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for Drugs and Drug Addiction



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EMCDDA
by the Reitox National Focal Point**

FRANCE

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

REITOX

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Summary

1. Drug policy: legislation, strategies and economic analysis

In France, new legal provisions in 2012-2013 focused mainly on supply reduction. More specifically, they aimed to regulate the sale of medication on the Internet and prevent counterfeiting. The government sought new bilateral agreements on international law enforcement cooperation. In the fight against local drug trafficking, measures that aim to reinforce domestic safety were also adopted.

In September 2013, the government's action plan against drug and addictive behaviours, prepared by the MILDT, was adopted during an interministerial committee meeting. This plan has three main priorities: to base public action on observation, research and evaluation; to take the most exposed populations into consideration to reduce risks and health and social harm; and to reinforce safety, tranquillity and public health, both locally and internationally.

The State budget credits approved to implement the anti-drug policy and treat addictive behaviour was €1,108 million in 2012. National Health Insurance Fund expenditures (*Assurance maladie*) to fund addiction structures amounted to €334 million in 2012. An additional €37 million in National Health Insurance funding went to two plans related to additions and health in prison settings. In total, the credits used by the government and National Health Insurance Fund in 2012 to implement the anti-drug and addiction behaviour prevention policy amounted to a total of €1,479 million, compared with €1,428 million in 2011.

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

The latest data available on the general population are those of the 2010 INPES *Baromètre santé* (health barometer survey of the French National Institute for Prevention and Health Education) and of the surveys conducted among teen and school populations (ESCAPAD 2011, ESPAD 2011 and HBSC 2010).

Data from the general population aged 15 to 64 years of age shows a current overall stabilisation of the levels of cannabis use (at around 8.4%). The increase in cannabis lifetime use is linked to a “stock” effect of former generations of smokers. Among the rarer substances, there was a significant increase in cocaine lifetime use and current use (from 2.4% to 3.6% and from 0.5% to 0.9% respectively). The survey furthermore revealed a significant increase in heroin lifetime use (from 0.8% to 1.2%) and hallucinogenic mushroom lifetime use (from 2.6% to 3.1%), whereas ecstasy lifetime use seems to be on the decline.

Among youths aged 11 to 17, the youngest are very little affected by the use of illegal drugs (lifetime use in children under the age of 13 was less than 6.4%). Cannabis remains the most widely used substance by young French people aged 15 and older. Of the other illegal drugs, poppers, inhalants and hallucinogenic mushrooms are the most frequently tried (by age 17, 9.0%, 5.5% and 3.5% of young people had tried these other drugs respectively, versus 41.5% for cannabis).

3. Prevention

Alcohol and tobacco prevention policies largely employ an environmental strategy established by lawmakers. Subsequently, in addition to health education measures, policies employ controls on prices (through taxation), sales (through composition and packaging), distribution and use (in young populations, in certain locations or in certain situations), as well as advertising restrictions.

The year 2012 was one of transition in expectation of the new policy strategies to prevent addictive behaviour. There were no new developments in this area. In 2012, the MILDT engaged into consultations with the different field players to determine a structured evidence-based prevention policy. The school setting (and mainly secondary educational environments) and the occupational environment remain the primary targets for universal prevention.

4. Problem drug use

A multi-centre “capture-recapture” study was launched at the end of 2010 in six French cities: Lille, Lyon, Marseille, Metz, Rennes and Toulouse. The prevalence data collected in these cities enabled a new assessment to be performed on the number of problem drug users in 2011, leading to estimates ranging from 275,000 to 360,000 people. The mean prevalence values estimated by the different methods seem to be on the rise compared with those of 2006. Nevertheless, it is difficult to confirm an increase given the wide, overlapping confidence intervals for these two years.

The 2012 ENa-CAARUD study demonstrated the significant social vulnerability of problem drug users who frequented harm reduction facilities:

- nearly half of these users (47%) were living in unstable housing conditions (i.e., were homeless, living in squats or living in temporary housing)
- one out of every four users did not have a legal source of income; 57% lived on social welfare (mostly RSA, Active Solidarity Benefit and AAH, Disability Living Allowance)
- approximately 14% of problem drug users had been incarcerated at some point during 2012.

One third (31%) of problem drug users had taken heroin in the last month, nearly 37% had taken High-Dose Buprenorphine (78% of these had taken HDB as a substitution treatment) and 36% had taken cocaine. According to the TREND observation scheme, there was an observed dispersion of the most fragile users, which in turn tended to worsen their precarious situation. There were also increasing problems related to chronic alcohol use in older users. Furthermore, the upward trend in heating and inhaling drugs continued, and spread to the use of substances other than heroin and cocaine.

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

The figures on new patients seen in outpatient CSAPAs in 2012 do not show marked changes in patient characteristics. Mean patient age rose steadily from 2005 to 2011, stabilising at nearly 31 years (30.8) in 2012. This "ageing" is essentially due to an approximate 10-point decrease in the proportion of 15-24-year-olds and a doubling in the proportion of 40-year-olds from almost 11% in 2005 to over 22% in 2012. The data on the primary drug for the 2007-2012 period revealed a slight downward trend for cannabis, despite the increase seen in 2011, and a nearly symmetric increase for opioids.

Nearly 150,000 people were reimbursed for opioid substitution treatments in 2011, with a clear predominance of HDB reimbursements (a typically French phenomenon) representing 71% of the total, even though the proportion of methadone is increasing every year.

6. Health correlates and consequences

The number of new AIDS cases among injecting drug users (IDUs) has fallen continuously since the mid-90s. Of the new AIDS cases diagnosed in 2011, 7.4% of these were among IDUs compared to one quarter in the mid-90s.

The prevalence of HIV and HCV infection appears to have been falling for several years, both because of public health measures and because of changes in practices by drug users. However, the reported HCV prevalence among IDUs is still high: it was approximately 33% in 2012, but the actual prevalence is most likely much higher.

According to the most recent data available, the number of fatal overdoses in 15-to-49-year-olds has stabilised at around 300 since 2008 (294 in 2010 compared with 305 in 2009). In 2010, opioid substitution treatments, and methadone in particular, allegedly caused more overdose deaths than heroin.

7. Responses to drug-related health correlates and consequences

The prevention of drug-related infectious diseases is based on the harm reduction policy, and particularly the distribution of sterile, disposable injection equipment as well as information on the risks related to drug use and on access to opioid substitution treatments. It is also based on encouraging people to undergo screening for HIV, HCV and HBV as well as inciting people to get vaccinated against HBV.

In 2010, 9.9 million syringes were sold or distributed by CAARUDs (including CAARUD automatic dispensing machines), non-CAARUD automatic dispensing machines and pharmacies (*Stéribox*[®] kits). Given the absence of data on syringes per unit in pharmacies, it is impossible to compare this figure with the 2008 estimate of 14 million and confirm the continuous downward trend since the late 90s. From 2008-2010, the proportion of CAARUD clients who had never been screened first declined, and then remained stable, before declining once again in 2012. The majority of users who stated being HIV- or HCV-infected had had at least one medical visit for their infection in the last year, but fewer of them were receiving appropriate treatment.

8. Social correlates and social reintegration

As in previous years, indicators in 2011 on the social situation of users seen in CSAPAs seemed to indicate a slight decrease in the precarious lifestyle of users. However, this may have been related to the increase in mean age and in the proportion of people with alcohol problems - two factors related to a lower level of precariousness. Nevertheless, in CAARUDs, there was an increase in the number of very precarious users seen.

Social support for drug users in France is mainly provided by specialised structures (CSAPA and CAARUD). However, in 2010, only 15% of CAARUD activities pertained to providing access to administrative and social entitlements. Of these activities, barely one quarter involved housing interventions, while job-seeking, job-maintaining and training activities only represented 10%.

Housing, training and employment programmes for drug users are implemented in specialised structures, but there is no system in place for monitoring their operations.

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

In 2012, the number of people accused by law enforcement for simple use was 5 to 6 times higher than for all other drug-related offences (119,185 versus 21,017). Arrests for simple use represented 86% of all drug-related offences. The remaining 14% were arrests for use-dealing or local trafficking; arrests for international trafficking occur with the lowest frequency (1% of all drug-related offences). Cannabis is the reason for 90% of use arrests and 70% of dealing and trafficking arrests.

From 1990 to 2010, the number of drug-related convictions doubled to nearly 50,100, of which more than 29,000 arrests were for simple use. The number of convictions for simple use experienced the biggest increase, tripling since 1990 and experiencing a real jump since 2004 (+16% of mean annual increase).

Convictions for driving under the influence of narcotics also rose sharply in recent years (16,264 in 2011 versus 12,428 in 2010 and fewer than 6,600 in 2008), representing a 31% increase over the last available year. Of these convictions 34% resulted in a prison sentence (a suspended sentence in 80% of these cases), nearly half resulted in a fine and 17% in an alternative sentence (usually driver's licence confiscation).

10. Drug markets

Some substances, such as heroin and cocaine, were readily available and accessible in 2012. This situation was intensified by the strong presence of networks importing heroin from Afghanistan through the Balkans into Europe and the investment of certain trafficking organisations from disadvantaged suburbs in cocaine. In addition, the proximity of storage countries (Belgium, Netherlands, Spain) for these two substances enabled direct supply to border wholesalers.

For heroin and cocaine, there has been an observed decrease in the purity of seized street samples.

Like in 2011, the two main phenomena that stand out in 2012 pertain to the cannabis and New Psychoactive Substances (NPS) markets. In addition to *cannabis factories* and *cannabis social clubs*, there were reports of an increase in commercial indoor growing by individuals in France. Although the Internet is still the main vector for purchasing new psychoactive substances, "direct" sales are being seen with increasing frequency on the alternative techno scene. These sales tend to occur through users or isolated dealers having obtained the product through the Internet and preferring to microtraffic rather than deal through organised networks.

Part A: New developments and trends

1. Drug policy: legislation, strategies and economic analysis

1.1. Introduction

Definitions

The term "drug user" refers to a person who uses narcotic substances. The legal authorities often consider the possession of small quantities of narcotics, as well as cannabis cultivation for the purposes of personal use, in the same category as drug use.

Any drug-related offence may result in arrest (by the police, the *gendarmerie* or the customs department) and will be referred to the judicial services. Offences are examined on a case-by-case basis by the public prosecutor who, based on the principle of the *opportunité des poursuites* (appropriateness of proceedings), decides to take legal action against the offender, to simply close the case or to propose other measures as an alternative to prosecution. This principle enables situation-appropriate interventions to take place by making punishments fit the crimes. It also explains why court practices differ, since local criminal policies have territorial differences.

Data collection tools

The main sources used are the *Code pénal* (Penal Code), *Code de la route* (Traffic Code), *Code de la santé publique* (Public Health Code), *Code de l'action sociale et des familles* (Social Action and Family Code) and *Code du sport* (Sports Code), as well as official documents on public expenditure.

Background information

Two types of legislation govern drugs in France. The use, possession and supply of legal drugs (such as alcohol and tobacco) are regulated, but not forbidden. On the other hand, illegal drugs classified as narcotics¹ (heroin, cocaine, cannabis and hallucinogens, for example) are subject to a ban that is chiefly enshrined in the law of December 31, 1970², the provisions of which have been incorporated into the Penal Code and the Public Health Code. Current regulations make it illegal to use or deal in any substance or plant listed as a narcotic (regardless of the substance). A user is considered both an offender and someone who is sick.

The Public Health Code stipulates that drug users may have free, anonymous access to addiction treatment. This is the result of the adoption of the 1970 French law on narcotics that created specialised treatment measures including structures that are today called CSAPAs

¹ The list of narcotic substances covered by the law is detailed in an order from the Ministry of Health, following a proposal from the Director General of the French National Agency for Medicines and Health Products Safety (ANSM, formerly the AFSSAPS), in conformity with international regulations.

² Loi n°70-1320 du 31 décembre 1970 relative aux mesures sanitaires de lutte contre la toxicomanie et à la répression du trafic et de l'usage illicite des substances vénéneuses. JORF du 3 janvier 1971

(National Treatment and Prevention Centres for Addiction) and CTs (Therapeutic Communities). Access to HIV³ and hepatitis screening centres that are affiliated with health establishments (CDAGs⁴ and CIDDISTs⁵) is also completely free of charge.

Hepatitis B vaccination and viral hepatitis screening are free of charge and anonymous⁶ when they are performed in a CSAPA (art. L.3411-4 of the Public Health Code). Since the circular of 9 November 2009⁷, drug users are also entitled to receive hepatitis B vaccinations in CDAGs.

People being treated in a CDAG or CIDDIST are not required to reveal their identity. Since the adoption of the HPST law of July 2009⁸ (art. 108, codified in the Public Health Code, art. L.3121-2 and L.3121-2-1), if therapeutically necessary, a CDAG or CIDDIST physician may lift anonymity provided that the express, informed and voluntary consent of the patient is obtained. The purpose of this provision⁹ is to improve the support given to people to procure health treatment. Moreover, if expressly requested, drug users who spontaneously go to a dispensary or health establishment may remain anonymous from the moment they are admitted (art. L.3414-1 of the Public Health Code).

To maintain the confidentiality of personal and medical information, health professionals are required to comply with medical and professional confidentiality.

Drug users without income or with low income, like any person residing in France with limited means, are entitled to free primary health care and hospital care. Since 1999, drug users are also entitled to coverage under France's CMU universal health care coverage scheme. The person seeking health care pays the medical expenses out of pocket and requests reimbursement. Moreover, there is free supplemental health care coverage which exempts the person seeking health care from having to advance health care expenses. Non-residents of France may request the *Aide médicale d'état* (AME), governmental medical assistance provided to foreigners without health coverage

Narcotics use

Under the terms of article L.3421-1 (formerly art. L.628) of the Public Health Code, the illegal use of substances listed as narcotics constitutes an offence subject to one year's imprisonment and a fine of €3,750. However, the Public Health Code authorises a prosecutor to suspend proceedings against a drug user if said user agrees to undergo treatment.

³ Circulaire DGS/PGE/1C n°85 du 20 janvier 1988, relative à la mise en place d'un dispositif de dépistage anonyme et gratuit du virus de l'immunodéficience humaine. BO Santé n°88-28 bis, Fascicule spécial : l'infection par le virus de l'immunodéficience humaine, 1988. (NOR ASEP8810054C)

⁴ Anonymous free screening centre

⁵ Centre for providing information, screening, diagnosing and treating sexually transmitted diseases.

⁶ Loi n°2007-1786 du 19 décembre 2007 de financement de la Sécurité sociale pour 2008. JORF n°296 du 21 décembre 2007. (NOR BCFX0766311L), art. 72.

⁷ Circulaire DGS/MC2 n°2009-349 du 9 novembre 2009 relative à la mise en œuvre de l'action II-1,3 du plan national de lutte contre les hépatites B et C 2009-2012 ayant pour objectif de permettre aux usagers de drogues de bénéficier d'un service de proximité assurant gratuitement le dépistage de ces hépatites et, le cas échéant, d'une vaccination contre l'hépatite B. BO Santé, Protection sociale et Solidarités n°12 du 15 janvier 2010. (NOR SASP0927192C)

⁸ Loi n°2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires. JORF n°167 du 22 juillet 2009. JORF n°167 du 22 juillet 2009. (NOR SASX0822640L)

⁹ Arrêté du 8 juillet 2010 fixant les conditions de la levée de l'anonymat dans les consultations de dépistage anonyme et gratuit et dans les centres d'information, de dépistage et de diagnostic des infections sexuellement transmissibles. JORF n°166 du 21 juillet 2010. (NOR SASP1007832A)

The "delinquency prevention law" of 5 March 2007¹⁰ provided for a wider range of law enforcement measures that could be taken against drug users. It introduced a new *ad hoc* penalty: a mandatory, paying training course to raise awareness of the dangers of narcotics use (€450 maximum, the sum of a 3rd class contravention). Introduced by means of article L 131-35-1 of the Penal Code and by articles R131-46 and R131-47 of the Penal Code in application of decree number 2007-1388 of 26 September 2007¹¹, the aim of this measure is to make offenders fully aware of the danger and harm generated by the use of narcotics, as well as the social impact of such behaviour. The awareness-building training course may be proposed by the authorities as an alternative to legal proceedings and to fixed penalty notice. An obligation to complete the awareness training course may also be included in the criminal ruling as an additional measure. It applies to all adults and to minors over the age of 13¹².

This 5 March 2007 law expands the scope of court-ordered drug treatment measures, which now can be ordered at any stage of criminal proceedings: originally conceived as an alternative to prosecution (resulting in a suspension of the legal process), court-ordered treatments can now be ordered as a sentence enforcement measure, including for persons who have committed an offence related to alcohol consumption.

Narcotics use and road safety

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

The law of 3 February 2003¹³ introduced a new offence punishing any driver whose blood test revealed the presence of narcotics. Drivers can be imprisoned for up to two years and be fined up to €4,500. These sentences can be increased to three years' imprisonment and a fine of €9,000 if alcohol is consumed in conjunction with the use of illegal substances. The law of 18 June 1999¹⁴ and its application decree (of 27 August 2001)¹⁵ introduced mandatory drug use screening for all drivers who have been involved in a traffic accident resulting in immediate death or any accident involving bodily injury when said driver is suspected of having used narcotics. Since the adoption of the French homeland security performance planning act¹⁶ (the so-called LOPPSI 2 law) and its application circular of 28 March 2011¹⁷, drug use screening is now mandatory for people involved in traffic accidents, whether fatal or not. Moreover, this 28 March

¹⁰ Loi n°2007-297 du 5 mars 2007 relative à la prévention de la délinquance. JORF n°56 du 7 mars 2007. (INTX0600091L)

¹¹ Décret n°2007-1388 du 26 septembre 2007 pris pour l'application de la loi n°2007-297 du 5 mars 2007 relative à la prévention de la délinquance et modifiant le Code pénal et le Code de procédure pénale. JORF n°225 du 28 septembre 2007. (NOR JUSD0755654D)

¹² Circulaire CRIM 08-11/G4 du 9 mai 2008 relative à la lutte contre la toxicomanie et les dépendances. BO Justice n°2008/3 du 30 juin 2008 (NOR JUSD0811637C)

¹³ Loi n°2003-87 du 3 février 2003 relative à la conduite sous l'influence de substances ou plantes classées comme stupéfiants. JORF du 4 février 2003. (NOR JUSX0205970L)

¹⁴ Loi n°99-505 du 18 juin 1999 portant diverses mesures relatives à la sécurité routière et aux infractions sur les agents des exploitants de réseau de transport public de voyageurs. JORF n°140 du 19 juin 1999. (NOR EQUX9800010L)

¹⁵ Décret n°2001-751 du 27 août 2001 relatif à la recherche de stupéfiants pratiquée sur les conducteurs impliqués dans un accident mortel de la circulation routière, modifiant le décret n°2001-251 du 22 mars 2001 relatif à la partie réglementaire du Code de la route (décrets en Conseil d'État) et modifiant le Code de la route. ORF n°198 du 28 août 2001. (NOR EQU0100214D)

¹⁶ Loi n°2011-267 du 14 mars 2011 d'orientation et de programmation pour la performance de la sécurité intérieure. JORF n°62 du 15 mars 2011. (NOR IOCX0903274L)

¹⁷ Circulaire du 28 mars 2011 de la LOPPSI en ce qui concerne l'amélioration de la sécurité routière. BO Intérieur n°2011-03 du 31 mars 2011. (NOR IOCD1108865C)

2011 circular makes it possible for public prosecutors to request random narcotics controls on all drivers present at a given time and location (art. L.235-2 of the Traffic Code, amended by LOPPSI article 83).

