Harms and Harm Reduction workbook

France - 2016

2016 National report (2015 data) to the EMCDDA by the French Reitox National Focal Point

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

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

1. The principle is that a template is produced for each workbook, and one version of this is provided to each country, in some instances pre-filled.
2. Answers to the questions should be entered into the "fields" in the template. The fields have been named with the question number (e.g. T.2.1). It will be possible to extract the contents of the fields using the field names.
3. Fields are usually displayed within a border, and indicated by "Click here to enter text". Fields have been set up so that they cannot be deleted (their contents can be deleted). They grow in size automatically.
4. The completed template/workbook represents the working document between the NFP and the EMCDDA. Comments can be used to enhance the dialogue between the EMCDDA and the NFP. Track changes are implemented to develop a commonly understood text and to avoid duplication of work.

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T0. Summary

- National profile

The number of overdose deaths in 2013 amounted to 237 among 15-49 year-olds (349 in total) according to the general death register (for which the data availability period is 2 years). According to the specific overdose death register (DRAMES scheme), opioid substitution medications were implicated in more than half of cases in 2014, and heroin in a quarter of cases. The mortality cohort study included 1,134 individuals, and for 955 (or 84%) of these subjects, the vital status was checked in December 2015. For men, the standardised mortality ratio was 5.6. For women, it was much higher (18.5).

In 2014, people infected through intravenous drug use represented only 1.1% of new cases of HIV infection. Furthermore, the biological prevalence of HIV among drug users having injected at least once in their life was 13.3% in 2011, while the biological prevalence of HCV in this population reached 63.8%. The seroprevalence of AgHB (which indicates chronic hepatitis B virus infection) was 2.1% among male drug users surveyed in Paris during the period from 2011 to 2013.

Harm reduction (HR) measures are intended for vulnerable populations whose substance use patterns expose them to major risks. These are notably based on the distribution of sterile single-use equipment (syringes, crack pipes, snorting equipment, injection and inhalation kits, etc.) and the diffusion of opioid substitution treatment. Preventing infectious diseases also relies on encouragement to undergo screening for HIV, HBV and HCV, as well as HBV vaccination. Another major objective of HR measures is to promote drug user access to social benefits (accommodation, training, employment, etc.), particularly for the most destitute and socially isolated individuals.

- Trends

The number of overdose deaths in the general death register increased in 2013, after declining for two consecutive years, preceded by a rise between 2003 and 2010. However, the fluctuations observed since 2011 should be interpreted with caution due to methodological changes. Between 2010 and 2014, opioid substitution medications were the main substances implicated in overdose deaths, ahead of heroin.

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

The number of HIV seropositive diagnoses associated with drug use remained stable between 2008 and 2014, following a steady decline between 2003 (date on which monitoring of this indicator began) and 2008. The number of new AIDS cases related to drug use has been steadily declining since 2003.

- New developments

The trialling of drug consumption rooms (DCR) falls within the scope of the law reforming the health system. Several cities volunteered to trial these DCR. Drug consumption rooms in Paris and Strasbourg are scheduled to open in autumn 2016, when the work on the facilities has finished. The specifications for these DCR are laid down by a decree, which defines their operating conditions in detail (organisations and populations concerned, location, personnel, etc.). The supporting structures for trialling the DCR in Paris and Strasbourg are described in two decrees.

Recommendations for treating HBV- and HCV-infected individuals and the utility of rapid diagnostic tests (RDT) for HCV, issued in early 2014, have promoted the continuation and strengthening of actions conducted in this area. Between 1 January 2014 and 30 June 2015, 18,600 patients suffering from chronic hepatitis C were thus treated with direct-acting antivirals. Since June 2016, the treatment of hepatitis C with direct-acting antivirals has been 100% reimbursed by the National Health Insurance Fund for drug users who exchange their equipment (irrespective of their stage of fibrosis). Since August 2016, CAARUDs and CSAPAs are allowed to perform rapid diagnostic tests for HCV and HIV. Also, the French National Authority for Health recommends the use of rapid diagnostic tests (RDT) for HBV as an additional screening tool to conventional laboratory screening, particularly for individuals attending the CAARUD and CSAPA.

As regards the implementation of a naloxone distribution programme (antidote to opioid overdose) in France, a proprietary medicinal product containing naloxone for nasal use obtained a cohort temporary authorisation for use in November 2015. It has been available since July 2016. Priority users are newly released inmates together with users after opioid withdrawal.

Furthermore, the acceptability of new injection kits was evaluated by drug users in 2015, so as to modify the contents of the currently available kits. This showed that the appropriation of the wheel filter (0.22-µ membrane filter added to the experimental kits) is central to the acceptability of these new tools. As support and education on the risks related to injection (AERLI) yielded positive results in trialling, two associations offer training to communicate its principles in the CAARUD.

Lastly, the first public hearing on harm reduction (HR) measures related to addictive behaviours took place on 7 and 8 April 2016 in Paris. At the close of this hearing, the hearing committee put forward 15 recommendations to improve the diffusion, appropriation and implementation of HR related to psychoactive substance use.

T1. National profile

T1.1 Drug-related deaths

The purpose of this section is to:

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

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

Overdose deaths

In 2013, 349 fatal overdoses were recorded in the National registry of causes of death (National Institute of Health and Medical Research - INSERM'S CépiDC department). The majority of these deaths (74%) occurred in males. The number of deaths is still underestimated as some overdose deaths are classified as “unknown cause”. In contrast, morphine overdose deaths occurring mainly among over 50-year-olds in palliative care, whether accidental or suicidal, might wrongly be included in the fatal drug overdose statistics. Emphasis should be placed on fatal overdose among 15-49 year-olds in order to overcome this bias. There were 237 deaths in this age group in 2013.

The fluctuations observed in recent years are probably related to the attempt to exclude "false-positive" cases (morphine overdose deaths in a palliative care or cancer context) according to a procedure which has not yet been fully systematized. Starting with 2014 deaths, T codes, infrequently used in France until then despite providing information on the substance implicated in poisoning, will be introduced. At present, the causes of death are often not stated in the death certificate in the event of medical/legal investigations. At the end of 2016, this certificate will be modified to include an additional medical section to be completed electronically by forensic scientists in the event of medical/legal post-mortem examinations. Consequently, the underestimation of overdose deaths could be limited in the future.

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

Toxicology of overdose deaths

The DRAMES scheme, which does not claim to be exhaustive, provides information on the substances implicated (alone or in combination) in deaths related to psychoactive substance abuse (ANSM 2016). In 2014, methadone was implicated in 44% of deaths (*vs.* 39% in 2013), and buprenorphine in 12% of cases. Overall, the proportion of opioid substitution medications, implicated in 55% of overdose deaths, remained stable. Heroin is implicated in 26% of fatal overdoses and cocaine in 14%. The percentage of deaths involving cannabis is 8%, *versus* 4% for amphetamines and MDMA/ecstasy. In 30% of deaths, several substances were involved.

Six deaths were directly caused by new psychoactive substances (as defined by the EMCDDA, which includes plants and extracts together with certain medications) - NPS - classified as illegal substances; these involve 4-MEC, 5-APB, butylone, ethylphenidate, ibogaine, GHB, mephedrone, PMA and PMMA. Eight deaths involve other NPS, not classified as illegal substances, some of which were medications (pregabalin, quetiapine, tramadol, venlafaxine, zopiclone).

In 2014, 83% of overdose deaths registered in DRAMES occurred in men. The mean age at the time of death was 36.7 years; the women concerned were younger than the men (33.2 years *vs*. 37.4 years on average).

