



**European Monitoring Centre
For Drugs and Drug Addiction**



**2010 NATIONAL REPORT (2009 data) TO THE
EMCDDA
by the Reitox National Focal Point
France**

**New Development, Trends and in-depth information on
selected issues**

REITOX

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Summary

1. National policy: legislation, strategies and economic analysis

Several laws on addictions treatment and combating narcotics trafficking were adopted in France over the period covered by this report. The new legislation in 2009 mostly involved territorial reorganisation of the care offered, bringing the terms of the French sports code in line with the World Anti-Doping Code and strengthening international cooperation in the field of narcotics trafficking. In 2010, the National Assembly adopted a law intended to facilitate legal investigations and take sanctions against dealers with regard to their drug dealing profits.

In terms of the adoption of implementing legislation relative to current laws, the decrees, circulars and orders adopted in 2009 and 2010 mostly build on the dispositions of the French Delinquency Prevention Act of 5 March 2007. These texts concern measures increasing safety in educational establishments and the implementation of the mandatory treatment. In addition, new legal texts were adopted in 2009 and 2010 within the scope of other laws concerning the vigilance of public bodies towards the appearance of new potentially dangerous substances (list of narcotics, list of poisoning substances, lists of substances and methods prohibited in sports, etc).

In terms of government policy, the national strategies begun in 2009 by central government are those defined in the government's 2008-2011 Combating drugs and drug addiction government action plan. With respect to addictions, the "drugs" plan restates the health measures from the 2009-2012 "hepatitis" plan and the 2009-2013 "cancer" plan. Nationally, the strategies of the government plan are broken down into inter-ministerial *département* plans, production of which is the responsibility of the *département* project leader. In terms of coordination, the *département* monitoring committee is responsible for seeking consistency with the specific plans in the *département* (*contrats de cohésion*, town contracts, public health programme, regional medical-social scheme, etc). It is the responsibility of the *département* project leader to mobilise local players in their efforts to apply the national strategies to prevent and combat trafficking. In health policy, the *département* project leader liaises with the regional project leader who is the special contact of the Regional Health Agency (ARS) which, since the adoption of the HPST law in July 2009, has become a sort of "one-stop-shop" for the national healthcare offering.

In terms of public expenditure, the overall State commitment to apply the drugs policy was estimated for the first time in 2009 to be €925.12 M, according to ministerial sources. The next financial year (draft finance law for 2011) should refine this estimate.

Application of the drugs policy is not the exclusive responsibility of the State. It is also part of the remit of the National Health Insurance Funds (*Assurance maladie*) which cover the common law health system for drug users. The main item of expenditure of the National Health Insurance Funds in this arena is the funding of addictology centres. Funding for this in 2009 was €286.67 M, €270.34 M of which were devoted to staff and operational expenditure for existing centres, 14.5 M€¹ were intended to fund the improvement or creation of new centres and €1.8 M to fund the introduction of new programmes in existing centres. The second leading item of expenditure for the National Health Insurance Fund was reimbursement of opiate substitution treatments. Because data is only published after four years, the reimbursement cost for opiate substitution treatments (OST) is not available for the year 2009. The cost of OST reimbursement in 2006 was €87 M. The third item of expenditure was the funding of health establishments to implement the measures stipulated in the addictions action plan: the hospital sector received funding of €24.67 M for this in 2009.

¹ €13.3 M in 2009 for the 2007-2011 addictions management and prevention plan, €1 M in accordance with the 2008-2011 government plan to create a new treatment community in 2009 and 0.2 M€ for the 2009-2012 hepatitis plan.

Profits from the sale of goods confiscated in criminal proceedings from narcotics cases produced an income allocated to a special fund (*fonds de concours*) administered by MILDT. In 2009, this fund was worth €11.4 M.

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

General population survey data were most recently updated in 2008. The last ESCAPAD survey (see Appendix V-K), conducted on 17-year-old youths during the day of defence preparation (JAPD), took place that year. The last ESPAD survey (see Appendix V-L) in schools with 16-year-olds took place in 2007, whereas the most recent data from the adult population date back to 2005 with *Baromètre santé*. In 2011, we will have the results of the *Baromètre santé* 2010 survey and the initial results of the ESCAPAD and ESPAD surveys conducted at the start of 2011.

The new information therefore only relates to the EROPP survey which provides information about beliefs, opinions and perceptions French people have with regard to psychoactive substances. Following its third edition in 2008, the results of which came out in 2010, the EROPP survey highlights three major changes in the perceptions and opinions of French people with regard to drugs over the last decade. Firstly, greater awareness of French people to the “danger of drugs” was found, regardless of the legal status of the substance. Secondly, there was some slippage in beliefs about the origin of the phenomenon of drug use, which was considered less as an “external” illness but more as an abnormal individual behaviour. Finally, beyond the widespread agreement with the public policies implemented in this field, French people had less “tolerant” and “liberal” opinions about the policies which should be pursued: they are increasingly in favour of prohibitive measures and less open to a harm reduction approach.

3. Prevention

The guide on the prevention of drug use in schools was updated in 2009-2010. It introduces the principle of a prevention programme lasting from the last year of primary school to the last year of secondary school. This guide was first published in 2005 under the auspices of the Ministry of Education and MILDT.

During 2009, MILDT organised parenting conferences which took place in May 2010 with the aim of updating the communication strategies to support parents in their role as active players in the prevention of legal and illegal drug use. The debates arising from these conferences were intended to enrich a government awareness campaign for parenting adults in 2010.

In order to define targeted measures suitable for professional settings and to provide consensually agreed appropriate changes to the labour laws, MILDT also held conferences on occupational risks related to the use of psychoactive substances.

MILDT organised two press campaigns in 2009. The first was on the subject “Drogues : ne fermons pas les yeux”, which was intended to “combat positive beliefs about drugs”. The second had two arms, alcohol and illegal drugs, in order to “emphasise the protective role of the law against the health and social dangers of high risk behaviour”.

4. Problem drug use

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

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

- increasingly diverse user populations;

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

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

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

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

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

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

6. Health correlates and consequences

The number of cases of AIDS in intravenous drug users (IVDU) has fallen continuously since the middle of the 1990s. This was confirmed in 2009 with less than 5% of intravenous drug users (IVDU) amongst new AIDS cases (compared to 8% in 2008).

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

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

7. Responses to health correlates and consequences

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

The new 2009-2010 hepatitis plan broadened the scope of infectious disease prevention according to several themes: firstly, with the objective of **preventing the first injection**; and secondly, by extending the measures targeting drug users to the entire population of the most vulnerable people (street youths, new migrants) and by including routes of drug

administration other than injection in high risk practices. Similarly, a reintroduction of early vaccination against hepatitis B in the general population should help to protect future DU.

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

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

8. Social correlates and social reintegration

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

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

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

Major trends seen in previous years remain stable. Cannabis is still the substance responsible for the largest number of arrests for drug offences, ahead of heroin and cocaine. The number of arrests for simple use remains high (approximately 140,000 procedures annually) as does the number of arrests for misuse of pharmaceutical drugs. The penal response to drug use is increasingly taking the form of measures other than prosecution, or in the event of prosecution, penalties involving substitution orders or fines. Prison sentences (including imprisonment) for drug users have remained relatively stable over the last 5 years: a lack of information about the application of these sentences makes it impossible to establish whether or not they are actually served.

For road accidents, 34.6% of the 63,500 tests performed in 2009 were positive. Major changes in testing are to be introduced in 2010: the number of tests performed will be increased to 100,000 because of the extensive use of salivary testing. Moreover, tests will become mandatory for all road accidents, for both fatal injuries and minor injuries.

10. Drug markets

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

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

For the greater part of 2009, the synthetic drugs market saw a severe shortage of MDMA both in "powder" and "tablet" form. With regard to this latter galenic form, dealers continued to supply the market with "ecstasy", but used MCPP instead of the traditional active substance. MCPP, which is legal in France, has relatively similar effects to MDMA. This phenomenon has led users to switch to amphetamines (speed) and cocaine, the latter spreading further into the population.

Although more marginal, 2009 saw the development of the use of ketamine outside the group of regulars in the alternative party scene. Ketamine appears to benefit from an

improving image because of better management of the effects of the substance through a harnessing of its use.

The striking finding in 2009 in terms of the composition of substances was the doubling in the proportion of heroin samples seized containing more than 30% purity, while the proportion of samples containing very low doses also increased.

Selected Issue 1

History, methods and implementation of national treatment guidelines

The first professional recommendations in France for the care of DU date back to 2002-2004. These concern substitution treatments and supplemented the initial ministerial directives of 1995 for the marketing of methadone and HDB. Polydrug use in 2007 and cocaine use in 2010 have led the authorities, professionals and institutions more recently to produce new professional good practice recommendations. This selected issue describes the process for producing and applying the main recommendations and emphasises the methodological procedures used. An ad-hoc literature review and a series of semi-structured face-to-face interviews with key experts enabled this investigation to be carried out.

A wide range of methods were used to produce the recommendations: small working group, consensus conference on “Clinical practice recommendations”, etc. An equally wide range of methods were used to examine the validity of the recommendations: in-house expertise, independent reviewers, etc. According to the information collected, the main weakness of these experiments is that the distribution of the recommendations usually ended with their publication. In future, the Higher Health Authority (HAS), the agency responsible for producing medical recommendations in France, intends to move increasingly towards scientifically validated methods.

Selected Issue 2

Mortality related to drug use: a comprehensive approach and public health implications

Official data on deaths from the use of psychoactive substances place France in an apparently enviable position, with a particularly small number of overdoses compared to other Western European countries. The peak in deaths seen until the middle of the 1990s has been followed by a significant fall in these overdoses, which has been interpreted as the direct result of an intentional harm reduction policy including the distribution of OST and deregulated prescription of HDB in particular.

Since 2003, a further rise in these overdoses has been seen, particularly associated with increasing availability of heroin and cocaine, together with new users, not as yet known to the care centres or low threshold services. This phenomenon is combined with occasionally conflicting findings, raising a suspicion that the actual number of overdoses is in fact underestimated. A need for better knowledge of the causes of deaths in drug users has led to cohort studies being set up, one of which is currently underway.

Part A: New development and trends

1. Drug policy: legislation, strategy and economic analysis

1.1. Introduction

Definitions

A drug user is an individual who consumes a narcotic substance. The possession of small quantities of narcotics is often placed in the same category by the legal authorities, in much the same way as cannabis growing when this is intended for personal use only. The same also applies to narcotics used as performance boosters (with the aim of enhancing professional, intellectual or sporting performance).

Any offence involving the use of narcotic substances may result in arrest (by the police, the gendarmerie or the Customs Department), and will normally be referred to the judicial service. Offences are examined on a case-by-case basis by the public prosecutor who, (based on the principle of the “opportunité des poursuites” (appropriateness of proceedings) may decide to take legal action against the offender, to simply close the case or to propose other measures as an alternative to legal proceedings. This principle of “opportunité des poursuites” allows for a response carefully tailored to each individual situation, but also explains the wide disparity in penal responses given by the courts. Nevertheless, all of the penalties and sanctions issued are based on the Penal Code.

Data collection tools

The main sources used to define the legal framework applicable in the drug field are the Penal Code, the Public Health Code and the Sports Code.

Background

Two types legislation govern drugs in France. The use, possession and supply of legal drugs (alcohol and tobacco, etc.) are regulated, but not forbidden. On the other hand, illegal drugs considered as narcotics², (heroin, cocaine, cannabis and hallucinogens, for example), are subject to a ban, chiefly enshrined in the law of December 31, 1970, the provisions of which have been incorporated within the Penal Code and the Public Health Code. The law of December 31, 1970 makes it illegal to use or deal in any substance or plant listed as a narcotic (making no differentiation among the substances). It makes no distinctions between drug users and dealers. Furthermore, it considers the drug user as a patient.

The use of narcotics

The legal framework outlawing the use of narcotics (whether in public or private) has not been changed since its inception (1970). The most recent proposal to change the law dates back to 2003, when the idea of punishing simple drug use with fines alone was suggested although this was ruled out by the government in July 2004.

Under the terms of article L.3421-1 of the Public Health Code (formerly art. L.628), the illegal use of substances listed as narcotics constitutes an offence subject to a maximum punishment of one year's imprisonment and a fine of €3,750. Furthermore, article L. 3411-1 also provides for a specific court-ordered treatment procedure, enabling the prosecutor to suspend proceedings against the drugs user if the latter agrees to undergo a course of treatment.

The guidelines governing penal policy in the fight against drug use were redefined by a series of circulars from the Ministry of Justice issued since the early 1970s, focusing (according to the period in question) on the need to more effectively treat or, on the contrary,

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

to more effectively punish drug use. As an example, the circular of June 17, 1999 calls upon the public prosecutors to "develop more diverse legal responses" to deal with arrested drug users at all stages of the criminal proceedings, with prison sentences being reserved for extreme cases and used as a last resort. Therapy-based alternatives to legal proceedings were therefore strongly encouraged, including court-ordered treatments for dependent drug users, a caution for occasional users (particularly users of cannabis), or dismissal of the case with referral to a addictology health/social care centre for other types of drug-related behaviours.

The "delinquency prevention law" of March 5, 2007 further reinforced the range of law enforcement measures available for use against drug users. Firstly, this law enabled judges to deal with narcotics offences using a simplified, "fast-track" procedure in order to provide a systematic penal response to narcotics use. To achieve this, it also introduced a new "personalised" punishment: an awareness-building training course focusing on the dangers of the use of narcotics products, this being both compulsory and paid for by the offender (up to a maximum of €450, equivalent to the cost of a class 3 fine). Introduced by means of article L 131-35-1 of the Penal Code and by articles R131-46 and R131-47 of the Penal Code in application of decree number 2007-1388 of September 26, 2007, the aim of this measure is to make offenders fully aware of the danger and harm generated by the use of narcotics in addition to the social impact of such behaviour. The course may be proposed by the authorities as an alternative to legal proceedings and penal agreements. An obligation to complete the course may also be included in the ruling as an additional measure. It applies to all adults and to minors over the age of 13³.

The law of March 5, 2007 also extends the scope for the application of court-ordered treatments, which can now be ordered at any stage of the legal proceedings. Originally conceived as an alternative to legal proceedings (resulting in a suspension of the legal process), court-ordered treatments can now be ordered as a sentence enforcement measure, including for those persons having committed an offence related to alcohol consumption. The law of 2007 also reinforced the available measures concerning the monitoring of the application of court-ordered treatments. It introduced the notion of "intermediate doctor" whose task it is to assess the medical appropriateness of the measure, inform the doctor chosen by the user of the legal framework in which it is being applied, verify the enforcement of the court-ordered treatment and inform the legal authorities of changes in the offender's medical situation.

Narcotics use and road safety

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

The law of June 18, 1999 and its application decree (August 27, 2001) introduced the automatic screening for narcotics for all drivers involved in a road traffic accident with immediately fatal consequences. The law of February 3, 2003 introduced a new offence concerning any driver whose blood test revealed the presence of narcotics. In such circumstances, the driver risks a two-year prison sentence and a fine of €4,500. These penalties may be increased to 3 years' imprisonment and a fine of €9,000 if alcohol use is also detected. Screening is obligatory in the event of any immediately fatal accident or any accident involving bodily injury when the driver is suspected of having used narcotics. This is authorised for any driver involved in any road traffic accident or committing certain offences under the terms of the Highway Code. It may also be carried out on drivers when valid grounds exist to believe that the said driver has used narcotics (art.L.235-2 of the Highway Code).

³ Décret du 26 septembre 2007 and circulaire du 9 mai 2008.

The use of narcotics in professional environments

The law increases the penal sanctions applicable to employees in a position of public authority (or those carrying out a public service activity or involved in national defence) committing drug use offences. They now risk a five-year prison sentence and a total maximum fine of €75,000. The staff of public transport companies committing drug use offences while on duty are also subject to these penalties, in addition to sanctions prohibiting them from carrying out their professional activities in the future and (where applicable) an obligation to undergo, at their own cost, an awareness-building training course concerning the dangers of narcotics use.

Drug-trafficking

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

The current legal arsenal also provides specific instruments and procedures to fight trafficking, and a number of these constitutes dispensations vis-à-vis common law. Consequently, the "immediate appearance" fast-track procedure can be used to organise action against small-scale traffickers following the introduction of the law of January 17, 1986 making it possible to immediately judge user-dealers following their arrest, in much the same way as the instigators of organised criminal networks. The legal measures aimed at fighting money laundering introduced in the late 1990s make it possible to pursue drug traffickers based on their outward signs of wealth. As result, the fact that an individual "is unable to account for resources corresponding to his lifestyle when in frequent contact with a drug user or trafficker" is considered an offence under the terms of the law of May 13, 1996 which outlaws "living off the proceeds of drugs".

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

Finally, the "delinquency prevention" law of March 5, 2007 provides for more severe penalties in the event of "directly inciting a minor to transport, possess, propose or sell narcotics" (up to 10 years in prison and a fine of €300,000). The penalties for offences committed under the influence of a narcotic substance or in a state of drunkenness have also been beefed up. Concerning the anti-trafficking aspects, the law provides for new investigative measures (including investigation based on the use of IT and communication technology⁴, undercover purchases, or procedures aimed at assessing risks early on).

The trafficking of synthetic drugs

The production and sale of "precursor" products which may be used for the production of narcotics has been governed ever since the introduction of the law of June 19, 1996.

⁴ Information technology

Opioid substitution treatments

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

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

Since 1993, a series of official texts and circulars have been published by the public authorities in order to "balance out" the distribution of prescribed substitution treatments in France. More recently, (in April 2008) the health authorities decided to reinforce the conditions for the prescription and issuing of buprenorphine and methadone. In order to obtain a refund, the patient must now obligatorily provide his doctor with the name of the pharmacist who will be issuing the drug. For his part, the doctor must mention his name on the prescription, which must be prepared by the named pharmacist.

The legal framework for harm reduction activities

The harm reduction policy vis-à-vis drug users is the responsibility of the state (article L3121-3 of the public health code modified by law number 2004-809 of August 13, 2004 - art. 71 JORF 17 August 2004). The harm reduction policy aimed at drug users seeks to prevent the spread of infections, deaths by overdoses through intravenous injection of the drugs and the social and psychological harm arising from the use of drugs classified as narcotics (article L3121-4 of the public health code modified by law number 2004-809 of August 13, 2004 - art. 71 JORF 17 August 2004).

The law of August 9, 2004 which set up the CAARUDs ("Harm reduction & support centres for drug users") states that along with the numerous other schemes and measures, "Harm reduction & support centres for drug users" should be used to further improve the harm reduction policy (article L3121-5 of the Public Health Code). Thus, the "Harm reduction & support centres for drug users"⁵ receive both individuals and groups, in addition to providing tailored advice and information for drug users. Support for drug users in obtaining access to treatment, which includes hygiene systems and access to basic emergency care, referral to specialised or general treatment systems, encouragement to undergo screening for transmissible infections, support for users in exercising their rights and gaining access to housing and professional reintegration, the availability of infection prevention equipment, and localised intervention outside the centre with a view to establishing contact with users.

The CAARUDs also carry out "social mediation" activities with a view to ensuring satisfactory integration within the neighbourhood and avoiding the kind of nuisances typically associated with drug use. Their coordination with other organisations has been stipulated by means of a circular⁶.

The issuing of syringes is authorised in dispensaries, in-house pharmacies located within health establishments and establishments dealing exclusively in medical/surgical and dental

⁵ R3121-33-1 modifié par le décret n°2005-1608 du 19 décembre 2005 - art. 5 JORF 22 décembre 2005 en vigueur le 1er janvier 2006.

⁶ Circulaire DGS/S6B/DSS/1A/DGAS/5C n°2006-01 du 2 janvier 2006 relative à la structuration du dispositif de réduction des risques, à la mise en place des centres d'accueil et d'accompagnement, à la réduction des risques pour usagers de drogues (CAARUD) et à leur financement par l'assurance maladie.

equipment or which possess a specialised department handling such sales (article D3121-27 of the Public Health Code). These may be issued free of charge by any not-for-profit association carrying out AIDS prevention or harm reduction activities among drug users, meeting the requirements described in the decree from the Minister of Health.

A national harm reduction standard for drug users⁷ has been prepared (art. D. 3121-33 of the Public Health Code) and approved via decree number 2005-347 of April 14, 2005. Among other things, this stipulates that all participants, health professionals, social workers or members of associations, in addition to any persons to whom these activities are addressed, must be protected from accusations concerning the use or the incitation to use drugs during their work.

Emerging trends in the national anti-drugs strategy

The first interministerial anti-drug plan dates back to 1995 (DGLDT 1995). The 2008-2011 government plan to combat drugs and drug addiction (currently underway) includes almost 200 measures and recommendations in terms of prevention, supply reduction, health/social care, research, observation and training or international cooperation. In the field of prevention, priority is given to the goal of preventing people from taking drugs for the first time, as the age at which experimentation begins has fallen. This targets young people and their close circle of acquaintances (parents, teachers, etc.). With regard to the law enforcement, the plan has identified a number of priorities in the fight against addictions: alcohol abuse among the youngest users, offences related to the use of narcotics, but also tobacco in public areas, cannabis trafficking, seizure and court-ordered confiscation, etc. In the healthcare and social integration field, the plan is intended to boost accommodation capacity for dependent persons by planning for new treatment programmes, particularly for minors, pregnant women or parents with young children and those leaving prison. Finally, in the field of international policy, the 2008-2011 plan has been designed to comply with three major objectives: the reinforcement (within a multilateral, European and bilateral framework) of action deployed at every stage of the trafficking routes (particularly in western Africa and the Mediterranean), in order to choke off the source of supply to cannabis and cocaine outlets in Europe and heroin outlets in central Europe and the Balkans. An increasing number of agreements have been reached with the states concerned in order to simplify international action against the misuse of chemical precursors (particularly concerning Afghanistan) and, finally, boosting Mediterranean cooperation to coordinate the fight against drugs in the Mediterranean area, etc.

Whereas the previous plan (2004-2008) set itself the goal of developing a policy chiefly focused on young people and prevention, with the aim, in particular, of "halting the spread of cannabis" among teenagers and young adults, the 2008-2011 plan (without further developing this point) has adopted an approach clearly centred on the application of the law and the deployment of targeted public information messages. The government plan can also be seen as a continuation of the 2007-2011 Plan for treatment and prevention of addictions from the Ministry of Health, adopted in November 2006⁸ which seeks to structure and enhance the availability of existing facilities and programmes (in hospitals, addictology health/social care centres or in primary care settings).

Public expenditure and budgets

Since the introduction of the Organic law relative to the finance laws of 2001, the state's general budget credits allocated to the public authorities are now presented on a "per mission" and "per programme" basis. In the fight against drugs, the state runs around 30 ministerial programmes. The state's efforts in terms of anti-drug policy can also be seen within larger-scale activities. This includes the credits allocated to the MILDT under the terms of programme 129 "Coordination of governmental work". The expenditure incurred by the

⁷<http://www.legifrance.gouv.fr/affichCode.do?idArticle=LEGIARTI000006908109&idSectionTA=LEGISCTA000006132372&cidTexte=LEGITEXT000006072665&dateTexte=20080617>

⁸ http://www.sante.gouv.fr/hm/actu/plan_addictions_2007_2011/sommaire.htm

health insurance system does not fall within this scope, although it can also be identified. This expenditure chiefly concerns the financing of Addictology health/social care centres, that is, “Addictology treatment, health/social support and prevention centres” (CSAPAs), “Harm reduction and health/social support centres for drug users” (CAARUDs) and therapeutic communities (TCs). Public expenditure on the drug prevention policy, treatment, or drug supply curtailment measures has been the subject of numerous studies in France⁹. A recent assessment of public expenditure devoted to the drug problem was carried out in 2007, concerning the credits allocated in 2005 (BEN LAKDHAR, C.). As the calculation methods were specific to the various estimates, tracking changes by means of a comparative analysis is not possible.

1.2. Legal framework

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

Nationwide health system organisation and steering of the health policy: **the Hospital, patients, health and territories law¹⁰ of 21 July 2009 (HPST) created a new regional key figure** with whom all professionals in the health system are now required to work. These are the Regional Health Agencies (ARS) stipulated in article 118 of the HPST law (Art. L.1431-1 to L.1435-7 of the CSP) (Code of Public Health).

Led by a director general, these are under the statutory control of the Ministers for Health, Health Insurance, the Elderly and the Disabled. The ARS are responsible for producing the regional health project which must be consistent with the national health policy and ensure the implementation of the programmes and actions adopted. The regional health project consists of a “regional strategic health plan”, some “regional schemes” in the areas of prevention, organisation of care and health/social support and “programmes” defining the specific ways in which these schemes will be run.

Two coordinating commissions have been created within the ARS to whom the ARS director general must refer before adopting the regional health plan. The remit of these commissions includes the areas of prevention, school health, occupational health, mother and child protection and social and care support.

The law also stipulates the introduction of the “regional health and independence conference” which is the designated ARS consultative body, which can make any proposals to the ARS director on the drawing up, implementation and assessment of health policy within the region. The regional conference is also responsible for organising the public debate on its choice of health issues and guaranteeing that representatives of health system users can express their opinions within it. The opinions of the conference are made public. These legal measures have come into force since application of Order no. 2010-177 of 23 February 2010, coordinating with law no. 2009-879 of 21 July 2009 (Official Journal of 25 February 2010).

Within this framework, pursuant to article L.3411-1 of the CSP, **the ARS are responsible for the healthcare of drug users**. The current CPS also stipulates that, *“the case of a person illegally using narcotics may be referred to the director general of the ARS either by a doctor's certificate or through a social worker's report.... In this case, he/she must undertake a medical evaluation and an assessment of the family, occupational and social life of the person concerned”*. Following the result of the medical examination, the director of the ARS must require the drug user to attend an accredited centre to follow a detoxification course or place him/herself under medical supervision (Art. L.3412-1 to L.3412-3). If the legal authorities pronounce a court-ordered treatment or a medical surveillance measure they

⁹ <http://www.ofdt.fr/ofdtdev/live/publi/pointsur.html>

¹⁰ Loi n° 2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires (NOR : SASX0822640L).

must inform the director of the ARS. The director of the ARS is also responsible for ensuring that the person concerned undergoes a medical examination by the “médecin relais” (intermediate doctor), whose role and tasks are stipulated in law no. 2007-297 of 5 March 2007, art. 47).

Since the adoption of the July 2009 law, the ARS are responsible for defining and organising the prison care (art. 55 of prisons’ law¹¹ no. 2009-1436 of 24 November 2009).

In addition, the HPST¹² approves the adoption of the measures required to modify the terms of the sports code on the health of sportsmen/women and the fight against doping (art. 85). In this context, Order¹³ no. 2010-379 of 14 April 2010 strengthens the measures for health protection and medical monitoring of sportsmen/women.

In terms of the fight against trafficking of doping substances, the April 2010 Order modifies articles L. 232-9 and L. 232-10 of the Sports Code and prohibits the possession or use of doping agents which appear on the list of prohibited substances and methods listed in the international agreement and prohibits the prescribing, administration or supply of these substances. The April 2010 Order harmonises and clarifies some of the terms of the World Anti-Doping Code which has been in application in France since 1st January 2009¹⁴. This Order therefore brought the terms of the French Sports Code in line with the principles of the World Anti-Doping Code.

International co-operation to combat narcotics trafficking, law¹⁵ no. 2009-1188 of 7 October 2009 ratified the international agreement of September 2007 creating an operational centre for analysis of maritime narcotics information. France signed this agreement alongside five other European states, (the Netherlands, Spain, Italy, Portugal, and the United Kingdom, including Northern Ireland).

In addition, law¹⁶ no. 2009-411 of 16 April 2009 approved the agreement between France and the international criminal police organisation Interpol, renewing the presence of these international organisations in France.

A proposed law to combat organised crime and major trafficking intended to facilitate legal seizure and confiscation. The proposed law was adopted on 28 June 2010 unanimously by the National Assembly. This paper proposes the adoption of a modernised extended procedural framework for patrimonial investigations and facilitates the application of sanctions against profits from crime.

¹¹ Loi n°2009-1436 du 24 novembre 2009 pénitentiaire (NOR:JUSX0814219L).

¹² The July 2009 HPST law introduced new arrangements to limit access of young people to alcohol and tobacco (prohibiting sales of alcohol to minors under 18 years old, limiting sales in service stations, advertising on the internet, prohibiting sales of flavoured cigarettes). This report does not consider these aspects of French legislation as it does not consider measures on legal drugs. New legislative changes have also dealt with non-substance addiction: the online gambling sector was opened to competition and regulation in 2010 (law no. 2010-476 of 12 May 2010). For the same reasons these aspects will not be discussed further in this report.

¹³ Ordonnance n° 2010-379 du 14 avril 2010 relative à la santé des sportifs et à la mise en conformité du code du sport avec les principes du code mondial antidopage (NOR : SASV1001939R).

¹⁴ For further details on the precise content of the Order, see the report to the President of the Republic on Order No. 2010-379 of 14 April 2010 on the health of sportsmen/women and harmonising the sports code with the principles of the World Anti-Doping Code (NOR:SASV1001939P).

¹⁵ Loi n°2009-1188 du 7 octobre 2009 autorisant la ratification de l'accord entre l'Irlande, le Royaume des Pays-Bas, le Royaume d'Espagne, la République Italienne, la République portugaise, la République française et le Royaume-Uni de Grande Bretagne et d'Irlande du Nord établissant un centre opérationnel d'analyse du renseignement maritime pour les stupéfiants. (NOR : MAEJ0830839L).

¹⁶ Loi n°2009-411 du 16 avril 2009 autorisant l'approbation de l'accord entre le gouvernement de la République française et l'Organisation internationale de police criminelle-Interpol relative au siège de l'organisation sur le territoire français (NOR: MAEJ0821535L).

1.2.2. Laws implementation

Prevention of delinquency at school: Several circulars have been adopted over the period 2009-2010. Circular¹⁷ of 8 June 2009 stipulates meetings co-chaired by the Prefect (senior local government officer) and public prosecutor to define operational safety directives. The chief education officers and directors of the *département* national education services are also invited to take part in these meetings, particularly to be able to take account of local difficulties in educational establishments. The circular¹⁸ of 23 September 2009 from the Minister of National Education also established the need to adopt a safety plan for the 184 second level establishments falling within the scope of the national prevention plan for delinquency and to assist victims and the partnership policies of the Home Office, Overseas departments and territories and Territorial Communities and the Ministry for National Education. Finally, the circular¹⁹ of 15 February 2010 recalls priorities for action, and sets objectives and timescales for these to be achieved. The four beacon measures announced in the circular of February 2010 are safety diagnostics, training in safety problems and crisis management and finally the introduction of mobile teams and “school safety” representatives. The safety representatives are “reference” local and national police and gendarmerie officers who, amongst others things, are responsible or organising preventive actions on drug addictions.

The decree²⁰ of 21 September 2009 on “médecin relais” (intermediate doctor) is also part of the continuation of measures applying the terms of law no 2007-297 on the prevention of delinquency of 5 March 2007. The intermediate doctors who are responsible for the health monitoring of court-ordered treatment handed out by the legal authorities are required to justify their monitoring activities to the Ministry of Health (numbers of patients followed up, number of interviews, etc.) in order to receive payments for these. The annex to the decree contains the activity report to be completed by the intermediate doctors on their follow up activities.

Public authorities’ vigilance to the emergence of new potentially dangerous substances: Since the end of 2008 the Health Authorities have taken several decisions. In 2009, “Spice²¹” (also known as Gorilla or Sence) was classified as a narcotic, followed in 2010 by “Tapentadol and its salts²²” and “4-methylmethcathinone or mephedrone and its salts²³”. In addition, “Butorphanol²⁴” was added to the list of psychotropic substances. The following substances were added to the list of systemic substances²⁵: “Bazedoxifene”, “Catumaxomab”, “Eslicarbazepine”, “Mifamurtide” and “Tramadol”. Since 25 January 2010, some medicinal products containing fentanyl²⁶ must be dispensed in fractionated amounts.

¹⁷ Circulaire du ministère de l’Intérieur, de l’Outre-mer et des Collectivités territoriales et du ministère de l’Education nationale relative à la sécurisation des établissements scolaires et au suivi de la délinquance du 8 juin 2009 (NOR : IOCK0912892/J).

¹⁸ Circulaire n° 2009-137 du 23-9-2009 du MEN - DGESCO B3-1, RLR : 552-4 (NOR : MENE0922207C).

¹⁹ Circulaire n° 2010-25 du 15-2-2010 du MEN - DGESCO B3-1, RLR : 552-4 (NOR : MENE1003863C).

²⁰ Arrêté du 21 septembre 2009 relatif à la rémunération des médecins relais (NOR : SASP0906176A).

²¹ Arrêté du 24 février 2009 modifiant l’arrêté du 22 février 1990 fixant la liste des substances classées comme stupéfiants (NOR : SASP0904649A).

²² Arrêté du 11 mai 2010 modifiant l’arrêté du 22 février 1990 fixant la liste des substances classées comme stupéfiants (NOR : SASP1012703A).

²³ Arrêté du 7 juin 2010 modifiant l’arrêté du 22 février 1990 fixant la liste des substances classées comme stupéfiants (NOR : SASP1014839A).

²⁴ Arrêté du 12 juin 2009 modifiant l’arrêté du 22 février 1990 fixant la liste des substances psychotropes (NOR : SASP0913395A).

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

²⁶ Arrêté du 25 janvier 2010 relatif au fractionnement de la délivrance de certains médicaments à base de fentanyl (NOR : SASP1002259A).

Sports environment, decree²⁷ no. 2009-93 of 26 January 2009 contains the new 2009 list of prohibited substances and methods. Decree²⁸ no. 2009-459 created a central police office to combat doping when the substances used by sportsmen/women are not those classified as narcotics by the Minister of Health's decree.

The telephone service **“Addictions drogues alcool info service” (drugs and alcohol addiction information service)** which has historically been under the auspices of MILDT became a public service of the Ministry of Health by the decree²⁹ of 9 November 2009. This service is now funded by the National Institute for Health Education and Prevention (INPES) and is under its direct authority. It brings together different Ministries and national associations in its administrative council.

Funded by MILDT, **two other former operators have had their mandates renewed** for a period of three years: the “Interministerial training centre for the fight against drugs” (CIFAD) by the decree³⁰ of 3 August 2009 from the Ministry of Health and Sports and the French Monitoring Centre for Drugs and Drug Addictions (OFDT) by the decree³¹ of 2 June 2010 from the Prime Minister.

The Ministry for Health and Sports has in the past had **a number of advisory commissions responsible for bringing their expertise to priority public health questions**. The decree³² of 6 June 2009 **has extended their mandates** for a further 5 years. The organisations affected by this June 2009 decree which have skills in prevention and management of addictions are the narcotics and psychotropics commission, the National AIDS council and the Committee of regional reference centres to combat infectious diseases.

1.3. National action plan, strategy, evaluation and coordination

1.3.1. National action plan and/or strategy

Guidance for actions on drugs at national level

The Inter-Ministerial strategic directions on drugs promoted in 2009 by the government are those set out in the 2008-2011 government “drugs” plan (see “National FR report, 2008”). This plan’s “health” section restates the measures adopted by the Ministry of Health in its 2007-2011 “addictions” plan (see “National FR report, 2007”). Two other national action plans, also under the statutory control of the Health Authorities, have recently strengthened the health measures in the 2008-2011 government “drugs” plan, specifically in the areas of prevention and treatment of hepatitis and cancer.

2009-2012 “Hepatitis” plan

In preparation since 2007, the national hepatitis B and C plan was released on 24 February 2009 by the Ministry of Health. The hepatitis plan is intended to last for a period of four years

²⁷ Décret n°2009-93 du 26 janvier 2009 portant publication de l'amendement à l'annexe de la convention contre le dopage, adopté le 13 novembre 2008 à Strasbourg, et à l'annexe 1 de la convention internationale contre le dopage dans le sport, adopté le 17 novembre 2008 à Paris (NOR : MAEJ0901116D).

²⁸ Décret n°2009-459 du 22 avril 2009 modifiant le décret no 2004-612 du 24 juin 2004 portant création d'un Office central de lutte contre les atteintes à l'environnement et à la santé publique (NOR : DEFD0905527D).

²⁹ Arrêté du 9 novembre 2009 du ministère de la santé et des sports approuvant la création du groupement d'intérêt public « Addictions drogues alcool info service » (NOR : SASP0925133A).

³⁰ Arrêté du 3 août 2009 du ministère de la santé et des sports, portant approbation de la reconduction de la convention constitutive du groupement d'intérêt public dénommé « Centre interministériel de formation antidrogues » (NOR : SASC0917762A).

³¹ Arrêté du 2 juin 2010 du Premier ministre, portant approbation des modifications de la convention constitutive du groupement d'intérêt public « Observatoire français des drogues et des toxicomanies » (NOR : PRMX1013875A).

³² Décret n° 2009-631 du 6 juin 2009 relatif à certaines commissions administratives à caractère consultatif relevant du ministère de la Santé et des Sports (NOR : SASX0912394D).

(2009-2012) and follows the National hepatitis C plan (1999-2002), the national hepatitis B and C programme (2002-2005) and the measures taken on 8 December 2005 on this subject. The priority populations for the plan include drug users, particularly injectors, as drug use is considered to be the main pattern of transmission of HCV. People with other at risk behaviours (multiple sexual partners) and who are vulnerable or in prison are also major targets for the plan.

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

The strategy required a combination of improved prevention and more accessible screening, while improving access to effective treatments and to care. The new hepatitis plan established priorities of reducing HCV and HBV transmission, increasing screening and access to care and introducing additional measures suitable for prisons. The plan pays particular attention to the quality of care and quality of life of people suffering from chronic hepatitis B and C. The 2004 public health law set other, more specific objectives for hepatitis involving reaching 80% primary vaccination cover against hepatitis B in children and 75% in 15-year-old adolescents. It also aimed to increase screening of people infected with the hepatitis virus by 25% and to reduce the prevalence of HCV infections in illegal drug users under 25 years old by at least 20%. The HCSP assessment report also examined the achievement of these objectives. Their conclusions and proposals will be used to produce the next public health law which will set the main orientations of health authority policy, including addictions. The hepatitis plan also envisages an inter-organisational monitoring committee responsible for its assessment. This task will be given to an external assessor and is intended to be in operation in 2012.

2009-2013 “Cancer” plan

The other plan adopted in 2009 in hepatitis prevention is the 2009-2013 cancer plan, launched by the President of the Republic on 2 November 2009. A budget of €732,659 M has been allocated to this plan in order to achieve the 118 actions programmed over a period of five years. The 2009-2013 cancer plan was produced from the report by Prof. Jean-Pierre Grünfeld (Grünfeld 2009) and is a continuation of the previous cancer plan (2003-2007), building on its achievements and adding new approaches, particularly to address the three major challenges which are the three horizontal priority themes in the plan:

- to take account of health inequalities for greater care equity and effectiveness in all measures to combat cancer;
- to analyse and take account of individual and environmental factors in order to personalise the health response before, during and after the disease;
- to increase the role of the general practitioner at all steps in care, in particular to help to improve life during and after the disease.

Guidance for actions on drugs at local level

The 2008-2011 government “drugs” plan sees the cascading of its national strategic directions in the local “drugs” plans. The “chef de projet départemental” (local drug project leader) working under the authority of the Prefect of the *département*³³ is responsible for producing the “plan départemental” (drugs local plan). The local drug project leader is also responsible for relaying national policy and adapting it to local situations and features. The plans are produced in a local steering committee which brings together the different

³³ Note n° 578 of 18 September 2008 from the President of MILDT for the attention of *département* project leaders. Copies to Prefects of *départements*.

State services. The monitoring committee is also responsible for seeking coherence with the existing specific plans in the *département* (social cohesion contracts, road safety plans, delinquency prevention measures, town contracts, public health programmes, planning on regional ambulatory and hospital care organisation and regional health/social care services and facilities). Measures in the local plans which fall within the usual activities of the decentralised services or national health insurance funds are funded from their respective budgets. Experimental activities from the inter-ministerial projects which bring together the decentralised services around common objectives such as inter-ministerial training, common information tools, prevention and knowledge for all services, are funded from devolved MILDT monies (€15 M in 2009 and €13 M in 2010). **The MILDT note³⁴ of 4 November 2009 to local drug project leaders** reaffirms their legitimate right to run the local activities by the administrative and institutional organisations and provides guidance for actions in 2010:

- **For prevention**, the emphasis must be placed on local actions to relay the messages from national communication campaigns in 2009 or those envisaged for 2010 about substance danger, the legal status of substances and parental role. A major additional part of the local plan is to mobilise the local social partners to drive preventive activities in the workplace and activities promoting the involvement of adults in prevention of drug use. Continuing on from the strategic directions of 2008 and 2009, the project leaders are responsible for developing preventive activities with schools and universities, leisure centres and particularly in populations in the hands of the legal system. As part of the delinquency prevention policy driven by the government “drugs” plan, development of awareness building training courses in the dangers of drug use for occasional users is being strongly encouraged.
- **In terms of health policy**, the local drug project leaders are encouraged to act in coordination with the regional project leader, the preferred contact for the regional health authorities. Since the HPST³⁵ law of July 2009 which established the principle of regionalising care systems (see 1.2.1), health actions must be planned and assessed regionally. In this situation it is the responsibility of the local drug project leader to ensure that local health activities contained in the regional programme meet the requirements of users in the *département* in terms of health education, care offered, social support and harm reduction.
- The local plan must also incorporate **activities to combat local dealing**. More specifically, it must target places where minor dealing, feeding into the black economy commonly occurs, which generates significant social nuisance, particularly at entrances to schools. The local drug project leader is responsible for mobilising local and regional workers in their efforts to combat dealers and their criminal assets.

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

Implementation and evaluation at national level

At the beginning of 2010, MILDT produced an initial interim report (Deugnier et al. 2010) of its activities to apply the national strategic directions from the government “drugs” plan. This initial report showed that 50% of the 193 measures in the plan had been achieved.

Information, communication, prevention

In information and communication, two “general public” national campaigns have been orchestrated by MILDT in October and November 2009: the *“Drogue, ne fermons pas les yeux”* campaign and the *“La drogue, si c'est interdit, ce n'est pas par hasard”* campaign (see chapter 3.5). In the field of prevention, the government plan intended to engage parents

³⁴ Note n° 683 of 4 November 2009 from the President of MILDT for the attention of *département* project leaders. Copies to Prefects of *départements*.

³⁵ Loi n°2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires (NOR : SASX0822640L).

together with actors in both management and labour concerned by addictions in the workplace in preventing addictive behaviour. Driven by this objective, MILDT placed these two subjects at the heart of its main forums and debates organised in 2009. These initial discussions with institutional players and actors in management and labour were used to prepare the two workshops which appear on the MILDT agenda for 2010: one on parenting and the other on addictions in the workplace (see chapter 3).

Law implementation and combating trafficking

Adopted by the delinquency prevention law of 5 March 2007, the “drug awareness-building compulsory training course” measure for occasional illegal drug users continued its impetus after a series of awareness-raising activities for the prosecution services. The MILDT summary indicates that several thousand people attended a training course.

In combating trafficking, international cooperation has been strengthened by common investigation teams to combat cross-border crime. The review produced by MILDT listed around twenty international teams at the end of 2009. The Mediterranean anti-drugs co-ordination centre also came into service in 2009 and two European liaison officer platforms to exchange information on international narcotics trafficking were opened. Targeted drug money activities were also carried out in 2009: organisational and training measures on the “Regional Intervention Group” (GIR) intended to improve the seizure system for criminal assets, awareness-raising activities for trafficking suppression service workers and funding for different countries considered to be knowledgeable in combating narcotics trafficking.

Care

In 2009, MILDT and the Health Authorities adopted experimental programmes for particularly vulnerable members of the public (young people in difficulties, people in prison, pregnant women and women with children, people experiencing social difficulties, etc.) within the health/social care system. These programmes covered around twenty cannabis clinics for young users in the CSAPA, around ten “Points écoute jeune” (Youth counselling and prevention consultations), four advanced consultations for women with children in residential social centres, one specialist team for women to promote addictions screening and access to support programmes, two centres providing immediate support for people in prison, etc. These programmes are being implemented in 2010.

Implementation and evaluation at local level

The MILDT note of 4 November 2009 to the local drug project leaders recalled the merits of assessing new projects, so that these could continue or new projects be adopted. The task of assessing activities conducted in 2009 was given to a commission working under the Prefect. This commission is intended to delegate the assessment task to a specialist sub-commission which would then be responsible for defining the strategies and projects to follow from January 2010 in their jurisdiction. The MILDT note of 2009 also recalls the need to introduce a methodological support mechanism in each region for project leaders intended to inform their strategic choices and produce relevant indicators to assess their effectiveness. This system integrates the methodological advice and observation work of the Centres for Information and Resources on Drugs and Addictions (CIRDD) which had been established by MILDT in 2005. **The MILDT³⁶ note of 28 July 2009 for the attention of regional drug project leaders** renewed the former regional support system provided by the associations in order to move from a network funding process to a system of funding projects and strengthening the interministerial nature of the system. The note also stipulates that a sum will be put at disposal by MILDT for the regional drug project leaders. This will be used to fund the organisation adopted from the call for tenders for a service agreement. In 2009, the CIRDD budget was €2.8 M and the regional allocation for tenders will remain the same in 2010.

³⁶ MILDT note n° 451 of 28 July 2009 for the attention of regional project leaders copied to the Prefects

1.3.3. Other drug policy developments

In the area of harm reduction, the adoption of the 2009-2012 “hepatitis” plan caused unhappiness amongst the main groups involved in harm reduction and former drug users from the associations. The AFR (French Association for Harm Reduction), ASUD (Drug user self support Association) and AIDS (French AIDS and hepatitis association) **press release of 25 February 2009** under the banner “the 2009-2012 hepatitis plan does not respond to the urgency of the hepatitis C epidemic” carried the main demands of fieldworkers, users and patients although they had been consulted by the health authorities when the plan was written. Their proposals envisaged setting up new experimental programmes such as ERLI³⁷ (Education programme on injection-related risks) or starting syringe exchange programmes in prisons. Another major demand of the associations was the opening of drug consumption rooms. The merits of providing drug consumption rooms for the most vulnerable users was recalled by the association workers in the World Hepatitis Day on 19 May 2009 and an initial demonstration was given in the ASUD premises on the same date.

In order to ask the Mayor of Paris and Ministry of Health to open user rooms in Paris, a **second press release** signed by the ASUD, ANITeA, ACT UP Paris, Gaïa Paris and SOS Hépatites Paris associations has been posted on the internet since 19 May to collect as many signatures from French people as possible. The second mass media campaign from the associations to increase awareness and inform the public and public bodies about the merits of caring for the users in greatest difficulty took place during the ANITeA workshops (National Association for Drug Abuse and Addictology Workers) on 11 and 12 June 2009. In this context, a new SCMR was opened in the “Cité des sciences et de l’industrie” in the ANITeA workshops. **The last association press release “Drug consumption room in Paris, 19 May” (15 December 2009)** reported new advances, particularly the undertaking by the Mayor of Paris to conduct a study which should enable user rooms to be opened and restating the desire of the association community to continue activities supporting these programmes.

1.3.4. Coordination arrangements

National interministerial coordination

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

Local interministerial coordination

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

³⁷ http://www.sidaparoles.org/IMG/pdf/Protocole_ERLI-2.pdf et http://www.sidaparoles.org/IMG/pdf/ERLI_L-avis_des_UD.pdf

1.4. Economic analysis

1.4.1. Public expenditure

The budget resources allocated to combat drugs and drug addiction come mostly from the State and the Assurance maladie (National Health Insurance Funds).

State funds

The financial contribution from the State to apply the drug policy relies on funds allocated to MILDT and to the Ministries concerned. Locally, the MILDT and Ministers devolve part of their funding to the local drug project leaders and decentralised state services respectively. The public funds allocated in 2009 for action in drug are contained in the “drugs” DPT annexed to the 2010 finance law.

MILDT funds

The sums allocated to MILDT are intended to drive and coordinate the interministerial activities to combat drugs, both nationally and locally. They are intended to fund common information, communications, scientific knowledge and training tools provided by MILDT to the Ministries concerned. They are also used to fund supporting actions to run new projects in the areas of prevention, health and social care, respect of the law and the fight against national and international drug trafficking. MILDT also devolves some of its funding to the drug project leaders (“Chefs de projet”) to apply the national policy on a *département* level. MILDT’s budget for 2009 was **€31.27 M**. The budget voted for 2010 is €29.78 million (PLF 2010). The funds awarded in 2008 were €25.58 million.

Ministerial funds

The contribution from ministries and decentralised services to the transverse drug and drug addictions policy in 2009 was estimated to be **€93.85 M** although this figure should be interpreted with caution: these sums involve around thirty ministerial programmes and the funding contribution to the transverse policy was estimated by each senior ministerial officer responsible for running the programme and the estimation methods used vary between programmes. This figure also does not include all of the funding allocated as it was not possible for some programmes (7 out of 28) to establish the proportion which was used specifically to run the drug and drug addictions policy. The budget voted for 2010 (PLF 2010) is €902.198 million. The budget allocated for 2008 was €864.080 million.

Assurance maladie funds

Public health resources from the Assurance maladie also need to be added to the State’s funding contribution towards combating drugs and drug addiction. These are funds allocated to health and social care and harm reduction policy for drug users which is mostly delivered by the addictology health/social care sector³⁸. The Assurance maladie also contributes to expenditure incurred by the prevention and treatment of addictions policy by reimbursing drugs used for substitution treatment. It also funds health and social care establishments to apply the measures from the specific national drug health plans (2007-2011 “addictions” plan, 2008-2011 government “drugs” plan, 2009-2012 “hepatitis” plan).

Addictology structures

The funding for the addictology structures in 2009 was **€286.67 M**, €270.34 M of which were allocated to pay staff and regular functioning expenditures of the existing structures, €13.3 M were intended to strengthen existing or create new CSAPA and CAARUD in accordance with the measures planned for 2009 in the 2007-2011 addictions plan, **€2.8 M**³⁹ to apply the

³⁸ Since the adoption of the 2004 public health law, the social security funding law must now include a new budget station to fund addictology medico-social establishments (ONDAM medico-social specific).

