2018

Harms and harm reduction workbook

France

2018 National report (2017 data) to the EMCDDA by the French Reitox National Focal Point

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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 2015 amounted to 236 among 15-49-year-olds (373 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), 406 overdose deaths were registered in 2016 with opiates implicated in 83% of cases. Opioid substitution medications were implicated in 46% of cases, heroin in 26% of cases and cocaine in 18% 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 2015 compared to 2013 and 2014. Between 2010 and 2016, opioid substitution medications were the main substances implicated in overdose deaths, ahead of heroin. Cocaine involvement is on the rise in deaths related to drug use since2014.

Nearly 12,000 hospital emergency presentations related to drug use were reported in France in 2015 (Oscour® network). More than a quarter of presentations were related to cannabis use and less than a quarter to opioid use, whereas cocaine was implicated in 7% of cases, other stimulants in 3% of cases, hallucinogens in 4% of cases and, lastly, multiple or unspecified substances were responsible in 36% of cases.

In 2016, people infected through intravenous drug use represented 1% of new cases of HIV infection. The number of HIV seropositive diagnoses associated with drug use remained stable since 2008, 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 is steadily declining since 2003.

Furthermore, between 2012 and 2016, 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 1.4% among drug users surveyed in the Coquelicot survey 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 and HCV treatment. Another major objective of HR measures is to promote drug user access to treatment and social benefits (accommodation, training, employment, etc.), particularly for the most destitute and socially isolated individuals.

Approximately 11.9 million syringes were distributed or sold to drug users in France in 2015. Pharmacy syringe sales in the form of injection kits, which represent a third of syringes distributed to drug users in 2015, 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 2015 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. The 2018-2022 national action plan on addiction makes provision for the creation of other facilities to cater for unmet needs, including in Paris.

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. 60,000 patients suffering from chronic hepatitis C were treated and cured by direct-acting antivirals (DAA) between 2014 and March 2018. During 2017, reimbursement of DAA (100% reimbursed by the National Health Insurance Fund) was extended to all adults with chronic hepatitis C irrespective of fibrosis stage.

As regards the implementation of a naloxone distribution programme (antidote to opioid overdose) in France, a proprietary medicinal product containing naloxone for nasal use (Nalscue®) obtained a marketing authorisation for use in July 2017. It has been available since January 2018. Priority users are newly released inmates together with users after opioid withdrawal. From August 2016 to December 2017, during the temporary cohort authorisation (which ended in January 2018), just over 1,000 naloxone kits were distributed to drug users.

A new death certificate, as well as an additional medical section, came into force in January 2018. The additional medical section 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.

As regards viral hepatitis, the priorities of the prevention policy include significant measures aiming to eliminate hepatitis C by 2025 in France; furthermore, infant immunisation against hepatitis B has been compulsory since January 2018. In order to achieve this objective, 3 key measures are being implemented: greater access to treatment for hepatitis C via new prescribers by encouraging city-hospital networks; increasing local screening via rapid diagnostic tests (RDT) as part of a combined approach for HIV, HCV and HBV, and improving prevention via innovative outreach actions aimed at priority populations far removed from the health system. As regards HIV-AIDS, the national sexual health strategy aims to eradicate the AIDS epidemic by 2030.

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

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)

Décès par surdose

In 2015, 373 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 (78%) 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. In 2015, these deaths account for 21% 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 236 deaths in this age group in 2015.

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)

Toxicologie des décès par surdose

The DRAMES scheme provides information on the substances implicated (alone or in combination) in deaths related to psychoactive substance abuse (CEIP-A Grenoble 2018). In 2016, opioids were implicated in 83% of the deaths reported in the DRAMES survey. Opioid substitution medications account for 46% of deaths: methadone is involved in 36% of deaths and buprenorphine in 10% of cases. Other opioid drugs (especially morphine) are involved in 14% of deaths, heroin in 26% and cocaine in 18% of fatal overdoses. The percentage of deaths involving cannabis was 7% (only deaths for which a cardiovascular pathology has been identified), versus 5% for amphetamines and MDMA and 3% for NPS. In 34% of deaths, several substances were involved.
Fourteen deaths were directly caused by new psychoactive substances; these involved the following molecules: mexedrone, 5-APDB, ocfentanil, diclazepam, deschloroetizolam (all 5 implicated for the first time in 2016) as well as 3-MMC, 4-MEC, mephedrone, butylone, 5-APB, 3F-phenmetrazine, methoxyphenidine.

In 2016, the first deaths related to ketamine were seen (2 cases).

85% of overdose deaths registered in DRAMES occurred in men. Mean age at the time of death was 38.9 years (38.0 for women and 39.1 for men) in 2016; this mean age increased 4.6 years since 2011.

The national health alert system related to the use of psychoactive substances brings together the National health directorate (DGS), *Santé Publique France* (the Public Health Agency), ANSM (the National Agency for Medicines and Health Products Safety), ANSES (the Agency for Food, Environmental and Occupational Health & Safety), 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.

This scheme listed 8 deaths in 2017 reported by various sources (police, TREND/SINTES network, dependence monitoring/serious adverse effects, private analysis laboratories, scientific publications, etc.), including 6 related to NPS use. In 2 cases of death, cathinones, alone or in combination, were used in a sexual context (chemsex): 3-MMC and 4-MEC were identified in a collected sample and in blood samples, respectively. Both users had also inhaled poppers and ingested medications for erectile dysfunction, sildenafil in one case and alprostadil in the other. Two other deaths were related to synthetic opioid use, carfentanil and ocfentanyl. Lastly, one death occurred further to injection of methoxetamine and another following intake of a line of 25x-NBOMe by a young girl who thought she was taking cocaine. As regards the two deaths involving "conventional" substances, the products implicated were codeine medications. One case may have been a suicide.

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 all deaths that occurred between 2010 and 2015. They are broken down as follows:

- 35.6% ill-defined causes: 19 causes unknown, 3 sudden deaths, 4 cases of cardiorespiratory arrest;
- 34.3% external causes: 13 cases of accidental drug poisoning or self-induced drug poisoning (3 of which involved methadone, 1 case of heroin poisoning, 1 case involving opioids without precision and 8 other cases where 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), 2 road traffic accidents, 1 suicide, 1 drowning, 1 case of multiple trauma due to a workplace accident and 1 homicide;
- 30.1% of causes related to disease: 7 cases of lung cancer, 2 cases of ENT cancer, 1 case of liver cancer, 1 ovarian cancer, 3 cases of gastrointestinal bleeding, 1 case of hepatitis C, 1 infectious acute respiratory disease, 1 case of asthma, 1 sleep apnea syndrome, 2 cases of ischaemic cardiomyopathy, 1 endocarditis, 1 case of dementia.

Deaths from unclear causes can correspond to some deaths resulting in forensic investigations (post-mortem examination and/or toxicology analyses) to find the causes of death, at the request of the prosecutor or judge, the final conclusions of which have not been communicated to the general mortality register (INSERM-CépiDc).