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

Mortality cohort studies

Between September 2009 and December 2011, a mortality cohort study enrolled 1,134 individuals, the majority seen in specialised drug treatment centre (CSAPA) and a few in low-threshold structures (CAARUD). In December 2015, the vital status was determined for 955 of them (or 84% of the enrolled subjects). The mean age at the time of inclusion was 35.3 years, and 77% were men. In this cohort, there were 73 deaths registered (53 men and 20 women). The mean age of death was 43.6 years. The causes are currently available for the 44 deaths that occurred between 2010 and 2013. They are broken down as follows: 48% ill-defined causes (15 causes unknown, 3 sudden deaths, 3 cases of cardiorespiratory arrest), 27% of causes related to disease (4 cases of lung cancer, 2 cases of ENT cancer, 1 case of liver cancer, 2 cases of gastrointestinal bleeding, 1 case of hepatitis C, 1 case of asthma, 1 case of sleep apnoea syndrome), 25% external causes (7 cases of drug poisoning or self-induced drug poisoning 3 of which involved methadone - for the other cases, the death certificates did not include any details on the substances in question -, 1 case of alcoholic coma, 2 road traffic accidents and 1 homicide).

For men, the standardised mortality ratio (SMR) is similar to that observed in the mortality cohort of people arrested for heroin, cocaine or crack use from 1992 to 2001 (SMR 5.2 – 95% CI: [4.9-5.5]). For women, the SMR is much higher (but with a wide confidence interval) than observed in the 90s cohort (SMR 9.5 – 95% CI: [8.0-11.3]) (see table below) (Lopez *et al.* 2004).

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

Table: Gross annual mortality rate and SMR in the 2009-2015 mortality cohort, by gender

	N	Number of person-years	Annual gross mortality rate per 1,000 person-years	SMR	95% CI
Women	220	1,161	17.2	18.5*	11.3-28.6
Men	735	3,959	13.4	5.6*	4.2-7.4
Total	955	5,120	14.3	7.0*	5.5-8.8

Source : Mortality cohort (OFDT)

Note : Reference year for gross mortality rates of the general population of metropolitan France (aged 15 to 85 years only): 2010.

Interpretation: women seen in CSAPAs or CAARUDs have a 18.5 times higher risk of mortality than women of the same age in the general French population, and this risk is statistically significant (*: p<0,001).

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

T1.2 Drug related acute emergencies

The purpose of this section is to:

- Provide a commentary on the numbers of drug-related acute emergencies

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

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

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

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

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

T1.3 Drug related infectious diseases

The purpose of this section is to:

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

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

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

Data based on biological samples
In 2011, the biological prevalence of HIV was 9.8% among drug users having injected and/or snorted at least once in their lives whilst the biological prevalence of HCV was 43.7%. When limited to injectors only, the biological prevalence of HIV increases to 13.3% among users having injected at least once in their lives and 63.8% for HCV, according to the Coquelicot survey (DREES 2015; Jauffret-Roustide *et al.* 2013b).

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

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

Among drug users having injected at least once in their lives and having carried out a test, 6.2% claimed to be HIV seropositive and 33.3% HCV seropositive in 2012 (Cadet-Taïrou *et al.* 2015).
These reported data are likely to underestimate these prevalences, especially for HCV.

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

Notifications of drug-related infectious diseases

In 2014, 74 injecting drug users (IDU) were newly diagnosed as HIV seropositive, i.e. 1.1% of all newly diagnosed cases. In 2013, this involved men in 77% of cases, 4% aged under 25 and 21% aged 50 or over. Half (53%) were born abroad, mainly in Eastern and Central Europe. The proportion of HCV co-infection reached 79% (Cazein *et al.* 2015).
The number of new AIDS cases among IDUs was estimated at 63 in 2014, i.e. 5.2% of all cases. Lastly, 70 AIDS deaths occurred among IDUs, i.e. 34.0% of all AIDS deaths.
No compulsory notification systems for diagnoses of chronic hepatitis C exist in France.
Only a quarter of acute hepatitis B cases (for which compulsory declaration was introduced in 2003) were declared in 2013. The number of acute hepatitis B cases diagnosed was estimated at 291, taking under-reporting into account, i.e. an estimated incidence of 0.44 (95% CI: [0.39-0.50] per 100,000 inhabitants in 2013. Among the cases declared, 5% of persons reported drug use in the 6 months prior to diagnosis (Brouard *et al.* 2016).

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

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

Drug-related infectious diseases - behavioural data

Whilst most drug users are now familiar with the concept of not sharing syringes, this is not the case for other injecting paraphernalia. Of recent injecting drug users seen in CAARUDs (low-threshold structures) in 2012, 8.3% state having shared their syringe in the last month, but one out of five (21.6%) shared at least one other piece of equipment (see table below). Moreover, 7.6% of CAARUD clients who had been incarcerated that year stated that they had injected, 38.4% stated that they had snorted and 1.4% stated that they had shared a "syringe*" during their imprisonment (Cadet-Taïrou *et al.* 2015).

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

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

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

Source: ENa-CAARUD 2012 (OFDT)

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

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

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

In 2011, in mainland France, the total number of people aged 18 to 80 years infected or having been infected with HCV (anti-HCV antibodies) was estimated at 344,500, i.e. a prevalence of 0.75%. The total number of people with a chronic infection (HCV RNA) is estimated at 192,700, i.e. a prevalence of 0.42%. Compared to the seroprevalence survey conducted in the general population in 2004, this 2011 estimation based on an epidemiological model taking into account the main groups exposed to HCV evidences a possible decrease in the number of individuals with chronic HCV infection. It also serves as a point of reference prior to the arrival of new treatments for hepatitis C (Pioche *et al.* 2016).
Between 1 January 2014 and 30 June 2015, 18,600 patients started treatment with direct-acting antivirals (DAA). Two-thirds of these were males, and age at treatment initiation was 58 years on average. Over this period, more than 1.5 thousand million euros were reimbursed by the National Health Insurance Fund for DAA (Dessauce *et al.* 2016).
The indications for DAA reimbursed by the National Health Insurance Fund are based on the severity of chronic hepatitis, evaluated by the degree of fibrosis (fibrosis score ≥ 2) and/or the existence of HIV co-infection (Ministère des finances et des comptes publics and Ministère des affaires sociales de la santé et des droits de la femmes 2015).

T1.4 Other drug-related health harms

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

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

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

Non-fatal overdoses
The only data currently available on a regular basis are those of the ENa-CAARUD survey of users frequenting CAARUDs. In 2012, 6.5% of these CAARUD clients stated having experienced a non-fatal overdose (loss of consciousness after taking of one or more substances) in the 12 months preceding the survey. Alcohol was the drug most often responsible for these overdoses (19.7%), followed by benzodiazepines (15.0%), cocaine (13.9%) and heroin (13.3%).

Psychiatric comorbidities
In 2012, 7.0% of users stated having been hospitalised in the last 12 months for psychological problems not related to withdrawal. Subsequently, nearly one out of five hospitalisations that had occurred in the last 12 months were for this reason. Hospitalisations for withdrawal were more or less at the same level (out of the 34.8%, or 854 users, who reported having been hospitalised in the last year) (Cadet-Taïrou *et al.* 2015).

T1.5 Harm reduction interventions

The purpose of this section is to:

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

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

Drug policy and main harm reduction objectives

The harm reduction policy towards drug users falls under the responsibility of the state (article L.3411-7 of the Public Health Code modified by article 41 of the law on health system reform of 26 January 2016 [Loi n°2016-41 du 26 janvier 2016 de modernisation de notre système de santé]). It aims to prevent health-related, psychological and social harm, the transmission of infections and overdose deaths related to the use of psychoactive or narcotic substances. It also applies to inmates (article L.3411-8 of the Public Health Code). The law of 9 August 2004 [Loi n°2004-806 relative à la politique de santé publique], which created CAARUDs (Support Centres for the Reduction of Drug-related Harms), stipulates that along with numerous other schemes and measures, these low-threshold structures should be used to further enforce the harm reduction policy (article L.3411-9 of the Public Health Code).
Since May 1987, the unrestricted sale of syringes is authorised in retail pharmacies, in-house pharmacies located within health establishments and establishments dealing exclusively in medical-surgical and dental equipment or that have a specialised department for such sales. Since March 1995, syringes may be issued free of charge by any not-for-profit association carrying out AIDS prevention or harm reduction measures among drug users and meeting the requirements described in a legislative order issued by the Ministry of Health (article D.3121-27 of the Public Health Code). The dispensing of syringes and needles to minors is only authorised upon presentation of a prescription (art. D.3121-28 of the Public Health Code). However, neither pharmacies nor associations are legally required to ask users for proof of their identity or age since 1987.