³⁹ Circulaire interministérielle n°DGS/MC2/DGAS/DSS/MILDT/2009/372 du 14 décembre 2009 relative à la sélection de projets dans le cadre de l’appel à projet pour la mise en œuvre des mesures relatives aux soins, à

implementation of health measures stipulated in the 2008-2011 government “drugs” plan and €0.2 M for the 2009-2012 “hepatitis” plan to purchase hepatitis B vaccines (see table below):

Table 1-1: Budget allocated to addictology structures for 2009 (Assurance maladie funding law)

Type of measure	Funding (in Euros)
	ONDAM for addictologie structures
Expenditure of existing CSAPA and CAARUD in staff and regular functioning	2,700,340
New CSAPA and CAARUD (budget allocated to measures in the addictions plan for 2009)	13,300,000
Purchase of hepatitis B vaccines (budget allocated to measures in the hepatitis plan for 2009)	200,000
Budget allocated to new measures for the health and social part of the 2008-2011 government plan for 2009	2,828,360
Split out in (1 à 8):	
Measure #1. New cannabis clinics for young users attached to the CSAPA of which:	669,615
Action #1.1. CJC in priority areas	396,866
Action #1.2. CJC in Youth Counselling Consultations (PAEJ)	69,297
Action #1.3. CJC in the structures receiving young people under legal protection and protection of youth (PJJ) and social assistance for childhood (ASE)	203,452
Measure #2. Advanced CSAPA consultations in residential social, reintegration centres receiving parents with children.	218,915
Measure #3. Specific programmes for women with children in CSAPA and CAARUD	117,426
Measure #4. Mobile early parent child care team	173,468
Measure #5. Short term rapid access reception programmes for people living prison	582,298
Measure #6. Reception for people leaving prison in the residential integration reception system (AHI)	9,000
Measure #7. Partnership between CSAPA, CAARUD and AHI structures	57,638
Measure #8. Creation of a therapeutic community	1,000,000

Hospital

In addition, hospitals received funding in 2009 of 24.67 million Euros as part of the Assurance maladie funding for health establishments to apply the following measures contained in the 2007-2011 “addictions” plan and the 2008-2011 government “drugs” plan⁴⁰:

- 10.16 million Euros to create or strengthen hospital addiction consultations;
- 9.24 million Euros to fund hospitalisations for complex withdrawal;
- 4.62 million Euros to create or strengthen addictology, care and liaison teams;
- 0.6 million Euros to set up a weekly specialist session in addictology in the UCSA for 100 prison establishments;
- 0.05 million Euros for training activities in the care of drug addict populations for health professionals;
- reimbursements of “Opiate substitution treatments”.

l'insertion sociale et à la réduction de risqué du plan gouvernemental de lutte contre les drogues et les toxicomanies 2008-2011 concernant le dispositif médico-social en addictologie.

⁴⁰ Circulaire n°DHOS/F2/F3/F1/DSS/1A/2009/78 du 17 mars 2009 relative à la campagne tarifaire 2009 des établissements de santé.

The social security system also reimburses drugs required for opiate substitution treatment, which forms a significant proportion of the Assurance maladie's expenditure for addictions. The most recent data published by the Assurance maladie relates to the reimbursement amounts for 2006, a figure of **€37.454 M**, 77.637 million of which were for reimbursements for buprenorphine and 9.818 million for methadone.

1.4.2. Budget

Amounts allocated to the support funds in 2009 from the sale of goods confiscated from legal narcotics proceedings were **€11.4 M** in 2009, the highest since this scheme was started in 1995. The support funds were redistributed by MILDT, 90% to the ministries responsible for combating trafficking and applying the law to fund procurement of equipment or services to combat drugs. The remaining 10% can be used to fund preventive activities carried out by the ministries concerned. In 2009 these receipts were divided between the ministries as follows: Ministry of the Interior (35%), Ministry of Defence (25%), Ministry for Justice (20%), Ministry of Finance (10%) and Ministry of Social Affairs(10%).

1.4.3. Social costs

At the initiative of the French Monitoring Centre for Drugs and Drug Addiction, the social cost of legal and illegal drugs have been published for around ten years. The first study (KOPP et al. 1998) dates back to the 1990s and examined the possible calculation methods (Kopp and Palle 1998). The initial estimates were presented in the Kopp and Fénoglio report (KOPP et al. 2000) on *the social cost of drugs*. This initial work estimated the annual costs to society to be €2,035.24 M. Regular re-estimates have been carried out since then. There are two reasons for the need to continually re-estimate these figures: firstly the publication of new data which were initially not available (for example, treatments of some diseases) and secondly, the need to take account of new calculation methods suggested by the public discussion on the previous results. Since then, further estimate was conducted: Kopp and Fenoglio⁴¹ (2004) estimated the social cost of illegal drugs to be €2,333.54 M and in 2005, the last work conducted by the same authors (Kopp et Fenoglio, 2006)⁴² re-estimated the social cost to be €2,824.44 M.

⁴¹ <http://www.ofdt.fr/BDD/publications/docs/epfxpkk6.pdf>

⁴² <http://www.ofdt.fr/ofdtdev/live/publi/rapports/rap06/epfxkm5.pdf>

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

2.1. Introduction

Drug use among the adult population

Though virtually non-existent in the early 1990s, surveys covering a representative sample of the population dealing with the use of psychoactive substances and their perception of drugs had developed significantly in France by the end of the last century. In several reports, the absence of such surveys was seen as the most obvious shortcoming in a system based largely on data derived from the health, social, security and legal institutions. (FAUGERON et al. 2002; HENRION 1995a; PADIEU 1995).

Indeed, only surveys carried out with a representative sample of French adults really make it possible to assess the level and type of use of such products among the population. The French Monitoring Centre for Drugs and Drug Addiction (OFDT) has been heavily involved in this area since 1997 in order to develop a device (system) offering both the reliable barometric monitoring of drug use and a quantitative overview of the main factors involved. Declaration-based surveys play a useful role in representing the general population in the monitoring of addictive behaviour in several ways. These include:

- quantifying the use levels for the various products;
- describing the diverse nature of drug use;
- assessing links with other factors;
- tracking changes and emerging trends over time.

Table 2-1 offers an overview which clearly ranks products in terms of the number of users. These figures are orders of magnitude and should be considered as such. Indeed, a margin of error exists, although this remains reasonable. For example, 12.4 million people have experimented at least once with cannabis during their life (lifetime use) means that the number of people actually experimenting with the drug is situated somewhere between 11.9 and 12.9 million. As we clearly see, it tends to be the legal substances (alcohol and tobacco) which are the most widely circulated among the population, but also those most frequently used (whether this concerns regular use or daily use). It appears that people experiment less often with tobacco than with alcohol although tobacco is far more frequently used on a daily basis, once again highlighting its highly addictive nature. Psychotropic medicines constitute a category all of their own due to the wide variety of uses encountered with them, these ranging from scrupulously respected medical prescriptions to illegal misuse (particularly in combination with alcohol), not forgetting usage on therapeutic grounds, although without a medical prescription. They tend to lag far behind the others in terms of use levels but nevertheless affect far more people than the illegal substances, with more than 8 million annual users. Cannabis is the main illegal substance circulating in France, with a prevalence level 10 times higher than cocaine and ecstasy and 20 times higher than heroin. More than half a million people use this drug on a daily basis.

Table 2-1: An estimate of the number of users of psychoactive substances in metropolitan France among 12- to 75-year-olds.

	Alcohol	Tobacco	Cannabis	Psychotropic medicines	Heroin	Cocaine	Ecstasy
Experimenters	42.5 M	34.8 M	12.4 M	15.1 M	360,000	1.1 M	900,000
Occasional	39.4 M	14.9 M	3.9 M	8.7 M	//	250,000	200,000
Regular	9.7 M	11.8 M	1.2 M		//	//	//
Daily	6.4 M	11.8 M	550,000		//	//	//

Sources: ESCAPAD 2008, OFDT; ESPAD 2007, INSERM/OFDT; EROPP 2002, OFDT; 2005 Health Barometer Survey, INPES, Data processed by the OFDT.

Caption:

- //: not available

- Experimenters: persons stating that they have used the substance at least once during their lives

- Occasional: used during the year (except tobacco: current smokers)

- Regular: alcohol consumed at least three times during the week for the adults and at least 10 episodes of use during the month for teenagers, daily tobacco use, sleeping tablets or tranquillisers used at least once during the week, cannabis used at least 10 times during the month

- Daily: daily use (except medicines: used "daily or almost" during the month)

NB: the number of individuals aged 12-75 years old in 2005 was approximately 46 million

Use among the teenage population

The teenage years are the time at which youngsters begin experimenting with psychoactive substances and occasionally move onto more regular use. Based on a self-administered and strictly anonymous questionnaire, the Survey on Health and Use on Call-up and Defence Preparation Day (ESCAPAD) provides an overview of use levels for psychoactive substances among young people aged 17, and presents recent changes in these practices by late adolescence. For its part, the European School Survey Project on Alcohol and Other Drugs (ESPAD) makes it possible to study usage by young people still at school, particularly those aged 16 (most of whom are still at school). Finally, the Health Behaviour in School-aged Children (HBSC, see Appendix V-E) survey carried out in 41 countries or regions throughout the Western world surveys pupils aged 11, 13 and 15 years old attending schools in mainland France concerning their health-related behaviour and their use of psychoactive products. Consequently, these three surveys make it possible to monitor the spread of drug use throughout the teenage years, between the ages of 11 and 17, and particularly the regular use of tobacco, alcohol and cannabis. However, it is in the late teenage years (17 years old) that the monitoring of use-related behaviour enables us to better distinguish those individuals who are fully-fledged drug users from those who have not chosen to use drugs.

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

Levels of drug use in the general population

Results of the last five-yearly general population survey in France (2010), the "Health Barometer" survey (see Appendix V-A) are currently being analysed. The data available from this survey date back to 2005 (BECK et al. 2006a). In 2005, 84.8% of 12- to 75-year-olds reported that they had consumed alcohol during the year, with an over-representation of males: 13.7% of French people reported that they drank daily – 20.3% of men and 7.3% of women. Smoking continued its downward trend, an almost-forty-year-old phenomenon: the proportion of 12- to 75-year-olds who reported that they smoked fell from 33.1% in 2000 to 29.9% in 2005. 30.6% of 15- to 64-year-olds in 2005 had used cannabis at least once in their lives. Conversely, experimentation with other illegal substances remains extremely low and is mostly seen in young adults. The different data available confirm that cannabis is the leading illegal drug used in France.

Table 2-2: Experimentation and use of psychoactive substances within the previous year, 15- to 64-year-olds in France in 2005 (%).

Substance	Experimentation	Use in previous year
Alcohol	92.2	86.0
Tobacco	78.2	NA
Psychotropic medicines	35.7	18.5
Cannabis	30.6	8.6
Poppers	3.9	0.6
Hallucinogenic mushrooms	2.7	0.3
Cocaine	2.6	0.6
Ecstasy	2.0	0.5
Inhalants	1.7	0.2
LSD	1.5	0.1
Amphetamines	1.4	0.2
Heroin	0.8	0.1
Crack	0.3	0.1

NA: not available. Source: INPES Health Barometer 2005, OFDT interpretation.

Opinions and beliefs about drugs

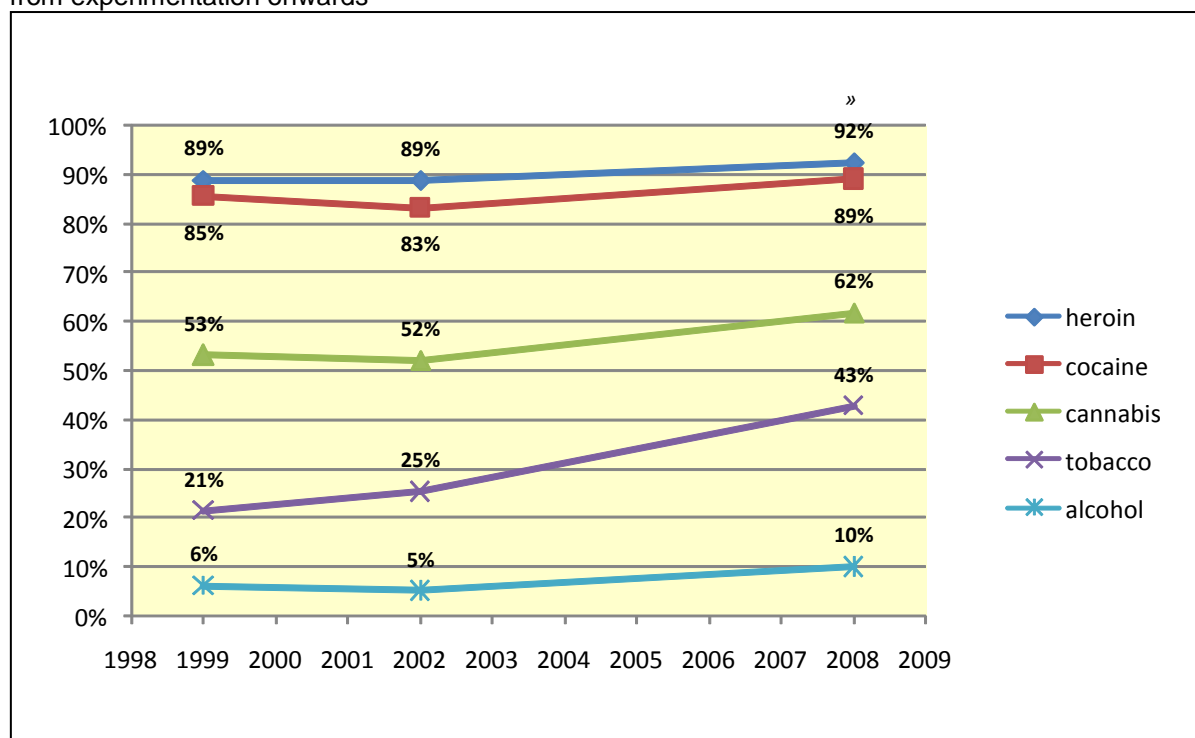
In its third edition, the EROPP survey (see Appendix V-J) reviewed changes in knowledge and opinions of French people on drugs and the main public actions undertaken in recent years. At the end of 2008, more than 2,000 15- to 75-year-olds, who were randomly selected, were questioned by telephone at home and invited to express their opinions by answering a questionnaire lasting about twenty minutes. The main subjects examined were the perception of danger linked to the use of psychoactive substances, fears aroused by such substances and opinions on current or future public policy measures taken in this regard.

Change in the perceived danger of drugs between 1999 and 2008

Overall, between 2002 and 2008, the feeling of the danger of experimenting with legal and illegal drugs has continued to increase (Costes, J. 2010). This perception, however, varies greatly, depending on the substance and its status.

Twice as many people as previously (10% vs. 5%) considered drinking alcohol to be harmful, from the very first drinks, in 2008. Its perceived danger, however, remains far less than for other substances. Negative opinions of cocaine and heroin with regard to their dangerousness have also increased, although these changes appear to be less significant given the very high proportion of people (over 80%) in 1999 and 2002 who already saw these substances as being associated with an immediate danger. We should note that, in 2008, a very large majority of people continued to consider heroin to be the most dangerous substance from initial experimentation onwards, still slightly ahead of cocaine (92% vs. 89%). The most pronounced increases were views on tobacco and, to a lesser extent, cannabis. 43% of people questioned now consider that even experimentation with tobacco is dangerous to health compared to only 25% in 2002. This 18-point rise was the largest found in the survey. The second very large rise (10 points) is that related to cannabis: 62% of people in the 2008 sample considered that experimentation with cannabis was harmful to health compared to 52% in 2002. These changes do not alter the ranking of the perceived danger of the substances. There are three clearly distinct groups: heroin and cocaine, which remain well in the lead of substances considered to be the most dangerous, followed by cannabis and tobacco, and finally alcohol, for which the change in perceived dangerousness remains small compared to the other substances, and which therefore lags far behind the others.

Graph 2-1: Change in perceived dangerousness of drugs between 1999 and 2009: “Percentage of people considering that use of tobacco, alcohol, cannabis, heroin or cocaine is dangerous to health from experimentation onwards”



Source EROPP 1999, 2002, 2008 – OFDT

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

In 2006, cannabis was the most widely used illegal substance by 15-year-old adolescents, 28% reporting that they had already taken cannabis at least once during their lives. More than 50% of the young people reported that they had used it in the previous month, more boys than girls (14% versus 11%).

With the exception of cannabis, experimentation with illegal or misused drugs remains rare (table 2-2). The most common products are solvents and inhalants accounting for 5% of experimenters, followed by cocaine or crack (3.0%), amphetamines, "medicines for getting high" (as they are referred to in the questionnaire) all hovering around the 2% mark, and lastly heroin and LSD, which are both below the 1% level. The residual category of "other products" is mentioned by 7.5% of young people although their content remains unknown. In particular, as already mentioned, the nature of these products is not known, (i.e. – whether they are psychotropic, illegal or overlapping with other product categories, and particularly with cannabis, which is known by a range of different names locally, according to its nature, its source and its quality).

Table 2-3: The use of illegal or misused products at the age of 15, over the last 12 months (%)

	Boys	Girls	Sex ratio	All
Inhalants	5	5	0.9 ns	5
Cocaine & crack	3	3	1.1 ns	3
Amphetamines	3	2	1.5 ns	2
Medicines for getting high	1	3.1	0.3***	2
Ecstasy	1	1	1.6 ns	1
Heroin	1	1	1.3 ns	1
LSD	1	1	0.8 ns	1

Key *, **, *** and ns: chi-2 test for a comparison of the sexes, respectively significant at the thresholds 0.05, 0.01, 0.001 and non-significant.

Source: HBSC 2006, processed by the OFDT.

For all of these products, the sex ratio is close to one and the variation between the sexes is non-significant, even for ecstasy and amphetamines (1.6 and 1.5 respectively), with the exception of "medicines for getting high", for which there is a higher propensity for experimentation among girls, as is the case for psychotropic medicines in general during the teenage years. The insignificant nature of the variations is chiefly due to the low numbers of experimenters concerned at this age (an age at which the distribution process is still largely incomplete). As such, this result is similar to that observed for experimentation with cannabis at the age of 11, which is rare, with users of both sexes.

Table 2-4: Tobacco, alcohol and cannabis use at 16 in 2007 (% and sex ratio)

	Boys (%)	Girls (%)	Sex ratio	Together (%)
Tobacco				
Experimentation (≥1 usage / life)	58	61	0,9 ns	60
Occasional use	11	15	0.7 **	13
Daily use	18	16	1.1 ns	17
Intensive use (≥10 cig./day)	5	4.6	1.1 ns	4.8
Alcohol and drunkenness				
Experimentation (≥1 usage / life), alcohol	89	88	1.0 ns	88
Alcohol ≥1 usage / year	82	81	1.0 ns	81
Monthly usage (≥1 usage / month)	66	62	1.1*	64
Regular use (10+/month) alcohol	18	9	2.1 ***	13
Experimentation (≥1 / life) drunkenness	47	45	1.1 ns	46
Drunkenness ≥1 / year	37	35	1.1 ns	36
Regular use (10+/year)	4.2	2.7	1.6 *	3,5
5 + drinks /single occasion during month	44	34	1.3 ***	39
Cannabis				
Experimentation (≥1 usage / life)	35	27	1.3 ***	31
≥1 usage / year	28	21	1.3 ***	24
Monthly usage (≥1 usage / month)	18	12	1.5 ***	15
Regular use (10+/month)	5.0	2.0	2.5 ***	3.5

Ns, *, **, ***: p-value for Chi² test for comparison between genders sexes: 0.05, 0.01 and 0.001.

Source: ESPAD 2007 OFDT-INSERM

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

	Boys 2008	Girls 2008	Sex ratio	All 2008	All 2005	Change 1 (05/08)	Change 2 (05/08)
Tobacco experimentation	70.5	71.0	1.0 ns	70.7	72.2	-2%	-1.5
Tobacco daily	29.9	27.9	1.1***	28.9	33.0	-12%	-4.1
Alcohol experimentation	93.5	91.7	1.0***	92.6	92.3	0.4%	0.3
Alcohol/month	80.5	74.2	1.1***	77.4	78.7	-2%	-1.3
Alcohol/regular (≥10 times per month)	13.6	4.0	3.4***	8.9	12.0	-26%	-3.2
Drunkness/lifetime	65.1	54.3	1.2***	59.8	56.6	6%	3.2
Drunkness/year	56.6	44.1	1.3***	50.5	49.3	2%	1.2
Drunkness/repeated (≥3 times previous year)	32.0	18.9	1.7***	25.6	26.0	-2%	-0.4
Cannabis/experimentation	46.3	37.9	1.2***	42.2	49.4	-15%	-7.2
Cannabis/month	29.5	19.8	1.5***	24.7	27.9	-12%	-3.2
Cannabis/regular (≥10 times per month)	10.7	3.9	2.7***	7.3	10.8	-32%	-3.4
Experimentation with							
Poppers	15.2	12.2	1.2***	13.7	5.5	148%	8.19
Inhalants	6.2	4.7	1.3***	5.5	3.6	54%	1.90
Hallucinogenic mushrooms	4.9	2.2	2.3***	3.5	3.7	-4%	-0.14
Cocaine	4.0	2.4	1.7***	3.3	2.5	29%	0.74
Ecstasy	3.6	2.1	1.7***	2.9	3.5	-18%	-0.63
Amphetamines	3.5	1.9	1.9***	2.7	2.2	24%	0.52
LSD	1.6	0.8	2.1***	1.2	1.1	10%	0.11
Heroin	1.4	0.8	1.9***	1.1	0.7	56%	0.39
Crack	1.3	0.7	1.7***	1.0	0.7	44%	0.31
Ketamine	0.8	0.4	2.1***	0.6	0.4	28%	0.12
Subutex®	0.8	0.3	2.5***	0.5	0.5	2%	0.01
GHB	0.5	0.3	1.6**	0.4	0.3	63%	0.17

Ns, *, **, ***: p-value for Chi² test for comparison between genders sexes: 0.05, 0.01 and 0.001.

Significant increases (p<0.05) are in bold types. Significant decreases are in italic.

1: Relative change computed with exact figures.

2: Changes computed with exact figures.

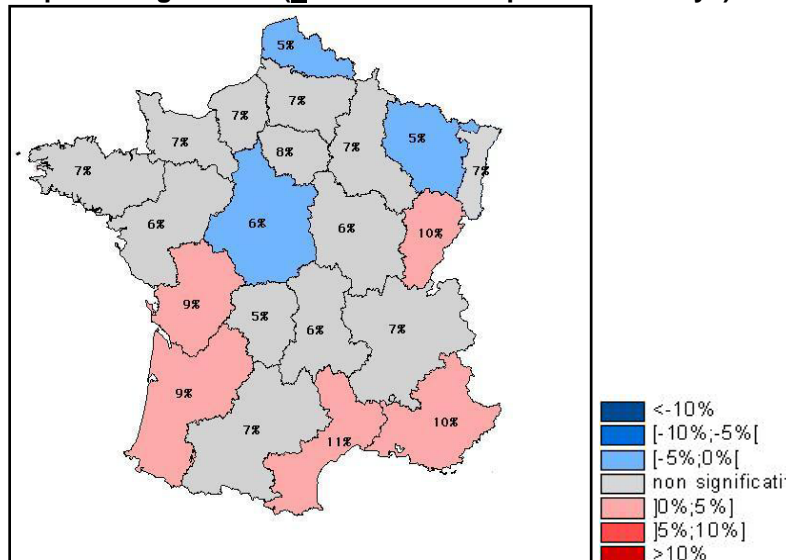
Source: ESCAPAD 2008 OFDT

HBSC and ESPAD surveys (Tables 2-3 and 2-4) produce similar results, despite some methodological variations between the two studies: important reductions of the diffusion of tobacco and cannabis use, stabilization or a possible decrease of alcohol drunkenness. For its part, ESCAPAD survey (Table 2-5) reveals a decline of alcohol regular use although it indicates also a slight increase of alcohol drunkenness over the past year. On the other hand, this survey reveals for the first time in eight years and increase of average ages of tobacco and cannabis experimentation. There probably is a change of behaviour in the first use of these substances.

There are nevertheless some worrying aspects, such as the dissemination of cocaine, amphetamines, crack, heroine and GHB, even if these uses remain marginal. The experimentation of GHB is declared by only 0.4% of 17 years old young people, the experimentation of crack and heroine by 1.1% and the experimentation of amphetamines and cocaine by respectively 2.2% and 3.3%. Thus there seems to be a renewed interest for stimulants in some marginal groups of the adolescent population, even if the fashion for

than in the rest of the country. The map of regular alcohol users has therefore changed considerably since 2005. In particular, the number of regions which stand out due to a high consumption of alcoholic drinks is less than in 2005 (4 regions compared to 6). In parallel, the number of regions which reported lower levels of use more than doubled between 2005 and 2008.

Map 2-3: Regular use (≥ 10 times in the previous 30 days) of cannabis in 17-year-olds



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

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

Study in the gay party scene

OFDT conducted an ethnographic study in 2007-2008 on the use of psychoactive substances in the gay party scene in Paris and Toulouse (Fournier et al. 2010).

The quantitative data available (*Presse gay* survey 2004) indicate higher levels of use in this population during the year compared to the general male population of the same age⁴³ (cocaine: 6.3% vs. 1.0%; ecstasy, 6.0% vs. 0.7%, poppers, 47.5% vs. 11.3%, etc.). The qualitative findings also revealed specific use in this population in terms of the substances used, routes of administration, associated substances and context of use.

This work on drug use in the male homosexual party scene had two purposes for OFDT. The first was to prepare for a possible extension of the ethnographic approach of the TREND (drug surveillance) system (see Appendix V-U), into the homosexual party scene, “a potential trend initiator”.

The second was the party group itself, in order to describe uses and gain an understanding of some reasons for use which appear to be relatively specific to this group. In particular, the study sought to understand the statistical relationship between the use of psychoactive

⁴³ Data from the standardised *Presse gay* survey on the structure per age group in the general population

substances and high risk sexual behaviour amongst members of the male homosexual party scene.

This study⁴⁴ firstly demonstrated that the reasons for using psychoactive substances and the routes of administration by male homosexuals in the party scene were no different from those of other users in the techno party scene. Many gay users started to use these substances in rave parties in the 1990s. The main substances used were the same as in the common techno party scene (alcohol, cannabis, cocaine, MDMA and, more rarely, ketamine), although poppers are also frequently used. Methamphetamine, which is almost absent from the party scene, is found very occasionally in the homosexual clubbing scene. Finally, Internet acquisition appears to play a greater role in supply than for other party users together with direct sourcing of substances which are not available in France in the major foreign capitals. These users also appear to acquire a degree of expertise on the effects of the substances, within the limits of the information available.

During a period when GHB/GBL use was causing local cases of coma in young party goers, and when experimentation with poppers was “skyrocketing” in 17-year-old youths, the study findings also enabled OFDT to understand how some substances used in this small population group could, depending on local factors, remain confined to this population or spread into the broader, young heterosexual party scene.

Secondly, the study revealed the specific nature of use in the gay party scene in Paris and Toulouse, compared to other party scenes: the use of these substances for sexual purposes. Whilst the techno culture is specifically asexual, sexuality lies at the heart of the gay party scene in which masculinity, and even hyper virility, are used as objects of desire. The substances are therefore acquired individually and used for sexual purposes, even becoming, for some people, essential for any sex act. They may facilitate relations with occasional partners and the sex act with a person who arouses little sexual interest, “lift inhibitions” to engage in new practices (particularly those which go against the ideal image of hyper virility), fulfil fantasies, enable the body to tolerate painful practices or the person to tolerate uncomfortable situations, or procure “chemical support” when there is a fear of failure.

Another aspect of the survey was the relationship between high risk sexual behaviour and use of psychoactive substances. In contrast to some American studies which tended to attribute a causal link between using psychoactive substances and disinhibited behaviour, there is nothing in this survey’s findings to support such a conclusion.

Firstly, for some people who heavily use psychoactive substances for sex, high risk behaviour occurs regardless of the extent to which the state of consciousness is altered. In other words, these people take risks even if they have not taken any (or a very limited quantity of) drugs. Secondly, some people who are less involved in drug use are more vigilant before engaging in sexual intercourse when they have taken a substance, since they see drug use as a risk in itself. Whilst an altered state of consciousness (following substance use) contributes to high risk behaviour by reducing some faculties of judgement and action, using this to wholly explain disinhibited behaviour does not take account of the complexity of the experiences of the homosexual men surveyed in this study.

These behaviours appear to be due to attitudes which are mostly psychologically, socially or rationally well established before the substances themselves are taken, and the substances only play an ancillary role. Some psychological vulnerabilities, proximity to or membership of groups which value high risk behaviour in sexuality or a fear of protection behaviour being interpreted negatively by the partner, all appear to play a much larger role in high risk behaviour than an altered state of consciousness due to one or more psychotropic agents.

⁴⁴ Some paragraphs in this review are taken almost *in extenso* from the report overview.

Study of populations in a residential centre

In 2008, OFDT launched the very first national survey on drug use in homeless populations. This survey had two purposes: the first was to pilot test a questioning tool for legal and illegal drug use in a “homeless” population which would be wholly comparable to estimators used in the general population.

The second was to establish the first national measurement of drug use (tobacco, alcohol, cannabis, cocaine) in the homeless population.

Another related aim was to test specific questions on drug uses in order to provide a better measurement of changes in substances taken and the methods of use thereof. For the past few years, a relatively young marginalised population, often with considerable polydrug use and specific methods of use, has been sharing the urban public space with the homeless population, which means that there may be some porosity of drug use behaviour between these different populations.

The survey was based on a two-level sampling plan (selection of residential centres and then individual people within the centres) and was conducted between March and April 2009 throughout mainland France in a population living in mother and child centres, residential and social reintegration centres (CHRS) and emergency residential centres (CHU), ensuring a wide representation of the situations seen amongst the homeless. It may contain representation bias because of a lack of people sleeping in premises not intended for habitation at the time of the survey (squats, public areas, caravans, etc.) although during winter, a number of these people may stay in emergency residential centres. A total of 1,954 people were questioned by professional surveyors in 160 residential centres throughout mainland France. The initial results of this survey will be available at the end of 2010.

3. Prevention

3.1. Introduction

Main points and references

The drug use prevention policy in France is based on early intervention aimed at youngsters in order to delay the age at which they begin their drug use. Since 1999, (also including the use of legal psychoactive substances such as alcohol, tobacco and psychotropic medicines), this has included not only the curtailment of "simple" use but also drug abuse. These principles were introduced and circulated via the so-called "*Parquet*" report (PARQUET 1997). They were also considered from a more practical angle in the guide for intervention in educational environments published by the Ministry of Education and the MILDT in 2005 (DESCO-MILDT 2006). These documents appear to be the only national references in terms of prevention. They consider theoretical approaches which have been scientifically validated but which nevertheless are provided for information only. State operatives and specialised associations in France are not subject to any precise dependency prevention protocol, although the general framework for the prevention of addictive behaviour in educational environments is based on the provision of health education.

The classification distinguishing between universal prevention, selective prevention or indicated prevention is not widely used even if these concepts (and particularly the first two) are gradually gaining ground in both professional and institutional circles. The messages and programmes tend to be based more on the type of use being targeted (for example "simple" use, abuse and binge drinking), a leftover from the "primary/secondary/tertiary" classification system, or on the institutional groups concerned by such actions (youngsters still at school, workers, persons referred by the justice system, etc.). Reference to « primary prevention » persists even if the notion has already changed over the past ten years to include abuse (essentially because of the inclusion of licit drugs in the general approach to addictions).

The general context and key players

The prevention of drug use is a logical extension of the services available under common law and guaranteed by the state or the representatives of the associations, based on the logic of proximity. Consequently, most dependency prevention activities fall under the notion of "universal prevention" and are organised via the educational system (schools or universities) when targeting youngsters. This also involves the wider educational community, regarding both the coordination and performance of these activities. In secondary education, each educational establishment and president of a Health and Citizenship Education Committee (CESC) defines the activities to be carried each year involving pupils. The establishment managers receive recommendations from their local administrative authorities which, in turn, are based on ministerial guidelines. Nevertheless, they also enjoy a high degree of autonomy in this area, ranging from primary through to higher education. The same applies to agricultural education establishments (which report to the Ministry of Agriculture and Fisheries). The CESC bring together the educational community and the relevant external partners, defining and coordinating the drug use prevention policy in schools and high schools. Since 2001, professionals in the field of agricultural education have benefited from the presence of the Adolescent Health Education, Counselling and Development Network (Reseda) which encourages dialogue, training and the circulation of drug prevention resources, as well as organising competitive tenders in the field of health education.

In professional environments, the prevention of the use of alcohol, drugs or psychotropic medicines is organised under the supervision of the occupational health departments, and in companies with more than 50 employees by the CHSCTs (committees for hygiene, safety and working conditions). It is governed by the Labour Code.

Prevention targeting "at risk" sections of society (referred to as "selective prevention") or users ("indicated prevention") is handled by specialised associations, particularly in the

suburbs or in legal establishments. These associations or specialised police/gendarmerie officers are also asked to participate in schools. The mutual insurance funds specifically dealing with students are also active in this area, working with young people in higher education.

The current state of monitoring and observation practices

Since 2006, the OFDT has been working on a national observation system for universal selective prevention practices related to the use of both legal and illegal drugs in France. This system, baptised "ReLION" (*Recueil d'indicateurs pour l'observation nationale des actions de prévention liées aux drogues licites et illicites* - Collection of local indicators for the national observation of prevention activities concerning legal and illegal drugs, see Appendix V-W) seeks to identify and initially track the key characteristics of local prevention activities carried out in this field. What makes this initiative unique is its coverage of numerous sectors and its independence vis-à-vis the financing processes for such activities (the educational, work, legal and community environments, etc.). After being trialled in 9 of the 26 French regions in 2007 at the request of the MILDT, its planned nationwide rollout has encountered a number of methodological difficulties in view of the large number and diversity of participants and information systems existing alongside one another in certain areas of activity. This extension is nevertheless being studied and will be introduced progressively given the difficulty of its incorporation due to the subject (principles of intervention and notion not stable yet, multisectorial character, etc.) and to the cautions identified (partial only evaluative potential, questions over the key indicators, etc.).

Thus, the statistical analysis of preventions actions undertaken, of their characteristics or of the share of the public who has benefited from an action are not yet available.

Despite the current absence of a national information system covering drug prevention practices, a number of changes can be clearly identified. Thanks to the efforts made since 1999 in order to professionalise and harmonise the range of preventive initiatives, several principles today appear to be prevalent: for example the inability of a purely informative approach to bring about a change in drug-related behaviour, the importance of the preventive role played by parents, an interactive approach or the development of sensitivity-related skills. Nevertheless, although they are widely known, these operational principles remain difficult to apply for many individuals.

The legislative framework

The Public Health Law of 2004, (incorporated within the Educational Code), sets a minimum target of one annual information session per uniform age group dealing with the theme of "the consequences of drug use on health, particularly concerning the neuropsychological and behavioural effects of cannabis, in junior and senior high schools ("*collèges*" and "*lycées*" in French)" ⁴⁵.

The legislative aspect tends to be based more on restricting access to the product concerned and offering judicial responses to the problem of illegal use, such as awareness-building courses focusing on the dangers of narcotics, provided for arrested users since 2008⁴⁶. Legislation concerning public use, publicity or access conditions to alcohol or tobacco has already been in place for a long while⁴⁷. More recently, in November 2006, the ban on

⁴⁵ Loi de programmation de la politique de santé publique n°2004-806 du 9 août 2004, NOR : SANX0300055L.

⁴⁶ Loi n° 2007-297 du 5 mars 2007 relative à la prévention de la délinquance et modifiant le code pénal et le code de procédure pénale, décret no 2007-1388 du 26 septembre 2007 pris pour l'application de la loi no 2007-297 et circulaire CRIM 08-11/G409.05.2008 relative à la lutte contre la toxicomanie et les dépendances du 9 mai 2008 (NOR JUS D0811637 C).

⁴⁷ We should mention for example: Ordonnance n°59-107 du 7 janvier 1959 et loi n°74-631 du 5 juillet 1974 interdisant la vente d'alcool aux mineurs de moins de 16 ans, loi n°91-32 du 10 janvier 1991 (dite Loi Evin) relative à la lutte contre le tabagisme et l'alcoolisme, JO du 12 janvier 1991, p. 4148 (NOR : SPSX9000097L), Loi n°2003-715 instaurant l'interdiction de vente de tabac aux mineurs de moins de 16 ans (JO du 3 août 2003). Décret n° 2006-1386 du 15 novembre 2006 fixant les conditions d'application de l'interdiction de fumer dans les lieux affectés à un usage collectif, NOR:SANX0609703D.

smoking in collective areas (the Evin law) was extended to cover premises welcoming the public, including workplaces in February 2007 and (since January 2008) all social areas.

National and local coordination and financing

The prevention policies targeting the use of both legal and illegal drugs are encouraged and coordinated by the MILDT via the multi-year government plans which it drafts, with the most recent being adopted in 2008 to cover the period 2008-2011. These are mirrored or sometimes enhanced via programmes from the various ministries (education in particular) or national plans concerning related themes (example: the fight against cancer, in 2003-2008).

The local adaptation of national guidelines is based on the work of the state's decentralised departments and the "drug and dependency" project leaders (appointed from among the staff at the *Préfectures*), who are the MILDT's direct representatives locally. The project leader defines and organises the prevention policy for the *département* (the sub-regional geo-administrative level). To do so, he has at his disposal various credits devoted to the fields of dependency prevention and the training of professionals.

Various cross-disciplinary local programmes (concerning health, the fight against social exclusion, public safety and/or urban policy) also make it possible to redistribute public credits for drug prevention. Additionally, the identification of priority areas for attention where education or urban planning is concerned (based on socio-economic, housing quality and educational indicators) makes it possible to concentrate additional resources on underprivileged populations.

At the same time, the national health insurance system also subsidises preventive activities via the FNPEIS⁴⁸, based on competitive tenders.

Measures designed to support decision-makers and professionals

The national institute for health education and prevention (INPES) has the task of assessing and developing preventive measures and implementing national programmes (particularly media campaigns).

The committee for the approval of preventive measures (coordinated via the MILDT) issues its opinion concerning the quality and relevance of the tools submitted to it.

In order to be fully represented in public debates and to encourage professional dialogue, the specialised associations are organised into federated organisations⁴⁹. These organise training courses, series of conferences, think tanks or documentary networks concerning the prevention of the use of psychoactive substances.

Finally, in each region, the project managers can draw upon the help of a technical support organisation focused, in particular, on the observation and local assessment of use levels and the public responses provided, in addition to project methodology.

National and local media campaigns

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

For around 10 years now, these campaigns have been initiated by the Interministerial Mission for the Fight Against Drugs and Drug Addiction (MILDT) often working with the National Institute for Health Education and Prevention (INPES) and the ministries concerned (health and justice, etc.).

⁴⁸ National fund for prevention, education and health information

⁴⁹ FNES: National federation of health education committees (www.fnes.info); ANPAA: National association for the prevention of alcoholism and addiction (founded in 1872, www.anpaa.asso.fr); ANITeA: National association of Drug Addiction Workers, (www.anit.asso.fr); FFA: French federation of addictology (www.addictologie.org); CRIPS: Regional AIDS information and prevention centre, (www.lecrips.net/reseau.htm).

These media activities are carried out at varying intervals and frequencies. Similarly, the nature of the drug prevention messages, the products mentioned (depending on whether a global approach has been adopted or otherwise) and the population groups targeted as a priority (young people, parents, the whole population and also, occasionally, professionals) vary according to the guidelines contained in the government anti-addiction plan.

The channels used for the deployment of these media activities are just as diverse and can include the press, posters, radio, the television but also (and increasingly so) the Internet. Finally, the budget devoted to such activities can vary from campaign to campaign.

These campaigns are most of the time subject to pre- and, above all, post-assessment tests. The purpose of these tests is to assess their impact in terms of audience, message retention and approval, allowing for a number of comparisons to be made.

3.2. Universal prevention

The current governmental drug plan sets down the principle of prevention intervention in all the everyday environments of the French population, and particularly in those where the younger members of the public are often found. This means a major commitment in secondary and also higher education, driven in particular by the greatly increasing problem of massive alcohol consumption. Such a global response approach also implies a specific dynamic directed towards families and adult referents, stimulating and supporting their role in drug prevention with young people, and towards occupational settings. Schools, families and workplaces were the three main areas of the government drug prevention activities in 2009.

3.2.1. School

Universal prevention targeted at legal and illegal drugs is the main approach used in schools in France. It is directed primarily towards pupils in secondary education although, since the publication of the school intervention guide in 2005 (under the auspices of the Ministry for National Education and MILDT), the last year of primary school (CM2 or *5th grade*) should address the issue of legal drugs, particularly tobacco, and therefore represent the first part of a prevention process continuing to the end of secondary school.

The main action in school prevention in 2009 was the update of the above intervention guide, which will not, however, be completed before the summer of 2010 as various other events also needed to be addressed (management of influenza risk, the problem of violence at school etc.). The updated version of the guide should be available at the start of the new school year (Autumn 2010).

Since 2006, prevention of addictive behaviour has been given new importance in basic national education through the definition of the “common base of knowledge and skills” (*socle commun de connaissances et de compétences* in French), i.e. the set of knowledge, skills, values and attitudes which all pupils must acquire by the end of mandatory schooling for their lives as future citizens⁵⁰. The “social skills and civics” sub-set and the “independence and initiative” one (skill subsets 6 and 7 respectively) illustrate the academic contribution of National Education to the development of individual and social attitudes, classically referred to as *life skills*, which may be used by pupils when they are offered drugs. The Ministry of National Education reported that 87.4% ($\pm 2.3\%$, $p=0.05$) of pupils at the end of the 9th grade (“*classe de 3ème*” in France) had effectively mastered the targeted social and civic skills in 2008⁵¹. They were 83% ($\pm 2.8\%$, $p=0.05$) to have acquired the skills concerning the “independence and initiative” skill subset. This calculation was based on an experimental

⁵⁰ Décret n°2006-830 du 11 juillet 2006 relatif au socle commun de connaissances et de compétences et modifiant le code de l'éducation, NOR: MENE0601554D.

⁵¹ Cross-cutting policy document. Projet de loi de finances pour 2010. Politique de lutte contre les drogues et les toxicomanies. Ministry for public accounts, budget and State reform.

protocol which will likely undergo changes since the related information feedback system should be improved.

3.2.2. Family

The family circle plays a vital part in the stimulation of adult referents to make them first-line prevention actors.

The role of the generic network represented by the REAPP (Parental counselling aid and support networks) was reaffirmed for this purpose. But the activity statistics for these services do not clearly indicate which interventions are related to problems of drug use or addiction.

The government endeavoured more specifically to initiate a public debate on the question of parenting and prevention. Conferences on parenting were prepared in 2009 and delivered in 2010 confronting the opinions of the different professional sectors involved (paediatric psychiatry, educational sciences, law, legal protection of youth, child welfare, etc.). The debates on parental authority, the legitimacy of parental intervention and parenting assistance should be integrated into a governmental awareness campaign for parents and other adult referents concerning their role as prevention actors, planned for 2010 (see 3.5).

The workplace should be seen increasingly as a possible setting to reach out to parents about drug uses among young people and problematic situations which their children may be faced with.

3.2.3. Community

In the French context, prevention work in the community refers to everything which is done outside of the school or university environment. These initiatives are mostly addressed at populations from areas deemed to be difficult and therefore fall under selective prevention. Universal community prevention is defined with reference to two areas: the workplace and the cultural and the sports and culture/leisure area.

The workplace is the most propitious capture environment to deliver prevention messages about the use of legal or illegal drugs to adults with regard to both themselves and their close friends and family (as suggested in 3.2.2). The government estimates that 20% of cases of absence from work are due to use of alcohol, psychotropic medicines or narcotics. The MILDT organised conferences on the subject “Illegal drugs and occupational risks” in 2009 which is planned for 25 June 2010. The aims are to adopt targeted measures and to bring appropriate consensus changes to the Labour Code. Two inter-regional forums were organised in July and in November 2009, prior to the national conferences of 2010.

As the governmental prevention action needs to be deployed in all of the everyday environments of French people and young people in particular, the sports domain also saw the adoption of new measures. These mostly, however, concerned doping behaviour involving psychotropic agents or narcotics. National inter-ministerial training had already been organised in autumn 2008 in order to define a standard regional training programme for prevention actors.

Finally, a third “community-based area” of public action in 2009 should be highlighted. In June 2009, an information campaign in the form of posters and display boards was directed, at foreign travellers staying in France, informing them about the legislation on the use and trafficking of narcotics, via airlines, shipping lines, airports, railway stations, tourist offices and travel agencies and guides.

3.3. Selective prevention in at-risk groups and settings

3.3.1. At-risk groups

Selective prevention of drug use is closely linked to prevention of drug trafficking and subsequent offences.

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

The OFDT, however, does not have information about the actions implemented in 2009 in these aims.

3.3.2. At-risk families

The interministerial activities to combat drugs do not directly target families deemed "high-risk" because of their drug use or addiction. Public actions with regard to these families are the shared responsibility of the *départements* (sub-regional decentralised authorities) and the law authorities. This largely decentralised policy (in the remit of "*departments*") is administered under the coordination of the Director General for Social Action and uses the generic assistance systems. We note, however, that the law of 5 March 2007 reforming child welfare⁵² amongst other things is notably intended to improve prevention with regard to children at risk of abuse or negligence, particularly when related to drug use or addiction problems.

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

The recreational environment groups together the alternative festive scene and the commercial festive scenes (bars and clubs). Since the so-called "Mariani et Vaillant" decree⁵³ dating from 2002, the institutional approach to prevention in the festive or recreational settings has not seen any particular recent changes apart from the introduction in July 2009 of the legal ban on offering or selling alcoholic beverages to minors under 18 years old in public places (article 93) and the legal ban on selling on an inclusive basis or unlimitedly giving out alcoholic drinks (free bars) (article 94)⁵⁴.

Since 2002, however, specialised workers have noted the split of the festive scene in smaller, but more numerous and more clandestine events, complicating the work of harm reduction workers. The latter have encountered difficulties to multiply their activities at the different sites and to keep informed about the events which are increasingly advertised through social networks (Facebook, etc.). Finally, with increasing injection amongst participants, syringe distribution now forms part of the landscape of these events.

3.4. Indicated prevention

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

⁵² Loi n°2007-293 du 5 mars 2007 réformant la protection de l'enfance, NOR: SANX0600056L.

⁵³ Décret no 2002-887 du 3 mai 2002 pris pour l'application de l'article 23-1 de la loi no 95-73 du 21 janvier 1995 et relatif à certains rassemblements festifs à caractère musical, NOR : INTD0200114D.

⁵⁴ Loi n° 2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires, NOR: SASX0822640L.

Awareness building courses on the dangers of narcotics are offered to people aged thirteen and more arrested for use as an alternative to prosecution, a “penal arrangement”⁵⁵ or as an additional sentence. This system is described in more detail in chapter 9.4.

The “cannabis clinics for young users” (CJC) are for young users and their parents. Of the users received in 2007 (85% of visitors), almost half were referred by the legal system (OBRADOVIC 2008). The CJC scheme is described in more detail in chapter 9.4.

3.5. National and local media campaigns

There was a particularly large number of national media campaigns in 2009.

The last large-scale media campaign on illegal drugs, run jointly by MILDT and INPES dates back to 2005 (“cannabis is a reality”). However, two successive campaigns took place in 2009⁵⁶.

These two campaigns (together with a third planned for the end of 2010 on “parenting” and the role of adults in prevention) are part of the 2008-2011 drugs and drug addictions plan.

The first campaign was based on the danger of drugs and was launched on 5 October 2009 by the Ministry of Health, MILDT and INPES, with the slogan “*Illicit drugs: keep your eyes opened*” (“*Drogues : ne fermons pas les yeux*”). This was intended to “*combat the positive messages associated with drugs*” and took place throughout the month of October on television, radio and the internet. The internet web scheme specifically targeted young people and was based on two tools: firstly, three films promoting an online games module, and three video banners. Total media investment in the campaign amounted to €2,972,000, taxes included.

The second campaign on the legal framework involved two arms, alcohol and illegal drugs, around a common aim, “*stressing the protective role of the law against the health and social dangers of high risk behaviour*”. This campaign, whose strapline for illegal substances was “Drug is illegal; it’s on purpose” (“*La drogue, si c’est interdit, ce n’est pas par hasard*”) took place on television, magazines and on the web from the end of November to 31 December 2009.

In terms of impact, an assessment of the system used in the first campaign, emphasising the danger of drugs, showed good overall results in terms of positive reception, although the results for recognition were lower: 81% of the people questioned in November said that they liked the TV and radio spots whereas 53% recognised the TV spot (the score in the 2005 cannabis campaign was 83%). It also appears that the internet arm had markedly more impact than the TV and radio spots in 15- to 24-year-olds, who particularly liked the irony and humour of the campaign (INPES 2010).

The 2nd “legal framework” campaign was not evaluated. The only information available shows a marked increase in the average number of visitors to the www.drogues.gouv.fr website which relayed the different activities (5,500 per day compared to 2,200 usually). There were a large number of downloads of a free I-phone games application called Idrunk intended to make young people aware of alcohol abuse with personalised messages for minors and for those over 18 years old (70,000 times by the end of January 2010).

⁵⁵ A procedure allowing the Public Prosecutor to propose one or more measures to a person who admitted to have committed a contravention or crime punishable by a period of imprisonment of 5 years or less.

⁵⁶ More specific, an information campaign for foreign travellers about the risks and penalties for breaches of the law on narcotics (posters and brochure hand-outs) also took place from June 2009.

4. Problem drug use

4.1. Introduction

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

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

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

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

Secondly, multicentre studies into local estimates of the prevalence of problem drug use (the NEMO study) have been carried out periodically by the OFDT. The most recent was carried out in 2005/2006 and involved six French towns and cities. These relatively convergent estimates indicate that problem drug use in these cities concerned between 6 and 15 people per 1000 inhabitants aged 15 to 64 years old.

4.2. Prevalence and incidence estimates of PDU

4.2.1. Indirect estimates of problem drug users

Local estimations: Capture-recapture method

Six “three-sample capture/recapture analyses” were carried out in 2005-2006 in order to estimate the number of problem drug users in Lille, Lyon, Marseille, Metz, Rennes and Toulouse (NEMO study) (Vaissade et al. 2009).

Data sources for problem drug users were identified and the data were collected from these sources over a six-month period between 2005 and 2006. These sources notably included the drug treatment centres, general practitioners, hospital units (infectious diseases, accident and emergency departments), low-threshold reception facilities (CAARUD), social services and law enforcement sources such as drug squads, the justice system, treatment units in prison and data held by the Central Office for the Repression of Narcotics Trafficking (OCRTIS). Data collection in prison was delayed for two months, compared to other data sources, in order to allow problem drug users entering prison during the last two months of the survey to be “captured” by other data sources. For each study (each town), the different data sources were grouped into three samples using a statistical criteria (an odds ratio between two data sources greater than one, suggesting possible linkage between both sources, leading to both data sources being combined) and a field criterion (when two data sources are locally known to be related).

Subjects were included in the study if they had resided for more than three months in one of the six cities, if they declared having used at least one illegal drug over the last 30 days (cannabis excluded): opiates, cocaine/crack, other stimulants and/or hallucinogens, and if they were 15-64 years old.

The results obtained in the six cities are the following:

Table 4-1: Estimates of problematic drug users (PDU) in 6 French cities and prevalence rates among the 15-64 year-old population, 2005-2006

	PDU estimates <i>confidence interval*</i>			15-64 years old population	prevalence rate (p 1000) <i>confidence interval</i>		
Lille	7 900	6 300	10 200	728 173	10.8	8.6	14.0
Lyon	8 400	6 300	11 800	788 893	10.7	8.0	15.0
Marseille	5 600	4 200	7 700	543 206	10.2	7.7	14.2
Metz	2 300	1 700	3 200	212 632	10.8	8.0	15.0
Rennes	1 500	1 100	2 300	196 389	7.6	5.6	11.7
Toulouse	5 400	4 300	6 900	534 132	10.1	8.0	12.9

estimates rounded to the nearest hundred ; population : INSEE, census 1999

* Cormack method (Ref : Cormack, R.M., Interval Estimation for Mark-Recapture Studies of Closed Populations. Biometrics, 1992. 48: p. 567-576.)

