

# Harms and harm reduction workbook

## 2022

### France

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## 2022 National report (2021 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: 1 000 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 most recent data from the National registry of causes of death (CépiDc) are from 2017 with 417 deaths. This number is probably underestimated.

In 2020, the specific DRAMES register reported 567 deaths related to the misuse of psychoactive substances (503 in 2019) and the specific DTA register recorded 117 deaths related to the use of analgesic drugs (145 in 2019).

Around 19 300 hospital emergency presentations related to drug use were reported in France in 2019 (Oscour® network). These presentations were related notably to cannabis use (29%), opioid use (26%) and cocaine use (12%). Between 2015 and 2019 there was an increase in the proportion of emergency presentations related to cocaine use (12% vs 7%).

Injecting drug use was rarely identified as a mode of infection for people who discovered their HIV status in 2020 (1.5%). At the time of discovery of HIV status, 5% of intravenous drug users were co-infected with hepatitis B virus (HBsAg) and 57% were positive for HCV antibodies.

- National profile and trends harm reduction

Harm reduction policy for drug users aims to prevent infections and fatal overdoses linked to substance use and to promote access to care and social rights for drug users. It calls on local actors and relies on:

- A government roadmap for the prevention and treatment of opioid overdose, which includes a naloxone dissemination programme: ready-to-use naloxone kits are available in health care institutions, specialised addiction treatment facilities and in pharmacies.
- A programme for the distribution of prevention materials based on a local offer (CSAPA and CAARUD, pharmacies, automatic distribution machines) and a postal needle exchange programme. The latter makes it possible to improve accessibility by removing obstacles related to geographical distance, opening hours and confidentiality.
- Opioid substitution treatments available in cities, in CSAPAs and in prison.
- National HIV and hepatitis prevention strategies: the actions implemented as part of these strategies focus in particular on strengthening community-based screening and rapid access to treatment and are in line with the objective of eliminating HIV by 2030 and HCV by 2025.
- The drug consumption rooms (DCR) known as “salles de consommation à moindre risque” (SCMR) have become the “Halte soins addiction” centres (HSA). (See T3 and drug analysis as a harm reduction tool in T.1.5.3).

- New developments

Since September 2021, naloxone has again been available in France as a nasal spray: Nixoid® nasal spray 1.8 mg/0.1 ml. It is added to the Prenoxad® intramuscular injection 0.91 mg/ml kit already available on the market. Nixoid® is subject to mandatory medical prescription.

The DCR experiment started in 2016 in Paris and Strasbourg for a period of six years has been extended until December 2025 to allow these harm reduction facilities to be opened in new areas. DCRs are evolving into “Halte soins addiction” (HSA) centres. The HSAs are spaces for harm reduction through supervised use and orientation towards a physical and psychological health pathway adapted to the situation of drug users. They can take the form of mobile units and can also be located in specialised medical and social facilities (CSAPA and CAARUD).

The regulatory scheme for funding and authorising the performance of rapid diagnostic test (RDT) by non-medical staff, which until now has only covered HIV and HCV, was extended to cover HBV in June 2021 ([order of 16 June 2021](#) setting out the conditions for performing RDTs).

With regard to OSTs, the range of opioid substitution drugs was expanded with the launch of Buvidal® in July 2021: a sustained-release injectable solution of buprenorphine, administered on a weekly or monthly basis. Buvidal® is reserved exclusively for professionals in hospitals or CSAPAs. In addition, the National Agency for Medicines and Health Products Safety (ANSM) set up a temporary scientific committee in April 2021 to propose the clinical modalities and conditions for prescribing and dispensing morphine in the treatment of opioid addiction.

In March 2022, the National Authority for Health (HAS) published a recommendation on the proper use of opioid drugs, which aims to reduce cases of overdose and physical addiction to opioids (HAS 2022).

A law to prevent the dangerous and diverted use of nitrous oxide was published in June 2021 ([Law no. 2021-695](#)).

## 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)

#### Overdose deaths

According to the National registry of causes of death, 417 direct drug-related deaths (DDLs) occurred in 2017. The number of deaths is most probably underestimated as some overdose deaths are classified as “unknown cause” (see the [2020 'HHR' workbook](#)). The majority of deaths occurred in men (74%). The under-25s accounted for 5% of deaths and the over-55s for almost a quarter (24%).

T1.1.2. If information is available, please comment on the substances involved in the overdose cases. If detailed toxicology is reported to the EMCDDA, please comment and elaborate on these findings. If detailed toxicology is not reported, please explain why and comment on available information (suggested title: Toxicology of overdose deaths)

#### Toxicology of overdose deaths

##### Deaths related to psychoactive substance abuse

For the year 2020, the specific DRAMES register reported 567 deaths related to substance abuse.

The majority of subjects whose death was directly linked to drugs were men (79%) and on average, were aged 38.4 years old (38.1 years old for men and 39.7 years old for women) (CEIP-A Grenoble 2021a). Opioids were the main substances involved in deaths (82% vs 77% in 2019). In terms of opioid drugs outside of opioid substitution medications, morphine was still the molecule most often involved. In total, 13 deaths were directly caused by new psychoactive substances (5 in 2019). For 11 of these deaths, 3-MMC was involved. In 37% of the deaths, several substances were involved (27% in 2019).

