Addictive Behaviours (MILDECA) . The Government Plan addresses the use of illicit and licit substances (narcotics, alcohol, tobacco, psychotropic medicines and new synthetic substances) and non-substance-related addictive behaviours (gambling, gaming, doping). It has three main priorities, which are addressed across five areas of action that structure the Government Plan: (i) promoting 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 evaluation studies; and (v) reinforcing coordination at the national and international levels. The Government Plan is supported by two consecutive action plans, covering 2013-15 and 2016-17. Both action plans detail specific objectives and actions for these periods, identify key stakeholders and detail the planned timelines and expected outcomes for delivering the strategy.

An intervention-based external evaluation of four priority areas (two per action plan) of the Government Plan was commissioned to examine the relevance of new experimental approaches (e.g. peer-led prevention, community action against drug trafficking). This external evaluation was complemented by an internal indicator-driven evaluation examining the effectiveness of the Government Plan in achieving the stated objectives.

**Focus of national drug strategy documents: illicit drugs or broader**




NB: Year of data 2016. Strategies with broader focus may include, for example, licit drugs and other addictions.

### National coordination mechanisms

France's drug policy is coordinated at the national level by MILDECA , which is the responsibility of the prime minister and prepares all government decisions on drug issues. MILDECA reports to the prime minister and is tasked with the organisation and coordination of France's policies against drugs and addictive behaviours. Its mandate covers the use of illicit and licit substances and non-substance-related addictive behaviours. Throughout France and its territories, MILDECA territorial representatives (*chefs de projet*) are responsible for coordinating drug policy at territorial level.

## Public expenditure

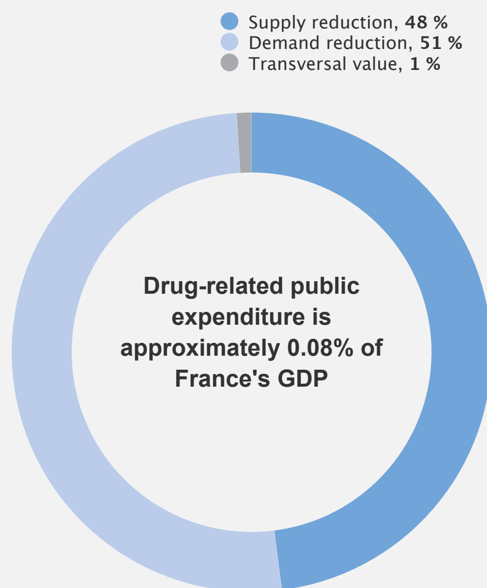
Understanding the costs of drug-related actions is an important aspect of drug policy. Some of the funds allocated by governments for expenditure on tasks related to drugs are identified as such in the budget ('labelled'). Often, however, most drug-related expenditure is not identified ('unlabelled') and must be estimated using modelling approaches.

The total drug-related public social costs for France have been estimated for 1996 and 2003. A new estimate of the social cost of drugs, alcohol and tobacco was published in 2015. According to this estimate, the social cost of illicit drugs amounted to EUR 8 700 million in 2010, less than the amount estimated for alcohol (EUR 118 000 million) or tobacco (EUR 122 000 million).

Since 2008, the total drug-related expenditure of central government has been presented annually in a budgetary document submitted to the French Parliament. In addition to the expenditure of the central government, estimates for total drug-related public expenditure include spending by the social security system. In 2015, total drug-related expenditure represented 0.08 % of gross domestic product (GDP) (approximately EUR 1.83 billion), with more than half of the total spent on health activities and social protection, and the remaining expenditure going on public order and safety and on multi-sectoral services working on drug-related initiatives.

The available data suggest that total drug-related expenditure increased gradually between 2008 and 2010, following the national fiscal consolidation trend registered in France. Between 2011 and 2013, drug-related expenditure grew rapidly before stabilising in 2014 and 2015. In 2015, growth in French GDP accelerated more than the growth in drug-related expenditure, which led to a fall in drug-related expenditure as a proportion of GDP in France.

**Public expenditure related to illicit drugs in France**




NB: Based on estimates of France's labelled and unlabelled public expenditure in 2015.

## Drug laws and drug law offences

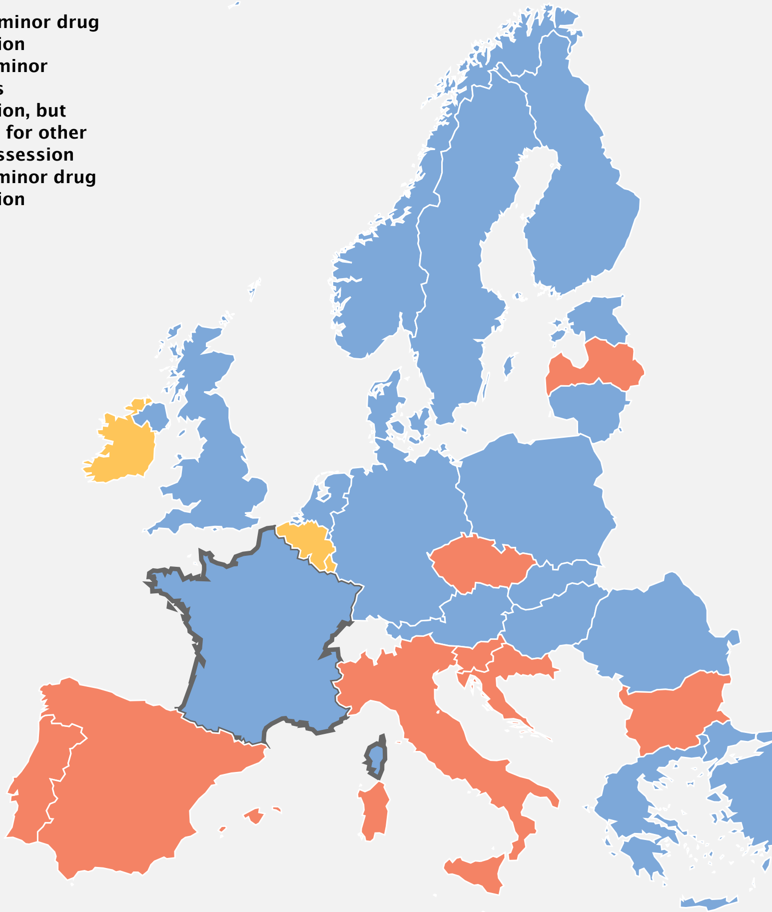
### National drug laws

The use and possession of illicit drugs are criminal offences in France. The law itself does not distinguish between possession for personal use or for trafficking, or by type of substance. However, the prosecutor will opt for a charge relating to use or trafficking based on the quantity of the drug found and the context of the case. Based on the principle of expediency, the prosecutor may decide to take legal action against the offender, simply close the case, or propose other measures as an alternative to prosecution. An offender charged with personal use faces a maximum prison sentence of one year and a fine of up to EUR 3 750, although prosecution may be waived or a simplified procedure resulting in a fine of up to EUR 1 875 can be ordered in minor cases. The maximum sentence increases to five years and the fine increases to EUR 75 000 if the offender endangered users of transport or if the offence was committed by a public servant while on duty. As with many crimes, sentences may be doubled in the event of a subsequent offence within a five-year period.

A directive of 9 May 2008 defined a new 'rapid and graduated' policy. In simple cases, drug users may receive a caution, but this should usually be accompanied by a requirement to attend a compulsory drug awareness course, introduced in March 2007, for which a non-drug-dependent offender may have to pay up to EUR 450. Drug-dependent individuals would continue to receive the therapeutic injunction directing them to treatment. If there are aggravating circumstances, such as in the case of recurring offenders, a term of imprisonment may be imposed. In 2012, a directive establishing a criminal policy strategy for drug-related crimes reiterated that, when sentencing, courts should take account of factors that suggest a simple drug use or drug dependence. The principle of proportionality calls for systematic penal responses and increasingly effective judicial measures in the case of more severe offences. The application of educational and health measures is prioritised for simple drug law crimes and for minors, in line with a general trend in the EU to reduce the severity of punishments for such offences.

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 EUR 7.5 million.

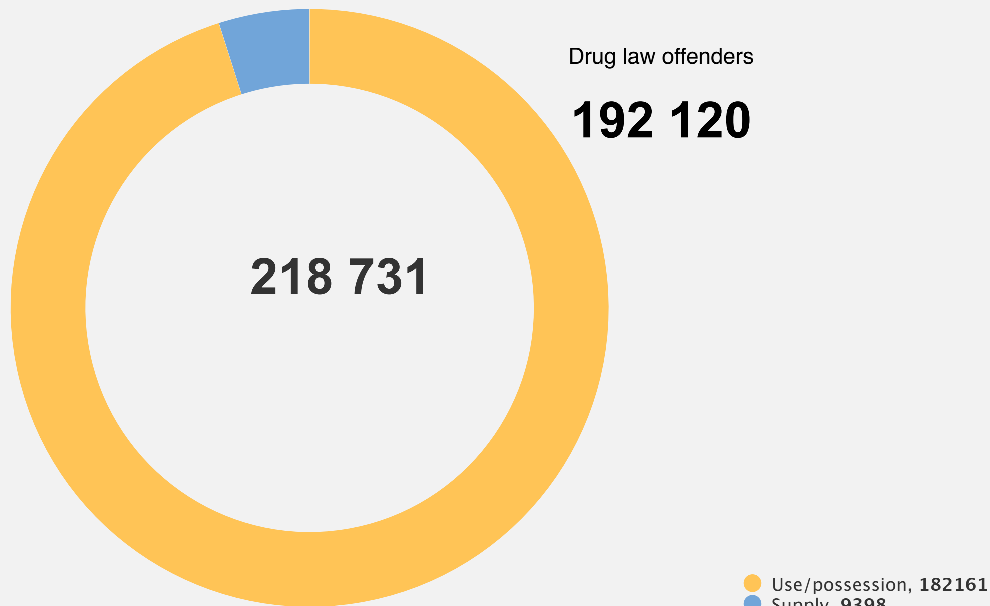
In France, new psychoactive substances are controlled under the Criminal Code by listing them as drugs by a decision of the Ministry of Social Affairs and Health. From 2012, generic classifications of chemical groups have been introduced, with a ban on most cathinones. Since 2015, putting synthetic cannabinoids and 25x-NBOMe (phenethylamine) derivatives on the market has been prohibited. In 2017, a new legislation came into force specifically to control synthetic cannabinoids.




## Drug law offences

Drug law offence (DLO) data are the foundation for monitoring drug-related crime and are also a measure of law enforcement activity and drug market dynamics; they may be used to inform policies on the implementation of drug laws and to improve strategies.

In France, the most recent data on drug law offenders are obtained from the database of the Ministry of the Interior (ETAT 4001). In 2016, a total of 192 120 drug law offenders were reported in France. However, this database does not provide details on the drugs involved. Since 2004, the reported numbers of drug law offenders charged have almost doubled, with drug use/possession offences being more common than supply offences.