Source : Nemo, OFDT

National estimates: EMCDDA protocol

Problem drug use has been defined, according to the EMCDDA definition, as intravenous or regular use of opiates, cocaine or amphetamines during the previous year in the 15-64 age group.

The following results are obtained from the three methods:

Table 4-2: National estimates with the EMCDDA protocol

	average estimate	CI-	CI+
treatment data multiplier	272 000	209 000	367 000
police multiplier	187 000	144 000	253 000
multivariate	264 000	189 000	338 000
rate / 1000 hab. 15-64 years			
treatment data multiplier	7,0	5,4	9,5
police multiplier	4,8	3,7	6,5
multivariate	6,8	4,9	8,7

Source : OFDT

The results obtained from the “multiplier-treatments” and “multivariate” methods converge. The third method shows markedly lower prevalences. Taking account of the three confidence intervals, the estimate range is found to be extremely wide, from 3.7 to 9.5 per 1,000 inhabitants between 15 and 64 years old.

Consideration alongside framework data on illegal drug use

The low prevalence of opiate, cocaine or amphetamine use very considerably limits the potential relevance of general population surveys to estimate this phenomenon. General population surveys provide us with estimates of the number of people who have used these substances at least once in their life (experimenters) or at least once in the previous year. We do not have estimates of the number of regular users of these substances (at least ten times over the previous month), as this behaviour is too rare to be measured in this type of survey. The following estimates were produced from the most recent general population surveys conducted in 2005 (BECK et al. 2006b).

Table 4-3: Estimates of cocaine and heroin life time and last year users, 2005

	Life time users	Last year users
Cocaine	1 100 000	250 000
Heroin	360 000	

Sources : ESCAPAD 2003, OFDT ; ESPAD 2003, INSERM/OFD/MJENR ; Baromètre santé 2005, INPES, exploitation OFDT

In view of these findings, we could have expected the estimates of the number of problem drug users to be less than those provided by the three methods used. This difference is partly explained by loss of social integration amongst problem drug users, as this particular population is not well covered by general population surveys.

Limitations inherent to each of the methods

The first “Multiplier method using treatment data” is based on sales data for the two medical drugs used for substitution treatment, which enable estimates to be made of the number of drug users taking these treatments. In view of the extensive availability of this type of treatment in France, these data represent an excellent base for application of this method. Substitution treatments theoretically only cover part of the target group, opiate users, although in practice there is considerable overlap between the uses of the different substances. These estimates, however, may be subject to some sources of bias, particularly misuse of the treatments or their diversion onto the black market. These sources of bias could lead to an overestimation of the population being treated, as misused medicines are not taken by “users receiving treatment”. Nevertheless, the substances are still taken by drug users. The method, therefore, is still robust if this relatively well documented phenomenon (Cadet-Taïrou, Agnès et al. 2004; COSTES, J.-M. et al. 2004; Escots, S. et al. 2004a) is consistent over all the French départements. This is not necessarily the case, as it is known that this misuse or diversion of treatment is concentrated in a few regions (CADET-TAIROU,

A. et al. 2004) (Paris region, Alsace, Languedoc) which do not include any NEMO study sites. There is therefore a risk that the numerator in the equation used in this method is overestimated and therefore that the final result is also overestimated.

The second “Police multiplier” method is based on an “arrests by the police for heroin or cocaine use” indicator which is relatively non-specific: it is an indirect indicator of drug use but also one of the extents of police activity in the field. This second factor is not necessarily consistent between départements. Another possible source of bias for this indicator is that the target it measures is slightly different from the definition of the target group (intravenous drug user or regular user of opiates, cocaine or amphetamine in the previous year for the 15-64 age group), as the offence does not distinguish between extent of use. An occasional user can be arrested and the police statistics do not distinguish between the types of use.

The third “multivariate indicator method” has the advantage of linking different data sources for which known prevalence estimates for 6 départements are extrapolated to the other 90 départements. Nevertheless, each of the four indicators used has its own limitations. Those relating to the number of people receiving substitution treatment and the number of arrests have already been described above. The “treatment data” come from an administrative source (activity report submitted to the statutory authorities). The reliability of declaration data on new patient intakes is debateable. In addition, intra and inter-centre double counts cannot be excluded. Stéribox® sales are an indicator of both the magnitude of intravenous drug use, which only corresponds to part of the definition of problem drug use, and the coverage of harm reduction practices, which may vary across France.

Finally, it must not be forgotten that these three methods are all based on local estimates obtained from the NEMO study: the first two methods used local estimates in order to estimate the proportion of the population hidden from the information source used, and the last method uses departmental estimates as anchor points for extrapolating data. There are inherent difficulties in using the “capture/recapture” method in drug addiction as it uses theoretical hypotheses which have not been completely confirmed in practice. The capture-recapture technique relies on the hypothesis that each person belonging to the target group (the subject of the estimate) has the same probability of being captured by the different information sources (the hypothesis that the population is homogenous) and on the hypothesis that the sources are independent, i.e. that being recorded in one system does not change the probability of being recorded in all the other systems. In reality, regular illegal drug users are not homogenous: some “manage” their use and are very unlikely to be “identified” either by the health and social system or by the legal system, particularly for cocaine use. There are also possible links between being “captured” by several sources. A user who has been arrested may be prosecuted or even imprisoned, making it impossible for him/her to be identified by a CSAPA or CAARUD during this period. The use of log-linear analysis with three data sources, however, makes it possible to get away from the hypothesis that the sources are mutually independent and according to the log-linear methods used, it appears unlikely that there is any interaction between the three sources. Finally, beyond these limitations on the bases of the hypotheses underpinning the method, the magnitude of the confidence intervals surrounding the NEMO estimates due to the small numbers of triplicates must be emphasised.

Comparison with previous estimates

The first methodologically documented estimates of problem drug use prevalence in France date from the middle of the 1990s. A demographic method used in 1995 based on 1993 data produced an estimate of at least 160,000 heroin addicts (COSTES, J.-M. 1995). A few years later, the first application of the European protocol, which was under construction, to the situation in France produced an estimate of 146-172,000 problem opiate users in France in 1995 (Observatoire français des drogues et des toxicomanies (OFDT) 1999).

It was during the same period that the capture/recapture method was first used in France for drug addiction (in the Toulouse metropolitan area) (BELLO, P. Y. 1998). The European

protocol was applied a second time at the beginning of this century, when the capture/recapture method was extended to several towns (CHEVALLIER 2001). The new estimate based on 1999 data was similar to the previous one: 146-180,000 problem opiate or cocaine users (Observatoire français des drogues et des toxicomanies (OFDT) 2002).

The raw figures, which increased from 160,000 in 1993 to 230,000 in 2006, suggest a marked increase in the phenomenon. This impression is misleading for at least two reasons. Firstly, the methods and, in particular, the subject of the estimate, have changed. The context has moved from the concept of "heroin addicts" (1993) to "problem opiate users" (1995) and then to the definition "problem opiate or cocaine users" (1999) and finally to "intravenous drug users or regular users of opiates, cocaine or amphetamines" (2006). The scope of the estimate has therefore broadened over time.

The second reason is the magnitude of the confidence intervals around the central estimates. It can be seen from the confidence intervals obtained from the capture/recapture method – which lies at the heart of all of the methods used – that the national estimate calculated for 2005-06 ranged from 144,000 to 367,000. For these reasons, it is difficult to conclude that there has been a clear increase in the estimates.

We can only highlight that there may have been an increase in the number of problem drug users. Other information sources also indicate, firstly, "ageing of the population concerned", with reduced mortality rates since the increase in substitution treatments at the end of the 1990s, and secondly, a degree of "population renewal" because of the spread of stimulants, the emergence of new opiate users and changes in the party scene, etc.

Finally, we should re-examine the theoretical definition produced by the EMCDDA. A problem drug user is defined as an intravenous drug user or regular user of opiates, cocaine, or amphetamines during the previous year in the 15-64 age group. To a greater or lesser extent, all of the methods proposed assume that the user can come into contact with one of the information sources used (arrest, treatment, health problems, death, etc.). These sources can extrapolate by estimating the number of people who have not yet come into contact with them but will do so in the future, but not the number of those "who will never come into contact with them". It is therefore extremely likely that our estimate does not cover all "regular opiate, cocaine or amphetamine users) because of the inability (of these methods) to detect "controlled" uses of the substance in a better socially integrated population.

Estimation of the number of regular heroin users

It would be useful to try to apply the European protocol in order to obtain an estimate of the number of heroin users in France. It is known that the magnitude of this behaviour in the French population cannot be obtained from data produced by general population surveys. This is firstly due to the fact that the prevalence of the phenomenon is below the limit which can be identified by these surveys, and secondly, to frequent loss of social integration of the population concerned.

Unfortunately, it is also impossible to apply the different methods of the European protocol described above to the limited field of heroin users. The breakdown by substance, which is available for some information sources, is not present in all of the sources these methods use. Therefore, if we wish to estimate the number of "problem heroin users" within the meaning of the EMCDDA definition, a figure which can be approximated to the number of "regular heroin users", the only solution is to search for the proportion of heroin users in the different drug user surveys and use this proportion to estimate the number of "problem drug users".

A mean estimate can be produced from these different available health data: 32% of problem drug users⁵⁷ are heroin users (use during the previous month).

⁵⁷ In view of the sources and data used, the range of substances can be considered to exclude cannabis.

It can therefore be estimated that approximately one third of problem drug users are active heroin users. To this third can be added a considerable proportion of people who were former heroin users, and who are now abstinent, either because they are receiving treatment (particularly substitution) or because they have moved on to other substances, and who may subsequently, either occasionally or regularly, take heroin again. This 32% figure can therefore be considered to be a minimalist estimate.

Estimation of the number of intravenous drug users

It would also be interesting to try to use the European protocol to obtain an estimation of the number of intravenous drug users in France. For the same reasons as above, this can neither be obtained from the general population survey data nor by directly applying the European protocol.

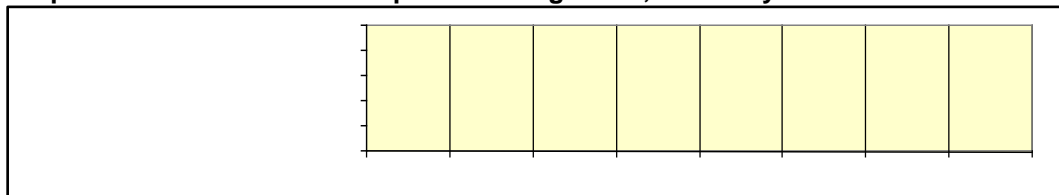
Here again the only solution is to look for the proportion of intravenous users in the different drug user surveys and apply this proportion to estimate the number of “problem drug users”.

The different health data available provide a mean estimate of 63% injecting at least once during their life and 35% injecting within the previous month.

Results summary

The aim of this work was to produce a new estimate of problem drug users in France, together with the corresponding prevalence rate. There is great temptation to emphasise the wide range of results obtained and produce a wide estimate range. This however risks reducing the visibility and understanding of the result. The role of the expert is to offer a single estimate (or narrow estimate range) which in his/her opinion is probably closest to the actual situation.

Graph 4-1: Narrow estimate of problem drug users, summary



In view of the inherent limitations of each of the methods used and described above, there is no “best method”. The values common to the confidence intervals for the three methods are therefore offered as the most likely estimation range, between 210 000 and 250 000 problem drug users in France en 2006 of which half involved in opiate substitution treatment. Indeed, it is estimated that 120 000 people have used opiate substitution drugs in the first half of 2007 (Observatoire français des drogues et des toxicomanies (OFDT) 2009).

Table 4-4: Problem drug use prevalence estimates in France, 2006

estimate range selected	210 000 - 250 000
rate/ 1000 hab. 15-64 years	5,4 - 6,4
central estimation	230 000
rate/ 1000 hab. 15-64 years	5,9
<i>including</i>	
- last month heroine users	74 000
rate/ 1000 hab. 15-64 years	1,9
- life time injecting users	145 000
rate/ 1000 hab. 15-64 years	3,7
- last month injecting users	81 000
rate/ 1000 hab. 15-64 years	2,1

Source : OFDT, 2008

Towards a new estimate

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

4.2.2. Estimates of incidence of problem drug use

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

4.3. Data on PDUs from non treatment sources

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

CAARUD's clients (CADET-TAIROU, A., M. GANDILHON, et al, 2010)

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

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

The general precariousness of drug users

According to the 2008 ENa-CAARUD study, the drug users visiting harm reduction centres in urban settings are on average quite "old" (at 34.1 years of age). Half of them (48.8%) are at

least 35 years old while the under 25s accounted for 18.2% of the entire sample (CADET-TAIROU A. et al. 2010).

This is a predominantly male population group (78.3%). The percentage accounted for by women tends to be higher among the youngest users. Consequently, although only 14.4% of the men were aged under 25, this was the case with 31.8% of the women (Cadet-Taïrou, A. et al. 2010, à paraître). They account for 38.0% of the under 25s.

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

In 2008, drug users visiting the harm reduction facilities in urban environments displayed a high degree of social vulnerability (Cadet-Taïrou, A. et al. 2010, à paraître).

- Among these, half (49.3%) are experiencing unstable housing conditions, with 60% of them being homeless or living in a squat while the others have some form of temporary housing⁵⁸.
- Almost a quarter have a salary or receive unemployment benefits (21.8%). More than half (51.7%) receive a social income benefit: the RMI (basic guaranteed income, 35.2%) or a disabled adult's allowance (13.9%). Finally, a further quarter have no legal income at all (and instead live off begging, illegal resources or prostitution) while just 1.1% are helped by their family or third parties. Furthermore, the PRELUD 2006 study (see Appendix V-G) shows that the income structure differs greatly according to the age-group concerned. Indeed, we should note that more than half of the under 25s had no legal income (Cadet-Taïrou, A. et al. 2008b).
- Overall, only 4.6% of clients of low threshold facilities have no social cover whatsoever⁵⁹, while 2.9% receive the AME (State Medical Aid Allowance). Half of the drug users visiting the CAARUD's (50.2%) are covered by the health insurance system thanks to the CMU scheme (Universal Health Cover).
- In terms of education, only 23.4% of them had reached baccalaureate level (A-level/High School Diploma) with or without sitting the exam. The majority (63.6%) possess a secondary education level vocational qualification (the CAP or BEP vocational training certificates) or did not progress beyond middle school.
- The vast majority are in possession of valid identity papers (whether French or foreign). However, 11% have no ID papers. Among these, half are living in France illegally, while the other half have lost their identity papers or had them stolen.

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

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

Heavy consumers of psychoactive substances

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

A third of the users interviewed had used heroin during the previous month although the most frequently consumed opioid continues to be HDB (high dosage buprenorphine). In

⁵⁸ Available for a period of less than six months

⁵⁹ Neither health insurance nor state medical aid.

2006, among those users who stated that they had taken it during the previous month, only half stated that they had used it purely for therapeutic reasons⁶⁰ (Cadet-Taïrou, A. et al. 2008b). In 2008, among the recent users of HDB, three quarters stated that they received it as a substitution treatment. HDB is also the product most regularly consumed by its users, three quarters of whom use it on a daily basis.

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

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

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

	Recent users (used during previous month)	% of recent users who are daily users
Cannabis	71.6%	53.5%
Alcohol	62.7%	48.7%
HDB	40.3%	74.2%
Heroin	29.3%	20.0%
Methadone	26.3%	68.7%
Morphine sulphate	14.8%	38.6%
Cocaine powder/ freebase	36.3%	9.5%
Crack	16.6%	25.1%
Amphetamines	14.1%	3.4%
Ecstasy	10.6%	0.6%
Benzodiazepines	27.9%	56.9%
Hallucinogenic mushrooms, plants and herbs,	8.6%	3.9%
LSD	10.8%	3.3%
Ketamine	7.4%	4.7%

Sources: ENa-CAARUD, 2008, OFDT/ DGS

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

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

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

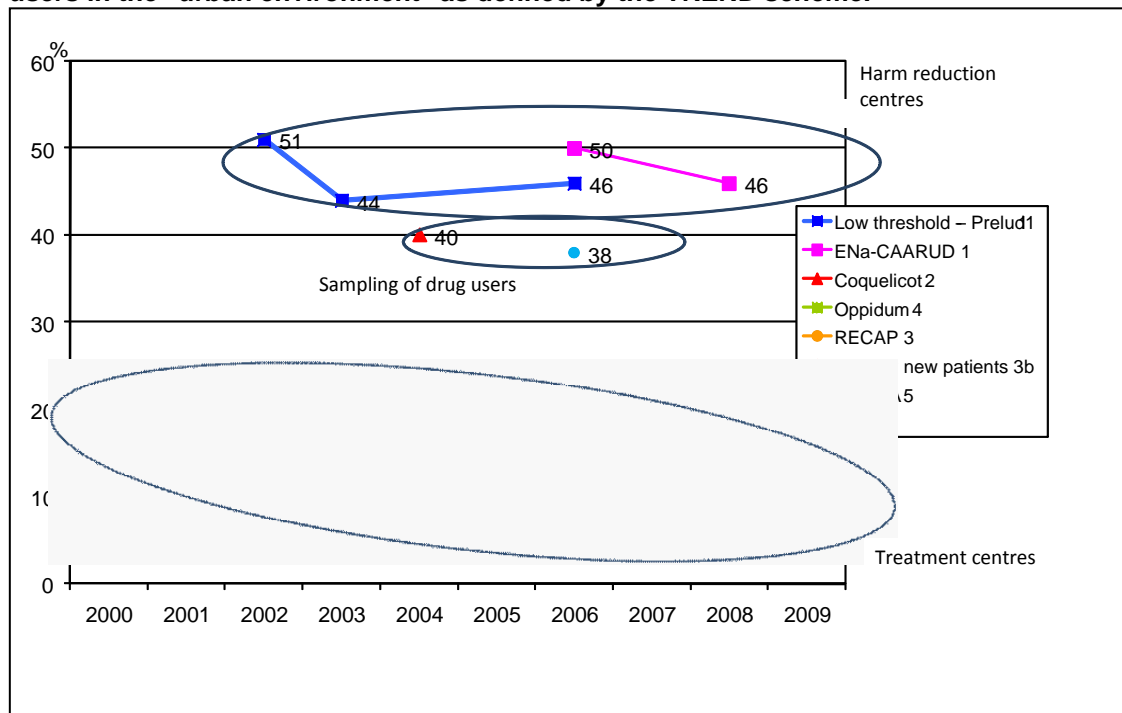
In 2008, among low threshold services' clients the users of frontline centres in urban locations (CAARUDs) 64.4% had injected at least once during their lives. The average age of the first injection was 20.7 years old (the median being 20 years old) (Cadet-Taïrou, A. et al. 2010, à paraître). Among CAARUDs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

⁶⁰ The question concerned the purpose of the drug use concerned. The person could choose between the following options: 1/To get off heroin or to try and cure yourself (the so-called "therapeutic" objective), 2 /To "get stoned", including coming down off a stimulant or to control cravings, 3/ Both.

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

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

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



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

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

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

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

Notes:

1/ Several routes of administration may be used by a consumer for the same drug. Consequently, the total percentages per drug may exceed 100%.

2/ Products listed according to the injection usage frequency

The TREND data: Key changes in 2008-2009 concerning uses and modalities of use

(CADET-TAIROU, A., M. GANDILHON, et al, 2010)

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

The increasing diversity of drug users

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

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

Furthermore, young, itinerant drug users (who may occasionally be minors and who find themselves without any support after having left the family home whether voluntarily or against their wishes) or who have left a social institution upon reaching adulthood, are now being mentioned and described as increasingly numerous and visible among CAARUD's clients. With some of them adopting behaviour patterns typical of the techno trend, these

individuals are characterised among other things by high proportion of young women within the groups and their willingness to undertake risky behaviour (including prostitution and injection with frequent equipment sharing, etc.).

A revival in heroin use

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

Increased experimentation with freebase cocaine

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

The growing availability and use of Ketamine

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

We can currently distinguish three types of ketamine users:

- Moderate users: generally found among the older users, they take low doses of ketamine, often combined with other stimulants, for its exhilarating, mind-blowing and "cottony" effects (the user has the impression that he/she is walking on cotton) and the unusual feeling of intoxication, inducing jerky movements likened to "*Egyptian dancing*".
- Extreme users: have higher dosage levels (in relation to the "tolerance" of a given user). The effects the users are seeking (or those they encounter whether they seek them or not!) are hallucinations similar to those brought on by LSD, but also more radical and heightened dissociation effects⁶¹ including out of body experiences (the sensation of being outside your own body) or "*putting out the fires*" to quote an expression used by a harm reduction professional (i.e., lying down and no longer being able to move without losing consciousness). Such practices are only used by a very small group of users, often people aged over 35 and experienced, seeking mystical experiences (such as "astral trip") or young people belonging to the more radical fringes of the festive/party setting and particularly young *wanderers* visiting the festive environment seeking an alternative

⁶¹ Dissociation is one of the aspects of a psychotic state and involves a breakdown of the conscious unit.

lifestyle or drug, who are also found in the urban environment. It appears to be among these people that we find the most radical practices, and in particular injection to bring on effects which can be difficult to control.

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

Intramuscular injections

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

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

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

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

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

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

The localised misuse of methylphenidate

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

Benzodiazepines and alcohol are still widely consumed

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

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

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

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

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

5.1. Introduction

Definitions

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

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

Data collection tools

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

The aim of RECAP is to be able to track the number, the characteristics and the patterns of use of legal and illegal drug users welcomed by the CSAPAs at both a regional and national level.

RECAP is based on the information systems already in place in the various specialised centres (reception sheets, computerised management of patient files, etc.) and a minimum core set of questions to be used by all staff operating in the drug addiction field.

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

Background

The treatment policy concerning users of illegal drugs can be characterised by several major distinctive periods in France. Before the 1970s, illegal drug users were treated in psychiatric hospitals. The adoption of the 1970 law which made it possible for any drug user to obtain anonymous and free treatment to wean themselves off drugs saw the growth of special outpatient centres or residential centres, with the latter welcoming drug users after withdrawal. On the one hand, the psychiatric institutions did not wish to specifically deal with ever-increasing numbers of drug users, while on the other hand, the teams from the various associations proved to be ready and willing to get involved in treating these patients. Despite this, the two treatment systems continued to coexist, with the latter gradually gaining in importance vis-à-vis the former. The second major milestone in treatment policy was brought about by the rise of the AIDS epidemic. The public authorities reacted quite late in comparison to other countries in introducing substitution and harm reduction measures in the early 1990s.

The choice made in France to proceed with the rapid, large-scale circulation of substitution treatments involving the use of high-dose buprenorphine has resulted in general physicians playing a greater role in the treatment of opioid users. At the same time, the rapid spread of AIDS and the adoption of a harm reduction policy as a direct result of this raised the question of the drug users' access to general hospitals rather than psychiatric establishments to deal with both their somatic problems and their addictions. In much the same vein as the measures adopted for the treatment of alcoholism, liaison teams were set up for drug users, both to encourage treatment in somatic care departments and to avoid drug users seen for physical health problems leaving the hospital without an assessment and a proposed course of treatment for their addiction being proposed to them. The idea of incorporating addictology within hospitals was carried through to its logical conclusion in 2007 and the plan issued by the Ministry of Health, (which will be covered in the following section).

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

5.2. General description, availability and quality assurance

5.2.1. Strategy/Policy

In the current period, the care policies of the public authorities have been defined in two plans adopted in 2006 and 2008. The first, the 2007-2011 Plan for the care and prevention of addictions, which only affects care and prevention, was produced by the Ministry of Health at the request of the President of the Republic. The second, the 2008-2011 government drugs and drug addictions plan, mentioned in the previous report, was produced by the president of MILDT, Etienne Appaire (see chapter 1). This second Plan, which considers care, prevention and suppression, incorporates objectives from the previous plan and also sets new specific objectives.

The 2007-2011 Plan for the care and prevention of addictions (MINISTERE DE LA SANTE ET DES SOLIDARITES 2006) reaffirms the need for a policy targeting all addictive behaviour, both use of illegal substances, alcohol and tobacco and non-substance addiction such as gaming. This plan mostly concerns increasing the resources for care for addictions in the hospital system and envisages the creation of addictology consultation services or addictology liaison teams in all hospitals with an emergency department. These consultation services or liaison teams must be able to group together all existing consultations in smoking cessation, alcohol, and drug addiction in a single place and in a single department. Addictology services offering simple or complex withdrawal regimes are to be created between now and 2011 for patients requiring more specific care or hospitalisation. The plan also stipulates that each university hospital (i.e. 26 establishments) will have an addictology sector which will be both an addictology service for patients and a regional reference training and research centre.

This plan also restates some objectives already under discussion, such as bringing the specialist drug and alcohol addiction services into the framework of CSAPA (Addictology Treatment, Support and Prevention Centres), extending the facilities for therapeutic residential care for illegal drug users through the creation of several therapeutic communities and the involvement of primary care medicine by strengthening addictology health networks. The 2007-2011 plan also states that precise reference texts need to be produced for the patient care strategy before, during and after their care.

All of these objectives are restated in the 2008-2011 Government drugs and drug addictions plan (MILDT 2008) which, however, stresses some of these more specifically and proposes new objectives. The objectives proposed by MILDT are described below:

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

5.2.2. Treatment systems

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

5.2.2.1. Organisation and quality assurance

The specialised scheme

These centres were created following the adoption of the 1970 law which included a number of measures guaranteeing free and anonymous treatment for all users of illicit drugs wishing to receive treatment. Virtually all of the French "departments" today have at least one Specialised Drug Addiction Treatment Centre (CSST).

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

Three types of CSST can be distinguished:

- outpatient treatment centres (numbering 216 in 2007);
- inpatient treatment centres including therapeutic communities (numbering 40 in 2007); more precisely, these centres are rehabilitation centres for patients after detoxification or patients following substitution treatment. Residential detoxification is carried on in general hospitals.
- treatment centres in prisons (numbering 16 in 2007); these centres could be compared to outpatient centres, located inside the prison, which only treat people that are presently in jail. Drug free quarters in prison do not exist in France.

The outpatient CSSTs are designed to meet the outpatient withdrawal requirements of patients. They can also organise and support patients wishing to undergo drug withdrawal treatments in hospital. Where substitution treatments are concerned, since 1993/1994 and until quite recently (2002) the doctors working in a CSST were the only doctors authorised to initiate methadone treatments, with repeat prescriptions subsequently being issued by community physicians. Patients can also be prescribed high-dose buprenorphine (HDB) via a CSST. Additionally, patients can seek support and guidance via a scheme (psychotherapeutic -type support) and social integration assistance.

In France, the concept of "Drug-free treatment" is not really used and it is difficult to equate this to a given type of institutional treatment. However, a very limited number of "therapeutic communities" which are supposed to offer drug free treatment have been recently created. An evaluation study of these new centres is now carried on. The results of this study are not yet available.

In the course of 2009, all CSST will have to get a new administrative agreement as CSAPA for a three year period.

A circular⁶² of 28 February 2008 describes the missions of the CSAPA. These are almost identical to those which were carried out by the CSST. The CSAPA are responsible for receiving, informing and ensuring the psychological, medical and social assessment and onward referral of all people with an addiction problem to any substance or a non-substance addiction coming to their premises. The CSAPA therefore provide medical, psychological and socio-educational care combined with harm reduction, with the option of specialising either in illegal drugs or in alcohol.

Treatment via the general healthcare system

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

A - Hospitals

As referred to in the health policy section, the addiction prevention and care plan stipulated a new organisation for addictology care in hospitals. The administrative circulars of 16 May 2007 and 26 September 2008⁶³ gave precise instructions about the organisation to be set up within the hospital system. Hospital addictology care is organised into an addictology sector bringing together different components with the aim of allowing each person with addictive behaviour to access nearby escalating global management and, if necessary, a specialist technical platform. This sector involves three different levels.

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

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

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

The circular of 26 September 2008 also states that the hospital addictology care sectors must act in coordination with the CSAPA and CAARUD (Reception and Harm Reduction Support Centres for drug users) specialised schemes, primary care doctors and health networks.

⁶² Circulaire n°DGS/MC2/2008/79 du 28 février 2008 relative à la mise en place des centres de soins, d'accompagnement et de prévention en addictologie et à la mise en place des schémas régionaux médico-sociaux d'addictologie. NOR: SJSP0830130C.

⁶³ Circulaire n°DHOS/O2/2008/299 du 26 septembre 2008 relative à la filière hospitalière de soins en addictologie. NOR : SJSH0830983C.

B - General practitioners

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

Furthermore, the general practitioners are the first to intervene regarding patients just beginning their use of illicit drugs. With this in mind, the public authorities plan on introducing special training for general practitioners to enable them to spot these users and to familiarise them with the therapeutic solutions best suited to the situation.

5.2.2.2. Availability and diversification of treatment

Medical treatments (substitution, withdrawal)

Withdrawal treatments used or monitored by staff in Specialised Drug Addiction Treatment Centres (CSSTs).

In 2007, an average of approximately 19 patients per centre underwent outpatient withdrawal treatment via an outpatient CSST (table 5-1) and almost 14 patients undertook withdrawal treatments in hospital with the support of a centre. The data shown in table 5-1 reveals a major increase in the number of withdrawal treatments undertaken between 2003 and 2004. However, this change is almost certainly linked to changes in the wording of the questions following the adoption of a new report in 2004. Nevertheless, the trend is clearly an upward one and this has been the case since the 1990s. This change needs to be put in perspective, as the total number of people welcomed by the specialist centres has also increased sharply since the late 1990s.

These average numbers of patients undergoing withdrawal treatment also include people withdrawing from alcohol. People received in these centres for alcohol problems only make up a small proportion of all of those seen in the centres although the possibility that alcohol is involved in a larger number of these withdrawal treatments cannot be excluded.

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

	1999	2000	2001	2002	2003	2004	2005	2006	2007
Average number of patients per CSST having undertaken outpatient withdrawal treatments provided by the CSST.	5.7	6.2	8.4	10.6	11.0	16.8	16.1	17.5	18.9
Average number of patients per CSST having undertaken a withdrawal treatment in hospital, with the support of the CSST (per centre)	N.Av	N.Av	N.Av	N.Av	N.Av	10.3	13.2	12.8	13.8

Source: Processing of the standard activity reports from the outpatient CSSTs 2005, DGS/OFDT.

Guide to the table: on average, 5.7 patients per CSST undertook an outpatient withdrawal treatment provided by the CSST in 1999. Note: the calculations were made by excluding those centres issuing more than 150 withdrawal treatments or who failed to answer the questions concerning their activity.

Substitution treatments for patients attending front-line structures

At the time of the 2006 Prelud survey, 60% of users stated that they were receiving a medically prescribed substitution treatment. In just under two-thirds of these cases, HDB was used (62.2%), while a third received methadone (32.4%). Finally, a minority (4%) received a treatment based on morphine sulphate.

On average, users receiving a substitution product tend to be older than those not receiving a treatment of this kind. While the average age of the latter stands at 32.1 years old, this rises to 33.6 years old for users receiving an HDB substitution treatment, 34.7 years old for those receiving methadone and 35.2 years old for those receiving morphine sulphate.

In 79% of cases for morphine sulphate, 59.0% for HDB but only 16% for methadone, the substitute drug was also mentioned among those substances used for extra-therapeutic

purposes. Thus, among drug users receiving morphine sulphate and HDB, it would appear that it is the prescribed drug itself which is most often mentioned as the substance causing the most problems by contributors (66% and 42% respectively). Indeed, among the active drug users interviewed via the CAARUDs, a majority use injection as the preferred route of administration, with sniffing or smoking being less common. On the other hand, among those receiving methadone, this drug is mentioned as problematic in only a small number of cases (9%), being outpaced by heroin (24%) and cocaine/crack (19%). Unlike the other two substitute drugs, methadone (when used outside the scope of a therapeutic programme) is almost exclusively used orally (96%) (Toufik et al., 2008).

The issuing of substitution treatments

Two medicinal products are used in the treatment of opiate substitution: methadone, prescription of which can only be initiated in the CSST or CSAPA and care institutions and High Dosage Buprenorphine (HDB) or Subutex®, which can be prescribed from the outset by any doctor. After first being marketed in 1996, HDB very quickly became quantitatively the leading treatment for opiate dependency in France. Since 2006, Subutex® has also not been the only available substance as generic preparations appeared on the market (particularly HDB Arrow® in 2006 and then HDB Merck® in 2007⁶⁴). The generic form was accepted above all by a number of users who were earlier in their drug addiction trajectory than the average user and were better integrated into a care protocol and more stable. The 2008 iteration of the OPPIDUM survey (see Appendix V-O) (Afssaps-CEIP 2008) showed that the average age of the 31% of patients receiving generic HDB in specialist care centres was two years younger than the others and that their average daily doses were approximately 1 mg less than doses taken by other patients.

Recent data from the Caisse nationale de l'assurance maladie (French National Health Insurance Organisation System) show that almost 125,000 people received reimbursements for opiate substitution treatments in 2008, with the particular French feature of a clear predominance of HDB which made up 80% of the total. In 2008, generics made up almost 30% of HDB reimbursements.

The proportion of patients treated with methadone, however, continues to rise and it should be noted that improving access to this drug was one of the recommendations from the Consensus Conference on substitution treatments in June 2004. French National Health Insurance Organisation System data also show that reimbursements for HDB increased by +24.3% compared to +155% for methadone over 4 years.

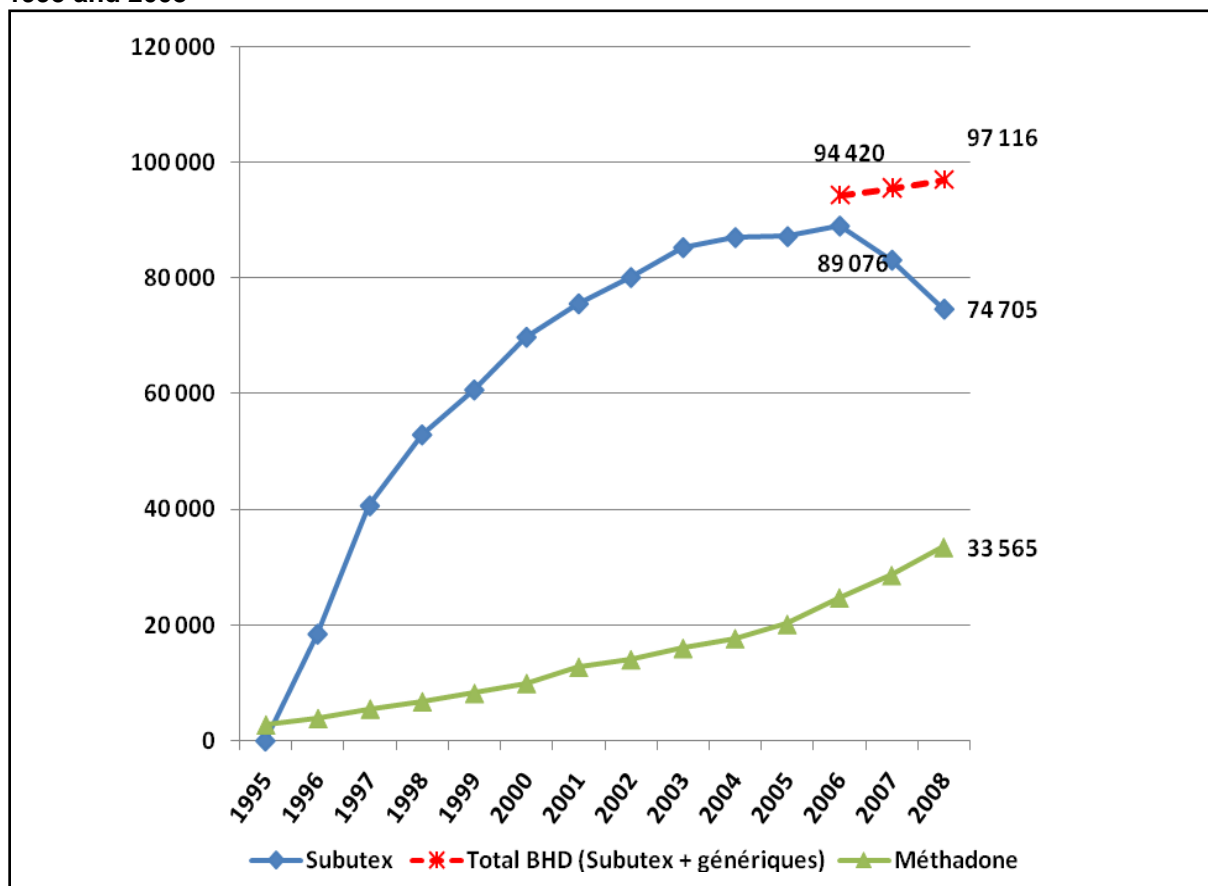
The graph 5-1 below shows the estimated numbers of patients treated with HDB and methadone in France. These come from the sales figures for the two substitution drugs provided by GERS⁶⁵ with the starting hypothesis that the average daily doses prescribed over a year were 8 mg for Subutex® and 60 mg for methadone. The amounts of Subutex® sold therefore are equivalent to 74,705 theoretical patients receiving a daily dose of 8 mg throughout 2008. A similar calculation for methadone produces a theoretical number of 33,565 patients (based on primary care and hospital reimbursement data). These are theoretical patients as not all actual patients are as compliant and do not all take treatment from 1st January to 31st December. In any given year, some may stop their treatment and others may start it. The number of people with at least one prescription for one substitution treatment is therefore logically higher than this number of theoretical patients.

HDB generics introduced after 2006 “compensate” the actual reduction in the number of patients taking Subutex® since 2006 as shown in the graph. An extrapolation permits to estimate the part of patients benefiting from generic forms (regular increase up to 30 % of HDB patients in 2008). In all, around 97 000 patients have received HDB (princeps or generic form) in 2008, in accordance with Health Insurance Organisation system data.

⁶⁴ HDB Merck became HDB Mylan ® in 2008

⁶⁵ Groupement pour l'élaboration et la réalisation de statistiques (Statistics Production and Analysis Group)

Graph 5-1: Opiate substitution treatments: estimated number of people receiving opiate substitution treatment (Subutex® 8 mg, generic forms of HDB, Methadone 60 mg) between 1995 and 2008



Source: GERS/SIAMOIS/InVS

Misuse and dealing of HDB

It is important to recognise that some prescribed HDB is misused and that it is not always taken for treatment. This proportion, however, has fallen since the Assurance maladie introduced a testing plan for opiate substitution⁶⁶ treatments, since one of the main indicators for HDB misuse (average daily dose over 32 mg/D⁶⁷) fell by two-thirds between 2002 and 2007. At the time, six per cent of people were taking more than 32 mg/D of HDB in 2002 compared to 2% in 2006 and 1.6% the following year according to a recent study (CANARELLI et al. 2009). In the same way as with the previous 2002 study, this study also found that two-thirds of people who had received reimbursements for opiate substitution treatments in 2006 and 2007 were taking regular treatment and therefore, in principle, were included in a treatment pathway. Not all of the other recipients of these treatments, however, are necessarily outside of any care process.

With the exception of the town of Toulouse, it appears that the measures used had only limited impact on HDB availability in the black market. Some regions, particularly the Paris and Marseilles regions and, to a lesser extent, the East of France, have seen, since 2007, the appearance of more organised dealing: fewer users re-selling their excess but more organised assurance maladie fraud carried out by collective organisation: “doctor shopping”

⁶⁶ The Assurance maladie testing introduced since 2004 mostly attempted to identify dealers (“patients” and also a few doctors and pharmacists) through reimbursement data and to correct the situation with users who have at least 5 prescribers or being given an average dose of more than 32 mg

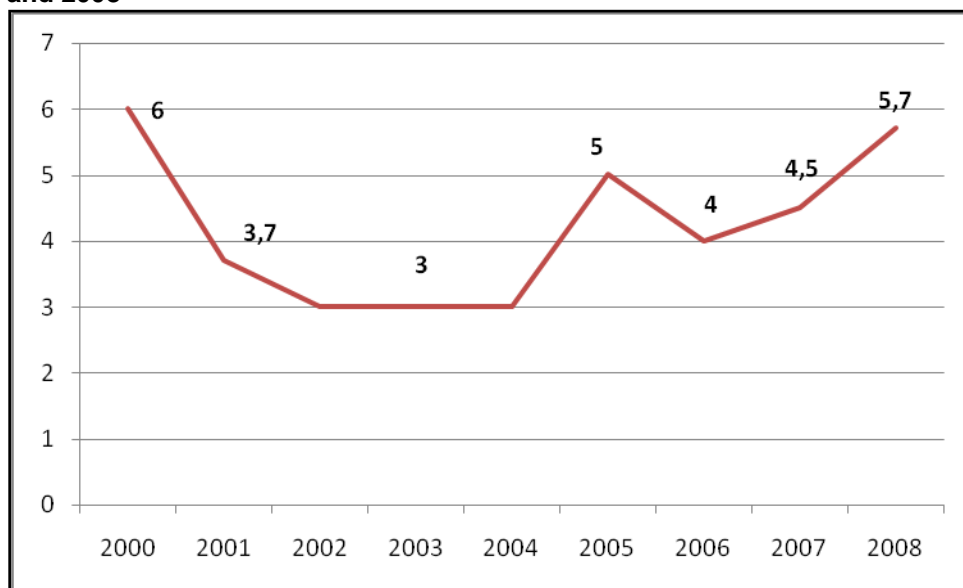
⁶⁷ The maintenance dose of HDB is 8 mg/D with a maximum dose of 16 mg/D. An average daily dose of more than 32 mg/D is an indicator of very suspicious HDB use (dealing and/or resale).

(theft of the *carte vitale* cards that grant health treatment rights in France, recruitment of “false users”, consultations in several *departments*, etc.).

Groundwork in the techno party arena has revealed that this substance is only used marginally and that its availability is also marginal except in very large events.

In 2008, HDB has therefore again been described as being very easily available and accessible on the black market although it is still more expensive (average 5.7 Euros for an 8mg tablet) and has therefore returned to the same price level as in 2000 (Graph 5-2) (CADET-TAIROU, A. et al. 2010).

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



Source: TREND / OFDT

Misuse involves three types of administration: injecting, sniffing and less often, smoking. Whereas injection remains the most widely used route of administration when the drug is not used for its therapeutic purpose, sniffing is the method used in “long-standing” injectors because of their deteriorating venous access and health complications from frequent injecting. In 2009 (Afssaps-CEIP 2009), 7% of users in a substitution protocol seen for treatment purposes injected HDB, 8% sniffed and a tiny proportion of users inhaled. Amongst those people also seen for treatment purposes, but who reported that they used HDB outside of a treatment protocol, 16% injected, 46% sniffed and 49% took the drug orally. The prevalence of HDB injection has continued to fall annually in this second group (34% in 2005) and this fall has accelerated markedly since 2006. Sniffing, however, has seen the reverse change (34% in 2007).

Methadone misuse

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

Substitution treatment in hospital

A survey conducted in 2007 by the OFDT (OBRADOVIC et al. 2008b) to assess the impact of circular no. 2002/57 of 30th January 2002 on initial methadone prescribing by doctors

practising in health institutions (hospitals and prisons) demonstrated that access to methadone had increased in these two areas six years after this circular was introduced.

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

Substitution treatment in prison

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

5.3. Access to treatment

5.3.1. Characteristics of treated clients (TDI data included)

Total number of clients receiving treatment

Data compatible with the TDI protocol are only recorded from people seen in the CSST in France. This is also not an exhaustive data collection exercise, as approximately a quarter of CSSTs did not provide data in 2009. The TDI data also only concern people who are starting or restarting treatment and other sources must therefore be used to provide a quantitative assessment of the total number of people seeking aid from professionals because of their problems with illegal drug use.

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

The only national data available for primary care is for people receiving substitution treatment. The figures shown above indicate that approximately 130,000 people were reimbursed for substitution treatment by the Social Security organisations in 2007. Some of these people are also included in the figures for people having gone to a CSST in 2007.

National data are available for hospitals from the PMSI⁶⁸ medico-economic information system about the number of hospitalisations with a main diagnosis of behavioural disorders due to use of psychoactive substances, excluding alcohol and tobacco (diagnoses ICD-10: F11 to F16, F18 and F19). There were 5,800 of these hospitalisations in 2007, 4,000 of which lasted over 24 hours. It should be noted that these results do not include attendances

⁶⁸ <http://stats.atih.sante.fr/mco/diagone.php>

at emergency services and relate to the hospital stays of 5,200 patients. Overlapping also exists between hospitalised patients and those seen in specialist centres or primary care. Other findings from 2005, from a liaison team activity report, which was only requested for one year, estimated the number of people seen in hospital outpatient consultations (i.e. people who are not hospitalised) for problems with illegal drug use at approximately 8,000. Again, it is not possible to add these figures to the others because of the many risks of overlapping between these people and those who are hospitalised or recorded in the other sectors described above. Hospital data are very patchy although it appears to be relatively clear that the number of people who have problems with illegal drug use and who were seen at hospital (excluding CSST) over a year was, until recently, relatively small compared to the total number of people seen in the CSST (maximum 10%).

Characteristics of all clients starting treatment in specialized centres

The profile of those persons receiving treatment shown in this paragraph corresponds to that of new patients having started treatment in 2009, exclusively via the outpatient treatment centres.

In 2009, 160 outpatient CSSTs participated in RECAP, equivalent to 74 % of all outpatient treatment centres. The data shown below concerns more than 44,000 patients (referred to as "new patients") who started a new episode of treatment in one of these centres during the year.

Those persons receiving treatment for the first time in their life (referred to as "first-time patients") accounted for 31 % of all new patients seen. For the other patients, these were new requests for treatment in a given centre or a renewal of treatment following a break in contact with the treatment centre in excess of six months. The percentage of first-time patients among all patients should be taken with caution since information concerning the existence of previous treatments is unknown in 24 % of cases.

In the use descriptions shown below, it has to be borne in mind that in approximately 21 % of the cases there is no information on the main drug.

Socio-demographic characteristics of patients

Among the new patients, 81% were male and aged on average 30.3 years. This mean age is actually the result from the mix of two subpopulations, cannabis users on one hand, with a mean age of 25 and opiates and cocaine users on the other hand with a mean age around 34. Patients seeking treatment for the first time in their lives have a slightly higher proportion of male among them (83 %) and are on average younger, with a mean age of 26. The most extensively represented age group among all treatment patients is that of the 20-24-year-olds (accounting for 20 % of patients) with the under 25s accounting for 33 % of the total. A little more than 19 % was aged over 40. In contrast, more than half of first treatment patients are under 25 and 8 % were aged forty or over. As will be seen further, this difference of age is closely related to the higher proportion of cannabis users among first treatment patients.

Table 5-2: Breakdown of patients by age (as a %), in 2009.

Age	All treatments	First treatments
< 20 y.o.	12.6	24.6
20-24 y.o.	20.4	27.9
25-29 y.o.	20.2	20.4
30-34 y.o.	14.8	11.5
35-39 y.o.	13.4	7.6
40-44 y.o.	9.3	4.0
45-49 y.o.	5.4	2.1
50 and over	3.9	1.9
Total	100.0	100.0

Source: RECAP / OFDT – 2009.

The two main sources of referral are the patient's own initiative (35%) and the justice system or the police (29%). In the case of the first treatment it can be noted that this latter source of referral accounts for almost half of the patients (48%). Most of the people referred by court or police are cannabis users. The results concerning the origin of the consultations are shown in Table 5-3.

Table 5-3: Breakdown of patients by treatment origin (as a %), in 2009.

Origin of the treatment	All treatments	First treatments
Patient's own initiative	35.5	23.3
Family or friend	9.3	9.5
Other specialised centres for drug users	6.4	1.7
General practitioners	7.2	5.2
Hospital or other medical establishment	5.0	3.6
Social services	3.7	4.0
Police, courts or court-ordered treatment	29.4	48.0
Other	3.5	4.7
Total	100.0	100.0

Source: RECAP / OFDT – 2009.

Patients most frequently live with their parents or alone (35 % and 29 %) and most often live in stable housing (77%). Nevertheless, 20 % of them stated that they live in precarious housing conditions. Due to the higher proportion of younger people among them, first treatment patients are less likely to live alone and more with their parents.

Table 5-4: Breakdown of patients by living status (with whom) (as a %), in 2009.

Living status (with whom)	All treatments	First treatments
Alone	28.5	22.3
With parents	35.3	46.2
Alone with child	2.9	2.2
With partner (alone)	12.5	11.6
With partner and child(ren)	11.4	9.8
With friends	3.2	2.6
Other	6.3	5.3
Total	100.0	100.0

Source: RECAP / OFDT – 2009.

Regarding their socio-professional situation, economically inactive or unemployed patients accounted for a total of 46 %, while just over a quarter (27 %) have a regular job and 14% are still at school or students (please see Table 5-5). First treatment patients differ from all treatment patients by a higher proportion of student and pupils and lower proportion of economically inactive. Where the patients' educational profiles are concerned, 63% of people treated in the CSSTs in 2009 had reached secondary school level. A total of 4% of users had

not got past primary school level and 32 % stated that they had an educational level above the *baccalauréat* (A-level/High School Diploma). Distribution of educational level is not different among first treatment patients.

Table 5-5: Breakdown of patients by professional situation (as a %), in 2009.

Professional situation	All treatments	First treatments
Regular employment	26.9	28.3
Student, secondary school pupil	13.7	22.6
Economically inactive	21.6	13.8
Unemployed	24.0	20.6
Other	13.9	14.7
Total	100.0	100.0

Source: RECAP / OFDT – 2009.

Drug use

Table 5-6 features a detailed breakdown of patients according to their declared main drug in 2009.

Almost half of the patients (46%) sought help from the treatment centres in 2009 for problems related to cannabis use. A majority of them (56 %) declared that they used cannabis on a daily basis. Proportion of first treatment patients with cannabis as primary drug is higher than for all treatment patients and reaches two third. Distribution of frequency of use is not different in the two groups. The importance of cannabis users among patient in treatment in France is partly the consequence of the large and still increasing number of arrest for cannabis use. Part of the arrested users is addressed to treatment centres by courts. The creation of young consumers treatment units, mainly dedicated to cannabis users, may seem to have played an important role in increasing the number of cannabis users in contact with treatment centres but, as will be seen later (section 5.5), data on total number of people treated for cannabis use since the end of the nineties show an increase that took place before the launch of the young consumers treatment units.

Opiates are identified as the main drug by 43 % of patients. In all, 80 % of them took heroin, with methadone accounting for 4% and other opiates (including HDB)⁶⁹ 17 %. Among the opiate users, almost 80% consumed the substances on a daily basis and 12 % took them regularly (i.e. several days a week). The opiates are generally sniffed (50%) or injected (25%). Proportion of first treatment patients with opiates as main drug is much lower than for all patients (25 % vs. 43 %). Distribution of frequency of use is similar in the two groups although there is a slightly higher proportion of daily use among first treatment patient. Injecting use as route of administration of opiates is much less frequent among this group than among all treatment patients (12 % vs. 25 %).

⁶⁹ For methadone and HDB, this means use not for therapeutic use.

Table 5-6: Breakdown (as a %) according to the main drug taken, 2009.