**Table:**

**Breakdown of drug-related deaths by substance(s) involved\*, alone or in combination\*\* in 2020**

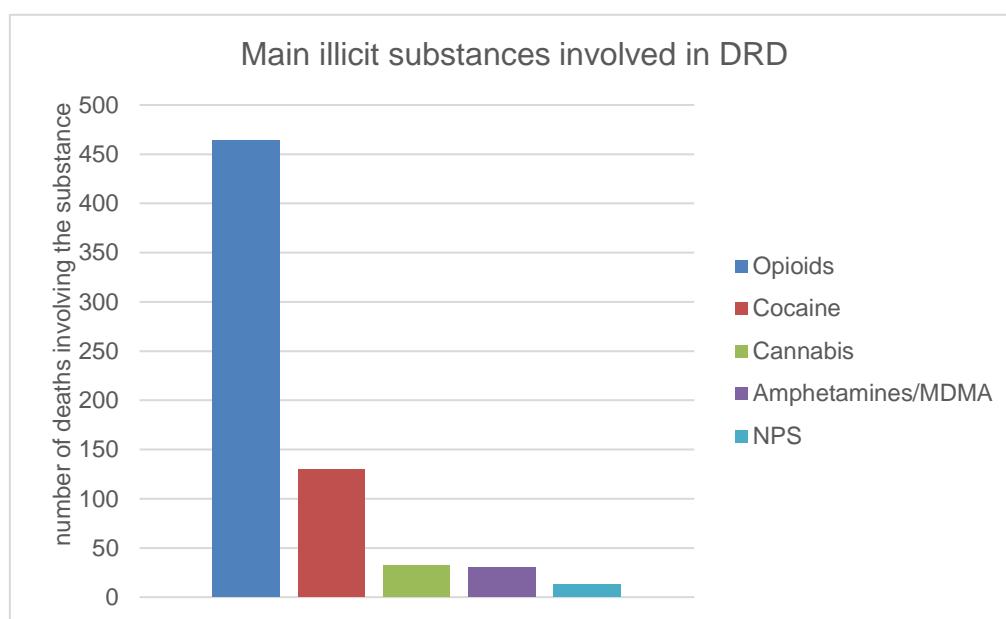
	n	%
<b>Opioids alone or in combination</b>	<b>464</b>	<b>82</b>
Opioid substitution medications	281	49
- of which methadone	230	40
- of which buprenorphine	53	11
Other opioid medications (non-OST)	56	10
- of which morphine (or metabolites)	29	5
- of which tramadol	14	2
- of which codeine	6	1
- of which oxycodone	6	1
Heroin	160	28

<b>Cocaine</b>	130	23
<b>Other illicit substances</b>	58	10
- of which cannabis	32	6
- of which amphetamines and MDMA/ecstasy	30	5
- of which NPS	13	2

Source: DRAMES (CEIP-A of Grenoble and ANSM, National Agency for Medicines and Health Products Safety)

\* Only deaths directly caused by drug use are mentioned.

\*\* Several substances can be involved in a death when no predominant substance has been determined.



### Deaths related to the use of analgesic drugs

For the year 2020, the specific DTA register reported 117 deaths related to the use of analgesic drugs (145 in 2019). Tramadol was still the main drug involved in direct deaths (47% of deaths), while morphine and oxycodone were involved in 21% and 16% of cases respectively. Fentanyl was involved in 4% of deaths.

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)

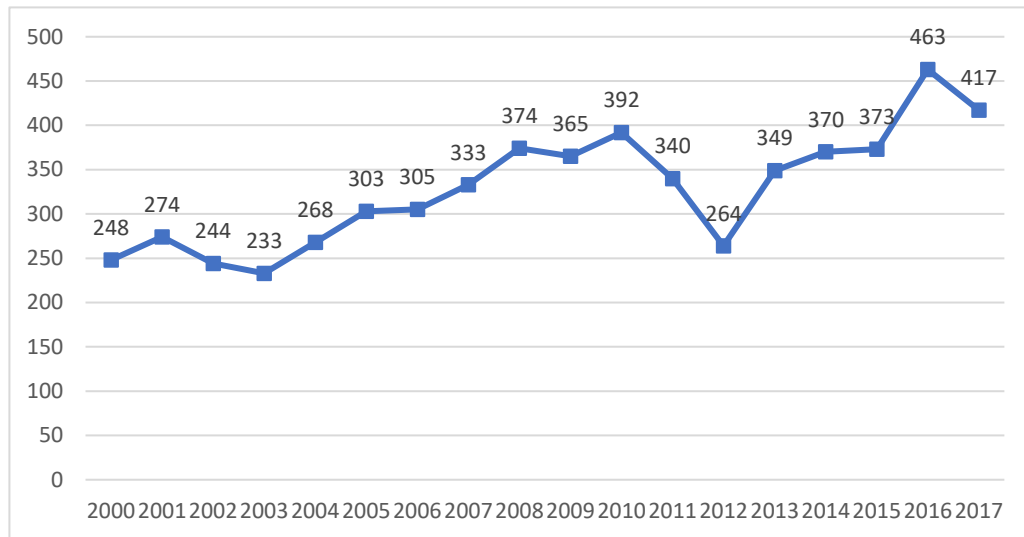
### Mortality cohort studies

See T1.1.3 of the [2018 'HHR' workbook](#).

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

In 2017 there was a 10% decrease in the number of DRDs compared to 2016. This decrease followed an increase of 24% between 2015 and 2016. The proportion of men among the deaths remained stable compared to 2016 (74% vs 78%).

**Overdose deaths due to narcotic and opioid medication use in France (2000-2017)**



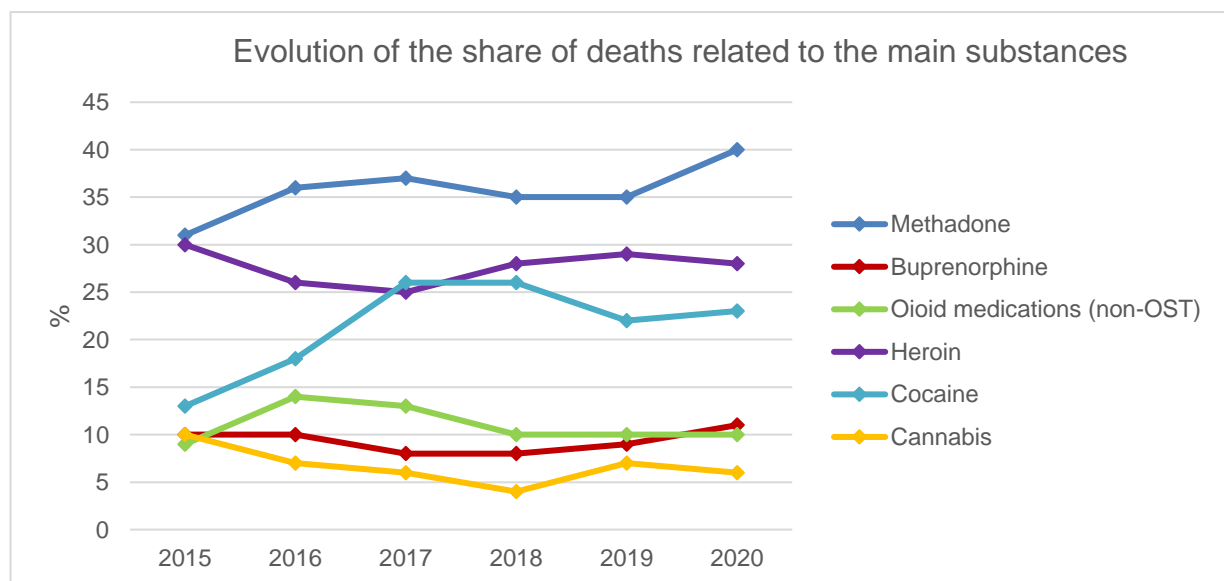
Source: INSERM-CépiDc, processed by the OFDT

Note: French adaptation of the EMCDDA selection B (F11, F12, F14, F15, F16, F18, F19, X42, X62, Y12).