## Drug use

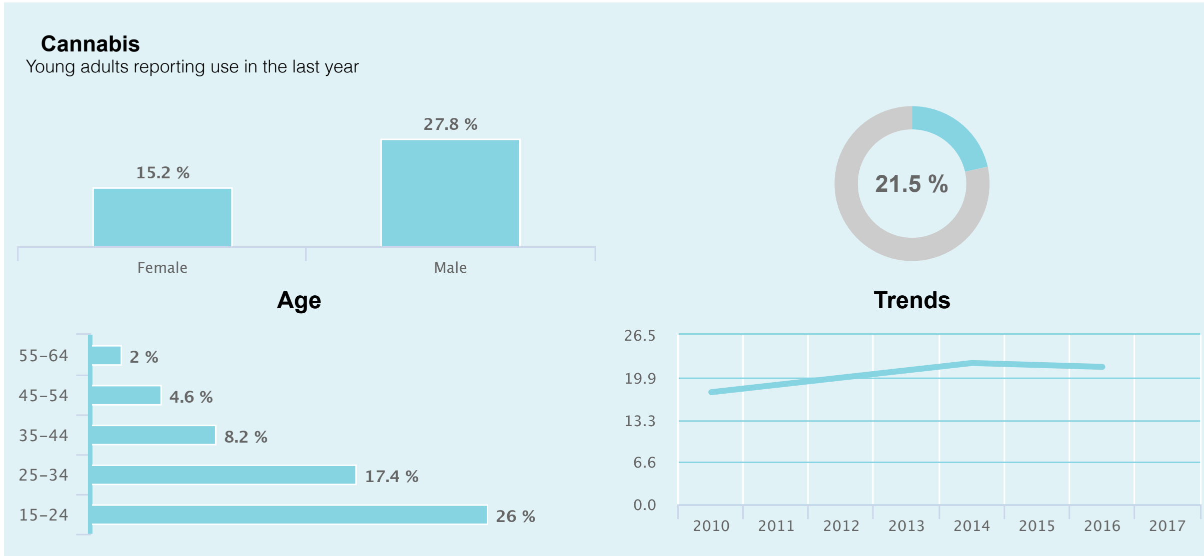
### Prevalence and trends

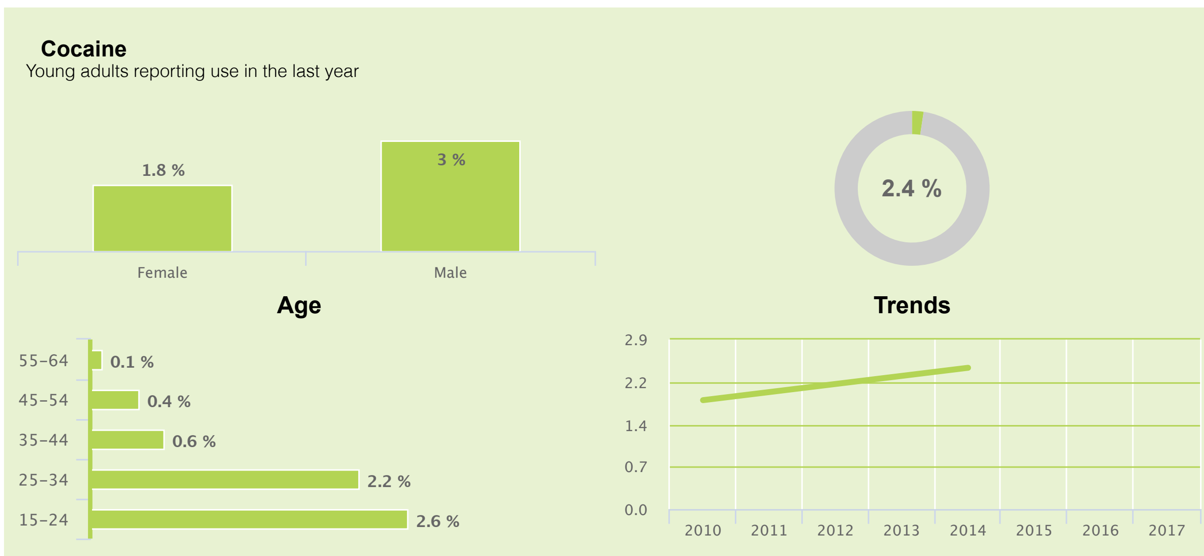
According to the most recent general population survey, cannabis remains the most widely used illicit substance in France, followed by cocaine, although at much lower levels. Cannabis and cocaine use have increased in the last two decades. Although the prevalence of synthetic stimulants use was lower than that of cocaine use, the last year prevalence of MDMA/ecstasy use, for instance, reached its highest recorded level in 2014. Young people aged 15-34 years reported the highest prevalence of cocaine and MDMA use in the last year.

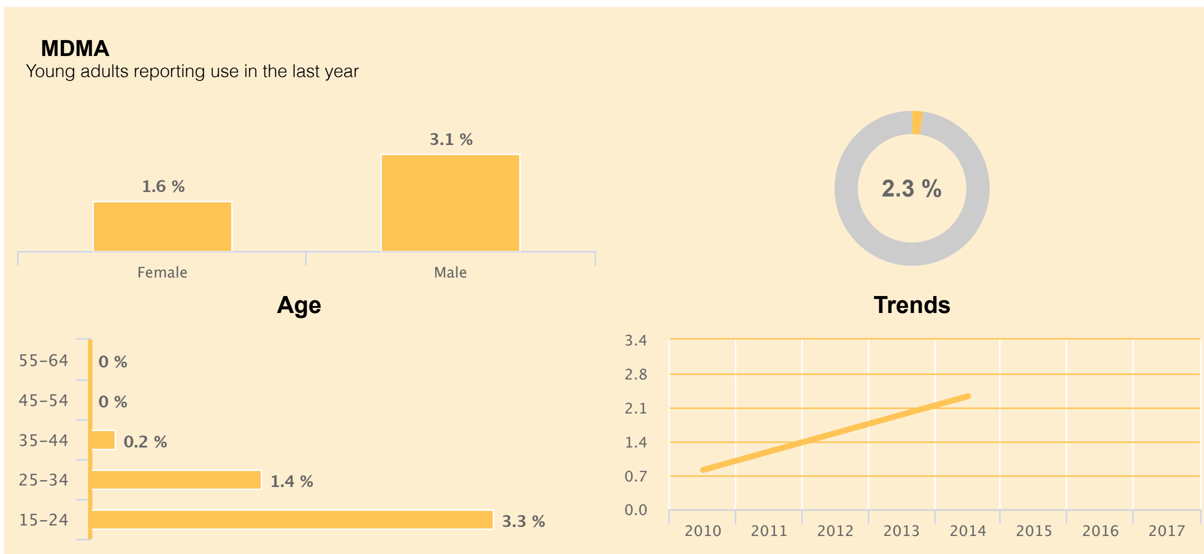
The latest general population survey indicated that the lifetime prevalence of synthetic cannabinoid use is 1.7 % among 18- to 64-year-olds.

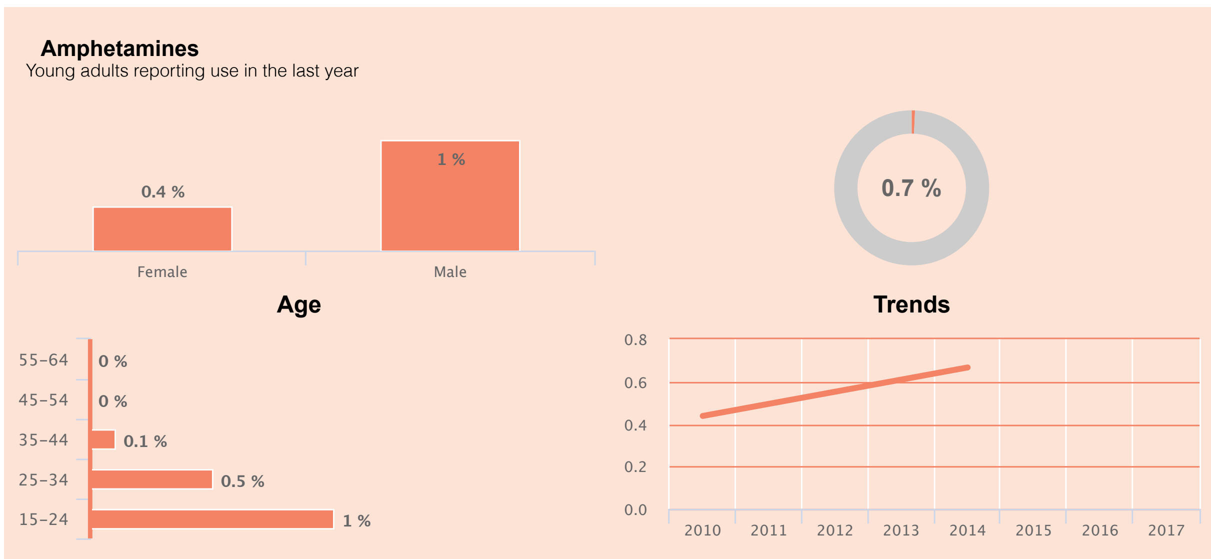
Paris and Bordeaux participate in the Europe-wide annual wastewater campaigns undertaken by the Sewage Analysis Core Group Europe (SCORE). This study provides data on drug use at a municipal level, based on the levels of illicit drugs and their metabolites found in wastewater. The results from Paris suggest a decreasing trend in MDMA levels between 2012 and 2016, with an increase in 2017. The levels of cocaine remained relatively stable until 2016 but recorded an increase in 2017. The levels of amphetamine and methamphetamine were very low, indicating limited use of these substances in Paris.

**Estimates of last-year drug use among young adults (15-34 years) in France**



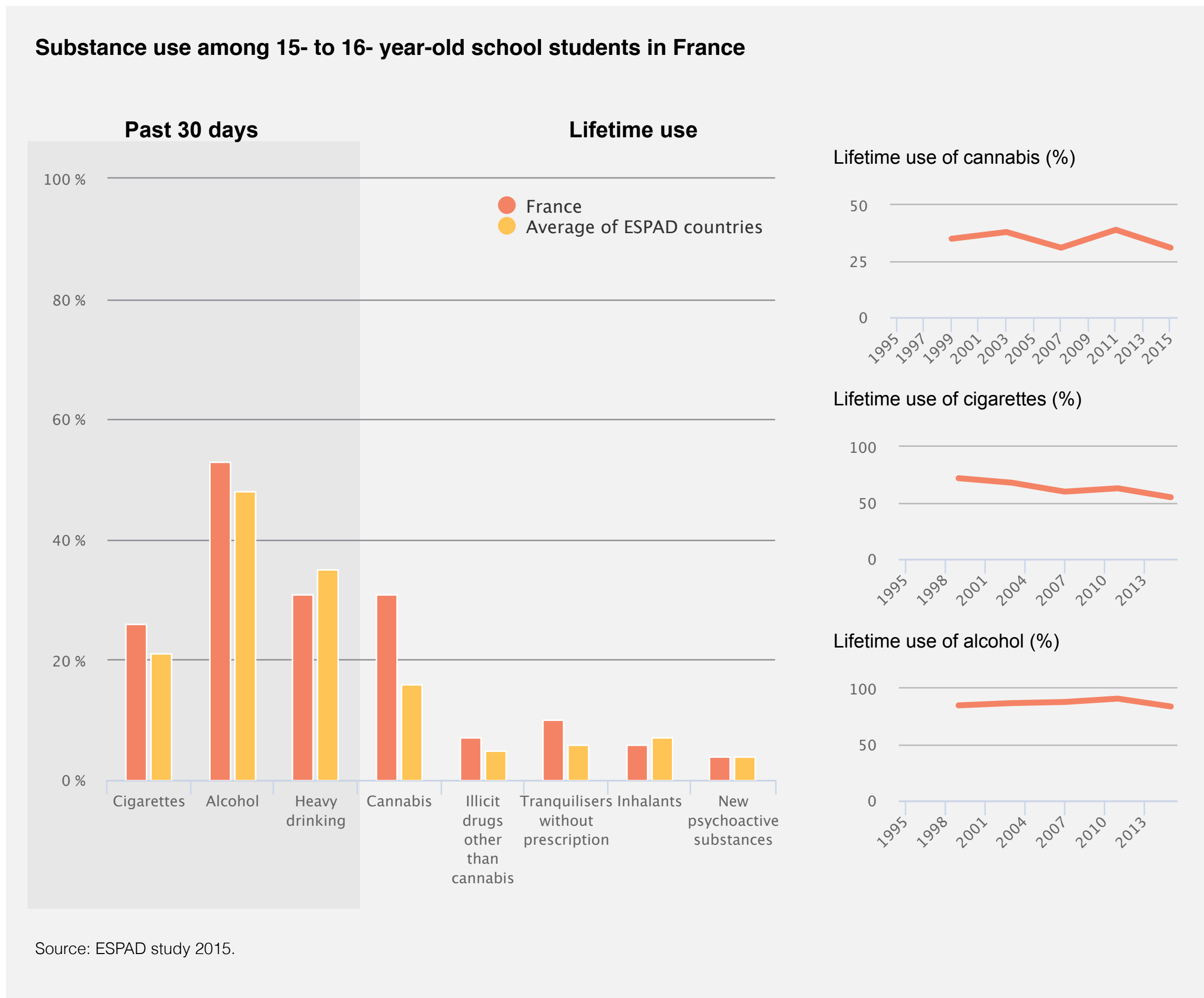






NB: Estimated last-year prevalence of drug use in 2016.

