2017

Harms and harm reduction workbook

France

2017 National report (2016 data) to the EMCDDA by the French Reitox National Focal Point

Supervision: Christophe Palle

Contribution to the workbooks

1.1 *Drug Policy*: Cristina Díaz-Gómez
1.2 *Legal Framework*: Caroline Protais, Cristina Díaz-Gómez
2 *Drugs*: Olivier Le Nézet, Agnès Cadet-Taïrou, Magali Martinez, Eric Janssen
3.1 *Prevention*: Carine Mutatayi, Caroline Protais
3.2 *Treatment*: Christophe Palle, Anne-Claire Brisacier, Caroline Protais
3.3 *Best Practice*: Carine Mutatayi
3.4 *Harms and Harm Reduction*: Anne-Claire Brisacier, Cristina Díaz-Gómez, Maitena Milhet, Thomas Néfau
4 *Drug Market and Crime*: Michel Gandilhon, Magali Martinez, Thomas Néfau, Caroline Protais, Cristina Díaz-Gómez
5.1 *Prison*: Caroline Protais
5.2 *Research*: Isabelle Michot, Maitena Milhet

Proofreading (French version): Julie-Émilie Adès, Ivana Obradovic (OFDT); Nicolas Prisse, president of the Interministerial Mission for Combating Drugs and Addictive Behaviours, and the project managers of the MILDECA
Proofreading (English version): Julien Morel d'Arleux, Anne de l'Eprevier
Bibliographic references: Isabelle Michot
Legal references: Anne de l'Eprevier

Table of Contents

T0. Summary

Please provide an abstract of this workbook (target: 1000 words) under the following headings:

- National profile and trends harms

Drug-related deaths: number, characteristics, trends and patterns

Emergencies: number, characteristics, trends and patterns

Drug related infectious diseases: notifications and prevalence incl. trends

- National profile and trends harm reduction

Main policies and strategies directed at reducing drug-related health harms; availability, geographical distribution of services, and access:

- New developments
- National profile and trends harms

The number of overdose deaths in 2014 amounted to 241 among 15-49 year-olds (370 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 41% of cases in 2015, and heroin in 30% 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).

The number of overdose deaths in the general death register remained stable among 15-49 year-olds in 2014 compared to 2013, after three years of decline. However, the fluctuations observed since 2011 should be interpreted with caution due to methodological changes. Between 2010 and 2015, opioid substitution medications were the main substances implicated in overdose deaths, ahead of heroin.

Nearly 10,000 hospital emergency presentations related to drug use were reported in France in 2015 (Oscour® network). A quarter of presentations were related to cannabis use and a quarter to opioid use, whereas cocaine was implicated in 7% of cases, other stimulants in 4% of cases, hallucinogens in 5% of cases and, lastly, multiple or unspecified substances were responsible in 35% of cases.

In 2015, people infected through intravenous drug use represented only 1.5% of new cases of HIV infection. The number of HIV seropositive diagnoses associated with drug use remained stable between 2008 and 2015, 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 remained stable in 2014, after steadily declining between 2003 and 2013.

Furthermore, between 2012 and 2015, the reported prevalence of HIV and HCV remained stable, both in the CAARUD and CSAPA context. This stability highlights the end of the declining prevalence of HCV among injecting drug users (IDU) observed since the beginning of the 2000s. The most recent data on biological prevalence are from 2011. The biological prevalence of HIV among drug users having injected at least once in their life was 13.3%, 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.

- National profile and trends harm reduction

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.

Approximately 11.3 million syringes were distributed or sold to drug users in France in 2016, these figures being very slightly higher compared to 2008. Pharmacy syringe sales in the form of injection kits, which represent a third of syringes distributed to drug users in 2016, fell by a quarter in 5 years, offset by the increase in distribution in CAARUDs, CSAPAs, automatic distribution machines and postal Needle and Syringe exchange Programme.

In France, the level of coverage in the syringe distribution is below the threshold defined by the EMCDDA: coverage is considered "good" from 200 syringes per injector per year. According to the latest estimates about 110 syringes were distributed by injecting drug users in 2016 in France.

- New developments

Trialling of drug consumption rooms (DCR), which falls within the scope of the health system reform law, began in Paris and Strasbourg in 2016.

Updated guidelines on the management of HCV-infected individuals, and on the HIV screening strategy urge the continuation and consolidation of action already taken along these lines, particularly among injecting drug users. In 2014 and 2015, 22,600 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).

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. Since May 2017, CAARUDs have been authorised to dispense naloxone kits, which had previously been limited to hospital pharmacies and hospital CSAPAs. The proprietary medicinal product Nalscue® obtained marketing authorisation in July 2017.

An additional medical section on death certificates was introduced in April 2017. This is used for stating the causes of death when known several days after death, for instance in cases of overdose death resulting in forensic investigations.

T1. National profile and trends

T1.1 Drug-related deaths

The purpose of this section is to

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

Please structure your answers around the following questions.

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

Overdose deaths

In 2014, 370 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, particularly occurring among over 50-year-olds, in a palliative care context (choosing a code corresponding to poisoning as the initial cause of death is incorrect in this case) may appear as drug user deaths. These deaths account for 22% of deaths assigned a code related to overdose. Emphasis should be placed on fatal overdose among 15-49 year-olds in order to overcome this bias. There were 241 deaths in this age group in 2014.

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. (Suggested title: Toxicology of overdose deaths)

Toxicology of overdose deaths

The DRAMES scheme provides information on the substances implicated (alone or in combination) in deaths related to psychoactive substance abuse (CEIP-A and ANSM 2017). In 2015, methadone was implicated in 31% of deaths, a clear reduction compared to 2014, and buprenorphine in 10% of cases. Overall, the proportion of opioid substitution medications, implicated in 41% of overdose deaths, decreased. Heroin was implicated in 30% of overdose deaths, on the rise compared to 2014, and cocaine in 14% thus remaining stable. The percentage of deaths involving cannabis was 10%, versus 8% for amphetamines and MDMA/ecstasy, on the increase, and 4% for NPS, also on the rise. In 33% of deaths, several substances were involved.

Fifteen 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 3-MMC, MDPV, 3F-phenmetrazine, methoxyphenidine, 5-MAPB (all 5 implicated for the first time in 2015) and 4-MEC, 5-APB, mephedrone and PMMA. Nine deaths involve other NPS, not classified as illegal substances, some of which were medications (quetiapine, tramadol, diphenhydramine, zopiclone).

In 2015, 81% of overdose deaths registered in DRAMES occurred in men. Mean age at the time of death was 36 years, both in men and women.

The national health alert scheme related to psychoactive substance use, which focuses on unusual events, listed 8 deaths in 2016 reported by different sources (police, TREND/SINTES network, Monitoring network for serious adverse effects, private analysis laboratories, scientific publications, etc.), including 6 related to NPS use. Arylalkylamines, alone or in blends, had been taken in 2 cases of death. In this category, 5-APB and 5-EAPB were identified in blood samples for one case, whereas x-APB was identified in a sample of powder belonging to the patient, accompanied by an LSD blotter, in the other case. The other 4 deaths related to NPS use concerned cathinones alone or in blends. 3-MMC was found in biological samples in 3 cases, and in combination with alpha-PVP and PV8 in one case. The latter case was related to use of 4-MEC and GHB, both of which were found in a blood sample, and the use of which was more than likely related to chemsex practices. Lastly, the latter two deaths, involving "conventional" substances, were related to use of MDMA in one case, and nitrous oxide in the other case.

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.
(Suggested title: Mortality cohort studies)

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 64 deaths that occurred between 2010 and 2014. They are broken down as follows: **38% ill-defined causes** (17 causes unknown, 3 sudden deaths, 4 cases of cardiorespiratory arrest), **34% external causes** (11 cases of drug poisoning or self-induced drug poisoning, 3 of which involved methadone, 1 case of heroin poisoning - for the 7 other cases, the death certificates did not include any details on the substances in question -, 1 case of alcoholic coma, 5 cases of dependence - with methadone and alcohol mentioned for one individual, alcohol only for another, and multiple drugs for the other 3 cases -, 1 suicide, 2 road traffic accidents, 1 case of multiple trauma due to a workplace accident and 1 homicide), **28% of causes related to disease** (7 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 pneumonia, 1 case of asthma, 1 case of ischaemic cardiomyopathy, 1 case of dementia).

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 drug users, 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 Trends: Please comment on the possible explanations of short term (5 years) and long term trends in the number of drug-induced deaths among adults, including any relevant information on changes in specific sub-groups. For example, changes in demography, in prevalence and patterns of drug use, in policy and methodology, but also in the data completeness/coverage; case ascertainment, changes in reporting

Short term trends

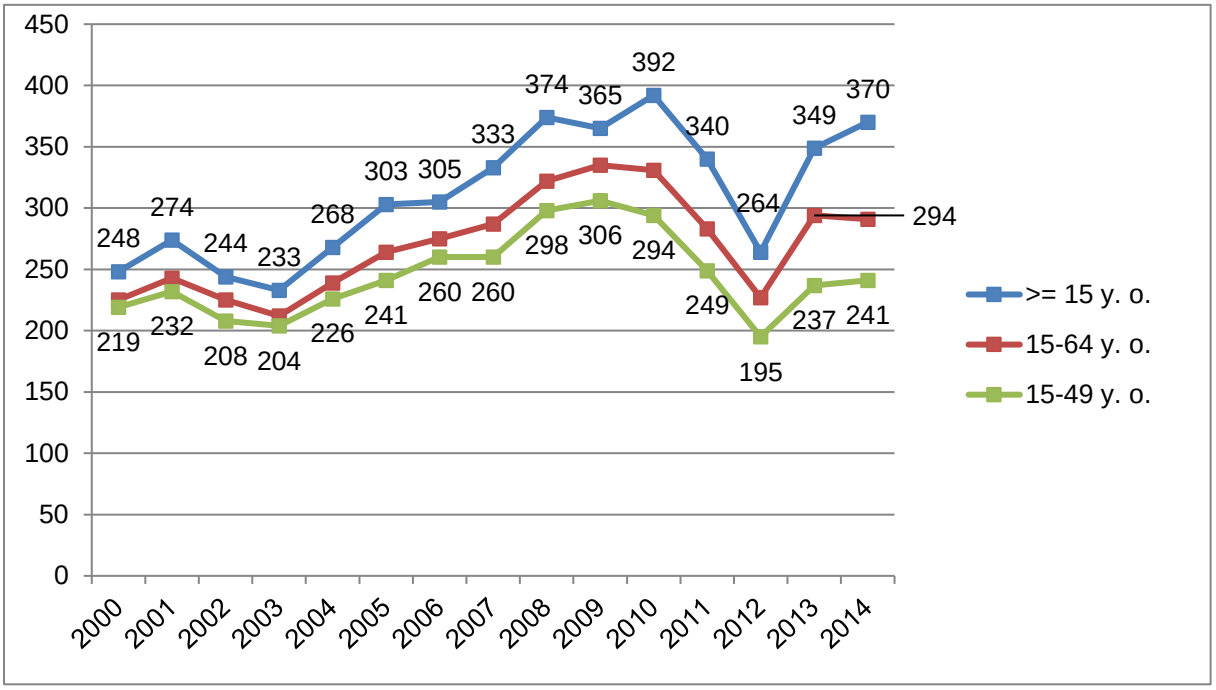
Drug-induced deaths

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 below). However, this reduction was to be interpreted with caution as changes in the coding regulations were introduced in 2011[1] and verification of deaths assigned code X42 for initial cause improved in 2012. 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), followed by stable levels among under 49s in 2014.