**Toxicology of drug-related deaths**

DRAMES register. The share of cocaine-related deaths increased between 2015 and 2019. Furthermore, between 2019 and 2020, there was an increase in the share of deaths involving methadone after a period of stability between 2016 and 2019. The increase in the share of deaths involving opioids was linked in particular to this increase. During the period, NPSs were involved in less than 5% of deaths.

It is difficult to interpret variations in the number of deaths collected from one year to the next, as the volunteer-based system is not exhaustive and the participation of toxicological experts varies from year to year.



DTA register (CEIP-A Grenoble 2021b). The share of tramadol-related deaths remained stable between 2016 and 2020, while the share of morphine-related deaths decreased. The stabilisation of the share of oxycodone-related deaths continued in 2020 after a sharp increase in 2017.

**Distribution of deaths\* according to the substances involved\*\***

	2015 %	2016 %	2017 %	2018 %	2019 %	2020 %
Tramadol	34	44	46	46	43	47
Morphine	32	26	29	29	25	21
Oxycodone	10	9.5	18	17	16	16

Source: DTA (CEIP-A of Grenoble 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.

See T1.1.4 of the [2021 'HHR' Workbook](#) about the measures adopted in 2020 to limit the misuse of tramadol.

*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)*

## T1.2. Drug related acute emergencies

The purpose of this section is to provide a commentary on the numbers of drug-related acute emergencies

T1.2.1. Is information on drug-related acute emergencies available in your country? If yes, please 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)

See T1.2.1 of the [2018 'HHR' workbook](#).

T1.2.2. If information is available, please provide a commentary on the numbers of drug-related acute emergencies by main illicit substances, e.g. cannabis, heroin/ other opioids, cocaine, amphetamine type stimulants, new psychoactive substances. Please feel free to add tables in this section (as most countries already do). This might facilitate the reading. Where appropriate please provide links to the original reports and studies (suggested title: Toxicology of drug-related acute emergencies)

### Toxicology of drug-related acute emergencies

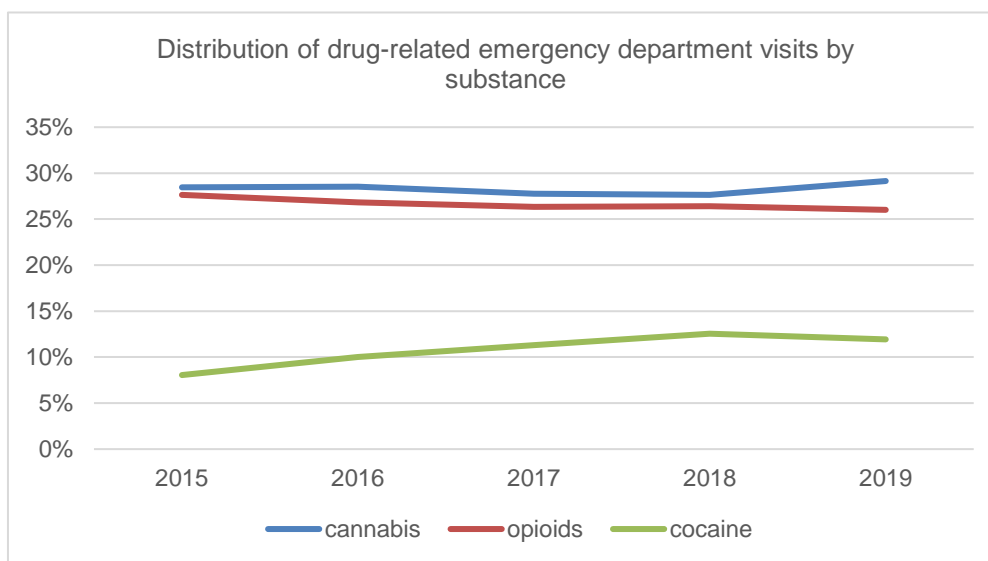
The Oscore® network covered in 2019 more than 93% of hospital emergency presentations in France, 73% of these presentations were subject to coding (at least one principal diagnosis). Among these coded admissions, 19 305 emergency admissions related to drug use were counted, i.e. 1.3% of emergency admissions for all codes (Santé publique France 2019). Cannabis, opioids and cocaine were the most commonly identified substances. Hallucinogens, other stimulants and volatile solvents were the cause in less than 5% of emergency admissions and nitrous oxide in less than 1% of admissions.



	2015 No. SU* = 634		2016 No. SU = 660		2017 No. SU = 686		2018 No. SU = 699		2019 No. SU = 696	
	n	%	n	%	n	%	n	%	n	%
Cannabis	4581	28	4847	29	4991	28	5137	28	5627	29
Opioids	4449	28	4557	27	4738	26	4910	26	5022	26
Cocaine	1296	8	1701	10	2035	11	2332	13	2302	12
Multiple/unspecified substances	4557	28	4700	28	5062	28	4945	27	5003	26
Hallucinogens	575	4	550	3	550	3	583	3	572	3
Other stimulants	428	3	423	2	425	2	464	2	554	3
Volatile solvents	171	1	174	1	173	1	166	1	137	1
Nitrous oxide	39	0.2	37	0.2	41	0.2	48	0.3	58	0.3

\*No. SU= Number of active OSCOUR® emergency services

Between 2015 and 2019 the proportion of cocaine-related emergency admissions increased while those linked to opioids and cannabis remained stable.



T1.2.3. 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.

See T1.2.3 of the [2018 'HHR' workbook](#).