A national harm reduction standard for drug users was prepared (art. D.3121-33 of the Public Health Code) and approved via the decree of 14 April 2005 [Décret n°2005-347 approuvant le référentiel national des actions de réduction des risques en direction des usagers de drogue et complétant le code de la santé publique]. This decree stipulates that all participants, health professionals, social workers or members of associations, in addition to any persons to whom these activities are addressed, must be protected from accusations concerning the use or the incitement to use drugs during their work.

The 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours (MILDT 2013) aims to open up new prospects in the field of harm reduction (HR):

- by promoting the acceptability of HR measures
- by extending the field of HR to all problem substances
- by developing population-based approaches (aimed at the most precarious users, young people, pregnant women – see workbook Drug Policy)
- by reinforcing accessibility and safeguarding the provision of HR measures
- by trialling innovative actions, such as drug consumption rooms (DCR – see T3.3).

Regarding hepatitis, the 2009-2012 national viral hepatitis B and C strategic plan (DGS 2009) was evaluated by the High Council for Public Health in 2013 (HCSP 2013). The HCSP did not recommend drawing up a new national plan because there is a lack of clear strategy, of consistency in the measures and in clearly identified and allocated financial resources. However, the HCSP did recommend making hepatitis a priority in the future national healthcare strategy.
In 2014, a recommendation report on the treatment of people infected with hepatitis B or C was drafted under the supervision of the National AIDS and viral hepatitis Research Agency (ANRS) and the French Association for the Study of the Liver (AFEF) at the request of the Ministry of Social Affairs and Health (Dhumeaux *et al.* 2014). This report suggests re-initiating hepatitis B and C prevention, to incorporate an organised approach to the phases of patient treatment and to support efforts towards equal access to screening and care.

The 2010-2014 national plan to combat HIV-AIDS and sexually transmitted infections (STIs) (Ministère de la santé et des sports 2010) was also evaluated by the HCSP (HCSP 2016). It considers that it is essential for behavioural and biomedical (screening and treatment specific to HIV) prevention resources to be mobilised as part of a general national sexual health strategy bringing together all aspects in the fight against STIs. The HCSP also recommends maintaining and reinforcing a policy to reduce the other most significant STIs (syphilis, gonorrhoea, Chlamydia infections, viral hepatitis). One of the 38 recommendations drawn up specifically concerns drug users: it focuses on improving awareness of the dangers of sexual performance-related drug use in terms of the transmission of HIV and hepatitis, particularly among men who have sex with other men.

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

Organisation of Harm reduction services

In order to guarantee a widespread access for drug users to harm reduction measures, the health authorities have promoted local services based primarily on pharmacies, primary care and dispensing machines. The medico-social system (CAARUDs and CSAPAs) supplements and develops this local access offer. The following indicators are useful to assess the actual coverage of the systems in place.

Level of involvement and location of pharmacy professionals
Nearly half (48%) of the retail pharmacies surveyed in 2010 by the ANSM stated having provided information on the prevention of infectious diseases to drug users, and 40% confirmed having syringe retrieval systems (Lapeyre-Mestre and Boeuf-Cazou 2011). Of the pharmacies surveyed, 79% see at least one patient per month being treated with opioid substitution treatment, 78% dispense *Stéribox*® units, but only 16% dispense individual syringes, and even fewer (1.2%) dispense *Stérifilt*®[1] and *Stéricup*®[2] units.

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

National coverage of medical-social harm reduction systems
In 2015, medico-social harm reduction facilities (CAARUD and CSAPA) covered the majority of the French territory: ten departments (out of a total of 101) do not have a CAARUD, and all departments have CSAPA. As regards the geographical distribution at national level, these facilities are highly concentrated in large towns. Hence, Paris and the Nord department (Lille) have the highest concentration of sites (approximately ten CAARUD), ahead of the Bouches-du-Rhône (Marseille), Gard (south-eastern France) and Seine-Maritime (north-west) departments, which have at least 4 facilities.

CAARUD harm reduction activities

In 2014, there were 144 CAARUDs throughout France. These are medico-social establishments funded by the French social security system. They operate in various places according to diverse methods. Their main actions include creating links with the most vulnerable drug users, access to essential services, health care and social rights. In 2014, nearly half of the activities carried out (41%) aimed to create an initial link with users. Measures to meet the most fundamental needs (basic hygiene) represented more than a quarter of the activities performed (22%). Actions aiming to reduce harm related to drug use and sexuality also mobilised professionals from the facilities (19%) whereas access to screening and vaccinations only represented a very marginal part of the interventions (1.4%). Social support activities concerned 9% of interventions performed by the facilities, considerably ahead of guidance to services offering opioid substitution medications and treatment for HIV and hepatitis (1.4% of activities) and psychological/psychiatric care for users, which was practically non-existent (1%). Primary care provision (nursing, dental, etc.) accounted for 4.6% of their activity (Díaz Gómez and Milhet 2016).

Although harm reduction measures constitute one of their missions, the role of the CSAPA cannot be quantified due to the lack of data.

Harm reduction on the party scene

In 2014, seven structures in ten (69%) had team working on the party scene, which provided an average of nine outreach interventions per year. Among these structures, one third (36%) achieved at least three interventions within the year. (Díaz Gómez *et al.* 2016). Other associations carrying out harm reduction measures are not included in the medical-social system. These are mainly humanitarian, community health or specialised associations that are not CAARUD-certified. Many of them work on the party scene.

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

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

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

Harm reduction services

The prevention measures used in France are of four types:

1) Distributing and recovering sterile, single-use equipment

Syringes and injection kits are sold without restriction in pharmacies (without a prescription since 1987). Injection kits are also distributed by or exchanged within harm reduction facilities (CAARUDs), specialised drug treatment centres (CSAPAs) and automatic distribution machines. For several years now, the availability of prevention material has gradually been extended to administration routes other than injection, with the distribution of snort kits and basing kits for crack smokers and the distribution of special foils for users who “chase the dragon” (inhaling the vapours produced by heating the substance placed on aluminium foil). Finally, distributing condoms (and encouraging their use) also helps reduce HIV virus contamination.

1.1) Distribution of sterile single-use prevention material by the CAARUD

The provision of prevention resources and the collection of soiled equipment are perceived as the key mission of HR facilities. The CAARUD play a key role in distributing injection equipment. In 2014, they supplied approximately 6.8 million syringes, two-thirds of which were collected by the teams (see table below). As regards the equipment distribution

methods, eight out of ten syringes were directly supplied by the teams in contact with drug users and 6% *via* automatic distribution machines (i.e. more than 400,000 syringes). The contribution by pharmacies partnering with the CAARUD (1,200 community pharmacies) amounts to 13% of syringes distributed (i.e. approximately 900,000) (Díaz Gómez *et al.* 2016).

Table: Distribution of sterile prevention material by the CAARUD network in 2014

Injection equipment	Single syringes	4,469,577
	Syringes in kits: automatic distribution machines	431,434
	Syringes in kits: teams	1,011,134
	Syringes in kits: pharmacy network	885,202
	Total number of syringes distributed	***6,797,347***
	Number of syringes collected	***4,231,650***
	Sterile containers	2,353,065
	Sterile filters	1,722,280
	Water (5-ml vials)	2,635,272
	Alcohol pads	2,732,391
	Total number of kits (automatic distribution machines, team)	***1,163,885***
Snorting equipment	Small paper pads	576,282
	Normal saline solution	112,668
	Other snorting equipment	13,906
Crack inhalation equipment	Measures	104,757
	Tips	50,236
	Crack filters	28,630
	Aluminium foil pads	260,431
	Blades	16,355
	Grids	1,474
	Bowls	175
	Total number of kits	***10,744***
STI prevention material	Male condoms	890,602
	Female condoms	40,250
	Lubricant gel	327,734
Other prevention materials	Alcohol tests	57,233
	Ear plugs	18,775
	Brochures, flyers (CAARUD)	174,445
	Brochures, flyers (partner pharmacies)	41,554

Source: CAARUDs 2014 activity reports (DGS – processed by the OFDT)

1.2) Distribution of syringes via automatic distribution machines

Apart from CAARUDs, other structures such as non-CAARUD associations and communities also distribute prevention equipment via dispensing machines and provide drug users with prevention kits such as the *Stéribox*® kit or *Kit+*[1]. In 2014, nearly 500,000 syringes were distributed via automatic distribution machines outside the CAARUD network (Duplessy 2015). The distribution of prevention material via this method aims to guarantee anonymity and 24-hour access to resources. There are close to 300 prevention kit dispensing units in operation in approximately half of French departments. However, the system is fragile since one quarter of the dispensers and one third of the exchange devices were in a bad state of repair (Safe association data).