Data on drug use among students are reported by the 2015 European School Survey Project on Alcohol and Other Drugs (ESPAD). This survey has been conducted every four years since 1999 in France and collects data on substance use among 15- to 16-year-old students. Lifetime use of cannabis reported by French students was about twice as high as the average (of 35 countries), while lifetime use of new psychoactive substances was more or less average, as was heavy episodic drinking in the past 30 days.




Source: ESPAD study 2015.

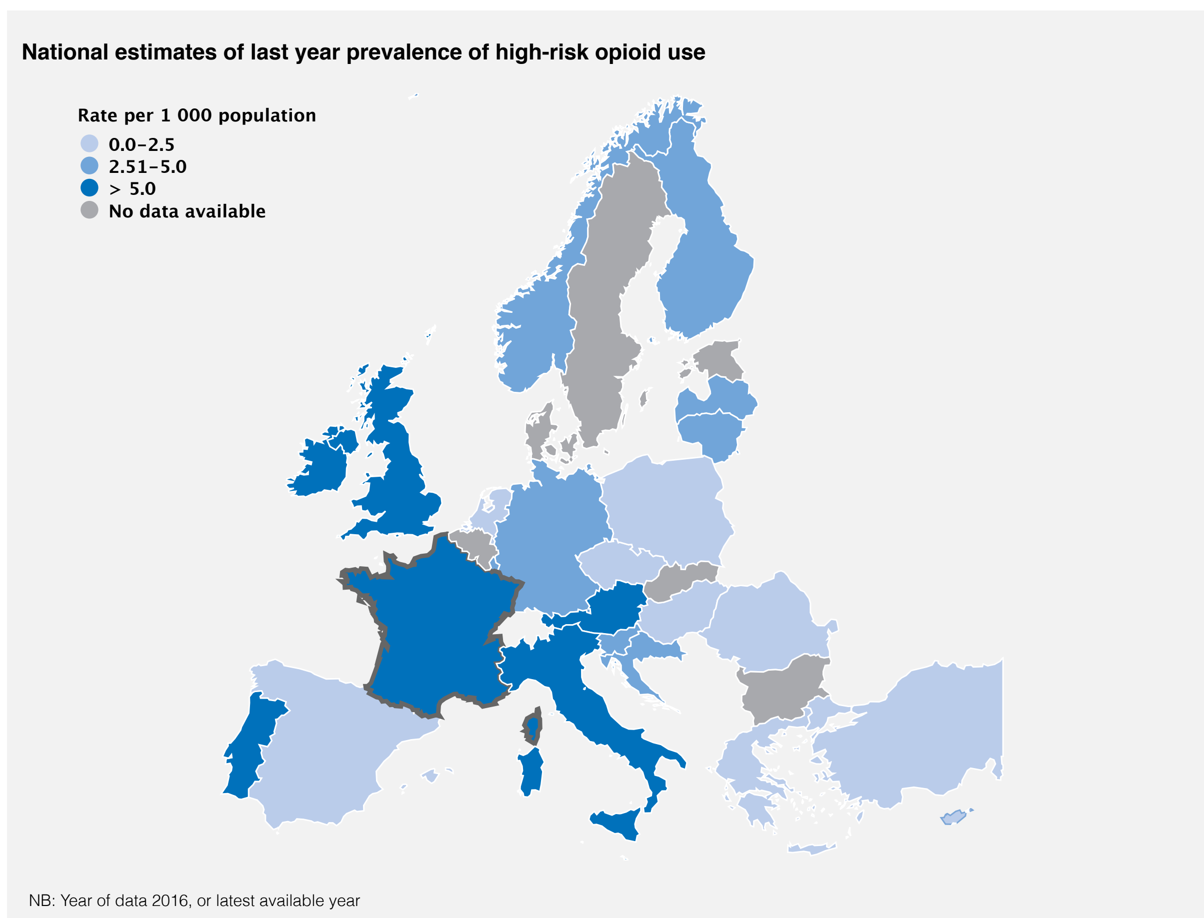
## High-risk drug use and trends

Studies reporting estimates of high-risk drug use can help to identify the extent of the more entrenched drug use problems, while data on first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform an understanding of the nature of and trends in high-risk drug use.

France is one of the EU countries where the estimated high-risk opioid use rate is above 5 per 1 000 of the adult population. Heroin and other opioids, such as illicitly used methadone, buprenorphine and morphine sulphate, are often injected, although smoking and inhaling practices are becoming increasingly common for heroin. In 2015, the estimated number of people who inject drugs was above 108 000 (2.68 per 1 000 of the adult population). According to data from low-threshold agencies, a large proportion of them injected cocaine. The data from the 2014 Health Barometer suggest that 2.2 % of adults (18- to 64-year-olds) exhibit high-risk cannabis use behaviour and the level of high-risk cannabis use has remained more or less stable over the years, despite the reported increase in the prevalence of cannabis use in recent years.

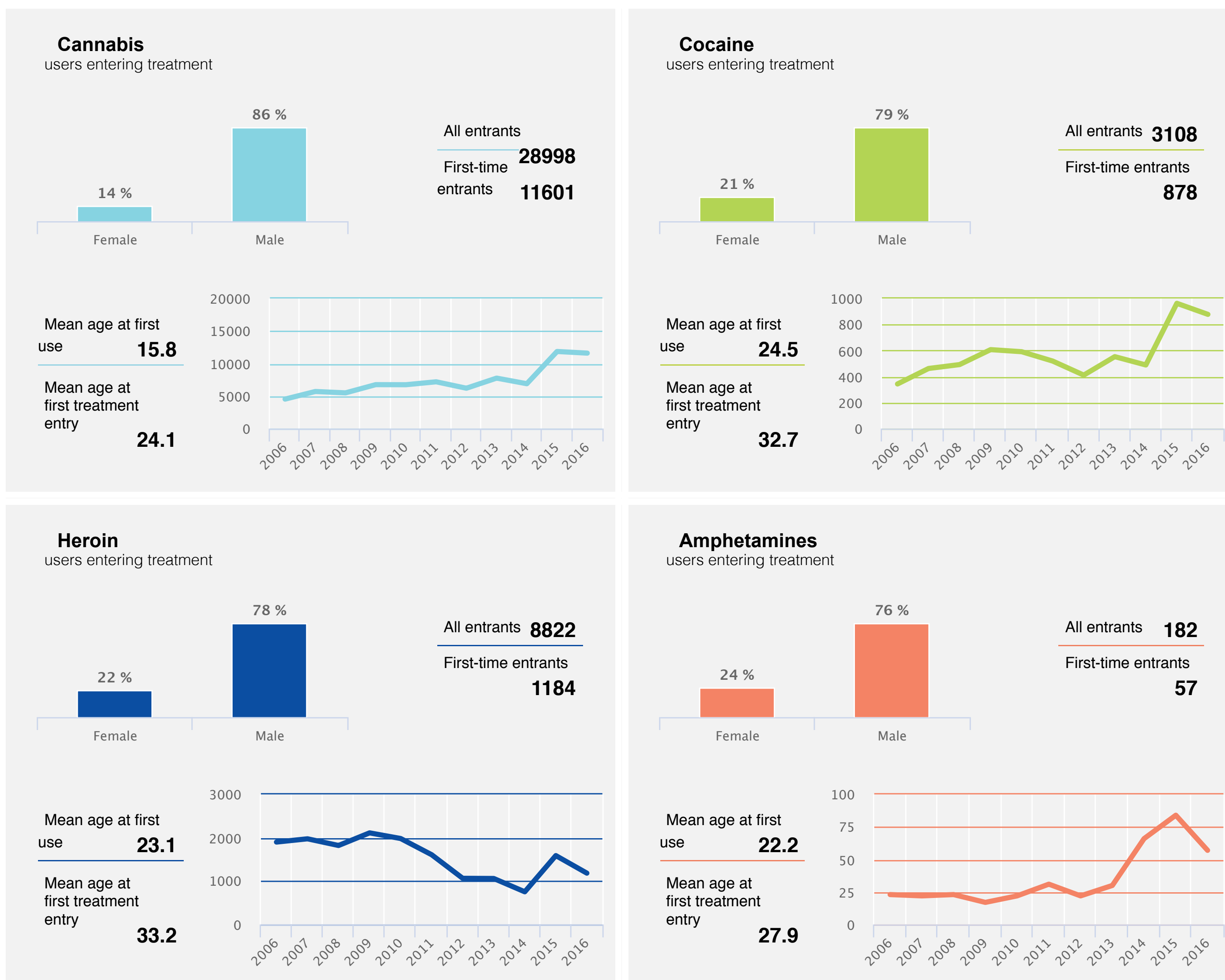
Data from addiction treatment and prevention centres (Centres de soins, d'accompagnement et de prévention en addictologie) indicate that cannabis was the most commonly reported primary substance for first-time clients entering treatment in 2016, followed by opioids (mainly heroin) and cocaine. Approximately one out of five treatment clients are female; however, the proportion of females receiving treatment varies by primary drug and type of programme.

**National estimates of last year prevalence of high-risk opioid use**




NB: Year of data 2016, or latest available year

**Characteristics and trends of drug users entering specialised drug treatment in France**




"NB: Year of data 2016. Data is for first-time entrants, except for gender which is for all treatment entrants. Variation in the number of clients may result from changes in the methodology, changing number of participant centres, percentage of patients with known substances and changes in the information of the treatment status of the client. Caution is required in interpreting recent trends."

# Drug harms

## Drug-related infectious diseases

In France, data on drug-related infectious diseases are collected from the national human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) monitoring database coordinated by the French Public Health Agency (Santé Publique France), and from self-reported or biological testing data from clients attending addiction treatment and prevention centres (Centres de soins, d'accompagnement et de prévention en addictologie, CSAPAs) or harm reduction facilities (Centres d'accueil et d'accompagnement à la réduction des risques pour usagers de drogues, CAARUDs). Studies on HIV and hepatitis C virus (HCV) prevalence among people who inject drugs (PWID) were carried out in 2004 and 2011 (the Coquelicot study ). The 2011 study indicated that HIV prevalence was 13 % among PWID, while nearly 64 % of PWID tested positive for HCV.

Despite the introduction of compulsory notification for symptomatic acute hepatitis B virus (HBV) infection in 2003, it is estimated that only a small proportion of HBV-positive individuals are reported. HCV infection is not on the list of compulsory notifiable diseases in France.

In 2016, 49 cases of newly diagnosed HIV infections were related to injecting drug use, which constituted less than 2 % of all new HIV diagnoses in 2016. The number of HIV seropositive diagnoses associated with drug use remained stable between 2008 and 2014, while some decline is indicated in recent years.