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]) (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

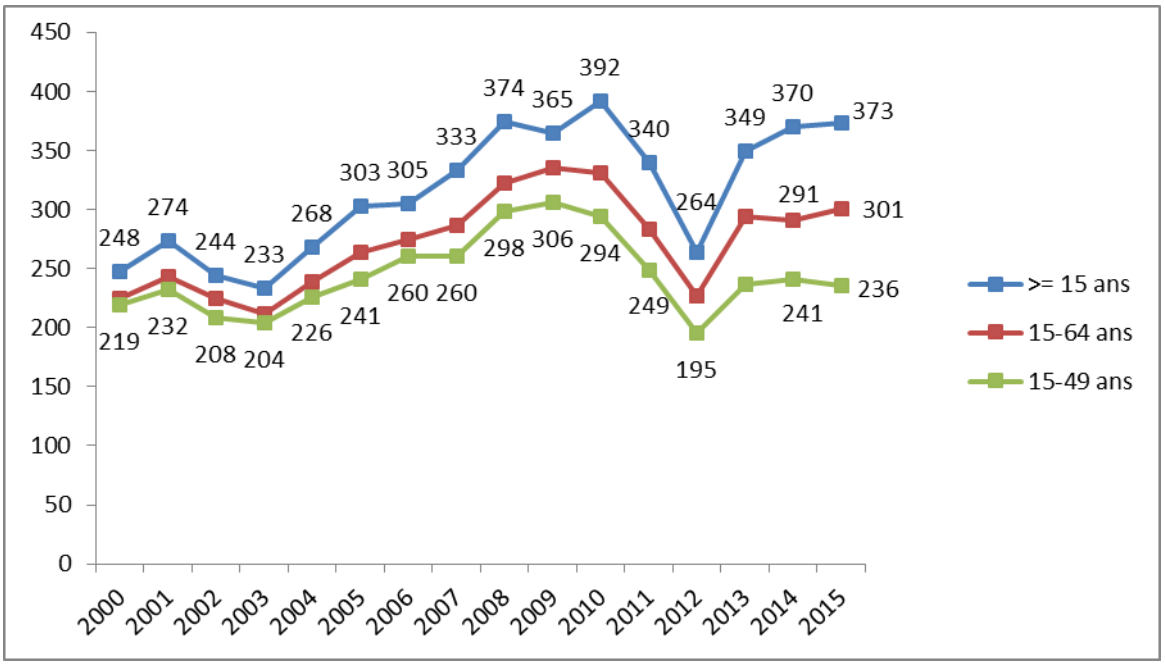
Drug-induced deaths

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 is 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 and 2015.

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 and deaths of drug users not related to an overdose) varying from one year to another (estimated at 19% in 2012, 27% in 2013, 29% in 2014 and 32% in 2015).

[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 since 2011.

Figure. Overdose deaths due to narcotic and opioid medication use in France (2000-2015)



Source: INSERM-CépiDc, processed by the OFDT
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 2016, 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 2016, the role of heroin decreases as that of opioid substitution medications increases. 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 measured in samples seized by police and *Gendarmerie* (from 7% in 2012 to 16% in 2015, then 15% in 2016) (Néfau 2017). In 2012, opioid substitution medications were implicated in the largest proportion of deaths (60%), while heroin was the least involved (15 %). Cocaine (regardless of its form, chlorhydrate or base) is implicated in 9% to 18% 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 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 2016

	2010		2011		2012		2013		2014		2015		2016	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Opioid substitution medications	130	**53**	160	**57**	187	**60**	153	**54**	134	**55**	140	**41**	188	**46**
- of which methadone	88	**36**	121	**43**	140	**45**	112	**39**	108	**44**	105	**31**	148	**36**
- of which buprenorphine	44	**18**	40	**14**	47	**15**	45	**16**	28	**12**	36	**10**	42	**10**

Other opioid medications (non-OST)	23	**9**	39	**14**	36	**12**	33	**12**	23	**9**	31	**9**	58	**14**
Heroin	82	**33**	54	**19**	47	**15**	57	**20**	62	**26**	103	**30**	106	**26**
Cocaine	25	**10**	30	**11**	36	**12**	25	**9**	33	**14**	44	**13**	75	**18**
Other illegal substances	8	**3**	16	**6**	31	**10**	47	**16**	32	**13**	74	**22**	64	**16**
- of which cannabis	na	**na**	7	**3**	15	**5**	31	**11**	19	**8**	36	**10**	30	**7**
- of which amphetamines and MDMA/ecstasy	7	**3**	9	**3**	15	**5**	14	**5**	9	**4**	27	**8**	22	**5**
- of which NPS							1		5	**2**	15	**4**	14	**3**
Others (psychoactive medicines, etc.)	6	**2**	8	**2**	9	**3**	43	**15**	36	**15**	55	**16**	63	**16**
TOTAL	247		280		310		285		243		343		406	
Number of participating toxicological experts	31		36		41		32		38		45		48	

Source: DRAMES (Network of the Regional Abuse and Dependence Monitoring Centres - CEIP-A and 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 (known as the DTA survey) conducted by the CEIP-A and ANSM collects cases of deaths related to analgesic medication use (CEIP-A 2018). A death cannot be listed in both DRAMES and DTA. Deaths occurring in a context of substance abuse and drug addiction are excluded from DTA (and included in DRAMES), and those occurring in the context of suicide are included in DTA (and excluded from the DRAMES survey).

This DTA survey listed 84 analgesia-related deaths (excluding deaths involving salicylic acid and paracetamol). The medications in question were tramadol (44% of deaths), morphine (26% of deaths), codeine (19%), oxycodone (10%), and le fentanyl (5 %). Buprenorphine, dihydrocodeine, dextropropoxyphene, ketamine and pregabalin are each involved in one death. Mean age at the time of death was 49 years (versus 43 years in 2015), 54% of deaths occurred in men.

The *Société française de toxicologie analytique* (SFTA) (French Analytical Toxicology Society) has issued guidelines for toxicology analyses in deaths involving NPS (SFTA 2018).
In 2016, 30 out of the 32 forensic institutes in France were asked about their death certification practices. Two institutes claimed that they never drew up death certificates. The other 28 institutes routinely draw up an initial death certificate when no initial death certificate exists. However, when a death certificate already exists, discrepancies in certification practices were observed: 13 institutes do not draw up a second certificate; 11 draw up a second certificate in exceptional circumstances (incorrect information, body initially unidentified) and 4 institutes routinely draw up a second certificate (CépiDC-Inserm and Santé publique France 2018).

A study conducted by CépiDc evaluated the variability in the transmission of death certificates in the event of suspect deaths over the period 2000-2013 by studying the declaration of a post-mortem examination, together with the time-space correlation between the unknown causes and other suspected causes. France is one of three European countries with the highest proportion of deaths from unknown cause (5.7%), whereas the rate of violent death (16.5%) is close to the median European value (16.0%) (Richaud-Eyraud *et al.* 2018).

T1.2 Drug related acute emergencies

The purpose of this section is to

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

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.