The fluctuations observed in recent years are partly related to the proportion of "false-positive" cases (morphine overdose death in a palliative care or cancer context) varying from one year to another (estimated at 19% in 2012, 27% in 2013 and 29% in 2014).

[1] Codes F10.0 to F19.0 (acute intoxication occurring in the context of mental and behavioural disorders related 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.

Figure: Overdose deaths due to narcotic and opioid medication use in France (1985-2014)



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

Toxicology of drug-related deaths

Between 2010 and 2015, opioid substitution medications were the main substances implicated in overdose deaths ahead of heroin. The numbers of deaths related to these two substances show contrasting variations. Hence, as observed in 2015, the role of heroin increases as that of opioid substitution medications decreases. The rise in the proportions of heroin-related deaths between 2012 and 2015 (15% and 30% of deaths, respectively) should be considered alongside the increase in heroin purity (from 7% in 2012 to 15% in 2014, then 11% in 2015).
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). The first cases of illegal NPS-related death were reported in 2013.

The variations in the number of deaths collected from one year to the next are difficult to interpret as the volunteer-based system is not exhaustive.

Table: Breakdown of drug-related deaths by substance(s) involved, alone or in combination**, from 2010 to 2015*

	2010		2011		2012		2013		2014		2015	
	n	%	n	%	n	%	n	%	n	%	n	%
Opioid substitution medications	130	53	160	57	187	60	153	54	134	55	140	41
- of which methadone	88	36	121	43	140	45	112	39	108	44	105	31
- of which buprenorphine	44	18	40	14	47	15	45	16	28	12	36	10
Other opioid medications (non-OST)	23	9	39	14	36	12	33	12	23	9	31	9
Heroin	82	33	54	19	47	15	57	20	62	26	103	30
Cocaine	25	10	30	11	36	12	25	9	33	14	44	13
Other illegal substances	8	3	16	6	31	10	47	16	32	13	74	22
- of which cannabis	na	na	7	3	15	5	31	11	19	8	36	10
- of which amphetamines and MDMA/ecstasy	7	3	9	3	15	5	14	5	9	4	27	8
- of which illegal NPS	na	na	na	na	na	na	1	na	5	2	15	4
Others (psychoactive medicines, etc.)	6	2	8	2	9	3	43	15	36	15	55	16
TOTAL	247		280		310		285		243		343	
Number of participating toxicological experts	31		36		41		32		38		45	

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).

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.

*T1.1.5 **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)

The annual survey on analgesia-poisoning deaths (APD) conducted by the CEIP-A and ANSM collects cases of deaths related to analgesic medication use. This survey listed 82 analgesia-related deaths (excluding deaths involving salicylic acid and paracetamol). The medications in question were tramadol (34% of deaths), morphine (32% of deaths), codeine (27%), oxycodone (10%), fentanyl (5%), dihydrocodeine (2%) and pregabalin (1%). Mean age at the time of death was 43 years, with an equal number of men and women.

T1.2 Drug related acute emergencies

The purpose of this section is to

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

Please structure your answers around the following questions.

T.1.2.1 Is information on drug-related acute emergencies available in your country?
If yes, please complete section T6.1 (Sources and methodology) and provide in T6.1 the definition of drug-related acute emergencies used and, if available, an overview of the monitoring system in place.
(Suggested title: Drug-related acute emergencies)

Drug-related acute emergencies

Data on hospital emergency presentations related to drug use were obtained from the Oscour® network (*Santé Publique France*) and the emergency room at the *Lariboisière* hospital in Paris, taking part in the Euroden project.

T.1.2.2 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. Please feel free to add tables in this section (as most countries already do). This might facilitate the reading.
Where appropriate please provide links to the original reports and studies.
(Suggested title: Toxicology of drug-related acute emergencies)

Toxicology of drug-related acute emergencies

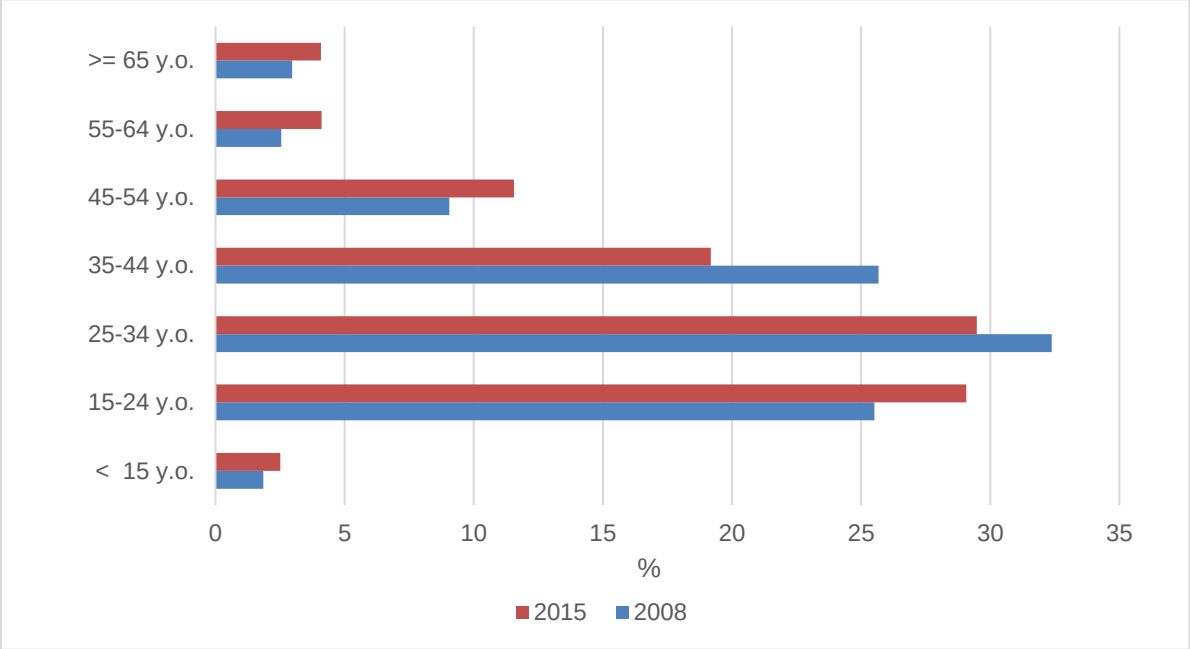
In 2015, the Oscour® network, which covers 86% of hospital emergency presentations in France, listed 9,765 acute emergencies related to drug use. 72% of individuals visiting emergency rooms for this reason were male, and 28% were female. Mean age was 34 years, with men being slightly younger than women (33 years vs. 36 years). A quarter of presentations were related to cannabis use and a quarter to opioid use, whereas cocaine was implicated in 7% of cases, other stimulants in 4% of cases, hallucinogens in 5% of cases and, lastly, multiple or unspecified substances were responsible in 35% of cases. The severity score upon arrival in the emergency room was low in three-quarters of cases, moderate in 18% of cases, high in 3% of cases, 2 individuals had died, and 4% of individuals had consulted for psychiatric reasons. Further to the emergency presentation, 35% of individuals were admitted to hospital, and 65% returned home.

The Paris sentinel site (emergency room at the *Lariboisière* hospital) taking part in the Euro-Den project listed 454 hospital emergency presentations due to acute drug intoxication between October 2013 and September 2014. The most frequently reported drugs were cannabis (21%), cocaine (18%), crack (9%), diazepam (9%) and bromazepam (7%). Only one substance was involved in 53% of cases, two in 29% of cases and three or more in 18% of cases. Combined alcohol use was observed in 45% of cases. Median age was 34 years, and 60% were male (Euro-DEN 2015). The Paris site reported 286 presentations between October 2014 and September 2015 (Euro-DEN Research Group and EMCDDA 2016).

T.1.2.3 Trends: Please comment on the possible explanations of short term (5 years) and long term trends in the number and nature of drug-induced emergencies, including any relevant information on changes in specific sub-groups. For example, changes in demography, in prevalence and patterns of drug use, in policy and methodology.

From 2008 to 2015, hospital emergency presentations related to drug use increased by 25% according to data from the Oscour® network based on a constant number of establishments. Although mean age has remained stable since 2008, distribution by age group has changed. The proportion of younger individuals (under 24) and older individuals (over 45) has increased, whereas the proportion of 25-44 year-olds has decreased.
The increase in the proportion of 15-24 year-olds is related to the rise in 15-17 year-olds, from 4% to 7%.