**Prevalence of HIV and HCV antibodies among people who inject drugs in France (%)**

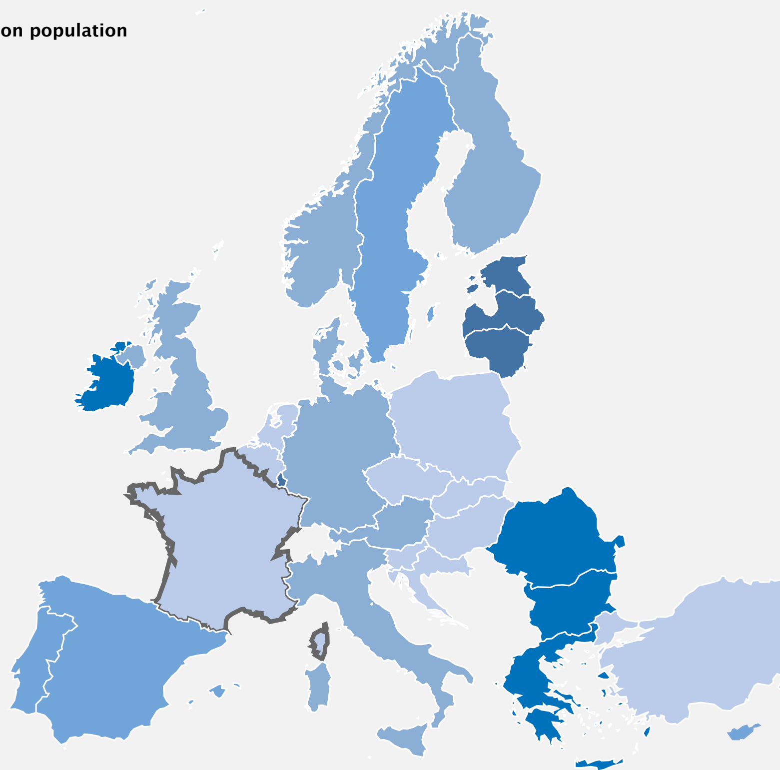
| region | HCV | HIV |
|---|---|---|
| National | : | : |
| Sub-national | 63.8 | 13.3 |

Year of data: HIV 2011, HCV 2011

Additional data on the prevalence of drug-related infectious diseases are based on self-reporting by PWID attending CSAPAs and CAARUDs; however, the reported prevalence may be underestimated, as many drug users are unaware of being infected. In a 2015 study conducted among CAARUD clients (the ENa-CAARUD survey), 4.65 % of 1 764 PWID reported being HIV positive, more or less stable since 2012, following a slight decline between 2006 and 2012. The CAARUD survey indicated that the prevalence of HCV among injecting drug users has also remained largely stable since 2012, and the decline observed from the beginning of the 2000s has come to an end.

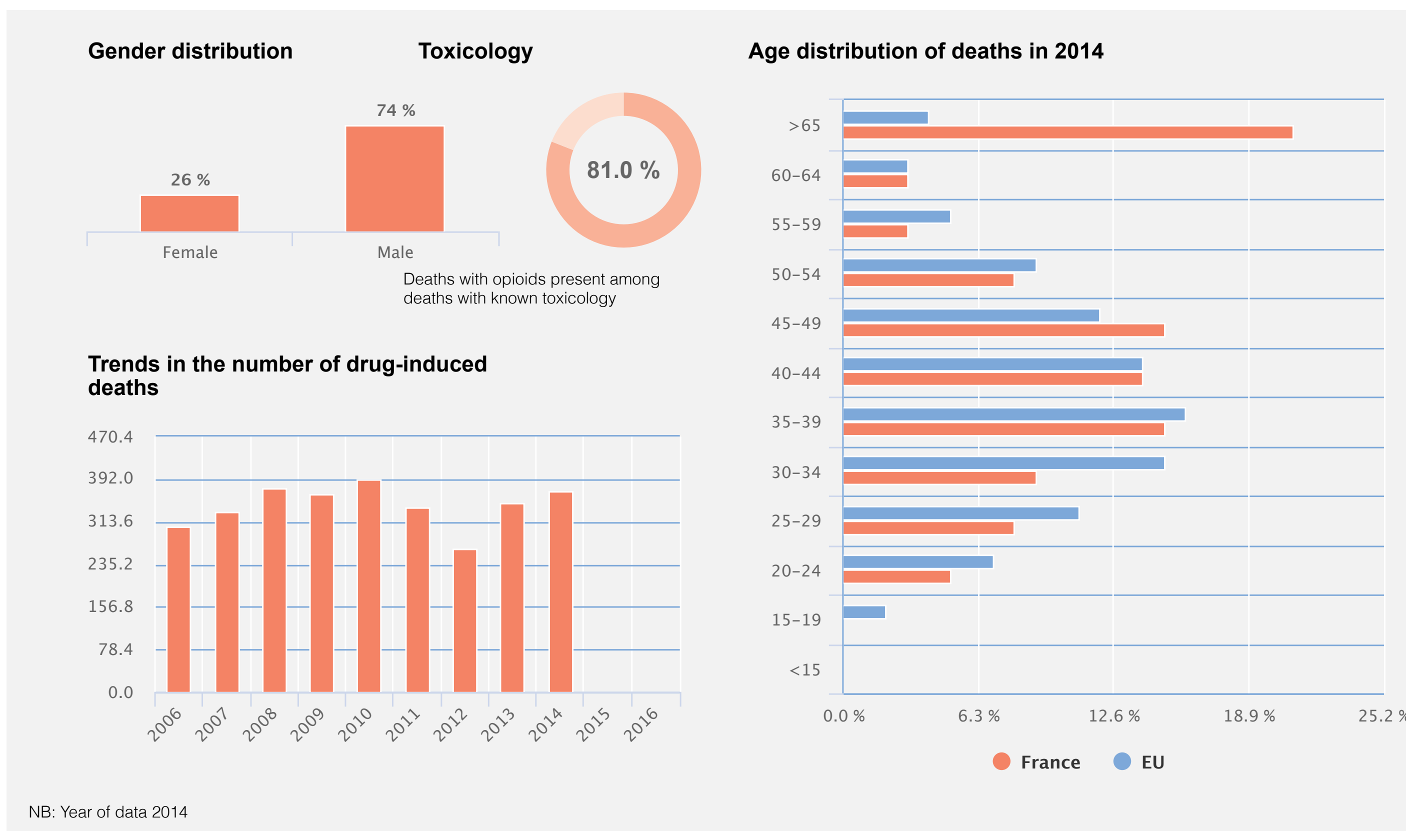
**Newly diagnosed HIV cases attributed to injecting drug use**

Cases per million population
<1.0
1.0–2.0
2.1–3.0
3.1–8.0
>8.0



NB: Year of data 2016, or latest available year. Source: ECDC.

**Characteristics of and trends in drug-induced deaths in France**




## Drug-related emergencies

Nearly 10 000 hospital emergency presentations related to drug use were reported in France in 2015 through the Oscour network, which covers almost 9 out of 10 hospital emergency presentations. One quarter of presentations were related to cannabis use and one quarter to opioid use, whereas cocaine, other stimulants and hallucinogens were implicated in a smaller proportion of cases. Around one third of the cases were due to use of multiple or unspecified substances. Around one third of those who sought emergency care were admitted to hospital, while the remaining clients were discharged home. In 2015, the mean age of clients was 34 years, with males being slightly younger than females (33 years versus 36 years). Although the mean age has remained stable since 2008, the distribution by age group has changed. The proportions of younger individuals (under 24 years) and older individuals (over 45 years) have increased, whereas the proportion of 25- to 44-year-olds has decreased. The increase in the proportion of 15- to 24-year-olds is related mainly to a rise in emergency presentation among 15- to 17-year-olds.

An emergency department from Lariboisière Paris hospital participates in the European Drug Emergencies Network (Euro-DEN Plus) project, which was established in 2013 to monitor acute drug toxicity in sentinel centres across Europe.

## Drug-induced deaths and mortality

Drug-induced deaths are deaths directly attributed to the use of illicit drugs (i.e. poisonings and overdoses).

Data on drug-induced deaths in France are collected from the General Mortality Registry (INSERM CépiDc) and the forensic Special Mortality Register (DRAMES, ANSM). The latest available data from the INSERM CepicDc refer to 2014 and indicate that more overdoses were reported in 2014 than each year during the period 2011-13. Nevertheless, it is suggested that the numbers of deaths may have been underestimated because of misclassification; for example, some drug-related deaths may be classified as ‘a death due to unknown cause’. In contrast, morphine overdose deaths, particularly those occurring among those aged over 50 year in a palliative care context, may be reported as drug-induced deaths. In 2014, nearly 70 % of drug-induced deaths were among 15- to 49-year-olds.

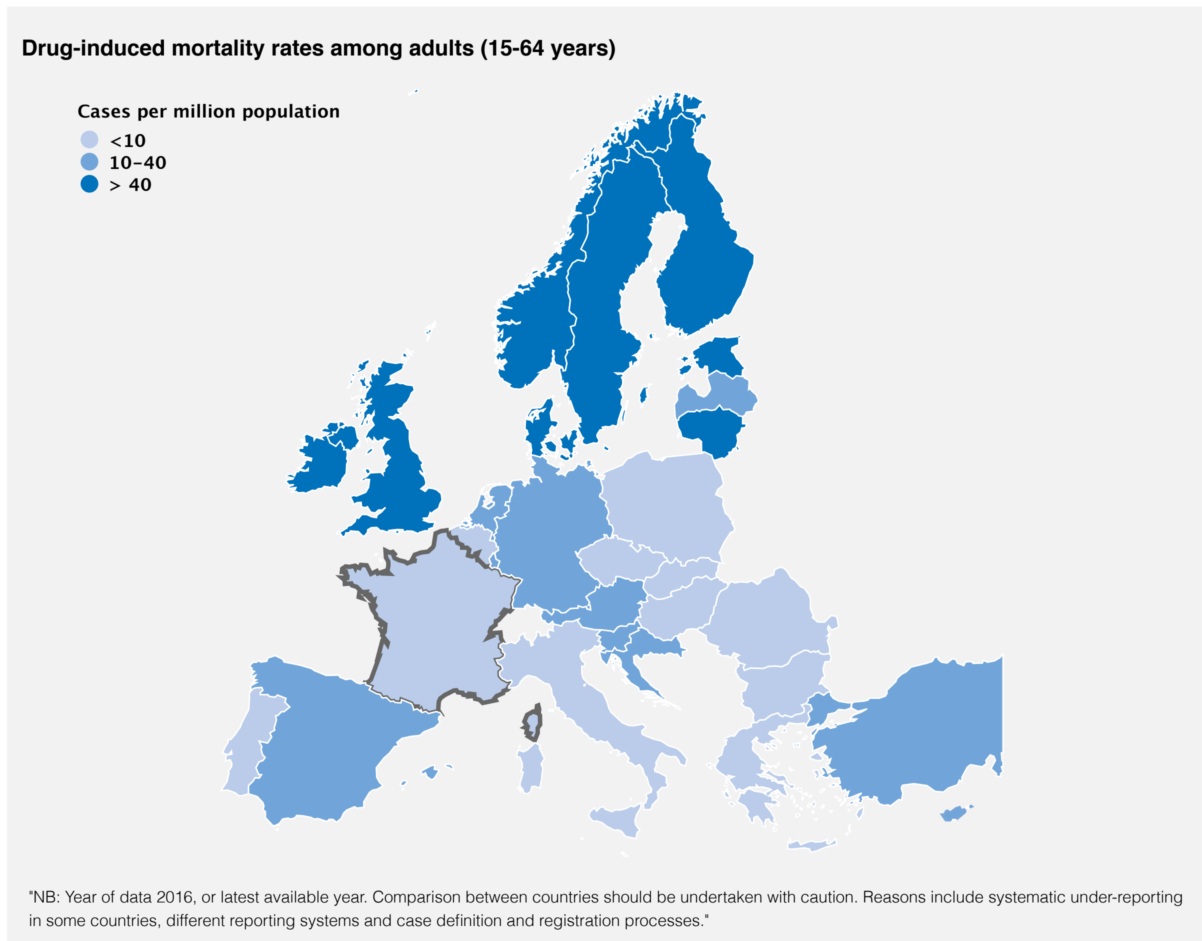
Toxicological data available from the Special Mortality Register indicate that opioid substitution treatment medications were involved in 4 out of 10 deaths recorded in 2015 and heroin was involved in about 3 out of 10 deaths. In the remaining cases, cocaine, cannabis, amphetamines, MDMA/ecstasy and new psychoactive substances were reported.

Additional data are available through the national health alert scheme related to psychoactive substance use, which focuses on unusual events reported by different sources (police, the TREND/SINTES network, the monitoring network for serious adverse effects, private analysis laboratories, scientific publications, etc.). In 2016, a total of eight deaths, of which six were related to new psychoactive substance use, were listed under this scheme.

The estimated drug-induced mortality rate among adults (aged 15-64 years) was 6.95 per million in 2014, which is less than the most

recent European average of 21.8 deaths per million.

Data from a 2009-15 mortality study among a cohort of 1 134 drug users treated at CSAPAs and CAARUDs indicate that there are significantly higher mortality rates among drug users than among the general population. Moreover, the standardised mortality ratio is markedly higher among females than males.