Narcotics use in professional environments

The law steps up the penal sanctions applicable to employees in a position of public authority (or those carrying out a public service activity or involved in national defence) who commit drug use offences. They now risk a five-year prison sentence and a total fine of up to €75,000. Public transport company employees committing drug use offences while on duty are also subject to these penalties, in addition to further sanctions prohibiting them from carrying out their professional activities in the future and (where applicable) requiring them to undergo, at their own expense, an awareness-building training course on the dangers of narcotics use. The 20 July 2011 law¹⁸ (article L.4622-2 of the Labour Code) establishes the operating procedures for occupational health services, stipulating that occupational physicians are to provide advice to employers, workers and their representatives on the measures needed to prevent drug use and alcohol consumption at the workplace (see chapter 3).

Drug-trafficking

Anti-drug trafficking law enforcement has changed since the late 1980s. Aggravating circumstances are considered to exist when a drug trafficking incident involves minors or takes place in an educational, teaching or administrative establishment. Current legislation therefore stipulates distinct punishments for different trafficking-related offence types: minimum penalties sanction dealing and selling drugs for personal use (an offence created by the law of 17 January 1986¹⁹). Maximum penalties can include life imprisonment and a fine of €7.5 million (law of 16 December 1992²⁰) for certain laundering operations (as defined in the law of 31 December 1987²¹ and categorised as a criminal offence by the laws of 23 December 1988²², 12 July 1990²³ and 13 May 1996²⁴).

Following the introduction of the law of 17 January 1986, the fast-track court appearance procedure can be used in proceedings against small-scale traffickers. This law made it possible to immediately judge user-dealers following their arrest, much in the same way as the instigators of organised crime networks. The legal provisions pertaining to anti-money laundering measures that have been in effect since the 1990s subsequently enable drug traffickers to be pursued based on their outward signs of wealth. As result, the fact that an individual "is unable to account for resources corresponding to his or her lifestyle when in frequent contact with a drug user or

¹⁸ Loi n°2011-867 du 20 juillet 2011 relative à l'organisation de la médecine du travail. JORF n°170 du 24 juillet 2011. (NOR ETSX1104600L)

¹⁹ Loi n°86-76 du 17 janvier 1986 portant diverses dispositions d'ordre social. JORF du 18 janvier 1986

²⁰ Loi n°92-1336 du 16 décembre 1992 relative à l'entrée en vigueur du nouveau Code pénal et à la modification de certaines dispositions de droit pénal et de procédure pénale rendue nécessaire par cette entrée en vigueur. JORF n°298 du 23 décembre 1992. (NOR JUSX9200040L)

²¹ Loi n°87-1157 du 31 décembre 1987 relative à la lutte contre le trafic de stupéfiants et modifiant certaines dispositions du Code pénal. JORF n°3 du 5 janvier 1988. (NOR JUSX8700015L)

²² Loi n°88-1149 du 23 décembre 1988: Loi de finances pour 1989. JORF du 28 décembre 1988. (NOR ECOX8800121L)

²³ Loi n°90-614 du 12 juillet 1990 relative à la participation des organismes financiers à la lutte contre le blanchiment des capitaux provenant du trafic des stupéfiants. JORF n°162 du 14 juillet 1990. (NOR ECOX9000077L)

²⁴ Loi n°96-392 du 13 mai 1996 relative à la lutte contre le blanchiment et le trafic des stupéfiants et à la coopération internationale en matière de saisie et de confiscation des produits du crime. JORF n°112 du 14 mai 1996. (NOR JUSX9400059L)

trafficker", is considered an offence under the terms of the law of 13 May 1996, which makes "living off the proceeds of drugs" illegal.

The law of 9 March 2004²⁵ allows for reductions in the sentences handed down to offenders for offences ranging from drug dealing to all forms of trafficking if, "by having informed the administrative or legal authorities, the offender has made it possible to put an end to the offence and possibly identify other guilty parties". This possibility for "penitents" to avoid a sentence for trafficking is a new feature the French penal process.

The "delinquency prevention" law of 5 March 2007 provides for more severe penalties in the event of "directly inciting a minor to transport, possess, propose or sell narcotics" (up to 10 years imprisonment and a fine of €300,000). The penalties for certain offences committed under the influence of a narcotic substance or in a state of drunkenness have also been made more severe. Moreover, legislation provides for new investigative measures (including investigations based on the use of Information and Communication Technologies (ICT), or undercover purchases).

Finally, the law of 9 July 2010 (the so-called "*Warsmann law*"²⁶) established a new penal procedure enabling assets of suspects to be seized to ensure that they are confiscated if the suspects are eventually found to be guilty.

Trafficking of drug precursors

The production and sale of chemical precursors that may be used to extract drugs or manufacture synthetic drugs have been controlled in France since the introduction of the law of 19 June 1996²⁷. This law is part of the framework of current European regulations on the misuse of raw materials commonly used in the chemicals industry to supply narcotics trafficking networks. The law classifies controlled chemical substances into three categories established by decree. The law also requires companies involved in producing, selling or transporting controlled chemical products to be authorised by the Ministry of Industry to do so²⁸. The French National Mission for the Control of Chemical Precursors (MNCPC) is responsible for granting and renewing such approvals.

Opioid substitution treatments

Opioid substitution treatments (OSTs) were introduced in France in the 1990s. The marketing authorisation for methadone, granted in March 1995²⁹, was followed a few months later by that

²⁵ Loi n°2004-204 du 9 mars 2004 portant adaptation de la justice aux évolutions de la criminalité. JORF n°59 du 10 mars 2004. (NOR JUSX0300028L)

²⁶ Loi n°2010-768 du 9 juillet 2010 visant à faciliter la saisie et la confiscation en matière pénale. JORF n°158 du 10 juillet 2010. (NOR JUSX0912931L)

²⁷ Loi n°96-542 du 19 juin 1996 relative au contrôle de la fabrication et du commerce de certaines substances susceptibles d'être utilisées pour la fabrication illicite de stupéfiants ou de substances psychotropes. JORF n°142 du 20 juin 1996. (NOR INDX9500023L)

²⁸ Décret n°96-1061 du 5 décembre 1996 relatif au contrôle de la fabrication et du commerce de certaines substances susceptibles d'être utilisées pour la fabrication illicite de stupéfiants ou de substances psychotropes. JORF n°287 du 10 décembre 1996. (NOR INDD9600699D)

²⁹ Circulaire DGS/SP3/95 n°29 du 31 mars 1995 relative au traitement de substitution pour les toxicomanes dépendants aux opiacés et Avis d'octroi d'autorisations de mise sur le marché de spécialités pharmaceutiques : AMM du 21 mars 1995 pour le Chlorhydrate de méthadone, 5, 10 et 20mg, sirop en récipient unidose. JORF du 28 juin 1995. (NOR SANM9501657V)

of high-dose buprenorphine (HDB) in July of that same year³⁰. Subutex® (HDB) has been on the market since February 1996. Generics have been on the market since 2006. Considered to be safer than methadone (and as such, not classified as a narcotic), HDB can be prescribed by any physician: this flexible prescription system (methadone was reserved for specialised centres only - at least for the initial treatment phase) led to a major surge in HDB substitution prescriptions, which today account for approximately 80% of all substitution drugs reimbursed by the National Health Insurance Fund (*Assurance maladie*). As a result, a second "doorway" to substitution through health establishments was opened with the circular of 30 January 2002³¹ which made it possible for any doctor practising in a health establishment to initiate methadone substitution treatment.

Since 1993, a series of official texts and circulars have been published to "balance out" the prescription and dispensing of substitution treatments in France. In April 2008³², the health authorities decided to reinforce the conditions for prescribing and dispensing HDB in order to prevent fraudulent use. To obtain reimbursement, patients are now required to provide their doctor with the name of the pharmacist who will dispense the medication. Since this 1 April 2008 legislative order, not only is it mandatory to inscribe the name of the dispensing pharmacist on a prescription, but it is also necessary to establish a treatment protocol in the event of misuse. Moreover, the French National Agency for Medicines and Health Products Safety (ANSM, formerly the AFSSAPS) has established a risk management plan for each HDB product on the market.

The legal framework for harm reduction activities

The harm reduction policy aimed at drug users is the responsibility of the state (article L3121-3 of the Public Health Code modified by article 71 of the law of 13 August 2004³³). The policy aims to prevent the transmission of infection, overdose fatalities, intravenous drug use and the social and psychological damage caused by drug addiction. The purpose of the law of 9 August 2004³⁴, which created CAARUDs, stipulates that along with numerous other schemes and measures, these low-threshold structures should be used to further enforce the harm reduction policy (article L3121-5 of the Public Health Code). Thus, CAARUDs admit individuals and groups³⁵ and provides drug users with customised advice and information, support in obtaining access to treatment (which includes assistance with hygiene and access to first aid care), referrals to specialised or general treatment systems, encouragement to undergo screening for transmissible infections, support in exercising their rights, access to housing and professional integration or rehabilitation, provision of infection prevention equipment, and local resources

³⁰ Avis d'octroi d'autorisations de mise sur le marché de spécialités pharmaceutiques : AMM du 31 juillet 1995 pour le Subutex à 0,4 mg, 2 mg et 8 mg, comprimé sublingual. JORF du 27 octobre 1995. (NOR SANM9502981V)

³¹ Circulaire DGS/DHOS n°2002-57 du 30 janvier 2002 relative à la prescription de méthadone par les médecins exerçant en établissement de santé, dans le cadre de l'initialisation d'un traitement de substitution pour les toxicomanes dépendants majeurs aux opiacés. BO Santé n°2002/8 du 18 février 2002. (NOR MESP0230029C)

³² Arrêté du 1^{er} avril 2008 relatif à la liste de soins ou traitements susceptibles de faire l'objet de mésusage, d'un usage détourné ou abusif, pris en application de l'article L.162-4-2 du Code de la sécurité sociale. JORF n°83 du 8 avril 2008. (NOR SJSP0808150A)

³³ Loi n°2004-809 du 13 août 2004 relative aux libertés et responsabilités locales. JORF n°190 du 17 août 2004. (NOR INTX0300078L)

³⁴ Loi n°2004-806 du 9 août 2004 on public health policy. Loi n°2004-806 du 9 août 2004 relative à la politique de santé publique. JORF n°185 du 11 août 2004. (NOR SANX0300055L)

³⁵ Article R.3121-33-1 modified by the Décret n°2005-1606 du 19 décembre 2005 relatif aux missions des centres d'accueil et d'accompagnement à la réduction des risques pour usagers de drogues et modifiant le Code de la santé publique. JORF n°297 du 22 décembre 2005. (NOR SANP0524015D)

outside the centre with a view to establishing contact with users. CAARUDs also perform "social mediation" to ensure satisfactory integration into the neighbourhood and to avoid the kind of nuisances typically associated with drug use. Their coordination with other organisations has been stipulated in a circular³⁶.

Since May 1987³⁷, 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 1995³⁸, syringes may be issued free of charge by any not-for-profit association carrying out AIDS prevention or harm reduction activities 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 the 1987 suspension of the provisions of the 1972 decree.

It is illegal to arrest someone for narcotics use only in the immediate vicinity of harm reduction facilities or needle exchange sites (for example, pharmacy Syringe Exchange Programmes). Moreover, simply having a syringe on one's person is not considered to be sufficient proof of an offence for which someone can be arrested.

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 2005³⁹. Among other things, this stipulates that all participants, health professionals, social workers or members of associations, in addition to any persons to whom these activities are addressed, must be protected from accusations concerning the use or the incitation to use drugs during their work.

Orientations of the national anti-drug strategy

The first interministerial anti-drug action plan dates back to 1983. The next governmental plan on drugs, which spans 2013-2017, has been prepared by the Interministerial Mission for the Fight against Drugs and Drug Addiction (MILDT) with the coordination of the involved ministries. The MILDT also coordinated and listened to the advice of its network of drug addiction project managers (working under prefects), associations, local elected officials, territorial subdivisions and professional partners. This plan was made public in September 2013 after its presentation before an interministerial commission chaired by the Prime Minister.

³⁶ Circulaire DGS/S6B/DSS/1A/DGAS/5C n°2006-01 du 2 janvier 2006 relative à la structuration du dispositif de réduction des risques, à la mise en place des centres d'accueil et d'accompagnement à la réduction des risques pour usagers de drogues (CAARUD) et à leur financement par l'assurance maladie. BO Santé n°2006/2 du 15 mars 2006. (NOR SANP0630016C)

³⁷ Décret n°87-328 du 13 mai 1987 portant suspension des dispositions du décret n°72-200 du 13 mars 1972. JORF du 16 mai 1987. (NOR ASEM8700689D) ; Décret n°88-894 du 24 août 1988 portant suspension des dispositions du décret n°72-200 du 13 mars 1972. JORF du 27 août 1988. (NOR SPSM8801069D) and Décret n°89-560 du 11 août 1989 modifiant le décret du 13 mars 1972 réglementant le commerce et l'importation des seringues et aiguilles destinées aux injections parentérales, en vue de lutter contre l'extension de la toxicomanie. JORF du 12 août 1989. (NOR SPSM8901501D)

³⁸ Décret n°95-255 du 7 mars 1995 modifiant le décret n°72-200 du 13 mars 1972 réglementant le commerce et l'importation des seringues et des aiguilles destinées aux injections parentérales, en vue de lutter contre l'extension de la toxicomanie. JORF n°58 du 9 mars 1995. (NOR SPSP9500414D)

³⁹ Décret n°2005-347 du 14 avril 2005 approuvant le référentiel national des actions de réduction des risques en direction des usagers de drogue et complétant le Code de la santé publique. JORF n°88 du 15 avril 2005. (NOR SANP0521129D)

Public expenditures and budgets

Public expenditures in the fight against drugs and drug addiction mainly fall within the scope of the budgets of the government and National Health Insurance Fund (*Assurance maladie*). The government's budget includes expenses for implementing public policy within the scope of law enforcement and anti-trafficking as well as international cooperation, training, observation, research, communication, information and prevention (particularly in the school environment). The majority of these health expenditures (primary care and hospital physicians) are covered by social security funds. Some of these expenditures are related to treatments for illnesses that were caused by drug use (cirrhosis, cancers), but for which assessments are only based on estimates. However, according to the most recent study available (Kopp *et al.* 2006b), these expenditures allegedly represent the majority of what is covered by the public authorities (€21.6 billion in 2003, mainly related to legal drugs).

Since the promulgation of the Constitutional bylaw on budget acts (the LOLF) of 2001⁴⁰, the funds allocated by the government to central administration and decentralised services are presented on a per-programme basis. The resources available for the alcohol, tobacco and illegal drugs policy are found within about thirty programmes that mainly involve the ministries of foreign affairs, culture, defence, economics, national education, higher education and research, the interior, justice, health and labour. The expenditures that are part of these different programmes are allocated to one of five drug public policy areas: prevention of use, law enforcement and anti-trafficking measures, the intensification and diversification of health treatment, research promotion, and finally, international actions. Since 2008, the government's budget for the fight against drugs has been presented in a transversal policy document (DPT) on drugs and drug addiction. The creation of this budgetary document, which follows government spending on an annual basis, is coordinated by the MILDT. The resources used by territorial subdivisions (especially regions, departments and towns) to prevent and fight against drug use cannot be identified.

The identifiable amounts attributed by the National Health Insurance Fund to preventing and treating addictions go towards reimbursing OSTs as well as funding specialised structures (CSAPAs, CAARUDs and CTs). To identify the health expenditure areas, the sources used were budget circulars, national health insurance rate campaigns and the reimbursement file for substitution medicine (the AMELI - MEDIC'AM file).

Public expenditure on the drug prevention policy, treatment, or drug supply curtailment measures has been the subject of numerous studies in France (Ben Lakhdar 2007b; Diaz Gomez 2012; Kopp *et al.* 2000; Kopp *et al.* 2004; Kopp *et al.* 2006b; Kopp *et al.* 1998). Estimates of the social costs (including, for example, lost income and lost productivity) have also been made (Kopp *et al.* 2000; Kopp *et al.* 2004; Kopp *et al.* 2006a; Kopp *et al.* 1998).

⁴⁰ Loi organique n°2001-692 du 1er août 2001 relative aux lois de finances. JORF n°177 du 2 août 2001. (NOR ECOX0104681L)

1.2. Legal framework

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

In France, the efforts of law makers in 2012-2013 were dedicated to regulating the sale of medications on the Internet and preventing counterfeiting. In the fight against local narcotic trafficking, measures that aim to reinforce domestic safety were also adopted. The government sought new bilateral agreements on international police enforcement cooperation, and several bills were discussed in Parliament. Overall, all legislation from the period focused on supply reduction.

Regulating the sale of medications on the Internet and preventing counterfeiting

The **order of 19 December 2012**⁴¹ on the reinforcement of the safety of the medication supply chain regulates the sale of medications through electronic media. It only authorises the electronic sale of medications by a retail pharmacy on its website. This legislation also establishes sanctions in the event of counterfeit medications. Manufacturing, selling or advertising counterfeit medications is punishable by five years imprisonment and a €375,000 fine. Should such medications pose a threat to human health, the sentence and fine increase to seven years imprisonment and a €750,000 fine.

Reinforcement of anti-trafficking surveillance at local level

Domestic security was another area in which there was legislation during the period. Narcotics trafficking was targeted by **the order of 12 March 2012**⁴². Since its adoption, public authorities with jurisdiction in areas at risk of narcotics trafficking are authorised to record public surveillance videos.

Reinforcement of international crime-fighting cooperation

In the second half of 2012, the National assembly and the Senate examined several bills authorising bilateral police enforcement agreements or treaties of friendship. The agreements and treaties pertain to the Republic of Serbia, the Republic of Kazakhstan, Georgia, the Islamic Republic of Afghanistan, the Lebanese Republic, the United Arab Emirates and Brazil.

1.2.2. Laws implementation

The decrees, circulars and orders adopted in 2012 and 2013 putting current legislation into effect are detailed hereinafter.

⁴¹ Ordonnance n°2012-1427 du 19 décembre 2012 relative au renforcement de la sécurité de la chaîne d'approvisionnement des médicaments, à l'encadrement de la vente de médicaments sur internet et à la lutte contre la falsification de médicaments. JORF n°297 du 21 décembre 2012. (NOR AFSX1240311R)

⁴² Ordonnance n°2012-351 du 12 mars 2012 relative à la partie législative du Code de la sécurité intérieure. JORF n°62 du 13 mars 2012. (NOR IOCD1129997R)

Prevention of drug use at the workplace

Within the scope of the law of 20 July 2011⁴³ (art. L.4622-2 of the Labour Code) on occupational medicine, the **DGT (General directorate for labour) circular of 9 November 2012**⁴⁴ specified the principles of the reforms on occupational medicine and health services, which aim to develop a culture of promoting health in the workplace.

Stepping up prevention regarding driving under the influence of narcotics

By distributing the **directive of 30 October 2012**⁴⁵, the **directive of 17 December 2012**⁴⁶ and the **directive of 27 June 2013**⁴⁷ on the stepping-up of traffic safety measures, the Minister of the interior wanted to strengthen law enforcement services (Police) efforts during public and school holidays to fight against addictive behaviours and reverse the high traffic mortality rates of previous years.

Health care treatment for inmates

Within the scope of the law of 18 January 1994⁴⁸ on public health and social security, a first guide to the health care treatment of inmates was distributed in 1994 to prison system health workers. This guide was updated for the first time in 2005 (Ministère de la santé et de la protection sociale *et al.* 2004). Since then, several laws and regulations have been adopted that have changed the scope of social protection and prison treatment protocols. These changes revealed the need to update the 2005 version. The **interministerial circular of 30 October 2012**⁴⁹ updated this guide. In its outline, the guide reiterates the current principles of the treatment offered to inmates and persons in detention, both physical and psychiatric, in compliance with the 2010-2014 “health/prison” strategic actions plan (Ministère de la santé et des sports *et al.* 2010). Furthermore, the guide offers a framework agreement for field workers to ensure that inmates take advantage of their social rights. Other framework documents are also enclosed within the guide, such as useful references on treating minors.