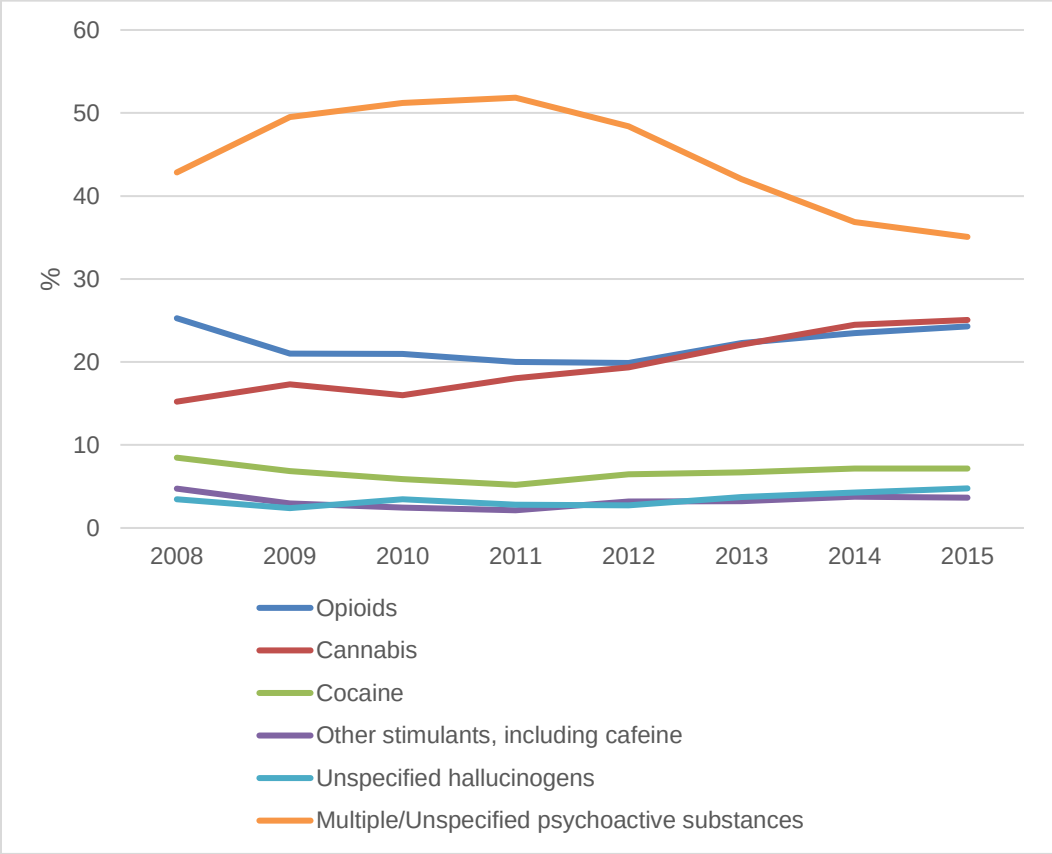
Figure. Distribution of hospital emergency presentations related to drug use by age group in 2008 and 2015.



Source : Oscour® network. Santé Publique France. Processed by the OFDT.

The substances implicated in hospital emergency presentations were not stated in a large proportion of cases, and fluctuated over the years (ranging from 35 to 52% of presentations), hence the changes in the distribution of the substances should be viewed with caution. The most apparent change concerns cannabis, more and more frequently implicated in emergency presentations, ahead of opioids since 2014.

Figure. Trends in the distribution of the substances implicated in hospital emergency presentations related to drug use from 2008 to 2015



Source: Oscour® network. Santé publique France. Processed by the OFDT.

T.1.2.4 ***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, bacterial infections, hepatitis A

Please structure your answers around the following questions.

T.1.3.1 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.
(Suggested title: Main drug-related infectious diseases among drug users – HIV, HBV, HCV)

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).

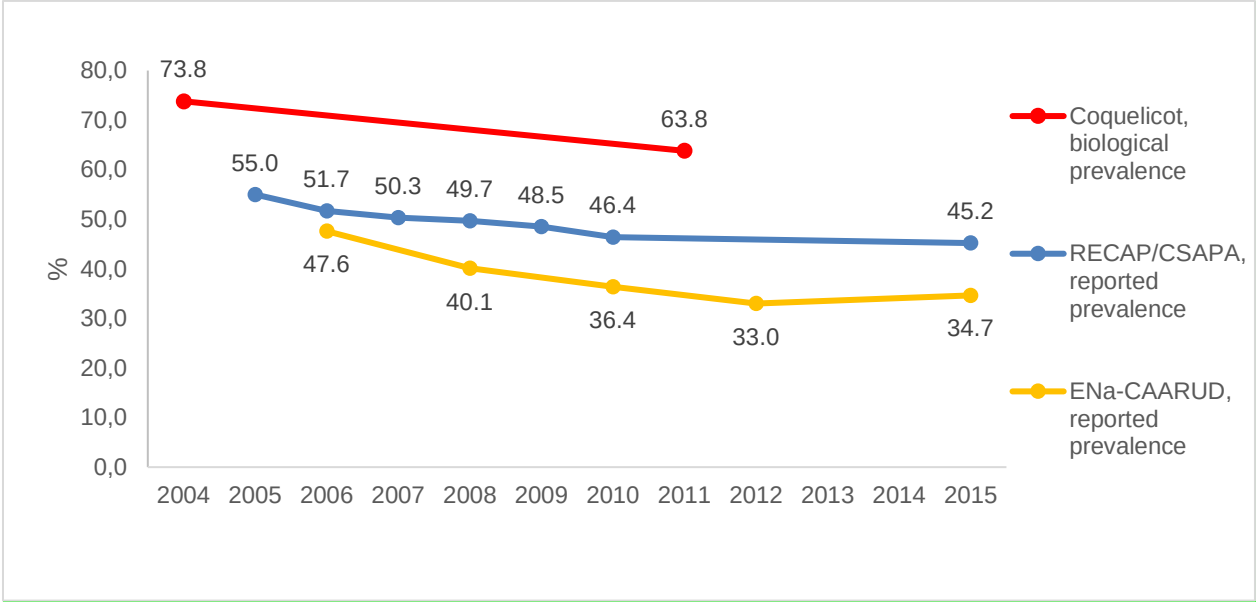
Among the 647 male drug users (injecting and/or snorting at least once in their lives) surveyed in Paris between 2011 and 2013 as part of the Coquelicot study, 15 were AgHB carriers, indicating chronic hepatitis B virus infection, which corresponds to a seroprevalence of 2.1% (Sauvage *et al.* 2015).

Reported data
The ENa-CAARUD survey, which was conducted for the fifth time in 2015, questioned 3,129 users seen over the course of a given week in CAARUDs. In 2015, the majority of drug users reported to have carried out a screening test on at least one occasion (89.7% for HIV -stable compared to 2012- and 83.2% for HCV - on the decline compared to 2012).
Among drug users having injected at least once in their lives and having carried out a test, 4,5 % declared to be HIV seropositive and 33 % HCV seropositive in 2015, a stable figure compared to 2012 (Lermenier-Jeannet *et al.* 2017).
These reported data are likely to underestimate these prevalences, especially for HCV.
In CSAPAs, the reported prevalence (among lifetime injecting drug user) corresponds to 7.1% for HIV and 45.2% for HCV, according to the RECAP system.

Trends

Prevalence and incidence 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 49.7 % in 2008 to 46.4 % in 2010, stable at nearly 8% for HIV) and the ENa-CAARUD survey (from 40.1% in 2008 to 33.0% in 2012, stable at 6.2% in 2012 *versus* 7.7% in 2008 for HIV) (Cadet-Taïrou *et al.* 2015). Between 2012 and 2015, the reported prevalence remained stable, both for HIV and HCV, both in the CAARUD and CSAPA context. This stability highlights the end of the declining prevalence of HCV among IDU observed since the beginning of the 2000s.
The incidence of HCV among drug users was estimated based on a mathematical model linking prevalence and incidence. The incidence of HCV fell from 7.9/100 person-years (95% CI 6.4-9.4) in 2004 to 4.4/100 person-years in 2011 (95% CI 3.3-5.9). Among active IDU, this incidence increases two-fold, and fell from 15.4/100 person-years in 2004 (95% CI 11.9-19.3) to 11.2/100 person-years in 2011 (95% CI 9.0-19.0) (Léon *et al.* 2017).

Figure. Trends in HCV prevalence among injecting drug users



Sources:

ANRS-Coquelicot/InVS: biological prevalence, lifetime IDU

RECAP/OFDT: reported prevalence, lifetime IDU attending CSAPAs

ENa-CAARUD/OFDT: reported prevalence, lifetime IDU attending CAARUDs

IDU: injecting drug users

CAARUD: low-threshold structures treating drug users

CSAPA: specialised drug treatment centres for drug users

T.1.3.2 ***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. (Suggested title: Notifications of drug-related infectious diseases)

Notifications of drug-related infectious diseases

In 2015, 88 injecting drug users (IDU) were newly diagnosed as being HIV seropositive (95%CI [58-117], i.e. 1.5% of all new diagnoses. This concerned males in 86% of cases, with a median age of 38 years. More than half (55%) were born abroad, almost exclusively in Europe (Santé publique France 2017). In 2013, the proportion of HCV co-infection reached 79% (Cazein *et al.* 2015).
The number of new AIDS cases among IDUs was estimated at 72 in 2015, i.e. 6.0% of all cases. Lastly, 29 AIDS deaths occurred among IDUs, i.e. 18.8% of all AIDS deaths.

The causes of death among HIV seropositive IDU who died in 2010 were divided between liver disorders (24.3%), non-viral hepatitis-related and non-AIDS-defining cancer (21.2%), cardiovascular disorders (13.2%), AIDS (10.1%), infections (9%) and other causes (22.2%). AIDS continued to be the leading cause of death among seropositive foreign heterosexuals (43%) and male homosexuals (33%) who died in 2010 (2010 ANRS-EN20-Mortality survey) (Lert *et al.* 2016).

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).

Trends

The annual number of new seropositive diagnoses among IDU has remained stable since 2008 following a major decline from 2003 (when mandatory notification of HIV was introduced) to 2008.

The number of new AIDS cases has remained stable since 2014. 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 and even weaker until 2014. 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.

T.1.3.3 ***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)

Prevalence data of drug-related infectious diseases outside the routine monitoring

A study conducted in Paris and in the Île-de-France region between 2011 and 2013 shows that Russian-speaking drug users treated in CAARUDs, who represent a third of new outpatient admissions in some of these facilities, have a particularly high seroprevalence of hepatitis C (nearly 9 out of 10 users), and more widespread injecting practices and opioid use than among the French-speaking population (Jauffret-Roustide *et al.* 2017).

T1.3.4 ***Optional*** *Please comment on available behavioural data (e.g. sharing, slamming…) Where appropriate please provide links to the original studies.*
(Suggested title: Drug-related infectious diseases - behavioural data)

Drug-related infectious diseases - behavioural data

Among IDU, ancillary equipment and needle sharing appeared to increase between 2012 and 2015. Among recent injecting drug users visiting the CAARUDs in 2015, 14% claimed to have shared their syringe in the past month compared to 8.3% in 2012, one in four shared at least one ancillary equipment item compared to 1 in 5 three years previously (table below), higher among women compared to men, regardless of the type of equipment (Lermenier-Jeannet *et al.* 2017). Moreover, in 2012 7.6% of CAARUD clients who had been incarcerated that year stated that they had injected, 38.4% stated that they had snorted and 1.4% stated that they had shared a “syringe” (since there are no syringe exchange programmes in prison, other objects, such as pens, can be used to inject) during their imprisonment (Cadet-Taïrou *et al.* 2015).