Toxicology of drug-related acute emergencies

In 2015, the Oscour® network (coordinated by *Santé publique France*), which covers 86% of emergency room (ER) admissions in France, recorded 11,633 drug use-related ER admissions, including 9,765 as the main diagnosis, i.e. 1.0‰ of ER admissions for all causes combined. On the scale of the French population, the rate of drug use-related ER admissions is 23 per 100,000 inhabitants (after adjustment taking the coverage rate into account). 73% of individuals visiting emergency rooms for this reason were male. Mean age was 34 years, with men being slightly younger than women (33 years vs. 36 years). More than a quarter of these presentations were related to cannabis use (27%), 23% were related to opioid use, cocaine was implicated in 7% of cases, other stimulants (MDMA/ecstasy, amphetamines) in 3% of cases, hallucinogens (hallucinogenic mushrooms, LSD) in 4% of cases and, lastly, multiple or

unspecified substances were responsible in 36% of cases. Further to the emergency presentation, 39% of individuals were admitted to hospital, and 61% 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.

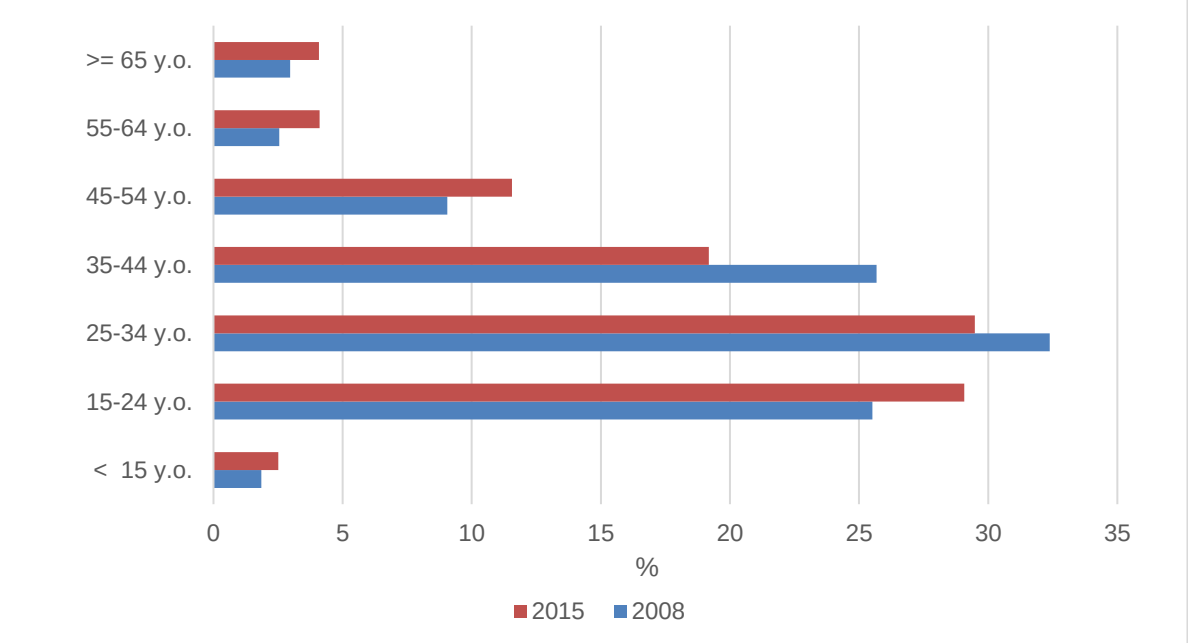
The most frequently reported drugs were cannabis (21%), cocaine (18%), crack (9%), diazepam (9%) and bromazepam (7%). Only one substance was involved in 53% of cases, two in 29% of cases and three or more in 18% of cases. Combined alcohol use was observed in 45% of cases. Median age was 34 years, and 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.

Analysis of the changes in the number of ER admissions does not appear to be possible over the 2008-2015 period owing to the sharp rise in the Oscour® scheme. The changes between 2008 and 2015 were, however, analysed in terms of the distribution of the substances involved, and according to gender and age group, based on the hypothesis that drug use-related ER admissions reported in Oscour® are representative of all admissions for this reason over this period, while the coverage rate of the Oscour® scheme increased owing to the inclusion of new emergency rooms.

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 6%.

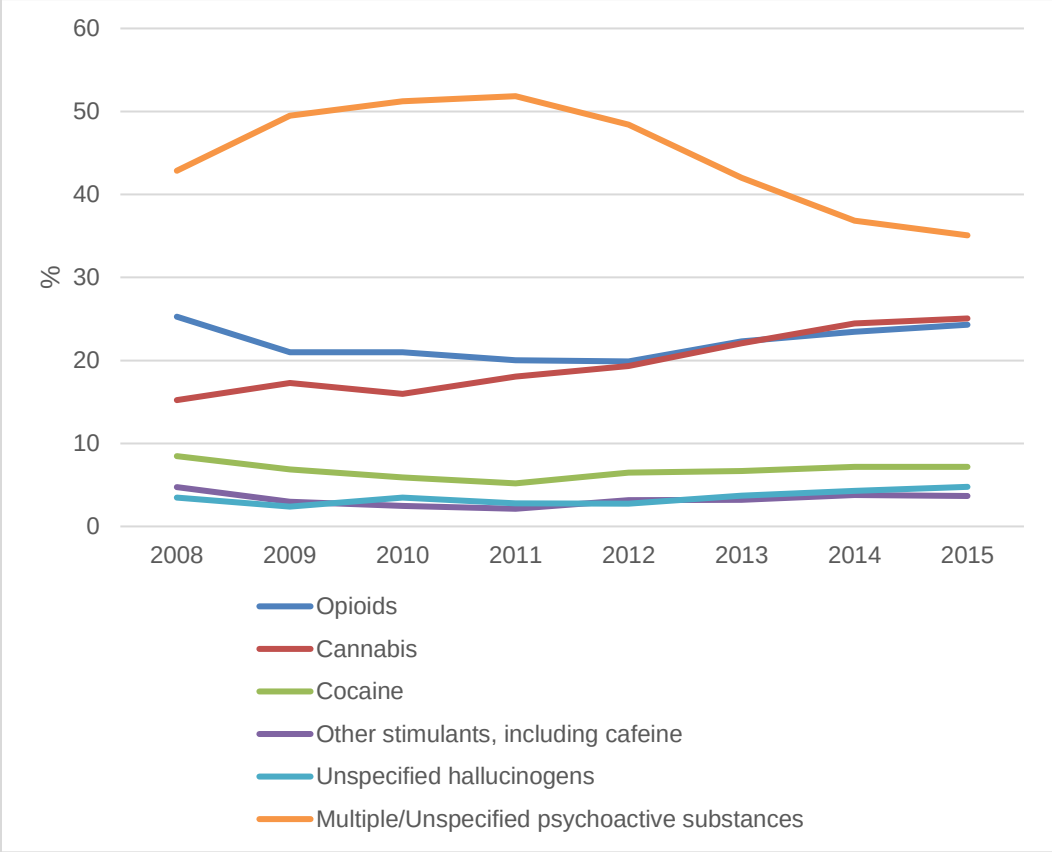
Figure. Distribution of hospital emergency presentations related to drug use by age group in 2008 and 2015



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 (unknown mixtures or substances), and fluctuated over the years (ranging from 36 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 2012.