New penal policy strategies for drug use

The circular of 16 February 2012⁵⁰ established new penal policy strategies for the legal authorities. While it reiterates consideration for the investigatory elements that suggest simple

⁴³ Loi n°2011-867 du 20 juillet 2011 relative à l'organisation de la médecine du travail. JORF n°170 du 24 juillet 2011. (NOR ETSX1104600L)

⁴⁴ Circulaire DGT n°13 du 9 novembre 2012 relative à la mise en œuvre de la réforme de la médecine du travail et des services de santé au travail. (NOR ETST1239145C)

⁴⁵ Instruction du 30 octobre 2012 relative au renforcement de la lutte contre l'insécurité routière à l'occasion des vacances de la Toussaint. BO Intérieur n°2012-10 du 30 décembre 2012. (NOR INTK1229204J)

⁴⁶ Instruction du 17 décembre 2012 relative au renforcement de la lutte contre l'insécurité routière pendant la période des fêtes de fin d'année. BO Intérieur n°2013-01 du 15 février 2013. (NOR INTK1229208J)

⁴⁷ Instruction du 27 juin 2013 relative au renforcement de la lutte contre l'insécurité routière pendant la période estivale. (NOR INTK1300208J)

⁴⁸ Loi n°94-43 du 18 janvier 1994 relative à la santé publique et à la protection sociale. JORF n°15 du 19 janvier 1994. (NOR SPSX9300136L)

⁴⁹ Circulaire interministérielle DGOS/DSR/DGS/DGCS/DSS/DAP/DPJJ n°2012-373 du 30 octobre 2012 relative à la publication du guide méthodologique sur la prise en charge sanitaire des personnes placées sous main de justice. BO Santé, Protection sociale et Solidarité n°11 du 15 décembre 2012. (NOR AFSH1238354C)

⁵⁰ Circulaire CRIM 2012-6/G4 du 16 février 2012 relative à l'amélioration du traitement judiciaire de l'usage de stupéfiants. BO Justice n°2012-02 du 29 février 2012. (NOR JUSD1204745C)

use or narcotics addiction and the principle by which punishment should be proportional to alleged crimes, the February 2012 circular emphasises the need to make penal response systematic and to reinforce the effectiveness of legal measures. Jurisdictions are primarily encouraged to resort to educational measures, such as awareness-building training courses, for a first offence involving simple use, and to social-health measures for addicted users (court-ordered treatment). With respect to minors, the response should remain educational and health-based. The circular also encourages appeal courts and tribunals to develop partnerships with associations to ensure that educational and social-health measures are effective.

Marketing authorisations for cannabis-based pharmaceuticals

Since the adoption of the **decree of 5 June 2013**⁵¹, the ANSM can grant marketing authorisations for medications containing cannabis or its derivatives. This decree modifies article R.5132-86 of the Public Health Code and authorises the manufacture, transport, import, export, storage, sale, trade, acquisition or use of cannabis-based pharmaceuticals. This decree, which entered into effect on 8 June 2013, is an extension of the 2011/83/EU⁵² directive that established a European Community code for medicinal products for human use.

Administration and storage of medicinal substances in pharmacies located in public health care establishments

The **Order of 12 March 2013**⁵³ on substances, preparations and medicinal products subject to narcotics regulation in medical-social or health care establishments with an in-house pharmacy abrogates the special provisions of previous orders (those of 31 March 1999⁵⁴ and 6 April 2011⁵⁵). It aims to simplify procedures: for example, regarding the dispensing of medication, paper forms can be replaced by computerised records; to renew a stock of medications, a monthly summary report now replaces the submission of copies of prescriptions. This order also stipulates new modalities for destroying narcotics (art. R.5132-36 of the Public Health Code).

Public authorities risk assessments and vigilance on the appearance of new and potentially dangerous substances

In France, the mission to assess the risks related to medicinal substances is mainly the task of the ANSM. When the processing of a dossier requires an additional opinion, the ANSM refers to its consultative Commission on narcotics and psychotropic substances. Since the adoption of

⁵¹ Décret n°2013-473 du 5 juin 2013 modifiant en ce qui concerne les spécialités pharmaceutiques les dispositions de l'article R. 5132-86 du code de la santé publique relatives à l'interdiction d'opérations portant sur le cannabis ou ses dérivés. JORF n°130 du 7 juin 2013. (NOR AFSP1308402D)

⁵² <http://new.eur-lex.europa.eu/legal-content/FR/TXT/?qid=1373552283066&uri=CELEX:32011L0083> [accessed 24/09/2013]

⁵³ Arrêté du 12 mars 2013 relatif aux substances, préparations, médicaments classés comme stupéfiants ou soumis à la réglementation des stupéfiants dans les établissements de santé, les groupements de coopération sanitaire, les groupements de coopération sociale et médico-sociale, les établissements médico-sociaux mentionnés à l'article R. 5126-1 du code de la santé publique et les installations de chirurgie esthétique satisfaisant aux conditions prévues à l'article L. 6322-1 de ce même code et disposant d'une pharmacie à usage intérieur. JORF n°69 du 22 mars 2013. (NOR AFSH1305477A)

⁵⁴ Arrêté du 31 mars 1999 relatif à la prescription, à la dispensation et à l'administration des médicaments soumis à la réglementation des substances vénéneuses dans les établissements de santé, les syndicats interhospitaliers et les établissements médico-sociaux disposant d'une pharmacie à usage intérieur mentionnés à l'article L.595-1 du code de la santé publique. JORF n°77 du 1er avril 1999. (NOR MESP9921062A)

⁵⁵ Arrêté du 6 avril 2011 relatif au management de la qualité de la prise en charge médicamenteuse et aux médicaments dans les établissements de santé. JORF n°90 du 16 avril 2011. (NOR ETSH1109848A)

the **decision of 1 February 2013**⁵⁶, a new commission has been established, but with basically the same privileges. The members of the new commission are selected based on their expertise in the area of narcotics, psychotropic substances and drug dependence. Institutional representatives are no longer part of the commission.

Within the scope of their potentially dangerous substances vigilance mission, in 2012 the Ministry of social affairs and health, along with the ANSM, registered all galenical forms of phentermine and cathinones on the narcotics list:

- **Order of 14 February 2012**⁵⁷ on the classification of all phentermine dosage forms as narcotics. Phentermine or 1,1-dimethyl-phenyl-ethyl-amine, is a phenylethylamine derivative whose structure is very similar to that of amphetamines. It was commercialised in France as an appetite suppressant from 1962 to 1988. Injectable phentermine had already been classified as a narcotic when the oral form was categorised as a psychotropic substance. Due to the potential for phentermine abuse, addiction and misuse, as well as the substance's amphetaminic profile, it is now listed as a narcotic regardless of its dosage form.
- **Order of 27 July 2012**⁵⁸, which classified cathinones as narcotics due to their similarity in structure to amphetamines. In order to prevent the rapid distribution of new psychoactive substances (NPS) on the Internet, for the first time France has used the so-called "generic" classification, which extends the ban to a group of substances from the same family, and no longer just to one single substance. This order pertains to all known cathinone-derived chemical classes in order to ensure that the narcotics list is regularly updated.

With respect to its addictovigilance mission, ANSM adopted since 2012, several decisions targeted to regulate the conditions for prescribing and dispensing certain medications due to the related risk of abuse:

- **Order of 9 March 2012**⁵⁹ on harmonising the prescription and dispensing conditions for medications subject to narcotics regulation. These are orally-administered medications containing flunitrazepam (Rohypnol[®]), buprenorphine (Subutex[®] and its generics / Suboxone[®] / Temgesic[®]), clonazepam (Rivotril[®] tablets and drops) and certain oral medications containing clorazepate dipotassium (Tranxene[®] 20 mg). The purpose of this order was also to clarify the scope of these measures.

⁵⁶ Décision DG n°2013-18 du 1er février 2013 portant création d'une commission des stupéfiants et psychotropes à l'Agence nationale de sécurité du médicament et des produits de santé. JORF n°34 du 9 février 2013. (NOR AFSM1300036S)

⁵⁷ Arrêté du 14 février 2012 modifiant les arrêtés du 22 février 1990 fixant la liste des substances classées comme stupéfiants et la liste des substances psychotropes. JORF n°44 du 21 février 2012 (NOR ETSP1204444A)

⁵⁸ Arrêté du 27 juillet 2012 modifiant les arrêtés du 22 février 1990 fixant la liste des substances classées comme stupéfiants et la liste des substances psychotropes. JORF n°178 du 2 août 2012. (NOR AFSP1230815A)

⁵⁹ Arrêté du 9 mars 2012 portant application de la réglementation des stupéfiants aux médicaments à base de flunitrazépam administrés par voie orale, aux médicaments à base de buprénorphine administrés par voie orale, aux médicaments à base de clonazépam administrés par voie orale et à certains médicaments à base de clorazépate dipotassique administrés par voie orale. JORF n°68 du 20 mars 2012. (NOR ETSP1207340A)

- **Order of 16 April 2012**⁶⁰ subjecting oral, midazolam-containing medications to special prescription and dispensing conditions. In 2011, when it was still being sold for domestic use, the ANSM examined the legislation for controlling and regulating the sale to the public of gamma-butyrolactone (GBL). In effect since 8 September 2011, the order of 2 September 2011⁶¹ prohibited not only the distribution and sale to the public of GBL, but also the commercialisation of 1,4 butanediol (both are converted in the body into gamma-hydroxy-butyrate - GHB) and the products containing them due to the high risk of addiction and abuse with these molecules.
- **Orders of 8 June 2012**⁶² and **28 June 2012**⁶³ subjecting oral, tianeptine-containing medications to special prescription and dispensing conditions due to the risk of drug addiction and misuse with these products.

Finally, due to their adverse effects on health, and in compliance with the directives of the Ministry of social affairs and health, preparations containing any of the following substances have been subjected to sales and access restrictions: almitrine, bupropion, chlordiazepoxide, duloxetine, naltrexone, venlafaxine, clorazepate dipotassium, diazepam, fluoxetine, hydrochlorothiazide, imipramine, metformin, methylphenidate, paroxetine and topiramate. These restrictions have been in effect since 10 June 2012 (the date of the French Official Journal publication of **both 12 April 2012 decisions**⁶⁴ of the Ministry of social affairs and health. Published in the Official Journal that same day, a third **12 April 2012 decision**⁶⁵ put a total ban on preparations containing clonazepam, meprobamate and synephrine. Moreover, on 19 April 2013, the ANSM announced the discontinuation of the sale of Rohypnol (flunitrazepam) 1 mg⁶⁶.

In the last **decision** mentioned here - a decision of the Council of State on **3 June 2013**⁶⁷ - the Council quashed the 29 June 2011⁶⁸ order of the Ministry of labour, employment and health in

⁶⁰ Arrêté du 16 avril 2012 portant application de la réglementation des stupéfiants aux médicaments à base de midazolam administrés par voie orale. JORF n°101 du 28 avril 2012. (NOR ETSP1220641A)

⁶¹ Arrêté du 2 septembre 2011 portant application d'une partie de la réglementation des stupéfiants à la gamma-butyrolactone (GBL), au 1,4-butanediol (1,4 BD) et aux produits qui en contiennent. JORF n°208 du 8 septembre 2011. (NOR ETSP1124197A)

⁶² Arrêté du 8 juin 2012 portant application d'une partie de la réglementation des stupéfiants aux médicaments à base de tianeptine administrés par voie orale. JORF n°142 du 20 juin 2012. (NOR AFSP1225501A)

⁶³ Arrêté du 28 juin 2012 portant application d'une partie de la réglementation des stupéfiants aux médicaments à base de tianeptine administrés par voie orale. JORF n°173 du 27 juillet 2012. (NOR AFSP1227710A)

⁶⁴ Décision du 12 avril 2012 portant restriction à l'importation, la préparation, la prescription et la délivrance de préparations magistrales, officinales et hospitalières définies à l'article L.5121-1 du Code de la santé publique, y compris de préparations homéopathiques, contenant l'une des substances suivantes : almitrine, bupropion, chlordiazépoxyde, duloxétine, naltrexone, pirféridone, roflumilast ou venlafaxine. JORF n°134 du 10 juin 2012. (NOR AFSX1224667S)

Décision du 12 avril 2012 portant restriction à l'importation, la préparation, la prescription et la délivrance de préparations magistrales, officinales et hospitalières définies à l'article L.5121-1 du Code de la santé publique, y compris de préparations homéopathiques, contenant l'une des substances suivantes : clorazépate dipotassique, diazépam, fluoxétine, furosémide, hydrochlorothiazide, imipramine, metformine, méthylphénidate, paroxétine, spironolactone ou topiramate. JORF n°134 du 10 juin 2012. (NOR AFSX1224673S)

⁶⁵ Décision du 12 avril 2012 portant interdiction d'importation, de préparation, de prescription et de délivrance de préparations magistrales, officinales et hospitalières définies à l'article L.5121-1 du Code de la santé publique, y compris de préparations homéopathiques, contenant du clenbutérol, du clonazépam, de l'exénatide, du liraglutide, du méprobamate, de l'orlistat ou de la synéphrine. JORF n°134 du 10 juin 2012. (NOR AFSX1224680S)

⁶⁶ <http://ansm.sante.fr/S-informer/Points-d-information-Points-d-information/Rohypnol-flunitrazepam-1-mg-Arret-de-commercialisation-Point-d-information> [accessed 24/09/2013]

⁶⁷ Arrêt n°352484 du Conseil d'Etat du 3 juin 2013 - Annulation de l'arrêté du 29 juin 2011 portant application d'une partie de la réglementation des stupéfiants aux produits contenant des nitrites d'alkyle aliphatiques, cycliques ou hétérocycliques et leurs isomères.

application of a portion of the narcotics regulations pertaining to products containing aliphatic, cyclic or heterocyclic alkyl nitrites and their isomers (poppers). The manufacture and sale of these poppers are no longer banned.

Regulation of the sale of medications on the Internet and preventing counterfeiting

The **Decree of 31 December 2012**⁶⁹ on the reinforcement of the security of the medication supply chain is part of the framework of the order of 19 December 2012, which aims to prevent the introduction of counterfeit medications into the legal commercialisation chain and to regulate the online sale of medications. The objective of this decree was also to transpose directive 2011/62/EU⁷⁰ to ensure the safety of the commercialisation of the medications.

1.3. National action plan, strategy, evaluation and coordination

1.3.1. National action plan and/or strategy

On 19 September 2013, the *action plan against drug and addictive behaviours* was adopted during an interministerial committee meeting chaired by the Prime Minister and attended by relevant ministers. The change to the name of this plan, which replaces the previous governmental action plans against drugs and drug addictions, exemplifies the government's desire to expand the policy to include all addictive behaviours.

The 2013-2017 plan has three main priorities:

- **To base public action on observation, research and evaluation** by developing our understanding of addictive behaviours, by supporting research for new medical treatments and innovative therapeutic strategies as well as research in the social sciences, and by turning research into a decision-making tool.
- **To take the most exposed populations into consideration to reduce risks and health and social harm** by preventing, delaying or limiting use in young populations, by improving treatment and support for female drug users, by making facilities more accessible to marginal populations (whether these populations are marginal in a geographic or a social sense) and by preventing addiction in the workplace.
- **To reinforce safety, tranquillity and public health, both locally and internationally, by fighting drug trafficking and all forms of criminality related to psychoactive substance use** by promoting the social acceptability of drug users, treatment systems and harm reduction measures through social mediation, by improving relations between the legal and health systems, by fighting local and international drug trafficking, and by taking into consideration emerging trafficking trends.

⁶⁸ Arrêté du 29 juin 2011 portant application d'une partie de la réglementation des stupéfiants aux produits contenant des nitrites d'alkyle aliphatiques, cycliques ou hétérocycliques et leurs isomères. JORF n°156 du 7 juillet 2011. (NOR ETSP1117877A)

⁶⁹ Décret n°2012-1562 du 31 décembre 2012 relatif au renforcement de la sécurité de la chaîne d'approvisionnement des médicaments et à l'encadrement de la vente de médicaments sur internet. JORF n°1 du 1er janvier 2013. (NOR AFSP1240709D)

⁷⁰ <http://new.eur-lex.europa.eu/legal-content/FR/TXT/?qid=1373532961493&uri=CELEX:32011L0062> [accessed 24/09/2013]

The government's main anti-drug policy strategies are in the **17 October 2012 mission letter** signed by the Prime minister. This mission was entrusted to the Chairperson of the MILDT, Danièle Jourdain Menninger, who was appointed by the Council of ministers on 9 September 2012.

The strategies encourage a global policy with an integrated and voluntary approach that is appropriate to all areas of action (prevention, health, research, anti-trafficking, law enforcement and training). The MILDT's international actions are also of significant importance. In terms of prevention, the Prime minister wishes to base his policy on scientific knowledge by adopting a strategy that incorporates prevention into civic education and integrates training to raise awareness on all risks, especially among young people. Furthermore, in order to ensure a consistent, coordinated prevention approach, the scope of public political expertise covers all substances (alcohol, tobacco, psychotropics and narcotics) as well as addictive behaviours (multiple drug use, doping and non-substance related addictions).

In order to improve the governance of public policy in the fight against drugs and addictive behaviours, the new plan will undergo a midterm review to determine the extent to which established objectives have been met and to propose any adjustments to take the final plan implementation phase into consideration.

The preceding plan (2008-2011) (MILDT 2008) was inspired by a drug use reduction policy aimed mainly at preventing people from experimenting with drugs in the first place and improving awareness of the law through targeted communication campaigns. This previous government plan can also be seen as a continuation of the 2007-2011 Ministry of Health Plan for addiction treatment and prevention⁷¹ (Ministère de la santé et des solidarités 2006), which seeks to structure and enhance the availability of existing facilities and programmes (in hospitals, medical-social centres and primary care settings). In this specific area, the plan's aim to foster new responses for vulnerable populations (young people, pregnant women, young addicted parents, cocaine and crack users and recently-released inmates) was what set it apart. This governmental plan focused on systematising and accelerating the application of penal responses to narcotics-use offences and on strengthening the fight against domestic and international trafficking (of cannabis, cocaine, heroin, and chemical precursors).

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

The prior governmental plan was implemented for the 2008-2011 period. The OFDT was entrusted with the task of monitoring the actions of this plan. The OFDT submitted its report to the MILDT in May 2011 (Díaz Gómez *et al.* 2011). This review examines the objectives of the 2008-2011 plan in terms of each of its five action areas: prevention, law enforcement, treatment/social rehabilitation/harm reduction, training/research/observation, and finally, international action. This report reiterates the basic structure of the plan (which is comprised of 44 major actions) and identifies, for each action, the most appropriate indicators for recording the governmental plan's progress. The report's main conclusions are presented as follows:

⁷¹ http://www.sante.gouv.fr/IMG/pdf/plan_addictions_2007_2011.pdf [accessed 24/09/2013]

Area 1: Prevention, communication and information

As in the preceding plan, the 2008-2011 governmental plan on drugs reaffirmed the need to extend efforts to prevent drug use to all social environments as reinforcement for the policy implemented in schools. Special measures targeted recreational areas and at-risk neighbourhoods (identified by policy on a municipal level) as well as the family circle (and parenting in particular), the higher education environment and the workplace.

The report told of a positive review overall for these prevention measures, although certain areas for improvement were identified:

- The report highlighted that, in compliance with the recommendations of the international literature, it would be beneficial to systematically follow-up national media campaigns in schools to reinforce the efficacy of school prevention activities.
- Other areas of prevention action mentioned in the 2008-2011 governmental plan on drugs, such as measures targeting the parents or the workplace, made considerable progress, especially in terms of raising awareness about these programmes. However, progress could still be made with more concrete actions (innovative projects).

Overall, best practices and rationalised responses could be improved in the area of prevention, which is difficult to assess and constantly changing.

Area 2: Law enforcement

With a long-term view to reducing the levels of drug use in the population, the objectives of the second area of the plan are twofold: use specific measures to dissuade people from using illegal drugs and abusing legal drugs (tobacco in public places, alcohol among young people, driving under the influence of alcohol), and fight all forms of drug trafficking (cyber crime, chemical precursors) by targeting the proceeds of narcotics trafficking.