Table: Prevalence of injection materials shared among CAARUD clients who had injected in the last 30 days, in 2015

	Men N = 1,182	Women N = 293	Total N = 1,475
Syringes	14.4%	16.1%	14.7%
Water for preparation	18.6%	28.6%	20.5%
Water for rinsing	9.7%	17.1%	11.2%
Spoons, containers	18.6%	39.2%	20.4%
Cotton/Filters	14.9%	22.2%	16.3%
Injecting paraphernalia (except syringes and needles)	22.84%	32.42%	24.75%
At least one item (including syringes and needles)	24.53%	34.13%	26.44%

Source: ENa-CAARUD 2015 (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)

T1.3.6 ***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)

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 2014 and 2015, 22,600 patients received treatment with direct-acting antivirals (DAA), and 20,300 patients were cured (Vaux *et al.* 2017).
DAA have been 100% reimbursed by the National Health Insurance Fund since August 2016, for individuals at high risk of virus transmission: drug users who share equipment, inmates, women planning a pregnancy [Instruction DGOS/PF2/DGS/SP2/PP2/DSS/1C n°2016-246 du 28 juillet 2016 relative à l'organisation de la prise en charge de l'hépatite C par les nouveaux anti-viraux d'action directe (NAAD)]. Previously, only individuals with severe chronic hepatitis (fibrosis score ≥2) and/or co-infected with HIV were covered by the National Health Insurance Fund for DAA.

T1.4 Other drug-related health harms

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

Please structure your answers around the following question.

T.1.4.1 ***Optional****. Please provide additional information on other drug-related health harms including co-morbidity. (Suggested title: Other drug-related health harms)*

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

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

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

T1.5 Harm reduction interventions

The purpose of this section is to

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

Please structure your answers around the following questions.

T1.5.1 Please summarise the main harm reduction-related objectives of your national drug strategy or other relevant policy documents (cross-reference with the Policy workbook). Include public health policies, strategies or guidelines relevant to the prevention and control of health-related harms, such as infectious diseases among PWID (e.g. HIV and hepatitis action plans or national strategies), and national strategies regarding the prevention of drug-related deaths. Trends: Please comment on current trends regarding these policies.
(Suggested title: Drug policy and main harm reduction objectives)

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 – seeT.1.5.3).

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. This report was updated in 2016 (Dhumeaux *et al.* 2016). On the occasion of the National Hepatitis B and C Awareness Day on 25 May 2016, the French Minister of Social Affairs and Health committed to opening up universal access to innovative treatments for hepatitis C (Ministère des affaires sociales et de la santé 2016). 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].

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. In 2017, the HAS (National authority for health) reassessed the screening strategy for HIV in France. It recommends that screening for HIV infection be prioritised in key populations, including IDU. It thus recommends stepping up screening frequency annually among IDU (HAS 2017).

T1.5.2 Please describe the structure of harm reduction service organisation in your country, including funding sources. Describe the geographical coverage. 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. Trends: Please comment on trends regarding harm reduction service organisation.
(Suggested title: Organisation and funding of 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 provided through low-threshold agencies and drug treatment facilities on access and scale of provision and the scale of provision, including interventions reported to the EMCDDA in SQ23/ST10. Please structure your answer to include services targeting at preventing drug-related emergencies and deaths and drug related infectious diseases. If available, address.

a) Emergency response training (settings, target groups) and naloxone distribution;
b) Supervised drug consumption facilities;
c) Post-release / transition management from prison to community provided by drugs facilities;
d) Injecting equipment and drug use paraphernalia (including non-injecting: foil, pipes, straws);
e) Integrated mental health and/or medical care service provision at drugs facilities:
- Vaccination
- Testing
- Infectious diseases treatment and care
- Mental health assessment.

f) O*ptional. Interventions to prevent initiation of injecting; to change route of administration of drugs; safer sex counselling, condom promotion among PWID, prevention of STIs*

Harm reduction services
The prevention measures used in France are of various types.

a) Naloxone distribution programme

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 reserved for pharmacists in charge of dispensing within hospital pharmacies and hospital CSAPA (ANSM and Indivior France 2016). Since May 2017, the dispensing of naloxone kits is also authorised in CAARUD. Marketing authorisation for Nalscue® (0.9 mg/0.1 ml naloxone) was granted in July 2017.

As of 25 April 2017, 258 physicians had registered with the cohort ATU scheme (91 of whom had included at least 1 patient), 236 dispensing pharmacists or physicians had registered, 676 patients had been included, and 479 Nalscue® kits had been distributed. Over the period concerned, two patients and five third parties were treated with Nalscue® with a favourable outcome for all 7 patients. No adverse reactions were reported (ANSM and INDIVOR UK Ltd 2017).

b) Drug consumption rooms

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]. This article 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.

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.

The Paris drug consumption room (DCR), run by the Gaïa association [Arrêté du 25 mars 2016 portant désignation du centre Gaia], has been open since 14 October 2016, 7 days a week, from 13:30 to 20:30, and has twelve injecting spaces and four inhalation spaces. At least five workers are present at the same time (including a doctor or nurse) in addition to security staff. In the first eight months of operation, the DCR recorded 31,400 visits, including 670 visits by different people. The number of users visiting appears to be stabilising around 200 visits per day (vs. 65 on the first day of opening). Visitors to the room comprise nearly 90% males, with a median age of 37.8 years, 40% with no resources, 52% in precarious accommodation or homeless, 48% are treated by an addiction specialist, 27% do not receive any medical or social care, 45% are HCV positive (40% of whom have never sought medical advice) and 5% are HIV positive. The two most widely used substances are Skénan® (morphine sulphate), injected during 43% of visits, and crack also used during 43% of visits (by injection in a third of cases). Four overdoses have occurred, all with a favourable outcome. The room offers medical or nursing appointments (509 appointments have taken place for 220 different users), social counselling (610 appointments attended by 188 different users) and screening for HIV, HCV and HBV. Fifty rapid diagnostic tests (RDT) for HIV (3 of which were positive), 41 RDT for HCV (5 of which were positive), 17 blotting paper tests (10 of which were positive for HCV RNA and 1 for hepatitis B) and 26 Fibroscan® exams (a non-invasive machine that can instantly detect liver fibrosis and assess its degree of advancement) were performed. Lastly, 2 patients completed treatment for hepatitis C. The room regularly organises open-door events in the mornings for the general public, with an information and mediation role (Avril 2017).

The second "Argos" DCR run by the Ithaque association [Arrêté du 25 mars 2016 portant désignation du centre Ithaque] opened in Strasbourg on 7 November 2016. It is open from 13:00 to 19:00, 7 days a week. As of 31 January 2017, the room had recorded 519 visits since it first opened, with 60 different users, 65% of whom were male. Cocaine is the leading substance used (50%) ahead of Skenan® (32%) and heroin (14%).

c) Harm reduction measures on release from prison

The terms of release for inmates with addiction problems are laid down in the interministerial memo of 9 August 2001 [Note interministérielle MILDT/DGS/DHOS/DAP n°474 relative à l'amélioration de la prise en charge sanitaire et sociale des personnes détenues présentant une dépendance aux produits licites ou illicites ou ayant une consommation abusive] and Annex 1 thereto (Specifications). External health and social treatment liaisons have been introduced for continued health and social guidance upon release (accommodation, treatment, social protection) with a view to social and professional reintegration. In cases where release cannot be anticipated (notably for defendants), information support provided by external liaisons is planned at the time of release. Since 2011, a reference CSAPA has been appointed for each prison offering support for these individuals, particularly upon release from prison (see "Prison" Workbook for more information). It should be pointed out that newly released inmates are identified by the health authorities as a priority beneficiary of the naloxone distribution programme (see above "Naloxone distribution programme").
In 2012 the Methodological guide on the health care of detainees (Ministère de la justice and Ministère des affaires sociales et de la santé 2012) reiterates the current principles of the treatment offered to inmates and persons in detention and the legal framework of the prison harm reduction scheme (see WB Prison part T1.3.2).

d) Distributing and recovering sterile, single-use equipment

Since 1987, syringes have been on unrestricted sale in community pharmacies (without a prescription). Injection kits (Stéribox) are also sold in pharmacies (since 1994) and distributed via automatic distribution machines (since 1995) to allow the most marginalised drug users to have access to syringes. Syringes and injection kits are also distributed by CAARUDs (since 2006) and CSAPAs (since 2008). The supply of equipment also extends to injection equipment distributed as part of the postal HR programme, launched in 2011.

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.

In total, approximately 11.3 million syringes are estimated to have been distributed or sold to drug users in France, for all schemes combined, according to the 4 distribution channels below.

d.1) Distribution of sterile single-use prevention material by the CAARUD and CSAPA

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).

Specifically regarding the equipment distribution methods via the CAARUDs, eight out of ten syringes were directly supplied by the teams in contact with drug users (5.5 million syringes) and 6% via automatic distribution machines managed by these organisations (i.e. over 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).

Tableau : 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 breath 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)

Since 2008 [Circulaire DGS/MC2 n°2008-79 du 28 février 2008 relative à la mise en place des CSAPA], CSAPAs must implement risk reduction measures for the public they take care of. In 2014, the CSAPA network distributed approximately 400,000 syringes.

d.2) Distribution of syringes via automatic distribution machines (outside of the CAARUD/CSAPA network)

Organisations specialising in addiction medicine are not alone in distributing prevention material via automatic distribution machines. Other structures such as non-CAARUD / CSAPA 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 2015, more than 600,000 syringes were distributed via automatic distribution machines outside the CAARUD/CSAPA network (Duplessy 2015). The distribution of prevention material via this method aims to guarantee anonymity and 24-hour access to resources.

In 2016, the total number of automatic distribution machines (CAARUD/CSAPA network and other operators) reached almost 300 operational automatic distribution machines for prevention kits in approximately half of French administrative 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 (2016 directory of automatic distribution machines, Safe association data).

[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.

d.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 2016, slightly more than 270,000 syringes were dispatched, compared to nearly 250,000 syringes in 2015. Slightly over a thousand users have benefited from the programme since it was introduced in 2011. The number of new outpatient admissions has been constantly rising since the programme was launched: from forty or so individuals in 2011, to over 600 beneficiaries in 2016. The main reasons for users turning to this scheme include: remote geographical location, inconvenient HR scheme opening hours, need for specific equipment not available in CAARUDs or CSAPAs, the desire for anonymity, difficulties experienced by users in discussing their opioid substitution medication injecting practices, …(De Postis 2013; Duplessy and Pourchon 2015).

d.4) Sale of syringes in pharmacies

In 2016, slightly less than 3.4 million syringes were distributed in pharmacies (in the form of *Stériboxes*®) compared to 4.5 million in 2011, i.e. a 25% drop in sales in 5 years.