Main drug	All treatments	First treatments
Heroin	33.8	21.2
Methadone	1.7	0.9
Other opiates	7.3	3.0
Cannabis (all)	45.8	66.6
Barbiturates	0.1	0.0
Benzodiazepines	1.7	0.6
Other hypnot. and tranquilizers	0.4	0.2
Cocaine	5.4	5.0
Crack	1.6	0.7
Amphetamines	0.2	0.2
MDMA and other derivatives	0.3	0.2
Other stimulants	0.0	0.0
LSD	0.2	0.2
Other hallucinogens	0.1	0.0
Volatile inhalants	0.2	0.3
Other substances (all)	1.0	0.8
Total	100.0	100.0

Source: RECAP / OFDT – 2009.

Cocaine is the third main drug, being mentioned by more than 5% of patients. Cocaine users declared that they use it every day (35%) or frequently (25%). The cocaine is sniffed (67%) or smoked (18%) and it is also injected by a non-negligible percentage of patients (13%). Cocaine is slightly less frequently mentioned as main drug among first treatment patients but the difference is not very important. Among cocaine users seeking treatment for the first time in their life, the percentage of persons injecting cocaine is smaller than among all treatment cocaine users (5 % vs. 13 %) while a larger proportion is sniffing this substance (76 % vs. 67 %).

Among all patients seeking treatment in 2009, more than three quarters (74%) stated that they had never used injection as a route of administration. Those patients having used intravenous administration can be broken down into two groups: 15% of them had not used this method recently and 11% stated that they had injected during the month preceding the interview. Those who used injection during the month gone by are mostly opiate users (81%): 53% are heroin addicts and 26% declared other opiates (including HDB) as their main drug. Nevertheless, a non-negligible number of people using injection as an administration method are receiving treatment for cocaine use (8%). The persons welcomed by the CSSTs for the first time in their lives tend to use intravenous administration less often than patients who have already received treatment. Thus, in 2009, 92% of first-time outpatients (considering all products together) had never used injection as an administration method (vs. 74% among all treatment patients).

5.3.2. Trends of clients in treatment

Patient data that are TDI-compatible have only been available in France since 2005. Consequently, changes in these data can only be genuinely monitored over a relatively short period of time.

The figures in Table 5-7 show a continuing increase in mean age for all patients beginning a new course of treatment and for patients having never before been treated. Examination of the change in distribution by age group (Table 5-8) shows that this ageing appears to be due, above all, to a fall in the proportion of 15- to 24-year-olds, particularly the 15- to 19-year-olds in favour of people who are 40 years old or older. This marked fall in the 15- to 19-year-old figure is also seen for “first treatment” requests with, however, a stabilisation occurring between 2007 and 2009. According to the data from the activity reports on CSST’s clients, the proportion of those under 18 years old, who are mostly cannabis users, rose rapidly at the start of the 2000s and then began to fall from 2005 onwards. It is important to bear in

mind when interpreting these changes that, according to the activity reports provided by the CSST, the number of people received has tended to increase annually. A fall in the proportion of the under-18-year-olds does not necessarily mean that their absolute numbers are falling.

Table 5-7: Mean age of patients, evolution 2005-2009.

	2005	2006	2007	2008	2009
All treatments	28.0	28.3	29.1	29.4	30.3
First treatments	24.1	25.0	25.9	26.2	26.0

Source: RECAP / OFDT – 2005 - 2009.

Table 5-8: Distribution of patients by age (as a %), evolution 2005-2009.

	2005	2006	2007	2008	2009
<15	0.6	0.8	0.7	1.4	1.2
15-19	16.0	14.8	11.9	11.3	11.4
20-24	24.8	25.2	24.7	23.3	20.4
25-29	19.0	19.4	21.2	21.4	20.2
30-34	16.6	15.4	14.9	14.6	14.8
35-39	12.3	12.3	12.5	12.7	13.4
40-44	6.8	7.1	8.4	8.4	9.3
45-49	2.5	3.2	3.5	4.2	5.4
50-54	0.8	1.2	1.4	1.7	2.3
55-59	0.3	0.5	0.6	0.7	1.0
60-64	0.2	0.2	0.2	0.3	0.4
>=65	0.1	0.1	0.1	0.2	0.3
Total	100.0	100.0	100.0	100.0	100.0

Source: RECAP / OFDT – 2005 - 2009.

Apart from the ageing trend of people received in the centres, the characteristics of patients have not changed much over the period 2005-2009. Consistent with the fall in the proportion of 15- to 24-year-olds, the percentage of people living with their parents has fallen from 42% to 35% whereas the proportion of those living alone has increased from 25% to 29%. For reasons also related to the change in age distribution, the proportion of pupils and students has fallen back from 17% in 2005 to 14% in 2009, whereas the proportion of people in regular employment has increased from 23% to 27%.

In terms of the main products, there is an increasing trend in the percentage of patients having difficulties with cocaine or crack (7.1% in 2009 compared to 5.7% in 2005). The percentage of drug users seen mainly because of opiate problems appears to have increased in 2009 (42.9%) after varying between 39% and 40% from 2005 to 2008. This relative increase is associated with an almost equivalent fall in the proportion of people seen with cannabis problems in 2009 (from 47.8% in 2008 to 45.8% in 2009). This change is to a large extent due to the participation of new centres in 2009. On a "like-for-like" basis, when only data from the centres who also took part in 2008 are analysed, the increase in the percentage of opiate users and fall in the percentage of cannabis users remain visible, but

are less significant (41.4% compared to 42.9% for opiates and 47.3% compared to 45.8% for cannabis).

Data on route of administration for 2005 to 2009 show a fall in the trend in the percentage of opiate and cocaine users taking the drugs intravenously.

Table 5-9: : Percentage of patients currently injecting by primary product, evolution 2005-2009.

	2005	2006	2007	2008	2009
1. Opiates (total)	24.8	24.6	20.9	21.2	20.9
11 heroin	20.6	20.5	17.0	17.8	17.2
12 methadone	17.4	13.2	11.3	10.3	12.0
13 other opiates	44.1	44.3	39.6	39.9	39.5
2. Cocaine (total)	15.4	16.2	13.1	14.4	13.7
21 cocaine	18.0	18.1	14.4	15.5	15.2
22 crack	6.6	8.8	7.8	10.7	9.3

Source: RECAP / OFDT – 2005 - 2009.

6. Health correlates and consequences

6.1. Introduction

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

HIV/AIDS and viral hepatitis

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

- The declared prevalence of HIV, hepatitis B and hepatitis C: initially recorded by the so-called "November" survey (information concerning patients visiting the CSSTs), this data was later supplied via the RECAP scheme (patients seen by the CSSTs and CSAPAs) from 2005 onwards (PALLE et al. 2007b), and via the surveys carried out involving patients seen by so-called low threshold services, and particularly the PRELUD and ENA-CAARUD surveys. The declared prevalence of HIV, hepatitis C and hepatitis B vary according to the studies and the routes of administration adopted by the users (injection and sniffing, etc.).
- The biological prevalence of HIV and hepatitis C (blood samples) supplied via the Coquelicot survey (see Appendix V-C) (JAUFFRET-ROUSTIDE, M. et al. 2006). The survey, which is intended to eventually become a national information system, has highlighted the variation between declared prevalence and measured prevalence of hepatitis C, particularly among the youngest users.
- The biological prevalence of HIV and hepatitis C (saliva samples) among users attending low threshold services: the PRELUD survey (the TREND report, 2007) which began in February 2006 in nine French towns and cities.
- Incidence estimates applied to cases of AIDS and those of HIV infection. The declaration of AIDS cases (InVS) has been in force since the early 1980s and has been compulsory since 1986. A new, anonymous declaration scheme was introduced in 2003 via a circular from the Directorate General for Health -DGS- (no.2003/60 of February 10, 2003), making it also compulsory to declare HIV infections. This system is combined with the virological monitoring of HIV.

The number of new AIDS cases related to injectable drugs has been falling constantly since 1994.

STIs and tuberculosis

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

Other infectious morbidity

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

Behavioural data

In France, quantitative informations are available (ENA-CAARUD study conducted by the OFDT and Coquelicot conducted by the InVS) as well as qualitative information (TREND scheme and qualitative section of the Coquelicot survey). They inform us on the drugs users own perception of their state of health and their at risk behaviours (CADET-TAIROU, A. et al. 2010; Cadet-Tairou, A. et al. 2008b; JAUFFRET-ROUSTIDE, M. et al. 2006). The surveys carried out as part of the TREND system among the drug users attending the low threshold

services previously supplied information concerning the perception of their state of health and the appearance of certain pathologies (Bello, P. Y. et al. 2004; BELLO, P.-Y. et al. 2005).

Psychiatric comorbidities

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

Drug-related deaths

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

- by drug dependence (CepiDc-INSERM). This category concerns all deaths for which the death certificate mentions drug dependence. For reasons related to the information circuit used, the availability of this data is however subject to a lead time of two years. The number of deaths through drug dependence fell between 1995 and 2002 before rising again after 2003. Some overdoses are listed as deaths with poorly defined causes.
- with the presence of psychotropic substances in the blood: the DRAMES scheme (see Appendix V-D) (Death involving the abuse of medicines and substances – AFSSAPS) lists cases of death having resulted in a legal investigation and a request for a toxicological analysis and/or post-mortem. The key objective of the DRAMES scheme is not to draw up an exhaustive description of the number of overdoses but rather to assess the substances causing the deaths and their combinations (particularly with medicines). The number of laboratories involved in the scheme has constantly increased (7 in 2002 and 19 in 2008). The number of deaths by opioid overdoses has increased in addition to that resulting from the misuse of substitution treatments (methadone and HDB) and stimulants.
- by overdose when the death results in legal proceedings (OCRTIS). This statistical source covers only those deaths notified to the police or the gendarmerie. It does not include deaths of French citizens by overdoses abroad and deaths occurring in hospitals. Since 1995, the number of deaths due to overdose recorded by the security forces fell continuously (- 80 % between 1995 and 2003) before rising again. The OCRTIS has published no new overdose data since 2008.
- related to AIDS, among intravenous drug users (InVS). The number of deaths by AIDS among intravenous drug users has been falling continuously since 1994.

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

6.2. Drug related Infectious diseases

6.2.1. HIV/AIDS and viral hepatitis

Surveillance system for HIV infection, new cases of AIDS

Since the introduction of mandatory notification of HIV in March 2003, there have been 32,594 reports of people found to be seropositive. Taking account of declaration times delays and under-declaration, the number of positive notifications in 2008 was estimated to be 6,500, a relatively stable figure compared to the previous year (6,400 in 2007) in line with the downward trend with regard to previous years (7,000 in 2006 and 7,500 in 2005).

Infection from injectable drug use (IDU) in 2009 made up slightly less than 2% of these new cases of infection (Table 6-1). The most common mode of transmission is heterosexual (44% of cases), particularly in women (66% of cases), followed by homosexual intercourse (22.6% of cases making up 36% of infections in men).

Table 6-1: People found to be HIV seropositive in 2003-2009 by mode of transmission (France, data as of 30/12/09).

Method of infection	Women		Men		Total	
	n ^a	%	n ^a	%	n ^a	%
Heterosexual intercourse	7,998	65.6	6,243	30.6	14,241	43.7
Homosexual intercourse	-	-	7,381	36.2	7,381	22.6
Drug injection	102	0.8	389	1.9	491	1.5
Others ^b	101	0.8	135	0.7	236	0.7
Not known	3,995	32.8	6,250	30.6	10,245	31.4
Total	12,196	100	20,398	100	32,594	100

a: Number of provisional cases not adjusted for under-declaration

b: 166 cases of mother-to-child transmission, 41 homosexual drug users, 10 transfusion patients and 2 haemophilia patients infected in the 1980s.

Source: InVS mandatory HIV infection notification system (data as of 30/12/09)

The number of new cases of AIDS in IDU has fallen continuously since the middle of the 1990s. Whereas IDU accounted for a quarter of people diagnosed at the AIDS stage at that time, they represented only slightly under 8% in 2008 and slightly under 5% in 2009 (provisional data).

Table 6-2: New cases of AIDS in IDU, 1999-2009.

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008*	2009*
IDU	313	248	260	207	176	168	121	98	85	75	23
Total new cases of AIDS	1,849	1,745	1,685	1,658	1,489	1,397	1,339	1,146	983	990	536
IDU proportion (%)	16.9	14.2	15.4	12.5	11.8	12	9.0	8.6	8.6	7.6	4.3

*: provisional data not adjusted for under declaration times as of 30/12/09

Source: InVS AIDS surveillance system. (Data as of 30/12/09)

PRELUD data

The survey among drug users attending low threshold services (PRELUD) conducted by the OFDT in 2006 provided a review of practices and use of psychoactive substances in a high prevalence user population. This was conducted voluntarily in "low threshold" services which have since become CAARUD⁷⁰. In 5 of the 9 PRELUD sites in 2006 (Dijon, Lyon, Metz, Rennes and Toulouse), each user interviewed was asked to give a salivary sample to test for marker antibodies of HIV and HCV infection. This PRELUD "bio" survey found that the prevalence of HIV infection was 8.5% amongst the people seen (ST9 Part 2). 5.0%⁷¹ of those who said that they were negative had a positive test.

⁷⁰ Reception and harm reduction support centres for drug users

⁷¹ Differences observed with the results of the Coquelicot survey can be explained by the following :

- The population is different (one involves injectors and "sniffers" seen in a wide range of institutions/centres and the other exclusively considers users from low threshold services who are, on average, 5 years younger);
- The method is different (in terms of laboratory testing and recruitment plan);
- The towns surveyed were also different.

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

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

Source: PRELUD 2006, Trend / OFDT

Reported data (the only data available to observe changes in France to date) obtained in the nine towns showed a decrease in reported HIV virus infection between 2003⁷² and 2006 from 10.2% to 6.2%.

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

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

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

Source: PRELUD 2006, Trend / OFDT

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

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

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

⁷² Last version of the “Low Threshold” survey in 2003 replaced in 2006 by the PRELUD survey.

ENa-CAARUD data

The aim of this national survey, conducted for the second time in 2008 among 3,138 users seen in 122 certified CAARUD⁷³, is to take account of the diversity and methods of use in a large population of current drug users. In particular, it provides information about the reported serological status of users seen in these centres (HIV and Hepatitis C). The majority of drug users in 2008 had had these screening tests performed (87.2% for HIV and 83.8% for HCV) of which 6% reported that they were positive for HIV and 28% for HCV. Similar screening rates were seen in the previous survey in 2006, (84% for HIV and 81% for HCV) although there were more positive declarations. In the same way as for the reported data from the PRELUD survey, data obtained from CAARUD users show a fall in declaration of HIV seropositivity (6.3% compared to 7.3% in 2006), although this fall is not significant. They do suggest, however, a significant fall in the prevalence of hepatitis C (28% compared to 35% in 2006, $p < 0.01$).

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

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

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

In the same way as for the PRELUD⁷⁴ survey, the proportion of users from low threshold facilities who had never had a screening test appears to have fallen over time with 13% in 2008 compared to 16% two years earlier for HIV and 16% compared to 19% for HCV.

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

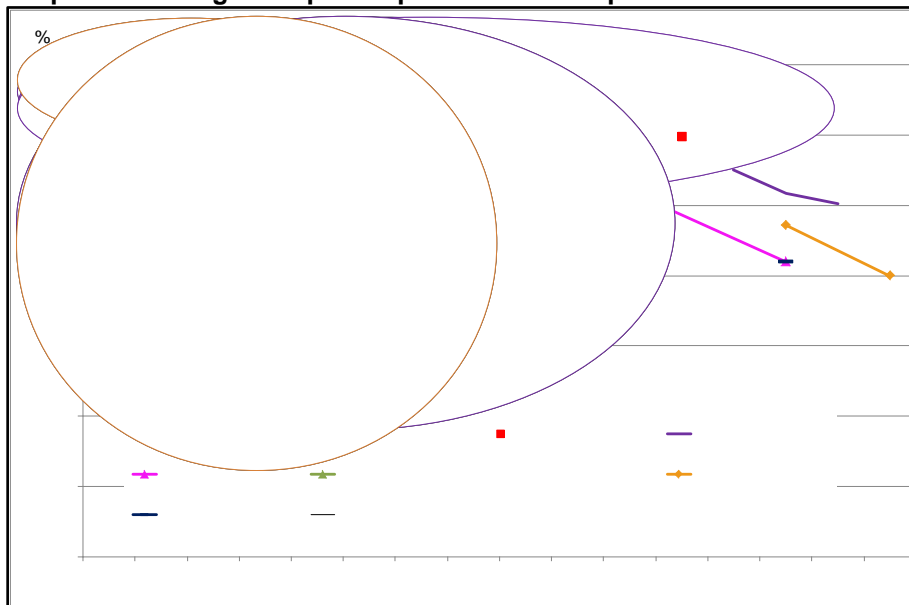
Summary

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

⁷³ The 2006 survey included on 3,349 users recruited in 114 CAARUD

⁷⁴ 10% of drug users seen in the PRELUD 2006 edition stated that they had never had a screening test for HIV in 2006 compared to 18% in 2003 (Low threshold surveys) and 16% declared that they had never had a test for HCV compared to 21% 3 years earlier.

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



Sources:

UDI/CSSTH: Injectible drug users in residential structures

UD/CSST-outpatient: Drug users treated in specialist care centres

UDI / RECAP/CSST: Drug users treated in specialist care centres

UDI/TREND/CAARUD: Injectible drug users who are low threshold facilities clients (CAARUD)

UDI/ENa-CAARUD: Injectible drug users using the CAARUD

UDI/PES: Injectible drug users using a SEP (syringe exchange programme)

UIDS /Coquelicot: Injectible and sniffing drug users, laboratory data

UDI/TREND bioPRELUD Injectible drug users who are CAARUD's clients, laboratory data

A national viral hepatitis B and C plan⁷⁵ was also started in France by the Ministry of Health in 2009 and envisages activities over 4 years (2009-2012). This involves 5 major objectives: increasing preventative activities to reduce the number of new possible infections, increasing screening activities⁷⁶ and access to care, setting up appropriate complementary measures in prisons (particularly for screening) and improving epidemiological knowledge on the subject.

Psychiatric comorbidities

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

6.2.2. STIs and tuberculosis

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

6.2.3. Other infectious morbidity

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

⁷⁵ This follows two other plans. The 1999-2002 Hepatitis C Plan and the 2002-2005 hepatitis B and C Plan

⁷⁶ The proportion of people aware of their hepatitis C seropositivity increasing from 57% to 80% and those aware of their hepatitis B seropositivity increasing from 45% to 65%

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

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

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

6.2.4. Behavioural data

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

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

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

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

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

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

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

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

6.3. Other drug-related health correlates and consequences

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

6.3.1. Non-fatal overdoses and drug-related emergencies

7.4% (224) of the users interviewed in 2008 in the ENa-CAARUD survey reported that they had had an episode of loss of consciousness after taking psychoactive substances in the previous twelve months (CADET-TA ROU A. et al. 2010).

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

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

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

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

6.4. Drug-related deaths and mortality of drug users

6.4.1. Drug-induced deaths (overdose/poisonings)

Fatal overdoses from drug use are shown in the following table. The General Mortality Register (C piDc) data from death certification processing follow the EMCDDA selection B⁷⁷, although the T codes are very rarely used in France. There is an increasing divide between all deaths recorded and those in people between 15-64 years old due, to a large extent, to

⁷⁷ Common definition of fatal overdoses applied to all European countries:
<http://www.emcdda.europa.eu/situation/diseases-and-deaths/3>

deaths in elderly people receiving palliative treatment (these deaths are most often coded X42).

Here again, the increase in overdoses in 2006 seen in the DRAMES data is explained by the increasing number of forensic laboratories taking part in the data collection. Numbers have remained almost stable since then and we may conclude that there is an upward trend in the number of overdose deaths between 2006 and 2008. This source also provides valuable information about the substances used, as it is based entirely on the results of toxicological tests.

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

Table 6.1 Data overviews in France from three sources					
Year	OCRTIS (police)	Deaths register			DRAMES (laboratories)
		(EMCDDA, selection B definition)			
		All	15-64 years old	15-49 years old	
2000	120	248	225	219	101
2001	107	274	243	232	na
2002	97	244	225	208	74
2003	89	233	212	204	64
2004	69	268	239	226	86
2005	57	303	264	241	68
2006	na	305	275	260	168
2007	93	333	287	260	192
2008	na	374	322	298	217

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

The data provided by the general mortality registry (CépiDc) show a continuous upward trend from 2003 onward. As false positives, such as deaths induced by the misuse of prescribed opioids painkillers, are very likely to be included in the grand total, drug induced deaths within restricted age ranges are shown in column 4 and 5, supporting the previous trend. Plausible explanations of the rise in the number of drug induced deaths are: increasing availability (heroin in particular); lowering prices (cocaine); emerging new types of substance users, steering clear of treatment centres or low threshold facilities and unaware of harm reduction practices; harmful and riskier uses for fear of being arrested (CADET-TAIROU, A. et al. 2010), etc. It should be underlined that women represented almost one fifth (19%) of the deaths recorded in 2000 and 15% only in 2008.

Illegal drugs were the main substances responsible in slightly more than half of the cases (52%) in 2008, substitution treatments in approximately 39% of cases and opiates (excluding substitution) in almost 9% of cases. Overall, opiates were the main cause in 84% of deaths, and cocaine, either alone or combined with other substances, in approximately 14%. The increasing number of overdoses between 2006 and 2008 is explained by an increase in the number of deaths from heroin (+ 20 cases) and methadone (+ 32 cases) overdoses.

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

	2006		2007		2008	
	Number	%	Number	%	Number	%
Heroin, alone or in combination	59	35.1	69	35.9	79	36.4
Cocaine, alone or in combination	31	18.5	39	20.3	30	13.8
Other illegal substances, alone or in combination	5	3.0	2	1.0	4	1.8
Methadone, alone or in combination	31	18.5	61	31.8	63	29.0
Buprenorphine, alone or in combination	20	11.9	11	5.7	21	9.7
Other opiates, alone or in combination	18	10.7	10	5.2	19	8.8
Others	4	2.4	0	0.0	1	0.5
Total	168	100.0	192	100.0	217	100.0
Number of services taking part	16		18		19	

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

The increase in the number of fatal overdose in the second half of the 2000s is confirmed by all three sources. This trend is explained by several factors: increased availability of heroin, the retail price of which has fallen and which has a less negative perception in users today than about 10 or so years ago, combined with a spread of its use into socially integrated, party going populations: their limited experience and lack of knowledge about the substances, their dangers and routes of administration result in higher risk behaviour (Cadet-Taïrou, A. et al. 2010b) .

Another cause is the more prevalent circulation of samples of heroin with a purity of over 30% in a market which has been dominated for several years by very poor quality heroin (see chapter 10).

Finally, the spread of polydrug use practices in both the party goers and amongst the most vulnerable users makes it more difficult to control the effects and amounts taken.

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

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

6.4.3. Specific causes of mortality indirectly related to drug use

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

7. Responses to health correlates and consequences

7.1. Introduction

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

With the exception of substitution treatments^{78 79}, changes in the supply and availability of treatment and harm reduction measures have not been closely monitored in France until recently due to the difficulty in gaining access to the necessary data. However, a number of indicators exist, making it possible to monitor the geographical coverage of addictology centres provided for drug users. Two surveys among respectively pharmacists and doctors, carried out by the INPES (National Institute for Health Education and Prevention) make it possible to measure the number and density of the health professionals (pharmacists and doctors) contributing to the harm reduction measures or treatments (the Health Barometer survey for Pharmacists and the Health Barometer survey for doctors).

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

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

From 2008-2009 onwards, two specific forms of action began to emerge:

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

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

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

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

⁷⁸ Circulaire n°DGS/MC2/2008/79 du 28 février 2008 relative à la mise en place des centres de soins, d'accompagnement et de prévention en addictologie et à la mise en place des schémas régionaux médico-sociaux d'addictologie. NOR : SJSP0830130C.

⁷⁹ Legal framework for substitution treatments: please see chapter 1

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

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

2) Specific tools and resources aimed at preventing drug related death are currently being prepared.

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

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

The prevention and treatment of drug-related infectious diseases

The prevention of drug-related infectious diseases initially targeted only HIV until the years 1999-2002, when the first national plan against hepatitis C was adopted. The preventive measures it contained chiefly concerned drug users, who account for the vast majority of new cases in France. This plan contains measures concerning prevention, screening, access to treatment and improvements to treatment. With the decline of HIV infection prevalence in drug users, the fight against viral hepatitis in this group has now become a central issue. The 2002-2005 plan entitled "the national hepatitis B and C plan" also includes hepatitis B. In December 2008, while awaiting the publication of a new plan, measures were taken aimed in particular at building awareness among health professionals of the need to vaccinate "at risk" individuals, including drug users⁸⁰. The new plan (2009-2012) is based on the same issues, but more extensively identifies the "at risk" groups in order to be better able to reach them. The prevention aspect is also aimed at the most vulnerable and precarious individuals in society, and particularly migrant populations. The 2009-2012 plan also plans to work on **preventing the first injection**. Furthermore, it also covers possible contamination by nasal drug taking or smoking, whereas up until now the French preventive system had scarcely considered this aspect.

The preventive measures used in France include:

⁸⁰ In France, vaccination against hepatitis B has never been compulsory although a campaign aimed at encouraging vaccination for babies and teenagers was organised up until 1988. After the end of this campaign, the general level of vaccinations has tended to decline. In 2004, this stood at 29% for children under the age of 24 months and 42.4% for teenagers aged 15 (BEH 2009 20/21 panel 1).

1) The harm reduction policy⁸¹

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

- The distribution and recovery of sterile, single-use equipment⁸². Syringes and injection kits are sold without restriction in pharmacies (no prescription required since 1987). Injection kits are also distributed or exchanged by low threshold services (CAARUDs) or by automatic distributors. For several years now, the availability of preventive equipment has gradually been extended to administration routes other than injection, with the distribution of sniff kits and base kits for crack smokers. Finally, the distribution of condoms (and an encouragement to use them) also contributes to reducing contamination by the HIV virus.
- The circulation of information concerning the drug related risks and the health education promotion.
- And finally, the distribution of substitution treatments from 1995 onwards (please see the "treatments" chapter) which seeks to reduce injecting drug use by reducing heroin use, but also to encourage access to treatment by providing a joint objective for both doctors and drug users making it possible to develop a strong bond between them.

The harm reduction system is chiefly based on local pharmacies (for the sale of equipment), the specialised medical/social system (low threshold services), and the non-medical/social services offered by the associations. This last scheme is essentially involved in recreational settings and in the management of syringe exchange machines. Finally, there are the municipal schemes involved above all in managing syringe distribution machines (a third of the schemes in France).

Treatment access points also contribute to reducing risks, either directly (through the provision of information or equipment, etc.) or indirectly (information and substitution treatments).

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

The plan sets to carry out activities on a more systematic basis in all services visited by drug users but also to inform them of the importance of screening and the effectiveness of the available treatments, in areas generally attracting precarious or migrant people. It also includes an information campaign aimed at the general population and health professionals.

Whereas the cost of screening for HIV infection and hepatitis C infection is covered up to a level of 100%, the search for indicators of chronic hepatitis B infection is only covered up to 65%.

The aim is to reduce the percentage of cases in which the disease is already highly advanced at the time infection is confirmed by screening.

The screening programme chiefly involves the CDAG (Free and anonymous screening centres). In 2006 there were 307 CDAGs in France in addition to 73 CDAG units operating in prisons. Users can visit them, possibly referred there or accompanied by staff from the CAARUDs. There are also local low threshold services or addictology centres initiatives which organise the collection of samples directly on site in the concerned centres. Finally, access to screening is also possible via the traditional treatment channels.

⁸¹ The legal harm reduction framework: please see chapter 1

⁸² Decree of 1987 concerning the unrestricted sale of syringes through dispensaries, circular dated 15/09/1994 authorising the widespread sale of the Stéribox through pharmacies, decree of March 1995 establishing the appropriate legal basis for the syringe exchange programmes and the provision of syringes free of charge by the associations, letter from the DGS of October 1995 concerning cooperation programmes with local authorities with regard to access to equipment => Art. D. 3121-27 of the Public Health Code

3) Encouragement to undergo vaccination against hepatitis B.

In addition to continuing to encourage "at risk" persons to get vaccinated, the new plan also seeks to encourage vaccination among the general population, for infants and teenagers.

Data to monitor the quantities of injection equipment delivered to drug users have been unavailable for several years. They are now collected again by the OFDT, based on syringe sales to pharmacies by the company Beckton-Dickinson, on the information system based on the CAARUDs (ASA-CAARUD, see Appendix V-V) standard annual report and on the assessments produced by various associations involved in the distribution of syringes.

These CAARUDs activity reports also makes it possible to monitor undertaken activities aimed at preventing infectious disease through the number of condoms distributed, and the average annual number of acts per client concerning access to screening for viral disease and vaccination against hepatitis B.

The monitoring of the policy aimed at encouraging access to screening is chiefly based on the ENa-CAARUD survey carried out every two years by the OFDT in CAARUD's clients. The percentage of users having already undergone screening for HIV or hepatitis C is now very high (above 85%) and a key factor here concerns the repetition of this screening. The OFDT monitors this, also measuring the percentage of users for whom the most recent "all clear" result dates back less than six months.

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

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

Ministerial measures introduced in December 2005 created "a co-ordinated treatment procedure for hepatitis C" organised around hospital contact points in order to improve liaison between GPs and the specialised medical services, in addition to the quality of treatment offered to patients and their overall quality of life. A "doctors" guide for hepatitis C was produced by the HAS in 2006 and will be updated every three years. A hepatitis B guide should follow.

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

The prevention of infectious diseases is also planned for drug users in prison. The new Hepatitis plan sees prevention in prison as one of its five strategic areas for attention (please see chapter 9).

Responses to drug use other health-related consequences

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

For economically disadvantaged population groups, access to treatment is possible thanks to the Universal Health Cover scheme. Irregular foreigners can benefit from the State Medical Aid if they ask for this aid. Nevertheless, a number of drug users living in extremely

precarious conditions have no document entitling them to cover of any form. Some minors, who are still covered by their parents with whom they no longer have any contact, are also without insurance. Consequently, a small percentage of CAARUDs clients (around 5 %) have no social cover whatsoever (ENa-CAARUD).

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

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

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

In 2009, the health alert system for use of psychoactive substances issued 3 public alerts, particularly through press releases and several communications targeting only drug professionals and user associations.

These alerts particularly concerned overdoses due to the circulation of heroin associated with a benzodiazepine, alprazolam, and the increasing number of heroin samples with a purity exceeding 30% on the French market, which is dominated by a very poor quality drug.

Three press releases were issued:

- Cas d'overdoses en Île-de-France Point de situation au 22 janvier 2009⁸³
- Cas d'overdoses en Île-de-France, Point de situation au 23 janvier 2009⁸⁴
- Dangers accrus liés à la grande variabilité de la composition de l'héroïne en France - 16 December 2009⁸⁵

Local communications for professionals are also produced when batches of heroin with a purity exceeding 30% are detected (from seizures and the SINTES system, see Appendix V-R).

One alert was issued through a press release following cases of coma after young users had taken GBL/GHB in discotheques in the South of France:

- Mise en garde sur la consommation de GBL (gamma-butyrolactone) - 24 September 2009⁸⁶

Other signals were monitored but were not discussed in press releases. The experience gained with this system clearly shows the merits of active surveillance systems such as TREND or SINTES, which allow the significance of the signal to be interpreted very quickly thanks to relatively accurate knowledge of users, practices, contexts and markets.

7.3. Prevention and treatment of drug-related infectious diseases

Some of the data provided in this section were obtained from relatively old surveys (2003). These are in fact the only ones available in 2010. New results from the same surveys will be published in 2011.

⁸³ <http://www.ofdt.fr/BDD/publications/docs/CPHero090123.pdf>

⁸⁴ <http://www.ofdt.fr/BDD/publications/docs/CPHero090126.pdf>

⁸⁵ <http://www.ofdt.fr/BDD/publications/docs/cp091216heroine.pdf>

⁸⁶ <http://www.ofdt.fr/BDD/publications/docs/cp090924gbl.pdf>

HR (Harm Reduction) Accessibility

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

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

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

Involvement of pharmacies in HR activities increased greatly at the end of the 1990s (Table 7-1). However, it remains limited to basic functions of distributing syringes and/or substitution medicines. The majority of pharmacists in 2003 were not ready to take part in a needle exchange programme.

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

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

Source: INPES, Health Barometer - Pharmacists

An average of 6.1 people were seen per month in a dispensing pharmacy in 2003 for a request for syringes or Stéribox® and 5.9 [5.3-6.5] for a request for OST (opiate substitution treatment).

Level of involvement of GPs

A third of general practitioners saw at least one drug user in 2003 (ARENES et al. 2000)

Certain features distinguish these practitioners from their colleagues. Their typical profile was: male, under 41 years old, practicing in a consultation cabinet; practicing in a conurbation with a population of more than 20,000; with more than 10% of their clientele benefitting from AMG (Free medical care); taking part in a drug addiction professional network.

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

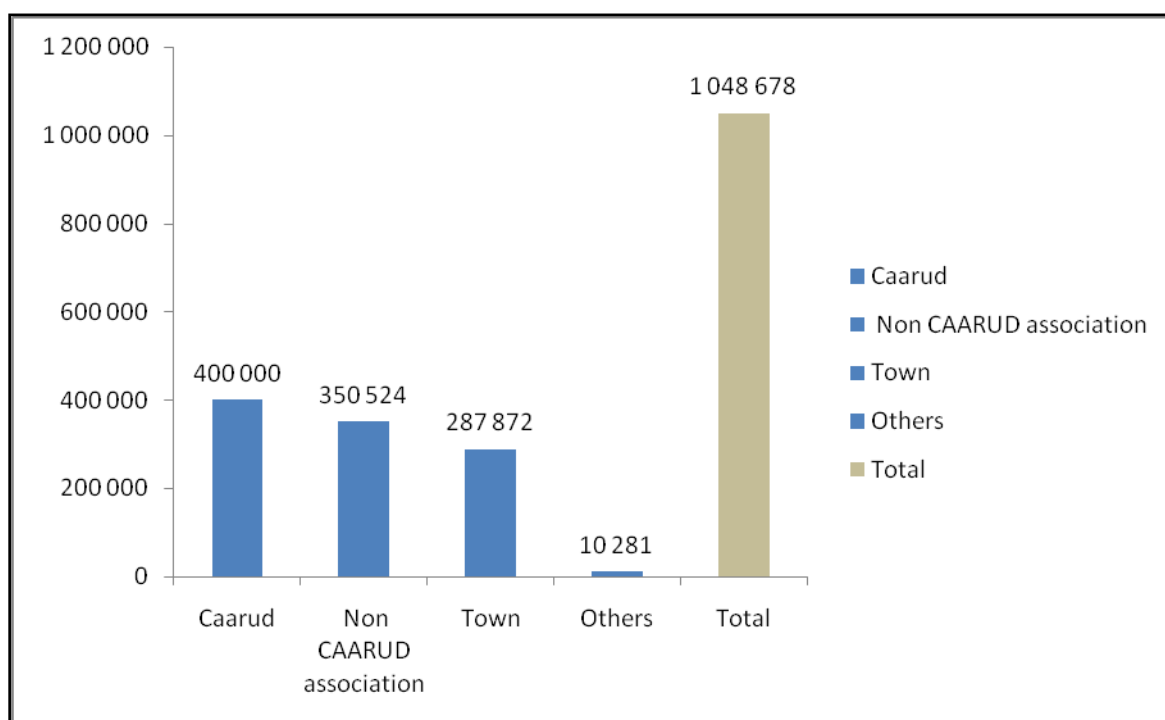
	1998/1999	2003
Proportion of general practitioners seeing at least one DU per month	35%	34%
Of which:		
Proportion of GPs prescribing OST	78.9%*	90.3%*
HDB (High Dosage Buprenorphine)	71.9%*	84.5%*
Methadone	12.6%*	26%*
Others	13.5%*	7.4%*

Source: INPES, Health Barometer – Doctors
 (*: diff. significant $p < 0.001$)

Doctors saw an average of 1.6 drug users per month in 2003 [1.3-1.9] (change since 1998 not significant).

Actual scope of dispensing machines and operational status

Dispensing machines for Stéribox® injection kits largely contribute to accessibility to injection equipment, not only quantitatively (they distribute slightly under 10% of the total number of syringes sold or distributed in France) but also through the service they offer (anonymity and 24h/24 access), allowing them to reach out to a different population than the other systems (Graph 7-1). There were 255 prevention kit distribution outlets and 224 syringe collection points in 2007, spread out through 56 départements. Slightly over 40% of French départements, therefore, did not have either of these facilities. These outlets/collection points distributed more than a million syringes and collected more than 600,000 used syringes. It is, nevertheless, a vulnerable system, as more than a quarter of the machines are ageing or in poor condition (DUPLESSY-GARSON C. 2007).

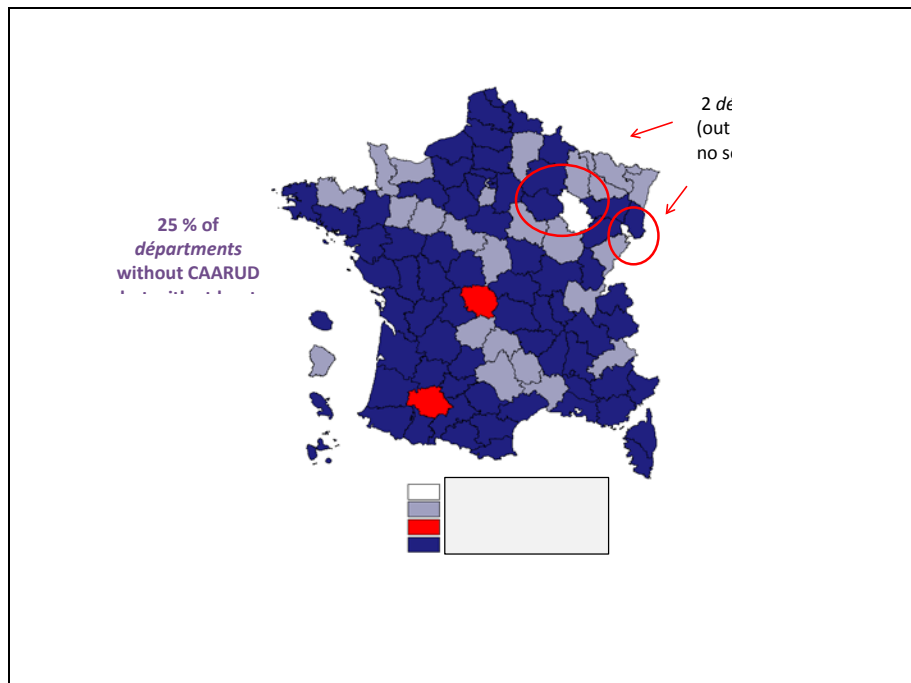
Graph 7-1: Number of syringes distributed through dispensing machines by operator type in 2007

Source : SAFE (2007) and ASA-CAARUD / OFDT (2007) surveys

National coverage by the HR socio-medical system (CAARUD, complementing CSAPA)

In 2008, the socio-medical harm reduction system covered most of France, although 27 (out of 100) départements did not have a CAARUD, two of which also did not have a CSAPA.

Map 7-1: Distribution of specialist services (CAARUD and CSAPA) in the different French départements



Source: for CAARUD, OFDT list from DGS information on authorised centres in 2008.
For CSST, OFDT list produced from DGS annual activity reports (last updated in 2007)

Awareness of HR

The TREND system reveals that groups of users who make little or no use of urban CAARUD services have little awareness of HR measures. This particularly involves errant poorly socially integrated young people but also "socially integrated" users who are beginning to inject, young people from working class districts and younger users in the party scene (CADET-TAIROU, A., M. GANDILHON, et al, 2010)

CAARUD HR activity

129 CAARUD were listed throughout France in 2008. These are socio-medical centres funded by the social security system which operate in various places with various means of intervention. Of these, 95% offer a fixed site reception service, 66% have street teams, 47% operate in squats, 40% have mobile teams, 39% work with teams in the party scene and 28% have developed prison activities. They largely contribute to the distribution of clean injection equipment (3.8 million syringes in 2008) and other preventative equipment (ancillary injection equipment, condoms, etc.).

The major activities these units undertake are: assistance with hygiene and first aid care, health education promotion activities, help with access to social rights, follow-up of the administrative and legal processes and seeking out of urgent residential accommodation.

More specifically, in terms of distributing prevention equipment, CAARUDs carried out the following activities in 2008:

- syringes: 2.3 M single syringe units and 530,000 kits (2 syringes) handed over personally to individual users, 200,000 kits (2 syringes) via dispensing machines managed by the centre;
- small injection equipment: 1.1 M filters and the same number of "cookers", 1.7 M of water vials, 2 M alcohol wipes;

- condoms: 782,000, 91% of which were male condoms;
- gel: approximately 292,000 units.

Assistance with access to OST and general care is one of the CAARUD's important missions:

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

The CAARUDs saw 48,000 people in 2008, with an average number of subjects seen at least once during the reference period of approximately 200 people per centre, although in reality the figures are very varied: 41 centres saw less than 200 people whereas only 11 CAARUDs saw more than 1,000 people⁸⁷ (CHALUMEAU 2010).

The role of the CSAPA in harm reduction, one of their mandates, cannot be described in the absence of information, as the system is too young.

HR in the party scene

Almost 40% of CAARUDs have a team working in the party scene.

In addition, a number of associations carrying out HR activities have not joined the medico-social system, particularly some humanitarian, community health and specialist associations. They are not certified as CAARUDs for various reasons: absence of fixed reception premises, failure to carry out all of the official mandates in the decree of 19 December 2005, absence of employees, administrative burden, concerns about a possible lack of independence or ability to innovate, the requirements formulated by some DDASS, according to which small associations or those which do not carry out all of the reference mandates should be grouped together, etc. This particularly applies to HR associations working in the party scene.

There is no global information available making it possible to compare the care offered and the needs of users in the party scene. Qualitatively, since the publication of the "Mariani and Vaillant"⁸⁸ decree of 2002, which describes the means by which parties are organised, the TREND system has seen the fragmenting of the non-commercial party scene into many small, undeclared free parties which take place without advertising in premises announced at the last moment to circles of people "in the know". These parties are increasingly less accessible to the HR associations, which do not have sufficient teams to attend them all (Sud rie et al. 2010).

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

The intervention methods in the party scene therefore depend primarily on the type of event - organised and on the ability of the workers to attend and organise their intervention (Table 7-3) (REYNAUD-MAURUPT et al. 2007). Parties taking place in private premises can very easily escape the attention of HR workers. Therefore, it is only when the initiative is taken by the event organisers that the HR associations can intervene and set up targeted actions. These involve promotion activities and distribution of information (leaflets about the risks

⁸⁷ See chapter 4 for a description of the clients seen at least once within the reference period ("*file active*" in French).

⁸⁸ D cret n  2002-887 du 3 mai 2002 (d cret Mariani et Vaillant)

related to drug use and risk prevention) and/or HR tools. In the case of public parties, information and prevention materials are distributed in addition to food and drink and first aid services, and reception and counselling areas or those intended for calming and reassuring drug users “chill out” are provided. When used, on-site substance testing is one way for workers in the party scene to make contact with drug users.

Table 7-3: Prevention activities in the party scene (Produced by the OFDT from Techno+ activity reports and from the “quanti-festif” survey 2004-2005

Type of event	Main interventions	Population
Free party: party event with fewer than 500 people or “paying” rave (without <i>prefect</i> permission)	Downloadable flyers for participants and organisers and the ability to order HR materials If the party is known about: information leaflets and materials (“flyers”)	Tekno music regulars, socially integrated persons
“Legal” free party: “multi-sound” party event with more than 500 people (2 days)	Stand or “chill out”	Large proportion of newcomers onto the Techno scene (most at risk).
Teknival: party event with more than 50,000 people (several days)	Creation of an “HR” village or even several: reception, information, equipment, counselling, reassurance, first aid, TLC facilities.	Often young new participants, minority proportion of IVDU
Clubbing or urban parties (free or paying entry)	“Flyers” (information and equipment leaflets) or stand for prevention activities	Generally mixed clientele, poor hygiene conditions
Town parades, festivals...	“Flyers” (information and equipment leaflets), mobile “stand” or “chill out” area	Many very young people

(OFDT/GRVS)

Availability of injection, smoking and sniffing equipment

From the different information sources, we can estimate that approximately 14 million syringes were sold or distributed to drug users in France in 2008. Comparing this number to the number of injecting drug users (81,000 recent injecting users) produces a ratio of approximately 170 syringes per user per year (COSTES, J.-M. et al. 2009). This figure, which is only an order of magnitude, appears to indicate relatively good access to syringes by injecting drug users in France. However, this figure is difficult to interpret first because there is no reliable assessment of needs and, second, because of the likely geographical differences (particularly in rural areas). Pharmacies play a central role in this availability of equipment.

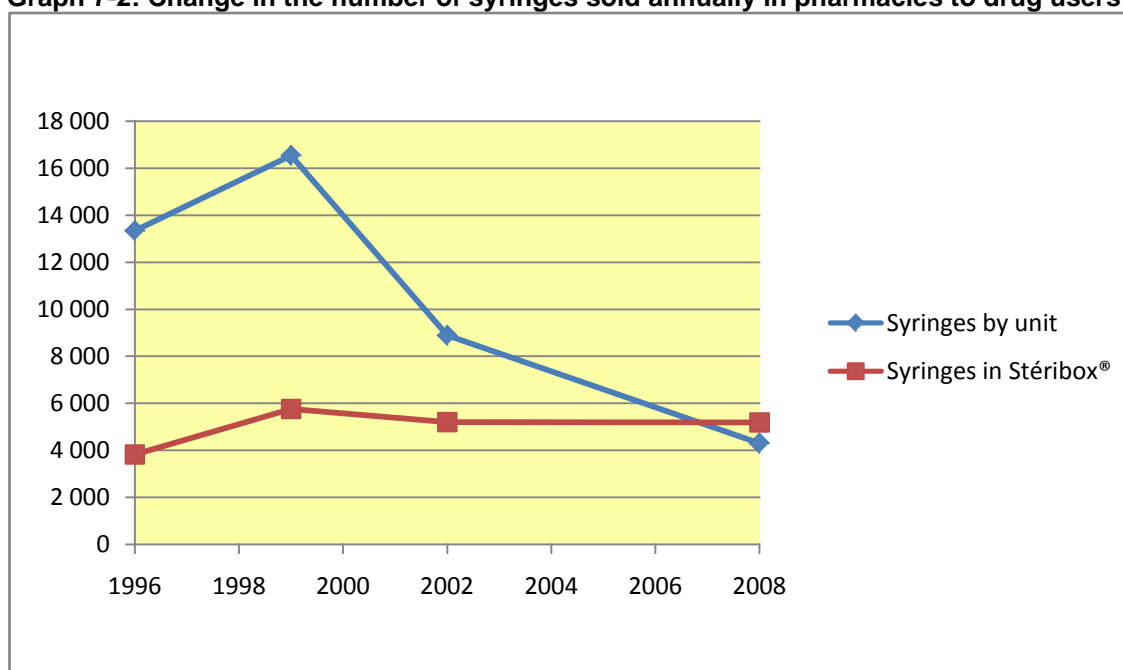
Table 7-4: Number of syringes dispensed by pharmacies or distributed by CAARUDs and dispensing machines in 2008

2008	Number of syringes sold or distributed (millions)
Pharmacy: units	4.3
Pharmacy: in Stéribox®	5.2
CAARUD: in units	2.3
CAARUD: in Stéribox®	1.0
Dispensing machines (2007 data)	1.0
Total	13.8

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

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

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



Source: OFDT from InVS, GERS and Becton Dickinson data

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

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

Another possible explanation may be that users are stopping intravenous drug use because of the diffusion of substitution treatments or, for some people, reduced injection frequency, injection becoming only an occasional habit. Whilst an increase in the number of drug users was seen between 1999 and 2005, the proportion of injectors appears to have fallen overall in the drug user population, except in some specific groups (BELLO, P.-Y., Cadet-Taïrou, A., Halfen, S., 2010; CADET-TAIROU, A., M. GANDILHON, et al, 2010).

One negative hypothesis would be a return to sharing behaviour and syringe reuse, which has been seen among some drug users, particularly the most vulnerable ones.

In 2008, 28,500 crack pipes were also distributed by the CAARUDs. 80% of these were from centres in the Paris region and in Guyana.

Finally, 197,000 items of sniffing equipment (rolling papers or sniff kits) were also distributed, mostly by the CAARUD working in the party scene (CHALUMEAU 2010).

Promoting screening and vaccination

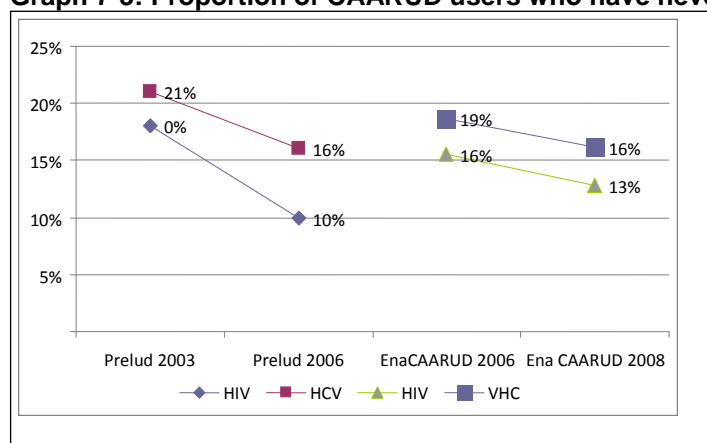
Out of approximately 55,600 drug users seen at least once during the reference period, the CAARUDs organised almost 32,000 hepatitis B or C and HIV infection screening tests (HCV: 12 200, HIV: 11 000, HBV 8,800). There were 1,300 actions taken to enable access to hepatitis B vaccination in this context.

At present, these figures only represent orders of magnitude. It will be possible to assess their robustness and the credit which can be given to them by regularly monitoring them and studying their changes over time.

Interim results: screening rates in drug users in France

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

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



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

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

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

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

	HIV		HCV	
	Number	%	Number	%
Had had the test	2722	87.2 %	2599	83.8 %
Had not had the test	400	12.8 %	504	16.2 %
Of those with a negative response*, date of last test				
Less than 6 months	961	41.0 %	711	43.1 %
6 months to one year	646	27.5 %	463	28.1 %
More than one year	739	31.5 %	474	28.8 %

* Declared results

Source: ENa-CAARUD 2008, OFDT, DGS

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

In 2004, the Coquelicot study in 5 French towns estimated that 2% of HIV positive users were not aware of their actual serological status. The bio-PRELUD study conducted in 2006 on 5 sites estimated this figure to be 5% (Cadet-Taïrou, A. et al. 2008b; Jauffret-Roustide, M., et al., 2009).