T1.2.4. **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

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

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

The most recent data on the biological prevalence of chronic hepatitis C (HCV RNA positive) among people who have experimented with intravenous drugs are from the 2016 Barotest survey, and the most recent data on declarative HIV and HCV serology are from 2019. (See T1.3.1 of the [2018 'HHR' workbook](#) and T1.3.1 of the [2021 'HHR' Workbook](#))

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

#### **Notifications of drug-related infectious diseases**

In 2020, injecting drug use was identified as the mode of infection in 1.5% of HIV-positive discoveries. Approximately 30 injecting drug users discovered their HIV status when they were already at an advanced stage (AIDS stage or CD4 count < 200/mm<sup>3</sup> excluding primary infection). At the time of discovery of HIV status, 5% of intravenous drug users were co-infected with hepatitis B virus (HBsAg) and 57% were positive for HCV antibodies (Santé publique France 2021).

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

See T1.3.3 of the [2018 'HHR' workbook](#).

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

See T1.3.4 of the [2018 'HHR' workbook](#).

T1.3.5. *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)

#### T1.4. Other drug-related health harms

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

T1.4.1. **Optional.** Please provide additional information on other drug-related health harms including co-morbidity (suggested title: Other drug-related health harms)

#### 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. Please specify the defined actions and targets and provide references to these documents in section T 5.1. 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). The objectives of harm reduction actions are defined in a national reference framework for harm reduction actions for drug users ([Decree n°2005-347 of 14 April 2005](#)):

- Preventing severe, acute or chronic infections, especially those related to the use of shared injection equipment
- Preventing acute intoxication, including fatal overdoses from drug use
- Preventing and managing acute and related psychiatric disorders
- Referring drug users to emergency services, general care, specialist care and social services
- To improve their physical and mental health and their social integration

The law provides harm reduction workers with legal protection in the context of the exercise of their harm reduction duties and specifies that harm reduction also applies to detained persons (Article L.3411-8 of the French Public Health Code, [Law No. 2016-41 of 26 January 2016](#) on the modernisation of our health system). The modalities of screening in prisons and the risk reduction policy are defined in a guide published jointly by the Ministry of Justice and the Ministry of Health and updated periodically (Ministère de la Justice and Ministère des Solidarités et de la Santé 2017).

The 2018-2022 National Plan for Mobilisation against Addictions (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, and preventing overdose. (See T.1.1.1 of the [2018 'HHR' workbook](#) for broad outlines of this plan).

#### Infection control

HIV and hepatitis prevention is part of the overall goal of eliminating HIV and HCV by 2030 and 2025, respectively. The objectives are set out in two plans of the Ministry of Health: the Priority Prevention Plan (Direction générale de la santé 2018) and the National Sexual Health Strategy (Ministère des Affaires sociales et de la Santé 2017). This includes reducing the time between infection and initiation of treatment and addressing the specific needs of vulnerable people including drug users.

#### Preventing acute poisoning

In France the majority of overdose deaths are due to opioids. The Ministry of Health has established a 2019-2022 opioid overdose prevention plan ("Preventing and Responding to Opioid Overdose") (Ministère des Solidarités et de la Santé 2019) with five objectives:

1. Improving professional practices
2. Ensuring ready-to-use naloxone is widely spread
3. Involving users and their friends and family
4. Networking everyone involved on a territorial level and promoting collaborative local action
5. Improving the vigilance, alert and response system

T1.5.2. Please describe the structure of harm reduction service organisation in your country, including funding sources. Describe the geographical coverage. Comment on its relationship to the treatment service provision system and the extent to which these are integrated or operate separately. Where possible, please refer to the EMCDDA drug treatment system map (see Treatment workbook) to identify the range of treatment providers that are also delivering harm reduction services. Trends: Please comment on trends regarding harm reduction service organisation (suggested title: Organisation and funding of Harm reduction services)

#### **Organisation of harm reduction services**

The organisation of harm reduction is based on medical and social structures (CAARUD, CSAPA). Outpatient structures (pharmacies, primary care) and associations contribute to this.

CAARUDs are low-threshold facilities. Drug users can benefit from counselling, information, provision of harm reduction materials and support in accessing care and rights. The treatment of users is anonymous and free of charge. Depending on the CAARUD, users are received in a fixed location and/or a mobile unit (truck or bus). CAARUDs can also organise "walkabouts" (street interventions) or hold meetings in social housing centres or in prisons. They can intervene in Youth Addiction Outpatient Clinics (CJC) and occasionally in party settings.

CSAPAs have a harm reduction mission in addition to their medical and psycho-socio-educational treatment of people suffering from addiction. They prescribe opioid substitution treatment (OST). However, the latter relies to a large extent on general practitioners. CSAPAs operate on an outpatient basis and/or with individual or collective accommodation. Consultations are free of charge and confidentiality is guaranteed. CSAPAs can work with prisoners and people leaving prison (See the 'Treatment' workbook).

CAARUDs and CSAPAs can be run by associations or public health care institutions. Their authorisation is granted for a period of 15 years. Renewal of the authorisation is subject to an assessment of the quality of the services they provide, according to a procedure drawn up by the National Authority for Health (Article L.313.1 of the French Social Action and Family Code).

CAARUDs and, more rarely, CSAPAs can work in partnership with pharmacies within the framework of syringe exchange programmes. The involvement of pharmacies in the programme is voluntary and unpaid. Partner CAARUDs and CSAPAs provide support to the pharmacies by giving them information on harm reduction and useful information for referring users to the local support network. Pharmacies also participate in harm reduction by selling prevention kits. Automatic distribution machines managed by associations or local authorities complete the scheme for distributing prevention kits (see T1.5.3).

#### *Funding*

The recognition of CSAPAs and CAARUDs as medico-social establishments (Article L312-1 of the Social Action and Family Code) secures their status and their funding, which is provided by the national health insurance scheme.

#### *Coverage of the territory*

In 2019, 148 CAARUDs were registered in France, including six located in French overseas departments. All departments have CSAPAs and only 5 departments (out of a total of 101) do not have a CAARUD. The facilities are highly concentrated in large urban areas. More than half (51% of CAARUDs, or 75 centres in 2018) are located in a municipality of at least 200 000 inhabitants. There are no centres in rural areas and only three are located in a small urban district (less than 20 000 inhabitants). The strong presence observed of harm reduction facilities in the major urban areas is notably linked to the relatively high number of CAARUDs located in Paris or in the greater Paris region (5% of the total number of CAARUDs identified at a national level).