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

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.* 2013).

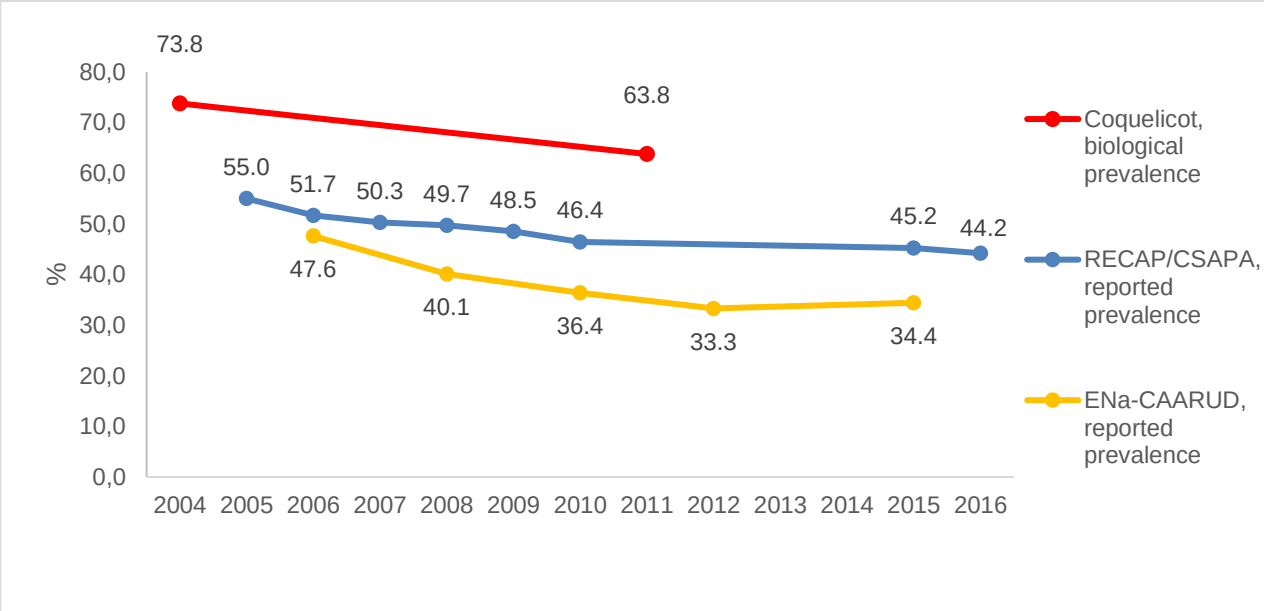
The seroprevalence of HBs antigen (HBsAg) was estimated at 1.4% [95% confidence interval (CI) 0.8-2.5] in the 1,718 people who use drugs (PWUD) attending harm reduction centres using data from the ANRS-Coquelicot multicentre survey conducted in 2011-2013. It varied between PWUD born in high (7.6%, 95% CI 2.7-19.1), moderate (2.2%, 95% CI 0.8-5.7) and low (0.7%, 95% CI 0.3-1.5) endemic zones. Factors independently associated with HBsAg carriage were being born in a moderate or high endemic zone or reporting precarious housing. Self-reported HBV vaccination history varied from 47.4% in high endemic zones, to 59.3% and 62.6% for moderate and low endemic zones, respectively. These results suggest that drug use plays a small and substantial role, respectively, in HBsAg carriage in PWUD born in high/moderate and low endemic zones (Brouard *et al.* 2017b).

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, 4,6 % declared to be HIV seropositive and 34.4 % 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 6.5% for HIV and 44.2% for HCV, according to the RECAP system in 2016.

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 for HCV, stable at nearly 8% for HIV) and the ENa-CAARUD survey (from 40.1% in 2008 to 33.3% in 2012 for HCV, stable at 6.2% in 2012 *versus* 7.7% in 2008 for HIV) (Cadet-Taïrou *et al.* 2015; Vaux *et al.* 2017). 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 IDUs, 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 2016, 66 injecting drug users (IDU) were newly diagnosed as being HIV seropositive i.e. 1% of all new diagnoses. This concerned males in 86% of cases. The proportion of diagnoses at an advanced stage is high among IDUs (43% *vs.* 27% among all diagnoses). More than half (59%) were born abroad, mainly in Eastern and Central Europe. The proportion of HCV co-infection is 66% and 15% for HBV co-infection among IDUs diagnosed as seropositive in 2016; 6% are co-infected with a bacterial sexually transmitted infection (Cazein et al. 2017; Santé publique France 2017).
The number of new AIDS cases among IDUs was estimated at 38 in 2016, i.e. 4.0% of all cases (Santé publique France 2018). Lastly, 36 AIDS deaths occurred among IDUs, i.e. 18% 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 (OFDT 2018c).

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 2016 (OFDT 2018b). This downward trend is also related to the reduction in the number of new cases of HIV infection related to injecting drug users.

The introduction of tritherapy in 1996 led to a four-fold reduction in the number of AIDS deaths among IDUs between 1994 and 1997. The number of deaths then continued to fall but at a slower rate, alongside a marked decrease in the prevalence of HIV among IDUs. These figures are now below the threshold of 100 deaths per year since 2009 (OFDT 2018a).

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).

The Hepcort multicentre study conducted between 2011 and 2015 in 732 HCV seronegative patients receiving opioid substitution medications, followed up in a community setting by general practitioners, evidenced a very low rate of seroconversion to hepatitis C (5 cases) (Aknine *et al.* 2018).

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

Drug-related infectious diseases - behavioural data

Among IDU, ancillary equipment and needle sharing appeared to increase between 2012 and 2015. Among recent injecting drug users visiting the CAARUDs in 2015, 14.5% 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	14.0%	15.9%	14.5%
Water for preparation	18.4%	28.6%	20.4%
Water for rinsing	9.6%	17.0%	11.1%
Spoons, containers	18.0%	27.5%	19.9%
Cotton/Filters	14.8%	22.1%	16.2%
Injecting paraphernalia (except syringes and needles)	22.4%	32.3%	24.4%
At least one item (including syringes and needles)	24.2%	34.0%	26.2%

* Figures adjusted relative to the 2017 workbook.

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.* 2013).

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 with a chronic infection (HCV RNA) was estimated at 192,700, i.e. a prevalence of 0.42%. In 2014, before direct-acting antivirals (DAA) became available, this population was estimated at 175,000 (Razavi *et al.* 2014). 60,000 patients were treated and cured by DAA between 2014 and March 2018. At the start of 2018, 110,000 individuals still require treatment, with between 58,000 and 69,000 unaware of their infection (Brouard *et al.* 2017a; Roudot-Thoraval 2018).