According to the data available at the time of the assessment, the tobacco objectives have basically been achieved or are on their way to being achieved. However, the alcohol and illegal drugs objectives are more difficult to assess due to the absence of specific evaluations, the increasing complexity of the narcotics market (changes in trafficking trends, a surge in new psychoactive substances) and the barely-visible impact of law enforcement on decreasing drug use.

During the governmental plan application period, the anti-drug trafficking resources had been bolstered and the pressure exerted by law enforcement services on the illegal drug market remained high (nearly 12,000 arrests for use-dealing per year and 8,000 for local trafficking, and approximately 110,000 seizures per year). The overall success of law enforcement anti-drug operations (quantities seized / number of seizures) had nevertheless declined due to the decline in volumes seized (with the exception of amphetamines) since 2008, which was a record year in terms of anti-trafficking law enforcement activity. However, the amounts seized rose, continuing the upward trend experienced since 2006 (nearly €18 million in 2009). They rose so much that the "Narcotics" support fund, which reportedly had not been very well supplemented since its creation in 1995, was better financed than ever before: €12 million confiscated from drug traffickers in 2009 were redistributed to law enforcement services specialised in fighting crime networks. Unfortunately, these sustained efforts did not succeed in having an effect on the financial accessibility of drugs: instead of deterring sales, the prices of certain illegal drugs fell (such as for herbal cannabis, heroin and cocaine) or remained stable (such as for cannabis resin

and ecstasy). These results bear witness to the difficulty that public policies have to impact narcotics supplies.

The indicators on the use of illegal drugs also demonstrate significant law enforcement activity, particularly regarding cannabis users: arrests stabilised at approximately 140,000 proceedings per year (of which 91% were due to cannabis), penal sanctions became more systematic (proceedings or alternatives to proceedings), court system responses to use offences became more diversified, mainly with the creation of a new measure targeting occasional users: "awareness-building training course on the dangers of narcotics use". Subsequently, narcotics users were more often controlled and subject to a response from the penal system. Driving under the influence of narcotics was also targeted: there were more frequent controls and prosecutions (see chapter 9).

Area 3: Treatment/social rehabilitation/harm reduction

The 2008-2011 efforts targeting health mainly focused on the organisation and reinforcement of available health and social services.

By establishing "liaison teams" in increasing numbers of hospital establishments and expanding the coverage of specialised consultations, hospitals reinforced their capacity to develop a strategy for identifying and providing early, opportunistic treatment to patients admitted to emergency departments due to difficulties with alcohol or other drugs. Subsequently, the coverage of liaison teams and specialised consultations improved, but still had not reached all hospital establishments with emergency departments by 2007-2008.

Furthermore, the coverage of counselling clinics for young users (CJCs) expanded during the first few years after the governmental plan was implemented. The purpose was to improve the young population's accessibility to appropriate, customised responses. Although rural coverage improved, the established objective was not totally attained according to the latest data.

Despite some territorial gaps in anti-addiction measures for treatment-seeking populations the situation improved overall. The 2008-2011 governmental plan on drugs encouraged experimentation with innovative responses, such as new treatment modalities for cocaine users or the opening of care units for recently released prisoners. The OFDT is currently conducting an assessment of these specific measures (Mutatayi *et al.* in press). Other innovative projects that encountered regional funding difficulties were never implemented (for example, social treatment for drug users seen in "microstructure networks" in the primary care setting). Another point to be improved pertains to the hospital/CSAPA/primary care relationship, which still seems to be an obstacle in the efficacy of the healthcare system, since no changes were observed in the number of hospital or primary care referrals towards adapted treatment structures in 2007-2008.

Former specialised structures experienced a change in their legal status. Their missions were expanded so that they could better treat all types of addictions. The purpose in changing these structures was to overcome the former alcohol/drug addiction dichotomy. An assessment is under way to determine whether these structures have truly been able to benefit by exchanging experience and expertise.

The governmental plan implemented specific measures for drug user subpopulations with excessively high risk of mortality, infectious disease and social exclusion (women or couples with children, recently-released prisoners, marginalised crack users). The primary contribution of the plan was to improve access to treatment and housing for these most vulnerable groups of

users. As a result, the range of treatment services was expanded and reinforced. Nevertheless, there are still significant unmet needs given the risks to which these populations are subjected, the excessive instability of these populations and their deteriorated health. The collective expertise of the INSERM (INSERM 2010), supported by the health authorities and integrated into the 2008-2011 plan, provided specific responses that have proven to be effective within similar populations outside of France. Harm reduction in prison populations remains a main priority.

Area 4: Training, research and observation

The governmental plan established ambitious research and training objectives to meet serious challenges. The efficacy of the actions to be undertaken requires continuous knowledge expansion and improved observation. The plan also sought to mobilise members of the scientific community as well as health professionals and ministerial agent. Moreover, actions were implemented to benefit relevant disciplines and concerned areas. Efforts also aimed to get professionals of the field involved in producing knowledge and in training. The plan was prepared to ensure the consistency of research in areas that have already been studied and lay the ground for new areas of investigation.

Subsequently, efforts were made to reinforce the research efforts of scientific communities involved in all areas of addiction research, whether clinical or related to human or social sciences. Different tools were used (call for tenders, research grants, involvement of national agencies, European and international partnerships) to stimulate research in the field and make it more attractive.

In addition to incentives to encourage long-term research on addictions, and particularly clinical research, the 2008-2011 governmental plan on drugs aimed to focus on new problems requiring the implementation of monitoring or the setting of *ad hoc* research (on problem gambling, excessive psychotropic drug consumption and mortality related to illegal drugs, for example).

In addition to these actions, a major section of the plan was dedicated to training and professionalising various categories of professionals or future professionals working in the field. Health professionals in particular were the subjects of intense efforts aimed at initial training.

It would be useful to reinforce all of the actions conducted with respect to the scientific community on a long-term basis. The field requires constant and renewed production of knowledge in order to highlight public action as well as to improve the efficacy of treatments. In addition, the scientific community, and the human and social sciences area in particular, has not yet been sufficiently mobilised to address addiction issues.

Area 5: International action

Internationally, the plan took advantage of the French European Union presidency to bolster European coordination and foster the creation of tools that encourage the pooling of European resources into one operational approach (for example, the creation of common investigation teams, European pact proposed by France).

The strategic Mediterranean basin has been the subject of particular efforts with stronger actions on drug routes (CECLAD-M, the Mediterranean anti-drug coordination centre) and the bolstering of neighbouring countries' abilities to deal with the phenomenon (national observatories created within the scope of the MedNet network).

1.3.3. Other drug policy developments

Within the scope of the harm reduction policy, an experiment with a drug consumption room will be conducted in the city of Paris. In 2013, the Ministry of Health, along with other relevant ministries, entrusted the MILDT with the task of providing the city of Paris with support in preparing for the project (see chapter 7).

1.3.4. Coordination arrangements

The MILDT is responsible for coordinating the governmental policy on fighting drug use and preventing addictive behaviours. On a local level, it uses its drug addiction project manager network.

National interministerial coordination

In order to improve the central coordination of interministerial actions, the State, through the amended finance law for 2008⁷² (article 138), provided the MILDT with a permanent operating mechanism for the drug and drug addiction policy: the transversal policy document (DPT), the first version of which was produced in 2009 as part of the 2010 budget law. Prepared every year by the MILDT in partnership with relevant ministerial representatives, the "drugs" DPT follows the State's efforts with respect to this interministerial policy. It is produced from the indicators of the annual performance project (PAP) linked to the ministerial programmes.

Territorial interministerial coordination

In compliance with **the circular of 14 February 2013**⁷³, the departmental network of the MILDT project managers ensures that there is consistency between the supply reduction and demand reduction actions. These project managers are responsible for developing departmental drugs and drug addiction prevention plans that adapt national strategies to territorial characteristics. Regions distribute the MILDT's decentralised funding while ensuring that the departmental project managers can supervise the network of local participants. The purpose of this organisation is to ensure the complementarity of the prevention actions implemented by regional health agencies and education authorities with those of the MILDT. Subsequently, since 2013, each regional project manager gets a grant (only for preventing drug use and drug addiction) whose amount is calculated based on objective criteria (number of departments, population of young people, drugs most frequently used by young people and number of drug-related offences).

⁷² Loi n°2008-1443 du 30 décembre 2008 de finances rectificative pour 2008. JORF n°304 du 31 décembre 2008. (NOR BCFX0826279L)

⁷³ Circulaire n°2013-75 du 14 février 2013 relative à l'organisation du réseau territorial de la MILDT

1.4. Economic analysis

1.4.1. Public expenditure

The governmental budget credit approved to implement the anti-drug policy and treat addictive behaviours was €1,094 million in 2013 versus €1,108 million in 2012 and €1,066 million in 2011 (Ministère de l'Economie et des Finances 2012).

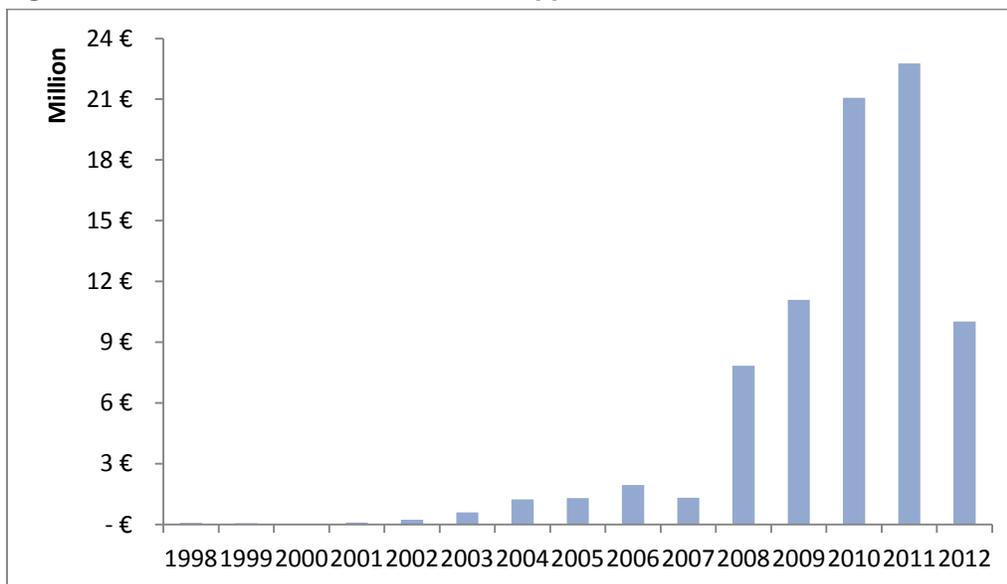
The National Health Insurance Fund (*Assurance maladie*) expenditures that can be identified in this area include funding for addiction medicine structures (CSAPAs, CAARUDs and CTs) of €334.1 million in 2012 versus € 318.6 million in 2011. There was an additional National Health Insurance Fund contribution of €19.9 million in 2012 versus €39.6 million in 2011 as part of the just-ended 2007-2011 Plan for addiction treatment and prevention. The National Health Insurance Fund also contributed €16.8 million within the scope of the 2010-2014 “health/prison” strategic actions plan on health policy for inmates, versus €4.1 million in 2011 (Ministère de l'Economie et des Finances 2012).

In total, the credits to be used by the government and National Health Insurance Fund in 2012 to implement the anti-drug and addictive behaviour prevention policy amounted to a total of €1,479 million versus €1,428 million in 2011. These amounts do not include the National Health Insurance Fund contribution to reimbursing substitution medications. The most recent data on this was from 2010 (the cost to National Health Insurance Fund for reimbursing these drugs was €93.5 million in 2010).

1.4.2. Budget

The proceeds from the "Narcotics" support fund are presented here. The proceeds of the sales of assets confiscated as part of narcotics penal proceedings are redistributed by the MILDT to the Ministries in charge of implementing the policy against drugs and addictive behaviours.

Figure 1.1: Evolution in the "Narcotics" support fund from 1998 to 2012



Source: MILDT

The "Narcotics" support fund was created in March 1995⁷⁴ at the initiative of the 1993 interministerial committee for the fight against drugs and drug addiction. The MILDT is still responsible for overseeing the distribution of the proceeds of assets confiscated from drug traffickers. The result of the preparatory work for the 17 March 1995 decree was the distribution of support fund financing to various ministries as follows: 90% of the amount must be redistributed to the ministries responsible for fighting drug trafficking and for law enforcement, to pay for the acquisition of equipment and services intended for anti-drug measures; the remaining 10% can be used to fund the prevention actions undertaken by the MILDT or relevant ministries.

After a significant increase in proceeds from 2008 to 2011, the support fund held €10.02 million in 2012. Since its creation, the fund has collected nearly €80 million.

1.4.3. Social costs

In the last dozen years or so, the OFDT has repeatedly examined the issue of estimating the social cost of legal and illegal drugs. The first study (Kopp *et al.* 1998) dates back to the 1990s. It examined the possible methods for calculation. The initial estimates were presented in *The social cost of drugs* (Kopp *et al.* 2000) report. This initial work estimated the annual costs to society to be €2,035.24 million in 1996. Since then, other estimates have been performed. The reasons for needing a continuous reassessment are twofold: the production of new, originally unavailable data (for example, treatments for certain diseases) and the need to take new methods of calculation into consideration. Hence, the 2006 study assessed the social cost of illegal drugs to be €2,824.44 million in 2003 (Kopp *et al.* 2006a). Compared with the 2000 estimates, the social costs of illegal drugs only increased by a factor of 1.39. In 2013, the health authorities (National health directorate) entrusted the OFDT with the task of performing a new estimate of the social costs of drugs.

⁷⁴ Décret n°95-322 du 17 mars 1995 autorisant le rattachement par voie de fonds de concours du produit de cession des biens confisqués dans le cadre de la lutte contre les produits stupéfiants. JORF n°71 du 24 mars 1995. (NOR BUDB9560005D) and Arrêté du 23 août 1995 fixant les modalités de rattachement par voie de fonds de concours du produit de cession des biens confisqués dans le cadre de la lutte contre les produits stupéfiants. JORF n°226 du 28 septembre 1995. (NOR SANG9502738A)

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

2.1. Introduction

One of the tasks of the OFDT is to monitor legal and illegal drug use and to keep track of changes on a national scale. Since 1997, it has contributed to the implementation of quantitative surveys on drug use from samples and/or sub-samples representative of the French population aged from 12 to 75. Repeated regularly, they also enable to monitor trends in substance use behaviour. It is therefore a question of:

- quantifying the levels of use of the different products;
- describing the diversity of this use (recent use, regular use, daily use, etc.);
- measuring links with other factors;
- observing trends;
- performing regional and departmental mapping;
- measuring representations, perceptions and opinions about psychoactive substances.

The general population surveys enable information to be obtained particularly about drug use and the most widely consumed drugs. The surveys also enable to quantify drug use in socially integrated populations. They are not suitable for identifying harmful drug use and dependency on illicit drugs (with the exception of cannabis, which is widely used) or the emergence of new drugs.

The use of various other additional observational tools such as the TREND (see Appendix V- TREND) and SINTES (see Appendix V- SINTES) monitoring systems, or the carrying out of specific qualitative or quantitative studies is necessary to reach the most vulnerable users, to observe recreational and party-scene users in a more precise fashion and to improve the understanding of phenomena through qualitative insight.

The survey system

The general population surveys system consists of five regular surveys, conducted in adults or adolescents, via two data-collecting methods: a telephone interview and a self-completed paper questionnaire. The first method applies to adults and young people aged 15 years and over. Two surveys use this method: the first is the illicit drug consumption survey, which is incorporated in the Health Barometer (see Appendix V- Health Barometer). It has been carried out every 5 years by the INPES since 1992. It interviews 15-75 year-olds (15-85 year-olds in 2010) on their health's behaviour and attitudes. The second is the survey on Representations, Opinions and Perceptions Regarding Psychoactive Drugs (EROPP) by the OFDT involving 15-64 year-olds.

These surveys do not describe all the heterogeneous practices of sub-populations. Hence the development of surveys among adolescents, the age when young people typically experiment with psychoactive substances and sometimes enter into a more regular drug use. The OFDT carries out three surveys (or collaborates on the "drug" section of these surveys) amongst this

population using the most suitable collection method, a self-completed paper questionnaire. The Health Behaviour in School-aged Children Survey, conducted in 41 countries or regions, questions 11, 13 and 15 year-old youngsters, still at school (see Appendix V- HBSC). The European School Survey on Alcohol and Other Drugs (ESPAD) enables the drug and alcohol use of 15-16 year-old youngsters, still at school, to be observed in 36 countries. To overcome the limitations of this survey in a school environment (lack of school dropouts, an underestimation of absenteeism, etc.), the OFDT has implemented a survey on health and substance uses of 17 year-olds (on call-up and preparation for defence day (ESCAPAD)) carried out on the National Defence and Citizenship Day (JDC, formerly known as the National Defence Preparation Day, JAPD). All called-up youngsters present on certain given days complete a questionnaire about their health, drug and alcohol use.

These three surveys of the adolescent population enable to observe the diffusion of drug use throughout adolescence, between 11 and 17 years, particularly the regular cannabis use.

Framework data

General population surveys give an idea of the number of users (Table 2.1). However, they are framework data and not exact estimations.

Among illicit drugs, cannabis remains the predominant substance by far, with an estimated 13.2 million people who have used cannabis at least once during their life. Close to one million people regularly use it in France. The use of cocaine, the second most consumed illicit substance, is well below this and affects around ten times less people. This statistic includes those who have used cocaine at least once in their life or at least once in the last year.

Table 2.1: Estimation of the number of psychoactive substance users in mainland France among 11 to 75 year-olds in 2010

	Illicit substances				Licit substances	
	Cannabis	Cocaine	Ecstasy	Heroin	Alcohol	Tobacco
Lifetime users	13.4 M	1.5 M	1.1 M	500 000	44.4 M	35.5 M
Including users in the previous year	3.8 M	400 000	150 000	//	41.3 M	15.8 M
Including regular users	1.2 M	//	//	//	8.8 M	13.4 M
Including daily users	550 000	//	//	//	5.0 M	13.4 M

Sources: Health Barometer 2010 (INPES), ESCAPAD 2008 (OFDT), ESPAD 2007 (OFDT), HBSC 2006 (medical department of the Toulouse Rectorat)

//: not available

Definitions:

Lifetime use: use of the substance at least once during their life (this indicator mainly serves to measure the distribution of a product in the population)

Use in the previous year or current use: consumption at least once during the previous year; for tobacco, this includes people who report that they smoke, even if only occasionally.

*Regular use: consumption of alcohol at least three times per week, *daily tobacco, and consumption of cannabis at least 10 times per month or at least 120 times during the previous year.*

NB: the number of individuals aged from 11 to 75 in 2009 (date of updating the census) is around 49 million. A margin for error exists even if it seems reasonable in this framework data. For example, taking the confidence interval into account, 13.4 million who have used cannabis at least once of their life indicates that the number of lifetime users probably ranges from 13 to 14 million.

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

Stabilisation in the levels of cannabis use amongst 15-64 year-olds (Standard Table 1)

Cannabis is by far the most widely used illicit substance in France. In 2010, among adults aged from 15 to 64 years, around a third (32.1%) admitted to having used cannabis during their lifetime. This experimentation affects more men than women (39.5% compared with 25%). 8.4% of 15-64 year-olds have used cannabis over the last 12 months (11.9% of men and 5.1% of women), whereas the overall proportion of users during the month is 4.6%.