In 2018, 1 717 pharmacies are involved in the Syringe Exchange Programmes (SEP) throughout the country (RESPADD 2018). Created in 2011, the remote syringe exchange programme aims to meet the needs of users who are far from the medical-social system.

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 (suggested title: Provision of harm reduction services)

- a) Describe how **infectious diseases testing** is organised and performed in your country, incl. for which infections drug users are screened, **and if testing is routinely available at drugs facilities**;
- b) Describe how **syringe distribution** is organised in your country (reference to ST 10 data),
- c) Which equipment and drug use paraphernalia (beyond syringes/needles) are provided (indicate your reply by "x" in relevant box- one per line);

If available, address:

- d) Take-home naloxone programmes and emergency response training (settings, target groups);
- e) Supervised drug consumption facilities;
- f) Post-release / transition management from prison to community, provided by drugs facilities;
- g) Vaccination, e.g. hepatitis B vaccination campaigns targeted at PWID;
- h) Infectious diseases treatment and care: e.g. describe referral pathways or care partnerships;
- i) Sexual health counselling & advice, *condom distribution*;
- j) *Optional. Interventions to prevent initiation of injecting; to change route of administration of drugs; mental health assessments.*

#### a) *Infectious diseases testing*

Drug users can be screened for HIV and hepatitis B and C at CAARUDs, CSAPAs and associations involved in screening for infectious diseases. Rapid diagnostic tests (RDT) are favoured at these facilities. In some of them, it is complemented by dried blood spot testing. The performance of the RDTs is governed by a financing and authorisation scheme which, since June 2021, has included the HBV RDT in addition to the HIV and HCV RDTs ([order of 16 June 2021 setting out the conditions for carrying out the RDTs](#)). In the event of a positive RDT, the person concerned is systematically referred, and if necessary, accompanied, to a doctor or a health service for a biological diagnosis. Some facilities can take the samples for

biological screening directly. Some CAARUD have Cepheid's GenExpert device which can measure the HCV viral load in less than 2 hours.

Drug users can also go to an anonymous and free screening centre (CeGIDD),<sup>1</sup> possibly referred or accompanied by CAARUD workers. Users who are furthest from harm reduction and care services can be screened during "external" screenings carried out by the CAARUDs and associations. The remote harm reduction scheme (SAFE association) offers the possibility of requesting blood or capillary screening for hepatitis C via the website [Access to screening \(depistage-hepatite.fr\)](http://depistage-hepatite.fr).

The other facilities that offer free screening are those providing sexual health services (CPEF, EICCF)<sup>2</sup>. Screening can also be done in the outpatient or inpatient health system. When social security coverage is available, HIV and HCV testing is covered at 100%, but screening for chronic HBV markers is currently only covered at 65%. Self-screening tests for HIV-infection screenings are available in pharmacies since September 2015 and complement the measures available to meet specific needs.

*b) Organisation of syringe distribution*

The supply of injection equipment is provided by 4 actors:

- CAARUDs and CSAPAs, which provide distribution on their premises, in mobile units where appropriate, but also via automatic distribution machines and via a network of partner pharmacies.
- Pharmacies that sell injection kits (Stéribox®).
- The managers of automatic distribution machines, such as associations and local authorities, who make prevention kits such as the Stéribox® or Kit+ available to drug users via these machines.
- The postal Needle and Syringe Exchange Programme coordinated by the SAFE association, which offers free personalised delivery of consumption materials.

The most recent data on the total number of syringes distributed by all actors is from 2018 with a total number of syringes of about 12 600 000. This figure is probably overestimated due to double counting. Indeed, the number of syringes distributed by the CSAPA via the syringe exchange programme is potentially counted twice (in 2018 the total number of syringes distributed by the syringe exchange programme is approximately 416 000 syringes).

In 2019, the CAARUDs, which supply the majority of syringes, distributed more than 8 240 000 syringes (approximately 8 065 000 in 2018).

*c) Distribution of equipment and drug use paraphernalia*

Type of equipment	routinely available	often available, but not routinely	rarely available, available in limited number of settings	equipment not made available	information not known
pads to disinfect the skin	X				
dry wipes	X				
water for dissolving drugs	X				
sterile mixing containers	X				
filters	X				
citric/ascorbic acid	X				

<sup>1</sup> CeGIDD: free information, screening and diagnosis centres on human immunodeficiency virus infection, viral hepatitis and infections.<sup>2</sup> CPEF: Family planning and education centres, EICCF: Family information, counselling and advice centres.

<sup>2</sup> CPEF: Family planning and education centres, EICCF: Family information, counselling and advice centres.

bleach				X except in prison	
condoms	X				
lubricants	X				
low dead-space syringes	X				
HIV home testing kits	X				
non-injecting paraphernalia: foil, pipes, straws	X				
List of specialist referral services: e.g. drug treatment; HIV, HCV, STI testing and treatment	X				

All the distributors of inhalation equipment (n = 13) are located in the Ile de France region.

d) Naloxone distribution programme

Currently two specialities are marketed in France:

- Prenoxad<sup>®</sup> intramuscular naloxone kits (0.91 mg/ml) are commercialised since June 2019. The Prenoxad<sup>®</sup> kit is available in pharmacies for 23 euros and in specialised facilities. This kit, whereby 65% can be reimbursed when prescribed, can also be purchased without a prescription.
- The Nyxoid<sup>®</sup> nasal spray kit, indicated for use in adolescents aged 14 and over and adults, has been available on the market since September 2021. The kit contains 2 single-dose vials of 0.1 ml. Each nasal spray delivers 1.8 mg of naloxone. Nyxoid<sup>®</sup> is available in health care institutions, CSAPAs and CAARUDs. The box of 2 vials costs €31.40 and is reimbursed at 65%. Nyxoid<sup>®</sup> is subject to mandatory medical prescription, whereas nasal naloxone 0.9 mg per unit, available in France until November 2020, was not subject to medical prescription.

A partnership between the remote harm reduction scheme (SAFE association) and a CSAPA (Nova Dona) has made it possible to send naloxone to users of this scheme by post. This option is currently limited to certain regions.