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.

e) Health care delivery in CSAPA and CAARUD

e.1) Encouragement to undergo vaccination against HBV

The hepatitis B vaccine is provided free of charge by CeGIDD (free information, screening and diagnosis centre) and CSAPAs. This vaccine is 65% reimbursed by the National Health Insurance Fund (Assurance maladie) as part of a general care system.

e.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)]. 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® exams (a non-invasive machine that can instantly detect liver fibrosis and assess its degree of advancement) 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, 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]. Lastly, screening via RDT may be carried out on minors.

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 2016a).

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.

e.3) Medical appointments

A number of CSAPAs offer psychiatric clinics and advanced clinics in the field of liver disease (to assess hepatitis C, and introduce treatment and follow-up).

f) 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*. Compared with drug users who injected for the first time prior to 1995, users who injected for the first time between 2006 and 2010 experimented with miscellaneous drugs before the first injection. At the time of their first injection they were older (21 year-olds vs 18 for users who injected for the first time prior to 1987) and most often injected alone, without the help or presence of another individual. The injected substance was most often heroin (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).

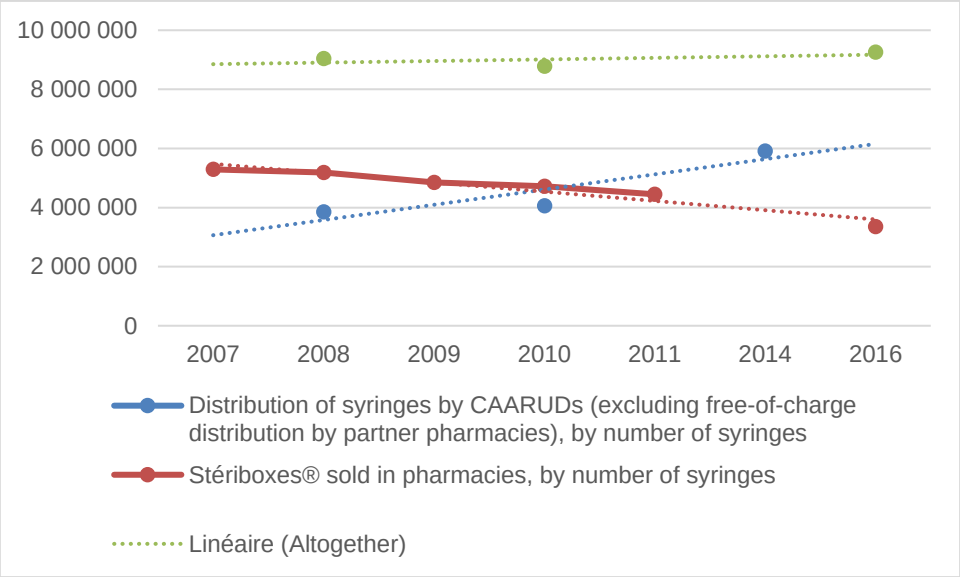
g) Support and education on injection-related harm

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 (Debrus 2013), 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.

T1.5.4 Trends: Please comment on current trends regarding harm reduction service provision. (Suggested title: Harm reduction services: availability, access and trends)
Trends: Syringe trends: Please comment on the possible explanations of short term (5 years) and long term trends in the numbers of syringes distributed to injecting drug users, including any relevant information on changes in specific sub-groups, and changes in route of administration.

In France, the two main channels for the distribution of syringes correspond to community pharmacies and CAARUDs. Together, these distribute 90% of syringes made available to injecting drug users. These two aggregate data sources for a given year appear to reflect the relative stability in the changes between 2008 and 2016 in the total volume of syringes distributed by pharmacies and CAARUDs. The decline in pharmacy syringe sales is offset by the increase in the number of syringes distributed in CAARUD.

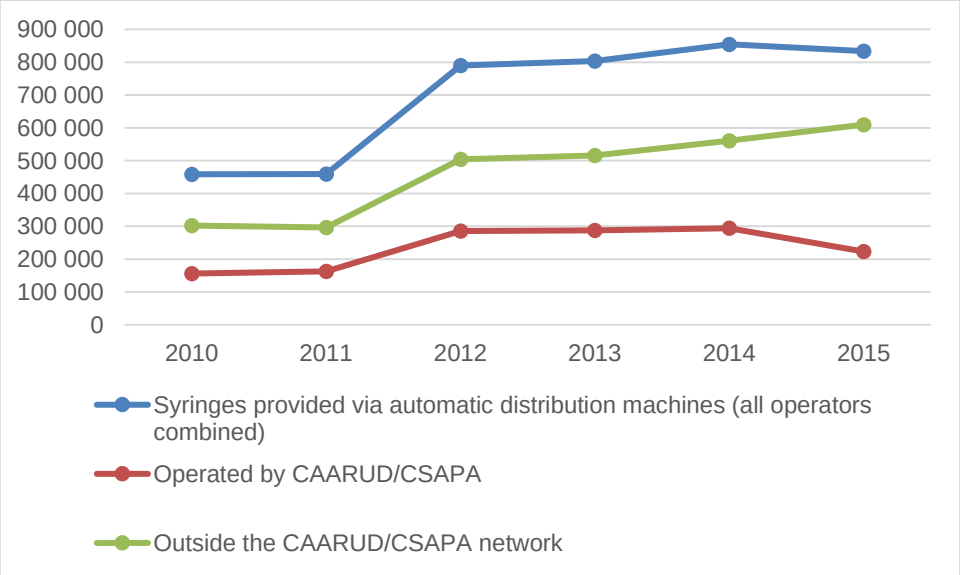
Trends in the distribution of syringes in France



Source: GERS and ASA-Caarud data, processed by the OFDT

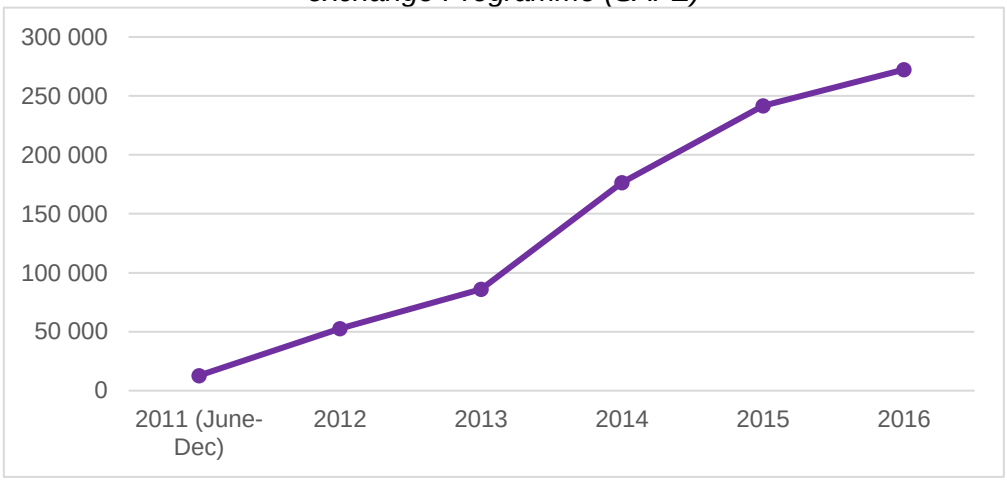
However, these trends should be interpreted with caution, owing to the numerous gaps in data over the period studied. Based on these aggregated data, the distribution of syringes in CAARUDs is assumed to have remained constant in 2016 relative to 2014. Distribution by CSAPAs accounts for 4% of the total volume; however, these figures are only available for 2014. Nonetheless, CSAPAs have been required to dispense HR equipment since 2008. The series of data on dispensing by automatic distribution machines and postal Needle and Syringe exchange Programme (NSP) run by the SAFE association, accompanying the national supply scheme for HR equipment, are complete.

Automatic distribution machines



As regards these other two sources, the supply of syringes via automatic distribution machines has remained relatively stable since 2008, and the postal NSP has increased spectacularly since it was first introduced (variation of approximately +400% between 2012 and 2016); however, these distribution channels only represent 4% and 2% of the total volume, respectively.

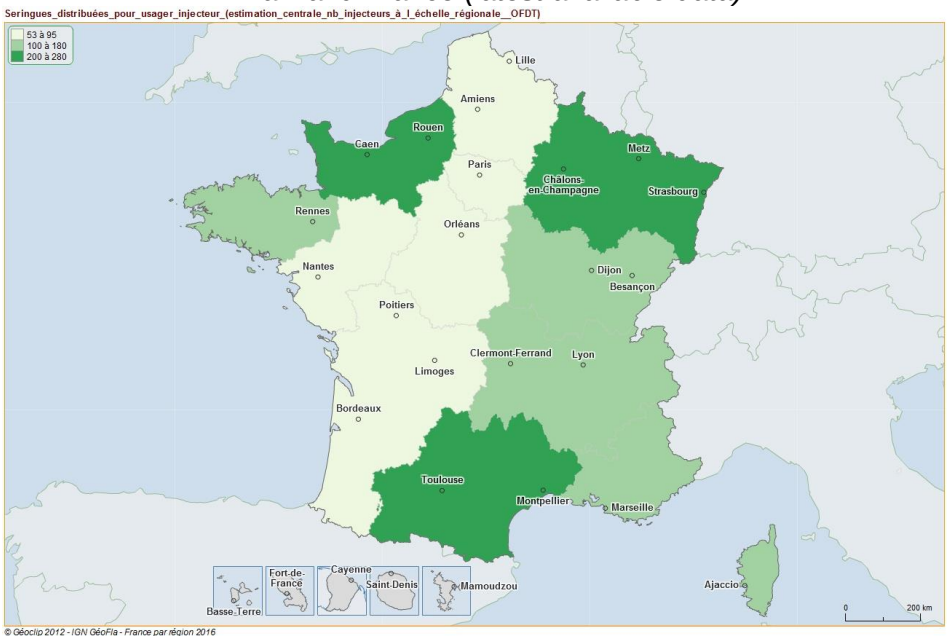
Distribution of syringes as part of the postal Needle and Syringe exchange Programme (SAFE)



The available data thus point to a slight increase; however, the total volume of syringes distributed in France still appears to be insufficient to guarantee good syringe coverage for injecting drug users (threshold for good coverage > 200 syringes per injecting drug user). Note that, in 2014, the OFDT estimated the number of past-year injecting drug users at 105,000 and the number of past-month injecting drug users at 85,000. Compared with the estimates put forward for 2006, the prevalence of past-month injecting practices remains stable, while prevalence in France remains below the average European levels (Costes 2009; Janssen 2016; Janssen 2017). Hence, it may be estimated that approximately 110 syringes were distributed per injecting drug user in 2016.

Taking into account the latest estimates on the prevalence of injecting practices in the past year, only a minority of regions in mainland France (Grand Est, Normandy and Occitanie) are observed to be above the threshold of 200 syringes per injecting drug user (see map below).