**Drug-induced mortality rates among adults (15-64 years)**

"NB: Year of data 2016, or latest available year. Comparison between countries should be undertaken with caution. Reasons include systematic under-reporting in some countries, different reporting systems and case definition and registration processes."

## Prevention

Drug use prevention policy in France is coordinated at the central level by the Inter-ministerial Mission for Combating Drugs and Addictive Behaviours (MILDECA) . The Ministry of National Education, the Ministry of Agriculture, the Ministry of Health, the Ministry of the Interior and the Ministry of Justice are other central stakeholders in the field of prevention. A partnership has been set up between MILDECA and the Inter-ministerial Committee on Crime and Radicalisation Prevention within which a number of programmes can be co-financed, focusing on support for those in the criminal justice system, drug trafficking prevention and tobacco regulations. The French prevention policy embraces all psychoactive substances, both illicit and licit, and other forms of addictive behaviour (e.g. gaming, gambling). It aims to prevent experimentation or to delay it, or to prevent and limit the use of these substances and participation in addictive activities. MILDECA provides funding to implement the national prevention priorities at a local level (regions, local communities), at which activities are coordinated by MILDECA territorial representatives. Decentralised credits for prevention activities are allocated by these MILDECA territorial representatives or by regional health authorities, while the French national health insurance system also provides funding for prevention. At a local level, prevention activities are implemented by a large number of professionals (school communities, non-governmental organisations, police/gendarmerie officers, etc.) and, since 2016, prevention has also officially fallen under the remit of addiction treatment and prevention centres (Centres de soins, d'accompagnement et de prévention en addictologie, CSAPAs), which are specialised drug treatment centres.

### Prevention interventions

Prevention interventions encompass a wide range of approaches, which are complementary. Environmental and universal strategies target entire populations, selective prevention targets vulnerable groups that may be at greater risk of developing substance use problems and indicated prevention focuses on at-risk individuals.

In France, priority is given to preventing drug use among young people in school settings, female drug users, partygoers, those in the criminal justice system and homeless people. Within the French Public Health Agency, the Health Promotion and Prevention Division's main focus is supporting national and regional health policies and practitioner networks by developing evidence-based interventions for prevention and health promotion, including transferring international programmes into a French context.

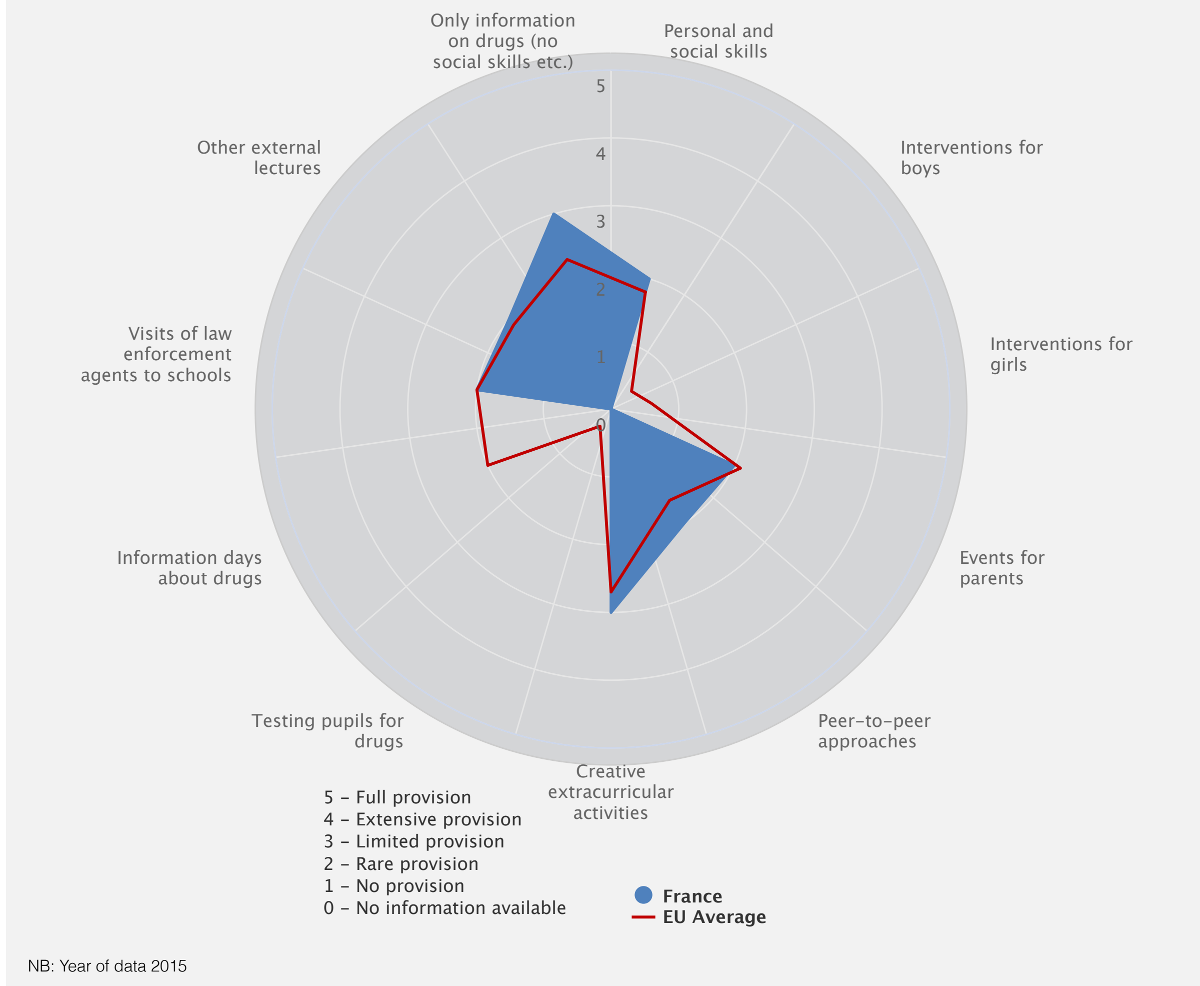
Environmental strategies on alcohol and tobacco are well developed and have substantial political support. In 2017, guidelines for alcohol consumption were revised, with new benchmarks for alcohol consumption. This revision should be supported by public authorities' coherent communication addressing taxation, availability and promotion, as well as education, communication and social marketing.

Universal prevention is the predominant type of drug use prevention in France, mostly carried out in secondary schools, with the school community involved in the coordination and implementation of prevention activities and external actors contributing as required (non-governmental organisations and police/gendarmerie officers). Best practice guidelines for addressing health and risky behaviours in school settings exist. While their use is encouraged, it is not compulsory. In September 2016, the Educative Health Pathway for pupils, which aims to reduce social inequalities in health and education, became the new framework for drug prevention in schools. The main focus of the school-based prevention activities, within the area of health education, is to develop students' individual and social skills. Some examples include life skills and prevention programmes in secondary schools, while experimental implementation of internationally validated programmes has also been reported. Drug prevention is also recommended for secondary and higher educational settings under the responsibility of the Ministry of Agriculture.

The prevention of licit and illicit substance use in the workplace, incorporating, although uncommonly, the use of screening for substance use, has been in the remit of occupational physicians since 2012. Staff representative bodies are also engaged in workplace prevention as part of the legal obligation to ensure employee safety and to protect employee health. Implementation varies across companies and services. Some community-based prevention activities are carried out in youth counselling centres. The recent government strategy aims to develop the training of educators in recreational centres for children and teenagers to encourage awareness-raising actions on addictive behaviours and risky sexual practices. Activities that aim to reduce risk related to psychoactive substance use in recreational settings are employed in some large cities and are provided at large music festivals and sporting events.

Selective prevention is mainly the responsibility of specialised non-governmental organisations and is mainly delivered outside the school setting. The actions are promoted within neighbourhoods, in recreational settings and in at-risk families.

As for indicated prevention, some 260 youth addiction outpatient clinics (CJCs) have been opened throughout France to carry out 'early screening and intervention' at approximately 550 consultation points. A requirement to reinforce the CJC system, in particular through training professionals, is specified in the current Government Plan for Combating Drugs and Addictive Behaviours . PANJO, a home-based early parenting assistance programme during pregnancy or the first few months after birth, recruited 500 pregnant women in 11 French departments for its second phase in 2017. 'Change le Programme' (CLP), an adaptation of the 'Break the Cycle' programme, aims to reduce the number of initiations into injecting, to delay them or to make them safer. TAPAJ, a programme addressing homeless young adults (aged 18 to 25 years) by providing a legal source of income as an alternative to begging, and as a means of reducing health and social risks, and by allowing quicker access to addiction services, has been implemented in 17 cities.




## Harm reduction

In France, one of the objectives of the Government Plan for Combating Drugs and Addictive Behaviours 2013-17 is to reduce risk among vulnerable populations that use drugs. In accordance with the provisions of the public health law of 2004 and the law on health system reform of 2016 , harm reduction policies aim to protect people who use drugs from acquiring injecting-related infections but also to prevent them from dying as a result of a drug overdose. Moreover, the law defines further public health priorities, such as providing referral to the care system, contributing to improving the health of people who use drugs and facilitating their social reintegration. Facilities designed to reduce risk and harm complement the work of specialised drug treatment centres (Centres de soins, d'accompagnement et de prévention en addictologie) and the network of harm reduction facilities (Centres d'accueil et d'accompagnement à la réduction des risques pour usagers de drogues, CAARUDs). They are mainly funded directly by the social security system and form an integral component of the response to drugs in France. All French regions are covered by at least one CAARUD.

### Harm reduction interventions

Harm reduction services provided in CAARUDs include needle and syringe programmes, advice on safer drug use and general health promotion activities, such as condom distribution. A state-subsidised kit containing sterile syringes and other paraphernalia is also available from pharmacies for a small fee or from dispensing machines for free. A recent estimate indicates that annually approximately 12 million syringes are distributed or sold to people who use drugs in France. Harm reduction measures have been expanded and diversified in recent years, following new drug use trends. Specific 'sniff and base kits' as well as foil are also being made available to drug users at harm reduction sites. Following the adoption of the 2016 law on health system reform, the first two experimental drug consumption rooms were opened in Paris and Strasbourg in 2016. These facilities are expected to operate for a six-year trial period, after which an evaluation of their impact on public health will be carried out.

As regards the implementation of a naloxone distribution programme, a naloxone product for nasal use has been available through hospital-based take-home programmes since July 2016, initially under temporary authorisation. Since 2017, the product obtained marketing authorisation and the programme was extended to all CAARUDs. Newly released inmates and those who have undergone opioid withdrawal treatment are defined as priority clients for the programme.

Screening for human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HCV) infections and sexually transmitted diseases is provided on an anonymous basis and free of charge at specialised information, screening and diagnosis centres. The costs of HIV and HCV antibody screening are fully covered by the French National Health Insurance Fund, while screening for markers of chronic HBV infection is reimbursed at a rate of 65 %. Specialised drug treatment centres also provide free screening for HIV and HCV infection and free vaccination against HBV for any drug user attending such a centre. The Ministry for Health and Social Affairs has committed to providing universal access to innovative treatments for HCV infection. Since June 2016, the treatment of HCV infection with direct-acting antiviral medication has been fully reimbursable by the National Health Insurance Fund for drug users who exchange their equipment (irrespective of their stage of fibrosis). Available treatment statistics for 2014 and 2015 document that 22 600 people suffering from chronic hepatitis C were treated using direct-acting antivirals.