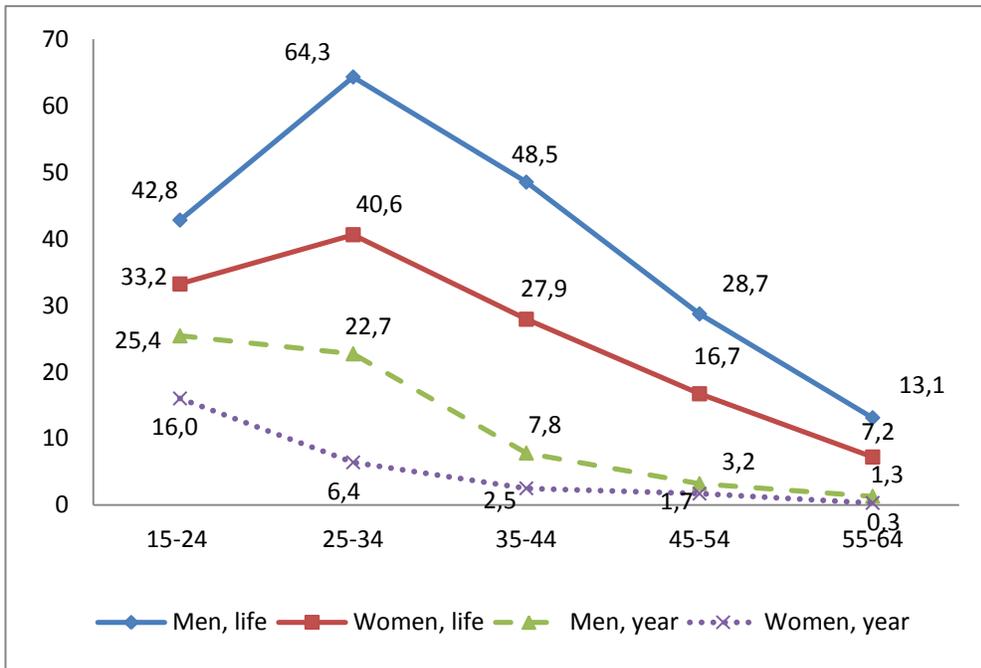
Although lifetime use went from 28.8% to 32.1% for all age groups between 2005 and 2010 (Table 2-2), cannabis use remains stable. The slight increase observed is linked to a “stock” effect of former generations of smokers.

Cannabis is mostly used by the younger generations with virtually negligible prevalence of consumption in the over 50 year-olds. Thus 20.8% of 15-24 year-olds were implicated in cannabis use over the twelve-month period preceding the survey.

In terms of gender distribution, among the proportion of people who have used cannabis at least once in their life, men in the 25 to 34 year-old age bracket (64.3%) are at highest with percentages decreasing thereafter to 13.1% amongst 55-64 year-olds (Figure 2.1). In women, cannabis lifetime users represent 37.0% of 15-34 year-olds and only 7.3% of 55-64 year-olds.

Amongst 15-34 year-olds, the stability of cannabis use hides some generational disparities: use over the last 12 months has increased in 20-24 year-old women (rising from 13.0% in 2005 to 16.4% in 2010), whereas the level of lifetime use is declining for girls aged 15-19 and males aged 15 to 24.

Figure 2.1: Proportion of people having used cannabis at least once in their life and at least once in the previous year, according to gender and age



Source: Health Barometer 2010, INPES, processed by OFDT

Significant increase in cocaine lifetime use for both sexes

Since the beginning of the 1990s, the availability of stimulants, cocaine or other synthetic drugs (ecstasy, amphetamines, etc.), has increased in France. The emergence and the related spread of the freebase form of cocaine⁷⁵, crack (whose use is nevertheless rare) occurred during the same decade.

With 1.5 million lifetime users aged from 11 to 75 (i.e. 3% of the general population) and 400,000 users over the course of the year, cocaine ranks second among the most widely consumed illicit substances, way behind cannabis and licit psychoactive substances. In 2010, 3.6% of 15-64 year-olds questioned by the Health Barometer had used it at least once in their lives and 0.9% had used it during the past year (Table 2-2). The significant increase in its diffusion is very marked. It reflects the accessibility of a substance that was once limited to the well-off. For some years, increasingly wide circles of society have tried it or used it. Current use (during the year) and lifetime use affects around three times more men than women.

The proportion of 15-64 year-olds who have used cocaine at least once has significantly increased three-fold in 15 years, from 1.2% in 1995 to 3.6% in 2010. It increased by a third between the last two Health Barometer surveys. Use in the previous year almost doubled between 2005 and 2010 among 15-64 year-olds, from 0.5% in 2005 to 0.9% in 2010 (Table 2.2), a statistically significant increase. First time use usually takes place at the average age of 23.1 years.

The age bracket mostly affected by cocaine use is young adults, with use becoming less frequent with increasing age. The proportion of cocaine lifetime users is highest amongst 25-34 year-olds (7.7% of the total, 11.2% of men, 4.4% of women). Fewer members of older generations have used the product at least once during their lifetime.

Similarly, use during the year primarily affects 15-24 year-olds (1.8% of the total, 2.6% of men, 1.0% of women) then decreases and becomes practically nil from the age of 55 onwards.

There are marked variations in the use of cocaine depending on socio-professional class or status. The population of lifetime users is highest amongst the unemployed (7.6%) compared to the actively employed, the inactive and the schoolchildren and students (4%). Logistic regressions have been used to check the principal socio-demographic characteristics related to use⁷⁶. All things being equal, comparisons between the unemployed and the actively employed confirm that more of the former are lifetime users than the latter and that there is no difference between school children/students and the actively employed. However, between 2005 and 2010, the percentage of cocaine lifetime users amongst the unemployed remained stable whereas that of the actively employed increased significantly (from 2.5% to 3.8%).

From a qualitative standpoint (TREND system data), the distribution of the use of cocaine in the peri-urban and rural areas, which has been apparent for a number of years, is continuing. This phenomenon can be explained by several factors, especially the emigration of the most disadvantaged people towards the outer zones of large urban centres. This sociologically integrated, but more fragile population from a professional perspective has also witnessed a

⁷⁵ Smokable form of cocaine obtained after the addition of bicarbonate or ammonia to cocaine hydrochloride (powder).

⁷⁶ Adjustment concerns age, gender, couple life, parenting, agglomeration category, level of qualifications and telephone equipment.

specific increase in the use of cocaine in recent years. This is essentially due to the spread of the techno music scene. Furthermore, the increase in micro-networks of user-resellers, who obtain supplies directly from local semi-wholesalers or across borders, has allowed cocaine to arrive more easily everywhere in France.

The consumption of other drugs remains marginal across the entire 15-64 year-old population. Nevertheless, some substances have witnessed an increase in distribution since 2005.

Heroin: increase in lifetime use and use during the year

Following a stable period between 2000 and 2005, lifetime use levels and use over the past 12 months rose significantly in 2011. The prevalence of heroin lifetime use went from 0.8% in 2005 to 1.2% in 2010 among 15-64 year-olds. It is higher in men (1.8% in 2010 vs. 1.3% in 2005). Heroin is used mainly by the under 35 year-olds: 2.1% admit to having used it at least once in their life and 0.5% to having used it in the past year. Consumption is marginal after the age of 35.

The upward trend towards heroin use highlighted in the 2010 Health Barometer confirms the qualitative observations of the TREND system, which noted increased consumption amongst the socially integrated (even “highly integrated”) and relatively young populations from the late 2000’s onwards, even if this phenomenon is still extremely restricted in quantitative terms. The image of heroin is becoming increasingly less repulsive to some young people familiar with psychoactive substances. Mainly snorted (or smoked) by new socially integrated users, heroin has freed itself from the three factors that linked it with decline and death: overdoses, AIDS and addiction, all three wrongly attributed to the sole practice of injecting. Furthermore, these young users see the availability of OST (opioid substitution treatment) as a “safety net” in case they become addicted to the substance.

Increase in lifetime use of all products except ecstasy/MDMA, glues, solvents and amphetamine.

The hallucinogenic mushrooms lifetime use has increased slightly in both genders whereas use over the last 12 months has remained stable. The levels of lifetime use of amphetamines have slightly increased over both periods, but remain statistically significant, going from 1.3% to 1.7%. The current use of ecstasy is decreasing. The low quality of ecstasy tablets, of which the average MDMA purity decreases year on year (see chapter 10), makes it a substance mainly consumed by the youngest party-scene users. Consumers are shifting to powder (or capsule) and crystal forms of MDMA, but particularly towards amphetamine, cocaine or other synthetic stimulants.

Poppers

According to the 2010 Health Barometer (Beck *et al.* 2011), poppers (which come in the form of small bottles to inhale), are the psychoactive substances most widely used at least once during lifetime after alcohol, tobacco and cannabis: 5.2% of 15-64 year-olds reported that they have used them at least once during their life. This figure was 3.7% in 2005. Much more common among men (7.0% vs. 3.5% of women), lifetime use of poppers is highest among 15-24 year-olds (8.5% against 4.3% in 2005). Increasing since 2005, the proportion of current users has gone from 0.6% to 0.9% in 2010, with the most marked increase among 18 to 24 year-old men. This product has been subject to fluctuating legislative classifications in recent years, ranging

from licit to illicit drugs: the 2011 decision to ban from sale some forms has been cancelled by the Council of State in June 2013⁷⁷ (see chapter 1).

Table 2.2: Trends in lifetime use and substances use of illicit psychotropic substances during the last 12 months (current use) amongst 15-64 year olds between 2005 and 2010 (%)

	Experimentation			Current use		
	2005	2010	2005 vs 2010	2005	2010	2005 vs 2010
Cannabis	28,8	32,1	↗	8,3	8,4	→
Poppers	3,8	5,2	↗	0,6	0,9	↗
Cocaine	2,4	3,6	↗	0,5	0,9	↗
Hallucinogenic mushrooms	2,6	3,1	↗	0,3	0,2	→
Ecstasy/MDMA	2,0	2,5	→	0,5	0,3	↘
Glues and solvents	1,7	1,9	→	0,1	0,4	↗
LSD	1,5	1,7	→	0,1	0,2	→
Amphetamines	1,3	1,7	↗	0,1	0,2	↗
Heroin	0,8	1,2	↗	0,1	0,2	↗

Source: Health Barometer 2010, INPES, processed by the OFDT

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

The initial results of the recent HBSC, ESPAD and ESCAPAD surveys are consistent in terms of the particular use of cannabis amongst adolescents in France. Cannabis is the most widely consumed illicit product amongst 11-17 year-old adolescents, especially males. In terms of lifetime use, in 2010, the use of cannabis was extremely rare amongst 11 year-olds and concerned 6.4% of 13 year-olds, representing an increase compared to 2006 figures (4,8%) and stabilised at 28.0% amongst 15 year-olds (HBSC).

Amongst older subjects, almost two out of five young people (39%) born in 1995 (aged 16 in 2011) have used at least once cannabis during their lifetime. A higher percentage was recorded amongst the girls. This represents an increase compared to the last data recorded in the 2007 ESPAD survey (30%). Amongst 17 year-olds, in 2011, 41.5% of these young people had used cannabis at least once in their life, with a stable trend being recorded over the 2008-2011 period. This stability is based on the continued decrease in boys and an upturn – albeit non significant - in young girls.

The reported use of cannabis over the last 30 days has proved to be marginal amongst the under 15 year-olds (HBSC). Cannabis is used by 24.0% of 16 year-olds (ESPAD), representing a significant increase compared to 2007 (15.0%), stabilising amongst 15 year-olds (HBSC, 12.5% vs. 14.4%, non significant change) and decreasing slightly in 17 year-olds (ESCAPAD) (22.4% vs. 24.7% in 2008).

A comparison of the results obtained in adolescent surveys highlights the following differences: a considerable increase in cannabis use over the last month in the ESPAD 2011 survey (15-16

⁷⁷ Arrêt n°352484 du Conseil d'Etat du 3 juin 2013 - Annulation de l'arrêté du 29 juin 2011 portant application d'une partie de la réglementation des stupéfiants aux produits contenant des nitrites d'alkyle aliphatiques, cycliques ou hétérocycliques et leurs isomères.

year-olds) (Hibell *et al.* 2012), stability in the HBSC 2010 survey (11-13 and 15 year-olds) (Currie *et al.* 2012) and a slight decrease in the ESCAPAD 2011 survey (17 year-olds) (Spilka *et al.* 2012). Two factors should be taken into consideration in an attempt to explain these differences. Firstly, these surveys investigate different generations (i.e. youngsters born in different years, depending on the survey). A generation effect cannot, therefore, be ruled out. The next surveys should confirm or invalidate this hypothesis. Secondly, this increase is all the more striking since the level measured for cannabis in the 2007 ESPAD survey was particularly low. The considerable drop recorded between 2003 and 2007 should now be analysed more efficiently. In fact, in 2011, cannabis use amongst French 15-16 year-olds reflected levels recorded between 1999 and 2003.

With the exception of cannabis, lifetime use of illegal or misused drugs remains rare. Solvents and inhaled substances are the most common substances amongst 15 year-olds (HBSC). These are followed by cocaine, crack and amphetamines, “medicines for getting high”, with heroin and LSD rounding off the picture.

Young people between 15 and 16 years of age (ESPAD) have also stabilised their use of other illicit drugs. There are no significant changes to report regarding lifetime use with these substances.

More and more 17 year-olds have used at least once in their lifetime illicit products and tested other substances: poppers (9.0%), inhalants (5.5%), hallucinogenic mushrooms (3.5%), cocaine (3.0%), amphetamines (2.4%) and ecstasy (1.9%). Little lifetime use has been reported with GHB, crack and heroin. The spread of these products has fallen overall between 2008 and 2011.

Table 2.3: 2008-2011 Changes in levels of psychoactive drug use by gender at 17 years old (% and sex ratio)

	Boys 2011	Girls 2011	Sex ratio	All 2011	All 2008	Change (1) (08/11)	Change (2) (08/11)
Cannabis lifetime use	44.0	38.9	1.13***	41.5	42.2	-1.7%	-0.7
Cannabis/month	26.3	18.5	1.42***	22.4	24.7	-9.3%	-2.3
Cannabis/regular (≥ 10 times per month)	9.5	3.4	2.84***	6.5	7.3	-11.0%	-0.8
Hallucinogenic mushrooms	4.8	2.1	2.29***	3.5	3.5	0%	0
Cocaine	3.3	2.7	1.22**	3.0	3.3	- 9.0%	-0.3
Ecstasy	2.2	1.6	1.39***	1.9	2.9	-34.5%	-1.0
Amphetamines	2.9	2.0	1.45***	2.4	2.7	-37.0%	-0.3
LSD	1.7	0.9	1.99***	1.3	1.2	8.3%	0.1
Heroin	1.0	0.8	1.18***	0.9	1.1	-18.2%	-0.2
Crack	0.9	0.7	1.35***	0.8	1.0	-20.0%	-0.2

Source: ESCAPAD 2011 OFDT

** , ***: p-value for Chi² test for comparison between genders: 0.01 and 0.001

(1): Relative change recorded with exact figures (in %)

(2): Absolute change recorded with exact figures (in points)

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

“Electro” party scene (“dance events”): cocaine - a common denominator

Use in the so-called “socially integrated” population cannot be limited to those frequenting the party scene, whether it be “alternative” events (free parties, raves, teknivals or alternative areas within more general festivals) or commercial settings (clubs, discos, music bars). It should however be noted that, in the intermediate classes of society at least, regular use of cocaine is often associated with the frequenting, at one time or another, of the party scene. In 2005, cocaine powder lifetime use affected 81.1% of those attending alternative events⁷⁸ and close to half (48.4%) of those found in commercial festive or “party” establishments playing “electro” music. First time use took place on average at 20.2 years old (study known as “quanti-festif 2005”).

The gay party scene

On completion of the 2007-2008 study of the gay party scene in Paris and Toulouse, continuous monitoring was carried out through an ethnographic investigation in Paris. This is justified on the one hand by the trend setter role adopted by male homosexuals, especially on the party and substance scene, and on the other hand by the actual or specific practices adopted by this group such as the use of substances during sexual activity. Two key points have emerged.

A trend known as “chem” plans (for “chemical plan”) is making significant headway within this group. This comprises the active search for sexual partners, especially via the Internet, based on highly specific criteria. The latter not only specify the type of sexual activity desired but also the substances consumed during such practices.

Another practice known as “slam” seems to be used only on the gay scene. This term refers to the intravenous injection of substances during sexual activity. It mainly concerns a fringe group of homosexual males, usually between 30 and 40 years old, but sometimes younger. It is practised by couples or in groups. It can be the aim of the meeting or an element of it. Preferred substances for injection include cocaine, methamphetamine or drugs purchased over the Internet (mephedrone, NRG3, 4 Mec, etc.). Ketamine is sometimes used but this is injected intramuscularly. Slam is often linked to sexual practices performed without protection but not exclusively. For some it is seen as an opportunity to familiarise themselves with injecting. Some sex-related drug users have become dependent (Foureur *et al.* 2013; Pfau in press).

⁷⁸ The study identified four affinity groups in this scene comprising individuals perceiving themselves and perceived by others as culturally similar: the alternative, urban party, clubbing and select groups. For the purposes of this article, the “clubbing” and “select” groups were joined together in a “commercial party scene” category. The distinction between the “clubbing” and “select” categories particularly lies in social class, the access routes to the group (co-optation in the “select” category”) and in the fact that the “select” group has a lower level of polydrug use since its consumption is generally limited to alcohol, cannabis and cocaine. Besides those fully integrated on a professional basis, the alternative scene attracts a significant proportion of people who, although they have a home and a network of family and friends, have a more unstable occupational status (“odd jobs”, fixed-term contracts, temping, etc.) and a fringe of marginalised users.

3. Prevention

3.1. Introduction

General points and references

In France, the scope of the drug use prevention policy has been expanded to include legal psychoactive substances (such as alcohol, tobacco and psychotropic drugs). The main principles of the policy are to prevent people from experimenting with drugs in the first place, or at least to delay experimentation, and to prevent or limit misuse. In schools, the general intervention framework focuses on preventing addictive behaviour, which more generally falls within the province of health education.

Prevention principles and policies are evidenced in a more institutional, practical way in the *Guide de prévention des conduites addictives en milieu scolaire* (Guide on preventing addictive behaviour in schools). Since 2005, this guide has been issued by the French Ministry of National Education and the MILDT (Interministerial Mission for the Fight against Drugs and Drug Addiction) (DESCO (Direction générale de l'enseignement scolaire) *et al.* 2005; DGESCO (Direction générale de l'enseignement scolaire) *et al.* 2010). The French National Institute for Prevention and Health Education (INPES) distributes information on scientifically-validated prevention methods (Bantuelle *et al.* 2008). These documents are still to be used for information purposes only: there is no specific protocol for governmental or associative drug use prevention workers to follow.

Since there is no suitable observation system, there is little review of the implementation of these principles and of best practices. However, certain ideas seem to have been more widely adopted, such as an understanding of the limitations of a purely informative approach, the relevance of developing psychosocial skills, or an interactive approach and the preventive role played by parents.

The general context and key players

The government implements drug use prevention initiatives, but can delegate this task to associations when a local approach is more appropriate.

The campaigns are mainly on universal prevention and are primarily conducted in secondary schools, where the education community is widely involved both for coordination and execution purposes. Head teachers chair a Health Education and Citizenship Committee (CESC) when it is established. CESC's bring together the educational community and the external partners in the area to define addiction prevention policy and actions in secondary schools. Local administrative authorities provide Head teachers with recommendations based on ministerial guidelines. However, individual establishments enjoy a high level of independence in this area.

There are three main categories of professionals who work with young people: education, health and social personnel, workers from associations that specialise in prevention and health education, and specially-trained law enforcement officers (FRAD, PFAD)⁷⁹.

Since 2006, preventing addictive behaviour has been given a new foothold in the basic missions of the French education system through defining the “*socle commun de connaissances et de compétences*” (“common base of knowledge and skills”). This common base encompasses all of the knowledge, skills, values and attitudes that every student must master by the end of mandatory schooling for their life as future citizens⁸⁰. Of these, “social and civic skills” and “independence and initiative skills” figure among the individual and social skills that form part of the life skills (Botvin *et al.* 2002) and likely to be employed by students when confronted with drugs.