Regional distribution of the number of syringes distributed per injecting drug user in mainland France (latest available data)



Source: OFDT

T1.5.5 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)

T1.5.6 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, primary health care system/GPs, or other sites and facilities providing testing of infectious diseases to significant number of people who use drugs, or drugs/outreach activities not covered above).
(Suggested title: Additional information on harm reduction activities)

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

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

Please structure your answers around the following question.

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

T1.7 Quality assurance of harm reduction services

The purpose of this section is to provide information on quality system and any national harm reduction standards and guidelines.
Note: cross-reference with the Best Practice Workbook.

Please structure your answers around the following question.

T.1.7.1 ***Optional****. Please provide an overview of the main harm reduction quality assurance standards, guidelines and targets within your country.*
(Suggested title: Quality assurance for harm reduction services)

Assurance qualité pour les structures de réduction des risques

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 triallin (see T.1.5.3).

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).

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 2016b). 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 2016a). 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.

T.1.7.2 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)

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

T3. New developments

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

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

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

Please structure your answers around the following questions.

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

An additional medical section on death certificates was introduced in April 2017 [Décret n°2017-602 du 21 avril 2017 relatif au certificat de décès]. This is used for stating the causes of death when known several days after death, and after the administrative and medical sections of the death certificate have been sent to the competent organisations and institutions. This additional medical section is completed by the physician who carries out the medical or scientific inquiry into the causes of death or judicial post-mortem, and is exclusively submitted in electronic format. Causes of death which are often not stated on the death certificate in the event of a forensic investigation could be determined in the future, and the underestimation of overdose deaths could then decrease.

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 *Haute Autorité de Santé* (the French national authority for health) recommended extending the scope of reimbursement for direct-acting antiviral medications in the treatment of hepatitis C to all patients infected with HCV, including asymptomatic carriers in fibrosis stage F0 or F1 (not included in the previous guidelines) in December 2017 (HAS 2016b).

The French Association for the Study of the Liver updated its guidelines on the treatment of hepatitis C virus in March 2017 (AFEF 2017).
The Ministry of Health renegotiated the price reduction for hepatitis C treatments with the Gilead pharmaceutical company, and the new prices came into force in April 2017 [Arrêté du 31 mars 2017 relatif aux conditions de prise en charge de spécialités pharmaceutiques].

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

Two drug consumption rooms (DCR) opened in autumn 2016 in Paris and Strasbourg (see T.1.5.3).

T4. Additional information

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

Please structure your answers around the following questions.

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

The national health alert system related to the use of psychoactive substances brings together the DGS, Santé Publique France, ANSM, ANSES, OFDT and MILDECA. It aims to organise information sharing between the different stakeholders and bodies concerned, and to improve the management of unusual events related to psychoactive substances, liable to result in health alerts being issued and then managed.

In July 2016, several cases of severe poisoning requiring hospitalisation were reported in Seine-Saint-Denis, concerning patients who regularly snorted cocaine. The disorders observed consisted of agitation combined with hallucinations. Tests conducted on blood samples and on the powder sample collected from the patient revealed the presence of cocaine and scopolamine. Scopolamine was detected in the analysed sample at a concentration of 15.2%. This concentration is considered high. Cocaine hydrochloride was detected at a concentration of 23.2% (relatively low concentration compared with the average concentrations measured during customs and police seizures, and on collections as part of the SINTES monitoring scheme the same year). A press release was issued by the Bobigny Public Prosecutor (Seine-Saint-Denis) and this information was diffused via numerous channels: press, radio and internet.

In September 2016, analysis of a sample collected via the SINTES scheme identified fentanyl in a sample sold as heroin in the Rhône-Alpes region. In addition, the social and medical emergency call centre unit in the region reported an increase in the number of fatal and non-fatal cases of poisoning among heroin users. The presence of substances containing fentanyl or fentanyloids was suspected, and there was a local communication drive to alert users to the risks related to use of these substances. However, no analyses of powder or biological samples were able to confirm the presence of these agents in the samples collected.

Furthermore, according to different sources (police, TREND/SINTES network, Monitoring network for serious adverse effects, private analysis laboratories, scientific publications, etc.), 13 non-fatal cases of poisoning were reported in 2016, including 3 confirmed by laboratory tests, involving 3-MMC used in the context of chemsex, 5-MeO-MIPT taken for alpha-PVP, and x-fluoroamphetamine (the isomer was not determined). Cases of poisoning in which the implicated agent(s) could not be confirmed by analysis of the biological samples but identified either by user declarations or analysis of the substance itself involved the use of alpha-PVP, alpha-PVP blended with alpha-PHP, alpha-PHP only, metafluorofentanyl, AB-FUBINACA, 5F-AKB-48 blended with 5F-PB22, AM-2201 blended with XLR-111 and used with cannabis, GBL and twice with 25I-NBOMe.
Lastly, two cases of driving under the influence of narcotic substances were reported by the police, in which analyses of blood samples were able to identify 3-MMC in one case and 4-MEC in the other.

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. Sources and methodology

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

Please structure your answers around the following questions.

T.5.1 Please list notable sources (including references to reports and grey literature) for the information provided above. (Suggested title: Sources.)
DRD: Please describe the monitoring system to complement ST5/ST6 (clarify source GMR, SR, other; coverage; ICD coding; underestimation; underreporting and other limitations).
Emergencies: please provide the case definition for reporting drug-related emergencies and, if applicable, an overview of the monitoring system in place and important contextual information, such as geographical coverage of data, type of setting, case-inclusion criteria and data source (study or record extraction methodology).
DRID: Please describe the national surveillance approach for monitoring infectious diseases among PWID. Please describe the methodology of your routine monitoring system for the prevalence of infectious diseases among PWID as well as studies out of the routine monitoring system (ad-hoc). Be sure that in your description you include all necessary information for the correct interpretation of the reported data, i.e.: clarify current sources, ad-hoc and/or regular studies and routine monitoring, settings, methodology of major studies. Representativeness and limitations of the results.
Harm Reduction: Please describe national or local harm reduction monitoring approaches and data flow, incl. syringe monitoring.

Sources

Drug-related deaths (DRD)

In France, there are currently three sources that list fatal overdoses:

1. 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 [accessed 22/08/2017]). 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).

   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).

2. 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.

   DRAMES: Drug and Substance Abuse-related Deaths
   Network of the Regional Abuse and Dependence Monitoring Centres (CEIP-A) and 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.
   Forty-five experts performed toxicological analyses within a forensic scope in the 2015 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.

3. **APD: Analgesia-poisoning deaths**
   Network of the Regional Abuse and Dependence Monitoring Centres (CEIP-A)
   National Agency for Medicines and Health Products Safety (ANSM)
   Introduced in 2013, this survey aims to collect cases of death related to analgesic drug use, to identify the medications involved, evaluate their hazards and estimate changes in the number of deaths. This survey is based on the prospective collection of cases of analgesia-related deaths, reported by expert toxicologists carrying out toxicology analyses requested by the courts to investigate causes of death. For these cases to be included, death must be attributed to one of the following substances: acetylsalicylic acid, buprenorphine, codeine, dextropropoxyphene, dihydrocodeine, fentanyl, hydromorphone, ketamine, morphine, nalbuphine, nefopam, oxycodone, paracetamol, pethidine, pregabalin or tramadol. Deaths occurring in a context of substance abuse and drug addiction are excluded, and

those occurring in the context of suicide are included, in contrast to the DRAMES survey.
Twenty-one toxicological experts performed forensic analyses for the 2015 edition of the survey. Cases included in the APD survey (excluding those involving salicylic acid and paracetamol) combined with DRAMES cases correspond to EMCDDA selection B deaths.

The number of AIDS deaths related to intravenous drug use can be estimated using the national HIV/AIDS monitoring database coordinated by *Santé publique France*.

Drug use-related hospital emergency presentations (Emergencies)

Oscour® network: Coordinated hospital emergency presentation monitoring network
Santé publique France (SPF)

After its creation in 2004, the hospital emergency network has gradually expanded. In 2015, 632 out of the 770 existing emergency units were part of the monitoring network, thus covering 86% of hospital emergency presentations in France. There is at least one emergency room in the OSCOUR® network for each French region. Coverage varies according to different regions.
Data collection is based on the direct extraction, without generating extra work for emergency room professionals, of anonymous information, taken from the patient's electronic medical record compiled during their visit to the emergency room. Sociodemographic (gender, age, department of abode), administrative and medical (main diagnosis, associated diagnoses, degree of severity, patient's destination after visiting the emergency room) variables are thus collected.
The OFDT analysed data from 2008 to 2015 on drug-related poisoning for the purposes of surveillance and annual monitoring.
Presentations to the emergency room in connection with drug use-related poisoning cover main diagnoses with EMCDDA selection B ICD codes (F11, F12, F14, F15, F16, F19, X41*, X42**, X44***, X61*, X62**, X64***, Y11*, Y12**, Y14***.

* in combination with codes T43.6
** in combination with codes T40.0-9
*** in combination with codes T43.6 or T40.0-9) and codes T40 and T43.6.

Euro-DEN and Euro-DEN plus: European Drug Emergencies Network

Euro-DEN was developed in 2013 at 16 sentinel sites located in 11 European countries. This project was initially funded by the European Commission Department for Justice. The network then expanded to 20 sentinel sites in 14 countries and is now known as Euro-DEN plus. It is currently funded by EMCDDA. In France, the emergency room of the Lariboisière hospital in Paris has been a part of this network since 2013.
The network of sentinel sites automatically collect data on harm (acute toxicity) associated with drug use.
The cases included comprise presentations to an emergency room for symptoms and/or signs of acute intoxication induced by illegal or recreational drug use, NPS or misuse of medications procured with or without a prescription. ER presentations due to alcohol poisoning only are excluded.
The data collected include demographic characteristics (age, gender, date and time of the presentation to the emergency room, date and time of the hospital discharge, place of abode), and information on the substance taken, together with the place and time of use. Lastly, data on clinical examination, type of treatment received, the patient's destination after the ER presentation and, where appropriate, death in hospital are collected.

Harm reduction

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 at local level. No data are available from 2012 to 2015, but only from 2016.

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

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.

HIV/AIDS Monitoring System

Santé publique France (SPF)

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 *Santé publique France*.

Acute Hepatitis B Monitoring System

Santé publique France (SPF)

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.

Bibliography

AFEF (2017). Recommandations AFEF sur la prise en charge de l'hépatite virale C. AFEF (Association française pour l'étude du foie), Paris. Available: http://www.afef.asso.fr/ckfinder/userfiles/files/recommandations-textes-officiels/recommandations/RecommandationsAFEFMars2017.pdf [accessed 27/10/2017].