In June 2020, the Ministry of Health published information and training materials on opioid overdose (updated in 2022): memos, posters, flyers for the public and health professionals (Ministère de la Santé et de la Prévention 2022). The government also supports an inter-association online training course called “Une heure pour apprendre à sauver une vie” or “One hour to learn how to save a life” ([www.naloxone.fr](http://www.naloxone.fr)).

e) Drug consumption rooms

Following the publication in 2021 of the INSERM evaluation report on the two DCRs opened as part of the experiment launched in 2016 (INSERM 2021), the regulatory context for DCRs has changed. [Law No. 2021-1754 of 23 December 2021 on the financing of social security for 2022](#) extends the experiment until December 2025 in order to allow them to be opened in new territories where the experiment could be of interest. It has also added the “access to care” orientation to their characterisation. DCRs are evolving into HSAs (“haltes soins addiction” or addiction care centres). The HSAs are spaces for harm reduction through supervised use and orientation towards a physical and psychological health pathway adapted to the situation of drug users. They can be opened in CSAPAs and CAARUDs and can take the form of mobile units. The specifications for the HSAs are national and are set out in an order ([order of 26 January 2022 approving the national specifications for addiction care centres](#)). The implementation of HSAs is entrusted to CSAPAs and CAARUDs.

The general objectives of HSAs are:

- To help reduce the risk of overdose, infection and other complications of drug use among active drug users by providing safe conditions for drug use and sterile and/or single-use personal equipment;
- To help to bring drug users and diverted drug users into a health pathway
- To contribute to improving users' access to rights, social services and accommodation or housing;
- To help reduce public nuisance, including the presence of injection equipment in the public sphere.

The HSAs must be part of a network of partnerships with medico-social and health facilities in order to strengthen referral and medico-psycho-social treatment, particularly psychiatric treatment.

f) Harm reduction measures on release from prison

See paragraph c) of section T1.5.3 of the [2017 'HHR' workbook](#) and also section T1.3.2 of the [2021 'Prison' workbook](#).

g) Hepatitis B vaccination and campaigns targeted at drug users

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

h) Infectious diseases treatment and care

Since 2019, a patient-specific care pathway has been possible for hepatitis C. The simplified management allows for an optimisation of the time between screening and treatment. A number of CSAPAs offer advanced hepatology consultations (to ensure the assessment of hepatitis C, the introduction of treatment and follow-up) and expert services for combatting viral hepatitis carry out “external” duties. (See paragraph h) of section T1.5.3 of the [2021 'HHR' Workbook](#)).

i) Sexual health counselling & advice, condom distribution

Preventing sexual risks through a comprehensive sexual health approach is at the heart of CeGIDD's mission. Condom distribution is one of CAARUD's and CSAPA's harm reduction goals. In addition, prevention kits (Steribox®), sold in community pharmacies, contain a condom.

j) Preventing first-time injection

See paragraph f) of section T1.5.3 of the [2018 'HHR' workbook](#).

k) Support and education on injection-related harm

See paragraph g) of section T1.5.3 of the [2017 'HHR' workbook](#).

l) Drug analysis as a harm reduction measure

Drug testing allows users of psychoactive substances to learn about the composition of their product by having it analysed. This service enables people to become informed, make choices based on reliable information and thus better protect and improve their health (See paragraph l) of section T1.5.3 of the [2021 'HHR' Workbook](#)).



The network formerly supported by *Médecins du Monde's* XBT mission is now called “Analyse Ton Prod” (Analyse Your Product). Led by *Fédération Addiction*, its aim is to coordinate and support actors who want to set up a harm reduction scheme. The OFDT is a partner in the network and participates in the working meetings to set up the scheme. “Analyse ton prod” is part of TEDI (Trans European Drug Information), a network of European organisations offering drug analysis as a harm reduction tool.

T1.5.4. Trends: Please comment on current trends regarding harm reduction service provision (suggested title: Harm reduction services: availability, access and trends)

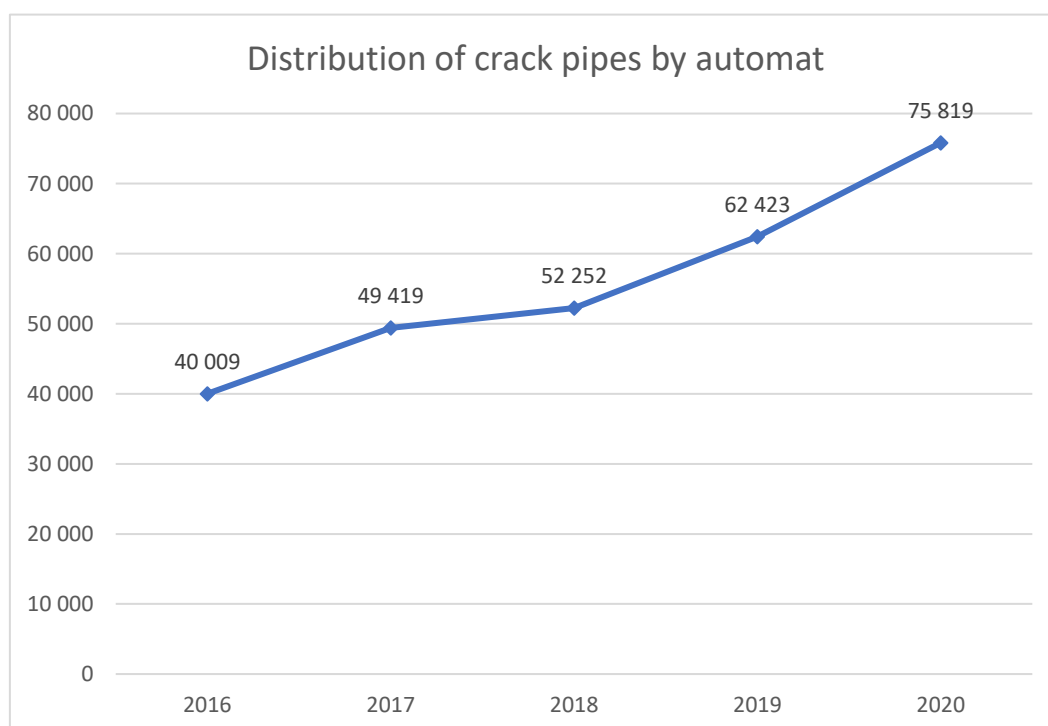
Trends: Syringe trends: Please comment on the possible explanations of short term (5 years) and long-term trends in the numbers of syringes distributed to injecting drug users, including any relevant information on changes in specific sub-groups, and changes in route of administration.