The corresponding figures for HCV positive users were 27% in Coquelicot (2004) and 8.5% in bio-PRELUD (2006). This difference may be due both to the large inter-site differences, the fact that Coquelicot measured blood serologies and bio-PRELUD measured salivary serologies (in the latter situation, only patients with detectable viraemia are positive and patients who have recovered are no longer positive) and the fact that the two studies were conducted two years apart (see also chapter 6.2). In 2006 (PRELUD), 36% of CAARUD users declared that they did not know their hepatitis B status (vaccinated, unvaccinated, uninfected or infected). Finally, a study conducted from the “hepatitis C reference poles” information system, which manages a proportion of patients carrying the hepatitis C virus, monitored the *proportion of late screening tests* in newly treated patients (Brouard 2009). In this case, a late test is defined as one performed in the year the patient started treatment, i.e. the patient is tested at a stage of the disease which already requires treatment. This proportion fell between 2001 and 2007 from 42.7% to 33.4% ($p < 0.01$) in the total patient group (regardless of the source of the infection). The proportion of intravenous DU in these late-tested patients did not change significantly (39.6% in 2001 compared to 35.5% in 2007 in men and 15.9% compared to 12.7 % in women) and it can be concluded that late testing is falling in DU in the same way as the group average. The same applies to late testing in DU who exclusively snort.

Access to treatment

Data obtained in 2008 from CAARUD users show that the majority of users aware of being infected by HIV are followed up medically, 89.8% having had at least one medical consultation for their infection during the year. Only 77.9% were prescribed treatment for the infection. This result is higher than that obtained in 2006 (68.5%), although not significantly different (CADET-TAIROU, A., M. GANDILHON, et al, 2010)

The same survey showed that two-thirds (70.5%) of people interviewed who said that they had tested positive for hepatitis C had had at least one consultation for their infection in the 12 months before the survey. Slightly over a quarter (28%) had been prescribed treatment for the infection. This number appears to have increased from the previous 2006 survey when only 22.5% of CAARUD's clients HCV positive reported that they had been given treatment ($p=0.02$).

2009-2012 national viral hepatitis B and C plan

The contents of the plan are shown in chapter 1: Drug policy. An assessment of the national hepatitis plan is planned for 2012.

7.4. Responses to other health correlates among drug users

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

Only 4.6% of CAARUDs clients in 2008 did not have social health cover (National Health Insurance funds, State Medical Assistance). More than half (54.8%) were covered by social funding (Universal Medical Cover, State Medical Assistance) and 6.3% had all of their costs paid because of a “long-term” illness (LTC) (CADET-TAIROU, A., M. GANDILHON, et al, 2010).

Provision of care and access to care together represented the second leading activity of the CAARUD in 2008 (treatments following social-integration activities).

8. Social correlates and social reintegration

8.1. Introduction

Concepts and definitions

Social harm

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

Social

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

The notion of cause and effect

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

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

Social reinsertion/social reintegration

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

Scope

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

In France, social policies are "universal", (i.e., they are aimed at all legal residents without distinction, and therefore to drug users too, even if they are not specifically named as a

"target group"). Nevertheless, people with drug addiction problems receive dedicated health and social assistance provided by specialised organisations (the CSAPAs and CAARUDs) and constitute the focal point for the "national drug policy" run by the Interministerial mission for the fight against drugs and drug addiction (MILDT).

Automatic access to national social policies...

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

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

In France, since the early 1980s a key principle has emerged which has formed the basis for all integration policies and which has had a high degree of influence on social integration schemes: access to (or a return to) employment is seen as the best means of combating poverty and is viewed as a vital factor underpinning social integration. The RMI (*revenu minimum d'insertion*: minimum benefits paid to those with no other source of income) introduced in 1988 entitles anyone to receive a minimum level of resources in addition to protection in the event of illness. On March 31, 2009, a total of 1.13 million households in France received the RMI. Since 2009 the RMI has been replaced by the RSA⁸⁹.

In addition to the employment issue, social integration policies in France have also focused on housing, economic poverty and health. Thus, the most recent "French report on national strategies for social protection and social inclusion - 2008-2010"⁹⁰ (reports submitted by each member state to the European Commission since the Council of Lisbon in 2000) includes the following major themes among its priorities for action: access to or a return to employment – housing – pensions and health. Additionally, four "population groups" are specifically identified: young people, persons from immigrant families, the disabled and the elderly.

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

...and dedicated social support

Consequently, among their various activities the CSAPAs are involved in social problems too. They issue information and handle social assessments, providing guidance to the

⁸⁹ The *Revenu de solidarité active* (Active Solidarity Benefit) guarantees an increase in revenue and tops-up the existing resources of those whose earnings are limited. The payment of the RSA is not subject to any time limit: the person may continue to receive the same sum as long as his or her situation does not change. Law number 2008-1249 of December 1, 2008 implemented the widespread availability of the Active Solidarity Benefit and introduced a reform of social integration policies NOR: PRMX0818589L

⁹⁰ <http://www.cnle.gouv.fr/Un-nouveau-rapport-pour-la-periode.html>

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

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

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

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

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

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

8.2. Social exclusion and drug use

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

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

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

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

8.2.1. Social exclusion among drug users

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

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

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

Source: OFDT RECAP 2009

(1) Temporary or institutional residence and prisoners

(2) Intermittent, paid activities, unemployed persons and other non-workers

(3) Unemployment payments, social welfare payments (RMI, AHH...), funds from third parties and other financial resources (including those without income).

(4) Below baccalauréat level (roughly equivalent to British 'A' levels) and equivalent, CAP-BEP and equivalent. The unemployment rate in France is inversely proportional to the level of education achieved, which may be used as an indicator of qualification status for workers, although it does not take account of improvements in said qualification status through continuing education and occupational experience. During the first four years after leaving initial education, a worker without a diploma or with only a BEP (roughly equivalent to the British GCSE) was more than two times more likely to be unemployed in 2008 than a worker with an upper secondary schooling diploma.

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

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

Observations made by CAARUD workers in 2008 through their activity reports (CHALUMEAU 2010) show an increase in marginalisation (poverty – vagrancy) of people seen, partly associated with the adverse economic climate and safety policies which can be disadvantageous to this population: the closing of squats, removals of people from town

centres, more frequent arrests (sometimes close to the care services), and certain difficulties CAARUD workers have in reaching these populations.

The CAARUDs have also seen an increased number of convictions and/or legal measures (*jour amende*, a fine in the form of a fixed amount to be paid per day; failing total or partial payment of said fine, the offender will be incarcerated for the number of days corresponding to the monies due, electronic tagging, etc.) and longer sentences. Almost 3,500 “legal files” were opened in 2008 and almost a third of the CAARUDs took action in prison settings (visits, preparation for release, etc.). They are also seeing a deterioration in housing-related issues. Access to emergency housing such as hostels or CHRS remains difficult and housing overall is the major problem, particularly in the Paris region. “Housing rights” cases have been filed. A difficulty shared by many CAARUDs is that of resolving housing problems for people with dogs.

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

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

8.2.2. Drug use among socially excluded groups

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

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

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

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

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

“**New migrants**” are mostly from central and eastern Europe but also from Northern Africa and to a lesser extent Asia. Whilst Paris brings together a very wide range of origins, other parts of France see mostly immigrants from former Soviet block countries (Russia, Bulgaria, Georgia, Ukraine, Belarus, Romania, Moldavia and countries making up the former Yugoslavia). These populations live in very precarious conditions, worsened by the illegal nature of their residence in France. They are mostly heroin and amphetamine injectors who also have high levels of medical drug use (particularly Subutex®). CAARUD workers are

striving to make these populations aware of the risk of viral transmission (HIV and hepatitis) as a result of their living conditions and the disapproval of injection within the groups they belong to. Major tensions are reported between these groups and the other more “historical” beneficiaries of the low threshold facilities.

Although the proportion of **women** attending specialist centres does not appear to be on the rise, professionals are worried about the population's increasing youthfulness and the extreme practices which have been observed. Most of these young women belong to the groups of poorly socially integrated young people listed above. They are less involved in dealing but more involved in money collection activities (prostitution, begging), presence in the CAARUDs (injection equipment) and administrative processes. More extreme drug use behaviour has been widely noted, particularly with a very rapid escalation to high risk injection (equipment sharing). In addition to prostitution, these women encounter the specific problems linked with promiscuity and the violence which characterises life on the street: vaginal infections, unwanted pregnancies, lack of contraception, etc.).

8.3. Social reintegration

Social support for drug users on treatment is provided, to a very large extent, by the specialist CSAPA and CAARUD services in France, through specific projects and programmes developed by these medical-social structures, acting as relays to the health and social protection systems provided under common law.

Through its 2008-2011 national plan, the MILDT has included the improvement of social integration and reintegration for persons with an addiction amongst its top priorities (MILDT 2008). This strategy is structured around 2 main objectives:

Objective 1: Give priority to the accommodation of persons in difficulty with their consumption of alcohol or illegal drugs within the integration accommodation reception system (AHI) on their release from prison:

- by setting up CSAPA advanced consultations in these structures and cross-discipline training;
- by writing a multi-disciplinary reference document in preparation for reintegration of prisoners with addictions;
- by creating short and quickly accessed reception programs offering care, social integration activities and accommodation.

Objective 2: To develop partnerships between medical-social structures (CAARUD and CSAPA) and the integration accommodation reception system; experiment with setting up consultations by professionals in medical-social structures in about twenty accommodation structures, and with setting up courses offering training in the two fields concerned.

In order to implement these strategies, on 23 February 2009, the MILDT launched a call for projects, in particular to apply measures on social integration. The projects chosen were announced in a circular of 14 December 2009, and it is far too early to give a detailed description of the projects adopted and funded, and especially to measure their impacts.

In terms of inter-institutional national partnerships, a working framework agreement was signed between the MILDT and the DGCS (Directorate General for Social Cohesion) in order to improve the link between the government action plan and social integration.

Through their annual activity reports, the specialist CAARUD structures report the measures implemented (number and nature). Reintegration measures (access to rights, housing and training-employment) are described, although they only represent a small part of their total activity, which is primarily centred on first line reception (“refuge” services, food, basic hygiene, etc.), harm reduction and care (CHALUMEAU 2010). Procedures carried out in

2008 for access of people seen in these structures to their rights are shown in the table below.

Table 8-2: Number of procedures carried out for access to rights 2008 by the CAARUDs

Access to rights		Accommodation and housing		Training and employment	
Administrative	8,369	Emergency housing	6,651	Employment	2,754
Social	7,027	Social housing	1,996	Training	1,263
Health	5,095	Private housing	1,761		
Justice	3,447	Residential treatment	1,001		
23,938 (61%)		11,409 (29%)		4,017 (10%)	

Source: ASA-CAARUD 2008/OFDT, DGS

Apart from the CAARUD activity reports, there are no tools available to precisely trace the programs followed in the different pathways of social integration for people on treatment. CAARUD activity reports give very little or no details about either the needs or actions-programmes undertaken. Work is currently ongoing to define and apply relevant indicators.

Hence, the information given in the following three paragraphs (on accommodation, education and employment) only provides a limited view of the national situation. This information is essentially the result of observations made by a group of experts (see structured questionnaire 28 – year 2009).

8.3.1. Housing

In 2009, only 77% of people on treatment for problem drug use lived in stable accommodation (independently, with friends/family or in an institution) (OFDT 2009).

The question of housing remains one of the social integration priorities, particularly in large towns, and desperately so in the Paris region.

The main options available are: **social housing, emergency social housing and residential treatment.**

Social housing in France essentially comprises HLM housing (low rent/council housing): 10 million people currently live in the 4.2 million homes managed by HLM administration centres, whose mission is to provide accommodation under optimal conditions for all those who cannot afford the rents proposed on the market. However, for several years now, the housing offer has been far short of demand. Whilst addicts on treatment are not subject to any demonstrable discrimination in terms of allocation procedures, they too suffer the effects of this shortage, unless they fulfil certain conditions giving them priority status. In mainland France in 2006, 1.2 million requests for HLM housing were not satisfied, 550,000 of which were from households which were already HLM tenants.

Some centres (particularly the CSAPA) are developing services facilitating access to individual accommodation, for example:

- "Sliding" tenancies ("*baux glissants*" in French): initially, the centre takes on the rental of the housing which belongs to private or public owners in order to sub-tenant legally. It signs the inventory of fixtures and lease and pays the rent to the owner. The housing allocation is directly paid to the centre and the remaining rent (rent minus housing allocation) is paid for by the sub-tenant. After a "probationary period" which may range from six months to a year, the tenancy "slides" and the sub-tenant then becomes the official tenant of the premises.
- "Educational" tenancy support: helping the tenant to optimise budget management and complete administrative tasks such as paying his bills, purchasing furniture, etc.

There are no data on the frequency or volume of these programmes.

Emergency social housing is a solution used by the specialist structures. This involves unconditional reception, i.e. with no selection of clientele. Accommodation is short term. The main structures and facilities which provide emergency social housing are:

- The CHRS (Lodging and Social Readaptation Centres): 360 CHRS in France report handling an emergency department;
- hostel overnight stays;
- night accommodation centres, sometimes in dormitories, and sometimes more individual;
- centres which operate throughout the day and offer accommodation for sometimes very short periods of time (a few nights), sometimes similar to the CHRS (usually in the region of 6 months, renewable);
- emergency accommodation centres (called “Sleep-ins” and now CAARUD) intended exclusively for drug users (three towns in France have this type of service, and one in French Guiana: Paris, Lille, Marseilles and Cayenne).

Apart from these latter centres, the emergency accommodation centres favour reception of “stabilised” people who do not present any behavioural disorders. This may exclude a number of people on treatment. Residents in all of these centres are asked to comply with the various in-house rules (no alcohol or drugs, no physical or verbal abuse, etc.).

Temporary housing or integration housing selects its residents and develops an integration project, while providing longer-term reception. A team of professionals is present continuously. The main structures which exist are:

- The residential social reintegration centres CHRS (there are 827 of these): the aim of the CHRS is to enable the people it receives to become personally and socially independent. They provide accommodation, reception services, particularly in emergency situations, help and social support and aid in adaptation to working life and social and occupational reintegration. The population which may be accommodated in the CHRS is wide, and includes people or families in serious financial, family, health or integration difficulties, particularly because of a lack of housing or poor housing conditions. The “categories of people admitted” may differ from centre to centre.
- Half-way houses: these are small social residences, each with ten to twenty-five lodgings, intended to receive extremely marginalised people. They offer them independent housing without length-of-stay conditions, common areas and increased assistance with everyday life (health, hygiene, food). Their aim is to fully integrate these structures into the local environment.
- Social residences: these offer a temporary furnished housing solution to households with limited income or those with difficulties in accessing ordinary housing for financial or social reasons, and who may require social support.

Despite the major efforts made by the specialist structures and these social “generalist” housing centres to offer solutions to people on treatment, the different players in the field have reported significant access difficulties. In an attempt to remedy the situation, the 2008-2011 Government Action Plan has promoted partnerships and joint working between the specialist addiction sector and the social housing sector: a call for projects was launched to promote these exchanges and 30 projects were selected and will be funded.

Finally, several specialist “**residential treatment**” centres, dedicated specifically to people on treatment, are available in France. All of these residential centres are administered by specialist medical-social structures (CSAPA):

- Post-treatment alcohol addiction centre or centre for care, follow on support and rehabilitation in alcohol addiction. They receive people dependent on alcohol after

detoxification, who show a need to consolidate their abstinence in a protected environment. Length of stay varies from 1 to 3 months and exits and visits are controlled.

- The Community Treatment Centre (CTC), also called the therapeutic community, is a care centre with community accommodation. The treatment community is similar to a structured, hierarchical, organised family unit. Each resident belongs to a group, with a group leader. Each group is responsible for different tasks such as cleaning, cooking, gardening and household maintenance. The community treatment centres can accept up to 50 people.
- The residential treatment centre (CTR), also called the post-treatment centre, is a care centre with community housing which accepts all drug addicts undergoing a voluntary care process. The CTR can accept up to 20 people. Initial length of stay is approximately 6 months, renewable. Some have long waiting times.
- Follow-on treatment apartments (ATR): individual or community apartments made available to former drug users who have begun a treatment process. The absence of permanent staff limits these centres to people able to live on their own. Some apartments can take couples and people with children.
- Temporary or emergency housing is offered to the dependent or formerly dependent person who is between two periods of care or in a “transition period”: before withdrawal, during stabilisation of withdrawal or substitution treatment, waiting for post-treatment admission or stable housing. This period can be adjusted according to the person's health and social needs. During this short stay (1 to 4 weeks), the person is accommodated in an individual or community apartment, and sometimes in a hotel room.
- The family reception network is a group of families trained and organised by professionals, which volunteer to take in a person on treatment for a period of time. The host families offer the drug addict a personalised relationship in a family environment, and are paid depending on the actual time a person spends with them.

Despite this range of residential treatment schemes, the overall service offer is still inadequate.

8.3.2. Education and training

In 2009, almost 23% of people on treatment had not successfully completed secondary level education, i.e. they had no general education or occupational training⁹¹.

People undergoing treatment do not have any specific programmes or schemes for training or refresher courses. Like the general population, and particularly those looking for work, they can however rely on the public and private occupational training organisations.

An identical situation exists for vocational skills training. The relevant measures are incorporated in the employment policy: the main operator is the National Agency for Employment (ANPE), whose mandate includes training advice, guidance and funding. There is no dedicated, specific training for vulnerable people, although three priority public targets have been identified: people who have been unemployed for a long time, young people and immigrants (particularly women). The VAE (Validation of acquired experience) and classical vocational skills training are the two main measures used.

8.3.3. Employment

Almost 24% of people on treatment in 2009 were unemployed, i.e. twice as many as in the active French population⁹².

⁹¹ OFDT RECAP information system

⁹² OFDT RECAP information system

There are no particular administrative barriers in France to access to employment on the “open work market” for people on treatment (such as screening or discriminatory medical situations), although it may be assumed that employers are reluctant to employ such people. The high unemployment rates seen are undoubtedly due to lower levels of training, often chaotic careers and a very tight job market.

In France, there is also an “intermediary job market” which is very well structured and recognised by the Labour Regulations (art. L 5121-1); it is covered by the term “integration through economic activity (IAE)”. Since 1977, “assisted contracts” have also existed (reducing the wage bill for the employer), intended for the most vulnerable people.

With effect from January 2010, these different assisted contracts will be grouped together within a single integration contract (CUI) for the commercial sector and a professionalization contract for the non-commercial sector.

The IAE system consists of different organisations dedicated to integration through economic activity (SIAE). These organisations are employers which must be accredited by the State. They sign agreements which define the conditions under which their activities take place, the assistance given to them and result objectives. The four main SIAE are:

- intermediary associations (AI);
- temporary integration work companies (ETTI);
- integration workshops and ateliers (ACI);
- integration companies (EI).

253,000 people were estimated to be employed by the different SIAE in 2006 (61,000 full time equivalents), but such job offers remain well below demand and “selection” occurs naturally top down; those encountering the greatest difficulties are, in fact, generally excluded from the schemes because of this.

Nevertheless, some specialist structures have developed their own occupational integration scheme or promote reorientation pathways and co-operation, in light of the difficulties encountered in assisting their beneficiaries with finding a job (Maguet et al. 2010).

Occupational activities should be considered as separate from integration/back-to-work activities, although they do offer a “foretaste” of the work environment. The “Espace association” (CAARUD) has set up a low-requirement-threshold workshop in which the persons received recover books, register them in a computerised database, package them, and distribute them to partner associations which run educational or humanitarian projects. This organisation has also created an in-house post entitled “social integration manager”, whose role consists in establishing a network of companies across his/her area of intervention, and facilitating contacts between candidates and potential employers, reassuring both parties with regard to their mutual concerns. This person’s extensive knowledge of both the companies and people received in the centre enables him to adapt employment offers to the expectations and skills of the latter.

The “*Drogues et société*” CSAPA invites patients from the care centre to take part in creative arts workshops in order to increase their sense of social utility: their creations can subsequently be used to illustrate information and prevention documents produced by the centre. This organisation also offers “reinvigoration” workshops (“*ateliers de redynamisation*”).

The *Fleuve* (Gironde) treatment community has an integration workshop and atelier (ACI). Residents are supported by a social-occupational worker and can join the integration aworkshop as part of a personal integration project for a period of six months.

The ALIA CSAPA (City of Angers) has set up integration assistance workshops in which work is described as a “treatment tool”. The work environment includes elements specific to

working life: commuting, biological and work cycle times, compliance with instructions, income management. These workshops (with multidisciplinary workers) offer a chance at immersion in the world of work and specific support for adults with an addiction problem.

Partnerships have been established between care centres and *régis de quartier* (integration companies). An essential pre-requisite for these partnerships to operate successfully is dialogue between the professionals from these two types of organisations, in order to better understand each other and discuss the specific features of drug addicts. These integration companies are not, in fact, trained or prepared to receive this type of population.

National organisations, such as the Aurore association, are developing in-house partnerships to promote access by people undergoing treatment (care centre) to the "integration through economic activity" services (integration ateliers and companies).

Work is currently underway to define social situation and social reintegration indicators, which should foster better identification of needs and therefore promote relevant national and local measures for people undergoing treatment.

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

9.1. Introduction

Definitions

According to the applicable laws, any person consuming and/or possessing and/or trafficking in narcotics is liable to a punishment which can range up to prison penalties. Simple drug users may face arrest and be condemned to a sentence possibly including imprisonment (please see the description of the legal framework in chapter 1).

For drug use offences, the Public Prosecution may decide to impose alternatives to prosecution instead of criminal proceedings before a court. These measures deferring criminal proceedings may take several forms such as a caution, a drug treatment referral order, a conditional discharge with a social or treatment referral, a settlement, a compensation measure or a penal mediation.

A second category of measures which can be used as alternatives to prison includes community service, court-ordered supervision in the community, drug treatment order, home detention with electronic monitoring, probation.

Delivery of the punishment and orders of the courts in custodial settings is ensured in the 194 prison settings recorded in France in 2009 with a total capacity of 51,997 prison places (i.e., useable operational capacity) in different categories of penal institutions:

- 111 remand centres and 30 remand wings (situated in penal institutions), holding pre-trial detainees (remand prisoners, prisoners with less than one year of their sentence left to run and newly sentenced prisoners awaiting transfer to another prison setting: detention centre or high security prison or prisoners having been convicted and sentenced). 62 prisons for sentenced detainees ('établissements pour peine') including:
- 35 penitentiaries ('centres pénitentiaires') including at least 2 wings for prisoners of a different detention status (remand centre, detention centre and/or high security);
- 23 detention centres ('centres de détention') and 34 detention centre wings, holding sentenced adults with the supposedly best prospects of social reinsertion. Their detention programme is chiefly aimed at "re-socialising" prisoners;
- 4 high security prisons ("maisons centrales") and 9 high security wings situated in penal institutions
- 13 situated in penal institutions of "semi-liberté"
- 1 resettlement prison ('centre pour peines aménagées') (used to house volunteer detainees benefitting from the open prison regime or outside placements, or those with less than a year remaining of their sentence in order to enable them to prepare for their subsequent social reintegration) and 2 resettlement wings in the main prisons;
- 6 penal establishments for minors, defined as establishments with a capacity limited to 60 minors divided into units of 10 places each. The purpose of these establishments is to combine punishment with education, i.e. to ensure that educational, sporting and cultural activities are central to the child's time in detention. Each minor is supervised by an educational officer working for the Youth Service and a penitentiary supervisor.
- 1 national public health establishment ('établissement public de santé national') at Fresnes (EPSNF).

Data collection tools

The data from the police or criminal justice system concerning drug offences has the advantage of being regular, sufficiently historical and easily accessible. On the other hand, this data does not provide a complete overview of the manner in which offences are dealt

with from arrest through to sentencing and possibly concerning the enforcement of the sentence.

- Arrests for drug offences are divided into two major categories: usage and trafficking (broken down into usage-resale, local trafficking and international trafficking); this data have been available since 1971.
- The sentences recorded by the National Crime Register (computerised since 1984, see Appendix V-B) contain details of the judgements issued against persons brought before the courts for drug offences. Consequently, we have access to a homogeneous statistical processing system enabling us to monitor changes in these sentences, both in terms of volume and structure, between 1984 and 2008. As changes in the drug laws during this period were limited, this offers a satisfactory degree of comparability enabling us to analyse changes in the penal sentences issued by the courts during this period.

A sentence can cover several offences but sentences are usually listed based on the main offence. The statistical categories used are as follows: the illegal use of narcotics, assisting another person to use them, possession/acquisition, manufacturing/use/transportation, proposal and sale, importing/exporting and other narcotics offences.

- Until 2003, it was the statistical processing of the data contained in the National Prisoners' Register which made it possible to analyse prison population flows and to track the persons incarcerated (whether for narcotics or other offences) during the detention period in question.
- Since 2003, the year in which the new version of the "National database of offenders" application came on stream, all offences resulting in a sentence are recorded (previously, only the main sentence had been recorded. Yet, the current state of the new version of this database does not tell us the ranking of the offence concerned (i.e. whether it is the main offence or a subsidiary offence), and consequently does not make it possible to identify those cases for which a narcotics offence was the main reason for incarceration. This limitation is particularly acute for drug use as these cases are often accompanied by more serious offences possibly constituting grounds for incarceration (the number of people incarcerated for drug use alone is currently unknown).

Over and above the regular activity indicators, the French framework for the production of knowledge concerning the use of drugs in prison also includes:

1. Institutional surveys. Initiated, designed and deployed by the governing authorities (the Ministry of Health or the Ministry of Justice, etc.), the results are published by these same authorities. They often comprise follow-up analyses of existing data (health forms for offenders received into prison, the number of substitution treatments prescribed in prison, data derived from the activity reports for the CSSTs operating in penal environments, etc.). The samples involved are large and seek to be as representative as possible of the prison population. The frequency of the surveys is irregular, just like the survey into the health en entrants into prison (see Appendix V-H). Among the surveys carried out by the various ministries' research departments, we should mention those from the DREES (the Ministry of employment, labour and social cohesion /Ministry for welfare, health and the family), carried out in 1997 and 2003, offering analyses of data from the health profile of offenders entering prison (use of psychoactive substances, substitution treatments, risk factors and pathologies recorded) noted during the initial medical examination at the time of arrival in the remand centres and remand wings in penal establishments. Similarly, the data supplied by the DGS-DHOS survey between 1999 and 2004 concerning substitution treatments in penal environments enables us to track changes in the number of treatments (continued or new treatments) and the drug maintenance treatment methods involved (methadone, Subutex®) during this period, whereas the surveys carried out "on a specific day" by the DHOS among detainees infected by HIV or

hepatitis C known by the medical teams operating in penal establishments (from June 23-27 2003, for example) describe the profile of known HIV-positive patients and hepatitis C sufferers seen by the outpatient treatment/consultation units operating in penal establishments.

2. Epidemiological surveys. Often backed by research institutes (for example the ORS PACA/INSERM), these are local or national and are also based on pre-existing data.
3. Quantitative sociological studies and research. Based on quantitative interviews with small samples of respondents, these surveys seek to describe user profiles and to document their routes through the incarceration and drug addiction process. This data is collected outside the period of incarceration.
4. Studies carried out by health care professionals. These quantitative or qualitative descriptive studies are initiated by professionals operating in penal establishments. They may suffer from a lack of methodological discipline but nevertheless provide an opportunity to benefit from the views and experience of the professionals concerned.
5. Official reports. Motivated by changes in the law or in regulations, by political issues or by an official appraisal or inspection role, their purpose is to put forward recommendations based on observations and assessments documenting the subject in question.
6. Publications from the NGOs. Their content may include a structured compilation of official reports (observations and recommendations), although the tone and form are different. More rarely, they may be based on a selection of data from a digest of data sources (Observatoire International des Prisons 2005).

To these sources should be added a number of more general documents concerning prisons, generally sociological or demographical works making it possible to understand the general context of the prison environment. Additionally, we should mention the use of various articles and documents which are often summaries of other works.

Background

Delinquency and drug use

The numerous surveys carried out on this topic have shown that drug users are more frequently responsible for serious and less serious offences. The number of acts of delinquency tends to increase in line with the frequency of use of psychotropic products.

The observed link between drug use among young people and problematic behaviour (acquisitive delinquency, absenteeism and expulsion from school, involvement in fights or vandalism, etc.) has also been established (BARRE et al. 2001).

In France, the survey carried out since 1998 at the request of the Ministry of Justice involving youngsters aged 14 to 21 years old processed by the courts' Youth Protection Service teams (*Protection judiciaire de la jeunesse* or PJJ) has revealed high prevalence levels: 60% of these youngsters had already taken cannabis during their lives (Ministry of Justice, 1998).

However, we should distinguish between drug offences in the strictest sense of the word, crimes and offences indirectly attributable to the abuse of psychotropic substances and all other lifestyle factors common to these types of deviant behaviour characterised by substance abuse and delinquency.

1. The first of these three categories and the easiest to understand includes all crimes and offences immediately related to drugs such as the use, possession, trafficking or manufacturing of illegal substances, all of which represent drug offences. To this, we should add cases involving driving under the influence of narcotics for example. In France, during 2008, 176,000 offences of this type were recorded by the Ministry of Home Affairs, a figure which has been constantly rising for more than 20 years now. Back in 1985, a total of 29,750 such offences were recorded.

2. The second group of offences which are indirectly attributable to the use of psychoactive products include acts of delinquency when these are associated in one form or another with the use of these substances without this however constituting an aspect of their definition (so-called "acquisitive" delinquency carried out in order to obtain the money needed to buy drugs).
3. The third and final category (and the category most likely to highlight the complex relationship between drugs and criminality): addictive and delinquent behaviour can be seen as two joint aspects of a deviant form of socialisation and lifestyles (JOURNET M. et al 1995). From this virtually ethnological viewpoint, the use of psychoactive substances should be seen as one occurrence among others in the risky behaviour pursued by the individuals in question. Most of the epidemiological and sociological work in France tends to favour this approach.

Drug use in prison

One third of the newly sentenced prisoners report using a drug or an illegally obtained medicine on a prolonged and regular basis during the one year period before custody (29,8 per cent cannabis) (Mouquet et al 2005).

Among the general population, in 2002, the regular use of illegal drugs concerned 6% of the 18/25 year-olds and 2 % of the 26/44 year-olds (LEGLEYE S. et al 2008). This data clearly points to an over-representation of drug users vis-à-vis the general population. Furthermore, more than one new inmate in ten reports use of several illegal drugs and 31% of the offenders entering the system report problem alcohol use (more than five glasses regularly consumed per day or five or six glasses consumed in succession at a single sitting at least once a week (Mouquet et al 2005).

The existing studies show that all products smoked, sniffed, injected or swallowed before incarceration continue to be used (albeit in reduced proportions) during incarceration (Rottily 2000). Furthermore, the use of more easily accessible products (such as medicines) tends to develop in penal environments. Generally speaking, we are seeing a relative transfer of use away from rare and illegal drugs, in favour of the use of medicines (Stankoff et al. 2000).

This use of narcotics, whether initiated or continued in prison, can seriously affect the health condition of the individuals concerned including the prevalence of serious abscesses, the risk of accidents when combining medicines and other products, severe and longer cravings, and the onset or worsening of psychological or psychiatric disorders. Moreover, detainees constitute a population group combining numerous risk factors considering the health and social consequences of drug use. The low levels of access to treatment experienced by this population group and more fundamentally the situations of precariousness and social exclusion they have often faced before incarceration (including a lack of stable accommodation or social security cover) all contribute to explaining the prevalence of "at risk" use behaviour among new detainees.

The prevalence of injection appears to be higher among this precarious population group, although the number of users administering drugs intravenously seems to be declining: 6.2% of the newly sentenced prisoners reported use of intravenous drugs during the year preceding their incarceration in 1997; in 2003, only 2.6% of them reported injection (Mouquet et al 1999). According to research outcomes, between 60 and 80% of detainees stop injecting during their incarceration. The 20 to 40% who carry on injecting tend to reduce the frequency of their injections, although increasing the quantities injected. They also tend to be more often affected by HIV and/or hepatitis C, with a high risk of contamination from shared equipment, unprotected sex and tattooing. Finally, detainees appear to be more affected by infectious diseases than the general population. The most recent data enables us to estimate that the prevalence of HIV in penal establishments is between 3 and 4 times higher than that encountered outside and that of hepatitis C is 4 to 5 times higher. As outside however, the prevalence of HIV has declined in prison while that of hepatitis C has increased sharply.

Upon arrival in prison, approximately 7% of newly incarcerated detainees state that they receive an opioid maintenance treatment. Eight times out of ten buprenorphine (referred to as Subutex®) is used (accounting for approximately 85% of all patients receiving substitution treatments)(DREES 2005).

During incarceration, this figure tends to decrease as in a certain number of establishments the treatments are not continued despite the requirements of the law of January 18, 1994 (which introduces an obligation to treat incarcerated patients in the same way as outpatients). The level of interrupted courses of treatment fell sharply between 1998 and 2004 but nevertheless concerned more than 1 treatment in 10 (data from the Department of Hospital Care and Treatment Organisation, and the Directorate General for Health). A survey conducted by the French Monitoring Centre for Drugs and Drug addiction (OFDT) has shown that access to methadone rose in penal institutions: among opioid dependent detainees, 35% were treated by means of a methadone-based opioid substitution treatment in 2006 (OBRADOVIC et al. 2008a), vs. 22% in 2004 (Department of Hospital Care and Treatment Organisation, and the Directorate General for Health, Ministry of Health). A third of establishments today have more than 50% of their patients undergoing substitution using methadone (despite major disparities). The average initial prescription levels in detention establishments are now similar to the levels recorded for opioid dependent outpatients (i.e. in hospitals), standing at between 23 (minimum) and 76 (maximum) mg per day. The OFDT has also established that the first prescription of methadone by medical teams operating in prisons is also up (28% vs. 72% of treatment continuations among detainees undergoing substitution with methadone (OBRADOVIC et al. 2008a).

Since the law of January 18, 1994, which transferred the responsibility for health in prisons from the Ministry of Justice to the Ministry of Health, with the creation of the Outpatient treatment/consultation hospital units intervening in prison, known as the 'UCSA' ('Unités de consultation et de soins ambulatoires' reporting to the local hospitals and operating in all penal establishments), the treatment of addiction in detention centres is now based on a threefold system: the Outpatient treatment units, which are present in all penal establishments, have responsibility for the somatic health of detainees; the Regional Hospital Medical/Psychological services ('SMPRs'), based in each of the 26 French regions, handle the mental health aspects of drug addicts in those establishments in which no local branch exists; and finally the "local addiction units" (addiction specialized CSSTs implemented in a number of penal institutions) have been involved since 1987 in the 16 largest establishments in France (covering approximately a quarter of the penal population). This general scheme is also accompanied by another, set up on an experimental basis: the Pilot Care Units for Prison Leavers ('Unités pour sortants') existing in seven establishments.

At the same time, the legal risk and harm reduction scheme operating in penal environments also offers various possibilities for drug addicted detainees to have access to treatment (the circular of December 5, 1996):

- Screening for HIV and hepatitis, theoretically proposed at the time of arrival (CDAG - Free and anonymous screening centres – voluntary) although this is not automatic for hepatitis C (source: POPHEC, *Premier observatoire en prison de l'hépatite C / First monitoring group for hepatitis C in prisons*);
- Prophylactic measures (hygiene measures and the provision of post-exposure treatments for both staff and detainees);
- The availability of condoms with lubricant (theoretically accessible via the UCSA);
- Access to opioid substitution treatments and the availability of bleach to disinfect any equipment in contact with blood (injection, tattooing and body piercing equipment).

No syringe exchange programme is available in the French prisons (an initiative considered "premature" by the Health and Justice Mission of 2000) nor any specific information programme in detention centres concerning contamination resulting of injection.

9.2. Drug-related crime

9.2.1. Drug law offences

Arrests for drug-related offences (OCRTIS 2009)

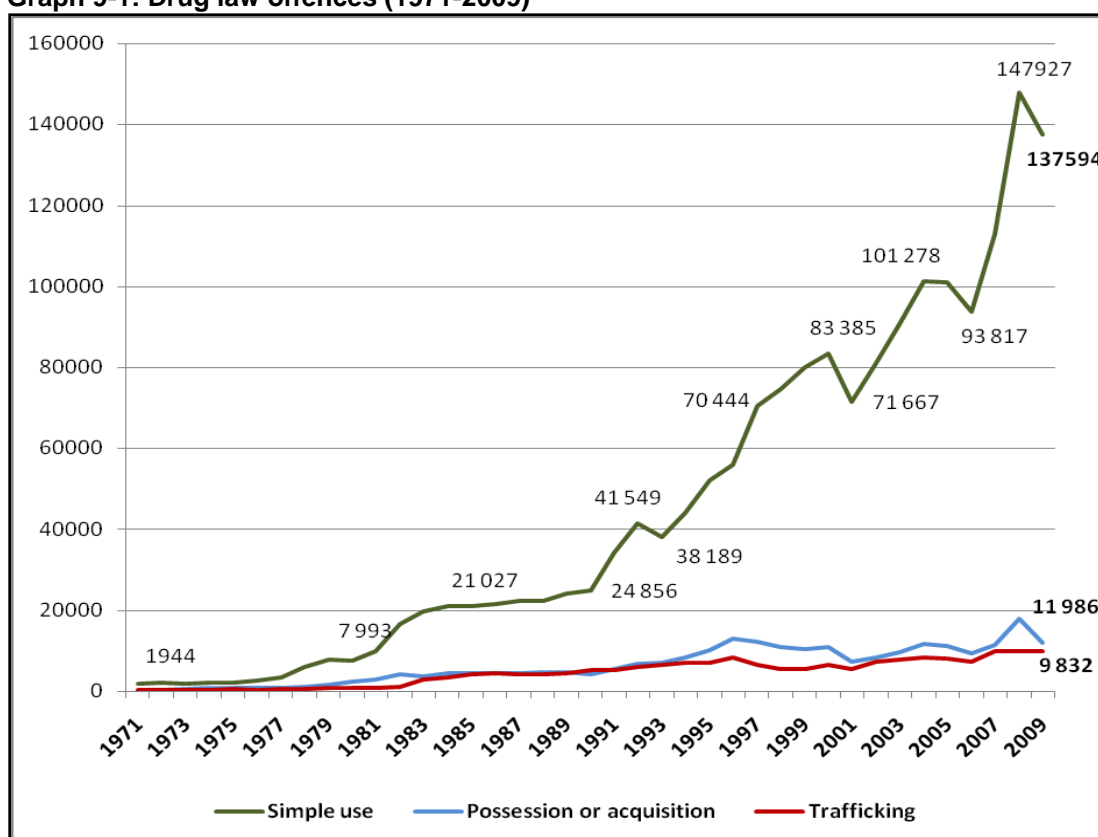
The number of drug law offences skyrocketed over the last 30 years (cf. Graph 9-1). Almost 90 % of all reported drug offences in France are related to drug use or possession for use. In 2009, cannabis remained the drug most often involved in drug law offences (90.8%). Police reports recording drug offences have increased consistently since the 80's, although it is not known precisely whether this is due to increased police activity, an increase in drug use and trafficking, or better performance of the data gathering systems (or other factors that we may not even guess).

Reasons for arrest

The “one-off” (or simple) use of narcotics remains the main reason for arrest, accounting for a total of 137,594 arrests, i.e. 86.3% of arrests for drug-related offences in 2009, a percentage which has slightly risen since 1998. In 2009, 11,986 arrests for use-dealing were recorded, the second leading reason for arrest, i.e. 7.5% of all arrests for drug-related offences.

The 21,818 arrests for trafficking recorded in 2009 can be split up into arrests for international trafficking and arrests for local trafficking, accounting for 6.2% of all arrests for drug-related offences.

Graph 9-1: Drug law offences (1971-2009)



Source: FNAIS, OCRTIS

Substances involved in the drug-related offences

Cannabis remains the main substance concerned by arrests for drug-related offences, regardless of the grounds for arrest, accounting for 90.8% of arrests for use and 69.9% of use-dealing and trafficking cases.

Table 9-1: Arrest for drug-related offences (by substance), 2009

	Use	% in the columns	Use/dealing and trafficking	% in the columns	Total	% in the columns
Cannabis	124 921	90.8%	15 258	69.9%	140 179	87.9%
Heroin	7 115	5.2%	2 974	13.6%	10 089	6.3%
Cocaine	3 768	2.7%	2 752	12.6%	6 520	4.1%
Crack	637	0.5%	205	0.9%	842	0.5%
Ecstasy	323	0.2%	149	0.7%	472	0.3%
Medicines (1)	409	0.3%	262	1.2%	671	0.4%
Amphetamines	210	0.2%	96	0.4%	306	0.2%
Mushrooms	66	0.0%	7	0.0%	73	0.0%
Other drugs (2)	145	0.1%	115	0.5%	260	0.2%
Total	137 594	100.0%	21 818	100.0%	159 412	100.0%

(1) Subutex®, methadone, skenar®, rohypnol®, other

(2) Khat, methamphetamines, LSD, opium, morphine, solvents, other

Source: OSIRIS, OCRTIS

After cannabis, heroin and cocaine are the main substances involved in the drug-related arrests. Arrests for heroin use are more frequent than those for cocaine use (5.2 vs 2.7%) with a similar picture for arrests for use-dealing and trafficking: arrests for the use-dealing/trafficking of heroin (2,974 in all) accounted for 13.6% of all arrests, while arrests for the use-dealing and trafficking of cocaine accounted for 12.6% of these arrests.

We should point out the relative importance in France of the number of arrests related to the misuse of medicines (particularly Subutex® but also unspecified substances, used in spite of the absence of any proof of a prescription), and those for hallucinogenic mushrooms.

The 2009 drop in the number of arrests is a major change, after a few years of continuous rise (cf. Table 9-2).

Table 9-2: Evolution in the numbers of arrests for drug-related offences (by substance), 2005-2009

	2005	2006	2007	2008	2009	Evol.08/09
Use						
Cannabis	90 905	83 980	97 460	133 160	124 921	-6.19%
Heroin	4 486	4 955	6 438	7 827	7 115	-9.10%
Cocaine	2 807	2 943	4 043	4 430	3 768	-14.94%
Crack	691	454	494	784	637	-18.75%
Ecstasy	1 272	753	751	619	323	-47.82%
Medicines	313	287	332	435	409	-5.98%
Amphetamines	263	191	294	364	210	-42.31%
Mushrooms	175	134	142	120	66	-45.00%
Other drugs	135	120	2 969	188	145	-22.87%
Total	101 047	93 817	112 923	147 927	137 594	-6.99%
Use/dealing and trafficking						
Cannabis	12 929	10 942	13 154	19 685	15 258	-22.49%
Heroin	2 170	2 100	2 952	3 792	2 974	-21.57%
Cocaine	2 571	2 561	3 116	3 168	2 752	-13.13%
Crack	370	202	269	264	205	-22.35%
Ecstasy	812	480	388	397	149	-62.47%
Medicines	200	194	245	314	262	-16.56%
Amphetamines	90	78	109	82	96	+17.07%
Mushrooms	39	20	10	17	7	-58.82%
Other drugs	77	92	1 154	107	115	+7.48%
Total	19 258	16 669	21 397	27 826	21 818	-21.59%

Source: OSIRIS, OCRTIS

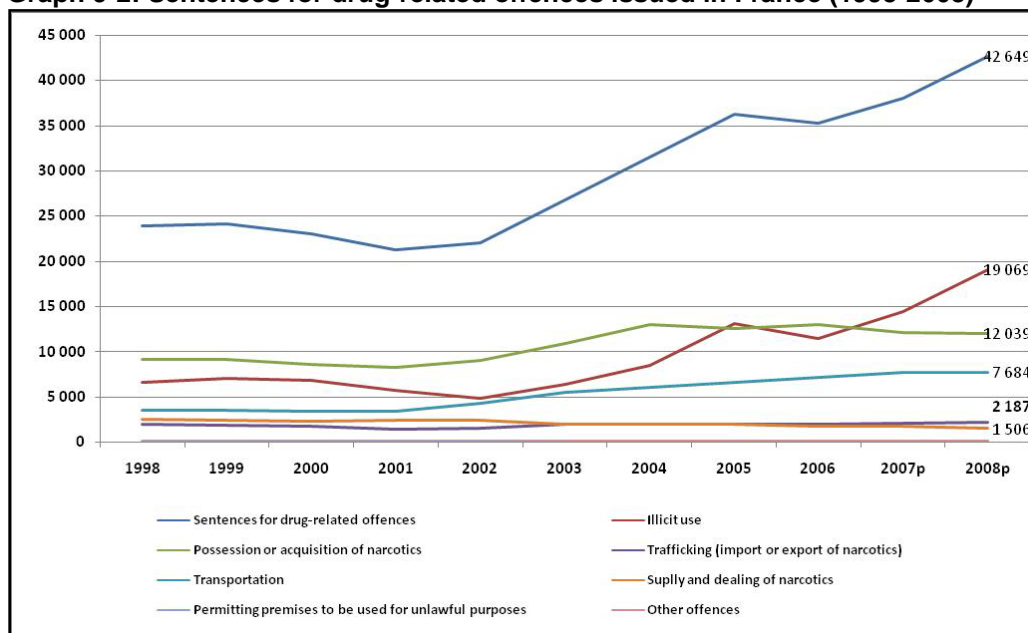
Information from the Ministry of Justice: Sentencing.

Sentencing statistics are published within a two-year interval (Justice, 2009). The following information therefore concerns year 2008 and is not officially considered as final.

A total of 42,649 sentences were issued in 2008 for cases in which a drug-related offence was listed as the main offence⁹³, i.e. 12.1% more than in 2007.

⁹³ A sentence may cover several offences (a frequently encountered situation where drug-related offences are concerned). The main offence is that listed first in the criminal record, although this may not always be the most serious offence.

Graph 9-2: Sentences for drug-related offences issued in France (1998-2008)



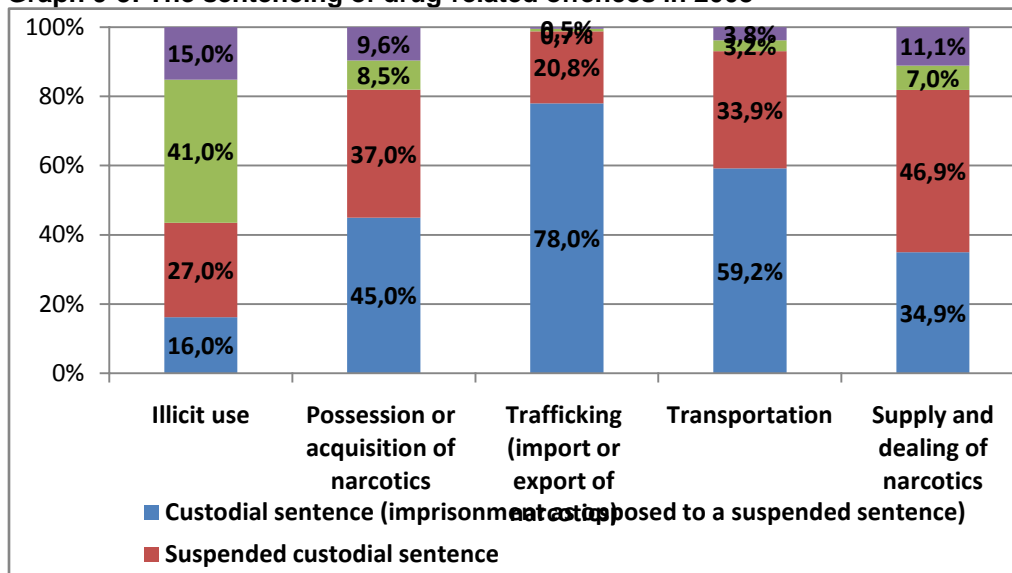
Provisional 2008 data.

Source: Data from the Statistical Yearbook of the Ministry of Justice 2009

In 2008, 19,069 sentences were issued for drug use (an increase of 33% in comparison to 2007). Representing 44.7% of offences, the drug use offence has become by far the first drug-related offence giving way to conviction (see graph 9-3).

In 2008, 80% of the convictions for trafficking resulted in a custodial sentence (imprisonment without remission or combined with a partial suspension), versus 16% of the drug use convictions, which mostly resulted in fines (41%) or alternative sentences such as day-fines or community service (15%).

Graph 9-3: The sentencing of drug-related offences in 2008



Provisional 2008 data.

Source: Data from the Statistical Yearbook of the Ministry of Justice 2009

Information from the Ministry of Justice: incarceration.

Flow data show that the numbers of drug offenders entering prison settings have been stable over the last 5 years. In 2009, 11,823 drug offenders were incarcerated, according to the National Prisoner Register (FND, see Appendix V-N).

9.2.2. Other drug-related crime

Driving after using narcotics ("Drug Driving"): Screening and sentencing in 2005-2006 (Ministry of the Interior (sous-direction de la statistique 2006))

A recap of the applicable legislation.

The law of June 18, 1999 and its application decree (of August 27, 2001) introduced automatic screening for narcotics for all drivers involved in a road traffic accident resulting in an immediate death, and the introduction of an epidemiological study (carried out between October 2001 and 2003) prior to a possible wide scale study (the SAM study). The law of February 3, 2003 introduced a new offence aimed at punishing any driver whose blood analysis revealed the presence of narcotics. Drivers in such a situation face a 2-year prison sentence and a fine of €4,500. These punishments may be increased to 3 years' imprisonment and a fine of €9,000 if alcohol has also been consumed.

A new drug testing procedures on roads has been introduced since the summer of 2008: oral fluid testing devices for the on-site screening of drivers suspected of having taken drugs have been authorized since 2005, but they have only been actually used since 2008⁹⁴. Until then, the screening procedure was performed with roadside urine tests, in the presence of a physician. This procedure was considered to be too complicated and not cost-effective enough. Since 2008, drivers suspected of driving under the influence of drugs have been screened with the Drugwipe® tests - even though Rosita (RoadSide Testing Assessment) and Rosita 2⁹⁵ have both concluded that improvements should be made regarding the detection of cannabis and benzodiazepines by the Drugwipe® tests. The screening and confirmation cut-off concentrations for THC, amphetamine-type stimulant drugs, cocaine and opiates in oral fluid are 15ng/ml, 50 ng/ml, 10 ng/ml and 10 ng/ml of saliva respectively (arrêté du 24 juillet 2008⁹⁶). False positives are supposed to be minimised by a blood test performed in a medical setting whenever the saliva test (performed on the roadside) proves positive for drivers tested for cannabis, amphetamine-type stimulant drugs, cocaine and opiates.

By the end of 2008, 52,000 testing kits had been distributed to police officers across France. This two-step system is still in force.

Screening (blood tests or urine tests if it proves impossible to obtain a blood sample) is compulsory in all accidents resulting in an immediate death, or in cases involving bodily injury when the driver is suspected of having taken drugs. Screening is also authorised for any driver involved in any road traffic accident or committing certain Highway Code infractions, or when there are reasonable grounds to presume that he may have used narcotics (art. L235-2 of the Highway Code).