**Availablity of selected harm reduction responses in Europe**

| Country | Needle and syringe programmes | Take-home naloxone programmes | Drug consumption rooms | Heroin-assisted treatment |
|---|---|---|---|---|
| Austria | Yes | No | No | No |
| Belgium | Yes | No | No | No |
| Bulgaria | Yes | No | No | No |
| Croatia | Yes | No | No | No |
| Cyprus | Yes | No | No | No |
| Czech Republic | Yes | No | No | No |
| Denmark | Yes | Yes | Yes | Yes |
| Estonia | Yes | Yes | No | No |
| Finland | Yes | No | No | No |
| France | Yes | Yes | Yes | No |
| Germany | Yes | Yes | Yes | Yes |
| Greece | Yes | No | No | No |
| Hungary | Yes | No | No | No |
| Ireland | Yes | Yes | No | No |
| Italy | Yes | Yes | No | No |
| Latvia | Yes | No | No | No |
| Lithuania | Yes | Yes | No | No |
| Luxembourg | Yes | No | Yes | Yes |
| Malta | Yes | No | No | No |
| Netherlands | Yes | No | Yes | Yes |
| Norway | Yes | Yes | Yes | No |
| Poland | Yes | No | No | No |
| Portugal | Yes | No | No | No |
| Romania | Yes | No | No | No |
| Slovakia | Yes | No | No | No |
| Slovenia | Yes | No | No | No |
| Spain | Yes | Yes | Yes | No |
| Sweden | Yes | No | No | No |
| Turkey | No | No | No | No |
| United Kingdom | Yes | Yes | No | Yes |

# Treatment

## The treatment system

In France, the provision of drug treatment is the responsibility of the regional and local authorities. Since 2003, it has been financed by the social security system. Two systems are involved in drug treatment: a specialised treatment system and the general healthcare system comprising hospitals and general practitioners (GPs). Some care is also provided through the harm reduction facilities of the low-threshold network (Centres d'accueil et d'accompagnement à la réduction des risques pour usagers de drogues).

Almost all of the 100 sub-regional administrative areas have at least one specialised treatment centre (Centre de soins, d'accompagnement et de prévention en addictologie, CSAPA). These centres, managed mainly by not-for-profit non-governmental organisations, provide both outpatient and inpatient care, and also provide care for prison inmates. Both pharmacologically assisted and psychosocial treatments are provided in the same centres. There are also eight 'drug-free' therapeutic communities, which operate separately from CSAPAs, and about 540 services for young drug users, which provide early intervention and psychological care on an outpatient basis.

The general addiction care system through hospitals is organised across three levels, with each new level building on services available at the previous level. First-level care manages withdrawal and organises consultations; the second level includes the provision of more complex residential care; and the third level expands the services to research, training and regional coordination.

Since 1995, opioid substitution treatment (OST) has been the main form of treatment for opioid users and has been integrated into a total therapeutic strategy for drug dependence, including for drug users in prison. Methadone and high-dose buprenorphine are used for OST, although in rare cases morphine sulphate is used for substitution treatment. Several directives regulate the dose, place of delivery and duration of OST, which is mainly prescribed in a primary care setting by GPs and is usually dispensed in community pharmacies. Methadone treatment can be started only in specialised centres or in hospitals.

**Drug treatment in France: settings and number treated**

Outpatient

Specialised Drug Treatment Centres (132000)

Low-Threshold Agencies (74800)

Inpatient

"Residential drug treatment" (1400)

Therapeutic communities (500)

Prison

Prison (10000)

NB: Year of data 2016

## Treatment provision

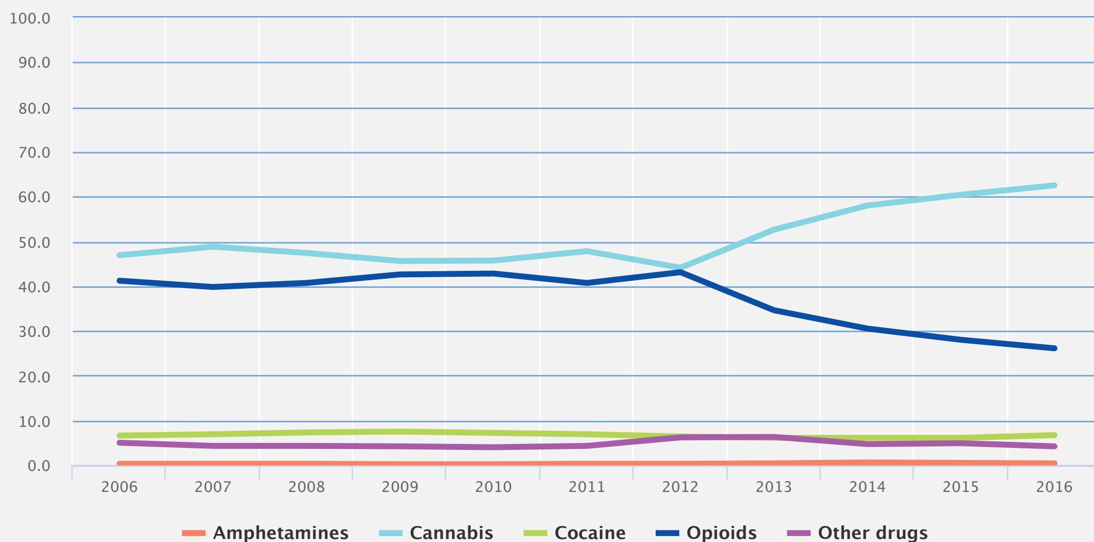
In France, treatment demand data are mainly collected from CSAPAs. Since 2016, the proportion of first-time clients requesting treatment for cannabis use has increased, while the proportion of first-time opioid users beginning treatment has declined. Among all treatment clients, the proportion of primary cannabis users entering treatment increased between 2011 and 2016, while the proportion of primary opioid users decreased. Four out of five first-time clients in 2016 entered treatment for cannabis use-related problems, while among all clients four out of six entered treatment because of cannabis use.

The high number and proportion of cannabis users among treatment clients in France may be attributed to several factors, including an increased number of people with problems related to cannabis use; the opening of specialised consultation centres for young users, mainly cannabis users; and a high number of referrals for treatment from the criminal justice system.

Many drug users, particularly opioid users, are treated in the general healthcare system at hospitals and by GPs rather than in CSAPAs, and therefore are not covered by the French system for data collection on addictions and treatments.

The number of OST clients steadily increased between 1995 and 2013, although since then it has remained rather stable with an estimated number of about 170 000 clients receiving this treatment. Buprenorphine, introduced in 1996, is still the most widely prescribed substance for OST, although the proportion of clients receiving methadone for OST is increasing.

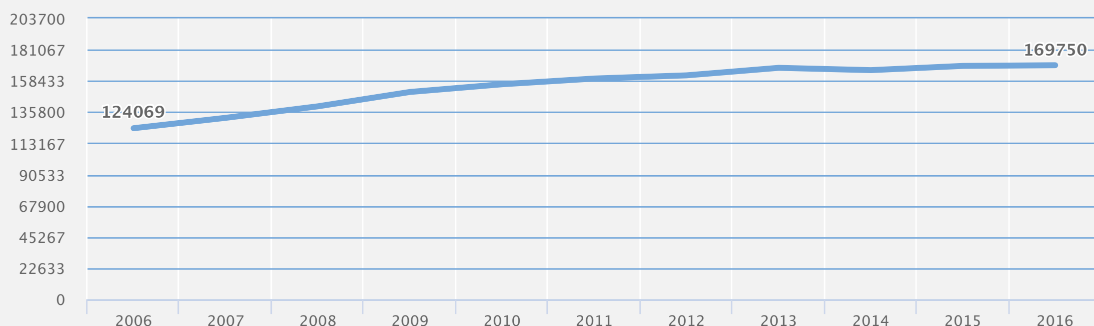
**Trends in percentage of clients entering specialised drug treatment, by primary drug, in France**




"NB: Year of data 2016. Variation in the number of clients may result from changes in the methodology, changing number of participant centres, percentage of patients with known substances and changes in the information of the treatment status of the client. Caution is required in interpreting recent trends."

**Opioid substitution treatment in France: proportions of clients in OST by medication and trends of the total number of clients**

Trends in the number of clients in OST




NB: Year of data 2016.

## Drug use and responses in prison

The French prison directorate administers almost 200 prison establishments.

In studies conducted more than 10 years ago, one third of new inmates in France reported prolonged, regular use of illicit drugs, mainly cannabis, but also cocaine and crack cocaine, as well as opioids, during the year prior to entering prison.

Recently, studies on the analysis of illicit drug metabolites in the wastewater outlets of three French prisons indicate that cannabis appears to be the most widely consumed illicit drug in prison, while heroin and cocaine play a marginal role. Residues of opioid substitution treatment and other medications were also detected, but in doses corresponding to those prescribed by the healthcare units.

In general, prison inmates in France have higher rates of drug-related infectious diseases than the general population, although a declining trend was noted in the last decade.

Since 1994, the Ministry of Health has been responsible for health in French prisons, and the treatment of drug dependency in prison settings is based on a three-tier system: prison-based hospital healthcare units, which are responsible for monitoring the physical health of inmates; regional medico-psychological hospital services established in each French region, which handle the mental health aspects of drug users in prisons if no specialised treatment centre (Centre de soins, d'accompagnement et de prévention en addictologie, CSAPA) exists in the prison; and CSAPAs for prisons, established in the 16 largest prisons in France and covering approximately one quarter of the incarcerated population and three quarters of existing establishments. Furthermore, a reference CSAPA is appointed for each prison to offer support to inmates with drug dependency problems, particularly after their release.

The 2010-14 action plan on health policy for inmates stipulated the implementation of screening programmes and harm reduction measures for inmates, which included screening for human immunodeficiency virus (HIV) and hepatitis infections upon arrival; hygienic measures; provision of post-exposure treatments for both staff and inmates; and provision of bleach to disinfect equipment in contact with blood. A new government strategy document, adopted in 2017 , emphasises the need to promote the health of detainees and includes among its priorities improved detection of addictive behaviours and screening for infectious diseases, as well as improved care in general and continuity of care after release.

Opioid substitution treatment is available and can be initiated in prison. The main substance prescribed is buprenorphine, although methadone is also provided.

## Quality assurance

The Government Plan for Combating Drugs and Addictive Behaviours 2013-17 addresses quality assurance by basing public action on observation, research and evaluation, and by reinforcing training strategies. Quality assurance is defined as 'promotion of evidence-based preventive strategies' and 'improvement of the quality of healthcare for patients receiving opioid substitution treatment (OST) and increasing its accessibility'.

In France, quality assurance in drug demand reduction (prevention, risk reduction, treatment and rehabilitation) builds on specific advocacy, guidelines or training from professional organisations or public health institutions, but it is not institutionally structured or imposed. As for risk reduction and treatment, different guidelines exist on (i) OST; (ii) early intervention and risk/harm reduction for crack cocaine or freebase users; (iii) clinics for young drug users; and (iv) the treatment of cocaine users. However, the implementation of these guidelines is not compulsory: there is no formal requirement to meet guidelines in order to obtain support or subsidies. Professional federations are also engaged in developing quality and professional supports; the new portal on addictions for health professionals is an example.

A growing, although still limited, number of prevention organisations are involved in adopting and implementing international evidence-based programmes. Nevertheless, establishing good and evidence-based practices in prevention is among the government's drug policy priorities. Within the framework of the Inter-ministerial Commission for the Prevention of Addictive Behaviours, the ASPIRE toolkit [https://www.ofdt.fr/aide-aux-acteurs/prevention/grille-aspire/ ) and (http://www.drogues.gouv.fr/cipca/grille-aspire] , a quality assurance tool inspired by the European Drug Prevention Quality Standards, was issued in January 2017.

The specialised drug treatment centres (Centres de soins, d'accompagnement et de prévention en addictologie, CSAPAs) and the low-threshold facilities (Centres d'accueil et d'accompagnement à la réduction des risques pour usagers de drogues, CAARUDs) are in the scope of the activities of the National Agency for the Quality Assessment of Health and Social Care Organisations and Services (ANESM) . They are only marginally affected by the existing accreditation and certification processes for health establishments under the French National Authority for Health. However, ANESM is also involved in quality control activities. It accredits external evaluators who carry out mandatory independent evaluations of activities and service quality every five years and also makes recommendations on professional best practices .

The National Institute for the Training of the National Police is the service for initial and continuing education for Police and Gendarmerie drug prevention officers. Over the last five years, several initiatives have been developed to increase knowledge and competence on addictions through medical curricula and continued training for health professionals, prevention or treatment practitioners, etc.