T1.4 Other drug-related health harms

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

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

Other drug-related health harms

The visibility of cannabis-related health problems appears to be growing. These problems are mentioned by all OFDT TREND scheme sites and affect somewhat well integrated populations, whether individuals attempting withdrawal or others no longer able to control their substance use despite memory or concentration disorders. In 2017, unusual reports of cannabinoid hyperemesis syndrome (CHS) were observed among health professionals interviewed as part of TREND. In practice, this involves cyclic episodes of acute, intense vomiting, accompanied by abdominal pain, occurring without any identified triggering factors among long-term cannabis users. The acute phase, only relieved by hot showers, persists for a few days but may be preceded and prolonged by chronic nausea. This little-known syndrome, of unknown cause and unable to be identified by tests, gives rise to recurrent misdiagnosis. At the same time, the addiction monitoring scheme has been receiving reports of these cases since 2013, with a marked increased since 2016 (Marillier *et al.* 2017; Schreck *et al.* 2018).

T1.5 Harm reduction interventions

The purpose of this section is to

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

T1.5.1 Please summarise the main harm reduction-related objectives of 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.

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 was updated in 2016 (Dhumeaux *et al.* 2016). 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.

Prevention policy priorities include a significant measure: elimination of hepatitis C by 2025 in France (the WHO worldwide target is 2030). In order to achieve this objective, 3 key measures are being implemented: greater access to treatment for hepatitis C via new prescribers by encouraging city-hospital networks; increasing local screening via rapid diagnostic tests (RDT) as part of a combined approach for HIV, HCV and HBV, and improving prevention via innovative outreach actions aimed at priority populations far removed from the health system (Direction générale de la santé 2018).

During 2017, reimbursement of direct-acting antivirals (DAA) (100% reimbursed by the National Health Insurance Fund) was extended to all adults with chronic hepatitis C irrespective of fibrosis stage [Instruction n°2017-246 du 3 août 2017]. Individuals at high risk of virus transmission (drug users who share equipment, inmates, women planning a pregnancy) already benefited from a 100% coverage of direct-acting antivirals (DAA) by the Health Insurance since August 2016 [Arrêté du 10 juin 2016 and Instruction 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.
DAA are subject to hospital prescription, by specialists in hepatogastroenterology, internal medicine or infectious diseases. A multidisciplinary meeting is no longer automatically required before initiating treatment with DAA. However, it is still recommended in complex cases [Instruction n°2017-246 du 3 août 2017]. Since March 2018, several DAA (Marivet®, Epclusa®, Socaldi®, Harvoni®, Vosevi®) have been available in community pharmacies, while the other treatments are only available in hospital pharmacies. The price of a treatment course (8 to 12 weeks depending on the combination of DAA) for a pan-genotypic treatment amounts to nearly €30,000 including VAT. Furthermore, on the National Viral Hepatitis Action Day, organised by the French Ministry of Solidarity and Health, the Director General for Health announced that curative treatments with DAA will be able to be prescribed by general practitioners for patients without hepatic comorbidities (Salomon 2018).

Screening still needs to be improved for individuals never having been screened (30% of infected individuals have no risk factors) and given new impetus and stepped up for individuals at risk (at-risk behaviour – injecting drug users, slamming -, migrants, inmates, psychiatric patients).
The French Association for the Study of the Liver issued guidelines in March 2018 for the elimination of hepatitis C virus infection in France, based on two main approaches: universal treatment and universal screening (AFEF 2018). (AFEF 2018). It proposes a treatment algorithm with the implementation of a simplified treatment pathway enabling local management.

A methodological guide aiming to increase access to screening and treatment for viral hepatitis intended for all socio-educational, paramedical and medical professionals in the specialised addiction medicine structures (CSAPA, CAARUD, ELSA, hospital addiction medicine departments, etc.) was drawn up by the Research Group on Social Vulnerability and presented during the National Viral Hepatitis Action Day (Hoareau and Reynaud-Maurupt 2018). Raising awareness with regard to screening should be a major line of action within the structures and outside their walls, as part of an outreach approach. Hence, drug users attending CSAPAs or CAARUDs should be routinely invited for screening (with combined HCV-HBV-HIV RDT, blotters and Fibroscan®) while leveraging advanced hepatology clinics, following the example of the treatment pathway in the Ile-de-France region.

A white paper on access to care among populations vulnerable to hepatitis C summarises and expands the previous reports and guides professionals towards more integrated, facilitated management, more targeted to particularly affected/vulnerable populations. It helps professionals in all fields to coordinate their practices, to achieve the objective of eradicating the epidemic in France by 2025 (Delile *et al.* 2018).

As regards hepatitis B prevention, vaccination of all infants has been compulsory since January 2018. This measure is part of the 2018-2022 National Health Strategy (Ministère des solidarités et de la santé 2017).

The National Sexual Health Strategy (2017-2030 agenda) (Ministère des affaires sociales et de la santé 2017), which is in keeping with the objectives of the National Health Strategy (particularly with its objective for "Promoting sexual health and sex education"), proposes a global approach to improving sexual and reproductive health which notably aims to eradicate the AIDS epidemic by 2030 and to reach the goal of "95-95-95" by 2020: such that 95% of people living with HIV know their status, 95% of people who know their seropositive status have access to treatment and 95% of people on treatment have suppressed viral loads. Action no. 4 endeavours to meet the specific needs of the most vulnerable populations, including drug users. The roadmap of the National Sexual Health Strategy (2018-2020) recommends organising, annually and at local level, specific screening campaigns for HIV, viral hepatitis and other STIs, including "outreach" programmes aimed at key populations including injecting drug users (action no. 4) (Ministère des solidarités et de la santé 2018) in compliance with the guidelines issued by the French National Authority for Health (HAS 2017).

The 2018-2022 national action plan on addiction (MILDECA 2018) aims to improve harm reduction resources by:
- adapting the reference framework for harm reduction workers
- adapting resources to needs
- continuing to trial drug consumption rooms
- preventing overdose

(Refer to the Drug Policy workbook for the main lines of this plan)

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.

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: 8 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, Lille and Marseille have the highest concentration of sites (respectively 9, 6 and 5 CAARUD). Two other urban centres, Bayonne and Nîmes, have 3 structures and ten or so other urban areas have 2 CAARUDs (Avignon, Bordeaux, Lyon, Metz, Montpellier, Mulhouse, Nancy, Nice, Rouen and Toulouse).The remaining towns concerned (approximately a hundred) have only one CAARUD.

CAARUD harm reduction activities

In 2015, 146 CAARUDs were registered in France, including six located in French overseas departments. The CAARUDs are predominantly funded by the National Health Insurance Fund, in compliance with the French Social Action and Family Code (Art. L. 314-3-3). Subsidies paid to structures located in mainland France in 2015 represent approximately €45.5 million and nearly €500,000 for structures located in French overseas departments. These receive operating subsidies of €1,000 on average per 1,000 inhabitants aged 20 to 74 in mainland France. Structures located in French overseas departments receive nearly €400 on average per 1,000 inhabitants. Relative to new CAARUD outpatient admissions, the budget only represents slightly over €100 per client taking part in the scheme compared to approximately €600 on average for structures in mainland France.