Agricultural secondary and higher education establishments are also relatively free to determine their level of commitment to prevention, but they are strongly encouraged by their supervisory ministry (the Ministry of agriculture) to invest in such efforts. Since 2001, professionals of agricultural education have enjoyed access to the Health Education, Counselling and Adolescent Development Network (RESEDA), which encourages dialogue, training and resource distribution on drug prevention, and extends invitations to tender in the field of health education.

Actions intended for students of establishments of higher education are organised by the S[II]UMPPS, or [inter]university preventive medicine and health promotion services. Several associations and complementary student health insurance companies also participate in this area.

At the workplace, preventing alcohol, drug or psychotropic drug use is partially regulated by the Labour Code and the Public Health Code. The extent to which occupational policies are implemented in companies to prevent the risks related to drug and alcohol use varies. Sometimes, they are limited to specific provisions of a company's internal rules and procedures, but they can also be part of a comprehensive company harm prevention policy that engages the staff representative bodies as part of the legal obligation to ensure employee safety and protect employee health. Preventing drug and alcohol use at the workplace is now clearly one of the roles of an occupational physician (according to the 20 July 2011 law⁸¹ that has been applicable since 1 July 2012). The prevention policy also incorporates screening procedures used by occupational physicians.

Prevention targeting “at risk” populations (referred to as “selective prevention”) or users (“indicated prevention”) is handled mainly by specialised associations or by law enforcement services, particularly in neighbourhoods (outside of the school environment) or as part of a legal response. Counselling clinics for young users (CJCs) and awareness-building training courses exist for these young users (see chapter 9).

⁷⁹ FRAD: *Formateurs relais antidrogue* (anti-drug liaison trainer of the French *Gendarmerie*); PFAD: *Policiers formateur antidrogue* (drug prevention educators of the French police force)

⁸⁰ Décret n°2006-830 du 11 juillet 2006 relatif au socle commun de connaissances et de compétences et modifiant le Code de l'éducation. JORF n°160 du 12 juillet 2006. (NOR MENE0601554D)

⁸¹ Loi n°2011-867 du 20 juillet 2011 relative à l'organisation de la médecine du travail. JORF n°170 du 24 juillet 2011. (NOR ETSX1104600L)

For the last decade or so, public authority media campaigns on drugs have been conducted by the MILDT, often in cooperation with the INPES and relevant ministries (Health, Justice). The nature of the drug prevention messages, the substances mentioned (depending on whether a global or another approach has been adopted) and the priority target populations (young people, parents, the general population, professionals) vary with governmental positions. The media used to deploy these activities are just as diverse and include, with increasing frequency, the Internet and social networks. The budget allocated to such activities can vary from campaign to campaign. These campaigns are usually subject to pre- and, sometimes, post-assessment tests (population, memorisation, approval).

Observation and data

There are no national systems in place to observe prevention actions in all of the main, active sectors of the area. The experimental RELIONPREDIL survey (see Appendix V-RELIONPREDIL) coordinated by the OFDT from 2006 to 2011 will no longer be conducted due to the low response rate among educational establishments.

Subsequently, very little data is available on the scope of preventive actions in the school environment. The ESPAD-France 2011 survey (see Appendix V-ESPAD) nevertheless did give some information regarding these actions. According to the March 2011 statements of the majority of students (at least 7 out of 10) in each class, 20% of high school classes (15-to-18-year-olds) had received information on tobacco, alcohol or illegal drugs in the last six months. If we only consider the classes in which half the students remember such an "event", this rate is 32% (Mutatayi 2012).

In summary, responses to prevention efforts in France come from key institutional players and the description of field actions is based on incomplete feedback.

The legislative framework

Relatively few legal texts regulate the drug use prevention. Since 2004⁸², French secondary schools have been required to provide at least one annual session per uniform age group to disseminate information on "the consequences of drug use on health, and particularly the neuropsychological and behavioural effects of cannabis". A major legislative framework regulates tobacco and alcohol advertising and use in public, as well as the taxation on these drugs, the purpose of which is to limit consumption.

National and local coordination and financing

The policies for preventing legal and illegal drug use are established by long-term government plans and coordinated by the MILDT (see chapter 1). These can be mirrored by or enhanced with programmes or national plans from various ministries (of National Education or Health in particular).

Governmental strategies are translated into departmental programmes to fight against drugs and addictions under the responsibility of "drugs and drug addiction" project managers (who work for the prefectures).

⁸² Loi n°2004-806 du 9 août 2004 relative à la politique de santé publique. JORF n°185 du 11 août 2004. (NOR SANX0300055L)

Since 2007, sales of assets seized during drug-trafficking repression have been turned over to the MILDT-managed Narcotics support fund. The majority (90%) of support fund is used for anti-trafficking purposes, while the remaining 10% is earmarked for prevention actions. The French National Health Insurance Fund (*Assurance maladie*) system also subsidises prevention actions through the French National Fund for Prevention, Education and Health Information (FNPEIS). Various cross-territorial local programmes (concerning health, the fight against social exclusion, public safety and/or urban policy) also make it possible to redistribute public credits for drug use prevention. Furthermore, the identification of priority areas for education and urban planning (based on socioeconomic, housing quality and educational indicators) makes it possible to channel additional resources into underprivileged populations.

Measures designed to support decision-makers and professionals

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

On their websites, the MILDT and the INPES provide drug use prevention tools whose quality was certified by each institution's validation entity (such as the Committee for the validation of prevention tools, until March 2012).

L'UNIRÉS, which is the health education network for French universities, offers training to health educators. The UNIRÉS designs and provides training tools, such as Profédus, which was developed for the University Institute for Teacher Training (IUFM) and the INPES, as well as for a platform for distance initial or continuing education.

Federated organisations⁸³ represent associations that specialise in public debate. These organisations support professional dialogue and implement training, conference cycles and think tanks on drug demand reduction.

Finally, in some regions, alongside "drugs and drug addiction" project managers are technical support structures responsible for developing projects and locally observing the levels of use and public responses.

3.2. Environmental prevention

3.2.1. Environmental prevention policies for alcohol and tobacco use

The commerce, distribution and use of alcohol and tobacco have well-established controls that are regularly reinforced. Since the 19th century, French legislation has regulated the commerce and distribution of alcohol, and originally did so for the purposes of taxation and maintaining public order. Since the 1960s, consideration for public health began influencing legislation. The first French law limiting tobacco advertising and use in public places and establishing measures

⁸³ FNES: Fédération nationale des comités d'éducation pour la santé (French National Federation of Health Education Committees); Fédération addiction (www.federationaddiction.fr); FFA: Fédération française d'addictologie (French Federation of Addictology), (www.addictologie.org); CRIPS: Centres régionaux d'information et de prévention du sida (Regional AIDS information and prevention centres) (www.lecrips.net/reseau.htm).

to provide information to users on the risks of tobacco use goes back to 9 July 1976⁸⁴ (the "*Veil*" law). The 10 January 1991 anti-tobacco and anti-alcohol law⁸⁵, the so-called "*Évin*" law, which was amended by the decree of 29 May 1992⁸⁶, consolidated the public health objectives advocated by the public health law of 1976 or the order of 1960⁸⁷ on preventing alcoholism. The *Évin* law banned smoking in places intended for communal use (except when explicitly authorised) and regulated the composition of tobacco products as well as tobacco advertising and taxation. This legislation also put limits on the advertising and sale of alcohol.

Use restrictions, and especially those pertaining to young people, have been reinforced in the last 10 years. The 21 July 2009 law⁸⁸ (the so-called "HPST" law) amended the French Public Health Code, restricting access to alcoholic beverages and tobacco products and establishing the major related principles of prevention and social/health treatment.

Taxation

Alcohol

The taxation scheme applied in France to alcohol and alcoholic beverages complies with the minimal taxation level determined by the Council of Europe⁸⁹. Taxation varies with the five beverage categories: wines, beers, other fermented beverages (such as cider), intermediary products (such as fortified wine) and other alcohols (mainly spirits).

Alcoholic beverages are subject to excise duties (consumption or distribution taxes) that vary with product type and alcohol by volume. In addition to excise duties, alcoholic beverages are subject to a VAT of 19.6% in France (applied to the price including the excise duties). By virtue of specific public health objectives, certain alcoholic beverages are subject to additional taxation. This is the case for alcopop taxes, which are established at €11 per decilitre of pure alcohol. Furthermore, beverages with more than 18% alcohol by volume (ABV) are subject to a social security contribution⁹⁰. The total proceeds of excise duties and social security contributions on alcoholic beverages go towards the disease and ageing branches of the health insurance fund for agricultural workers and, as such, any new or modified duties are included in the provisional projects for the Social Security Budget Act (PLFSS) voted on by the Parliament. Through ministerial legislative order, duties on alcoholic beverages are raised every year in proportion to the rate of growth of the consumer price index excluding tobacco products for the year before last.

⁸⁴ Loi n°76-616 du 9 juillet 1976 relative à la lutte contre le tabagisme. JORF du 10 juillet 1976.

⁸⁵ Loi n°91-32 du 10 janvier 1991 relative à la lutte contre le tabagisme et l'alcoolisme. JORF n°10 du 12 janvier 1991. (NOR SPSX9000097L)

⁸⁶ Décret n°92-478 du 29 mai 1992 fixant les conditions d'application de l'interdiction de fumer dans les lieux affectés à un usage collectif et modifiant le code de la santé publique. JORF n°125 du 30 mai 1992. (NOR SANP9201055D)

⁸⁷ Ordonnance n°60-1253 du 29 novembre 1960 modifiant le code des débits de boissons et des mesures de lutte contre l'alcoolisme. JORF du 30 novembre 1960

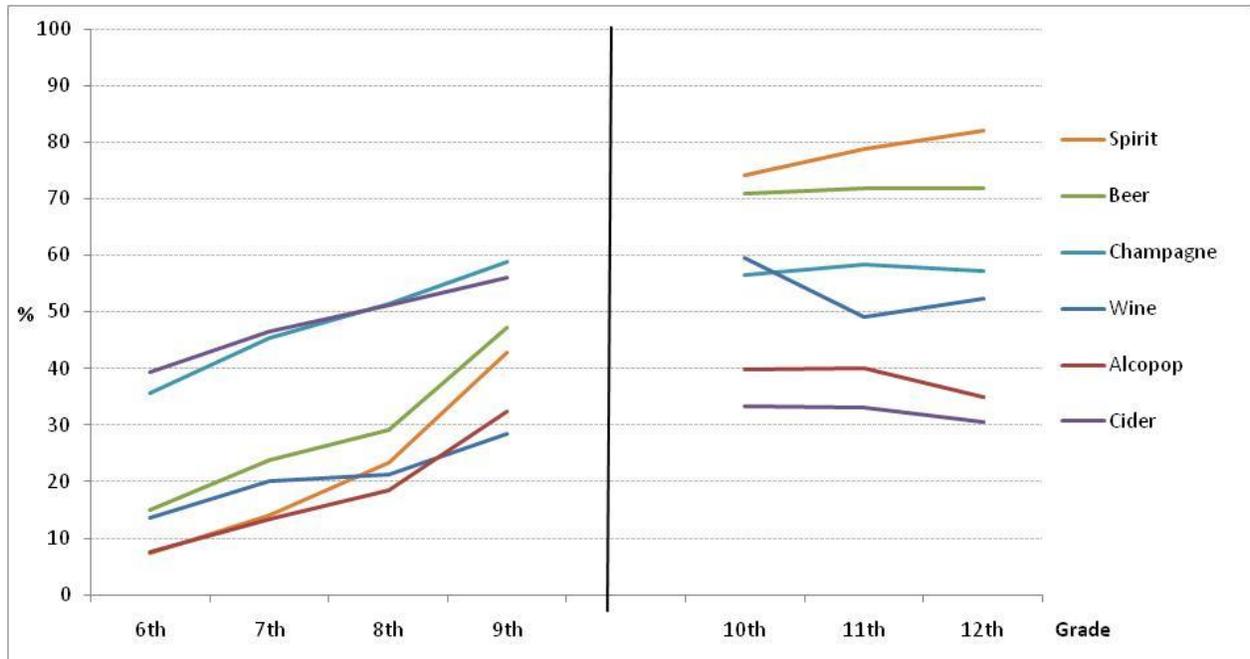
⁸⁸ Loi n°2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires. JORF n°167 du 22 juillet 2009. (NOR SASX0822640L)

⁸⁹ Council Directive 92/83/EEC of 19 October 1992 on the harmonization of the structures of excise duties on alcohol and alcoholic beverages, Official Journal L 316 of 31 October 1992, p.21-27 and Council Directive 92/84/EEC of 19 October 1992 on the approximation of the rates of excise duty on alcohol and alcoholic beverages. Official Journal L 16 of 31 October 1992, p.29-31

⁹⁰ Loi n°2011-1906 du 21 décembre 2011 de financement de la sécurité sociale pour 2012. JORF n°296 du 22 décembre 2011. (NOR BCRX1125833L)

Although they only represent one quarter of the volume of pure alcohol sold in France (versus 58% for wines), more heavily-taxed spirits contribute 82% to fiscal alcohol revenue (Palle 2013). Furthermore, consumption of spirits by teens is fairly widespread. Indeed, the consumption of beer and spirits rose sharply among 14-to-15-year old teens (at the end of junior high school), reaching the highest levels of use among older, high school-aged teens (Spilka *et al.* 2013). In 16-to-18-year-olds, beer and spirits are the alcoholic beverages most frequently drunk in the last month (by 78% and 72% of high school students respectively) (Figure 3.1).

Figure 3.1: Alcoholic beverages drunk in the last year or month by French teenagers, by grade (%)



Sources: HBSC 2010; ESPAD 2011 (OFDT, INSERM)

The tax revenue collected on wine consumption represented 4% of the total revenue and dropped by 10% from 2000 to 2011, while the consumption of spirits rose by slightly more than 10% (Palle 2013). At the end of 2012, one litre of pure alcohol consumed as spirits was taxed approximately €22, consumed as beer was taxed €7.20 and consumed as wine was taxed €0.37. On 1 January 2013, the excise duties on spirits rose from €1,660 to €1,689 per hectolitre of pure alcohol and the social security contributions on alcoholic beverages with 18% ABV or more was set at €542.33 per hectolitre of pure alcohol, compared with €533 in 2012 (Table 3.1). Beer taxation rose by 160%. For the consumer, this was €0.5 more per 25 cl of 4.5% ABV beer.

Table 3.1: Taxation of alcoholic beverages from 2011 to 2013

		2011	2012	2013
Excise duties	Alcohols (spirits)	1,514.47 €/hlpa*	1,660 €/hlpa*	1,689.05 €/hlpa*
	Non-sparkling wines (vins tranquilles)		3.60 €/hl	3.66 €/hl
	Beers with less 2.8% ABV	1.36 €/hl	1.38 €/hl	3.60 €/hl
	Beers with more 2.8% ABV**	2.71 €/hl	2.75 €/hl	7.20 €/hl
Social security contributions (≥ 18% ABV since 2012)	Alcohols (spirits)	1.6 €/l (≥ 25°)	533 €/hlpa*	542.33 €/hlpa*

Source: Arrêté du 15 décembre 2012 fixant pour l'année 2013 le tarif des droits d'accises sur les alcools et les boissons alcooliques prévus aux articles 402 bis, 403 et 438 du Code général des impôts ainsi que le tarif des contributions prévues aux articles 520 B et 520 C du Code général des impôts. JORF n°299 du 23 décembre 2012. (NOR BUDD1242585A)

* hlpa: hectolitre of pure alcohol

** General Social Security scheme

Tobacco

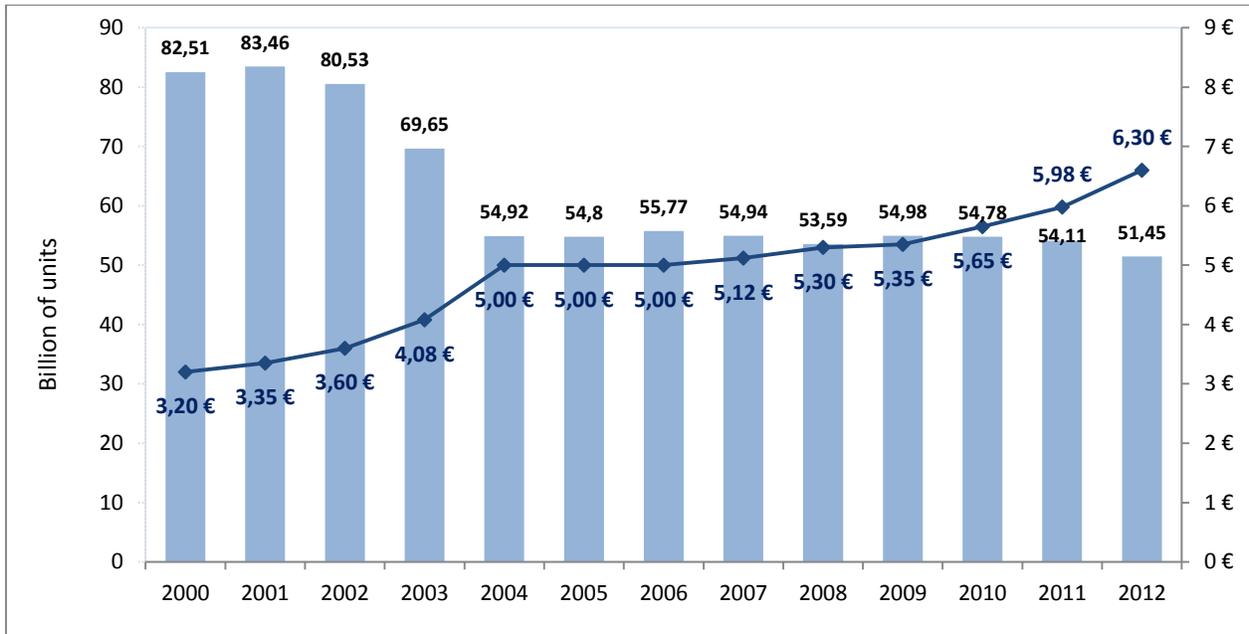
Tobacco is excluded from the list of products included in the consumer price index. This exclusion has enabled regular price increases to take place on tobacco products for the purpose of restricting tobacco use.

Tobacco products are subject to an *ad valorem* tax: VAT of 19.6% and consumption duties in proportion to the weighted mean retail selling price of all products except cigarettes. For cigarettes, duties are broken down into a specific part per 1,000 cigarettes irrespective of their price (€27.58) and a part proportional to the retail selling price (54.57%, or €5.70 per pack of 20 units) in addition to the VAT.

For each tobacco product, a retail price (expressed per 1,000 units or per 1,000 g) is set for the entire French territory. The retail price, which is higher than the minimum, government-established price, is determined by approved manufacturers and suppliers. It becomes applicable after being approved by decree and cannot be below the total of the cost price plus taxes.

Cigarettes sold in France are among the most expensive in Europe (Lermenier 2013). The price of tobacco increased sharply in 2003 (successive increases of 8% in January and 18% in October) and in 2004 (+9%). Since then, the increases witnessed in 2007, 2009, 2010, 2011 and 2012 (all of which were in the order of 6%) increased the price per pack sold to €6.60. Despite this, official retail cigarette sales were stable until 2012, when they experienced their sharpest decrease since 2005 (Figure 3.2). The steepest 2003-2004 price increases caused a shift in consumption from cigarettes to rolling tobacco, and this trend is steady: rolling tobacco sales increased 18% from 2007 to 2012.

Figure 3.2 : Cigarette sales and annual average price per pack of the most widely sold brand from 2000 to 2012



Sources: Altadis / DGDDI (French customs)

In 2012, tobacco products in France generated turnover of 17.9 billion Euros, of which 8.6% represented tobacco shop revenue, 13% manufacturer and distributor revenue and nearly 78.5% government revenue in the form of tax revenue (Lermenier 2013). In 2012, the French government received €14 billion in taxes (including VAT), representing growth of 1.8% compared to the previous year.