The following documents form a framework for quality assurance in France: *Abus, dépendances et polyconsommations: stratégies de soins — Recommandations de la commission d'audition* ; *Prise en charge des consommateurs de cocaïne — Recommandations de bonnes pratiques professionnelles* ; and *La réduction des risques et des dommages dans les Centres d'accueil et d'accompagnement*

*à la réduction des risques pour usagers de drogues* . In addition, Addict'aide , is a virtual village dedicated to helping those addicted to alcohol, drugs or gambling.

## Drug-related research

In France, the Ministry of National Education, Higher Education and Research (MENESR) designs, coordinates and implements national policy on research and innovation, covering areas ranging from neuroscience, public health and clinical research applied to social sciences through academic organisations such as the National Centre for Scientific Research (CNRS) and the National Institute of Health and Medical Research (INSERM). MILDECA is the central structure, reporting to the prime minister, for coordinating governmental action in the drugs field, as well as promoting and funding drug-related research.

The French national focal point, the Observatoire français des drogues et des toxicomanies (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. The dissemination of data and research results is also part of its mandate, together with publishing these results in national and international scientific journals, and promoting the use of research results in practice and policymaking. Additionally, non-governmental organisations and foundations (such as the Fondation de France) representing practitioners, users and companies (alcohol suppliers, the tobacco industry and pharmaceutical laboratories) also regularly fund surveys and research projects in this area. Currently, research on drugs and addictive behaviours is also among the strategic priorities of national thematic research alliances. Public authorities have identified the following key priorities: to increase understanding of addictive behaviours through supporting multidisciplinary work, epidemiological research on the health and social effects of use among young people, and strengthening monitoring schemes and surveillance networks on addictive behaviour; to strengthen clinical research in the field of dependencies, particularly work on innovative drug treatments and new therapeutic strategies; to develop research on prevention; to develop evaluation research; and to improve the interface between researchers and policymakers.

A large number of research studies have been published recently , particularly studies in the field of basic research, population-based epidemiological studies, studies on demand reduction and studies on drug markets. Between 2010 and 2016, the number of French scientific publications on drug-related research increased by 30 % and public expenditure on research into addictive behaviours increased from EUR 13.5 million to EUR 17 million.

## Drug markets

The cannabis market in France has undergone changes in the last six years. Seizure data indicate that the cannabis resin market remains larger than the herbal cannabis market, although the latter is becoming increasingly dynamic. In France, herbal cannabis, the only illicit substance produced locally, is cultivated mainly by individuals on a small scale, although in recent years the increasing involvement of some criminal groups has been noted. Cross-border trading of herbal cannabis, mainly from the Netherlands but also from Spain and from Albania, has also been reported. Cannabis resin, the main drug trafficked in France, originates from Morocco and enters France through Spain, although some organised groups increasingly use Libya as a transit country or smuggle it directly via the Mediterranean route. The market for cannabis resin competes with that for herbal cannabis, and widespread law enforcement operations increase the costs and reduce the profitability of trafficking operations. There is also evidence that the potency of cannabis products has increased in recent years. In addition, some of the traditional cannabis resin trafficking organisations have been refocusing their work on more profitable operations, such as cocaine trafficking.

The cocaine market accounts for the second largest share of the French illicit drug market. Cocaine is mainly trafficked from South America, with French overseas departments and territories in the Americas playing an increasing role in these activities.

Heroin, originating in Afghanistan, is mainly trafficked via the Balkan route, enters the country primarily from the Netherlands, and is intended for domestic use and further transit to the Spanish and Italian markets. The heroin market, although in decline compared with the 1990s, has shown some signs of revival in the last few years in some parts of France, where user-dealer micro-networks play an important role in maintaining the availability of heroin. Moreover, the strong presence of Albanian criminal networks specialising in dealing heroin has been noted in eastern France. There is also a significant illicit market for opioid-containing medications, mainly diverted from healthcare services.

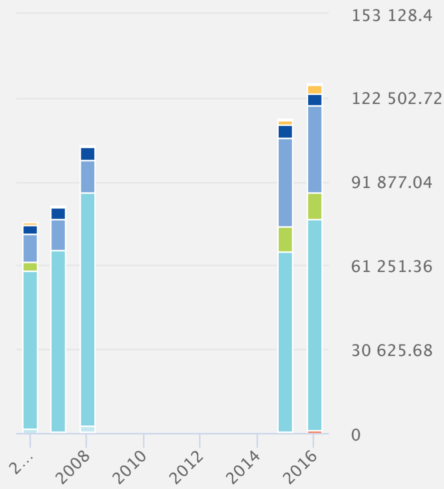
Synthetic stimulants are chiefly smuggled from the Netherlands and Belgium. France is also a transit country for dealers targeting the United Kingdom and Spain. Since 2009, the MDMA/ecstasy market has experienced renewed dynamism and there has been a diversification in marketed products, in addition to the appearance of high-potency products targeting mainly those in recreational settings and young people. New psychoactive substances (NPS) are offered through various segments of an internet-based market, and those arriving in France are mainly produced in Asia, particularly in China and India. Seizures of NPS indicate that cathinone-type substances dominate the market, followed by arylcyclohexylamines (primarily ketamine) and synthetic cannabinoids. In 2016, a total of 44 substances were identified for the first time in France, eight of which were identified for the first time in the EU.

Particular concern in the last two years has been raised over an unprecedented increase in violence associated with drug trafficking in several French cities.

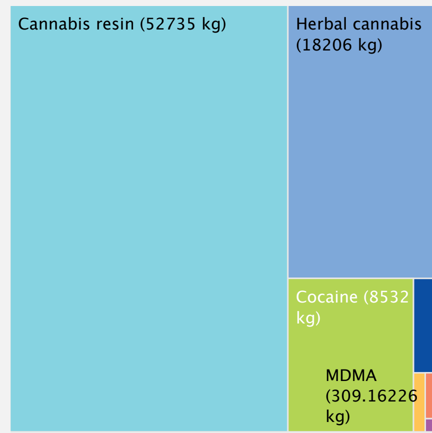
Taking into account the nature of the illicit drug market in France, one of the main priorities of law enforcement remains interception of cannabis and cocaine trafficking routes in the Mediterranean and Caribbean. Law enforcement focuses also on money laundering and reducing drug supply at a national level.

**Drug seizures in France: trends in number of seizures (left) and quantities seized (right)**

Number of seizures




Quantities seized




"NB: Year of data 2016. 2009-2014 data are not available due to changes in the French reporting system. 2015 and 2016 data are not comparable with years 2006-20008 as they are underestimated (data from the Gendarmerie are not available)."

## Key statistics

Most recent estimates and data reported

| | Year | Country data | EU range Min. | EU range Max. |
|---|---|---|---|---|
| **Cannabis** | | | | |
| Lifetime prevalence of use - schools (% , Source: ESPAD) | 2015 | 31.5 | 6.5 | 36.8 |
| Last year prevalence of use - young adults (%) | 2016 | 21.5 | 0.4 | 21.5 |
| Last year prevalence of drug use - all adults (%) | 2016 | 11.1 | 0.3 | 11.1 |
| All treatment entrants (%) | 2016 | 62.5 | 1.0 | 69.6 |
| First-time treatment entrants (%) | 2016 | 78.0 | 2.3 | 77.9 |
| Quantity of herbal cannabis seized (kg) | 2016 | 18206 | 12 | 110855 |
| Number of herbal cannabis seizures | 2016 | 31736 | 62 | 158810 |
| Quantity of cannabis resin seized (kg) | 2016 | 52735 | 0 | 324379 |
| Number of cannabis resin seizures | 2016 | 77466 | 8 | 169538 |
| Potency - herbal (% THC) (minimum and maximum values registered) | 2016 | 0 - 28 | 0 | 59.90 |
| Potency - resin (% THC) (minimum and maximum values registered) | 2016 | 0 - 70 | 0 | 70 |
| Price per gram - herbal (EUR) (minimum and maximum values registered) | 2016 | 7 - 10 | 0.60 | 111.10 |
| Price per gram - resin (EUR) (minimum and maximum values registered) | 2016 | 5 - 9.2 | 0.20 | 38.00 |
| **Cocaine** | | | | |
| Lifetime prevalence of use - schools (% , Source: ESPAD) | 2015 | 4 | 0.9 | 4.9 |
| Last year prevalence of use - young adults (%) | 2014 | 2.4 | 0.2 | 4.0 |
| Last year prevalence of drug use - all adults (%) | 2014 | 1.1 | 0.1 | 2.3 |
| All treatment entrants (%) | 2016 | 6.7 | 0.0 | 36.6 |
| First-time treatment entrants (%) | 2016 | 5.9 | 0.0 | 35.5 |
| Quantity of cocaine seized (kg) | 2016 | 8532 | 1 | 30295 |
| Number of cocaine seizures | 2016 | 9480 | 19 | 41531 |
| Purity (%) (minimum and maximum values registered) | 2016 | 0 - 89.2 | 0 | 99 |
| Price per gram (EUR) (minimum and maximum values registered) | 2016 | 60 - 75 | 3.00 | 303.00 |
| **Amphetamines** | | | | |
| Lifetime prevalence of use - schools (% , Source: ESPAD) | 2015 | 2.3 | 0.8 | 6.5 |
| Last year prevalence of use - young adults (%) | 2014 | 0.7 | 0.0 | 3.6 |
| Last year prevalence of drug use - all adults (%) | 2014 | 0.3 | 0.0 | 1.7 |
| All treatment entrants (%) | 2016 | 0.4 | 0.2 | 69.7 |
| First-time treatment entrants (%) | 2016 | 0.4 | 0.3 | 75.1 |
| Quantity of amphetamine seized (kg) | 2016 | 274 | 0 | 3380 |
| Number of amphetamine seizures | 2016 | 822 | 3 | 10388 |
| Purity - amphetamine (%) (minimum and maximum values registered) | 2016 | n.a. | 0 | 100 |
| Price per gram - amphetamine (EUR) (minimum and maximum values registered) | 2016 | 10 - 20 | 2.50 | 76.00 |
| **MDMA** | | | | |
| Lifetime prevalence of use - schools (% , Source: ESPAD) | 2015 | 2.2 | 0.5 | 5.2 |
| Last year prevalence of use - young adults (%) | 2014 | 2.3 | 0.1 | 7.4 |
| Last year prevalence of drug use - all adults (%) | 2014 | 0.9 | 0.1 | 3.6 |
| All treatment entrants (%) | 2016 | 0.4 | 0.0 | 1.8 |
| First-time treatment entrants (%) | 2016 | 0.6 | 0.0 | 1.8 |
| Quantity of MDMA seized (tablets) | 2016 | 1236649 | 0 | 3783737 |
| Number of MDMA seizures | 2016 | 3461 | 16 | 5259 |
| Purity (MDMA mg per tablet) (minimum and maximum values registered) | 2016 | n.a. | 1.90 | 462 |
| Purity (MDMA % per tablet) (minimum and maximum values registered) | 2016 | 0 - 63 | 0 | 88.30 |
| Price per tablet (EUR) (minimum and maximum values registered) | 2016 | 6 - 10 | 1 | 26.00 |
| **Opioids** | | | | |
| High-risk opioid use (rate/1 000) | 2015 | 5.6 | 0.3 | 8.1 |
| All treatment entrants (%) | 2016 | 26.1 | 4.8 | 93.4 |
| First-time treatment entrants (%) | 2016 | 12.3 | 1.6 | 87.4 |
| Quantity of heroin seized (kg) | 2016 | 1080 | 0 | 5585 |
| Number of heroin seizures | 2016 | 4312 | 2 | 10620 |

| Purity - heroin (%) (minimum and maximum values registered) | 2016 | 0 - 76 | 0 | 92 |
|---|---|---|---|---|
| Price per gram - heroin (EUR) (minimum and maximum values registered) | 2016 | 25 - 45 | 4.00 | 296.00 |
| **Drug-related infectious diseases/injecting/death** | | | | |
| Newly diagnosed HIV cases related to Injecting drug use -- aged 15-64 (cases/million population, Source: ECDC) | 2016 | 0.7 | 0 | 33.00 |
| HIV prevalence among PWID* (%) | 2015 | 4.7 | 0 | 31.50 |
| HCV prevalence among PWID* (%) | n.a. | n.a. | 14.60 | 82.20 |
| Injecting drug use -- aged 15-64 (cases rate/1 000 population) | 2015 | 2.68 | 0.10 | 9.20 |
| Drug-induced deaths -- aged 15-64 (cases/million population) | 2014 | 6.95 | 1.40 | 132.30 |
| **Health and social responses** | | | | |
| Syringes distributed through specialised programmes | 2014 | 12 314 781 | 22 | 6469441 |
| Clients in substitution treatment | 2016 | 169750 | 229 | 169750 |
| **Treatment demand** | | | | |
| All entrants | 2016 | 56482 | 265 | 119973 |
| First-time entrants | 2016 | 16127 | 47 | 39059 |
| All clients in treatment | 2016 | 243000 | 1286 | 243000 |
| **Drug law offences** | | | | |
| Number of reports of offences | 2016 | 218731 | 775 | 405348 |
| Offences for use/possession | 2016 | 182161 | 354 | 392900 |