In its press release of February 18, 2010, the Interministerial Road Safety Committee announced certain changes to the screening of drivers under the influence of narcotics, particularly an increase in the number of roadside saliva tests. The new measures decided on for 2010 envisage:

⁹⁴ Loi du 3 février 2003 relative à la conduite sous l'influence de substances ou plantes classées comme stupéfiants (<http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000235043&dateTexte=>) ; Loi du 12 juin 2003 renforçant la lutte contre la violence routière (<http://droit.org/jo/20030613/EQUX0200012L.html>) ; Comité interministériel de sécurité routière du 24 janvier 2005, promouvant le recours aux tests oraux de fluides réalisés sur le bord de la route et l'introduction systématique des tests salivaires (http://www2.securiteroutiere.gouv.fr/IMG/pdf/DP_CISR_24-01-05.pdf) ; Arrêté du 24 juillet 2008 modifiant l'arrêté du 5 septembre 2001 fixant les modalités de dépistage des stupéfiants et des analyses et examens prévus par le décret n°2001-751 du 27 août 2001 relatif à la recherche de stupéfiants pratiquée sur les conducteurs impliqués dans un accident mortel de la circulation routière (NOR SJSP0817087A).

⁹⁵ As a reminder, the ROSITA reports were submitted to the European Commission in 2006. Their objective was to question the clinical validity of saliva tests with regard to cannabis detection. The THC present in urine and blood was detected in less than half of the tests (46%).

⁹⁶ Arrêté du 24 juillet 2008: http://www.legifrance.gouv.fr/jopdf/jopdf/2008/0730/joe_20080730_0044.pdf

- 1- Increasing the number of narcotics tests to 100,000 per year, particularly through the increased use of saliva tests.
- 2- Making drug screening mandatory in all cases of physical injury whereas, until now, this has only been optional. It does, of course, remain mandatory for fatal accidents.
- 3- Leaving the police to decide whether to screen in accidents without injury or if a driver is presumed to have taken narcotics.
- 4- Performing a test in all cases of Highway Code infringement.
- 5- being able to perform random controls on the instruction of the Public Prosecutor (as is the case with blood alcohol tests)
- 6- Making the offender pay for the cost of the blood laboratory tests which are mandatory if a saliva test is positive to any drug. Until now, these investigations were paid for by the taxpayer: from now on, the offender will be the one to pay a sum of €300 per test. If, however, the result is negative, no payment will be requested from the driver and the investigation will be paid for by the Ministry for Justice.

Screening in 2009

Approximately 63,500 narcotics tests were performed in 2009, 34.6% of which produced a positive result. The Ministry for the Interior statistics did not state whether these only concerned the saliva tests or whether this figure also included laboratory tests.

Sentencing in 2008

The number of sentences issued for driving after using narcotics has risen in the last few years : 2,976 in 2005, 3,988 in 2006, 5,185 in 2007, 6,589 in 2008 (source : National Crime Register).

In 2008, 6,589 sentences were issued, i.e. 27% more than in 2007. Among these sentences, 42.2% resulted in a prison sentence (of which only 15% involved partial or total imprisonment without remission). Another 42.2% involved a fine and 15.6% an alternative sentence (most often a driving license confiscation).

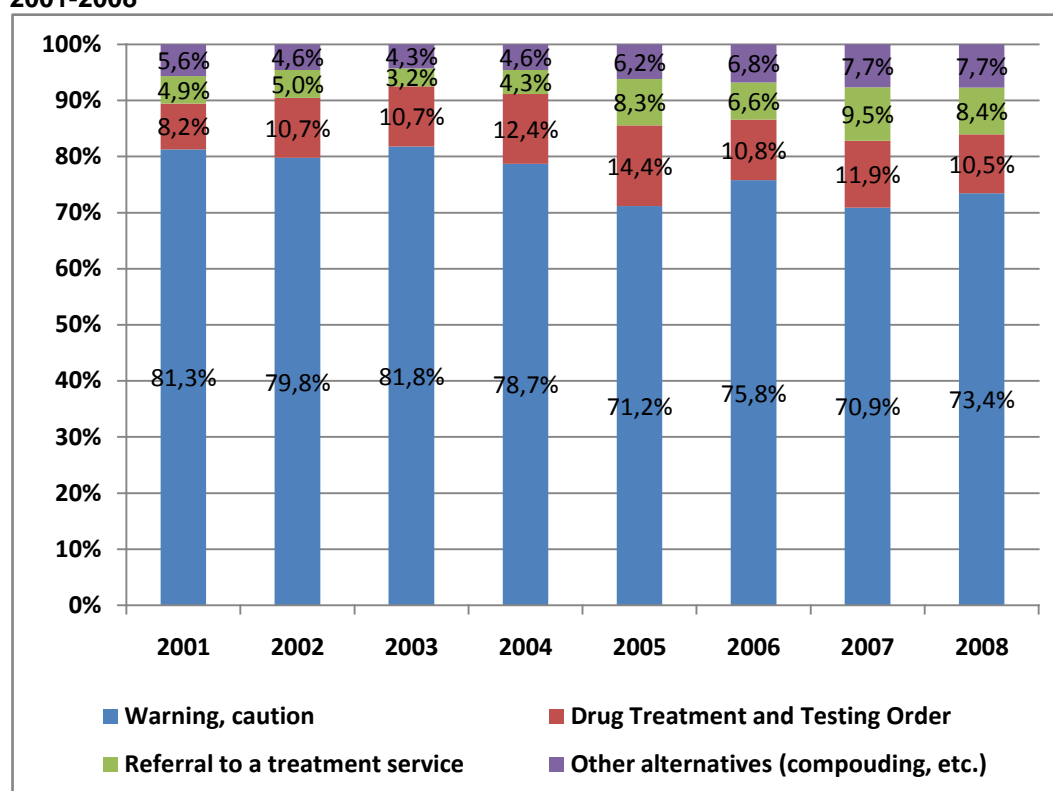
Punishments tend to be less severe for driving under the influence of narcotics alone or for refusing to cooperate. However, they are more severe in the event of injury (8.4 sentences out of 10 result in imprisonment) and especially in the case of manslaughter, 45% of which result in imprisonment without remission, for an average duration of 9.6 months each.

9.3. Prevention of drug-related crime

The French criminal justice system contains an array of court-ordered treatment options, some of them including quasi-compulsory treatment (conditional discharge with a drug treatment referral, mandatory treatment, legal reminder possibly associated with a health care referral). Compulsory treatment in itself can be used as an alternative measure to either prosecution (deferred prosecution, mandatory treatment ["injonction thérapeutique"]) or imprisonment (as an alternative or supplement to existing criminal justice sanctions and procedures: court-ordered treatment for drug offenders within a deferred sentence, a pre-trial intervention, a community sentence, diversion, probation).

Examination of penal statistics for the Paris region (which represents 25% of national prosecutions for drug offences) reveals an increase in the number of narcotics use cases handled by the courts between 2001 and 2008. This figure has almost doubled from 10,261 to 17,353. At the same time, amongst all of the decisions, the proportion of case closures (proceedings closed) fell and the proportions of alternatives to legal action conversely increased (cf. table 9-3-1). Whilst rare until the end of the 1990s, alternatives to legal proceedings now make up 70% of the decisions issued with regard to drug users, whereas the proportion of cautions issued has fallen.

Graph 9-4: Distribution of the alternatives to prosecution prescribed to drug use offenders, 2001-2008



Source: Data collected from the Cassiopée Infocenter, Ministry of Justice (Paris area only)

The most recent examples of the extension of the QCT options can be found in the counselling cannabis clinics for young users ("consultations jeunes consommateurs") which have been in operation since 2004. It has been shown that 50% of the outpatients admitted in these clinics (screening, counselling and brief intervention) were referred by the criminal justice system, especially among males and young adults (OBRADOVIC 2009). Attendance at these counselling sessions was either an alternative measure to court proceedings (66%) or a mandatory care penalty (for 26% of outpatients), given that failure to seek mandatory care resulted in immediate imprisonment (<http://www.ofdt.fr/ofdtdev/live/english-tab/engpubli/tends.html>).

In addition to these different treatment options, the range of alternatives to prosecution offered to drug offenders has been extended since the law of March 5, 2007 and the April 16, 2008 decree (cf. chapter 1). Adults or minors caught possessing marijuana have to complete a drug awareness course which they must pay for. As outlined in Justice Circular 08/11 dated 9 May 2008⁹⁷, all people who use relatively small amounts of illegal drugs should be sentenced to penalties. The educational goal of these compulsory training courses is to inform offenders about drugs, their use and misuse and the existing drug-related policies and laws and the consequences of violating them.

In 2008, 1600 persons were sentenced to a drug awareness compulsory training course were, 300 of which implied minors (i.e. less than 20%). The Ministry of Justice set up a monitoring system to assess the implementation of the courses over the first year, during the last three trimesters of 2008 and the first trimester of 2009 (Ministry of Justice, 2009). Half of the courts (45.3%) responded (n=82): the available data, based on a sample of 27,175 cases involving drug use, show that 9% of the penalties delivered by the courts included

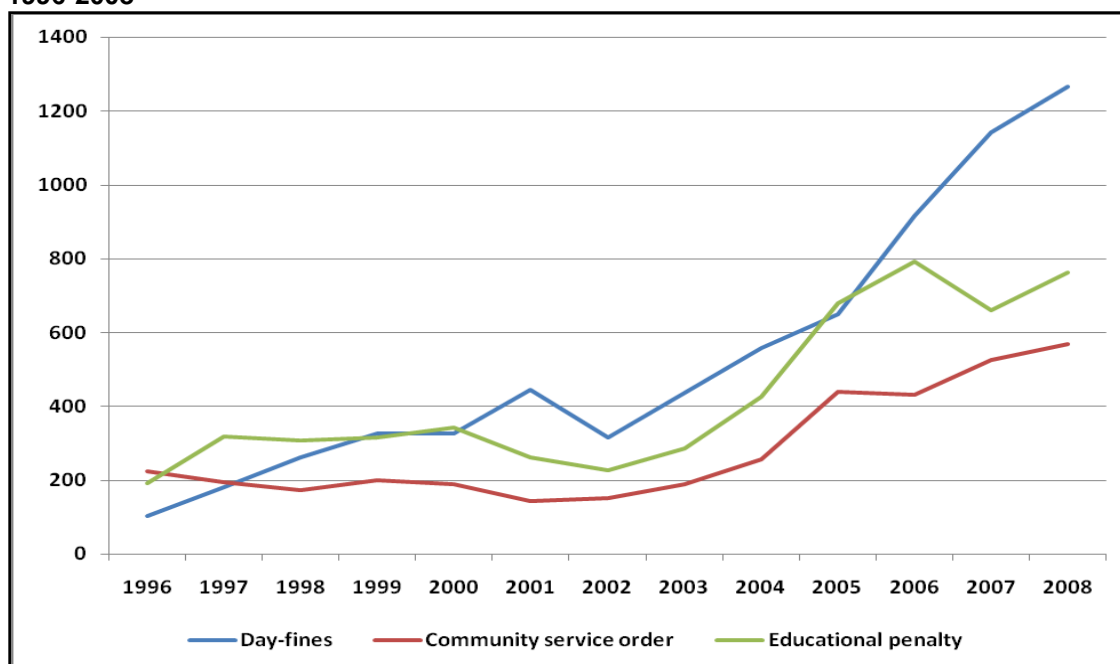
⁹⁷ Circulaire CRIM 08-11/G4-09.05.2008 relative à la lutte contre la toxicomanie et les dépendances (NOR JUS D0811637C)

attendance at drug awareness courses (n=2.311, in 42 of the 82 responding courts) and 14% were under mandatory treatment (n=3.815, in 44 of the 82 responding courts): 95% of these penalties were delivered as alternatives to prosecution. Additionally, 395 drug awareness courses concerned drug users under 18 (17% of penalties) and 1,916 implied adult drug users (83%). As far as DTTOs are concerned, 467 of them involved minors (12%) and 3,348 adult drug users (88%). The survey conducted by the Ministry for Justice among the courts of law also highlighted a wide disparity in the responses. While some courts make widespread use of mandatory treatment and awareness-raising courses, drawing on the support of a dynamic network of associations within their jurisdiction, others appear less willing to use this new system.

9.4. Interventions in the criminal justice system

Further along in the criminal procedure, the individuals convicted for infringing the 1970 Drug Law may benefit from an alternative to imprisonment penalty, rather than a prison sentence or a fine. These alternatives to imprisonment may take various forms: community service, 'jours-amendes' penalties (day-fines, literally, corresponding to days in prison paid off by fines), or other types of penalty. Although the national data on this topic are fragmentary, they show a rise in the numbers and proportions of these measures applied to simple drug users.

Graph 9-5: Distribution of the alternatives to imprisonment prescribed to drug use offenders, 1996-2008



Provisional 2008 data.

Source: Data from the Statistical Yearbook of the Ministry of Justice 2009

9.5. Drug use and problem drug use in prison

The most recent study on that topic was carried out in 2003. It revealed that 33% of people entering prison reported regular use of illegal drugs or diverted medicines during the year preceding their incarceration, while in the general population, the regular use of illegal drugs concerned 6% of 18 to 25-year-olds in 2002, and 2% of 26 to 44-year-olds. These data clearly reveal an over-representation of drug users compared to the general population. Although the currently available data need updating, it is acknowledged that 29,8% of inmates report using cannabis in the past year, 7,7% report cocaine or crack use in the same

time frame, 6,5% mention heroin use, 5,4% diverted medicine use and 4,0% report LSD, ecstasy or inhalants use in the past year (data recorded in 2003, DREES, 2005).

Studies have shown that all substances smoked, sniffed, injected or swallowed prior to incarceration continue to be used, although in lower quantities, during imprisonment (Rotily (2000). Furthermore, the use of easy-to-obtain substances, such as medicines, has increased in penal establishments. Generally, we are seeing a relative transfer of use away from illegal and rare drugs, to medicines (Stankoff et al. 2000).

The use of narcotics, whether initiated or continued in prison, has a major influence on the state of health of the individuals concerned, including serious abscesses and the risk of accidents when medicines are combined with other substances, severe and longer withdrawal symptoms, in addition to the occurrence of psychological or psychiatric disorders. Furthermore, detainees constitute a population group more likely to combine risk factors where the health and social consequences of drug use are concerned. The low level of access to treatment experienced by this population group, and more fundamentally, the situations of precariousness and exclusion which they often faced prior to incarceration (including the lack of a stable home or Social Security cover, etc.) help explain the prevalence of "high risk" consumption among new detainees.

The use of injection as an administration method tends to be higher among this precarious population, although the number of intravenous users appears to be diminishing: in 1997, 6.2% of new detainees stated that they had taken drugs intravenously during the year preceding their incarceration (Mouquet et al 1999). In 2003, only 2.6% of new detainees stated that they used injection as an administration method. According to surveys, between 60 and 80% of prisoners stop injecting while in prison. Those who continue injecting reduce the frequency of their injections, but they seem to be the largest injectors and are more often infected with HIV and/or hepatitis C. This means that the risks of contamination when sharing equipment, engaging in unprotected sex or adding tattoos are very high.

9.6. Responses to drug-related health issues in prisons

Even though prison conditions came under fire from several parliamentary, institutional and international reports, France's prison population continued to rise in 2009 compared to the number of places available. The prison population stabilised in France in 2009, at a high level of 63,277 prisoners in June 2009, for a total capacity of 51,000. French prisons are largely overpopulated with an average occupancy rate of 140%. Overall, approximately two-thirds (63%) of prisons were over-populated, 7% of which reached an occupancy rate of 200% (i.e. two prisoners per place). The overall occupancy in 2008 was 126% in France compared to an average of 102% in Europe. The overall stable figure masks an increase in the number of sentenced prisoners and a fall in the number of accused persons.

Consistent evidence stresses the difficulties inherent in offering individual health care in overpopulated prison settings, especially for drug users. This concern is endorsed in several national action plans, such as the Viral Hepatitis Strategic Plan ("Plan Hépatites 2009-2012") or the "Second Plan national santé environnement". In the context of the new penitentiary law project, a national Chief Inspectorate of Prisons and Other Closed Institutions (such as immigration removal centres, young offender institutions, etc.)⁹⁸, currently labelled as the "general controller of the jails", was nominated in 2008. A team of 21 inspectors was appointed, with a budget of 3,182 millions Euros in 2009. The responsibility of the Chief Inspectorate of prisons was to report on the general treatment of prisoners in prisons and on conditions in prisons. The first 2008 review pointed out that prisoners had to cope with restricted living space, lack of intimacy, poor sanitation, the spread of disease, unsatisfactory food, and inadequate healthcare (Le Contrôleur général des lieux de privation de liberté

⁹⁸ Loi n°2007-1545 du 30 octobre 2007 instituant un Contrôleur général des lieux de privation de liberté (NOR: JUSX0758488L) ; Décret n° 2008-246 du 12 mars 2008 relatif au Contrôleur général des lieux de privation de liberté. <http://www.legifrance.gouv.fr/WAspad/UnTexteDeJorf?numjo=JUSX0758488L>

2009). The second annual report examined other important features of prison life such as, firstly, activities offered to prisoners and, secondly, the use of video surveillance (Chief Inspector of all Custodial services, 2010).

One objective of the 2008-2011 national action plan on drugs was to “improve care and continuity of care provided to drug and alcohol users in prison”. The Plan called for a strategy of coordinated prevention and care actions for addictions in prisons related to the guidelines already identified in the August 9, 2001 interministerial memo. This general orientation led to specific measures:

- The setting up of hepatology sessions in prisons, including the supply of Fibroscan®;
- The dissemination of good professional practice guidelines on opiate substitution treatments,
- The study of better ways of providing information about HIV and hepatitis, and of the benefits of screening and its renewal if markers are negative.

A national call for tenders was launched, with the aim of appointing agencies to coordinate short and accessible reception programs dedicated to released prisoners, within the existing social and medical-social structures (with accommodation), in cooperation with hospitals intervening in prison facilities. Outcomes should be evaluated in the future.

9.6.1. Drug treatment (including number of prisoners receiving opioid substitution treatment)

Few of the 186 penitentiary institutions in France have developed a specific care programme for drug addicts. Addiction centres exist in 16 large correctional institutions: pilot Care Units for Prison Leavers (UPS) were opened in 7 prisons in 1997 (2 closed in 2003) and CCAAs were opened in only 3 establishments. The 102 Penitentiary Services for Reintegration and Probation (SPIP) play a role in the social monitoring of all detainees and their reintegration upon release from prison; they ensure social reintegration for drug addicts (including those who began treatment in prison) by guiding them towards partner organisations in the form of government bodies or associations.

Theoretically, substitution medicines can be prescribed to prisoners in the same way as for the rest of the population in order to start or continue a programme of treatment with Subutex® (since 1996) or methadone (since the issuing of circular number 2002/57 dated January 30, 2002). All adult prisons are required to provide substitution treatments to inmates when they arrive in the establishment (under the terms of circular DGS/DH/DAP dated December 5, 1996). The Ministry of Health has carried out four successive surveys concerning substitution treatments (March 1998, November 1999, December 2001 and February 2004) which show that it is easier for heroin-addicts to obtain substitution treatments outside of prison (as opposed to when they are incarcerated), despite the fact that the percentage of the prison population receiving substitution treatments has increased: 2% in 1998, 3.3% in 1999, 5.4% in 2001 and 6.6% in 2004, with a majority of high-dose buprenorphine treatments (78% in 2004 vs. 22% of methadone-based treatments). The percentage of people interrupting their substitution treatments upon arrival in prison has fallen, dropping from 19% in 1999 to 5.5% in 2001.

The most recent survey on that specific topic was carried out in 2007 (OBRADOVIC et al. 2008b) showed an increase in access to methadone in prisons. Among the opioid-dependent prison population, 40% were patients receiving methadone maintenance treatment. Among the difficulties most often encountered when prescribing methadone, the most frequent concerns identifying the patient's release date, early release (40%) being taken into account. The second constraint as far as initial prescription is concerned is related to the short time prisoners remain in detention, particularly in remand centres, which does not make it possible to monitor the detainee patients over the long term. Additionally, almost a quarter of professionals responding to the survey (24%) stated a preference for HDB when it comes to

treating opioid-dependent prisoners. Furthermore, 22% of establishments mentioned difficulties in finding a follow-up organisation to take over prisoners' treatment upon their release, and a similar number of professionals mentioned a lack of staff (20%), resulting in a negative impact on the organisation of methadone distribution. However, it must be mentioned that several penal establishments continued to cite doctors' reticence to prescribe opiate substitution treatments in penal establishments, and more than a quarter stated that they had issued no prescriptions for methadone during the six-month period concerned in 2006.

Furthermore, it has also been demonstrated that opioid-dependent patients reporting maintenance therapy when entering prison had poorer health statuses, higher levels of opioid use and longer criminal histories. Also, they were less socially integrated than the opioid-dependent patients without maintenance treatment (Marzo JN et al. 2009).

9.6.2. Prevention and treatment of drug-related harm

Harm minimisation strategies are directed towards reducing harm, in many cases by altering drug using behaviours and effects (acquisition, drug use, and withdrawal). No new strategic document since the 2008-2011 governmental plan has addressed the public issues encountered on the three levels of drug-related harm:

- Drug acquisition harms may be related to the risks of being exposed to high-risk situations, such as criminal behaviour (either being exposed to or conducting criminal acts such as drug dealing, robbery, etc.).
- Drug use harms related to the drug used, the amount consumed, and the method of administration, generating pharmacological effects and consequences on the individual's health (for example, injection drug use may lead to open wounds, vein problems, abscesses, skin breakdown, HIV and other infectious diseases when sharing needles and paraphernalia, and, of course, the risk of overdose).
- Drug withdrawal harms related to the effects of reducing or eliminating drug use that may impair the individual's work and social functioning.

9.6.3. Prevention, treatment and care of infectious diseases

Infectious illnesses seem to be more rampant among prisoners than among the general population. The most recent data indicate that the prevalence of HIV in the prison population is somewhere between 3 and 4 times higher than that noted among the general population and that of hepatitis C is about 4 to 5 times higher. Just like "on the outside", however, the prevalence of HIV in prison is receding while that of hepatitis C continues to grow sharply.

There is no legal provision in France for syringe exchange and related programs. A Penitentiary Administration circular has allowed the free and systematic distribution of bleach to detainees since 1996 but no evaluation was conducted to assess the implementation of such a directive.

No legal text explicitly prohibits tattooing. However, regulations state that condoms must be made available, especially in the hospital units (UCSA).

Prevention of infectious diseases

New arrivals are screened for substance misuse problems. Upon their arrival in prison, all detainees are offered a medical consultation provided by an outpatient consultation and treatment unit (UCSA), with tuberculosis screening, a voluntary and confidential HIV test and, more recently, screening for Hepatitis C along with Hepatitis B vaccination. Regional medico-psychological hospital services (SMPP) are responsible for psychiatric care in 26 penitentiary institutions (larger prisons in general), while the UCSA deal with physical care.

The 2008-2011 'Combating Drugs and Drug Addiction' Government Action Plan set an aim of improving "care and continuity of care provided to drug and alcohol users in prison" in order

to reduce the associated risks and prevent relapse, considering that "the means offered within the existing system are insufficient to control these problems". It thereby proposes to change the regulations such that prison hospital units, the consultation and ambulatory care units (UCSA), can control care for addictions, to define care objectives to be achieved for addicted persons and to increase the financial resources for these services. It also calls for the introduction of a 'genuine prison addiction plan', including in particular the set-up of hepatology consultations, including the supply of Fibroscan®, addiction and hepatitis training for health professionals and information about hepatitis C for users.

9.6.4. Prevention of overdose-risk upon prison release

The 2008-2011 Government Action Plan recommended that "a good professional practice guide (particularly concerning opiate substitution treatment)" be produced and distributed. With the support of MILDT, the International prisons observatory did in fact produce and distribute a practical guide for prison leavers in 2009.

9.7. Reintegration of drugs users after release from prison

The 2008-2011 Government Action Plan also envisages the creation of "short and quickly accessed reception programmes for released prisoners, within existing social and medical-social structures, in relation with the hospital related to the prison", highlighting "difficulties with accommodation [...] on release from prison". In the far wider context of the work conducted by MILDT on therapeutic communities in general, thought has been given to the existence of these centres in the prison setting or to the creation of establishments of this type receiving prison leavers.

10. Drug markets

10.1. Introduction

Any attempt to understand the market for illegal drugs requires an assessment of the *availability* and *accessibility* of a given substance, of changes in the quantities seized and an analysis of changes in its street price.

Finally, monitoring the supply of a drug also means monitoring its composition (its level of purity and the products used to cut it).

Availability and accessibility

Availability can be defined as the overall presence of a substance in a given geographical area. This availability is referred to as "noticeable" when it is spotted by special observers referred to as "sentinels", specifically devoted to this role.

Accessibility refers to the degree of effort required by an average user possessing the necessary financial resources to obtain the substance concerned. Consequently, a substance may well be available but not particularly accessible. There are several degrees of accessibility, which can be measured based on factors such as the time needed to gain access to the substance, the locations concerned (public/private), the time (night or day) and the type of network involved.

The main source of information in this area is provided by the ongoing monitoring scheme "Recent Trends and New Drugs" (*Tendances récentes et nouvelles drogues* or TREND) which has provided chiefly quantitative information (accessibility, availability and price) since 1999 concerning the users and the various key players in the fields of prevention, treatment or suppression. This scheme focuses its observational efforts on two environments: the urban environment and the "festive" environment. The first includes areas frequently visited by active drug users (squats, the street, low threshold structures and transit areas, etc.) while the second refers to festive or "party" events or establishments mainly related to the techno, alternative (teknival, free-party, etc.) or commercial scenes (clubs).

The product analysis scheme referred to as the National Poison/Substance Identification System (*Système national d'identification des toxiques et substances* or SINTES), a participant in TREND, provides information concerning the circulation of rare and emerging products.

Surveys among the general population concerning the noticeable accessibility, supply and availability of the various illegal substances can provide us with data concerning the most widely available products.

Seizures and the structure of trafficking activities

France is a transit country for drugs intended in particular for the Netherlands, Belgium, the UK, Italy and beyond. It is therefore very difficult to separate the quantities of drugs intended for the domestic market and those which are only passing through. The trafficking aspect in France must therefore be assessed based on the products encountered, as the acquisition and destination countries vary according to the drug concerned.

In France, three main types of supply networks for illegal drugs can be distinguished:

- Networks linked to major criminal organisations which are often encountered at the "bulk" or "semi-bulk" sale stage;
- Networks of "retailers" based on a strict organisational structure (manager/dealer/tout/lookout, etc.);
- "Micro-networks" of user-dealers.

The main source of information is the data from the law enforcement services (the police, customs and gendarmes) produced and published on an annual basis under the responsibility of the OCRTIS (the Central office for the repression of drug related offences). This report includes among other things the quantities of illegal drugs seized in France, the number of arrests (for usage, usage-resale or trafficking) related to narcotics offences, the prices involved and any information concerning the structure of the trafficking networks.

Additionally, the TREND scheme provides qualitative information concerning access to the products and micro-trafficking.

Prices

Two useful resources make it possible to gather details of the unit sales prices of illegal products:

- The TREND network, based on quantitative questionnaires completed by the low threshold centres and staff operating in the techno/party environment on each site involved in the scheme, where for each substance concerned (illegal drugs or misused medicines) the retail price and an estimate of the lowest, highest and general price is requested.
- A periodical survey from the OCRTIS, based on data collected at 69 sites spread throughout metropolitan France, which records the median semi-bulk and retail prices of illegal substances.

Drug composition and purity

The composition of the product refers to all of the substances present in a sample.

The purity (or content) corresponds to the percentage of the psychoactive product being sought.

The product also includes cutting agents and additives. These terms refer to any substance added to the main product. They may be pharmacologically active or otherwise.

The detection threshold is the minimum quantity of a substance allowing for its identification in a sample.

The quantification threshold is the minimum quantity of a substance allowing for its dosage in a sample.

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

- Analysis of chemical composition of substances seized. This data supplied by the law enforcement services' laboratories and grouped together in the report from the OCRTIS (Central office for the repression of drug related offences);
- And analyses derived from data collection campaigns involving drug users as part of the OFDT's SINTES scheme (National Detection System of Drugs and Toxic Substances).

Analyses of seizures

The analysis of seizures by the law enforcement laboratories provides the main source of information on the composition of illegal products in France. The annual report from the OCRTIS provides a summary of all of the data concerning the composition of the illegal substances seized and analysed by all of the law enforcement services (the customs, police and gendarmerie) during the year, for the whole country. This offers a set of results from the analysis of seizures without taking account of the volume of each seizure, with the exception of cocaine for which a distinction is made between airport seizures and street seizures. On the other hand, not all of the seizures are analysed.

For the purpose of the analysis, (and with the exception of a few cases) the dosage level of the main psychoactive agent is estimated. All other substances are simply identified.

The exchange of information between the EWS (Early Warning System) and the SINTES scheme (of which it is the national correspondent) also allows for the identification of new drugs.

The SINTES is also linked to the laboratories of the various legal authorities (the Customs Department, gendarmerie and police) by an agreement which officially establishes and authorises an exchange of information concerning drugs in circulation. Following a specific request from the OFDT, they provide information concerning the nature and composition of drugs recently seized or attracting particular attention from the OFDT and/or the EMCDDA.

The SINTES scheme

The SINTES scheme is based on the principle of the collection of samples of illegal drugs obtained directly from drug users. The drugs collected are forwarded to a toxicological analysis laboratory which determines their composition. At the same time, the drug user is asked to complete a questionnaire in order to identify the use scenario for the product and its purchase price. This makes it possible to directly correlate the price and purity of a given product. It includes two aspects:

- The OBSERVATION aspect provides an annual overview of the composition of a particular illegal product, (2006: cocaine / 2007-08: heroin / 2009: synthetic products). The SINTES-Observation scheme is largely based on the national TREND network which is itself organised into seven regional coordination units. Each "collector" is selected and trained according to his networks and his skills, by the regional coordinator under the responsibility of the OFDT who then supplies him with his collector's card. Each year, between 350 and 450 samples of the product being studied are collected from a similar number of different users. This is consequently the main aspect of the SINTES scheme when it comes to obtaining details of the composition of the product on a national basis for a given year.
- The MONITORING aspect is more particularly specific to the health alert system. Any professional working with drug users may ask the OFDT for authorisation to collect an illegal product on condition that this product has generated undesirable and unusual effects for users or if it is new in some way. The annual number of collections is generally between 40 and 60.

The contributions made by this aspect are limited exclusively to the identification of newly circulating drugs and up-to-date information concerning the composition of certain substances at a given moment and in a given location.

All of the pharmacologically active substances are identified, on condition that they are included in the laboratory database. On the other hand, only the main psychoactive substances undergo a dosage estimate unless requested otherwise.

10.2. Availability and supply

10.2.1. Perceived availability of drugs, exposure, access to drugs

Cannabis

Cannabis is the most extensively used narcotic product in France. Although cannabis resin is still widely available in France due to the presence of well-established drug networks (which import it either directly from Morocco or indirectly from Spain) and regardless of fluctuations in certain local markets, the fact nevertheless remains that a number of major trends can be identified that appear to point to significant future changes in the market. Not least of which include a growing preference shown by users in France and the rest of the European continent for herbal cannabis, which appears to be increasingly available.

Heroin

In France, heroin is available in two chemical forms: the "white" hydrochloride form and the "brown" freebase form. The white form accounts for a very minor share of the black market and only circulates through highly specific channels, for example in certain sections of the Asian immigrant community (the Chinese community in particular) and users based in the Paris region, who by their very nature are not particularly visible. On the other hand, the freebase form dominates the market. Following a downturn after the introduction of substitution treatments in France in the second half of the 1990s, observers working in the area of drug use have noted a greater availability of brown heroin since 2006. This may involve more marginal low threshold services' or specialised treatment centres' clients, or certain festive "party" settings around alternative or underground countercultures linked to the electronic music scene (CADET-TAIROU, A., M. GANDILHON, et al, 2010). In 2009, this trend was confirmed by virtually all parts of the TREND system.

Cocaine

Cocaine availability has been constantly increasing in France since the late 1990s and the early 2000s. This is a regular, ongoing process and does not appear to have retreated or stopped. Indeed, the demand for cocaine hydrochloride is extremely dynamic in widely varying sections of the French population, ranging from the very well-off to the most marginalised low threshold services' clients.

Ecstasy, amphetamines and other synthetic drugs

In the case of ecstasy, it is important to fully understand the state of the market and the supply side in order to distinguish between the various forms in which this product circulates (i.e. tablets, gel or powder). Although the tablet is the most widespread form found in France, it is true that the market is much less dynamic than it was a decade ago when the techno movement began growing in the mid-1990s. On the other hand, for several years now the powdered form (known as MDMA) is increasingly available in various party settings. This form benefits from the growing appeal of cocaine hydrochloride, to which it is frequently assimilated, and from the growing popularity of "snorting". In view of its relatively high price, it only concerns a specific clientele in the "party" market (discotheques and nightclubs) that contribute to the extremely discreet nature of distribution networks, of which we currently know relatively little.

In 2009, however, there has been a generalised shortage of MDMA. Analysis shows indeed that ecstasy tablets are essentially composed of mCPP. The majority of the very few MDMA powder available do not include MDMA. The market turns to amphetamines and other synthetic stimulants (notably the 2CB).

Amphetamine (speed) supply remains dynamic and targets a specific, clearly-identified segment of users who view speed as a cheap alternative to cocaine because it is available in powdered form and is snorted. This product is predominantly available in the alternative scene (the techno/party settings) but also appears to be gaining ground in nightclubs and discotheques as increasing numbers of consumers become dissatisfied with ecstasy tablets.

Although methamphetamines are sometimes reported in some foreign capitals (in the gay party milieu) and exceptional testimonies of its artisanal manufacturing for private needs of users, this substance is not yet really available in France. Probably for commercial reasons, the dealers present as methamphetamines samples which are mainly composed of MDMA.

Hallucinogens

The market for hallucinogens is divided into two sub-markets: one for synthetic products such as LSD, and the other for natural products such as hallucinogenic mushrooms or *Salvia divinorum* (Seer's sage).

For about 10 years, the LSD market in France has been extremely volatile due to the ups and downs of a supply side that depends greatly on the law enforcement services' activities in the substance producer countries, such as Belgium or the Netherlands. Consequently,

during some years observers within the TREND network report virtually zero availability, while at other times LSD appears to be extensively present within the market. Since 2006, supply of the drug appears to have experienced no major interruptions and LSD is available in particular in "party" settings associated with free parties and teknivals where the drug appears to be actively sought by a fringe group of consumers comprised of young thrill seekers.

On the other hand, when we consider availability and supply, there seems to be an increase in the availability of ketamine and GHB/GBL in 2008 and 2009 among groups that were not previously consumers. Although the use of ketamine and GHB/GBL chiefly concerns highly specific settings (*travellers* for the first and the homosexual "party" scene for the second), it appears that over the last two years these substances have started to become popular with new groups of users. For ketamine, these are believed to be marginalised individuals involved on the fringes of the "techno" scene, and for GHB/GBL a young, socially well-integrated clientele, nightclubs and discotheques goers (CADET-TAIROU A. et al. 2009). The supply side for these two products does not appear to be driven by organised networks, with the drugs instead being produced on an amateur basis or acquired via the Internet.

Regarding natural hallucinogens, the situation is the same as for herbal cannabis. Supply is boosted by strong demand for so-called organic products or those with a high "mystic" value such as herbs which are used in traditional societies for inducing shamanic trance states, such as *Salvia divinorum* or *Datura* (REYNAUD-MAURUPT 2006). Furthermore, supply is further encouraged by the use of the Internet as a channel, allowing users to obtain their supplies without taking major risks, generally from the Netherlands and the United Kingdom.

10.2.2. Drugs origin: national production versus imported

Herbal cannabis is the only illegal substance to be produced in France by "Grow your own" enthusiasts, often at home or on an amateur basis.

This phenomenon is related to several factors. The first is the current trend developing that prefers the use of so-called "organic" products which are presumed to be of better quality. The second lies in the increasing care taken by users to avoid arrest, by avoiding the black market and dealers, and instead using "home grown" or obtaining products from friends who themselves use this method. Whatever the case, the phenomenon appears to have increased sharply over the last decade. The most recent data in this field, which dates back to 2005, estimates the number of cannabis growers at somewhere between 100,000 and 200,000 people, and the total tonnage of domestic grown cannabis at around 30 tonnes. (TOUFIK, A. et al. 2007). Furthermore, the various law enforcement services have noted an increase in the cross-border trading of weed from Belgium and the Netherlands, (countries in which cannabis growing has soared due to the involvement of organised crime, resulting in high volume production).

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

Cannabis

The cannabis resin consumed in France comes from Morocco from where it is imported, usually via Spain, by criminal networks organised. Today, the market for cannabis resin appears to be more or less dynamic due to increasing competition from weed produced in France and in the rest of Europe, and by the effects of policies aimed at eradicating cannabis production in the Kingdom of Morocco, and furthermore by a growing trend for the criminal networks which traditionally import this product to also begin importing cocaine hydrochloride alongside the cannabis resin, resulting in the latter being occasionally abandoned altogether due to its low level of profitability.

Heroin

The trend towards an increasing availability of heroin in the French market is encouraged by the renewed dynamism of the supply side seen over the last decade in Afghanistan, the source country for 90% of the heroin consumed in France. The rise in opium and heroin production has encouraged the growth of criminal organisations (particularly Turkish and Albanian gangs) who import heroin through the Balkans into France and sell it on a semi-bulk or bulk basis to networks of retailers (who are also generally involved in the trafficking of cannabis resin imported from Spain and Morocco), based on housing estates around the main French urban centres. Furthermore, alongside these networks which are controlled by organised crime, we also find what the police refer to as *secondary networks*, i.e. small-scale organisations chiefly comprised of user-resellers who obtain heroin in countries bordering on France such as Belgium and the Netherlands (these countries being traditional storage sites for heroin arriving via the Balkan route (OCRTIS (Office central pour la répression du trafic illicite de stupéfiants) 2009). All of these factors contribute to the increasingly diffuse nature of this product's presence in France, and to a certain extent have helped to "rehabilitate" the product in the eyes of specific groups of drug users.

High-dose buprenorphine

Ever since its launch in 1996, the high-dose buprenorphine prescribed for heroin substitution treatments has been the subject of trafficking on the black market in urban areas, often aimed at an extremely marginalised drug-users (TOUFIK, A. et al. 2010). This trafficking is organised by two types of groups. The first group, which displays a certain degree of organisation, has major quantities of tablets available for sale on the black market by falsifying prescriptions and multiple prescriptions, while the second group (chiefly comprised of users receiving the substitution treatments themselves, who choose to carry out small-scale dealing in the products) tends more to concern users helping one another out when they are out of stock, rather than highly organised drug dealing operations. In 2009, it appears that despite enhanced monitoring and control methods employed by health insurance funds in the French regions, demand remains buoyant although occasional shortages may occur in one city or another. The availability of the drug is therefore high, as is its level of accessibility, since (in stark contrast to the situation with illegal drugs such as heroin or cocaine) an open drug scene for the sale of HDB drugs exists in many French cities.

Cocaine

The supply of cocaine is increasing constantly and has benefited from the restructuring underway over the last 10 years which has encouraged its diffusion throughout the whole country. This restructuring has been driven by the fact that importers of cannabis resin produced in Morocco have converted over to the sale of cocaine, the trafficking of which is far more profitable than that of resin (with a sales price of €30 per gram for cocaine compared to approximately €2 per gram for cannabis resin). This trend is further encouraged by changes to the major international cocaine trafficking routes, which increasingly tend to be similar to those of cannabis. The law enforcement services estimate that between 20 and 30% of the cocaine seized in Europe travels is smuggled via western Africa, continuing through the countries of North Africa which are traditional sources for cannabis resin. Another factor is also contributing to this trend for cocaine to replace cannabis resin, namely the relative dissatisfaction of European consumers with resin. In any case, the development of multi-drug networks solidly established for decades now in the suburbs around the French urban areas has encouraged the growth of a major supply side for cocaine.

The second key factor which explains the large availability of cocaine right now also lies in the development (as is the case with heroin) of networks of user-resellers supplying a small clientele obtaining their supplies from the countries bordering on France: Spain, Belgium and the Netherlands (GANDILHON M. et al. 2010). These hundreds of "micro-networks" have ensured the greater availability of cocaine, which now reaches into both urban and rural areas alike.

The second type of cocaine found in the French market is known as "crack" and "free base". These two different expressions actually refer to the same product but are used by different client groups.

Unlike hydrochloride, the distinctive feature of crack is that it is found in highly specific markets in particular geographical areas. Indeed, in the vast majority of cases, crack is intended for a clientele comprised of extremely marginalised users chiefly found in Paris and in the overseas departments of Guiana, Guadeloupe and Martinique (MERLE S et al. 2010). In 2009, two phenomena resulted in changes to the supply of this drug. Firstly, a number of users who previously consumed crack in Paris, mainly in the working class 18th and 19th districts, have now been moved to the Seine-Saint-Denis department north of the city, notably due to police interventions. Secondly, it has been confirmed that at least part of the Parisian crack supply chain is being increasingly handled by networks of individuals specialised in the resale of cannabis resin, to the detriment of traditional resellers who are usually from West Africa and particularly from Senegal.

For its part, "free base" (unlike crack) is not marketed via a drug user's resale system put in place by organised networks. In most cases, the product is manufactured by the users themselves. Furthermore, free base involves a completely different clientele than that of the "crackers", namely a population group comprised of members of the underground techno movement (travellers and nomads, etc.) generally found at free parties dance events.

Ecstasy

It appears that the low level of demand for ecstasy in its "tablet" form has caused criminal organisations to lose interest in this product (GIRARD G et al. 2010). In 2009, most of the supply side found in the French market was comprised of micro-networks that obtain their supplies abroad (from Belgium, the Netherlands or Germany) or less commonly from Eastern Europe's organised crime networks.

Other synthetic drugs: growth of traffic on Internet

As everybody French people can have access to Internet sites who sell psychoactive substances. These sites have sharply grown in number these past years and in 2009 especially. The SINTES scheme has been able to identify in party scenes some of the new synthetic stimulants who are sold by these sites, the distribution of these substances has kept very modest in France.

The experimented users familiarised with buying substances on Internet (and especially the Parisian gay party milieu) seem to have experimented with these substances, as did groups of young people in one locality (Lorraine). But in 2009, these substances are not yet known by the vast majority of users in the party scenes (dance events) where they are sold under other names⁹⁹

10.3. Seizures

10.3.1. Quantities and numbers of seizures for all illicit drugs

In 2009, the number of narcotics seizures¹⁰⁰, all products taken together, totalled 108,022 representing a fall of just under 4% compared to the previous year. However, these remain at historically high levels compared to the late 1990s and the early 2000s.

⁹⁹ Lahaie E. et A. Cadet-Taïrou : « Méphédron et autres stimulants de synthèse en circulation. Note d'information SINTES, march 2010 ; Cadet-Taïrou, Trend report.

¹⁰⁰ This year we do not have data on the number of seizures for each of the illegal substances in question.

Table 10-1: Quantities of drugs seized (kilograms), in 2006-2009 and evolution in 2008-2009 (%)

	2006	2007	2008	2009	Change 08/09
Drugs seized					
Herbal cannabis	3,773 kg	3,047 kg	3,422 kg	3,495 kg	2.13%
Cannabis resin	67,891 kg	34,182 kg	71,075 kg	56,073 kg	-21.11%
Cannabis seeds	57 kg	51 kg	30 kg	45 kg	48.86%
Heroin	1,051 kg	1,035 kg	1,117 kg	970 kg	-13.19%
Cocaine	10,166 kg	6,578 kg	8,214 kg	5,211 kg	-36.55%
Crack	8 kg	6 kg	12 kg	12 kg	5.62%
Amphetamines	77 kg	307 kg	109 kg	564 kg	417%
Ecstasy (tab)	1,488,919	1,359,912	342,923	106,597	-68.92%
LSD (units)	5,589	13,107	90,021	10,209	-88.66%
Ketamine	5 kg	2 kg	65 kg	3 kg	-94.06%

Source: FNAIS, OCRTIS 2010

Regarding cannabis resin, the downward trend witnessed since 2004 (the year which marked the historical high point of seizures in France with around 100 tonnes seized), has continued with a fall in seizures of more than 20% in 2009 compared to 2008. On the other hand, the growing attraction of weed and "home grown" products is also becoming increasingly evident as cannabis seed and plant seizures have increased by approximately 50% compared to 2008.

Though down by around 13% compared to the previous year, heroin seizures in 2009 remained high, approaching a tonne (970 kg); a quantity almost 5 times higher than seizures performed in France in the late 1990s.

On the other hand, seizures of cocaine have fallen by 36.5%, for a total of 5,211 kg in 2009. This fall is significant when compared to the historical peak reached in 2006 with around 10 tonnes. However, when looking back over the last 15 years we soon see that cocaine seizures in France remain at a historically high level (more than six times the quantity seized when cocaine began to circulate in the early 1990s).

Furthermore, the loss of interest in ecstasy tablets has been confirmed once again, with seizures down by approximately 70% compared to 2008, now standing at the lowest levels recorded in France over the last 15 years.

10.3.2. Quantities and numbers of precursor chemicals used in the manufacture of illicit drugs

With the exception of herbal cannabis, France is currently not (or only marginally) a producer country for illegal drugs. That's why no data exists concerning seizures of precursor chemicals.

10.3.3. Number of illicit laboratories and other production sites dismantled and precise types of illicit drugs manufactured there

The last major case involving the dismantling of a production laboratory dates back to 2005. This was a cocaine production unit located at Le Perreux in the Val-de-Marne *département*.

10.4. Prices/purity

10.4.1. Price of illicit drugs at retail level

Cannabis

According to OCRTIS¹⁰¹, the median price for herbal cannabis in 2009 was approximately 7 Euros, within a band of between 5 and 10 Euros per gram. This price is slightly up compared

¹⁰¹ The retail and wholesale prices of cannabis, heroin, cocaine and ecstasy have been obtained from the OCRTIS publication *Les prix des stupéfiants en France en 2009 (Narcotics prices in France in 2009)*.

to previous years. This phenomenon is explained by the fact that an increasing percentage of consumers appear to display a marked preference for high-quality products.

The bulk wholesale price as measured by the police stands at 3,500 Euros per kilogram.

The median price of cannabis resin has remained stable. In 2009, this stood at 5 Euros per gram. The wholesale price for the same year was 1,950 Euros per kilogram.

Heroin

In 2009, the median price per gram of brown heroin was approximately 40 Euros and has remained at around this level since 2006 after having fallen sharply since the late 1990s when its price hovered around the 70 euro level. The bulk wholesale price for brown heroin has also remained unchanged at around 10,000 Euros per kilogram.

High-dose buprenorphine

Since 2008, the price per 8 mg tablet of HDB marketed in its Subutex® form, the only variety (or almost) available on the black market in major urban centres, rose slightly, standing at 5.5/6 Euros in 2008 and 2009 compared to 4 Euros in previous years (CADET-TAIROU, A., M. GANDILHON, et al, 2010). This price rise is believed to be related to difficulties in keeping the market supplied due to the strict control measures put in place for prescriptions by health authorities.

Cocaine

The price per gram of cocaine hydrochloride has remained stable for five years after having been halved compared to the late 1990s. In 2009, the median price was around 60 Euros. The wholesale price has also remained stable at 30,000 Euros per kilogram.

Ecstasy

When considering the price of ecstasy, we need to distinguish between the "tablet" and "powder" form.

According to the 2009 SINTES survey on synthetic products, the average price of an ecstasy tablet is 7.3 Euros. The fall in the price of tablets observed over recent years appears to have ended in 2009. This may be the result of the low levels of availability of MDMA tablets seen during 2009, a fall which has not continued into early 2010. On the contrary, OCRTIS data reveals a fall in prices, which have slipped from 6.5 Euros in 2008 to 5 Euros in 2009. The bulk wholesale price (1,000 tablets) has also fallen, from 1,500 Euros to 1,000 Euros.

10.4.2. Purity/potency of illicit drugs

Cannabis

The average THC content (the active ingredient in cannabis) in herbal cannabis has not changed compared to previous years, remaining stable at around 8% (Institut National de Police Scientifique 2010). The same applies for resin, for which the THC level has remained unchanged at around 10%.

Heroin

According to a national survey carried out between March 2007 and June 2008 by the SINTES system of the OFDT, involving 369 samples collected in nine regions of metropolitan France, the average level of brown heroin is 7.1% while 50% of the samples collected revealed a heroin purity level of below 5%. Due to its methodology, the above-mentioned survey made it possible to examine the direct link between price and purity. The results in this field have shown that a high retail purchase price is no guarantee of a high level of purity. The opposite is also true, as the SINTES survey has shown that it is in the Nord-Pas-de-Calais, the French region in which the price per gram of brown heroin is lowest (at an average of 29 Euros), that we find the highest concentration of heroin at 8.4% (LAHAIE E et al. 2010).

Samples of brown heroin seized by police in 2009 reveal average purity levels of 14%. This presents a very slight increase compared to the concentrations of heroin seized since 2002 (for which the levels have been between 10% and 12%). The explanation for this phenomenon lies in the increasing number of seizures of high heroin concentration (which have doubled between 2008 and 2009).

Cocaine

The cocaine content of the samples seized on the street stood at between 10 and 30% and has not changed since the early 2000s.

Ecstasy

Where the powders are concerned, the average 70% MDMA content obtained from the data provided by the 2009 SINTES survey has not been confirmed by OCRTIS data (47%, i.e. a slight reduction compared to those in 2008, when the proportion stood at 52%). According to all sources, the price per gram is around 50 Euros.

10.4.3. Composition of illicit drugs and drug tablets

Heroin

Since the beginning of the 2000s, more than nine heroin samples out of ten have been found to contain a mixture of caffeine (20% and 40%) and paracetamol (between 40% and 60%) which consequently remains the main cutting product.

The remainder is comprised of inert products such as sugars and Mannitol.

Pharmacologically active adulterants such as diazepam, phenacetin, dextromethorphan and alprazolam have been identified in several samples during 2009. In most cases their concentration was below 1%.

Cocaine

When cocaine arrives in France it has already been cut using psychoactive substances such as levamisole, hydroxyzine and diltiazem. It is then re-cut with other psychoactive substances such as phenacetin, lidocaine and sugars before being resold on the street.

Ecstasy

In 2009, a quarter of the tablets sold as ecstasy actually contained mCPP (SINTES data). Lactose is the sugar most frequently used to cut ecstasy.

Part B: Selected issues

11. History, methods and implementation of national treatment guidelines

11.1. Introduction

11.1.1. Rationale and objectives

The present chapter provides an insight on the place and the role of guidelines regarding the harmonization and improvement of drug addiction treatment in France. Hereafter the term “guidelines” is used to qualify a compilation of recommendations. It might be used alone in a purpose of fluency, but being understood that it refers to guidelines on treatment related to illicit drug addiction.

Many studies demonstrate the positive influence of the application of evidence-based professional guidelines on the organisation and the quality of a care system (Grimshaw et al. 2004). This kind of document appears as a key tool to bridge the gap between evidence and practice (Cabana et al. 1999). As a matter of fact, during the last decades, many countries have shown an increasing interest in the implementation of good practice guidelines. In 2009, the World Health Organization (WHO) too published guidelines for psychosocially assisted pharmacological treatment of Opioid Dependence (WHO 2009). Vesting a mission of promotion of good practices, the European Monitoring Centre on Drug and Drug Addiction (EMCDDA) question themselves about the extent, scope and conditions of application of drug treatment guidelines in the Member States of the European Union (EU).