1.3) Postal syringe exchange programme
In 2011, the Safe association began experimenting with an alternative equipment access programme through the postal service. Users call or email the association, which assesses their use and needs and ensures that users are followed by a professional. The syringe exchange programme via the post sends customised drug use equipment free of charge. They also deliver a prevention message and refer users to a CAARUD or CSAPA when requested or possible. In 2015, this postal syringe exchange programme delivered almost 250,000 syringes against 240,000 in 2014 and enrolled 482 active drug users in its patient intakes (against 300 in 2014). The reasons why these users employ this method are structural (geographic distance, poorly-adapted hours of operation, need for specific material – wheel filters, ascorbic acid - that are not available in CAARUDs) or personal (desire for anonymity, difficulty to acknowledge in CSAPAs that he/she injects his/her opioid substitution treatment) (De Postis 2013; Duplessy and Pourchon 2015).

1.4) Sale of syringes in pharmacies
The latest available data are from 2011: according to the Siamois scheme, approximately 4.5 million syringes were distributed in pharmacies (in Stéribox® form).
From the various information sources, we can estimate that approximately 12 million syringes were distributed or sold to drug users in France.

2) Encouragement to undergo screening for HIV, HCV and HBV infections and the ease of access to this screening
The screening programme is chiefly carried out in anonymous free screening centres (known as CDAGs). In 2011 there were 344 CDAGs in France in addition to about a hundred CDAG units operating in prisons. As from 1 January 2016, these facilities have merged with information, screening and diagnosis centres on sexually transmitted diseases (CIDDIST) to create free information, screening and diagnosis centres on human immunodeficiency virus infection, viral hepatitis and sexually transmitted infections (CeGIDD) [Arrêté du 1er juillet 2015 relatif aux centres gratuits d'information, de dépistage et de diagnostic (CeGIDD) des infections par les virus de l'immunodéficience humaine et des hépatites virales et des infections sexuellement transmissibles]. This merger aims to improve visibility and accessibility of the scheme for prevention and screening of HIV, hepatitis B and C and sexually transmitted infections for users. This service will remain free of charge; however, management may be anonymous or not, according to the user's choice when consulting.
Users can visit CeGIDDs, and may be referred there or accompanied by CAARUD staff members. There are also local harm reduction measures or treatment centres that organise the on-site collection of samples for screening purposes. CSAPAs also provide screening free of charge. Finally, access to screening is also possible via the traditional care system. However, whereas the cost of screening for HIV and HCV infections is 100% covered by the French National Health Insurance Fund (*Assurance maladie*), the screening for chronic HBV markers is only reimbursed at a rate of 65%.

Some CAARUD patients underwent Fibroscan®[2] exams to assess the level of hepatic fibrosis and, if necessary, enable drug users to be referred for more extensive testing. At the request of the National health directorate (DGS), in May 2014 the National authority for health (HAS) issued recommendations on the utility of rapid diagnostic tests (RDTs) for HCV in the hepatitis C screening strategy (HAS 2014). Given their performance and advantages (simple to use, quick results, acceptable, no initial venous sample needed, can be used in a remote setting), the HAS positions RDTs as an additional screening tool that could be of interest for drug users in particular. HCV RDTs could be used in CSAPAs and CAARUDs by health care or non-medical professionals provided that the latter group has first followed training (for both HIV and HCV). In the event of a positive result, systematic confirmation is required using immunoenzymatic testing (third generation Elisa) on venous samples. However, it is imperative to firstly put in place a treatment network downstream to facilitate access to patients who have been screened positive and to coordinate all

stakeholders and health professionals involved in the hepatitis C treatment process. Reiterating the recommendations issued by the HAS, Article 39 of the French law on health system reform of 26 January 2016 extends the practice of RDT from health professionals only to personnel in community or prevention facilities having received appropriate training [Arrêté du 1er août 2016 fixant les conditions de réalisation des tests rapides d'orientation diagnostique de l'infection par les virus de l'immunodéficience humaine (VIH 1 et 2) et de l'infection par le virus de l'hépatite C (VHC) en milieu médico-social ou associatif]. Rapid diagnostic tests can thus be performed within CAARUDs and CSAPAs (see T3.2). Lastly, screening via RDT may be carried out on minors.

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

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

4) Distribution of opioid substitution treatments (OSTs)
OSTs are available in France since 1995 (see Treatment workbook). They contribute to reduce intravenous injection (preventing the first injection and/or encouraging users to give up the injecting route) by reducing heroin use, but also by encouraging access to treatment by providing a common objective for both physicians and drug users. This makes it possible to develop a strong therapeutic relationship between them.

[1] Prevention kits are intended to limit the risks of transmitting infectious diseases among injecting drug users. These kits comprise 2 syringes, 2 alcohol wipes, 2 bottles of sterile water, 2 sterile aluminium containers (to replace spoons), a cotton filter, a dry wipe (to dab the injection site after administration), 1 condom, instructions for use and general prevention messages.
[2] A non-invasive machine that can instantly detect liver fibrosis and assess its degree of advancement.

T1.5.4 ***Optional****. Where possible, provide any contextual information helpful to understand the estimates provided in ST10 'Syringe availability' and ratings in SQ23 'Prevention and Reduction of Health-Related Harm associated with drug use'.*
(Suggested title: Contextual information on routine harm reduction monitoring)

T1.5.5 ***Optional****. Please provide any additional information you feel is important to understand harm reduction activities within your country.*
Information on services outside the categories of the 'treatment system map' may be relevant here (e.g. services in pharmacies/dedicated to HIV/AIDS or other drug related infectious diseases testing sites not linked to hospitals, e.g. other types of facilities offering testing of infectious diseases targeting people who use drugs, or drugs/outreach activities not covered above.

Additional information on harm reduction activities

Preventing first-time injection
The contexts and circumstances surrounding the initial injection of psychoactive substances were examined in the "Priminject" survey conducted from October 2010 to March 2011 by *Santé publique France* (ex-National Institute for Prevention and Health Education - INPES). Mean age at first injection increased, in line with a longer duration of drug use prior to first injection and experimentation with more diverse substances (Cadet-Taïrou and Brisacier 2013; Guichard *et al.* 2013).

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

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

Trialling of DCR
The trialling of drug consumption rooms (DCR) was planned as part of the 2013-2017 Government plan for combating drugs and addictive behaviours (MILDT 2013). The authorisation to open DCR is laid down in Article 43 of the health system reform law [Loi n° 2016-41 du 26 janvier 2016 de modernisation de notre système de santé]. This trial scheme will be implemented by the CAARUD, in separate premises from those normally used for their other missions (see T3.3).

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

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

T.1.6.1 ***Optional****. Please provide additional information on any other relevant targeted health interventions for drug-related health harms.*
(Suggested title: Targeted interventions for other drug-related health harms)

T1.7 Quality assurance of harm reduction services

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

Note: cross-reference with the Best Practice Workbook.

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

Quality assurance for harm reduction facilities

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

The national reference on harm reduction among drug users, appended to the Decree of 14 April 2005 [Décret n°2005-347 approuvant le référentiel national des actions de réduction

des risques en direction des usagers de drogue et complétant le code de la santé publique], stipulates the conditions of intervention concerning HR measures, the objectives for distribution of prevention material and the themes covered by the information on drug use-related harm and its prevention. The other points examined in this reference include the diffusion of health alerts, the places of intervention, the types of intervention personnel taking part in HR measures, confidentiality, participation in the monitoring of psychoactive substance use and participation in trialling new preventive strategies or resources.