Actions to promote the wide distribution of naloxone and the involvement of users and their families in the prevention of overdoses are continuing. The range of products on offer has expanded with the launch of Nixoid<sup>®</sup>, but its accessibility remains limited by the requirement for a medical prescription.

The extension of the experimental DCRs, which have become HSAs, should enable these harm reduction spaces to be opened in new areas.

The distribution of syringes by automatic distribution machines remains a fragile scheme. In fact, the fleet of automatic distribution machines is ageing and their durability on certain sites is not guaranteed for local political reasons or because of repeated acts of vandalism. Thus, in 2021, out of a fleet of 270 automatic distribution machines, 13 were out of service and 14 had been dismantled and not reinstalled. Of the 243 operational automatic distribution machines, 124 required maintenance work.

The distribution of crack pipes by automatic distribution machines, currently only available in the Île-de-France region, saw a strong increase between 2016 and 2019. As part of the 2019-2021 Crack Plan, new distribution sites have been set up (SAFE 2021).



Source: Report on the National Automatic Distribution Machine Scheme - SAFE Association

## Syringe trends

In 2020, new outpatient admissions for the postal syringe exchange programme increased by 40% to 1 384 users (Association SAFE 2020). This increase was partly due to the COVID-19 pandemic and lockdown.

T1.5.5. **Optional.** Please provide any additional information you feel is important to understand harm reduction activities within your country. Information on services outside the categories of the 'treatment system map' may be relevant here (e.g. services in pharmacies/dedicated to HIV/AIDS, 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

T1.6.1. **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)

### Targeted interventions for other drug-related health harms

The issue of drug use in the context of "chemsex" has been significantly addressed by public authorities in recent years. For example, they commissioned a report on this subject in 2018 (Milhet 2019) and more recently a second report in 2021 (Benyamina 2022). The latter, published in 2022, established the state of play on chemsex and its health impacts and made recommendations on the prevention and reduction of the risks related to this practice. These recommendations are implemented as part of the 2021-2024 sexual health roadmap (Ministère des Solidarités et de la Santé 2021). One of these actions is to improve the identification and treatment of people practising chemsex. In addition, community health workers and associations, including remote harm reduction, are setting up initiatives to develop harm reduction messages and actions aimed at chemsex users and to encourage their referral to the care scheme.

## 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.

T1.7.1. **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 T1.7.1 of the [2017 'HHR' workbook](#).

T1.7.2. **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.

T3.1. Please report on any notable new or topical developments observed in drug related deaths and emergencies in your country since your last report (suggested title: New developments in drug-related deaths and emergencies)

Cf. T1

T3.2. 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)

Cf. T1

T3.3. 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)

The "Analyse Ton Prod" product analysis network continues to be structured and developed. Pilot laboratories are developing and testing analytical procedures. A link has been made between the OFDT's SINTES monitoring scheme and this new network.

In addition, the OFDT participates in the scientific committee of the evaluation project financed by MILDECA for the *KnowDrugs* application. This application, developed by the harm reduction association Ithaque, is a tool intended for users and aims to disseminate objective information to help reduce the harm related to the use of psychoactive substances. The objective of this evaluation is to assess the interest of this tool in the French harm reduction framework with a view to its deployment across the whole country. Depending on the evaluation of the tool, a Europe-wide deployment could also be envisaged.

**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.

T4.1. **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.)

T4.2. **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.

T5.1. Please list notable sources (including references to reports and grey literature) for the information provided above (suggested title: Sources)

**DRD:** Please describe the monitoring system to complement ST5/ST6 (clarify source GMR, SR, other; coverage; ICD coding; underestimation; underreporting and other limitations).

**Emergencies:** please provide the case definition for reporting drug-related emergencies and, if applicable, an overview of the monitoring system in place and important contextual information, such as geographical coverage of data, type of setting, case-inclusion criteria and data source (study or record extraction methodology).

**DRID:** Please describe the national surveillance approach for monitoring infectious diseases among PWID. Please describe the methodology of your routine monitoring system for the prevalence of infectious diseases among PWID as well as studies out of the routine monitoring system (ad-hoc). Be sure that in your description you include all necessary information for the correct interpretation of the reported data, i.e.: clarify current sources, ad-hoc and/or regular studies and routine monitoring, settings, methodology of major studies. Representativeness and limitations of the results.

**Harm Reduction:** Please describe national or local harm reduction monitoring approaches and data flow, incl. syringe monitoring. Where possible, provide any contextual information helpful to understand the information on needle and syringe programmes, drug consumption rooms and take-home naloxone programmes reported in ST 10 "Harm Reduction". Such context can be: statutory evaluation requirements, reports to funding bodies, research projects.

Provide references of policy documents relevant to the reduction of drug-related health harm.

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T5.2. Where studies or surveys have been used please list them and where appropriate describe the methodology (suggested title: Methodology)

### **Drug-related deaths**

#### **The National registry of causes of death**

The census of causes of death has existed in France since 1968. It is based on the death certificate issued by the doctor who pronounced the death. Death certification is mandatory in France. It is therefore a comprehensive register.

Annual statistics of causes of death are carried out by the Epidemiology Centre on Medical Causes of Death (CépiDc) of the National Institute for Health and Medical Research (INSERM) according to an internationally standardised procedure. The coding of causes of death is based on the 10<sup>th</sup> revision of the International Classification of Diseases (ICD10). Due to the infrequent use of the T code in France, direct drug-related deaths (DRD) are extracted from this registry by using an adaptation of the EMCDDA B selection: only codes X42, X62, Y12, F11, F12, F14, F15, F16 and F19 are retained.

There is an underestimation of DRDs in this registry. This is partly due to the fact that the results of forensic investigations are not always transmitted to the CépiDC, which does not allow the temporary code "causes unknown or ill-defined" initially assigned to them to be changed. The introduction in 2018 of an additional medical section transmitted directly to the CépiDC by the doctor who carried out the medical or scientific research into the causes of death or the forensic autopsy should make it possible to improve the quality of the data, if it is effectively used. Conversely, there may be false positives. Indeed, deaths by morphine overdose occurring in persons over 50 in a palliative care context, may appear as deaths of drug users. Also, data for year N are only available in year N+2 at the earliest and the registry is not very informative about the substances involved.