AFR and DGS (2012). Réduction des risques en milieux festifs. Référentiel national des interventions. Association française pour la réduction des risques (AFR), Paris. Available: http://a-f-r.org/referentiel-national-des-interventions-de-rdr-en-milieux-festifs-2/ [accessed 27/10/2017].

ANSM (2015). Compte rendu de la séance n°21 du 26 novembre 2015. Commission évaluation initiale du rapport entre les bénéfices et les risques des produits de santé. Agence nationale de sécurité du médicament et des produits de santé, Saint-Denis. Available: http://ansm.sante.fr/var/ansm_site/storage/original/application/3547b9b460e4ad0571cbae84e8fc19c5.pdf [accessed 27/10/2017].

ANSM (2016). Retour sur la séance du 14 avril 2016 de la Commission des stupéfiants et psychotropes. ANSM (Agence Nationale de Sécurité du Médicament et des produits de santé), Saint-Denis. Available: http://ansm.sante.fr/L-ANSM2/Commissions-consultatives/Commission-des-stupefiants-et-des-psychotropes/(offset)/3 [accessed 27/10/2017].

ANSM and Indivior France (2016). Autorisation temportaire d'utilisation de cohorte. Protocole d'utilisation thérapeutique et de recueil d'informations. Nalscue 0,9 mg/0,1ml solution pour pulvérisation nasale en récipient unidose (Chlorhydrate de naloxone). Available: http://ansm.sante.fr/var/ansm_site/storage/original/application/2b98cf8dc3a0f7c4f815c1dd8c5f56a1.pdf [accessed 27/10/2017].

ANSM and INDIVOR UK Ltd (2017). Autorisation temporaire d'utilisation de cohorte. Résumé du rapport de synthèse périodique n° 9. Nalscue 0,9 mg/0,1 ml, solution pour pulvérisation nasale en récipient unidose. Période du 26/03/2017au 25/04/2017. Available: http://ansm.sante.fr/var/ansm_site/storage/original/application/cfd88acd61d6ff0c5a9a79601674a874.pdf [accessed 27/10/2017].

Avril, E. (2017) Espace GAIA, first DCR in Paris since October 2016: first results and perspectives *Drug-related infectious diseases expert meeting, 15 June 2017.* Lisbon, EMCDDA.

Balteau, S., Bonnet, N., Creyemey, A., Debrus, M., Fournier, V., Guichard, A. *et al.* (2014). Change le programme. Aider les injecteurs à gérer les demandes d'initiation à l'injection et les risques associés. Ressources pour préparer l'intervention. Ministère des affaires sociales, de la santé et des droits de femmes ; INPES, Paris.

Brouard, C., Pioche, C., Léon, L., Lot, F., Pillonel, J. and Larsen, C. (2016). Incidence et modes de transmission de l'hépatite B aiguë diagnostiquée en France, 2012-2014 [Incidence and routes of transmission of acute hepatitis B diagnosed in France, 2012-2014]. BEH - Bulletin Épidémiologique Hebdomadaire (13-14) 237-243.

Cadet-Taïrou, A. and Brisacier, A.-C. (2013). Responses to drug-related health correlates and consequences (chapter 7). In: Pousset, M. (Ed.), 2013 National report (2012 data) to the EMCDDA by the Reitox National Focal Point France. New development, trends and in-depth information on selected issues. OFDT, Saint-Denis.

Cadet-Taïrou, A., Saïd, S. and Martinez, M. (2015). Profils et pratiques des usagers des CAARUD en 2012 [CAARUD client profiles and practices in 2012]. Tendances. OFDT (98).

Cazein, F., Pillonel, J., Le Strat, Y., Pinget, R., Le Vu, S., Brunet, S. *et al.* (2015). Découvertes de séropositivité VIH et de sida, France, 2003-2013 [New HIV and AIDS diagnoses, France, 2003-2013]. BEH - Bulletin Épidémiologique Hebdomadaire (9-10) 152-161.

CEIP-A and ANSM (2017). DRAMES (Décès en relation avec l'abus de médicaments et de substances). Principaux résultats de l'enquête 2015. Agence nationale de sécurité du médicament et des produits de santé (ANSM), Saint-Denis. Available: http://ansm.sante.fr/var/ansm_site/storage/original/application/01c99bad61b61c11e17ed6c81cb86eb4.pdf [accessed 27/10/2017].

Costes, J.-M. (2009). Prévalence de l'usage problématique de drogues en France : estimations 2006. Tendances. OFDT (69).

De Postis, R. (2013). Safe, le programme d'échange de seringues postal : un vrai besoin. Le Courrier des Addictions 15 (4) 22-25.

Debrus, M. (2013). L'éducation aux risques liés à l'injection de drogues. Quels enseignements retenir après un an d'expérience ? VST - Vie Sociale et Traitements (118) 7-14.

DGS (2009). Plan national de lutte contre les hépatites B et C 2009-2012. Ministère de la santé et des sports, Paris. Available: http://solidarites-sante.gouv.fr/soins-et-maladies/maladies/maladies-infectieuses/article/programmes-et-plans-nationaux-de-lutte-contre-l-hepatite-b-et-c [accessed 27/10/2017].

Dhumeaux, D., ANRS and Association française pour l'étude du foie (AFEF) (2014). Prise en charge des personnes infectées par le virus de l'hépatite B ou de l'hépatite C. Rapport de recommandations 2014. EDP Sciences, Les Ulis. Available: http://www.afef.asso.fr/ckfinder/userfiles/files/actualites/INTERIEUR-CV.pdf [accessed 27/10/2017].

Dhumeaux, D., Ministère des affaires sociales et de la santé, ANRS, Conseil national du sida et des hépatites virales (CNS) and Association française pour l'étude du foie (AFEF) (2016). Prise en charge thérapeutique et suivi de l'ensemble des personnes infectées par le virus de l'hépatite C. Rapport de recommandations 2016. EDP Sciences. Available: http://social-sante.gouv.fr/IMG/pdf/rapport_.pdf [accessed 27/10/2017].

Díaz Gómez, C. and Milhet, M. (2016). Les CAARUD en 2014. Couverture, publics et matériels de RdRD distribués [Overview of CAARUDs in 2014. Coverage, populations and harm reduction supplies distributed]. Tendances. OFDT (113).

DREES (2015). Prévalence du VIH et du VHC chez les usagers de drogues fréquentant les structures de prise en charge et de réduction des risques. L'état de santé de la

population en France. DREES (Direction de la recherche des études de l'évaluation et des statistiques), Paris.

Duplessy, C. (2015). Rapport d'activité 2014. Association SAFE, Paris.

Duplessy, C. and Pourchon, F. (2015). Bilan de 3 ans d'expérimentation de la réduction des risques à distance (2011-2014). Association SAFE, Paris.

Euro-DEN (2015). Rapport final du projet Euro-DEN (Réseau européen des situations d'urgence associées aux drogues). Available: www.emcdda.europa.eu/attachements.cfm/att_250377_EN_Euro-DEN%20Final%20report%202015%20French.pdf [accessed 27/10/2017].

Euro-DEN Research Group and EMCDDA (2016). Hospital emergency presentations and acute drug toxicity in Europe. Update from the Euro-DEN Plus research group and the EMCDDA. Publications Office of the European Union, Luxembourg.

Fédération Addiction (2015). Agir en réduction des risques en CSAPA et en CAARUD. Rapport d'enquête. Fédération Addiction, Paris. Available: https://www.federationaddiction.fr/reduction-des-risques-parution-du-rapport-denquete/ [accessed 27/10/2017].

Fédération Française d'Addictologie (2016a). 1ère Audition publique 2.0 "La réduction des risques et des dommages liés aux conduites addictives". Rapport d'orientation et recommandations de la Commission d'audition. Fédération française d'Addictologie, Paris. Available: http://www.addictologie.org/dist/telecharges/FFA2016_RapportOrientation&Recos.pdf [accessed 27/10/2017].

Fédération Française d'Addictologie (2016b). 1ère Audition publique 2.0 "La réduction des risques et des dommages liés aux conduites addictives". Livret de l'Audition publique (programme et rapports des Experts et du Groupe bibliographique). Fédération Française d'Addictologie, Paris. Available: http://www.addictologie.org/dist/telecharges/FFA2016_Audition-Livret.pdf [accessed 27/10/2016].

Fournier, V., Michaud, P., Michels, D. and Whalen, M. (2014). Change le programme. Aider les injecteurs à gérer les demandes d'initiation à l'injection et les risques associés. Guide de l'intervention. Ministère des affaires sociales, de la santé et des droits des femmes ; INPES, Paris.

Guichard, A. (2012). Adaptation du programme *Break the cycle* au contexte français. Protocole. INPES, Saint-Denis.

Guichard, A., Guignard, R., Michels, D., Beck, F., Arwidson, P., Lert, F. *et al.* (2013). Changing patterns of first injection across key periods of the French Harm Reduction Policy: PrimInject, a cross sectional analysis. Drug and Alcohol Dependence 133 (1) 254-261.

HAS (2014). Place des tests rapides d'orientation diagnostique (TROD) dans la stratégie de dépistage de l'hépatite C. Recommandation en santé publique. Haute Autorité de santé, Saint-Denis. Available: http://www.has-sante.fr/portail/upload/docs/application/pdf/2014-05/place_des_trod_dans_la_strategie_de_depistage_de_vhc-_rapport.pdf [accessed 27/10/2017].

HAS (2016a). Place des tests rapides d'orientation diagnostique (TROD) dans la stratégie de dépistage de l'hépatite B. Recommandation en santé publique. Haute Autorité de santé, Saint-Denis La Plaine. Available: http://www.has-sante.fr/portail/upload/docs/application/pdf/2016-07/recommandatin_place_des_tests_rapides_dorientation_diagnostique_trod_dans_la_strategie_de_depistage_de_lhepatite_b.pdf [accessed 27/10/2017].

HAS (2016b). Recommandation du collège. Prise en charge de l'hépatite C par les médicaments antiviraux d'action directe (AAD). Elargissement du périmètre de remboursement. Haute Autorité de santé, Saint-Denis La Plaine. Available: https://www.has-sante.fr/portail/upload/docs/application/pdf/2016-12/recommandation_college_hepatite_c.pdf [accessed 27/10/2017].

HAS (2017). Réévaluation de la stratégie de dépistage de l'infection par le VIH en France. Haute Autorité de santé, Saint-Denis La Plaine. Available: https://www.has-sante.fr/portail/upload/docs/application/pdf/2017-03/dir2/reevaluation_de_la_strategie_depistage_vih_-_recommandation.pdf [accessed 27/10/2017].