The decree of 22 March 2016 [Arrêté portant approbation du cahier des charges national relatif à l'expérimentation d'espaces de réduction des risques par usage supervisé, autrement appelés « salles de consommation à moindre risque »] describes in detail the specifications for DCR, with their general and specific objectives (to help reduce the risk of overdose and infections), together with all of the provisions relative to trialling (see T3.3).

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

The acceptability of harm reduction premises was the subject of an assessment and guidelines which identify the necessary steps to ensure liaison between HR schemes and their partners, whether institutional in nature (regional health agencies, town councils, federations of town councils, law enforcement services, social services, etc.) or private (lessors, tradesmen, neighbours, etc.) (Le Naour *et al.* 2014).

Fédération addiction drew up a survey report, resulting from a project conducted between 2012 and 2015 alongside 88 CAARUD and 126 CSAPA, shedding light on HR measures as part of the medico-social system and providing a detailed overview of the realities in the field (Fédération Addiction 2015).

T2. Trends

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

T2.1 Please comment on the possible explanations of short term (5 years) trends in the following data sets, including any relevant information on changes in specific sub-groups:

a) drug-induced deaths among adults
b) prevalence and notifications of infections, e.g.
    i) newly diagnosed HIV cases with drug use as a risk group
    ii) notifications of AIDS cases related to injecting drug use…
c) drug-related acute emergencies
d) numbers of syringes distributed to injecting drug users

For example, changes in demography, in prevalence and patterns of drug use, in policy and methodology.

Short term trends in drug-related harm reduction

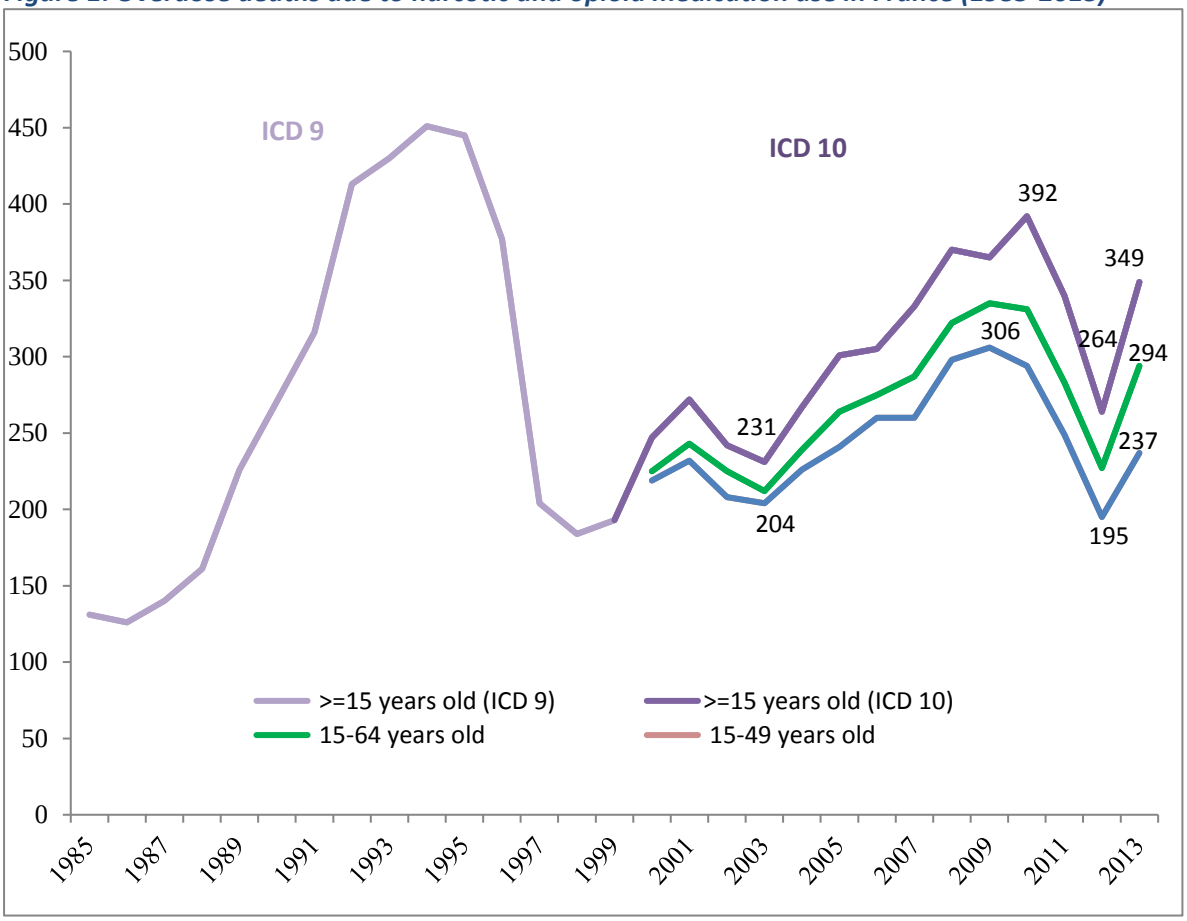
Drug-induced deaths among adults

After a period of increase from 2003 to 2010, data from the mortality register revealed a decrease in the number of fatal overdoses in 2011 and 2012 (see figure 1). However, this decrease should be interpreted with caution since there were changes in coding rules in 2011[1] along with a better control of the deaths registered under X42 as primary cause in 2012[2].

There was a new increase in the number of overdose deaths in 2013, partly due to the rise in "false-positive" cases (morphine overdose deaths in a palliative care or cancer context).

The fluctuations observed in recent years are probably related to the attempt to exclude these "false-positive" cases according to a procedure which has not yet been fully systematised.

Figure 1: Overdose deaths due to narcotic and opioid medication use in France (1985-2013)



Source: INSERM-CépiDc
Note: French adaptation of the EMCDDA selection B (F11, F12, F14, F15, F16, F19, X42, X62, Y12).

[1] Codes F10 to F19 (Mental and behavioural disorders due to psychoactive substance use: F11 for opioids, F12 for cannabis, F14 for cocaine, F15 for other stimulants, F16 for hallucinogens, F19 for multiple drugs or other psychoactive substances) may no longer be used as primary causes and are replaced by X41, X42, X61, and so on depending on the substance and the context. Consequently, fatal methadone or buprenorphine overdoses, formerly coded F11.0, are now coded X42.
[2] In 2012, deaths coded X42 (accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens]) as primary cause have been subject to systematic verifications to rule out deaths by morphine overdose in palliative setting and deaths from a pathology that led to the prescription of opiate analgesics. In 2012, deaths coded X42 showed a marked decrease, probably because of fewer deaths being wrongly coded.

Toxicology of drug-related deaths

Between 2010 and 2014, opioid substitution medications were the main substances implicated in overdose deaths ahead of heroin, showing contrasting changes. Hence, in 2010, opioid substitution medications were implicated to a lesser extent (53%) with heroin to a greater extent (33%). In 2012, opioid substitution medications were implicated in the largest proportion of deaths (60%), whereas heroin was implicated to a lesser extent (15%). Cocaine is implicated to a relatively stable extent, in 9% to 14% of deaths. As from 2011, reports of deaths involving cannabis emerged, linked to the growing awareness among toxicology experts of the cardiovascular toxicity of cannabis (infarction, stroke).

Table: Breakdown of drug-related deaths by substance(s) involved, alone or in combination**, from 2010 to 2014*

	2010		2011		2012		2013		2014	
	n	%	n	%	n	%	n	%	n	%
Opioid substitution medications	130	53	160	57	187	60	153	54	134	55
- of which methadone	88	36	121	43	140	45	112	39	108	44
- of which buprenorphine	44	18	40	14	47	15	45	16	28	12
Other opioid medications (non-OST)	23	9	39	14	36	12	33	12	23	9
Heroin	82	33	54	19	47	15	57	20	62	26
Cocaine	25	10	30	11	36	12	25	9	33	14
Other illegal substances	8	3	16	6	31	10	47	16	32	13
- of which cannabis	na	na	7	3	15	5	31	11	19	8
- of which amphetamines and MDMA/ecstasy	7	3	9	3	15	5	14	5	9	4
Others (poppers, psychoactive medicines, etc.)	6	2	8	2	9	3	43	15	36	15
TOTAL	247		280		310		285		243	
Number of participating toxicological experts	31		36		41		32		38	

Source: DRAMES (ANSM)

* Only deaths directly caused by drug use are mentioned.
** Several substances can be involved in a death when no predominant substance has been determined.
na: non applicable
Note: The proportion for the "other" category increased since 2013 due to a methodological change (inclusion of cases involving psychoactive medicines in combination).