According to the definition from the U.S. Institute of Medicine used by the EMCDDA, guidelines are “systematically developed statements to assist practitioners and patients' decisions about appropriate interventions for specific circumstances” (Field et al. 1992). But guidelines are neither a collection of ready-made solutions, nor a so-called “cookbook medicine”. They are not more likely to reflect individual opinions. In contrast it must be a decision-making tool for healthcare professionals that are not based on intuition or ideology but rather on scientific findings supporting their application in practical work (Helou et al. 2000).

In France, the High Authority for Health (HAS), former ANAES¹⁰², defines clinical practice guidelines as “proposals developed according an explicit method in order to help healthcare professionals and patients to seek for the most suitable care related to specific clinical situations”. Guidelines are based on systematic literature reviews and expert opinion. They can be requested by diverse public or private bodies (Health ministry, scientific societies, associations, etc.). In the field of drug addiction, demands are generally referred to the HAS which can also launch a reflection at its own initiative.

Referring to evidence is essential to ensure the quality of guidelines (Brownson et al. 2003). But stating scientific evidences does not induce best practices in itself. The implementation of guidelines depends on many factors, affecting in particular the reliability of the recommendations and their acceptance by the target-public (Grol, R. 1997) (Grol, R. et al. 1998). These factors partly intervene when guidelines must be diffused towards professionals. Therefore, contribution from all the stakeholders is essential not only to gather reliable and up-dated data, but also to define a relevant and realistic implementation strategy (Hartnoll 2004).

In the light of these elements, both the definition and implementation processes of the targeted guidelines are considered in this study of the French situation. According to the EMCDDA's query, an historical narration of the emergence of the guidelines developed in

¹⁰² Agency for Accreditation and Evaluation of Scientific Evidence.

France precedes the description of these two phases. From then on, the evocation of the implementation of guidelines designates not only their application by the targeted professionals but also the whole accompanying measures deployed in this aim (since the final utilisation of guidelines has not been evaluated in general). The focus is on the treatment of illicit drug uses, excluding the issue of the addiction to licit drugs (alcohol, tobacco, etc.). The main objective is to figure out possible ways, in the national context, to enhance a better integration of knowledge of evidence-based good practices in respect to drug addiction treatment. A comparison with the guidelines edited by the WHO is to be found in Annex IV.

11.1.2. Method

The study covers five out of the six identified treatment guidelines related to illicit drug use. The inclusion of the guidelines dealing with detoxification (1998) has not appeared relevant given the French context characterised by the predominance of opioid maintenance treatment and the regular decrease of both demand and supply of opioid detoxification programmes. The final list of the studied guidelines is:

- Access to methadone in France (Auge-Caumon et al. 2002)
- Therapeutic strategies for opiates addicts: place of substitution treatments (ANAES 2004)
- Reducing the misuse of opiate substitution medication (2004) (ANAES 2004)
- Abuse, addiction and polyuse: strategies of care (HAS 2007)
- Strategies of care for cocaine users (HAS 2010)

A review of key documents – official political or legislative texts and the treatment guidelines themselves – was carried out as a first step.

The development and the implementation of addiction treatment guidelines being poorly documented, an original data collection was required. Therefore, 15 field experts, field actors and stakeholders (*i.e.* 80% of the interviewees originally selected for their deep knowledge of the question) expressed their perception of the events and the existing logics and stakes, through semi-structured face-to-face interviews. The aim was to gather the institutional, professional, researchers and users' standpoints all together.

Finally a benchmarking model has enabled to highlight the strengths and gaps of the successive guidelines and to some extent to visualize the technical evolutions of their development.

11.2. History and overall framework of the substitution

The law of 31 December 1970¹⁰³ sets the legal framework of the drug policy in France. It stipulates that drug use is an offence but drug users can avoid prosecution by complying with a drug treatment, ever since anonymous and free of charge. The objectives of this law are also to repress trafficking and to control the use of drugs (Derks et al. 1999) (Angel et al. 2005). From then on drug addiction has become a matter of national solidarity directly within the competence of the State. In 1982 a cross-departmental body was established to coordinate the public action in the fields of prevention, health and social care, law enforcement and international cooperation. This body became the interministerial Mission for the fight against drug and drug addiction (MILDT). It operated under Ministry of Health before coming under Prime Minister in 2009.

¹⁰³ Loi n°70-1320 du 31 décembre 1970 relatif aux mesures sanitaires de lutte contre la toxicomanie et de l'usage illicite des substances vénéneuses

This so-called law of 1970 has not been fundamentally modified since then but many ministerial directives (decrees and circulars) were issued to supplement the patterns of health and social care towards drugs addicts.

Historically, drug treatment responses developed in France have largely been influenced by a psychoanalytical approach. In the 60s, drug addicts were addressed to psychiatric hospitals for detoxification, like alcoholic people. At that time, treatment basically focused on abstinence. In a way, from the adoption of the anti-drug law, the State entrusted the specialists, mainly psychiatrists and psychologists, with the care to drug addicts: the psychological and behavioral disorders implicated in addiction appealed to individual clinical responses. These professionals developed a psychoanalytical approach, based on a relation of trust between the drug-addicted patient and the practitioner and still aimed at abstinence. This practice became more and more professionalized over the 70s. The overrepresentation of psychiatrists in the edification of drug treatment knowledge must also be related to the relative reluctance from the traditional health system to undertake drug users, seen as a problematic population. Furthermore, the predominance of specialists in the field might have contributed to arise the feeling among general practitioners (GP) that this issue was not their affair especially since they were poorly trained on the subject. Until the early 1990s, the more curative vision of drug addiction related care tended to delay a more global apprehension of the problem and finally the acceptance of the pragmatic approach of risk reduction (Boekhout van Solinge 1996). The main professional actors thought that prescribing opiates to a drug addict could not but comfort the ascendancy of the product over the patient. For the political authorities, the extension of substitution would have left the door opened for the liberalization of drug use.

The beginning of the 1990s has seen a volte-face, particularly because of the HIV epidemic. A social movement emerged uniting sociologists, activists from the AIDS support groups, humanitarian associations, public health specialists, GPs and also drug users themselves. It pledged in favor of risk reduction policy and methadone programmes denouncing the dramatic health repercussions of the drug policies in force. These actors were inspired by several European examples (in particular Belgian, Dutch and Swiss experiences) but also by changes observed in their everyday practice. Actually, the humanitarian sector coped with a crisis situation due to the increasing demand of care from HIV infected drug injectors. In parallel, in face of the important and increasing wave of drug users needing care related to HIV infection, more and more GPs and hospital professionals were confronted with specific addiction health problems among these patients. Drug addiction has become a matter of intervention for many of these professionals who had been mostly kept aside until then. Some GPs started to prescribe opiates (e.g. codeine, temgesic), not only to favour their patients' survival but also to help them to feel in better condition to enter a process of treatment and to survive. These were the first approaches of substitution treatment which would be officially adopted later on, in the mid 1990's.

The report of the commission for the reflection on drug and drug addiction, the so-called Henrion report (Henrion 1995b), delivered in 1995 to the Minister of Health evoked "a health and social catastrophe": France reported at that time one of the highest prevalence of HIV infections in Europe. Getting aware of those consequences, government finally introduced harm reduction measures (syringe exchange programmes) in order to contain the AIDS epidemic. As France was quite late in offering opiate substitution to drug addicts and as public opinion was still shaken by the previous scandal of the HIV contaminated blood, the authorities had to react as quickly as possible to prevent further infections and deaths.

In 1995, specialised centres were authorized to provide methadone¹⁰⁴. One year later, High Dosage Buprenorphine (HDB) was chosen as main substitution substance, despite its higher cost compared to methadone. France opted for this molecule since it could be prescribed in primary health care, which was considered as frontline system to respond to the important

¹⁰⁴ Circulaire DGS n° 4 du 11 janvier 1995

wave of demands (Escots, S. et al. 2004b; Escots, S., Fahet, G. 2004). This was quite naturally accepted among the general practitioners who started to prescribe HDB. The conversion was less simple among specialists, who were gradually organising methadone programmes (Coppel, A. 2004). In a way, HDB was left to general practitioners. This rapid and important shift in the French policy caused an animated polemic. They particularly issued from professionals who considered opiate substitution seen like a setback for the therapeutic ambition. Questions subsisted about the GPs' ability to take the change of direction towards substitution on. They rooted in the perception of their lack of training and of insufficient psychosocial care facilities to address drug addicted patients to (Bergeron 1999). At the time, the only directive from authorities concerned the maximum duration of any prescription of HDB fixed at 28 days (*versus* 14 days for methadone)¹⁰⁵. As the risk of overdose was not perceived yet and in the absence of any other specification, physicians were free to determine the dosage to prescribe. In the opposite, strict controls were imposed for methadone in order to prevent such accidents. But some of the first prescribers could work in a network, compare their practices and then fine-tune the pharmacological indications. The collaboration between GPs and the hospital sector could also rely on the specific so-called "ville-hôpital" network. The principles of the clinical practice, empirically conceived and tested, diffused via addictology networks (Coppel, A. 2004).

Few years later, the improved access to harm reduction and substitution cares resulted in a sharp fall in the number of fatal overdoses (184 in 1998 vs. 451 cases in 1994) and a decrease of the prevalence of HIV infections among drug injectors (10 % in 2007 vs. 30% in the early 90s). A major change had taken place in France and had demonstrated the efficacy of opioid substitution treatment. Faced with these incontestable outcomes, many drug specialised centres reconsidered their position and adopted the principle of substitution.

Thus, the large diffusion of substitution treatment brought to the surface other issues like misuse and related health damages but also the apparition of a black market, in particular based on HDB. But those issues were not immediately handled, the priority being at first the consolidation of the still recent substitution policy (Coppel, A. 1998).

At the beginning of the 2000s, even though opposition still existed, substitution was entered in the clinical practices of the drug specialised and hospitals sectors and the GPs as well. However there was still a great heterogeneity throughout France regarding the accessibility to methadone programmes, the latter being very limited in many *départements* (sub-regional decentralised territories, 100 in total). In this context, France then entered in a phase of reflection characterised by the elaboration of the first formal guidelines on the drug use treatment.

In 2002, ministry of Health published the first recommendations aimed at improving the access to methadone. Two years later, the French federation of addiction (FFA) together with the ANAES (currently the HAS, *High Authority for Health*) organised a consensus conference with a special focus on HDB (ANAES 2004). On that occasion, most of the conclusions of the 2002 report were also reaffirmed. For the first time in this field, representatives of drug users have been associated to deliberations. For many professionals, the 2004 consensus conference was marked by a strong feeling of acceptance, support and even enthusiasm: at the end of the conference, opposition to substitution had softened.

The year 2004 was also marked by the adoption of several measures aimed at curbing the misuse of substitution substances. The Law of 13 August 2004 relative to National Health Insurance (CNAMTS)¹⁰⁶ imposes on any patient "to indicate to his attending physician, for each prescription, the name of the pharmacist who will be responsible for the delivery (of the medicine)" and imposes on any physician "to mention this name on the prescription that must be issued by the concerned pharmacist for acceptance of financial liability" (Article L.162-4-

¹⁰⁵ Circulaire DGS n° 29 du 31 mars 1995 (DGS/SP3/951°29)

¹⁰⁶ Loi n°2004-810 du 13 août 2004 relative à l'assurance maladie. NOR: SANX0400122L

2). In addition, the National Health Insurance launched during the same year a National Action Plan on the Control of substitution treatments *"to fight against fraud and abuse while preserving the right of patients to benefit with quality care"*. Together with the Ministry of Health and the French Agency for Safety of Health Products (AFSSAPS), it also proposed clinical practice guidelines (CPG) focusing on the prescription of opioid substitution medication so as to reduce their potential misuse. These ones were published by the ANAES and the AFSSAPS in 2004 (ANAES 2004).

Later on, the HAS published two other guidelines to improve quality of addiction treatment. The raising concern about polyuse among drug users lead to the elaboration of the guidelines on the subject, in 2007 on the request of the French Federation of Addictology (HAS 2007). Faced with the sharp rise of the prevalence of cocaine use reported in France and the increase of treatment demands related to this product, the HAS studied the question. On the basis of the available international scientific works dealing with cocaine use treatment, it supervised the development of specific guidelines, published in June 2010 (HAS 2010). At last, more recent guidelines taking over the involvement of drug users referred to medico-social addictology establishments were issued in April 2010 by the ANESM¹⁰⁷. But their ins and outs could not be analysed within the scope of this study.

11.3. Characteristics of the definition and implementation patterns of the existing guidelines

A synopsis of the studied guidelines is provided in Annex 1. It provides details on their objectives, the intervention or groups targeted as well as the contributors, the method applied for their elaboration (including quality control) and finally the implementation measures organised. The common points and relevant specificity of the development processes of these documents are also commented in this work.

A benchmarking chart offers a visual comparison of these features guidelines in respect to a theoretic ideal model (please see charts 11-1 and 11-2), according to the criteria noted hereafter. Nonetheless, it is important to mention that more detailed information was available regarding guidelines on opioid substitution (2004 consensus conference). Because of lack of information, the guidelines related to the misuse of opioid substitution medication (2004) are not included in this comparison.

11.3.1. Definition process

Four criteria were taken into account for the analysis of the process of definition of the selected guidelines:

- the multidisciplinary of contributors;
- the evidence-based nature of the methods applied to define the guidelines contents;
- the evidence-based nature of quality control;
- the conciliation propensity of the whole process.

Contributors

In France, representative bodies of specialised professionals (federations, national associations) and public health authorities (ministry of Health, National Insurance, etc.) are the *sine qua non* protagonists of the elaboration process of guidelines related to drug addiction treatments. Guidelines can be produced at the instigation of any of these bodies. Any of them can be at the instigation of guidelines. For this purpose, they seize the public health agency that will supervise works (HAS, former ANAES, which is the first producer of medical guidelines or AFSSAPS that specifically publishes recommendations on

¹⁰⁷ National Agency for the Evaluation and the quality of the social and medico-social establishments and services.

medications). In general rule, other categories of contributors are consulted: field actors, researchers, epidemiological data providers or even representatives of drug users. Their diversity and representativeness of profiles varied from one to another experience but in general the consultation mainly focuses on physicians. Pharmacists or nurses are more scarcely associated and sociologists, economists or jurists are even more rarely so. The authors' notoriety contributes to legitimizing these guidelines and to promoting them towards professionals (Davis et al. 1997). In other words, the commitment of influential professionals (constituting a kind of leadership) allows the introduction of innovative clinical practices among peers.

Definition methods

The elaboration of the French drug treatment guidelines did not follow any imposed conceptual model. As a matter of fact, different methods were applied for the successive experiences: restricted work group, public hearing, audit or, more recently, the evidence-based method of clinical practice guidelines (CPG) (please see box below).

The clinical practice guidelines or CPG method usually involves promoters (initiators and funding providers), the steering committee (determining the subject, problems, contributors and handling logistics), the working group (that sums-up knowledge and prepares recommendations) and the reading group (validating outputs and providing with additional information and expert advice). It is based on three phases: the preliminary phase to define the method and objectives, the development phase including data collection (e.g. through literature review, surveys, etc.) and finally the dissemination phase including impact evaluation (ANAES 1999).

Although the deep reasons of these methodological choices could not be certified through this study, cultural or corporative preferences could certainly be invoked. For instance, the consensus conference has a good image in France and benefits from a good acceptance from professionals and public opinion (Durand-Zaleski I 1992).

When expectations for socio-political cohesion co-existed with scientific and deontological purposes, methods like consensus conference or public hearing were privileged. By allowing a conciliatory dynamic, these methods are liable to favour a better support towards conclusions by the majority of people. Another advantage is that these approaches also constitute a communication event.

This dimension is probably what was missing for the recent experience regarding guidelines on cocaine uses. As a matter of fact, although the scientific rigour of their definition has not been contested, their applicability was questioned by some professionals who did not find in them all the answers to their daily practical questions.

Quality control methods

In general, quality control rules applied while defining these guidelines could not be clearly described through the interviews. That suggests that they solely consisted in an on-going internal peer assessment. In 2009-2010, for the guidelines relative to cocaine use treatment, the HAS preferred to develop an ad hoc grading system on the quality of evidences.

Usually The HAS uses the AGREE criteria to evaluate the guidelines written under its responsibility, developed according to the method of clinical practice guidelines (CPG). Nevertheless it could not apply these evaluation criteria to the two guidelines dealing with the misuse of substitution medication (2004) and cocaine use (2010), both developed according to this CPG method.

The Appraisal of Guidelines Research and Evaluation (AGREE) questionnaire and its criteria were developed by scientists and health policymakers at the beginning of 2000s so as to assess the quality of clinical practice guidelines (CPG) developed by local, regional, national or international groups. This generic tool can be applied to any type of CPG regarding any health problem, medical intervention or type of care (AGREE Collaborative Group 2000)

Conciliation dynamic

The coordinators' capacity to consider the whole positions expressed over the elaboration process supports the future acceptance of guidelines. This could explain for instance that, despite previous strong oppositions, the 2004 guidelines on the substitution strategy have had better echoes than most of recommendations issued till now in relation to addiction treatment (see Chart 11-1). At that time, the shared willing of improving therapeutic practices through the consensus conference on substitution has certainly contributed to the cohesion of the discourse. For many people, this frame of mind symbolized the "end of the war" and the official acceptance of substitution treatment.

Apparently, the conciliation dynamic potentially stirred up while defining guidelines may weight on the perception of their impact or their social utility to some extent.

11.3.2. Implementation process

The implementation process of treatment guidelines begins in fact as soon as the phase of their conception considering the persuasion strength and communication skills of influential contributors. However implementing guidelines covers specific and proper steps: the stages of adoption, publishing and active diffusion (like training, reminder systems, etc.) before the final phase of appropriateness.

The implementation measures organised in France are examined here against four criteria:

- the multidisciplinary of promoters, as an indicator of their representativeness and legitimacy while sustaining the adoption of guidelines;
- the accessibility of publications, in other words the operational and pragmatic nature, characterising a primary level of dissemination;
- the existence of accompaniment measures, in particular for active information strategy (i.e. a second level of dissemination);
- the used resources and means to support the application of guidelines.

Multidisciplinary of promoters

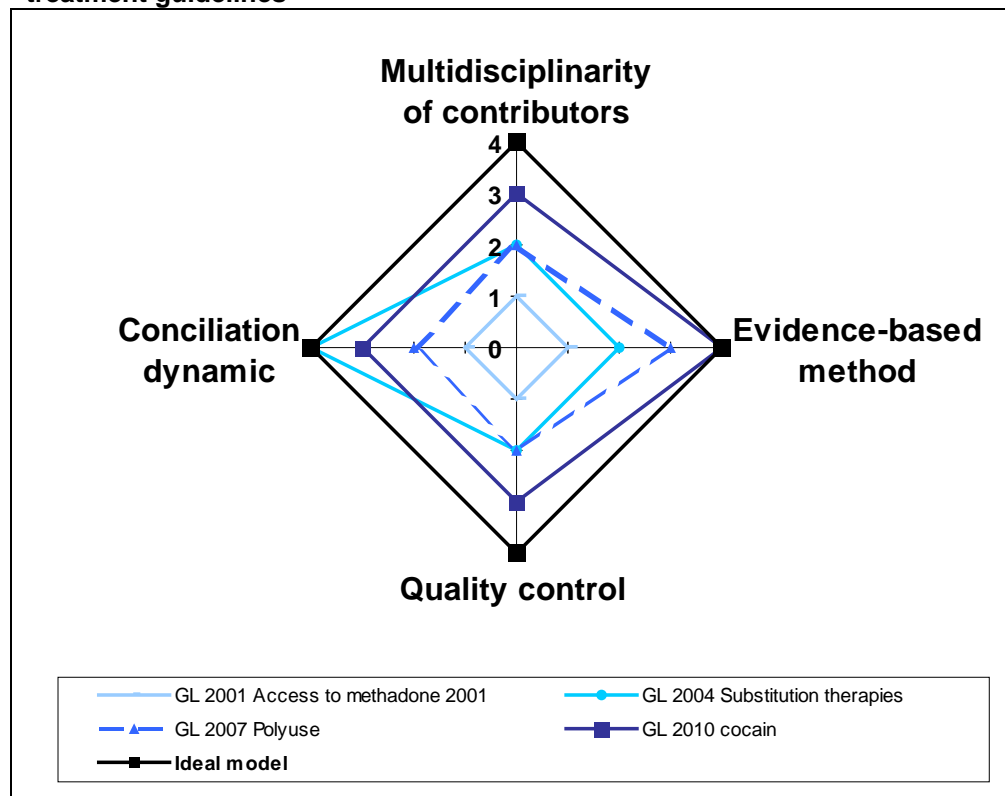
In most cases, key figures (leaders) could promote guidelines introducing them to colleagues or other audience. Therefore, these personalities and the specific professional networks did play an important role in the communication in favour of guidelines. The involvement from these experts may take over more punctual diffusion and communication measures. But such assets could rarely be optimized by a clear promotion strategy, once guidelines achieved. Specific communication initiatives took place when a pharmaceutical company or professional associations got involved as it was the case for the 2004 guidelines on substitution therapeutic strategy. The place left to the economic actors directly interested in the substitution market raised some ethical questions. This is why, in that case, the communication and training sessions organized by the pharmaceutical laboratory were organized in collaboration with the ministry of health and/or representative of professional bodies. Given the very restricted public funding, the possible resort to private funding proved to be helpful.

Accessibility of publications

In all cases, the guidelines were published in medical reviews and on the websites of the involved institutions or associations. Most often, a short version was also produced in order

to facilitate the distribution of recommendations and an easier access for practitioners. On one occasion, the HAS announced the publication of new guidelines through newsletters to physicians. But it stopped these mailings given the difficulty of updating the addresses database. Other publication forms were produced, as brochures or letters to general practitioners, summing-up the recommendations that directly concerned them. After the 2004 consensus conference, reminder systems like doctor letters were diffused, but punctually.

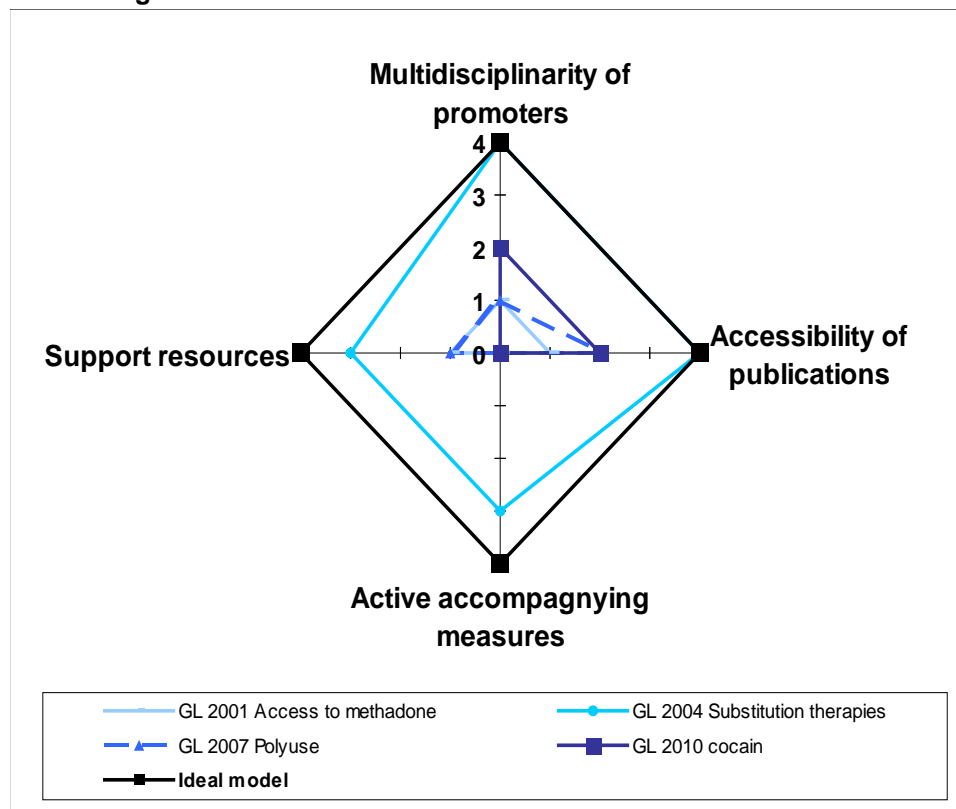
Chart 11-1: Benchmarking of definition processes of the French drug treatment guidelines



Categories of the benchmarking – Definition process

Bench-mark	Multi-disciplinarity of contributors	Evidence-based method	Conciliation dynamic	Quality control
1 Very low level	Policy makers, concerned professionals ¹⁰⁸	Professional empirical expertise	Epidemiological identification of needs	Internal
2 Low level	Level 1 + final target population	Partial literature references	Level 1 + consulting the diverse existing stakeholders	Independent
3 Moderate level	Level 2 + researchers	Systematic review	Level 1 + active contribution of the diverse existing stakeholders	Cross independent
4 High level	Level 3 + other relevant professionals	Level 3 + standardized grading of evidence	Level 3 + consensus	Level 3 + process evaluation

Chart 11-2: Benchmarking of implementation processes of the French drug treatment guidelines



Categories of Benchmarking – Implementation process

Bench-mark	Multi-disciplinarity of promoters	Written Information tools	Active Information tools ¹⁰⁹	Support resources
1 Very low level	Policy-makers	Written material, Internet (Online version)	Academic continuous education	Legislative texts
2 Low level	Level 1 + Strategic change actors ¹¹⁰	Level 1 + short version of GL	Opinion leader and audit feedback	Level 1 + specific funding
3 Moderate level	Level 2 + Economic actors	Level 2 + targeted short version	Interactive workshops/ seminars/ trainings	Level 2 + prescription control system OR implementation unit
4 High level	Level 3 + Final target population	Level 3 + Newsletter, prescription reminder system	Durable combination of the aforesaid components	Level 2 + prescription control system AND Implementation unit

¹⁰⁹ Adapted from the SIGN work (SIGN: Scottish Intercollegiate Guidelines Network)

¹¹⁰ Corporations, experts, personalities

Accompaniment measures

Several studies from the Cochrane Effective Practice and Organisation of Care group (EPOC group) enabled to put into a hierarchy, according to their effectiveness, possible patterns of communication in relation to the implementation of policies (see table below). According to this classification, targeted and interactive surpass the other patterns of communication as for assuring an appropriate diffusion and facilitating the integration of information (ANAES 2000) (Grol, R. et al. 2003). Quite logically, the combination of these types of interventions appears more efficient than each one separately (SIGN 2008).

Table 11-1: Effectiveness of communication patterns for effective implementation of a policy

Not effective	Low effective (Mixed effects)	Moderate effective	High effective
- Continuous medical education	- Opinion leader - Conferences	- Audit-feedback - Mass media campaign	- Interactive training

In France, no accompaniment measures (such as training, workshop, seminars) were organised at national level to support the publication of drug treatment guidelines. They were often discussed but did not ever materialize on a national level. Whatever they were, they remained punctual.

In 2004 meetings and trainings for practitioners were locally organised by the pharmaceutical company distributing HDB. This laboratory also sponsored brochures for practitioners and drug users.

Some years after the publication of the 2004 consensus conference, academic modules of addictology were integrated in the initial medical curricula. Now, short modules of continuous training and diploma in addictology also exist. But overall, the integration of clinical recommendations in these curricula is not assessed.

Resources and support system

In France neither law nor any control body compels practitioners to apply the issued recommendations. The only control in force has been established by the National Health Insurance (CNAMTS) and concerns abusive or suspicious prescriptions (mean daily dose of HDB > 32mg). It aims at reducing the misuse of the substitution medication.

On the other hand, professional orders (physicians or pharmacists' ones) can provide for clinical or technical advice. But there is neither local nor national administration overseeing the substitution treatment delivered. Except for the creation of the *département* committees for the follow-up of opioid substitution treatments (which finally disappeared), adequate resources were not developed so as to support the application of guidelines. No permanent resources unit (ex.: mediators, dedicated staff) liable to help practitioners to understand or to implement recommendations, could be set up neither locally nor nationally, neither by health authorities, nor by professional organisations.

Through the reported experiences, gaps identified in respect to the implementation systems of guidelines seem to be largely imputable to the recurrent lack of funding, major obstacle to a structured, proactive and viable implementation strategy.

Available evaluation details

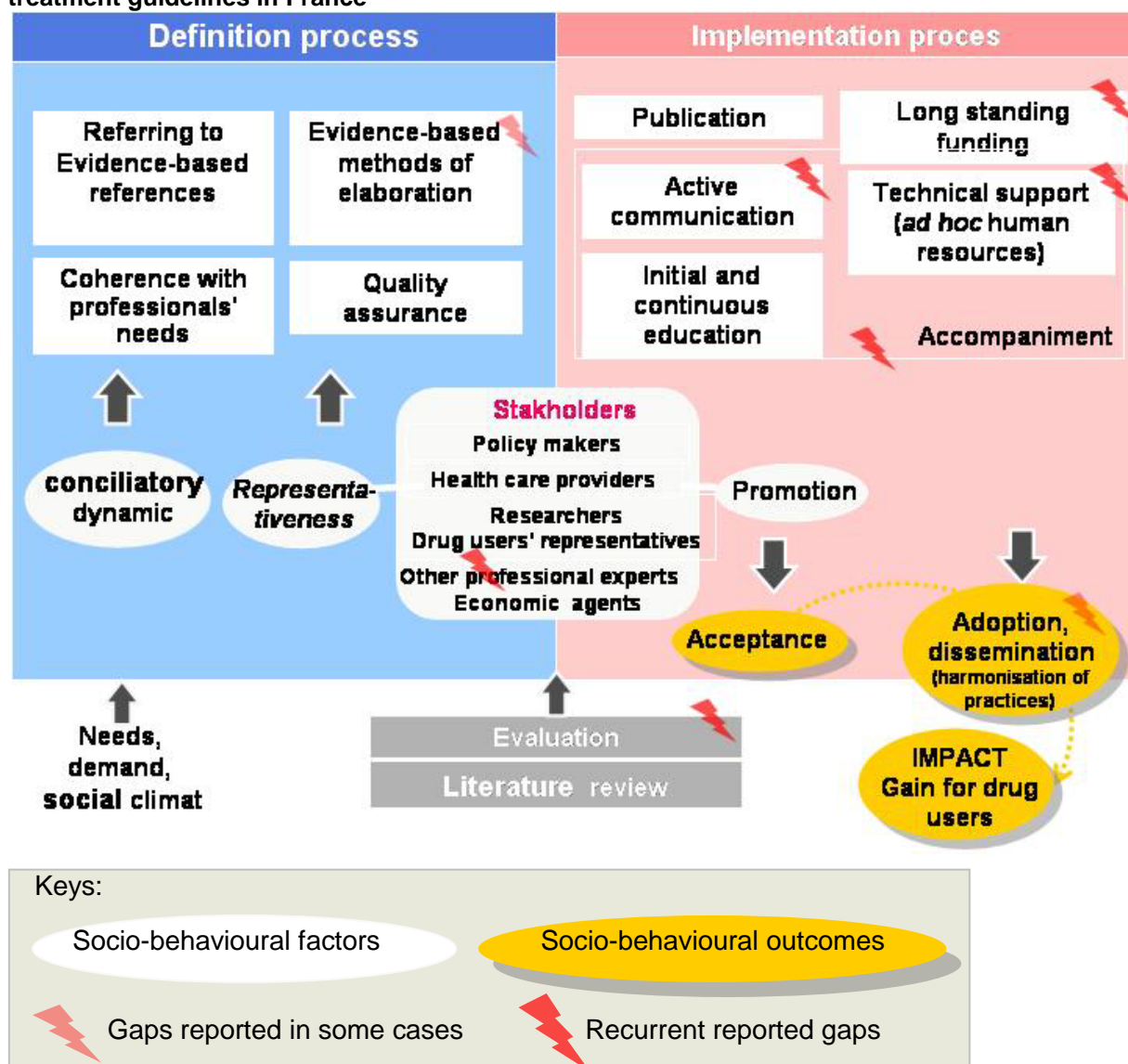
None of the reported experiences was evaluated. Nonetheless, with the passing of time, professionals have perceived that the diverse guidelines have had a limited impact, apart from the benefits attributed to the 2004 consensus conference regarding the social climate among professionals. The main criticisms refer to recurring weaknesses in the accompaniment of the guidelines.

A recent study carried out by the ANITeA (forthcoming publication) shows a great heterogeneity of substitution practices and knowledge on good practices among specialised treatment centres (CSAPA). These findings tend to confirm the perception expressed by the experts interviewed for the present study.

Literature reveals that the lack of visibility about the impact of guidelines is not exceptional, at least in the field of addictions. Although there are sufficient sources defending the implementation of evidence-based approaches, the latter are generally underused in drug addiction treatment (Institute of Medicine 2005).

The chart below sums up the influencing factors weighting on the production and implementation processes of French guidelines on drug addiction treatment as well as the main weaknesses.

Chart 11-3: Determining factors of the definition and implementation of drug addiction treatment guidelines in France



11.4. Possible paths of improvement

Some paths of improvement can be drawn from this analysis. However their budgetary weight has not been estimated in the scope of this study.

Involving from the beginning to the end of the process the different concerned publics, in particular opinion leaders, is essential in order to manage correctly all stakeholders' expectations and to find realistic methods to sustain changes. The opinion leaders' commitment and accountability prove to be important to achieve effective development and diffusion of guidelines just like appointed human resources and support conditions are necessary to sustain their viability.

As a matter of fact, the promotion of guidelines must be long-standing, beyond the simple phase of their publication, and proactive. A particular impetus must be put on communication and support systems. The gaps identified in these domains are bound to the absence of specific public funding.

An action plan would have allowed to structure the coordination of a cost-effective and sustainable implementation. If such an action plan is built in the future, it could deal with the following points:

1. Setting up a national network for reflection and exchange on experiences;
2. Continuous education and training, and specific lectures in academic curricula;
3. Establishment of a help service for practitioners (resource unit) for the application of guidelines;
4. Process formative evaluation; further researches on successful implementation experiences;
5. Research on drug users' acceptance of the recommended approaches;
6. Regular review of guidelines;
7. Monitoring of drug treatment demands

The monitoring of treatment demands and the integration of academic lectures are the only aspects performed on a regular basis nowadays in France.

11.5. Conclusion

The French High Authority for Health (HAS) produced six treatment guidelines related to drug use. On the basis of literature review and key experts' interviews, this study covers the production process (definition and implementation) of five of these guidelines (detoxification matter having been excluded). Most of the guidelines deal with opioid substitution that has become from the mid-1990's the major treatment pattern in France.

The drug care system has been for a long time mainly dominated by the psychoanalytical approach. With the coming of HIV epidemic, especially among drug injectors, France adopted, though quite lately, substitution treatment in a risk reduction and harm reduction perspective. The large proportion of GPs committed or potentially concerned by drug related care has been one of the main reasons that made France opt for buprenorphine in the mid-1990s. But the advent of substitution was marked by important dissensions in the medical world. At the beginning of the 2000s, the need to pacify the debate on substitution was almost as important as the need of harmonizing practices. In this way, the production of guidelines has also been a field for reconciliation.

All formal recommendations were created in the 2000's according to diverse methods: through restricted working group, public hearing, audit or Clinical Professional Guidelines (CPG) method. Quality assurance processes also varied from internal discussions to cross independent revisions. But the methods applied for the grading systems of recommendations and the evaluation criteria themselves are unclear.

Though the method of definition of guidelines and of quality control did not always follow the most recognized international standards, this absolutely does not allow any depreciation of the quality of recommendations. The most obvious gaps concern above all the diffusion of the guidelines which rarely went beyond a primary level consisting in their publication.

Communication and assistance to professionals also lacked. Nowadays, the intervention of opinion leaders is a major asset in the production of guidelines, particularly when they defend innovative practices. It appears as a key ingredient not only so that guidelines contents gain in consistency but also to favour their acceptance by professionals and finally the adoption of new practices.

Barriers such as the lack of financial and human resources and other organizational or ideological issues, restrain the integration of evidence-based approaches in routine practice. In France, incontestably, future endeavours must focus on support resources and means likely to strengthen the implementation of guidelines.

The relatively short period of time between the publication of guidelines and the identification of the option problems at their origin suggests that authorities more spontaneously resort to this type of tool in the field of addiction. Due to the high costs of their organization, the HAS, the main producer of medical recommendations in France, will probably not organize anymore consensus conferences. In the future, it has decided to refer more and more to evidence-based methods like Clinical Practice Guidelines (CPG).

Appendix a: Synopsis of guidelines related to addiction treatment

Guidelines (year)	Objectives	Targeted interventions	Targeted professionals	Actors	Method and quality control	Implementation resources
Access to methadone in France (2002) <i>Reviewed and renewed by following consensus conference in 2004</i> http://lesrapports.ladocumentationfrancaise.fr/BRP/024000177/0000.pdf	To formalize, clarify and organise public health policy regarding substitution treatment <ul style="list-style-type: none"> ▪ To develop and to sustain what works, to assess and correct what does not work ▪ To improve the quality of care with substitution treatment in prisons ▪ To improve ease of use of methadone and to enhance adherence to therapy among drug addicts 	Substitution treatment	Field health care providers ¹¹¹	Initiator and promoter: Delegated Minister of Health Contributors: Health professionals (Psychiatrist, Internist Pharmacist, GP)	<ul style="list-style-type: none"> ▪ Report ▪ Professional empirical expertise ▪ Internal quality control 	<ul style="list-style-type: none"> ▪ Publication (92 pages) ▪ Online version ▪ Sub regional committees to support opioid substitution treatment

¹¹¹ Drug addiction specialists, Psychiatrists, GPs

Guidelines (year)	Objectives	Targeted interventions	Targeted professionals	Actors	Method and quality control	Implementation resources
Therapeutic strategies for opiates addicts: place of substitution treatments (2004)	<p>To determine goals and expected results for substitution treatment</p> <p>To identify the necessary modalities of support for implementation and follow-up of treatment</p> <ul style="list-style-type: none"> ▪ To find ways for the adoptions of treatments in primary health care <p>To promote good practices in the management of patients receiving treatment</p>	<p>Substitution treatment provided with methadone and high dosage of buprenorphine (HDB)</p> <p><i>More details: see section 4</i></p>	Field health care providers	<p>Initiator: FFA</p> <p>Contributors: Health professionals¹¹², ANAES, Representatives of drug users</p> <p>Promoters: ANAES, FFA, Pharmaceutical laboratories, Health professionals, Representatives of drug users</p>	<ul style="list-style-type: none"> ▪ Consensus conference ▪ Partial literature references ▪ Independent quality control ▪ Prescription control system 	<ul style="list-style-type: none"> ▪ Publication of a short and long versions of guidelines (15/40 pages) ▪ Online version ▪ Extra short version addressed to GPs ▪ Brochures ▪ Trainings/Worksh ops

http://www.has-sante.fr/portail/upload/docs/application/pdf/TSO_court.pdf (short version)

http://www.has-sante.fr/portail/upload/docs/application/pdf/TSO_%20long.pdf (long version)

¹¹² Psychiatrists, GPs, MDs specialized in Public Health or in Addiction, Pharmacists, Psychologists and others

Guidelines (year)	Objectives	Targeted interventions	Targeted professionals	Actors	Method and quality control	Implementation resources
Reducing the misuse of opiate substitution medication (2004)	<ul style="list-style-type: none"> ▪ To identify available substitution medication, their misuse and the determinant factors ▪ To improve the prescription by monitoring and reassessing patient's treatment and follow-up ▪ To improve the organization of care 	<ul style="list-style-type: none"> ▪ Diagnostic according to DSM-IV or CIM-10 ▪ Prescription of medication 	Field health care providers	<p>Initiator: Ministry of Health, CNAMTS, AFSSAPS</p> <p>Contributors: Health professionals¹¹³, ANAES, Representatives of drug users</p> <p>Promoters: ANAES, AFSSAPS</p>	<ul style="list-style-type: none"> ▪ Clinical practice guidelines ▪ Partial literature references ▪ Cross independent quality controls 	<ul style="list-style-type: none"> ▪ Publication (15 pages) ▪ Online version ▪ Fact sheets for prescribing physicians as reminders for good practices ▪ Centres for Evaluation and Information on Pharmacodependence (CEIP) ▪ Prescription control system
http://www.has-sante.fr/portail/upload/docs/application/pdf/opiaces_recos.pdf						
Abuse, addiction and polyuse: strategies of care (2007)	<ul style="list-style-type: none"> ▪ To educate all professionals involved in the management of various addictions ▪ To provide these professionals with operational recommendations ▪ To propose studies, programmes and trainings 	<ul style="list-style-type: none"> ▪ Application of the Addiction Severity Index (ASI) ▪ Therapeutic care 	<ul style="list-style-type: none"> ▪ Field health care providers, especially the ones in contact with the youth, pregnant women, elderly, inmates, precarious population, sportsmen ▪ Researchers 	<p>Initiator: Ministry of Health</p> <p>Contributors: Health professionals, HAS Representatives of drug users</p> <p>Promoter: HAS</p>	<ul style="list-style-type: none"> ▪ Public Hearing ▪ Systematic review ▪ Independent quality control 	<ul style="list-style-type: none"> ▪ Publication (36 pages) ▪ Online version
http://www.has-sante.fr/portail/upload/docs/application/pdf/reco_polyconsommations_-_version_finale_2007_12_21__21_47_28_78.pdf						

¹¹³ Psychiatrists, GPs, MDs specialized in Public Health or in Addiction, Pharmacists, Psychologists and others

Guidelines (year)	Objectives	Targeted interventions	Targeted professionals	Actors	Method and quality control	Implementation resources
Strategies of care for cocaine users (2010)	<ul style="list-style-type: none"> ▪ To improve health care of cocaine users ▪ To facilitate their identification and the cessation 	<ul style="list-style-type: none"> ▪ Counselling ▪ Psychological follow-up ▪ Detoxification ▪ Psychotherapy 	⇒ Field health care providers, especially the ones in contact with pregnant women and young people ¹¹⁴	<p>Initiator: Ministry of Health</p> <p>Contributors: Health professionals, HAS Representatives of drug users, Researchers</p> <p>Promoter: HAS</p>	<ul style="list-style-type: none"> ▪ Clinical practice guidelines ▪ Systematic review and standardized grading of evidence ▪ Cross independent quality controls 	<ul style="list-style-type: none"> ▪ Publication of a short and long versions of guidelines (28/148 pages) ▪ Online version
http://www.has-sante.fr/portail/upload/docs/application/pdf/2010-05/consommation_de_cocaine_-_recommandations.pdf (short version) http://www.has-sante.fr/portail/upload/docs/application/pdf/2010-05/consommation_de_cocaine_-_argumentaire.pdf (long version)						

¹¹⁴ In primary health care, hospitals or specialised centres.

Appendix b: List of participants by alphabetic order

Christine BARBIER	<i>General Department of Health (DGS)</i>
Henri BERGERON	<i>National Centre for scientific research (CNRS)</i>
Anne COPPEL	Public health sociologist specialised in the field of addiction
Jean-Pierre COUTERON	<i>President of the association ANITeA</i>
Patrice DOSQUET	<i>National Authority for Health (HAS), Head of the guidelines department</i>
Isabelle FERONI	<i>National Institute of Health and Medical Research (INSERM)</i>
Albert HERSZKOWICZ	<i>General Department of Health (DGS)</i>
Laurent KARILA	Hospital psychiatrist
Bertrand LEBEAU	<i>Clinical physician in specialised drug addiction treatment centres</i>
William LOWENSTEIN	<i>President of the TSO group (addiction commission)</i>
Michel MALLARET	<i>President of National Commission on Narcotic and psychotropic Drugs (CNSP)</i>
Alain MOREL	<i>President of French Federation of Addiction (FFA)</i>
Dominique MEUNIER	<i>Association ANITeA</i>
Fabrice OLIVET	President of the Association of self-help for drug users (ASUD)
Pascale REDON	<i>Department of Health (DGS)</i>

Appendix c: List of abbreviations

AFSSAPS	<i>Agence française de sécurité sanitaire des produits de santé</i>	French agency for safety of health products
AGREE		Appraisal of Guidelines Research and Evaluation
ANAES	<i>Agence Nationale d'Accréditation et d'Evaluation en Santé</i>	Agency for Accreditation and Evaluation of Scientific Evidence
ANESM	<i>Agence nationale d'évaluation et de qualité des établissements et des services sociaux et médicosociaux</i>	National Agency for the Evaluation and the quality of the social and medicosocial establishments and services
ANITeA	<i>Association nationale des intervenants en toxicomanie et addictologie</i>	National Association of Drug Abuse and Addictology Workers
ASUD	<i>Auto-support des usagers de drogues</i>	Association Self-help for drug users
CNAMTS	<i>Caisse nationale d'assurance maladie des travailleurs salariés</i>	National Health Insurance of salaried workers
CPG	/	Clinical Practice Guidelines
DGS	<i>Direction générale de la santé</i>	General Department of Health
FFA	<i>Fédération française d'addictologie</i>	French Federation of addiction
GL	<i>Recommandations</i>	Guidelines
GP	<i>Médecins généralistes</i>	General practitioner
HAS	<i>Haute autorité de santé</i>	High Authority for Health
HDB	<i>Buprénorphine haut dosage</i>	High Dosage Buprenorphine
InVS	<i>Institut national de veille sanitaire</i>	National Institute for Health Surveillance
MD	<i>Médecin</i>	Medical doctor
MILDT	<i>Mission interministérielle de lutte contre la drogue et la toxicomanie</i>	Interministerial Mission for the Fight against Drug and Drug Addiction
OFDT	<i>Observatoire français des drogues et des toxicomanies</i>	French Monitoring Centre on Drugs and Drug Addictions
WHO	<i>Organisation mondiale de la santé</i>	World Health Organisation

Appendix d: Comparison with the WHO guidelines

Guidelines are considered by the World Health Organisation (WHO) as an indispensable tool for promoting “best practices” in the treatment of drug addiction due to the great number of publications on treatment principles and guidelines (WHO et al. 2008). Considering this increased interest, the WHO recently published guidelines for psychosocially assisted pharmacological treatment of opioid dependence (WHO 2009). These guidelines were set up by an international expert group, in collaboration with the United Nations Office on Drugs and Crime UNODC. They respond to a resolution from the United Nations Economic and Social Council ECOSOC. They are based on a systematic review of available literature and consultation with experts from all relevant fields. A study carried out by the Centre for interdisciplinary addiction research (CIAR, Hamburg University) has shown a large diversity between the EU Member States regarding the number and contents of drug treatment guidelines (Zurhold et al. 2009). In this section, the French recommendations referring to opioid substitution are compared to the WHO guidelines. Further comments are provided below the table.

For each listed WHO recommendations, the following question is answered:					
Do the present guidelines include this recommendation?					
Name of Assessors: Tiphaine Canarelli (OFDT) & Stefanie Schütte (Public Health master)		Yes	No	Not Applicable specify	No answer
1.	Choice of treatment				
1.2	For the pharmacological treatment of opioid dependence, clinicians should offer opioid withdrawal, opioid agonist maintenance and opioid antagonist (naltrexone) treatment, but most patients should be advised to use opioid agonist maintenance treatment.	<input type="checkbox"/>	<input type="checkbox"/>	X	<input type="checkbox"/>
1.3	For opioid-dependent patients not commencing opioid agonist maintenance treatment, consider antagonist pharmacotherapy using naltrexone following the completion of opioid withdrawal.	<input type="checkbox"/>	<input type="checkbox"/>	X	<input type="checkbox"/>
2.	Opioid agonist maintenance treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.1	For opioid agonist maintenance treatment, most patients should be advised to use methadone in adequate doses in preference to buprenorphine.		X		
2.2	During methadone induction, the initial daily dose should depend on the level of neuroadaptation; it should generally not be more than 20 mg, and certainly not more than 30mg.	<input type="checkbox"/>	X	<input type="checkbox"/>	<input type="checkbox"/>
2.3	On average, methadone maintenance doses should be in the range of 60–120 mg per day.	<input type="checkbox"/>	<input type="checkbox"/>	X	<input type="checkbox"/>
2.4	Average buprenorphine maintenance doses should be at least 8 mg per day.	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.5	Methadone and buprenorphine doses should be directly supervised in the early phase of treatment.	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.6	Take-away doses may be provided for patients when the benefits of reduced frequency of attendance are considered to outweigh the risk of diversion, subject to regular review.	<input type="checkbox"/>	X	<input type="checkbox"/>	<input type="checkbox"/>
2.7	Psychosocial support should be offered routinely in association with pharmacological treatment for opioid dependence.	<input type="checkbox"/>	<input type="checkbox"/>	X	<input type="checkbox"/>
3.	Management of opioid withdrawal				
3.1	For the management of opioid withdrawal, tapered doses of opioid agonists should generally be used, although alpha-2 adrenergic agonists may also be used.	<input type="checkbox"/>	<input type="checkbox"/>	X	<input type="checkbox"/>
3.2	Clinicians should not routinely use the combination of opioid antagonists and minimal sedation in the management of opioid withdrawal.	<input type="checkbox"/>	X	<input type="checkbox"/>	<input type="checkbox"/>
3.3	Clinicians should not use the combination of opioid antagonists with heavy sedation in the management of opioid withdrawal.	<input type="checkbox"/>	X	<input type="checkbox"/>	<input type="checkbox"/>
3.4	Psychosocial services should be routinely offered in combination with pharmacological treatment of opioid withdrawal.	<input type="checkbox"/>	X	<input type="checkbox"/>	<input type="checkbox"/>
4.	Pregnancy				
4.1	Opioid agonist maintenance treatment should be used for the treatment of opioid dependence in pregnancy.	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.2	Methadone maintenance should be used in pregnancy in preference to buprenorphine maintenance for the treatment of opioid dependence; although there is less evidence about the safety of buprenorphine, it might also be offered.	<input type="checkbox"/>	<input type="checkbox"/>	X	<input type="checkbox"/>
5.	Guidelines on closed settings				
5.1	Do the present guidelines agree with the “Clinical guidelines for withdrawal management and treatment of drug dependence in closed settings ”?	<input type="checkbox"/>	<input type="checkbox"/>	X	<input type="checkbox"/>

Further comments are furnished underneath, referenced according to the recommendation numbers used in the table.

1. Choice of treatment

The guidelines recommend opioid withdrawal and opioid agonist maintenance but no antagonist maintenance treatment. Therefore, pharmacotherapy-using naltrexone does not exist and opioid agonist maintenance treatment is advised in France.

2. Opioid agonist maintenance treatment

2.1 Two opioid agonist maintenance treatments exist: methadone and high dosage buprenorphine (HDB). None of those two treatments is more recommended than the other. However, the guidelines mention that methadone is more adequate for injecting drug users. On the other side, methadone can be only prescribed in a restricted way (specialised centres) whereas HDB can be given to the patient by every physician and in the primary health care.

2.2 The initial dose for methadone is between 10-40 mg per day and can be increased by 5-10 mg from 1 to 3 days per week without exceeding 50% of the initial dose.

The daily initial dose for buprenorphine is 4 mg to 8 mg and can be increased by 1 to 2 mg from 1 to 3 days until the optimal dose.

2.3 The majority of patients treated with methadone are stabilized by a dose of about 60-100 mg per day but some people need higher doses. No maximum dose has been indicated for methadone.