Control of sales and distribution (composition, packaging)

Alcohol

The production and sale of alcoholic beverages are regulated by the French Public Health Code (which in 2000, integrated the entire *Code des débits de boissons et de lutte contre l'alcoolisme* -Drinking Establishment and Alcoholism Prevention Code-, which was first written in 1954). In France, the production and sale of the following products are banned: wine-based aperitifs over 18°, anise-based spirits over 45°, bitters and other beverages over 30°.

Since October 2007, all packaging units of alcoholic beverages commercialised in France, including those that are imported, must bear a pictogram or a health message recommending that pregnant woman abstain from consuming alcohol (art. L. 3322-2 of the French Public Health

Code). Both forms are regulated by criteria for legibility, visibility and intelligibility defined in the 2 October 2006 order⁹¹.

The sale of alcohol has been subject to authorisation since 1941⁹². There are four different licence types for on-licence drinking establishments and two licence types for off-licence establishments and restaurants. The licence types vary with the category of alcoholic beverage sold. Only licence IV authorises the sale of any type of alcoholic beverage (OFDT 2012).

Since the 2009 HPST law, the French Public Health Code has prohibited the unlimited sale or free supply of alcoholic beverages for commercial purposes (except during parties or traditional festivals or authorised tastings). This ban targets open bars (bars with an entry fee that entitles the consumer to unlimited drinks) (article L. 3322-9 of the French Public Health Code). During “happy hours”, it is mandatory to offer lower-priced non-alcoholic beverages (art. L.3323-1 of the French Public Health Code).

Formerly authorised between 6 a.m. and 10 p.m., the sale of alcohol at petrol stations is now only authorised from 8 a.m. to 6 p.m. It is strictly prohibited to sell refrigerated alcoholic beverages intended for immediate consumption at petrol stations (art. 94).

Tobacco

In France, tobacco products can only be legally purchased through a network of authorised retailers (registered with the government). The purchase of tobacco by Internet or through any other telecommunications medium (such as telephone or fax) is prohibited, regardless of where the retailer is located (art. 568 ter of the General tax Code).

Several legal provisions govern the packaging or composition of tobacco products, and especially those tobacco product forms that appear to be the most attractive to young people. Hence, the sale of packs of fewer than 20 cigarettes⁹³ and the sale of cigarettes presented in attractive colours with sweet flavours and aromas is prohibited.

Cigarette and other tobacco product packaging must display the "Seriously harmful to your health" warning, the composition of the product and the average tar, nicotine and carbon monoxide content. Since April 2012, all tobacco product packaging must display a health message with a captioned photograph that covers 40% of the back of the packaging as well as the abbreviated telephone number for the Tobacco Information Service telephone helpline⁹⁴. Moreover, this packaging cannot display text or figures that indicate diminished harmfulness compared with other tobacco products.

The maximum tar content, established at 15 mg in 1991 by the *Évin* law, has continued to drop since: today, this maximum content is 10 mg per cigarette. This maximum content is determined by a Ministry of Health legislative order.

⁹¹ Arrêté du 2 octobre 2006 relatif aux modalités d'inscription du message à caractère sanitaire préconisant l'absence de consommation d'alcool par les femmes enceintes sur les unités de conditionnement des boissons alcoolisées. JORF n°229 du 3 octobre 2006. (NOR SANX0602395A)

⁹² Loi du 24 septembre 1941 modifiant la loi du 23 août 1940 contre l'alcoolisme. JORF du 8 octobre 1941

⁹³ Loi n°2003-715 du 31 juillet 2003 visant à restreindre la consommation de tabac chez les jeunes. JORF n°178 du 3 août 2003. (NOR SANX0306354L)

⁹⁴ Arrêté du 15 avril 2010 relatif aux modalités d'inscription des avertissements de caractère sanitaire sur les unités de conditionnement des produits du tabac. JORF n°92 du 20 avril 2010. (NOR SASP0931273A)

Protected areas in public and at the workplace

Alcohol

A drinking establishment can be prohibited from operating by prefectural order in "protected areas" (educational, cultural, athletic, religious, hospital, training and youth recreational establishments) under penalty of penal sanctions (art. L.3335-1 of the French Public Health Code). These orders are mandatory for health and athletic establishments.

Public intoxication is currently subject to a second class fine (€150). The offender may be detained at the closest police station until reasonably sober. Intoxication at athletic events is an offence punishable by imprisonment, especially in the event of violence. However, stadium refreshment stands, which were banned in 1991, were reintroduced in 1998.

The Labour Code prohibits the presence of inebriated persons at the workplace and aims to limit the presence of alcoholic beverages at the workplace to fermented beverages (wines, beers and ciders) only. Such alcoholic beverages are banned from dispensing systems. The head of the company uses policies and procedures to establish the general context of the consumption and distribution of these beverages within the company. These policies and procedures must specify conditions for possible blood alcohol level controls. By virtue of individual freedoms, an employee can only be required to submit to a breathalyser to prevent or halt a dangerous situation related to handling hazardous products or machinery or to prevent the operation of a motor vehicle, such as those used for collective transport⁹⁵. Blood alcohol testing does not necessarily need to be performed by a physician. An employer may not use blood alcohol level results to support a claim of employee misconduct.

Tobacco

The French Public Health Code prohibits smoking in enclosed, covered public areas or at the workplace, in "social" establishments (such as bars, hotels, restaurants, casinos and discotheques), in health establishments, in public transport, and in public and private schools, as well as in establishments where minors are counselled, trained or housed (including open areas, such as school courtyards) (art. R.3511-1 of the French Public Health Code)⁹⁶. Smoking areas can be installed, except in health establishments and establishments frequented by minors.

Protection of minors

Alcohol

The public authorities have been working for a long time to limit excessive use of alcohol among young people, and their efforts have focused on adopting regulations intended to restrict access to alcohol. Until the 2009 HPST law, the sale of alcohol to minors under the age of 16 was prohibited. Since that law, this ban applies to all minors and to any kind of alcoholic beverage distribution to minors (including distribution free of charge) in drinking establishments, in places

⁹⁵ Circulaire DRT n°83-5 du 15 mars 1983 relative à l'application des articles 1 à 5 de la loi du 4 août 1982 concernant les libertés des travailleurs dans l'entreprise. BO Emploi n°16 du 21 mai 1983

⁹⁶ Décret n°2006-1386 du 15 novembre 2006 fixant les conditions d'application de l'interdiction de fumer dans les lieux affectés à un usage collectif. JORF n°265 du 16 novembre 2006. (NOR SANX0609703D)

of commerce and in public areas. The person providing the beverages can require the client to provide proof of age. Failure to comply with the ban on sales (on- or off-licence) or to offer alcoholic beverages free of charge (whether in limited or unlimited quantities) is punishable by a €7,500 fine. Such non-compliance is subject to additional sanctions: a temporary prohibition to sell alcohol for a year at the most, and the obligation to undergo training in parental responsibility (art. 131-35-1 of the French Penal Code). In the event of subsequent offences, the offenders are subject to one year imprisonment and a €15,000 fine.

Tobacco

At present, French law prohibits the sale or free distribution of tobacco products (e.g., cigarettes, rolling tobacco, hookah tobacco, pipe tobacco, cigars, cigarillos) or their components – including papers and filters – to all minors under the age of 18, and not just to minors under the age of 16 (art. 3511-2-1 of the French Public Health Code). Merchants can require purchasers to present identification. A display reiterating the legal ban must be placed where it can be publicly seen in tobacco shops and other authorised tobacco retail outlets.

Violations are subject to fines for second class offences (up to €150) unless the offender shows proof that he or she was duped with respect to the minor's true age.

Alcohol and road safety

Driving a motor vehicle under the influence of alcohol is an offence that has been punishable by law in France since 1965⁹⁷. Since 1995⁹⁸, the legally tolerated blood alcohol level for all drivers has been 0.5 g/l of blood (0.25 mg/l of expired air). Driving a vehicle with levels higher than the aforementioned is an offence in France under the jurisdiction of the *tribunal de police* (police court, French authority dealing with petty offences attracting a fine) or the *tribunal correctionnel* (criminal court, French penal authority prosecuting criminal offences), depending on the recorded blood alcohol level. This offence is subject to a fine (from €135 to €4,500), a loss of driver's licence points, driver's licence suspension or selective withdrawal, and even imprisonment. In the event of bodily injury, the sanctions are harsher and can reach up to 10 years imprisonment in the event of *homicide involontaire* (involuntary manslaughter) due to negligence regarding safety or care.

Restrictions on advertising

Alcohol

The law prohibits propaganda or advertising to promote alcoholic beverages of over 1.2% ABV using media that is imposed on everyone, and minors in particular (television, cinema). However, such advertising is authorised in the adult press, on billboards or through mass mailing, on the radio (for certain categories and at certain time slots determined by Council of state decree) and during events, such as in agricultural shows. In 2009, the HPST law authorised online advertising for alcoholic beverages, except on websites "intended for young people". The messages may not be intrusive or complimentary, or encourage consumption.

⁹⁷ Loi n°65-373 du 18 mai 1965 modifiant l'article L.1er du Code de la route. JORF du 20 mai 1965

⁹⁸ Décret n°95-962 du 29 août 1995 modifiant les articles R.233-5, R.256 et R.266 du Code de la route. JORF n°201 du 30 août 1995. (NOR EQU9500428D)

The advertising formats have restrictions: promotional documents may not mention the name of the product, its presentation, its sales conditions, its mode of consumption or its site of production. All advertising messages must mention that alcohol abuse is dangerous for a person's health. Nevertheless, in 2005, lawmakers softened the regulations governing collective advertising for wine by authorising references to the olfactory and gustatory characteristics of products.

Offences are punishable by a fine of €75,000 and the equivalent of 50% of the expenses dedicated to the illegal activity; the advertising campaign can be ordered to be brought to a halt. The authorities are rarely the party initiating the prosecution. Rather, the plaintiff is usually an anti-alcoholism association.

Tobacco

Promoting sales and discounted or free distribution is prohibited, except for tobacco shops and for professional publications or publications available to the non-EU public only. Since May of 2006, indirect advertising and propaganda are also banned for derivative products that evoke tobacco or an ingredient "through their graphics, presentation or other distinctive characteristics".

French television stations can re-broadcast motorsport competitions that take place in countries where tobacco advertising is authorised. However, the 2009-2013 French Cancer Plan proposed as an objective the "use of legislation to put an end to point of sale advertisement and advertisement during televised, re-broadcasted motorsport events".

Tobacco company sponsorship is also prohibited. Offences are subject to a €100,000 fine. The fine can be even higher, up to 50% of the expenses incurred during the illegal operation (L 3512-2 of the French Public Health Code). Anti-tobacco associations can be the plaintiffs and are often very active in pursuing offences.

3.2.2. Other social or normative changes

Any person wishing to sell alcoholic beverages off-licence from 10 p.m. to 8 a.m. is required to following training on the rights and obligations related to this activity (art. L.3331-4 of the French Public Health Code) under penalty of a €3,750 fine.

The HPST law (art. 95) also reinforces the power of municipalities to ban off-licence alcohol sales at night (from 8 p.m. to 8 a.m.). Failing to comply with bans established through municipal orders leads to a fourth class fine. In recent years, given the risks of violence and drunk driving, several "night life charters" were drawn up between local decision-makers (prefectures or municipalities) and drinking establishment operators.

All drinking establishments likely to close between 2 a.m. and 7 a.m. must make certified chemical or electronic alcohol breathalyser tests available to the public (by order of 24 August 2011⁹⁹).

Violence prevention and school environments

In 2012, the Minister of National education developed several measures for preventing violence in schools. These measures are likely to help prevent drug use in these environments. In September 2012, 500 security and prevention assistants were dispatched to those schools most exposed to violence. Their mission is to help analyse the situation in their establishments and then promote a prevention policy and improvement in the educational environment. This measure provides support for the mobile security teams¹⁰⁰ that were implemented in 2010¹⁰¹.

In November 2012, the Ministry of National Education appointed a delegation responsible for preventing and fighting against violence in schools. One of the objectives of this delegation is to promote the kind of calm school atmosphere that fosters educational success and reduces social inequality¹⁰².

3.3. Universal prevention (SQ 25 2013)

The year 2012 was one of transition in expectation of the new policy guidelines to prevent addictive behaviours. However, there were no new developments in terms of drug use prevention. The highlights of the government's universal, selective and indicated prevention actions of recent years are summarised in the previous (2012) edition of the national report. In this report, we will focus on some interesting developments from 2012 to the spring of 2013 that instituted short- or medium-term changes.

The MILDT committed to a series of consultations with key national players to better define the priorities of the government's prevention, health/social care and law enforcement activities with respect to addictive behaviours. Ministries increasingly agree on the need to move public action towards programmed, structured responses based on evidence.

With this in mind, in early 2013 the MILDT contacted the French National Institute for Health and Medical Research (INSERM) to coordinate a group review of addictions in young people (in press), which should also address preventive measures with respect to this group. The year before, a qualitative survey also examined what motivates young people in their addictive behaviour.

⁹⁹ Arrêté du 24 août 2011 relatif aux conditions de mise à disposition de dispositifs certifiés permettant le dépistage de l'imprégnation alcoolique dans les débits de boissons en application de l'article L. 3341-4 du code de la santé publique. JORF n°228 du 1 octobre 2011. (NOR DEVS1121148A)

¹⁰⁰ Multidisciplinary teams (composed of, for example, educational personnel, teachers, law enforcement officers, and mediators) which, in case of high levels of tension or a crisis related to a lack of security, help establishments restore protection for staff and students, as well as property, and improve the treatment of students with behavioural problems.

¹⁰¹ Circulaire n°2010-25 du 15 février 2010 relative au plan de sécurisation des établissements scolaires : actions prioritaires. BO Education nationale n°10 du 11 mars 2010. (NOR MENE1003863C)

¹⁰² <http://www.education.gouv.fr/cid68983/prevention-et-lutte-contre-les-violences-en-milieu-scolaire%A0-%A0point-d-etape.html> [accessed 24/09/2013]

All of these elements were used to help devise the next action plan against drug and addictive behaviours, which has been made public in September 2013.

For the same period, several discussion frameworks were established that were directly or indirectly related to drugs and drug use prevention.

3.3.1. School environment

In 2012, actions to prevent addictive behaviour did not give rise to any particular measures, but there were some interesting developments in certain related areas.

On 5 June 2013, the National Assembly (followed by the Senate on 25 June) adopted, during a second review, a radical reform of the *Ecole de la République* (National Education), which promotes health among students as a national education mission and helps foster success and reduce health inequalities. According to the law of 8 July 2013¹⁰³, promoting health relies on implementing prevention, information and health monitoring actions among students, screening students for problems that may interfere with learning, entrusting students with responsibility vis-à-vis health risks and preventing and reducing addictive behaviour and psychological suffering.

The Ministry's review of the school environment, and in particular within the scope of the ministerial delegation responsible for preventing and fighting against violence in schools, reveals the disparities in the actions for preventing at-risk behaviour (such as drug involvement, violence, intimidation/harassment, sexuality, etc.).

3.3.2. Family environment

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3.3.3. Community

In the French context, prevention work in the community refers to everything that is done outside of the school or university or occupational environment.

Each year in France, nearly 4 million children and teenagers are received at recreational centres. The Ministry responsible for youth and the MILDT also published a 2012 guide for organisations that train people who watch over children and teenagers to facilitate the implementation of awareness-raising actions in different educational and recreational settings for young people (such as before or after school and holiday centres) (DJEPVA-MILDT 2012). Furthermore, since January 2012, training to obtain a certificate to work with young people (BAFA) includes a section on preventing addictive behaviour and on sexual practices to prepare future workers at schools and camps to provide appropriate responses in situations they may encounter with at-risk minors.

¹⁰³ Loi n°2013-595 du 8 juillet 2013 d'orientation et de programmation pour la refondation de l'école de la République. JORF n°157 du 9 juillet 2013. (NOR MENX1241105L)

3.3.4. Workplace

From 2010 to 2012, significant efforts were made to promote addiction prevention at the workplace: there was a national conference on « *Drogues illicites et risques professionnels* » (Illegal drugs and risks at the workplace) on 25 June 2010, and a guide that was created under the supervision of the General directorate for labour (DGT) and the MILDT was issued in January 2012. This guide was entitled « *Repères pour une politique de prévention des risques liés à la consommation de drogues en milieu professionnel* » (References for a policy to prevent risks related to occupational drug use) (DGT-MILDT 2012).

The prevention policies in certain at-risk sectors and jobs made headway.

The opinion issued by the National Ethics Advisory Committee for the Life Sciences and Health (CCNE) in May 2011¹⁰⁴ paved the way for company-by-company and branch-by-branch negotiations on the need for prevention and a framework for employee screening.

3.4. Selective prevention in at-risk groups and settings (SQ 26 2013)

3.4.1. At-risk groups

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3.4.2. At-risk families

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

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3.5. Indicated prevention (SQ 26 2013)

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3.6. National and local media campaigns

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¹⁰⁴ Avis n°114 du 5 mai 2011. Usage de l'alcool, des drogues et toxicomanie en milieu de travail. Enjeux éthiques liés à leurs risques et à leur détection. Paris, Comité Consultatif National d'Éthique (CCNE), 2011, 29 p.

4. Problem drug use

4.1. Introduction

France has been recording national estimates of the number of problem drug users since the mid 1990s. The latest estimate performed by the OFDT (NEMO study, see Appendix V-NEMO) was for 2011 and follows the estimates performed in 1995, 1999 and 2006. The definition of problem drug use has, however, changed from one study to the next: in 1995, the criterion for being included in this category was the use of opioids; in 1999, this criterion was expanded to include cocaine. The definition proposed by the EMCDDA in 2004 was adopted for the 2006 and 2011 estimates: the concept of problem drug users includes users (between 15 and 64 years of age) of any drug administered intravenously or regular users of opiates, cocaine or amphetamines. However, there is a slight difference between the approach used in France and the EMCDDA recommendations. In the studies conducted in 2006 and 2011, all patients who consumed or injected the aforementioned substances within the 30 days prior to the study were considered to be problem drug users. The use of this inclusion criterion does not, however, indicate whether use has been ongoing for one year, which is a condition stated in the European protocol. The purpose of this criterion was probably to exclude “occasional” users. In practice, almost all recent users of these substances or of intravenous drugs who are seen in treatment and harm reduction facilities are long-term users.

It should also be noted that, as in 2006, the 2011 estimate focuses solely on metropolitan France.

The 2006 and 2011 estimates were produced using three methods recommended by the EMCDDA and applicable to the French situation: multiplier method using treatment data – in this case the sale of opioid substitution treatment (high-dose buprenorphine and methadone), multiplier method based on arrest data provided by the police and *gendarmerie*, and a multivariate indicator method based on indirect indicators of problem drug use and local estimates of prevalence calculated using the capture/recapture technique. All of the national estimates obtained are in fact based on the results of local prevalence estimates using the capture-recapture method for the following six French cities: Lille, Lyon, Marseille, Metz, Rennes and Toulouse (Cadet-Tairou *et al.* 2010b; Vaissade *et al.* 2009). The local prevalence of problem use will be broached in the first section. The national results will be presented in a second section.

In France, where some drug users slip through the administrative information system net due to respect for anonymity, prevalence studies must rely on an actual census performed at the local level by overworked professionals. These censuses are not compatible with long rounds of questioning, the priority being to establish all the facts. This is why it is impossible to describe problem drug users in detail using data from prevalence studies. The characteristics of these users are presented in section 4.3 of this chapter and are described using the results of the ENa-CAARUD 2012 survey (see Appendix V-ENa-CAARUD) conducted among users attending harm reduction facilities.