Prevalence and notifications of infections

In 2011, the biological prevalence of HCV declined compared to 2004 (63.8% *versus* 73.8%) while remaining stable for HIV (13.3% versus 11.3%) among drug users having injected at least once in their lives (DREES 2015).

These trends are identical to the changes in the reported prevalence of HCV and HIV among injecting drug users originating from the RECAP scheme (from 47.7% in 2008 to 43.8% in 2012, stable at nearly 8% for HIV) and the ENa-CAARUD survey (from 40.1% in 2008 to 33.3% in 2012, stable at 6.2% *versus* 7.7% in 2008 for HIV) (Cadet-Taïrou *et al.* 2015). This decrease in reported seropositivity is particularly marked in under-25s who had injected: it decreased from 22.5% in 2006 to 8.5% in 2010 and 7.6% in 2012 (Cadet-Taïrou *et al.* 2015).

The annual number of newly diagnosed seropositive cases among IVDU has remained stable since 2008 while the new AIDS cases has declined steadily since 2003 (63 new cases in 2014 *versus* 284 in 2003).

*T2.2 **Optional.** Please comment on the possible explanations of long term (greater than 5 years) trends in the following data sets, including any relevant information on changes in specific sub-groups:*

a) drug-induced deaths among adults
b) prevalence and notifications of infections e.g.

i) newly diagnosed HIV cases with drug use as a risk group
ii) notifications of AIDS cases related to injecting drug use

c) drug-related acute emergencies
d) numbers of syringes distributed to injecting drug users
For example, changes in demography, in prevalence and patterns of drug use, in policy and methodology.

Long term trends in drug-related harm reduction

Drug-induced deaths
After peaking in the mid-1990s, the number of overdose deaths rapidly declined notably as a result of the development of OST and loss of interest in heroin. The changes in the nomenclature used to state the causes of death on the certificates, implemented in 2000, make it difficult to interpret the changes at the start of the new decade.

Notifications of infections
The number of HIV seropositive cases among IVDUs have fallen steeply from 2003 (when mandatory notification of HIV infection started) to 2008, before stabilising.
Following a dramatic decline in the number of new AIDS cases among IVDU between 1995 and 1997, notably related to the introduction of tritherapy delaying entry into the symptomatic phase of infection, the rate of this decrease was slower but almost consistent until 2009. This downward trend is also related to the reduction in the number of new cases of HIV infection related to injecting drug users.

These trends can be explained by different factors: the impact of the different public health measures taken in France (and harm reduction measures in particular), greater accessibility to treatment, greater access to screening, changes in drug use practices and a drop in injection in particular.

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

T3. New developments

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

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

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

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

No new developments.

T.3.2 Please report on any notable new or topical developments observed in drug related infectious diseases in your country since your last report.
(Suggested title: New developments in drug-related infectious diseases)

New developments in drug-related infectious diseases

The French Association for the Study of the Liver updated its guidelines on the treatment of the viral hepatitis in February 2016. It recommends universal access to treatment in the short term, emphasising that there is no medical rationale for refusing a patient (including IDU) effective treatment without major side effects (AFEF 2016). During the national day event on the control of hepatitis B and C which took place on 25 May 2016, the Minister for Health and Social Affairs committed to universal access to innovative treatments for hepatitis C (Ministère des affaires sociales et de la santé 2016). This initiative goes hand in hand with the new negotiation of the prices of these treatments. Furthermore, since June 2016, the treatment of hepatitis C with direct-acting antivirals has been 100% reimbursed by the National Health Insurance Fund for drug users who exchange their equipment (irrespective of their stage of fibrosis) [Arrêté du 10 juin 2016 relatif aux conditions de prise en charge de spécialités pharmaceutiques disposant d'une autorisation de mise sur le marché inscrites sur la liste visée à l'article L. 5126-4 du code de la santé publique].

Article 39 of the French law on health system reform of 26 January 2016 extends the practice of rapid diagnostic tests (RDT) from health professionals only to personnel in community or prevention facilities having received appropriate training [Arrêté du 1er août 2016 fixant les conditions de réalisation des tests rapides d'orientation diagnostique de l'infection par les virus de l'immunodéficience humaine (VIH 1 et 2) et de l'infection par le virus de l'hépatite C (VHC) en milieu médico-social ou associatif]. Rapid diagnostic tests can thus be performed within CAARUDs and CSAPAs, provided that these facilities received an authorisation from the Regional Health Agency. RDTs can be performed by nurses, midwives, doctors and pharmacists [Arrêté du 1er août 2016 déterminant la liste des tests, recueils et traitements de signaux biologiques qui ne constituent pas un examen de biologie médicale, les catégories de personnes pouvant les réaliser et les conditions de réalisation de certains de ces tests, recueils et traitements de signaux biologiques].

The HAS recommends the use of RDT for HBV (HBs Ag) as an additional screening tool to conventional laboratory screening, once it can be shown to be more suitable for reaching non-screened or inadequately screened at-risk populations, such as individuals frequenting the CAARUD and CSAPA (HAS 2016).

T.3.3 Please report on any notable new or topical developments observed in harm reduction interventions in your country since your last report.
(Suggested title: New developments in harm reduction interventions)

New developments in harm reduction interventions

The trialling of drug consumption room (DCR) is laid down in Article 43 of the law on health system reform [Loi n°2016-41 du 26 janvier 2016 de modernisation de notre système de santé]. It stipulates that persons in possession of and consuming narcotic substances for their own personal use in a DCR cannot be prosecuted for illegal use and possession. Professionals working at a DCR and acting in accordance with their supervisory duties are also protected from prosecution for being complicit or facilitating the illegal use of narcotics. The specifications for DCR, laid down by the decree of 22 March 2016 [Arrêté portant approbation du cahier des charges national relatif à l'expérimentation d'espaces de réduction des risques par usage supervisé], describe in detail the general and specific objectives (the first of which is to help reduce the risk of overdose and infections), the duration of the trial (6 years), the facilities concerned (the CAARUD are entrusted with running the DCR but in separate premises from their normal missions), the targeted population (vulnerable injecting drug users, aged over 18 years, with multiple risk factors), the location (close to areas of drug use), funding, national supervision, together with the

objectives and methods for evaluation. Several cities volunteered to trial these DCR. Paris (with the CAARUD run by the Gaïa association [Arrêté du 25 mars 2016 portant désignation du centre Gaia]) and Strasbourg (with the CAARUD run by the Ithaque association [Arrêté du 25 mars 2016 portant désignation du centre Ithaque]) are scheduled to open one room each in autumn 2016, once the work on the facilities has finished.
At local level, these specifications describe the missions of the DCR, the layout of the various spaces, the equipment to be supplied, the operation of the room together with the regulations, the protocols and resources to be set in place, the composition of the team, partnerships and state health service contracts, participation in the surveillance and health alert system, the local steering committee and evaluation of activities.

The evaluation of the trial, conducted by the INSERM (see Research workbook) will notably focus on its impact on public health. A cohort of drug users, COSINUS (cohort for the evaluation of drug consumption rooms) will be recruited and the impact of the room will be studied with efficacy endpoints such as the reduction in high-risk practices for the transmission of HCV and HIV, together with the improvement in mental health, socioprofessional integration, access to accommodation and treatment, and the reduction in criminal acts. The evaluation will also focus on the social acceptability of the HR measures and the reduction of nuisance in public spaces.