HCSP (2013). Evaluation du Plan national de lutte contre les hépatites B et C 2009-2012. Haut Conseil de la santé publique, Paris. Available: http://www.hcsp.fr/Explore.cgi/Telecharger?NomFichier=hcspr20130416_evaluationplanhepBC0912.pdf [accessed 27/10/2017].

HCSP (2016). Evaluation du Plan national de lutte contre le VIH-sida et les IST 2010-2014. Haut Conseil de la Santé Publique, Paris. Available: http://www.hcsp.fr/explore.cgi/avisrapportsdomaine?clefr=547 [accessed 27/10/2017].

Hesse, C. and Duhamel, G. (2014). Evaluation du dispositif médicosocial de prise en charge des conduites addictives. IGAS (Inspection Générale des Affaires Sociales), Paris. Available: http://www.ladocumentationfrancaise.fr/rapports-publics/144000578/index.shtml [accessed 27/10/2017].

Janssen, E. (2011). Drug-related deaths in France in 2007: Estimates and implications. Substance Use and Misuse 46 (12) 1495-1501.

Janssen, E. (2016). Usagers de drogues pratiquant l'injection intraveineuse. Estimation 2014 en France métropolitaine. Note 2016-04. OFDT, Saint-Denis.

Janssen, E. (2017) Estimating the number of people who inject drugs: a proposal to provide figures nationwide and its application to France. Journal of Public Health10.1093/pubmed/fdx059, 10.1093/pubmed/fdx059.

Jauffret-Roustide, M., Le Strat, Y., Couturier, E., Thierry, D., Rondy, M., Quaglia, M. *et al.* (2009). A national cross-sectional study among drug-users in France: epidemiology of HCV and highlight on practical and statistical aspects of the design. BMC Infectious diseases 9 (113) 1-12.

Jauffret-Roustide, M., Benoit, T. and Santos, A. (2013a). Evaluation des outils de réduction des risques liés à l'injection. Cermes3 (Inserm U988) and InVS.

Jauffret-Roustide, M., Pillonel, J., Weill-Barillet, L., Léon, L., Le Strat, Y., Brunet, S. *et al.* (2013b). Estimation de la séroprévalence du VIH et de l'hépatite C chez les usagers de drogues en France - Premiers résultats de l'enquête ANRS-Coquelicot 2011

[Estimation of HIV and hepatitis C prevalence among drug users in France - First results from the ANRS-Coquelicot 2011 Survey]. BEH - Bulletin Épidémiologique Hebdomadaire (39-40) 504-509.

Jauffret-Roustide, M., Serebroskhaya, D., Chollet, A., Barin, F., Pillonel, J., Sommen, C. *et al.* (2017). Comparaison des profils, pratiques et situation vis-à-vis de l'hépatite C des usagers de drogues russophones et francophones à Paris. Enquête ANRS-Coquelicot, 2011-2013 [Comparison of social profiles, practices and situation toward hepatitis C among Russian-speaking and French-speaking drug users in Paris, France. ANRS-Coquelicot Study, 2011-2013]. BEH - Bulletin Épidémiologique Hebdomadaire (14-15) 285-290.

Lapeyre-Mestre, M. and Boeuf-Cazou, O. (2011). Rôle du pharmacien dans la réduction des risques liés à la toxicomanie. Point de vue des patients sous médicaments de substitution aux opiacés (MSO) et des usagers de drogues. U1027 INSERM - Unité de Pharmacoépidémiologie de Toulouse - AFSSAPS-CEIP.

Le Naour, G., Hamant, C. and Chamard-Coquaz, N. (2014). Faire accepter les lieux de réduction des risques : un enjeu quotidien. Centre d'Etude et de Recherche sur les Pratiques et l'Espace, CERPE, Lyon. Available: http://halshs.archives-ouvertes.fr/halshs-00977418 [accessed 27/10/2017].

Léon, L., Kasereka, S., Barin, F., Larsen, C., Weill-Barillet, L., Pascal, X. *et al.* (2017). Age- and time-dependent prevalence and incidence of hepatitis C virus infection in drug users in France, 2004-2011: model-based estimation from two national cross-sectional serosurveys. Epidemiology and Infection 145 (5) 895-907.

Lermenier-Jeannet, A., Cadet-Taïrou, A. and Gautier, S. (2017). Profils et pratiques des usagers des CAARUD en 2015. Tendances. OFDT (120).

Lert, F., Paye, A., May, T., Tron, L., Salmon, D., Roussillon, C. *et al.* (2016). Caractéristiques sociales et comportementales des personnes séropositives pour le VIH décédées en 2010 en France métropolitaine : quelles implications pour la prise en charge ? [Social and behavioral characteristics of HIV-infected persons died in 2010, Metropolitan France: which implications for health care?]. BEH - Bulletin Épidémiologique Hebdomadaire (41-42) 749-754.

Lopez, D., Martineau, H. and Palle, C. (2004). Mortalité des personnes interpellées pour usage d'héroïne, de cocaïne ou de crack [Mortality of individuals arrested for heroin, cocaine or crack use]. Tendances. OFDT (36).

MILDT (2013). Government plan for combating drugs and addictive behaviours 2013-2017. MILDT, Paris. Available: http://www.drogues.gouv.fr/sites/drogues.gouv.fr/files/atoms/files/plan_gouvernemental_drogues_2013-2017_eng_df_0.pdf [accessed 27/10/2017].

Milhet, M. (2016). Évaluation de l'acceptabilité des kits EXPER' par les usagers de drogues. OFDT, Saint-Denis13/07/2017].

Ministère de la justice and Ministère des affaires sociales et de la santé (2012). Prise en charge sanitaire des personnes placées sous main de justice. Guide méthodologique. Ministère de la Justice, Ministère des affaires sociales et de la santé, Paris. Available: http://www.justice.gouv.fr/art_pix/Guide_Methodologique__Personnes_detenues_2012.pdf [accessed 27/10/2017].

Ministère de la santé et des sports (2010). Plan national de lutte contre le VIH/SIDA et les IST 2010-2014. Ministère de la santé et des sports, Paris. Available: http://www.sante.gouv.fr/IMG/pdf/plan_national_lutte_contre_le_VIH-SIDA_et_les_IST_2010-2014.pdf [accessed 27/10/2017].

Ministère des affaires sociales et de la santé (2016). Marisol TOURAINE s'engage pour un accès universel aux traitements innovants contre l'hépatite C. Communiqué de presse du 25 mai 2016 [online]. Available: http://solidarites-sante.gouv.fr/IMG/pdf/250516_-_cp_-_hepatite_c.pdf [accessed 27/10/2017].

Palle, C. and Vaissade, L. (2007). Premiers résultats nationaux de l'enquête RECAP. Les personnes prises en charge dans les CSST et les CCAA en 2005 [The initial national results of the RECAP survey. Persons treated in the CSSTs and CCAAs in 2005]. Tendances. OFDT (54).

Pioche, C., Pelat, C., Larsen, C., Desenclos, J.-C., Jauffret-Roustide, M., Lot, F. *et al.* (2016). Estimation de la prévalence de l'hépatite C en population générale, France métropolitaine, 2011 [Estimation of hepatitis C prevalence in the general population, metropolitan France, 2011]. BEH - Bulletin Épidémiologique Hebdomadaire (13-14) 224-229.

Reynaud-Maurupt, C. (2013). Intervention précoce et réduction des risques et des dommages : usage de cocaïne basée, crack, free-base. Guide de prévention destiné aux professionnels. AIRDDS Bretagne, Rennes.

Roux, P., Le Gall, J.-M., Debrus, M., Protopopescu, C., Ndiaye, K., Demoulin, B. *et al.* (2016a). Innovative community-based educational face-to-face intervention to reduce HIV, hepatitis C virus and other blood-borne infectious risks in difficult-to-reach people who inject drugs: results from the ANRS-AERLI intervention study. Addiction 111 (1) 94-106.

Roux, P., Rojas Castro, D., Ndiaye, K., Debrus, M., Protopopescu, C., Le Gall, J.-M. *et al.* (2016b). Increased uptake of HCV testing through a community-based educational intervention in difficult-to-reach people who inject drugs: Results from the ANRS-AERLI Study. PLoS One 11 (6) e0157062.

Santé publique France (2017). Découvertes de séropositivité VIH et de sida en 2015. Point épidémiologique. Santé publique France, Saint-Maurice. Available: http://invs.santepubliquefrance.fr/Dossiers-thematiques/Maladies-infectieuses/VIH-sida-IST/Infection-a-VIH-et-sida/Actualites/Decouvertes-de-seropositivite-VIH-et-de-sida.-Point-epidemiologique-du-23-mars-2017 [accessed 27/10/2017].

Sauvage, C., Pascal, X., Weill-Barillet, L., Molinier, M., Pillonel, J., Leon, L. *et al.* (2015). Prévalence de l'antigène HBs dans deux populations exposées : les usagers de drogues (ANRS-Coquelicot 2011-2013) et les hommes ayant des relations sexuelles avec des hommes (Prevagay 2009) à Paris, France [Prevalence of Hepatitis B surface antigen in two exposed populations: drug users (ANRS-Coquelicot 2011-2013) and men who have sex with men (Prevagay 2009) in Paris, France]. BEH - Bulletin Épidémiologique Hebdomadaire (19-20) 353-359.

Vaux, S., Pioche, C., Brouard, C., Pillonel, J., Bousquet, V., Fonteneau, L. *et al.* (2017). Surveillance des hépatites B et C. Santé publique France, Saint-Maurice. Available: http://invs.santepubliquefrance.fr/Publications-et-outils/Rapports-et-syntheses/Maladies-infectieuses/2017/Surveillance-des-hepatites-B-et-C [accessed 27/10/2017].

T.5.2 Where studies or surveys have been used please list them and where appropriate describe the methodology. (Suggested title: Methodology.)

Methodology

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 Santé Publique France (SPF)

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

ENa-CAARUD: National survey of low-threshold structures (CAARUD)
French Monitoring Centre for Drugs and Drug Addiction (OFDT)

Conducted every two or three 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 2015 survey was conducted from 14 to 27 September: 3,129 individuals completed the questionnaire and were included in the analysis. Out of the 167 CAARUDs registered in France, 143 took part in the survey (i.e. 86%). The data collection rate (proportion of users for whom the questionnaire was completed relative to all users encountered during the survey in the CAARUDs having taken part in the survey) was 64% in 2015.

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 2016, approximately 173,000 patients seen in 251 outpatient CSAPAs, 10 residential treatment centres and 5 prison based CSAPAs for an addiction-related issue (alcohol, illicit drugs, psychoactive medicines, behavioural addiction) were included in the survey.