#### **The Specific Registers DRAMES and DTA**

The 2 surveys records deaths that have been the subject of a judicial investigation and of a request for toxicological analysis and/or autopsy as part of the search for the cause of death. The analyses are carried out at the at the Public Prosecutor's request. The deaths are notified to the ANSM and to the CEIP- A in Grenoble by volunteer toxicologist analysts throughout France, the number of which varies according to the year.

##### **■ DRAMES: Drug and Substance Abuse-related Deaths**

Set up in 2002, the survey includes substance abuse-related deaths that meet the EMCDDA definition of direct drug-related deaths. Suicide deaths are excluded. The investigation aims to describe the circumstances in which the body was found, the stage of abuse at the time of death

and the results of the autopsy, as well as to identify and quantify the substances involved by means of blood tests. The DRAMES register is not exhaustive.

▪ **DTA: Analgesia-poisoning deaths**

Introduced in 2013, this survey includes cases of death related to analgesic drug use. For these cases to be included, death must be attributed to one of the following substances: acetylsalicylic acid, buprenorphine, codeine, dextropropoxyphene, dihydrocodeine, fentanyl, hydromorphone, ketamine, morphine, nalbuphine, nefopam, oxycodone, paracetamol, pethidine, pregabalin or tramadol. Deaths occurring in a context of substance abuse and drug addiction are excluded, and those occurring in the context of suicide are included. The DTA register is not exhaustive.

The cases included in the DTA register (apart from those involving salicylic acid and paracetamol) added to those of DRAMES correspond to the deaths of the EMCDDA B selection.

**Drug use-related hospital emergency presentations**

**Oscour® network: Coordinated hospital emergency presentation monitoring network**

*Santé publique France, SpF (French Public Health Agency)*

Data collection is based on the direct extraction 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). In 2021, the surveillance network covered 93.3% of emergency department visits in the country.

Presentations to the emergency room in connection with drug use-related poisoning cover main diagnoses with EMCDDA selection B ICD codes (F11, F12, F14, F15, F16, F19, X42, X62, Y12, T40, T43.6).

**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.

**VIH/sida and viral hepatitis (Hepatitis B and C)**

Estimates of prevalence levels among drug users were based on data collected within the scope of various surveys:

- The reported prevalence of HIV, HBV and HCV are delivered since 2005 (Palle and Vaissade 2007), these prevalence numbers have been supplied by the RECAP scheme of patients seen in CSAPAs and by surveys of patients seen in low-threshold structures (CAARUDs), particularly ENa-CAARUD surveys.

- The biological prevalence of HIV and HCV, determined using blood samples, were collected from the Coquelicot survey (Jauffret-Roustide *et al.* 2009) conducted in 2004 and 2011.
- Estimates of the national incidence of AIDS, HIV infection and acute hepatitis B infection were also performed.

### **Système de surveillance VIH/sida**

*Santé publique France, SpF (French Public Health Agency)*

Notification of new AIDS cases has been mandatory since 1986. The new HIV diagnoses were introduced in 2003 [[Circulaire DGS/SD5C/SD6A n°2003-60 du 10 février 2003 relative à la mise en œuvre du nouveau dispositif de notification anonymisée des maladies infectieuses à déclaration obligatoire](#)]. HIV data is the combination of biological information from biologists and epidemiological and clinical information from clinical physicians. AIDS notifications, which are anonymised from the outset, are only sent by physicians.

Virological monitoring (Elisa test based on the detection of specific antibodies) is carried out in parallel by the National HIV Reference Centre.

Since April 2016, biologists and clinicians have been required to report their diagnoses online via the e-DO web application ([www.e-do.fr](http://www.e-do.fr)). To estimate the actual number of HIV-positive test results, data must be adjusted to take into account under-reporting (around 30%), missing data and reporting delays. As reporting behaviours have changed as a result of the shift from paper to online reporting, the data correction method has had to be adapted. The current method has been applied retrospectively to all cases diagnosed since 2010 in order to analyse temporal developments. This method resulted in a higher number of estimated HIV-positive discoveries than previously produced.

### **Acute Hepatitis B Monitoring System**

*Santé publique France, SpF (French Public Health Agency)*

Any case of acute hepatitis B that meets the following criteria should be reported: anti-HBc IgM detected for the first time or, if IgM was not tested for, HBsAg and total anti-HBc antibodies demonstrated, in the diagnostic context of acute hepatitis. The collected data help describe the epidemiological profile of infected individuals and to estimate the incidence in France and any changes thereof. To do this, the data coming from reports are corrected for under-reporting, this underestimation being assessed at 85-91% in 2010. They also help assess the impact of the prevention policy by quantifying the spread of the hepatitis B virus.

### **Barotest 2016**

*Santé publique France, SpF (French Public Health Agency)*

The Health Barometer is a telephone survey, that has been repeated regularly since 1992, by taking a random sample compared to a representative sample of the general metropolitan population aged 15-75, with the aim to monitor the main behaviours, attitudes and perceptions regarding risk taking and the state of health of the population residing in France.

In 2016, infectious diseases was one of the survey's main subjects, including testing for HCV, HBV and HIV throughout life, the HBV vaccination and major high-risk exposures to HCV, HBV and HIV. A virological component called "Barotest" has been linked to the Health Barometer. At the end of the interview, participants over 18 with social coverage were offered free HCV, HBV and HIV testing by taking a sample of their own blood at home on blotting paper (research on anti-HCV antibody, HCV RNA, HBsAg, anti-HIV antibody) (Lydié *et al.* 2018). Nearly four in ten people (39%) who were offered the "Barotest" accepted, i.e. 6 945 people.



## **Drug users in treatment**

### **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).

In 2019, 2 735 fully completed questionnaires were included in the analysis (compared to 3 129 in 2015 and 2 905 in 2012). Between 1 and 161 questionnaires per CAARUD (20 on average) are included in the database. The data were adjusted according to the weight of the annual active files of each structure in the national active file of CAARUDs in 2018 (i.e., 65 602 individuals received at the premises and mobile units).

### **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.