As regards the implementation of a naloxone distribution programme in France, in February 2015, the Commission on narcotics and psychotropic substances voted in favour of the nasal route of administration for naloxone by drug users and third parties. Priority users are newly released inmates together with users after opioid withdrawal (ANSM 2016). Naloxone for nasal use has been exempted from list I of poisonous substance [Arrêté du 13 octobre 2015 modifiant l'arrêté du 22 février 1990 portant exonération à la réglementation des substances vénéneuses destinées à la médecine humaine]. Consequently, dispensing does not require a medical prescription; however, it is still a medication only available in pharmacies. The proprietary medicinal product Nalscue® (naloxone for nasal use) from the pharmaceutical company Indivior was granted a cohort temporary authorisation for use (ATU) in November 2015 (ANSM 2015). It has been available since July 2016 [Arrêté du 26 juillet 2016 modifiant l'arrêté du 17 décembre 2004 modifié fixant la liste prévue à l'article L. 5126-4 du code de la santé publique]. Only physicians practising in a CSAPA setting, in hospital addiction medicine departments, in emergency departments, in any other departments in which an addiction liaison and treatment team operates (ELSA) and in prison treatment units may include patients in the cohort ATU. Supply is exclusively reserved for pharmacists in charge of dispensing within hospital pharmacies and hospital CSAPA (ANSM and Indivior France 2016).

Furthermore, in 2015, further to the guidelines resulting from the 2011 Coquelicot survey (Jauffret-Roustide *et al.* 2013a), two new injection kits (EXPER' kits) were trialled, at the initiative of the National health directorate (DGS), with a view to promoting access for drug users to more effective equipment (in terms of protecting against fungal, bacterial and infectious risks) than that contained in the kits currently distributed. Trialling took place alongside users at 4 CAARUD and those taking part in the postal HR programme. The acceptability of these new resources was evaluated by drug users based on a survey via ethnographic observation and in-depth interviews with 55 drug users (Milhet 2016). The wheel filter (0.22-µ membrane filter), included in the new kits, is central to acceptability by drug users. Half of them took the filter, while the other half rejected it, despite the very consistent profiles between the 2 groups. The drug users had specific assessment criteria with regard to the essential properties of a good filter: easy to handle, rapid filtration, satisfactory delivery of the substance, preserved sensations. According to their priorities, they rejected the filter when there were no guarantees for these key criteria.

The AERLI (support and education on injection-related harm) project is an interventional study following on from the ERLI (education on injection-related harm) mission implemented by the *Médecins du Monde* (MdM) association since 2009, after several years of development and trials (for more information, see http://www.sfsp.fr/tmp/20121112_481514_3296.pdf), together with the injection support (AAI) trial developed by AIDES over the same period. The principle of ERLI and AAI lies in training, for existing injecting drug users, on lower-risk injection practices via sessions which begin by observing drug users injecting their usual substance themselves. The risks taken into consideration not only include viral transmission (HIV and HCV) but also local complications of injecting. These projects were evaluated as part of the ANRS-AERLI study, conducted jointly by the AIDES and MdM associations and National institute of health and medical research (INSERM) unit U912 in 8 participating CAARUD (intervention group) and 9 control CAARUD (control group). In terms of results, although high-risk injections (with regard to viral transmission) remained stable among the 129 control drug users, in six months, these had significantly decreased among the 113 drug users having benefited from this intervention. Likewise, over a period of twelve months, the latter experienced fewer injection complications (Roux *et al.* 2016a). The intervention by AERLI also seems to have had a positive impact on the increase in HCV screening among IDU (Roux *et al.* 2016b). In 2016, *Fédération Addiction* and the AIDES association have been offering training on the implementation of AERLI in the CAARUD setting.

Lastly, the first public hearing on harm reduction (HR) measures related to addictive behaviours, organised by the *Fédération Française d'Addictologie* (FFA) with the support of the DGS, the Interministerial Mission for Combating Drugs and Addictive Behaviours (MILDECA) and the HAS, was held on 7 and 8 April 2016 in Paris and was streamed live on the Internet (Fédération Française d'Addictologie 2016a). At the close of this hearing, the hearing committee drew up 15 recommendations to improve the diffusion, appropriation and implementation of HR measures related to psychoactive substance use (Fédération Française d'Addictologie 2016b). These notably include the assessment of the existing experience of self-support groups and mutual support associations, the decriminalisation of drug use, the merging of the CSAPA and CAARUD, the opening of lower-risk consumption spaces within existing premises (CAARUD and CSAPA) with a scheme to analyse the substances used, and the accessibility of the different approaches and HR measures in a prison setting.

T4. Additional information

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

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

T.4.2 ***Optional****. Please use this section to describe any aspect of drug related harms and harm reduction that the NFP value as important that has not been covered in the specific questions above. This may be an elaboration of a component of drug related harms and harm reduction outlined above or a new area of specific importance for your country.*
(Suggested title: Further Aspects of Drug-Related Harms and Harm Reduction.)

T5. Notes and queries

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

Yes/No answers required. If yes please provide brief additional information.
T.5.1 Is there any evidence of an increase in acute emergencies or deaths related to stimulants? If yes, please provide links or references to further information if available.

YES	According to the DRAMES information system, the number of deaths related to an amphetamine-type stimulants (amphetamine, MDMA/ecstasy, methamphetamine ...) amounts to 9 cases in 2014 (4% of all deaths). Between 2010 and 2013 the number of cases was between 5 and 15. These numbers are too small to identify changes over time. The proportion of cocaine-related deaths increased slightly in 2014 (14% against 10% between 2010 and 2013). No national data are available on the use of emergency services related to stimulant use. The Poison Control Centre of Angers, manages poisoning cases in western France, which represent 30,000 calls per year from an 11 million people population. Phenethylamine poisoning cases reported to the Angers Poison Control Centre, from January, 2007 to December, 2013 were examined in 2014 (Le Roux *et al.* 2015). The aim of this specific investigation was to describe the pattern of exposure to all phenethylamines as well as the circumstances under which these poisonings occurred and the consequences. MDMA/ecstasy (38%), amphetamine (18%) and methamphetamine (14%) were the most commonly reported. Synthetic cathinones (10%) and the 2C series (7%) were also found. The most frequently reported symptoms included anxiety and hallucinations (49%), mydriasis and headache (41%), tachycardia (40%) and hypertension (15%). Complications such as seizures (7%), cardiac arrest (5%), toxic myocarditis (1%) and haemorrhagic stroke (1%) were also observed. Of the patients, 77% received hospital care and 12% were admitted to an intensive care unit, 5 deaths occurred and 2 patients presented with neurological sequelae.

T6. Sources and methodology

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

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

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

Methodology

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

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

- The reported prevalence of HIV, HBV and HCV: since 2005 (Palle and Vaissade 2007), these prevalence numbers have been supplied by the RECAP scheme of patients seen in CSAPAs and by surveys of patients seen in low-threshold structures (CAARUDs), particularly ENa-CAARUD surveys.
- The biological prevalence of HIV and HCV, determined using blood samples, were collected from the Coquelicot survey (Jauffret-Roustide *et al.* 2009) conducted in 2004 and 2011.
- Estimates of the national incidence of AIDS, HIV infection and acute hepatitis B infection were also performed. AIDS case and AIDS death reporting, which has existed since the early 80s, has been mandatory since 1986. A new anonymous reporting measure implemented in 2003 following a circular issued by the National Health Directorate (DGS) [Circulaire n°2003-60 du 10 février 2003] made HIV-infection reporting obligatory as well. This system is accompanied by HIV virological monitoring. Reporting of acute hepatitis B infection has been required since 2004.