Nearly all CAARUDs see their clients in permanent premises or in a mobile unit. CAARUDs most frequently operate from permanent premises (74%), and half of these structures have mixed counselling facilities (simultaneously operating from both types of facilities). In 2015, the annual new CAARUD outpatient admissions were estimated at nearly 75,000 individuals. The proportion of new users visiting the facilities in 2015 represents 32% in permanent premises and 28% in mobile units, i.e. nearly 14,000 and 4,000 individuals,

respectively. Female clients are in the minority, with women accounting for 18% of visitors to CAARUD premises, and 22% of clients followed up by mobile units, i.e. 7,000 and 3,000 women, respectively.

Their main actions include creating links with the most vulnerable drug users, access to essential services, health care and social rights. Hence, in 2015, the most common actions involved maintaining social links or counselling (40%), harm reduction measures related to drug use and sexuality (22% of actions carried out) and responding to the most basic needs (basic hygiene) corresponding to 18% of total actions. Actions relating to care and access to services are observed to a relatively lesser extent (6% and 5%, respectively). Access to screening for infectious diseases and vaccinations, and access to housing and training are observed to a very marginal extent in these interventions (between 1% and 2%). In 2015, slightly less than thirty or so individuals attending harm reduction facilities had access to free screening for hepatitis B and C that year. Major variations are observed between various CAARUDs. Furthermore, while the majority of facilities appear to have offered their clients free hepatitis screening (more than 70% for hepatitis C and 60% for hepatitis B), access to vaccination for HBV seems very limited (this only appears to be offered by a small minority of facilities).

The intervention processes are fairly similar. In 2015, practically all CAARUDs offered users orientation services and support projects (99% and 97%, respectively). As regards practical intervention procedures, individual interviews have been shown by far to be the most common practice (99%) and nearly nine out of ten CAARUDs (85%) proposed workshops (photography, theatre, journaling). Lastly, slightly over a third of structures organised self-help and self-support groups (43%).

Social mediation is also an important part of the activities at harm reduction facilities. In 2015, CAARUD professionals worked to promote the acceptability of the facilities day to day with the local authorities (82% of facilities), residents (72% of facilities) and the police (62% of facilities). Furthermore, eight out of ten facilities (83%) met with partners from the health networks to facilitate onward referral to the primary care setting and to encourage pharmacies to commit to needle and syringe exchange programmes (SEP) (Díaz Gómez 2018).

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 addition to counselling, support and orientation activities, the teams may also be present during one-off music events (teknivals, festivals, concerts) among the recreational settings. In 2015, seven out of ten facilities (68%) carried out this type of intervention, attending nine events on average per year. In order to carry out their prevention action, the facilities set up stands to distribute brochures and information flyers, along with harm reduction materials suited to substance use in the recreational setting. They also set up relaxation (*chill-out*) areas for users. The median number of individual team interventions alongside drug users was slightly over 150 per event. 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) Optional. 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. 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.

Between August 2016 and December 2017, 343 physicians had registered with the cohort ATU scheme (166 of whom had included at least 1 patient), 302 dispensing pharmacists or physicians had registered, 1,623 patients had been included, and 1,057 Nalscue® kits had been distributed. Over the period concerned, 23 individuals received Nalscue®: 21 individuals overdosed (5 patients covered by the ATU and 16 third parties), and 2 patients covered by the ATU who self-administered Nalscue® without symptoms of overdose and who developed reactions related to opioid withdrawal. No adverse reactions were reported among individuals who received Nalscue®. The ATU ended on 8 January 2018 (ANSM and INDIVOR UK Ltd 2018). The HAS Transparency Committee has approved its inclusion on the list of proprietary medicinal products reimbursed to individuals covered by health insurance (with a proposed reimbursement rate of 65%) and on the list of proprietary medicinal products authorised for hospital use (HAS 2018).

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 stipulates that persons in possession of and consuming narcotic substances for their own personal use in a DCR cannot be prosecuted for illegal use and possession. Professionals working at a DCR and acting in accordance with their supervisory duties are also protected from prosecution for being complicit or facilitating the illegal use of narcotics.

The specifications for DCR, laid down by the decree of 22 March 2016 [Arrêté portant approbation du cahier des charges national relatif à l'expérimentation d'espaces de réduction des risques par usage supervisé], describe in detail the general and specific objectives (the first of which is to help reduce the risk of overdose and infections), the duration of the trial (6 years), the facilities concerned (the CAARUD are entrusted with running the DCR but in separate premises from their normal missions), the targeted population (vulnerable injecting drug users, aged over 18 years, with multiple risk factors), the location (close to areas of drug use), funding, national supervision, together with the objectives and methods for evaluation.
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 National Institute of Health and Medical Research (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 CAARUD Gaia] has been open since 17 October 2016. It is located in the Gare du Nord area, near to where a growing drug use scene has developed in the past ten or so years. The room, located in a building at the Lariboisière hospital, but with a separate entrance, is open 7 days a week from 13:30 to 20:30 and comprises a counselling room, twelve spaces for injection (20 minutes maximum per injection), four for inhalation (30 minutes maximum per inhalation), a cubicle reserved for education on injection risks, a rest room, offices for social and medical appointments, and a room for social integration activities. At least five workers are present at the same time. The team consists of a department manager (1 full-time equivalent - FTE), educators (13 FTE), nurses (7 FTE), a doctor (0.5 FTE plus one weekly session by a psychiatrist), a social worker (1 FTE), an administrative position (0.5 FTE), peer workers and voluntary workers, together with a mediator (security staff, 2 FTE).
From October 2016 to December 2017, the drug consumption room (DCR) hosted 903 different people, and recorded 76,120 visits, including 54,864 injections. The number of clients appears to stabilise at 165 visits per day on average, with a peak of more than 200 visits per day. The two most widely used substances are Skénan® (morphine sulphate), injected during 47% of visits, and inhaled crack (28% of visits) or injected crack (10%). Buprenorphine injection is observed more rarely (7% of visits), along with methadone (injected alone in 5% of visits and combined with injected crack in 2% of visits). Intravenous heroin is reported for 1.5% of visits.

Seventy-six cases of malaise or overdose occurred, requiring the emergency services to be called (ER) or intensive care on 34 occasions. Narcan® was administered in 5 cases at the DCR and once in the ER. The room offers medical or nursing appointments (527 medical appointments took place for 244 different users and 1,156 nursing procedures for 288 users, 70 cases of physical assistance during appointments, hospital admissions and for examinations, 40 vaccinations - influenza and hepatitis A), social appointments (1,152 appointments took place for 243 different users, 200 users benefited from the weekly presence of the National Health Insurance Fund, with 165 cases of clients receiving physical assistance for social and legal procedures) and screening for HIV, HCV and HBV. 96 rapid diagnostic tests (RDT) for HIV (3 of which were positive), 75 RDT for HCV (13 of which were positive), 36 blotting paper tests (19 of which were positive for HCV RNA and 1 for HIV) and 27 Fibroscan® exams (a non-invasive machine that can instantly detect liver fibrosis and assess its degree of advancement) were performed. Lastly, 7 patients completed treatment for hepatitis C. Rounds were stepped up (9 per week, including 2 in the morning), enabling 3,842 contacts with users, collection of syringes and responses to resident requests. The room regularly organises open-door events in the mornings for the general public, with an information and mediation role (Avril 2017; Avril 2018).