2.4 For HDB, the majority of people are stabilized between 8 and 16 mg per day. However, some require higher doses of 16 mg per day (24 mg exceptionally). Maximum dosage authorized by the marketing authorization is 16 mg per day. So if higher dosages are expected it is recommended that the prescriber requires a specialist opinion (CSAPA, ES, addictologist, psychiatrist, etc.).

2.5 The initial treatment is prescribed for 1 or 2 days, with daily delivery, which requires the collaboration of the pharmacist. He must be contacted by the prescriber by telephone and must agree on the conditions. His details will be listed on the prescription secure. The contacts between prescriber and pharmacist must be regular.

In the initial phase, it is recommended that consultations are done several times a week to adjust the dosage if necessary, to reassess the effect sought by the person, to estimate adherence, to investigate the association with other psychoactive substances and to deepen the therapeutic alliance. Therefore, the first weeks a therapeutic relationship has to be established, assessing the patient's situation and adapting treatment.

For methadone, the regulation requires a urine test before starting treatment and a supervision.

2.6 No take-away dose has been specified in the present guidelines

2.7 Offering routinely psychosocial support in association with pharmacological treatment for opioid dependence is not mentioned in the present guidelines. However, cooperation between health care and social workers are highly recommended in the guidelines. Marketing authorization stresses on this global approach (medical, psychological and social).

3. Management of opioid withdrawal

Three different management methods of opioid withdrawal are recommended: prompt and progressive withdrawal and change of molecule in order to stop substitution treatment.

None of those methods is more recommended than another.

Prompt withdrawal: Withdrawal is done in hospital with symptomatic treatment (central antihypertensives, BZD, hypnotics)

Progressive withdrawal: Withdrawal is done in outpatient with a gradual reduction of doses, for example from 1 mg to 2 mg for HDB and 5 to 10 mg for methadone

Change of molecule: It is recommended to reduce gradually the dosage of medication that the patient wants to stop before changing the molecule.

The transition from methadone to HDB requires a dose reduction at least up to 30 mg and free interval of at least 24 hours between the last dose of methadone and the first dose of HDB; the passage of buprenorphine to methadone requires also a free interval, lasting a little less (16 hours can be sufficient).

3.1 For the management of opioid withdrawal, tapered doses of opioid agonists are recommended but alpha-2 adrenergic agonists are not specified.

4. Pregnancy

The prescription of opioid agonist maintenance treatment is recommended, at best before a wanted pregnancy or in the first or the second quarter. However, the initialization of opioid agonist maintenance treatment in late pregnancy is controversial.

The perinatal effects of methadone and HDB are identical. Therefore, there is no preference given to one specific maintenance treatment.

5. Closed settings

The physician must ensure continuity of care in closed settings and prevent withdrawal syndromes, although the actual drug consumption in prison is not known.

A training of teams of health workers and of prison administrator is recommended to support treatment programmes including assessment and socio-psychological approaches in practice (misuse, traffic, lack of privacy, etc.).

Since the 30th of January 2002, any doctor practising in a health establishment is authorised to suggest a methadone-based substitution treatment to any opioid-dependent adult. Until then, this possibility was reserved for doctors working in specialised drug addiction treatment services (associations or hospitals), and operating in open or penal environments. The growth in the initial prescription of methadone in both hospitals and prisons has been included in the governmental plan to combat illegal drugs, tobacco and alcohol (2004-2008).

It is also recommended to develop a best practice guide (promoted by the General Department of Health, Prison Service and health and social actors) which would facilitate the establishment of opioid maintenance treatments and allow a surveillance of prisoners in better conditions.

12. Mortality related to drug use: a comprehensive approach and public health implications

12.1. Introduction

Achieving a reduction in mortality from overdoses of illegal substances or of non-prescribed medical treatments remains a major public health challenge in France, as stated once again in the 2008-2011 plan presented by the *Mission interministérielle de lutte contre les drogues et la toxicomanie* (Interministerial Mission to Fight against Drugs and Drug Addiction or “MILDT”). Waging a more effective fight against this phenomenon requires regularly updated knowledge of the latest trends, and therefore the availability of effective measurement tools. On this particular point, the situation may appear somewhat paradoxical: there are several official sources providing records of deaths related to overdoses by illegal substances, but these continue to be hampered by the suspicion of under-recording (Lecomte et al. 1994; Lepère et al. 2001; Janssen, E. 2010). These sources, the estimated levels in addition to the methodological limitations, have already been extensively described in the various national reports submitted to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The question as to their validity has become a particularly acute one due to the increasing number of overdoses recorded since 2003.

The creation of cohorts of users and their monitoring over the long-term (i.e. several years), offers an alternative and supplementary approach vis-à-vis these records which supply transversal data. The higher mortality levels found among drug users in France when compared to those of the general population have been the subject of several studies (Gremy et al. 1997; Lopez et al. 2004). In France, we currently only have access to the results of a retrospective survey carried out in the early 2000s. Several recommendations have been made by the scientific, public health and epidemiological communities for the creation of a prospective cohort study. In order to meet this twofold need, the OFDT has launched a study meeting the requests of the EMCDDA and drawing upon the network of treatment centres for drug users and low threshold or harm reduction centres.

The causes of death among users of psychoactive substances are not limited to overdoses alone. The sharing of the equipment used to take such substances (syringes, water, straws, etc.) remains one of the leading factors behind the circulation of fatal diseases such as AIDS and hepatitis. Specific registers exist, providing information about the changes noted during the last two decades.

12.2. Recent follow up mortality cohort studies among PDUs

12.2.1. Retrospective study of heroin, cocaine and crack users

In France, we currently only have access to a single finalised cohort study, for which the results have been published. This was carried out by the OFDT, working with the police via the *Office central de répression des trafics Illicites de stupéfiants* (Central Office for the Repression of Drug-Related Offences or “OCRTIS”), based on a retrospective cohort study of drug users arrested by the police (Lopez et al. 2004)¹¹⁵.

This study comprised a total of 42,500 individuals born in France and arrested in 1992, 1993, 1996 or 1997 for the use or use of heroin, cocaine or crack and persons arrested for the use or use of cannabis. A third group of individuals arrested for the use of ecstasy was also created,

¹¹⁵ For further details, go to: <http://www.ofdt.fr/BDD/publications/docs/eftadlk5.pdf> for the English version.

although the low numbers of people involved did not allow for a reliable analysis of mortality levels. Statistical analysis was only possible for those persons arrested for the use/dealing of heroin, cocaine and crack.

The cohort of individuals arrested for the use of heroin/cocaine/crack included approximately 23,000 people, 82% of whom were male, with an average age of 27. Just over 70% were unemployed or with no stated profession. They tended to be more numerous in the regions of northern and north-eastern France and the Mediterranean rim. Most of the individuals in this group (52%) had been arrested more than once. Following the comparison of databases, 1,016 deaths of members of this cohort were recorded between 1992 and 2001. Among these deaths, 609 causes (coded based on the ICD9 rules) were documented. The 407 remaining deaths could not be categorised at the time the data was analysed.

Over the whole observation period, the gross mortality rate stood at 7.3 deaths per thousand person-years (PY). The mortality rate among the persons arrested logically increases with the age at the time of arrest (3.8 per thousand PY for those under 25 vs. 17.9 among the 45-59-year-olds) and is higher among men than among women (7.7 per thousand PY vs. 5.3). The gross mortality rates declined sharply over the observation period. Calculated over the four years following the arrest, the mortality rate of persons arrested for heroin/cocaine/crack use in 1996/1997 was almost half that for persons arrested in 1992/1993 (on average 6.2 per thousand PY compared to 10.3 per thousand PY). Standardised data makes it possible to compare data from the cohort with that of the French population. At an equal age, men arrested for the use of heroin, cocaine or crack have a risk of death five times higher than the average French male. For the women arrested, the risk vis-à-vis the French female population as a whole is higher than nine.

The standardised mortality ratios broken down according to the immediate cause are shown in the table below:

Table 12-1: SMR by cause of death and by gender: cohort of persons arrested for heroin, cocaine or crack use (1992-1999).

Causes	Men	Women
Infectious and parasitic illnesses	22.0***	23.2***
Including known AIDS and HIV infection	24.0***	28.7***
Tumours	2.3**	3.2*
Mental problems	42.6***	139.9***
Incl. drug dependence	102.7***	677.4***
Diseases of the nervous system and sensory organs	1.5	-
Diseases of the circulatory system	3.5***	12.9***
Diseases of the respiratory system	5.1**	5.9
Diseases of the digestive system	4.9***	14.5**
External causes of trauma and poisoning	4.1***	10.2***
Including traffic accidents	3.1***	5.4**
Accidental intoxication	26.2***	-
Other accidents and after-effects	10.0***	22.7**
Suicides	3.5***	12.6***
Homicides	10.7***	-
Poorly defined symptoms, signs and morbidity	12.0***	34.9***

Benchmark year: 1997, 15-54 years old. *** p<0.001; ** p<0.01; * p<0.05. Source: Lopez et al. 2004.

The deaths of persons arrested for heroin, cocaine or crack use for whom the causes of death are known can be broken down as follows: 20% for death by overdose directly related to drug use, 13% for death by AIDS, just over a third for death by external causes of trauma and poisoning (including 10% due to traffic accidents and 11% to suicides), leaving a fifth of deaths for which the cause is unknown. The remaining 15% include deaths by tumours and diseases of the circulatory, respiratory and digestive systems.

This study suffers from several important limitations. The first is that it is focused on a particular type of user, who is likely to have been arrested by the law enforcement agencies. This restricted population group only corresponds to a certain user profile, for which we lack information pertaining to use (frequency and administration methods). The second corresponds to a hypothesis of custody on the grounds of drug use. However, in practice it is known that law enforcement agencies tend to use illegal substance use as grounds for detention, as this tends to be easier to prove than illegal narcotics dealing. A third limitation addresses the failures among the databases, concerning 11% of the individuals being monitored.

12.2.2. The prospective cohort study of user health/mortality

The creation of a prospective cohort study of users of illegal substances remains the only valid solution if we are to be able to estimate mortality risks (through a quantitative approach) and the causes of death (through a qualitative approach). This solution, the organisation of which is methodologically complicated and very costly, has so far not been adopted in France.

In order to avoid this problem, the prospective cohort study is based on the participation of treatment centres issuing specialised care to drug addicts, which have become widespread with the development of the harm reduction policy. This choice offers a number of major advantages including a wider panel of subjects and a more diverse sample of the user population, specially trained staff fully experienced in the reality out in the field, in addition to an established network

familiar with requests for information. The next step was to constitute an information source recording the centres' activities. Such a scheme exists in France: this is the *Recueil Commun des Addictions et Prises en charge* (Common data collection on addictions and treatments), an application of the TDI protocol in France organised since 2005 by the OFDT (Palle et al. 2007a). It lists all individuals receiving treatment for addiction via the *Centres de soins spécialisés en toxicomanie* (Outpatient specialised drug addiction treatment or “CSSTs”) and the *Centres de cures ambulatoires en alcoologie* (Alcohol Outpatient Cure Centres or “CCAAs”), which have been grouped together since 2007 under the title *Centres de soins d'accompagnement et de prévention en addictologie* (Centres for Treatment, Assistance and Prevention of Addiction or “CSAPAs”, as part of the 2007-2011 government plan for the treatment and prevention of addictions). Finally, the CAARUD (*Centres d'accueil et d'accompagnement à la réduction des risques pour usagers de drogues* or Reception and harm reduction support centres for drug users), which include the low threshold centres, are in permanent contact with active users, and particularly the most vulnerable, who are not seen by the treatment centres. The financing of their activities by the Social Security system, which began in 2005, has been accompanied by an obligation to carry out a survey, the ENa-CAARUD, which was organised for the first time in 2006 under the responsibility of the OFDT (Toufik, A. et al. 2008a). The questionnaire completed as part of this survey is a modified version of the RECAP questionnaire, which is also used for the CAARUDs' bi-annual survey. In addition to the socio-demographic characteristics (age, sex, educational level, profession, source of income, etc.), the questionnaire also gathers details of drug use (types, frequency, methods, etc.) and the general state of health of the drug users¹¹⁶.

The inclusion criteria are defined as any individual in contact with a low threshold structure or having started a course of treatment in a treatment centre for the use of one or several illegal substances (to the exclusion of cannabis when this is the only problem drug) or an opioid substitution treatment when this is outside the scope of medical supervision. These individuals can be both minors and adults, regardless of the substance concerned, the method for initiating treatment (voluntary, spontaneous, or at the request of a third party), or the number of possible previous treatments undertaken. For identification purposes in the registers concerned, the individuals must be of French nationality or a beneficiary of the French social security scheme.

The various centres participate on a voluntary basis, with certain centres refusing the abandonment of anonymity required in order to track the health status of the users concerned. Although the previously described retrospective cohort study was based on police data, which obligatorily includes named data, the last names, first names, dates and places of birth must be supplied by individuals agreeing to participate in this prospective cohort study. This is a particularly sensitive subject among the community of individuals involved in the drug addiction field, and their wholehearted commitment to the project is required in order to ensure that users are fully informed. To date, 97 centres have officially agreed to participate in the study.

12.3. Complementary sources with drug-related mortality information

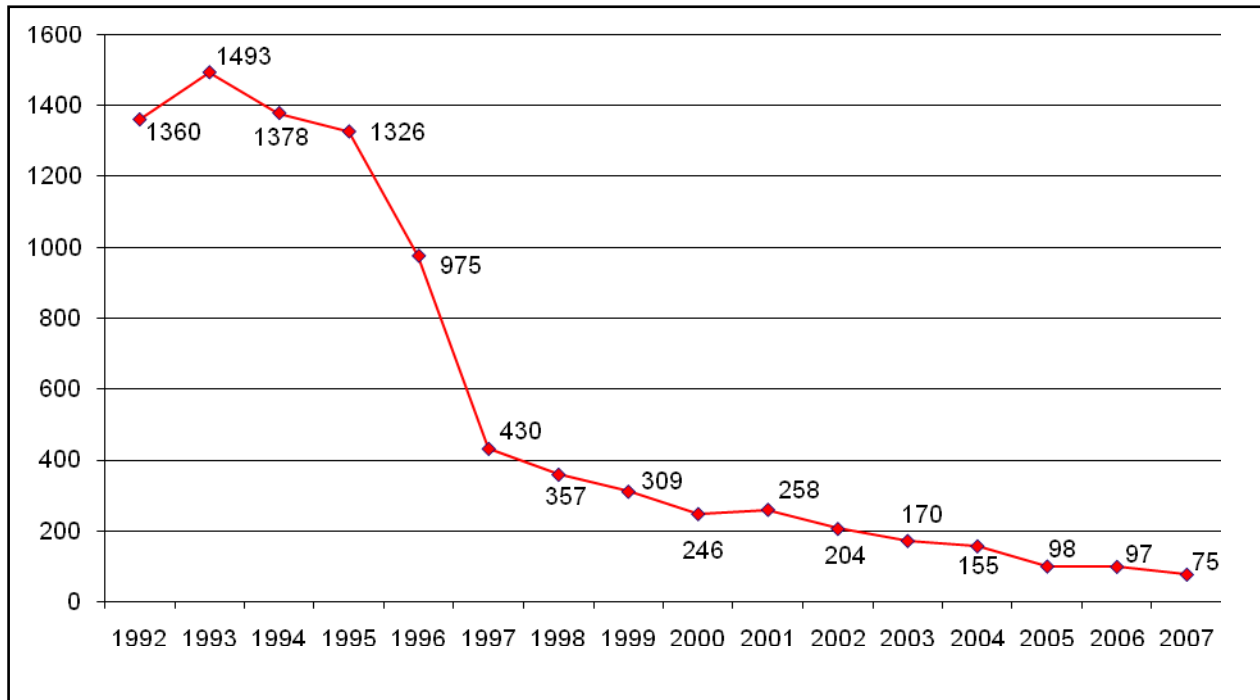
Death by illness (HIV and hepatitis)

No specific monitoring or information systems exist in France with regard to the death of drug users through infectious diseases (AIDS or hepatitis C). However, a national HIV/AIDS monitoring system is in place (see Appendix V-T), coordinated by the *Institut de veille sanitaire* (the national health watch institute or “InVS”), based on the compulsory requirement to declare AIDS cases (incumbent upon all clinical practitioners since 1986) and cases of HIV infection (compulsory since 2003).

¹¹⁶ For further methodological details and to view the questionnaire, go to: <http://www.ofdt.fr/ofdtdev/live/reserve/cohorte2009.html>

The purpose of these announcements is to describe the population of HIV positive individuals or AIDS sufferers in order to be able to track the infection dynamics in order to better adapt preventive action. Consequently, this system makes it possible to obtain information according to the contamination method of the subjects concerned. In particular, it is possible to obtain annual data concerning the number of AIDS deaths among intravenous drug users (Graph 12-1).

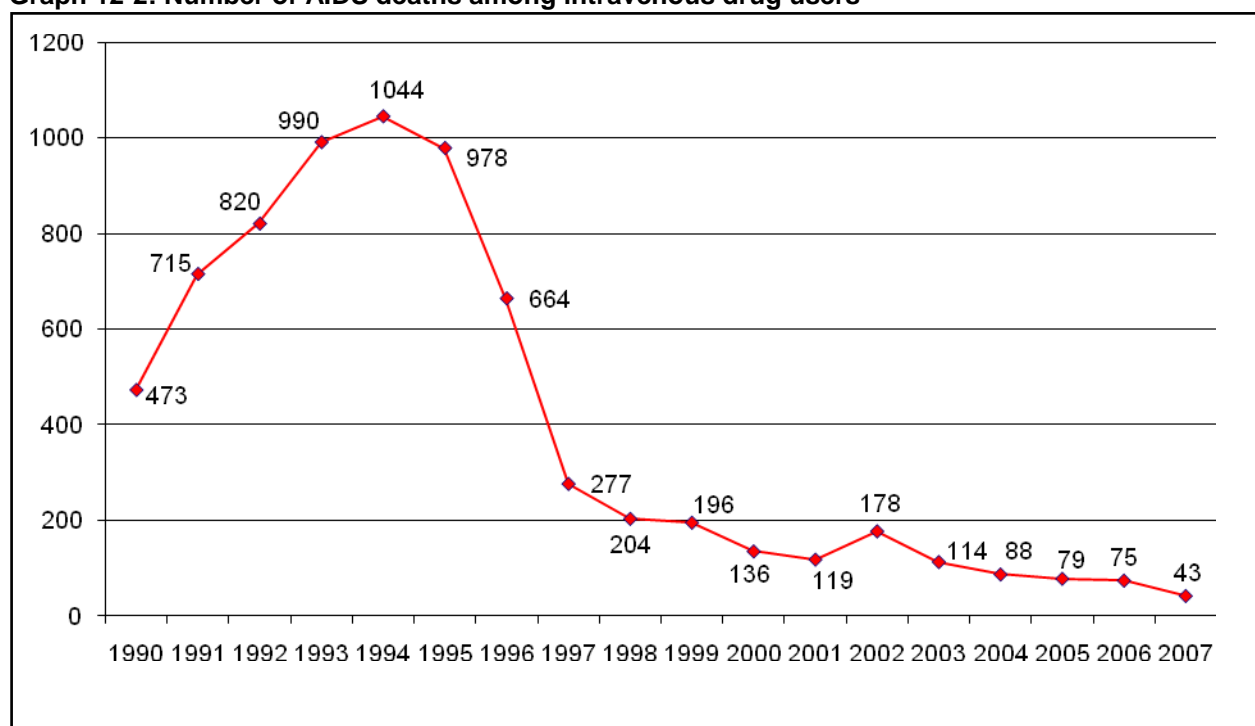
Graph 12-1: Number of new AIDS cases declared among intravenous drug users.



Source: InVS.

AIDS deaths among intravenous drug users are shown in Graph 12-2. A downward trend in the number of deaths linked to intravenous contamination began in the mid-1990s and has continued at a slower pace since 1999. In 2007, just under 50 deaths through AIDS were recorded. Deaths among intravenous drug users nevertheless accounted for 20% of all AIDS deaths in 2007.

Graph 12-2: Number of AIDS deaths among intravenous drug users



Source: InVS.

The general mortality register maintained by the *Centre d'épidémiologie sur les causes médicales de décès* (the Inserm's centre of epidemiology for medical causes of death or *CépiDC*) is a national database of the medical causes of death, compiled on an annual basis from information supplied by the death certificates issued by doctors. This information is coded in accordance with the International classification of diseases (ICD), the rules for which make it possible to select the initial cause of death, based on which the "cause of death" statistics are issued on an annual basis. Hepatitis C is covered by three separate categories (*B17.1: acute hepatitis C*, *B18.2: chronic viral hepatitis C*, *B19: unspecified viral hepatitis*). Cases of HIV or AIDS are covered by the categories *B20 to B24*, according to the infectious diseases, malign tumours or other infections to which HIV can give rise. Although this information system can provide an overall estimate of annual deaths due to HIV or AIDS, it is not however able to specify the percentage of deaths related to intravenous infection with regard to this total. Indeed, mentioning the use of a drug is neither automatic nor compulsory and the decision as to whether to include such information is made exclusively by the GP completing the death certificate.

12.4. Public health perspectives

Three information sources concerning deaths through drug use are available in France. These are the database of the medical causes of death maintained by the general mortality register (*CépiDC*); the OCRTIS database; the *Décès en relation aux abus de médicaments et de substances* database (DRAMES - Deaths in relation to the abuse of medicines and drugs) from the *Agence française de sécurité sanitaire des produits de santé* (French Health Products Safety Agency or "AFSSAPS"). Their data is shown in table 2.

Table 12-2: Deaths by overdoses in France according to 3 sources.

Year	OCRTIS	CépiDc		DRAMES
		(selection B)		
		All	15-64 y.o.	
2000	120	248	225	101
2001	107	274	243	n.av
2002	97	244	225	74
2003	89	233	212	64
2004	69	268	239	86
2005	57	303	264	68
2006	n.av.	305	275	168
2007	93	333	287	192
2008	n.av.	374	322	217

N.av: not available. Sources: OCRTIS, DRAMES, CépiDc, various reports.

The DRAMES data does not make it possible to identify a clear trend, with the increasing overdoses noted in 2006 being explained by the increasing number of forensic organisations and laboratories taking part in the data collection campaign. This number has remained generally constant since this date, leading us to conclude that there was an upward surge in the number of deaths by overdose between 2006 and 2008.

The profile of the persons dying as a result of an overdose is drawn up based on the data from the CépiDC (applying selection B). This population group is limited to 15-64-year-olds. Fatal overdoses tend to be a masculine trait, with a sex ratio of around five (this ratio is approximately 4 for users receiving treatment). The percentage accounted for by women has fallen over these eight years. The average age of death is higher among women (36.8 years old) than among men (33.4 years old). Gender differences tend to concern the types of drugs having led to the death. Among the men, two-thirds of deaths arose as a result of behavioural problems related to the use of several drugs. Among the women, the percentage of such deaths only accounts for half of the total, with the percentage of accidental overdoses or suicides being higher. More than half (52%) of users were economically inactive at the time of their death, while 43% had a job and the situation of the remaining 5% was unknown. The deceased tend to be of a modest socio-economic level. Among those deceased whose employment status was known, more than half were workers (53%) and more than a third were office workers or involved in the intermediate professions (36%). These are followed by self-employed professionals and executive staff (6%), craftsmen and shopkeepers (5%) and farmers (1 %).

12.4.1. The main causes of death

Most of the overdoses through behavioural problems recorded in the mortality register are listed in the "poly-drug use" section. This reflects both the method of use prevailing among drug users, but also the difficulty in accurately identifying the products from death certificates.

The DRAMES supplies valuable information concerning the drugs used, insofar as this is based entirely on the results of toxicological analyses. In 2008 (table 3), illegal substances were involved (as the main product) in just over half of the cases (52%), substitution treatments in almost 39% of cases and opioid medicines (non-substitution) in almost 9% of cases. Overall, opioids are chiefly involved in 84% of cases and cocaine (alone or combined with other products) in approximately 14%. Between 2006 and 2008, the increasing number of overdoses

is chiefly explained by the rising number of people dying as a result of overdoses of heroin (+20 cases), and methadone (+32 cases).

Table 12-3: The main substances involved in overdose deaths in 2007-2008 (DRAMES data).

	2006		2007		2008	
	N	%	N	%	N	%
Heroin alone or combined with other products	59	35.1	69	35.9	79	36.4
Cocaine alone or combined with other products	31	18.5	39	20.3	30	13.8
Other illegal substances (alone or combined)	5	3.0	2	1.0	4	1.8
Methadone alone or combined with other products	31	18.5	61	31.8	63	29.0
Buprenorphine alone or combined with other products	20	11.9	11	5.7	21	9.7
Other opioid medicines, alone or combined	18	10.7	10	5.2	19	8.8
Others	4	2.4	0	0.0	1	0.5
Total	168	100.0	192	100.0	217	100.0
Number of departments taking part	16		18		19	

Source: AFSSAPS. Only deaths directly caused by drug use are mentioned.

12.4.2. The main risks

The rise in the number of deaths through overdoses in the second half of the 2000s can be explained by the appearance of new, younger users associated with the festive environment, whose use frequency tends to be more irregular and who are relatively unknown to the treatment centres. Less aware of harm reduction messages, their limited experience and lack of knowledge of the substances concerned and their chosen methods of use tend to result in higher-risk behaviour.

The growing use of cocaine and other stimulants since the early 2000s in addition to the increased availability of heroin, (the retail price of which has fallen and which today has a somewhat less negative reputation among users than was the case a decade ago) are further explanations for this trend. Intravenous injection practices have changed as a result of the risk reduction policy. However, this is a growing usage method among users of cocaine, ecstasy and amphetamines. We should also note the appearance of the intramuscular injection of HDB (Cadet-Taïrou, A. et al. 2010a).

A number of professionals have highlighted the emergence of a new relationship between harm reduction policies and repressive policies over recent years (Cadet-Taïrou, A. et al. 2010a). Tighter controls and a greater willingness to jail offenders should be viewed in light of the appearance of newer, riskier and more spontaneous uses. A number of centres have also reported difficulties in maintaining contact with certain categories of users, particularly those with the most precarious lifestyles.

12.4.3. Priority areas

Bringing about a reduction in the number of fatal overdoses in France remains one of the priorities in the various anti-addiction plans. The latest three-year plan (2008-2011) from the *Mission Interministérielle de lutte contre les drogues et la toxicomanie* once again specifically

mentions this¹¹⁷, although no specific strategy is indicated: achieving a reduction in mortality caused by drug use should be brought about by reducing the drug use itself.

Field activities aimed at reducing mortality caused by drug use are being carried out by harm reduction associations, often subsidised by public funds, although in practice, these are not coordinated by the state. The work carried out by these organisations is neither coordinated nor synchronised. Furthermore, no "best practices" guide exists.

12.5. Conclusion

Reducing mortality levels among users of narcotics or non-prescribed medicines is a recurrent health and political theme, without there being any specifically targeted measures. A reduction in mortality must be achieved through a reduction in uses.

Three surveys take stock of fatal overdoses in France while two other databases record deaths of drug users through AIDS and hepatitis. The underestimation of the number of fatal overdoses continues to pose a serious problem even if the corrected estimates remain below the levels seen in neighbouring countries (the UK and Germany). Despite these problems, all three sources confirm an increasing number of fatal overdoses in France since the mid-2000s. The greater availability of stimulants, (particularly cocaine and ecstasy), the persistence of injection as an administration method, the falling price of heroin and the appearance of new types of users who are less aware of harm reduction measures are just some of the explanations put forward for this phenomenon.

An initial retrospective cohort study including individuals arrested for the use of certain narcotics has made it possible to quantify the excess mortality characteristic of drug users. A second, prospective survey is based on users receiving treatment or visiting harm reduction centres. Non-fatal overdoses are also receiving greater attention (Fairbairn et al. 2008), even if very little data is currently available in France (Cadet-Tairou, A. et al. 2010a). The various aspects of this theme are specifically analysed in the cohort study underway.

¹¹⁷ <http://www.drogues.gouv.fr/site-professionnel/plan-gouvernemental/plan-gouvernemental-20082011/>

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Ireb (Institut de recherches scientifiques sur les boissons). Base de données bibliographiques:

http://www.ireb.com/html/form_fr.htm. 15/09/2009.

Ofdt. Atlas régional des consommations de produits psychoactifs des jeunes Français - Exploitation régionale de l'enquête ESCAPAD 2005:

<http://www.ofdt.fr/ofdtdev/live/donneesloc/atlas.html>. 08/10/2010.

Ofdt. ILIAD - Indicateurs locaux pour l'information sur les addictions:

<http://www.ofdt.fr/ofdtdev/live/donneesloc/indic.html>. 08/10/2010.

Ofdt. Répertoire des sources statistiques:

<http://www.ofdt.fr/ofdtdev/live/donneesnat/sources.html>. 08/10/2010.

Ofdt. Séries statistiques:

<http://www.ofdt.fr/ofdtdev/live/donneesnat/series.html>. 08/10/2010.

Ofdt. SIMCCA. Système d'information mensuel sur les consultations cannabis:

<http://www.ofdt.fr/ofdtdev/live/donneesnat/simcca.html>. 08/10/2010.

C - Alphabetic list of relevant Internet addresses

AFR (Association française pour la réduction des risques):

<http://a-f-r.org>

AFSSAPS (Agence française de sécurité sanitaire des produits de santé):

<http://www.afssaps.fr>

ANITeA (Association nationale des intervenants en toxicomanie et addictologie):

<http://www.anitea.fr>

ANPAA (Association nationale de prévention en alcoologie et addictologie):

<http://www.anpaa.asso.fr>

ASUD (Autosupport et réduction des risques parmi les usagers de drogues):

<http://www.asud.org>

CRIPS (Centres régionaux d'information et de prévention du sida):

<http://www.lecrips.net>

F3A (Fédération des acteurs de l'alcoologie et de l'addictologie):

<http://www.alcoologie.org>

FNORS (Les Observatoires régionaux de la santé et leur fédération):

<http://www.fnors.org/index.html>

Hôpital Marmottan:

<http://www.hopital-marmottan.fr>

INPES (Institut national de prévention et d'éducation pour la santé):

<http://www.inpes.sante.fr>

MILDT (Mission interministérielle de lutte contre la drogue et la toxicomanie):

<http://www.drogues.gouv.fr>

OFDT:

<http://www.ofdt.fr>

SFA (Société française d'alcoologie):

<http://www.sfalcoologie.asso.fr>

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Appendix IV - List of abbreviations

AAH	Adult disability allowance
AFSSAPS	French Health Products Safety Agency
AMM	Marketing authorisation
ANAES	National Agency for Health Accreditation and Evaluation
ANITeA	National Association of Drug Abuse and Addictology Workers
ANPAA	National Association for the prevention of alcoholism and addiction
ANRS	National AIDS research agency
ASUD	Drug users' self-support association
BEP	Vocational diploma
BHD	High dosage buprenorphine (HDB)
CAARUD	Reception and harm reduction support centres for drug users
CAMPS	Early Medico social Services Centres
CAP	Vocational training certificate
CAST	Cannabis abuse screening test
CCAA	Outpatient Alcoholism Treatment Centres
CDAG	Anonymous free screening centre
CDO	Departmental agreements on objectives in Health and Justice
CEIP	Drug Dependency Information/Evaluation Centres
CEL	Local educational contract
CépiDC	Centre for epidemiology of the medical causes of death
CESC	Health and Citizenship Educational Committees
CFES	French committee for health education (now INPES)
CHRS	Accommodation & rehabilitation centre for persons of no fixed abode
CIFAD	Interministerial training centre for the fight against drugs
CIM	International classification of diseases (ICD)
CIRDD	Centres for information and resources on drugs and dependencies
CJN	National police (criminal) records
CLS	Local security contracts
CNAMTS	National State Health Insurance Office for Salaried Workers
CNRS	National centre for scientific research
COM	Pacific French overseas territories
CPAM	French government department dealing with health insurance
CPDD	Drug & dependencies project leaders

CRIPS	Regional AIDS information and prevention centre
CSAPA	Addictology treatment, support and prevention centres
CSST	Specialised centres for drug addicts
DAP	Prison service (Ministry of Justice)
DAPSA	Support facility for Parenthood and Addiction Care
DATIS	National “Drugs, Alcohol and Tobacco Information Service” telephone helpline
DDASS	Direction of Health and Social Affairs at local level - for the Département
DESCO	School education Office (Ministry of youth, education and research)
DGS	General Health department (Ministry of health and Welfare)
DH	Hospitals directorate (Ministry for Health and Welfare)
DLPAJ/CSR	Directorate of civil liberties and legal affairs, sub-department for traffic and road safety (Ministry of the Interior and Regional Planning)
DOM	French overseas territories
DRAMES	Death involving abuse of medicines and substances (AFSSAPS)
DRD	Drug related Death (EMCDDA definition)
DRESS	Directorate for research, studies and evaluation of statistics (Ministry of health and Welfare; Ministry of social affairs, labour and solidarity)
DSM	Diagnostic and statistical manual of mental disorders
DTTO	Drug Treatment and Testing Order
ENVEFF	National Survey on Violence Against Women
EROPP	Survey on Representations, Opinions, and Perceptions Regarding Psychoactive Drugs (OFDT)
ESCAPAD	Survey on Health and Use on Call-Up and Preparation for Defence Day (OFDT)
ESPAD	European School Survey Project on Alcohol and other Drugs (INSERM- OFDT- MJENR)
ESSAD	Specialized Home Care Unit
FFA	French federation of addictology
FNAILS	National Drug-Related Offence’s Record (OCRTIS, Ministry of Interior)
FNES	National Federation of Health Education Committees
FRAD	Anti-drug shift trainers (Gendarmerie)
GECA	Group of Studies on Pregnancy and Addictions
GIP	Public interest group
IC	Confidence range
ILS	Drug-related offences
INPES	National Institute for Health Education and Prevention (former CFES)

INRETS	National Institute for Research on Transport and Safety
INSERM	National Institute for health and medical research
INVS	National health watch institute
IST	Sexually transmitted infections
IT	Treatment order
IVG	Termination of pregnancy
JAP	Judge responsible for the execution of sentences
JAPD	Day of defence preparation
JO	Journal Officiel
LOLF	Organic Law Pertaining to Finance Laws
M€	Million(s) of Euros
MILAD	Mission for the Fight Against Drugs (Ministry of the Interior)
MILC	Interministerial mission for the fight against cancer
MILDT	Interministerial mission for the fight against drugs and drug addiction
MST	Sexually transmissible diseases
OCRTIS	Central Office for the Repression of Drug-related Offences
OEDT	European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)
OFDT	French Monitoring Centre for Drugs and Drug Addiction
OMS	World Health Organisation
OPPIDUM	Monitoring of illegal psychoactive substances or those that are used for purposes other than medicinal (CEIP)
OR	Odd ratio
PA	person-year
PAEJ	Youth reception and counselling centre
PES	Syringe exchange programme
PFAD	Anti drug trainer / police officer
PRAPS	Programmes for access to preventive measures and health care for people in vulnerable situations
PRS	Regional health programmes
PRSP	Regional Public Health Programmes
RDR	Risk and harm reduction (policy)
RECAP	Common data collection on addictions and treatments
RMI	Minimum income
RSM	Standardised mortality ratio
SAM	Road Safety epidemiological survey on narcotics and fatal road accidents

SFA	French Society of Alcoholology
SIAMOIS	System of information on the accessibility of injection equipment and substitution products (InVs)
SINTES	National Detection System of Drugs and Toxic Substances (OFDT)
SMPR	Regional hospital medical/psychological services
SPIP	Prison service for integration and probation
TDI	Treatment demand indicator
THC	Tetrahydrocannabinol
TREND	Emerging Trends and New Dugs (OFDT)
UCSA	Outpatient treatment/consultation unit
UDC	Coordination Unit for Maternity and Risk Situations
UDVI	Intravenous (or injectable) drug users
UPS	Care unit for prison leavers
VHB	Hepatitis B virus

Appendix V – List of sources

A - Baromètre santé (Health Barometer)

French Institute for Health Promotion and Health Education (INPES)

This is a five-yearly telephone survey of a representative sample of the population living in France. The first edition was conducted in 1992. This survey examines smoking, alcohol, medical drug and illegal drug use and much other behaviour which influence health (use of care, depression, screening practices, vaccination habits, sports, violent behaviour, sexuality, etc.).

The survey is conducted by the French Institute for Health Promotion and Health Education (INPES) in partnership with the “Caisse nationale de l’assurance maladie des travailleurs salariés”, the Ministry of Employment and Solidarity, the French Monitoring Centre for Drugs and Drug Addiction (OFDT), the “Fédération nationale de la mutualité française”, the “Haut comité de la santé publique”, the Interministerial Mission for the Fight against Drugs and Drug Addiction (MILDT) and the National Federation of Regional Health Monitoring Centres (FNORS).

B - CJNI: National Crime Register

Sub-directorate for statistics, studies and documentation (SDSED) of the Ministry of Justice.

Information on sentences has been obtained from 1984 through the study of the National Crime Register. This information describes the different offences for which sentences have been handed down by judges, the type of procedure, nature of the sentence, duration or sum concerned and the specific characteristics of the people sentenced (age, sex and nationality).

As sentences may be handed down for several offences, the concept of the main offence, which in principle is the most serious, is useful (the offences may also be listed in the order given in the report, although a consistency check is carried out depending on the magnitude of the sentence). This is the most commonly used concept in Ministry of Justice statistics. Other counting units can be used to refine the analysis. In the case of narcotics use, for example, sentences for use as an associated offence (for example, the commonest associations and corresponding sentences) or for use alone.

Sentenced persons and the sentences themselves must not be mixed up. A person sentenced twice in a given year is counted twice in the sentencing statistics.

In accordance with the Penal Code, cannabis is not distinguished from other narcotics in these data.

C – HIV and HCV prevalence survey in drug users (Coquelicot-2004)

Conducted by: The National Health Monitoring Institute (InVS).

This study combines an epidemiological arm (combined with self-sampling of capillary blood onto “dry spot”) intended to measure the prevalence of HIV and HCV infection in drug users and a socio-anthropological arm to understand determining factors in risk-taking.

D – Deaths involving abuse of medicines and substances (DRAMES)

The French Health Products Safety Agency (Afssaps) and the Marseilles Drug Dependency Information/Evaluation Centres (CEIP).

This study uses a continuous collection method and was set up in order to obtain the most exhaustive data possible on deaths occurring from use of psychoactive substances in the context of drug abuse or addiction.

This enables:

- substances involved in psychoactive substance abuse deaths, regardless of whether they are medical drugs or otherwise, to be identified;
- quantitative data (blood measurements) to be collected about the substances responsible;
- a more detailed estimate of the number of drug-related deaths in France by reducing under-notification of some deaths due to toxic effects, particularly those occurring in a medico-legal situation and therefore not declared to the Health Authorities for legal confidentiality reasons.

E – Health behaviour in School-aged Children (HBSC) survey

University of Edinburgh for the HSBC network and for France by the medical department of the Toulouse regional education authority: a quantitative survey in 11-, 13- and 15-year-old school pupils being educated in mainland France.

This is intended to:

- Understand attitudes, behaviours and opinions of young people about their use of psychoactive substances (particularly alcohol and tobacco, but also illegal drugs), their health and lifestyles;
- measure changes in behaviour and these lifestyles over time;
- carry out international comparisons

F – National survey in centres for accommodation and assistance with the reduction of risks for drug users (CAARUD) (ENa-CAARUD)

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

Biennial quantitative survey of users received/seen by the CAARUD.

The aims of this survey are:

- to provide monitoring indicators for the number and characteristics of drug users;
- to adapt the responses of professionals and public authorities to the needs and expectations of this population of people in difficulty;
- to monitor trends in terms of use and help identify new trends

G – Survey among drug users attending low threshold services (Prelud)

French Monitoring Centre for Drugs and Drug Addiction.

This annual quantitative survey from 2000 to 2003, and then biennial or triennial thereafter, is designed to obtain knowledge about and monitor users of psychoactive substances and their practices.

The population studied consists of users attending low threshold facilities that provide support to drug users: harm reduction centres (shops, needle exchanges, etc.), so called “low-threshold” services, including “low threshold” methadone distribution centres. It should be pointed out that the people interviewed are not necessarily representative of users attending these centres as participation in the survey is voluntary.

H – Prison entrants health survey

Directorate for Research, Studies, Evaluation and Statistics (DREES) (Ministry of Health and Solidarity)

The prison entrants health survey was conducted for the first time in 1997 in all prisons and in the prison quarters of penal establishments. It collects information about risk factors for the health of entrants from the admission medical visit and diseases recorded on admission,

identified in particular by treatments being taken. Declared use of psychoactive substances includes daily smoking, excessive alcohol consumption (>5 glasses per day) and “prolonged regular use during the 12 months before imprisonment” of illegal drugs, including cannabis.

I – Survey on the care of drug addicts in the medical-social system (in a given month)

Directorate for research, studies, evaluation and statistics (DREES, formerly CESI, Ministry for Health and Solidarity)

This survey was created at the beginning of the 1980s in order to monitor the number and characteristics of drug users seen in the addictology centres (mostly the specialised centres for drug addicts – CSST), health establishments (general public or specialist psychiatry public hospitals and some private psychiatric hospitals) and some social establishments handling prevention, referral or housing activities for drug users.

This survey was conducted, always in the month of November*, from 1989 to 1997, and then in November 1999 and 2003 (the date of the last edition).

All of the patients seen that month are interviewed: illegal drug users or people misusing psychotropic medical drugs. Overlapping (double counting) between the centres cannot be ruled out, but is likely to be limited given the relatively short observation period.

J - EROPP: Survey on Representations, Opinions, and Perceptions Regarding Psychoactive Drugs

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

This survey measures opinions and perceptions of the population about drugs and the related public actions. The people surveyed are also asked about their use.

The first survey was conducted in 1999 and was a telephone survey based on a quota sample (by sex, age, occupation of the household reference person, region and category of conurbation) in people between 15 and 75 years old representative of the population in mainland France.

K - ESCAPAD: Survey on Health and Use on Call-Up and Preparation for Defence Day

French Monitoring Centre for Drugs and Drug Addiction (OFDT) in collaboration with the National Service Directorate (DSN)

The ESCAPAD survey is conducted annually by OFDT in partnership with the National Service Directorate (DSN) and is carried out during the Day of Defence Preparation (JAPD) which has replaced national service in France. Once a year, the young people participating in a Defence Preparation Day session fill out an anonymous self-completed questionnaire administered throughout the country about their use of legal or illegal psychoactive substances and their health and lifestyle.

The adolescents questioned are mostly 17 years old, French nationals and most are still in secondary education, although some have already entered the world of work, are apprenticed or in higher education.

L - ESPAD: European School Survey Project on Alcohol and Other Drugs

National institute for health and medical research-(INSERM, U472)/French Monitoring Centre for Drugs and Drug Addiction (OFDT)/Ministry for Youth, National Education and Research (MJENR)

This is a school survey on use, attitudes and opinions on drugs. ESPAD is conducted every four years at the same time and is used to monitor French and European trends in drug use. Pupils are selected randomly from classes after stratification.

M - FNAILS: National Drug-Related Offence's Record

Central Office for the Repression of Narcotics Trafficking (OCRTIS)

All procedures relating to narcotics legislation offences, conducted by the local police services and gendarmerie (including the overseas départements) are recorded in FNAILS, except for offences recorded by customs and not resulting in the writing of a statement.

FNAILS contains information about arrests (classified as simple use, use/dealing, local trafficking, international trafficking) and seizures. The substance listed is the "dominant drug", i.e. the substance mostly used by the user or which is held in the largest amount by the trafficker. When this rule cannot be used, the "hardest" substance is recorded.

Since 2006, FNAILS has been administered through an IT application called OSIRIS (Statistical information and research tool for drug-related offences) which automatically incorporates information from the customs and gendarmerie.

N - FND: National Prisoners' Register

Prison Service (DAP), Ministry of Justice

Since 1993, statistics on sentences served have been produced from the National Prisoners' Register (FND). This record identifies prison flows for the year, i.e. the number of people entering and leaving prison establishments between 1st January and 31st December in the year, for each offence. The difference between incoming and outgoing prisoners is used to determine the number of people in the prison establishments on a given date.

A new version of FND has been in preparation since 2003. Unlike the previous version, it takes account of all offences resulting in the sentence for each imprisonment, whereas only the main offence was used previously (see CJNI). The offences are also described in more detail. Narcotics offences are now broken down into use, sale, possession, trafficking, aiding and abetting use, inciting use and unspecified narcotics offences compared to only four categories previously (use, sale, trafficking, other narcotics offence). A slippage of data from the former "trafficking" category to the "possession" category has been reported.

In accordance with the Penal Code, cannabis is not distinguished in these data from the other narcotics.

O – Monitoring of illegal psychoactive substances or those that are used for purposes other than medicinal (OPPIDUM)

Network of Drug Dependency Information/Evaluation Centres (CEIP) and French Health Products Safety Agency (AFSSAPS).

OPPIDUM is an annual, national pharmaco-epidemiological study conducted in October each year. It is coordinated by the CEIP network which is responsible for recruiting centres which manage patients with drug abuse or addiction problems or who are receiving opiate substitution treatment. It has been conducted since 1990 in the PACA region and since 1995 nationally. Its objectives are to:

- monitor the use of psychoactive substances by people with drug addiction;
- describe the specific characteristics of the people concerned;
- assess the potential of pharmaceutical products for abuse and addiction.

P – CSST Activity Reports: Use of activity reports from Drug Addiction Treatment Centres

Directorate General for Health (DGS)/French Monitoring Centre for Drugs and Drug Addiction (OFDT)

Since 1998, the Drug Addiction Treatment Centres (CSST) have completed an annual standard activity report which is sent to the Departmental Directorate of Health and Social Affairs (DDASS). These reports are then sent to the DGS which processes them with the assistance of the OFDT. The aim of this data collection exercise is to monitor the activity of the centres and the number and characteristics of the patients received. Epidemiological data are not recorded patient by patient but for all people received in the centre.

A common activity report to the CSST and the Outpatient Alcoholism Treatment Centres (CCAA) was introduced from 2004.

Q - RECAP: Common data collection on addictions and treatments

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

This system was set up in 2005 and continually collects information about patients in the outpatient specialist drug addiction and alcohol treatment centres. Annual results are sent in April of the following year to OFDT which analyses them.

The data collected relate to patients, their current management and treatments taken, uses (substances used and medicines taken as part of the care) and their health.

Cannabis users described through RECAP are those for whom cannabis is the substance used during the previous 30 days which, in the opinion of the care team, currently poses the greatest problem to the patient and led the person to seek care.

This system is replacing the DREES month spot survey

R - SINTES: National Detection System of Drugs and Toxic Substances

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

The SINTES system is intended to document the toxicological composition of illegal substances in circulation in France. The informations incorporated in this system come from two sources:

- communication of toxicology test results performed on seizures by the law enforcement services' laboratories (Institut national de police scientifique, Institut de recherche criminelle de la gendarmerie nationale and customs laboratories) to OFDT;
- investigations conducted by OFDT based on samples of substances obtained directly from users. These collections are governed by a strict regulatory framework and obtained by specifically trained survey workers.

In its initial version of 1999, the system only examined synthetic substances. From 2006 onwards its scope has been extended to cover all illegal substances.

S – Road offences and testing statistics

Road safety sections (Bureau des usagers de la route et de la réglementation des véhicules - Sous-direction de la circulation et de la sécurité routières - Direction des libertés publiques et des affaires juridiques - Ministry for the Interior and National Works)

Since 2004, the Road Safety Section's publication combines statistics on tests performed by the local police services and gendarmerie and offence statistics (offences and infringements) of the Highway Code recorded by these services. These data are communicated monthly to the Ministry and are published nationally.

Information is given on speeding offences, driving without a licence, blood alcohol and, since 2004, the use of narcotics. For narcotics use, the number of screening tests and positive tests is described depending on the circumstances of testing (fatal accidents, body or material injury, offences, suspected use of narcotics without accident or offence). Positivity rates should be

interpreted with considerable caution as, in view of the particularly high positive test rates, it is likely that the screening and detailed result testing are not carried out at random but target the drivers who are most likely to test positive for narcotics.

The annual total of the different narcotics offences is also listed: driving a vehicle after using substances or plants classified as narcotics, driving a vehicle after using substances and under the influence of alcohol and refusal of the driver to have tests or investigations performed to determine whether he/she was driving after using narcotics.

In accordance with the Penal Code, cannabis is not distinguished in these data from the other narcotics.

T – AIDS surveillance system in France

This data collection system has been run continuously since 1982 by the InVS. It has the following objectives:

- to provide epidemiological surveillance on AIDS;
- to measure the incidence of the disease;
- to measure the impact of access of seropositive people to testing;
- to measure the impact of primary prophylaxis prevention actions;
- to measure the impact of therapeutic management before the AIDS stage;
- to measure AIDS-related mortality.

U - TREND: Emerging Trends and New Drugs

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

The aim of the TREND system, which has been established since 1999, is to provide information about illegal drug uses and users and on related emerging phenomena. These cover either new phenomena or existing ones which have not yet been detected by the other observation systems.

The observations are conducted in two social settings chosen by the high likelihood of finding new or not as yet observed phenomena, even if these do not alone affect the entire reality of drug use in France:

- the urban settings defined by TREND cover mostly low threshold services ("Drop ins" and Needle Exchange Programme) and open scenes (streets, squat, etc.). Most of the people met and observed in these settings are problem users of illegal drugs living in particularly precarious conditions;
- the techno party settings which describe places where events are organised around this music. These include the so-called "alternative" techno setting (free-party, teknivals, etc.) and also clubs, discothèques and private parties for their "techno" events.

The system is based on a data set analysed by local coordinators who produce site reports which are then put into a national perspective:

- qualitative continuous collection instruments coordinated by OFDT and run by a network of local coordinating entities (Bordeaux, Lille, Lyon, Marseille, Metz, Paris, Rennes and Toulouse) with a joint information collection and analysis strategy;
- the SINTES system, an observation system geared towards detecting and analysing the toxicological composition of illegal substances;

- recurring quantitative surveys, particularly with low threshold services clients;
- use of results from partner information systems (particularly ESCAPAD, EROPP, FNAILS);
- and quantitative or qualitative subject-based investigations to provide more in-depth information on the subject.

V – National analysis of CAARUD activity reports. ASA-CAARUD

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

This annual study of standardised activity reports from the Reception and harm reduction support centres for drug users (CAARUD) is the second instrument of a set of epidemiological data collection mechanisms, the first of which was the national survey in Reception and harm reduction support centres for drug users (ENa-CAARUD), which concentrated more specifically on people seen in these centres.

ASA-CAARUD provides information about the type of activities developed and services available to clients.

W – Collection of local indicators for the national observation of prevention activities concerning legal and illegal drugs (ReLION)

French Monitoring Centre for Drugs and Drug Addiction (OFDT); Drug and Addiction Information and Resource Centres (CIRDD)

This is a qualitative, biennial survey intended to:

- document the main features of local prevention actions on legal and illegal drug use (alcohol, tobacco, psychotropic medical drugs, cannabis, ecstasy, doping substances, etc.);
- It identifies changes in prevention practices at different national levels through simple identifiers used in the field – for whom, from whom, when and how.