Drug-related deaths
In France, there are currently two sources that list fatal overdoses:

- The national statistics on the medical causes of death (CepiDc-INSERM). Since 1968, this registry has been listing information from death certificates on all deaths in the past year. Fatal overdoses are those for which the death certificate mentions codes from the International Classification of Diseases (ICD-10) that are on the list of codes established by the EMCDDA (selection B: http://www.emcdda.europa.eu/publications/methods/drd-overview [Last accessed 13/09/2016]). Without going into further detail here, this is a group of codes mentioning the use of an illegal substance or certain medications. Some fatal overdoses are nevertheless coded under "deaths with poorly defined causes" and therefore are not registered. Furthermore, the substances responsible for death are poorly detailed in this source, since the most frequently seen wording is that of polydrug use without any further specifications. These data only become available two years after they are recorded. The underestimation of overdose deaths has been estimated at 30% among 15-49 year olds in 2007 (Janssen 2011).
- The information system known as DRAMES (Drug and Substance Abuse-related Deaths). This information system records deaths that involved legal proceedings and a request for a toxicology analysis and/or autopsy. Volunteer toxicological analysts report these cases throughout the French territory. Analyses are performed upon the request of the public prosecutor's office. The definition of overdose used is very similar to the definition accepted by the EMCDDA (illegal substances and opioid substitution treatments) but do not include suicidal deaths. Contrary to the preceding source, DRAMES is not exhaustive. First of all, DRAMES does not cover all toxicology laboratories, and secondly, the system only lists deaths for which the judicial system requested a toxicological analysis, and such requests are not systematic. Therefore, DRAMES data are mainly useful in determining a breakdown of fatal overdoses according to the substance that caused them.

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

ANRS-Coquelicot: a multi-centre, multi-site study on the frequency and determining factors in practices that lead to a high risk of HIV and HCV transmission in drug users
National Institute for Health and Medical Research (Cermes3-Inserm U988) and French Institute of Public Health Surveillance (InVS)
The purpose of this study is to measure the prevalence of HIV and HCV infection in drug users through a face-to-face questionnaire and a blood sample taken by the user himself for biological testing. The study focuses on users' perceptions of their health and healthcare, use practices (substances and routes of administration), knowledge of transmission modes for HIV, HCV and HBV, and at-risk practices (e.g., context in which they first used drugs, sharing of equipment, use of condoms).
The first study was conducted in 2004 in five French cities (Lille, Strasbourg, Paris, Marseille and Bordeaux) on 1,500 users who had injected or snorted at least once in their life. In 2011, the sampling changed a bit: it was no longer cities, but urban areas, and two departments (Seine-Saint-Denis and Seine-et-Marne) were added; drug user recruitment focused on specialised services (CSAPAs, CAARUDs, residential structures) not including general medicine. This survey of took place between May and July 2011, and questioned 1,568 drug users in 122 structures. The participation rate was 75%. Of these users, 92% agreed to provide a blood sample from their finger.

DRAMES: Drug and Substance Abuse-related Deaths
French National Agency for Medicines and Health Products Safety (ANSM)
Implemented in 2002, this information system uses a continuous method for collecting data in mainland France and was set up in order to obtain the most exhaustive data possible on deaths occurring from use of psychoactive substances in the context of drug abuse or addiction. The system also aims to describe the circumstances under which the body was discovered, the level of abuse at the moment of death and the results of the autopsy, as well as to identify and quantity the substances involved, through blood testing.
Thirty-eight experts performed toxicological analyses within a forensic scope in the 2014 edition of the survey. DRAMES includes drug-related deaths (the definition of which is similar to that of the European Monitoring Centre for Drugs and Drug Addiction, except for suicides) for which toxicological analyses were performed by experts who took part in the study.

ENa-CAARUD: National survey of low-threshold structures (CAARUDs)
French Monitoring Centre for Drugs and Drug Addiction (OFDT)
Conducted every two years since 2006 in all CAARUDs (on mainland France and in French overseas departments), this survey determines the number of users seen in these structures, the characteristics of these users and their use patterns. Each user who enters into contact with the structure during the survey undergoes a face-to-face interview with someone working at the structure. The questions asked are on use (frequency, age of experimentation, administration route, equipment-sharing), screening (HIV, HBV and HCV) and social situation (social coverage, housing, level of education, support from friends and family).
The 2012 survey was conducted from 26 November to 7 December: 4,241 completed or "non-responder" questionnaires were collected in 142 CAARUDs. After eliminating duplicates (299) and "non-responders" (1,037), 2,905 individuals (in 139 CAARUDs) were included in the analysis. The 2015 edition took place from September 14 to 27: the database is currently being analysed.

Mortality cohort study among drug users
French Monitoring Centre for Drugs and Drug Addiction (OFDT)
A cohort of drug users seen in the specialised centres (CSAPA, CAARUD) was incorporated between September 2009 and December 2011 by the OFDT. One thousand individuals were included in 51 volunteers CAARUD and 17 volunteers CSAPA and responded to a questionnaire similar to that of the RECAP scheme. Their vital status was questioned in July 2013 and then again in December 2015. If appropriate, the causes of death are filled. This study describes the causes of death, calculates standardised mortality indices (Standardised Mortality Ratio), quantifies the years of life lost and identifies risk factors associated with the occurrence of death. The main limitation of a cohort study without longitudinal follow-up (excluding vital status) is to ignore developments on drug use and treatment of users after their inclusion in the study.

RECAP: Common Data Collection on Addictions and Treatments
French Monitoring Centre for Drugs and Drug Addiction (OFDT)
This system was set up in 2005 and continually collects information about clients seen in National Treatment and Prevention Centres for Addiction (CSAPAs). In the month of April, each centre sends its results from the prior year to the OFDT, which analyses these results. The data collected relate to patients, their current treatment and treatments taken elsewhere, their uses (substances used and substance for which they came in the first place) and their health. The common core questions help harmonise the data collection on a national level and fulfil the requirements of the European Treatment Demand Indicator (TDI) protocol.

In 2014, approximately 189,000 patients seen in 258 outpatient CSAPAs, 10 residential treatment centres and 6 prison based CSAPAs were included in the survey.

National registry of causes of death

Centre for epidemiology of the medical causes of death (CépiDc) of the National institute for health and medical research (INSERM)

Since 1968, the INSERM'S CépiDC department has been recording all deaths observed on French territory. The information on the causes of these deaths comes from the death certificate (paper or, since 2007, electronic) completed by the physician recording the death. They are coded by the INSERM following the 10th revision of the International Classification of Diseases (ICD 10). This system enables annual, national statistics on medical causes of death to be established in cooperation with the French National Institute for Statistics and Economic Studies (INSEE), which oversees National Directory for the Identification of Natural Persons (RNIPP) containing all information from birth, marriage and death records. In some cases, information pertaining to the causes of death that are to undergo forensic investigation is not always submitted to the INSERM. These deaths remain classified as cause unknown, generating an under-representation of certain causes in the statistics (especially violent deaths and fatal overdoses).

SIAMOIS: System of information on the accessibility of injection equipment and substitution products

Group for the Production and Elaboration of Statistics (GERS)

This database was designed in 1996 to follow trends in access to the sterile injection material available in pharmacies, and trends in opioid substitution medications. Latest data available are from 2011.

Acute Hepatitis B Monitoring System

French Institute for Public Health Surveillance (InVS)

In March 2003, it became mandatory in France to report acute hepatitis B cases. Like for HIV and AIDS, HBV-positive individuals are anonymised as soon as they are tested in a laboratory. The testing laboratories report all suspected acute hepatitis B cases to the prescribing physician, who, in the event of a past medical history of hepatitis B, makes a report to the inspecting physician of the relevant Regional Health Agency (ARS).

The collected data help describe the epidemiological profile of infected individuals and to estimate the incidence in France and any changes thereof. To do this, the data coming from reports are corrected for under-reporting, this underestimation being assessed at 85-91% in 2010. They also help assess the impact of the prevention policy by quantifying the spread of the hepatitis B virus.

HIV/AIDS Monitoring System

French Institute for Public Health Surveillance (InVS)

Since 1986, reporting new AIDS cases has been mandatory. Reporting newly diagnosed HIV infection cases became mandatory in 2003. The HIV data incorporate biological information from laboratories and epidemiological and clinical information from prescribing physicians. Only physicians can report AIDS cases, and such reporting has been anonymised from the very beginning.

Since 2003, approximately 2,500 biologists and 16,000 clinicians have taken part in mandatory HIV and/or AIDS reporting. At the same time, virological monitoring (Elisa test to detect specific antibodies) is performed by the National HIV reference centre. This totally anonymous information is sent to Regional Health Agencies (ARSs) and then to the InVS.