The second DCR run by the Ithaque association [Arrêté du 25 mars 2016 portant désignation du CAARUD Ithaque] opened in Strasbourg on 7 November 2016. It is open from 13:00 to 19:00, 7 days a week, and is located on the site of Hôpital Civil. The room consists of four main areas: a reception area, a waiting room, a consumption room with six injection spaces, four inhalation spaces and two spaces for snorting, and a rest room. There are 3 additional offices reserved for medical appointments, psychologist or social worker appointments or individual interviews. From its opening until 31 October 2017, the room hosted 391 different users, including 254 consumption room users, i.e. 50 to 80 visits per day. Cocaine is the main substance used (37%) ahead of Skénan® (26%), heroin (15%), buprenorphine (15%), crack-freebase (4%) and speedball (2%). 51% of users are prescribed OST. Patterns of use are injection (in 85% of cases), smoking (8%), snorting (5%) and inhalation (2%). Four overdoses required intervention by the emergency services, all with a positive outcome. As regards infectious diseases, 20% of users are seropositive for HCV, 2.5% for HBV and 1.3% for HIV. In terms of screening, 183 RDT were performed (76 HIV, 68 HCV and 39 HBV) together with 48 Fibroscan® resulting in the diagnosis of 13 patients seropositive for HCV (with 7 users unaware of their status) and no patients seropositive for HIV or HBV. The needle and syringe exchange programme run by the room dispensed 88,000 syringes (Association Ithaque 2017; Bader 2018).

The 2018-2022 national action plan on addiction will continue to adapt the schemes already authorised, with a view to strengthening them and overcoming any difficulties encountered. The plan also envisages creating other facilities to cater for unmet needs, including in the Ile-de France region.

c) Harm reduction measures on release from prison

See paragraph c) of section T1.5.3 in the 2017 Harms and harm reduction workbook and also section T1.3.2 of the 2018 Prison workbook.

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 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 harm reduction 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.

The supply of injection materials is based on the following four distribution methods:

- Distribution by the CAARUDs, CSAPAs and partner community pharmacies
- Sales of injection kits in pharmacies in *Stéribox*® form and sales of single sterile syringes
- Distribution of syringes via automatic distribution machines (outside the CAARUD/CSAPA network)
- Postal needle and syringe exchange programme

In total, approximately 11.9 million syringes are estimated to have been distributed or sold to drug users in France in 2015, for all schemes combined.

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 harm reduction facilities. The CAARUD play a key role in distributing injection equipment and sterile prevention material (see table below). In 2015, CAARUDs contributed 7.3 million syringes to harm reduction resources.

*Table. Distribution of sterile prevention material by the CAARUD network (in thousands of units) in 2015**

Injection equipment	
Single syringes	4,700
Syringes in kits: automatic distribution machines	500
Syringes in kits: teams	1,100
Syringes in kits: pharmacy network	1,100
Total number of syringes distributed	*7,300*
Needles	300
Sterile containers	2,500
Sterile filters	1,400
Water (5-ml vials)	2,700
Alcohol pads	2,800
Snorting equipment	
Small paper pads	700
Normal saline solution	200
Other snorting equipment	14
Snorting kit	2
Crack inhalation equipment	
Measures	140
Tips	60
Blades	20
Crack filters	100
Inhalation kits	20

STI prevention material	
Male condoms	850
Female condoms	40
Lubricant gel	270
Other prevention materials	
Alcohol breath tests	40
Ear plugs	30
Brochures, flyers (partner pharmacies)	50
Brochures, flyers (CAARUD teams)	150

Source: CAARUDs 2015 activity reports (DGS – processed by the OFDT)

** This table shows the harm reduction materials dispensed by the teams at the facilities and via automatic distribution machines in the CAARUD network, but also by partner pharmacies. It does not list materials supplied outside the CAARUD scheme.*

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 2015, the CSAPA network distributed overall approximately 430,000 syringes. More specifically, 104,000 injection kits containing 2 syringes were distributed by 127 centres, i.e. approximately a third of existing outpatient CSAPAs. Half as many centres distributed 1 cc syringes (approximately 170,000 syringes) and only 39 CSAPAs distributed 2 cc syringes (55,000 syringes).

d.2) Sale of syringes in pharmacies

Sales of syringes in pharmacies in *Stéribox*® form represent the second most important distribution method for sterile injection materials. As data transfer was suspended between 2012 and 2015, information is only available on *Stéribox*® sales from 2016. Since data transfer resumed, sales were seen to fall by a quarter in 5 years. This downward trend continued in 2017. Hence, the number of syringes sold in community pharmacies in *Stéribox*® form decreased from 4.5 million in 2011 to 3.35 million in 2016.

d.3) 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.
The total number of automatic distribution machines (CAARUD/CSAPA network and other operators) reaches 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).

d.4) 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. In 2015, nearly 250,000 syringes were dispensed as part of the postal needle and syringe exchange programme (SEP). Slightly over a thousand users have benefited from the programme since it was introduced in 2011. 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).

e) Health care delivery in CSAPA and CAARUD

See paragraph e) of section T1.5.3 in the 2017 Harms and harm reduction workbook.

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). This was adapted and designed for France between 2012 and 2014 by INPES (now part of *Santé publique France*). 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 conducted by a trained professional. 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). The evaluation of the intervention, conducted by RESPADD in partnership with the Île-de-France regional health observatory, showed that the "*Change le programme*" approach could be implemented in CAARUDs. However, the intervention highlighted tensions within the CAARUDs between the collective and individual approaches, and also between social and health objectives. Furthermore, this intervention does not fall within the scope of the predominant rationale aiming to accompany injection and make it safer. As regards the results, the "*Change le Programme*" approach gave rise to the expected changes in terms of behaviours, perceptions and intentions after three months, although modest, as is often the case in psychological-behavioural interventions (Michels *et al.* 2017). However, the intervention could be made more effective by including follow-up halfway along the process (for instance, with a second interview to remind the participant – the user – of the concepts and messages discussed during the initial interview. Nevertheless, this type of approach cannot influence the macro-structural and structural conditions which lead to injection (type of substances injected, market situation, presence of open spaces or large numbers of injecting drug users, poverty among users, social relations and between sexes, etc.) and which represent negative environments and additional risk factors for causing non-injecting drug users to start injecting (Werb *et al.* 2016).

g) Support and education on injection-related harm

See paragraph g) of section T1.5.3 in the 2017 Harms and harm reduction workbook.

[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.

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.