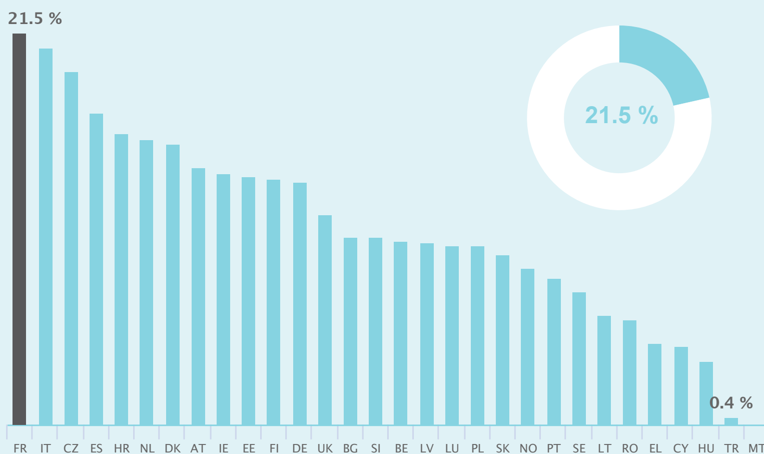
* PWID — People who inject drugs.

## EU Dashboard

### EU Dashboard

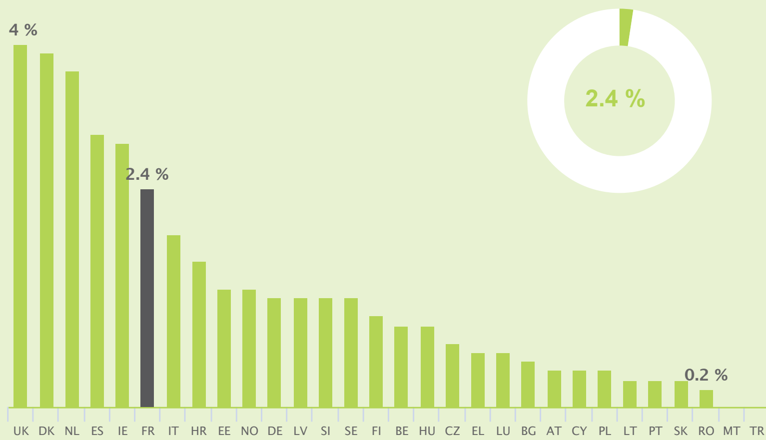
**Cannabis**

Last year prevalence among young adults (15-34 years)



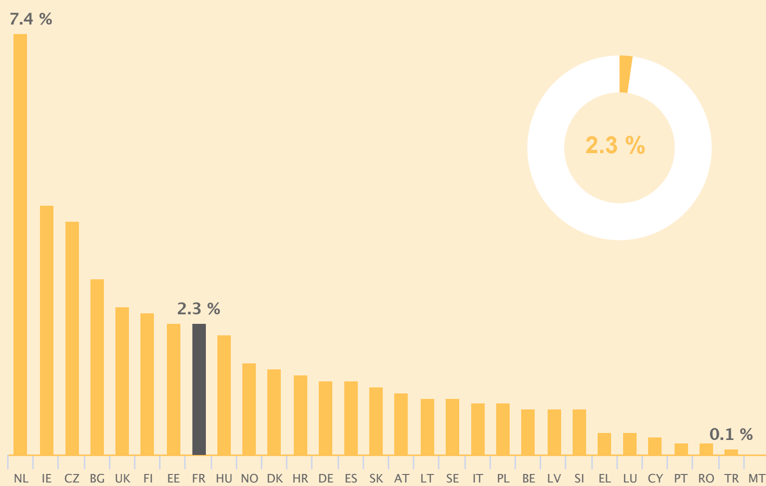
## Cocaine

Last year prevalence among young adults (15-34 years)



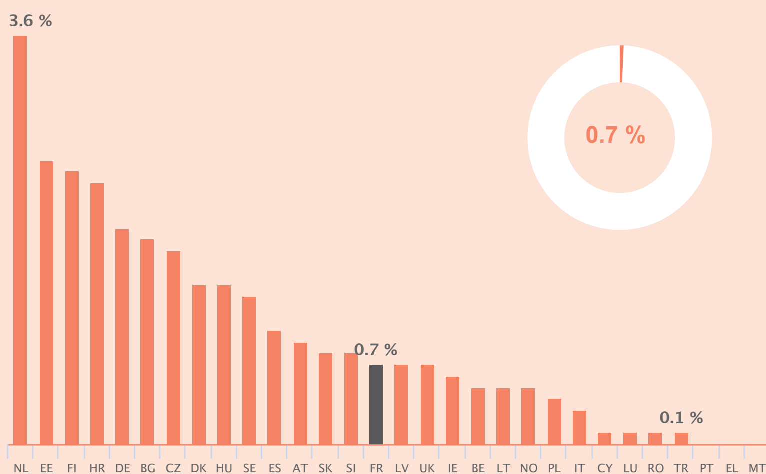

## MDMA

Last year prevalence among young adults (15-34 years)

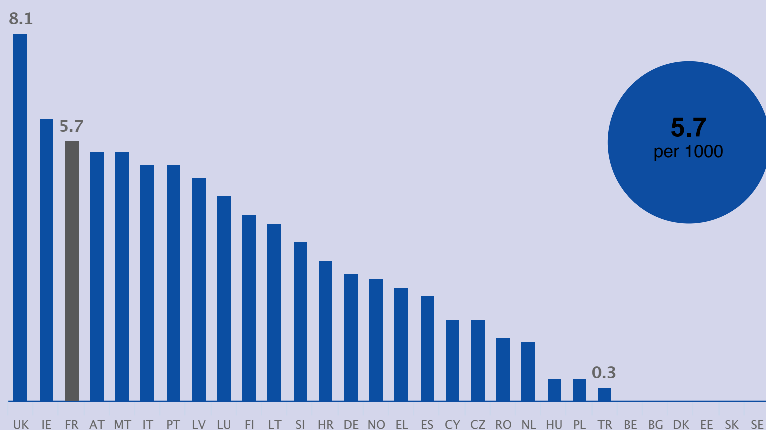



## Amphetamines

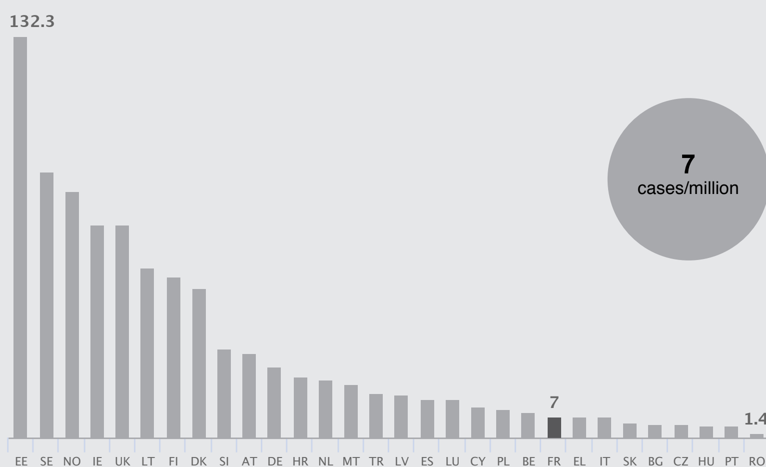
Last year prevalence among young adults (15-34 years)



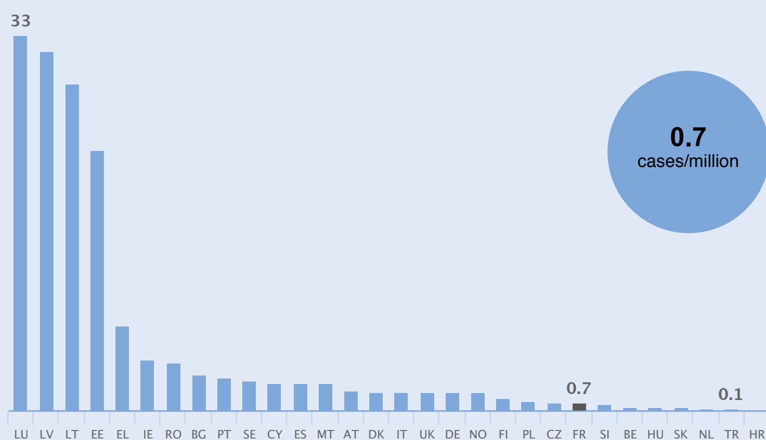
**Opioids**
High-risk opioid use (rate/1 000)

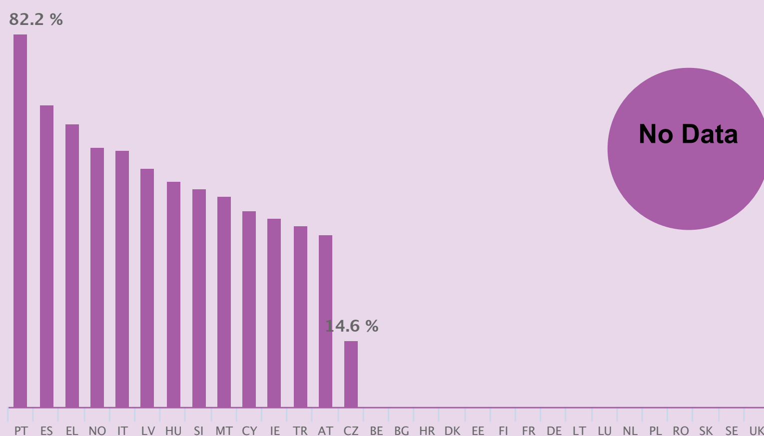



**Drug-induced mortality rates**
National estimates among adults (15-64 years)




**HIV infections**
Newly diagnosed cases attributed to injecting drug use






NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, di?erences may be due to reporting practices. Detailed information on methodology, qualifcations on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Countries with no data available are marked in white.

## About our partner in France

Since 1996, the French Monitoring Centre for Drugs and Drug Addiction (Observatoire français des drogues et des toxicomanies, OFDT) has been entrusted, as an independent body, with the coordination of all drug- monitoring activities in France, and has acted as the national focal point. The OFDT is also responsible for the evaluation of drug policies in France. Since 1999, its areas of activity have included licit substances (alcohol, tobacco and medicines) in addition to illicit drugs and addictive behaviours. The OFDT is mainly funded by the Inter-ministerial Mission for Combating Drugs and Addictive Behaviours (Mission interministérielle de lutte contre les drogues et les conduites addictives, MILDECA), an inter-departmental body composed of representatives of different ministries, which is responsible for the overall coordination of activities against drugs and drug dependency in France. For a comprehensive picture of the French drug situation, please refer to the national report 2016 to the EMCDDA

## Observatoire français des drogues et des toxicomanies

(French Monitoring Centre for Drugs and Drug Addiction)

3, Avenue du Stade de France
F-93218 Saint Denis la Plaine Cedex
France
Tel. +33 141627716
Fax. +33 141627700
Head of national focal point: Mr Julien Morel d'Arleux