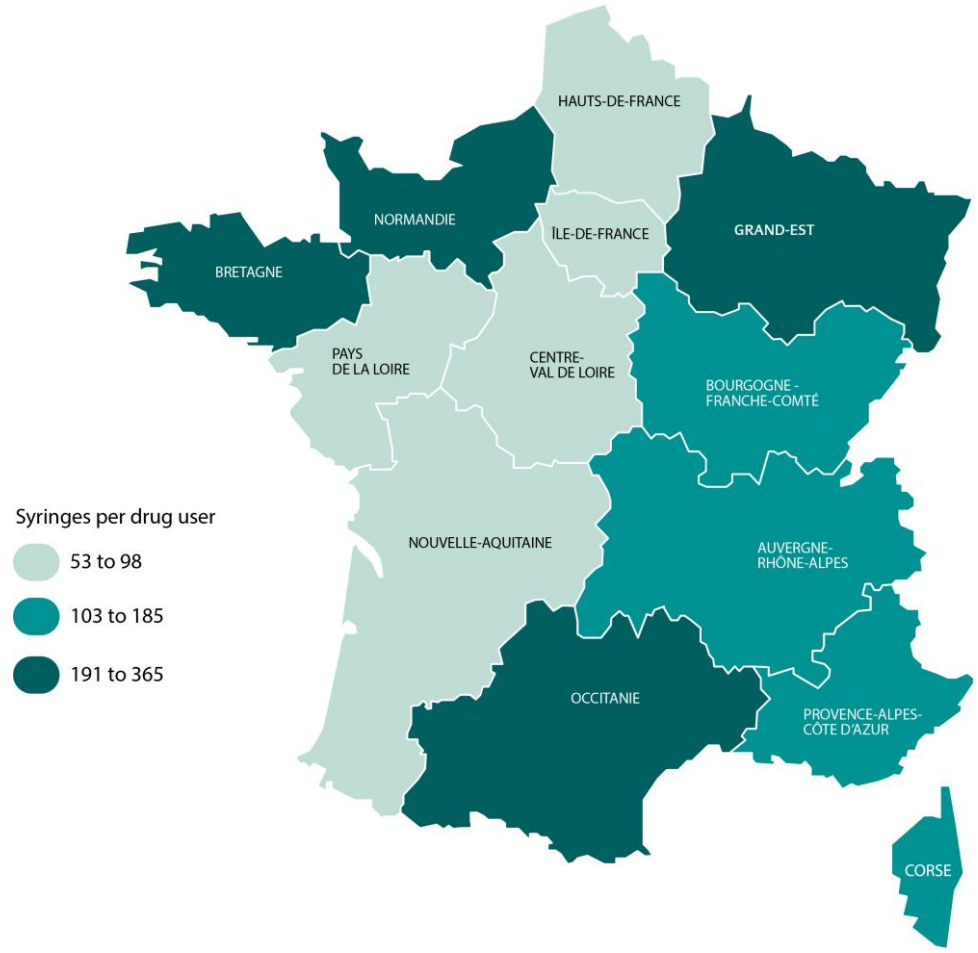
In France, the two main channels for the distribution of syringes are CAARUDs and community pharmacies. Together, these distribute 90% of syringes made available to injecting drug users. These two aggregate data sources appear to reflect a slight increase in the changes between 2008 and 2015 in the total volume of syringes distributed. The decline in pharmacy syringe sales is offset by the large increase in the number of syringes distributed in CAARUD. These trends should be interpreted with caution, owing to the numerous gaps in data over the period studied.

Furthermore, CSAPAs have been required to dispense harm reduction materials since 2008, but no data were collected until 2014. Since then, the provision of prevention materials by CSAPAs has remained somewhat stable (390,000 syringes in 2014, compared to 430,000 in 2015 and 2016).

As regards the other two sources that complement the national supply mechanism for harm reduction equipment, 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.

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 2015, the OFDT estimated the number of past-year injecting drug users at 100,000. 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 115 syringes were distributed per injecting drug user in 2015, i.e. a “medium” syringe distribution according to the coverage levels proposed by EMCDDA (distribution of 100-200 syringes per injecting drug user over the past 12 months). On a regional scale, syringe distribution is low in five out of thirteen regions in mainland France: Hauts-de-France, Île de-France, Centre-Val de Loire, Pays de-la-Loire and Nouvelle Aquitaine (Díaz Gómez 2018; Janssen 2017).

Regional distribution of the number of syringes distributed per injecting drug user in mainland France in 2015



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

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

T1.7 Quality assurance of harm reduction services

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

Note: cross-reference with the Best Practice Workbook.

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

Quality assurance for harm reduction services

See section T1.7.1 of the 2017 Harms and harm reduction workbook.

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.

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.

The new death certificate came into force on 1 January 2018 [Arrêté du 17 juillet 2017 relatif aux deux modèles du certificat de décès]. The instructions for completing the death certificate (on the back of the certificate) state that the "forensic post-mortem examination required" section should be ticked in the event of overdose. The medical section of the death certificate comprises a new insert on the apparent circumstances of death (including "suicide", "ongoing investigations", "unknown"), another insert on the investigation into the cause of death ("yes, medical investigation", "yes, forensic investigation" or "no"); lastly, there are another two inserts for acute death and the site of the triggering event for violent

death. The additional medical section to the death certificate, created in April 2017 [Décret n°2017-602 du 21 avril 2017 relatif au certificat de décès], came into force in January 2018 [Arrêté du 17 juillet 2017 relatif aux deux modèles du 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 forensic inquiry into the causes of death, 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

See section T1.5.1 of this workbook.

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)

T4. Additional information

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

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

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

T5. 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.

T.5.1 Please list notable sources (including references to reports and grey literature) for the information provided above.

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

See the description of sources on drug-related death in section T5.1 of the 2017 Harms and harm reduction workbook.

Drug use-related hospital emergency presentations

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 or related diagnoses with EMCDDA selection B ICD codes (F11, F12, F14, F15, F16, F19, X42, X62, Y12, T40, 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

ASA-CAARUD: National analysis of the CAARUD standardised annual activity reports

French Monitoring Centre for Drugs and Drug Addiction (OFDT) / National Health Directorate (DGS)

Each year, the facilities send the National Health Directorate (DGS) and Regional Health Agencies (ARS) a standard activity report; these are then sent to the OFDT for analysis. The data collected make it possible to monitor the activity of the scheme since 2008. These data shed light on issues relating to geographical coverage, the allocated resources and access to CAARUDs. The information collected and analysed by the OFDT also enables the characteristics of the populations visiting harm reduction facilities and the activities of the professionals involved to be examined. Lastly, the ASA-CAARUD questionnaire offered to the facilities aims to document the distribution of injection and snorting materials, together with harm reduction resources for inhalation and the prevention of sexually transmitted infections. The questionnaire is based on a shared approach, initiated by the French Association for Drug Use-related Harm Reduction (AFR), in partnership with the OFDT and the health authorities.

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)

See the description of sources on HIV/AIDS and viral hepatitis among drug users in section T5.1 of the 2017 Harms and harm reduction workbook.

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T.5.2 Where studies or surveys have been used please list them and where appropriate describe the 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, 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 2017, approximately 208,000 patients seen in 260 outpatient CSAPAs, 15 residential treatment centres and 3 prison based CSAPAs for an addiction-related issue (alcohol, illicit drugs, psychoactive medicines, behavioural addiction) were included in the survey.