4.2. Prevalence and incidence estimates of problem drug use (PDU) (ST 7 2013)

Local prevalence

In order to obtain local prevalence estimates of problem drug use by the capture-recapture method, it is vital to record attendance information at several “locations” for drug users satisfying the aforementioned definition of problem drug users. These data can therefore provide the number of users seen in one or more locations in each city. This information is at the heart of the statistical modelling approach used to estimate the total number of problem drug users. All of the institutions likely to encounter drug users in the six aforementioned cities were contacted and asked to participate in the user census produced within the framework of this study. These institutions included specialised addiction treatment centres (outpatient CSAPA facilities and CSAPA in remand centres), hospital units, low-threshold structures (CAARUDs), rehabilitation centres in contact with vulnerable and homeless people, general practitioners and law enforcement officers in some areas. The information was collected over a six-month period (from January to June 2011) in each city. The information thus collated was sent to the OFDT where it was subsequently analysed.

The number of problem drug users in each city was initially estimated using log-linear modelling, as in the previous study. However, poor cross-checking between the various locations led to unstable models and extremely broad confidence intervals. An alternative method based on estimating the probability of each person appearing in more than one “location” based on a certain number of subject-specific characteristics (such as age, gender, housing and reported substances) was used in order to improve the quality of the estimate. The link between the probability of a person attending several locations and explanatory variables was modelled using logistic regression. Related, statistically significant coefficients were then applied to each individual using linear combination. All of the coefficients were used to estimate the actual size of the population (Böhning *et al.* 2009a; Böhning *et al.* 2009b). This method was applied to the 2006 data in order to ensure comparability between the two years.

In 2011, estimated prevalences ranged from 8.9 per 1,000 inhabitants aged 15 to 64 years in Rennes to 13.7 per 1,000 inhabitants in Metz (Table 4.1). The related confidence intervals were particularly broad for both these cities. A comparison of the prevalences recorded in 2011 and 2006 showed an increase in the number of problem drug users. However, the rather broad confidence intervals due to the number of subjects and poor cross-checking between locations do not allow us to conclude that there was a statistically significant increase.

Table 4.1: Estimate of the number of problem drug users and prevalence (‰) among 15-64 year-olds, per site, in 2011

Site	Observed	Estimated*	95% CI	2011 Prevalence	95% CI	2006 Prevalence	95% CI
Lille	1,143	8,300	7,900-8,700	11.2	10.7-11.7	10.5	8.6-14.0
Lyon	956	9,200	8,900-9,500	10.2	9.8-10.5	10.6	8.0-15.0
Marseille	618	6,600	6,100-7,100	11.4	10.5-12.3	10.3	7.7-14.2
Metz	309	3,300	2,000-5,900	13.7	9.0-26.9	10.8	8.0-15.0
Rennes	296	1,800	1,200-2,600	8.9	6.0-13.3	7.6	5.6-11.7
Toulouse	976	7,500	7,100-7,900	13.1	12.4-13.8	10.1	8.0-12.9

* Rounded up or down to the nearest hundred.

Source: NEMO 2011 (OFDT)

Prevalence estimates since 1999 can only be compared for the three cities included in successive surveys and for heroin and cocaine users only. Toulouse, which witnessed a marked increase in prevalence throughout the period in question, is in direct contrast with the other two cities, where prevalence was more stable (Table 4.2).

Table 4.2: Prevalence estimates for heroin and cocaine problem drug users and prevalence (‰) among 15-64 year-olds, per site, 1999-2011

Site	1999 Prevalence	95% CI	2006 Prevalence	95% CI	2011 Prevalence	95% CI
Lille	6.2	5.2-7.2	6.4	4.9-7.9	6.9	5.7-8.7
Marseille	6.4	5.8-7.6	6.1	4.2-6.9	6.7	6.2-7.3
Toulouse	4.3	4.0-4.7	6.7	5.2-8.3	8.7	6.9-11.1

Source: NEMO (OFDT)

National estimate

The number of problem drug users estimated at national level varies with the method employed, and ranges from 222,000 (multiplier applied to arrest data) to 340,000 (multivariate method), which corresponds to a prevalence of 5.5 per 1,000 and 8.4 per 1,000, respectively (Table 4.3). The multiplier method applied to treatment data gives an intermediate prevalence of 7.5 per 1,000. Estimates based on arrest data are lower than the other two estimate types, and especially those obtained with the multiplier method, with no cross-checking at all between confidence intervals. In 2006, the range of values adopted at national level, i.e., 210,000 to 250,000 users, corresponded to the overlap zone of the confidence intervals calculated for each estimation method. Adopting the same principle for the 2011 data led to the exclusion of the multiplier method applied to arrests. The only estimate retained was based on treatment data and the “multivariate indicator” estimate. A rather large range in values was thus obtained, namely 275 000 to 360 000 problem drug users. The upper and lower prevalence limits associated with these estimates are 7 per 1,000 and 9 per 1,000. This result places France in the middle in terms of European Union ranking.

Table 4.3: Estimate of the number of problem drug users in metropolitan France in 2011

Estimation method	2011 Estimate	95% CI	2006 Estimate	95% CI
Treatment multiplier	299,000	238,000-360,000	272,000	209,000-367,000
Arrest multiplier	222,000	176,000-267,000	187,000	144,000-253,000
Multivariate indicator	340,000	275,000-410,000	264,000	189,000-338,000

Source: NEMO (OFDT)

Overall, the three estimation methods reveal a marked rise in the prevalence of problem drug use since the 2006 estimates. However, given the broad confidence intervals, it is difficult to confirm any increases. It can simply be pointed out that an increase in the number of problem drug users seems plausible. In fact, other information sources indicate, on the one hand, the “ageing of the population concerned”, with reduced mortality rates given the increase in the use

of substitution treatments in the late 90s, and on the other hand, a degree of “population renewal” because of the more widespread use of stimulants, the emergence of new opioid users and changes in the party scene.

These estimates are useful markers despite leaving a considerable margin for uncertainty. The limits of the various estimation methods should, however, be discussed. The multiplier method using treatment data is based on the sales figures of two opioid substitution treatments, which enables the number of drug users receiving these treatments to be estimated. Given the extensive availability of this type of treatment in France, these data represent an excellent base for the application of this method. Nevertheless, these estimates may be affected by the misuse of these treatments, which tends to vary with geographic area. This lack of geographic homogeneity could lead to a slight overestimation of the prevalence of problem use with this method.

The second method, known as the “multiplier method using arrest data”, is based on the number of arrests for heroin or cocaine use, which can be considered an indirect indicator of drug use and of the activity of the police services and the *gendarmerie* in anti-drug campaigns. The importance attached to this mission is also likely to vary from one geographical area to the next without always reflecting differences in drug use. Another possible bias in the use of this indicator is that people arrested by the police for using opioids or cocaine do not always exactly meet the criteria for being problem drug users. It is difficult to establish whether this type of bias tends to underestimate or overestimate the number of problem drug users.

The third method, the “multivariate method”, based on indirect indicators of problem drug use, has the advantage of comparing different data sources. From this data, known prevalence estimates for six *départements* (through six cities) are extrapolated to the 90 other French departments. Nevertheless, like the first two methods, this method is based on the local prevalence estimates presented in the previous section. Given the complexity and cost involved in carrying out the survey in each city to obtain an estimate, the number of cities has been limited to six, which remains too few to work out a national estimate. The precision and reliability of the estimates would be increased if estimates were carried out in a higher number of cities. This appears to be impossible in the French context at the present time. Furthermore, the French administrative system is still characterised by a high level of data protection. Subsequently, in contrast with other countries, this protection makes it impossible to confirm the presence or absence of a drug user in several administrative data sources and to multiply local prevalence estimates relating to problem drug use.

4.2.1. Indirect estimates of problem drug users (PDUs)

There is no indirect estimate of the number of problem drug users in France.

4.2.2. Estimates of incidence of problem drug use

No publications are currently available in France concerning the incidence of problem drug use.

4.3. Data on PDUs from non-treatment sources

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

CAARUD clients

From a quantitative viewpoint, the data used to describe those users most heavily involved in drug use is obtained from the surveys carried out in the CAARUD low-threshold structures (Support Centre for the Reduction of Drug-related Harms). Although a certain percentage of the drug users seen in CAARUDs are also enrolled in a healthcare system, these users tend to be more focused on managing their drug addiction than on receiving treatment. CAARUDs welcome users who, on the whole, tend to be more inclined to use several types of drugs and who lead more precarious lifestyles than those seen by the various treatment systems. However, this data is insufficient when it comes to describing non-recreational drug users as a whole.

The probable under-representation among the youngest users and wandering young users from the party scene ("travellers", who are often accompanied by dogs) using these centres on a less frequent basis should be noted in these data. For their part, the more socially integrated drug users are even less likely to use the CAARUDs facilities (Cadet-Tairou *et al.* 2010a).

The results of the 2012 ENa-CAARUD survey are characterised by a more than 10% increase in response rate compared with the 2010 version (73.7% vs. 60% in 2010¹⁰⁵). The main reason for the lack of response is user refusal to respond to the questionnaire (42.7%), followed by a lack of time for CAARUD professionals in charge of issuing the questionnaire (32.7%). In 17.8% of cases, this problem was due to the inability of the user to speak French. After an observed decrease in precariousness indicators from 2008 to 2010, 2012 reveals an increase. Moreover, this concurs with the qualitative elements available (see chapter 8) and the hypothesis that the decrease in precariousness witnessed in 2010 was due to a drop in the number of the most precarious users surveyed.

Drug users were interviewed in a specific treatment centre as a matter of priority (87.8%). The remainder (12.2%) were surveyed by a mobile unit or an outreach team.

Drug users are getting older and older

This is still a predominantly male population group (80.5%). The percentage accounted for by women tends to be higher among the youngest users. Women represented 34.8% of users under the age of 25 and 42.5% of users under the age of 20. Likewise, in 2012, 9.4% of users under the age of 25 were men while 20.8% were women. The difference between the average age of men and women was fairly stable (2.7 years in 2006 and 2.8 years in 2012).

In 2012, drug users who frequented harm reduction facilities in urban areas were relatively old on average (35.9 years, or 0.4 years older than in 2010) (Saïd *et al.* in press). The proportion represented by users over the age of 45 increased from 9.6% in 2006 to 19.4% in 2012, since many users continue to frequent CAARUDs as they get older (Table 4.4).

¹⁰⁵ The increase in response rate was due in part to a campaign to promote the survey to CAARUD professionals.

Table 4.4 : Breakdown of CAARUD users by age class (in %) from 2006 to 2012

	2006	2008	2010	2012
Under 25 years of age	17.9	18.2	14.0	11.6
From 25 to 34	36.3	33.0	32.2	34.3
Over 34 years of age	45.7	48.8	53.8	54.1

Source: ENa-CAARUD (OFDT)

The general precariousness of drug users

Six out of ten people seen in a CAARUD lived alone or only with their children (60.6%) and 22.8% lived with a partner. The remainder lived with friends or parents. Women less frequently lived alone than men and more frequently lived with a partner (42.9% vs. 18.2%). More than half of these women were mothers (51.1%).

In 2012, drug users visiting harm reduction facilities in urban environments displayed a high degree of social vulnerability (Saïd *et al.* in press) (see chapter 8).

- Of these vulnerable drug users, half (46.7%) lived in unstable housing conditions: 58% of them were homeless or living in a squat while the others had some form of temporary housing¹⁰⁶.
- Fewer than one out of every five (16.5%) received a salary or unemployment benefits. More than half (56.6%) received social welfare: Active Solidarity Benefit (RSA) or Disability Living Allowance (AAH) or more rarely, income from their family or a third party. Finally, one quarter (26.8%) did not have any legal means of income and needed to resort to begging and/or prostitution for example. The structure of the resources differs considerably depending on the age group in question. Indeed, we should note that two thirds of the under-25 age group (66.6%) had no legal income.
- Most (87%) drug users seen in CAARUDs are affiliated to a Social Security scheme, but 64% only had CMU coverage¹⁰⁷. Of the 13% who stated that they do not have any national health coverage, two thirds do not have AME (state medical assistance for foreigners without medical coverage).
- The vast majority were in possession of valid identity papers (whether French or foreign). However, 13.1% had no identity papers.
- Drug users frequenting CAARUDs are in frequent contact with the law enforcement system. In 2012, 14.2% of these users had been incarcerated on at least one occasion during the year. One in six men (16%) and 7.2% of women had been incarcerated.

Heavy users of psychotropic substances

The substances most frequently consumed by those users who responded to the survey in 2012 were still cannabis and alcohol (Table 4.5).

¹⁰⁶ Available for a period of less than six months.

¹⁰⁷ Universal Medical Coverage (or CMU in French) provides minimal health insurance coverage for people who do not make contributions to the Social Security scheme.

Approximately one-third (30.8%) of the users encountered in 2012 had taken heroin in the previous month, but the most widely consumed opiate was still HDB (37.1%). Among the recent users of HDB, three quarters (78.4%) stated that they received it as a substitution treatment. HDB was also the substance most regularly consumed by its users, over three quarters (78.3%) of whom consumed it on a daily basis.

The use of cocaine in its hydrochloride (powder) form or in the form of freebase concerns more than one out of three drug users seen by the CAARUDs (36.1%). Regarding the use of crack (cocaine purchased in its freebase form) the national data tends to mask a major variation between the Paris region and the rest of France, as its use prevalence is respectively 48% and 6%.

The use of MDMA, amphetamines and hallucinogenic drugs among CAARUD-frequenting drug users is chiefly accounted for by those users who also frequent the techno/party settings (with the exception of certain natural hallucinogens).

Table 4.5: Prevalence of drug use in the last month (in %) among drug users seen in CAARUDs in 2012

	Recent users (used in the last month)	% of recent users who are daily users
Cannabis	72.8	51.1
Alcohol	65.5	52.1
HDB	37.1	78.3
Heroin	30.8	20.1
Methadone	27.0	73.7
Morphine sulphate	17.2	43.8
Powder/freebase cocaine	36.1	12.0
Crack	17.5	27.5
Amphetamines	12.8	5.3
Ecstasy	12.3	3.1
Methylphenidate (Ritalin®)	1.9	13.9
Benzodiazepines	30.5	62.5
Hallucinogenic plants and mushrooms	7.5	4.6
LSD	7.2	1.6
Ketamine	8.6	0.9

Source: ENa-CAARUD (OFDT)

When interviewed in 2012 on the subject of which substance posed the most problems for them, drug users most frequently mentioned an opioid (39.1%), the main one being HDB (16.4%). Heroin was only mentioned by 11.5% of the users. Alcohol was mentioned by more than one in five users (21.7%). Cocaine (7.8%) and crack (6.9%) were the stimulants mainly referred to as the most problematic substances by 15.9% of surveyed users

In 2012, 64% of CAARUD users had injected at least once during their lives. The average age at first injection was 21.3 years (median age was 20 years) and had not varied since 2006. The number of users who had injected in the last month (46.1%) has also remained stable since 2006.

An increase in injecting was reported (in the qualitative data) around the mid-2000s, although this practice appears to be concentrated, not only at certain sites but also among certain non-integrated population groups referred to as "travellers" or "wanderers". In the population seen in

harm reduction facilities, other routes of administration (inhalation and snorting) are on the rise, and are being adopted as additional routes of administration for users already using a certain route or routes (Table 4.6).

The use of injection appeared to be frequent for opioid (except for methadone) and for cocaine use, which was injected by more than half (52.8%) of CAARUD users, but also for ketamine (31.8%) and amphetamines (32.7%). An increase in the number of heroin users who snort (51.6% vs. 47.7% in 2010) and who smoke (31.6% vs. 28.9% in 2010) was also observed. It was also noted that cocaine (purchased in powder form) is smoked as freebase (after base transformation) by a third of cocaine users encountered in CAARUDs. This figure is also increasing, as highlighted in the qualitative data collected (32.9% vs. 30.9%). If we also take crack users (who have purchased freebase cocaine) into consideration, more than half (55.0%) of recent cocaine and/or crack users also smoke cocaine.

Table 4.6: Routes of administration of drugs used in the last month by drug users seen in CAARUDs in 2012

	N	Injection (%)	Oral route (%)	Snorting (%)	Inhalation / Smoking (%)
Morphine sulphate	497	84.3	15.9	10.1	1.1
Heroin	887	51	0.8	51.6	31.6
Cocaine	1,040	52.8	0.6	46.9	32.9
HDB	1,071	54.2	45.9	25.9	5.1
Ketamine	247	31.9	5.7	75.1	0.9
Amphetamines	369	32.7	31.8	62.5	3.6
Ecstasy	356	21.8	70.6	34.8	11.1
Codeine	193	5.9	92.4	3.5	2.4
Benzodiazepines	879	5.4	95.8	3.4	0.5
LSD	208	0	97.3	2.7	1.1
Crack	504	4.2	0.2	2.9	98.9
Methadone	778	2.4	98.1	1.3	0.1
Hallucinogenic plants	217	0	91.7	1.6	13.5
Alcohol	1,889	0.3	99.9	0	0
Cannabis	2,098	0.1	3.1	0.4	98.7

Source: ENa-CAARUD (OFDT)

N.B. Several routes of administration may be used by a user for a given substance. Consequently, the total percentage per substance may exceed 100%.

TREND data: key changes in 2011-2012 concerning uses and modalities of use (Cadet-Tairou et al. 2013b)

Information on the main trends related to the market (trends on Internet drug trafficking and emerging molecules in particular) can be found in chapter 10.

With regard to users, the TREND scheme (see Appendix V-TREND) revealed two trends that are not entirely new, but are intensifying.

Dispersion of the most disadvantaged users, putting them at further disadvantage

This is the result of several phenomena. Expulsion from squats by the authorities leads to repetitive drug user displacement from city centres to the periphery, and vice-versa. These displaced drug users either find themselves relegated to the edge of cities in "camps/shanty towns" along ring roads or in outlying areas, or they go to less visible, subterranean locations, such as basements, parking garages and rubbish storage areas. These elements contribute to a deterioration in living and health conditions for the most marginalised users, and harm reduction facilities claim that they increasingly are having difficulties in reaching this population. Others, often less marginalised users (i.e., those who are not "on the street" but who are having difficulty on the job market), settle in outlying or even rural areas, where they have difficulty gaining access to care and harm reduction measures.

The dispersion of users to rural areas is related not only to the urban exodus, but also to users who start using in rural areas (based on the micro trafficking which promotes accessibility to substances) and leads to an expansion of drug use to new territory. Difficulties in finding employment also play a significant role in the regularity of use. According to the still-fragmented data collected by TREND sites, use in rural areas does not seem to be specific; access to information, harm reduction and treatment remain a major problem¹⁰⁸.

The increasing burden of problems related to chronic alcohol use as users age

Harm reduction and treatment professionals have confirmed that, as the oldest alcohol abusers get older, "age-related" pathologies are frequently brought on by underlying chronic alcohol abuse. Such diseases are more serious and appear earlier in this context, and there are not enough structures for these drug users.

Hence, several sites have once again reported the omnipresence of the use of alcohol among drug users, and primarily strong beers use because of their cheap price. A TREND site even mentioned an increase in alcohol consumption among precarious drug users.

Moreover, the 2010-2011 trends, such as the increase in the practice of chasing the dragon¹⁰⁹ (smoking route), continued in 2012 This practice is spreading to substances other than heroin and cocaine (freebased first for such use), such as the powdered form of MDMA. This phenomenon is primarily seen on the alternative party scene (free parties, "off zones" of festivals) by heroin users who employ this route of administration but also affects now a wider circle. The provision of "aluminium"¹¹⁰ by harm reduction facilities at party sites seems to promote this use. Against this background, chasing the dragon basically replaces snorting, which irritates nasal mucous membranes. Other reasons given by MDMA users to explain this kind of use include intensifying the high due to more rapid absorption by the alveoli in the lungs and seeking the empathogenic effect of the substance. Therefore, the inhalation route of administration for MDMA tends to be used at the end of parties ("after") to help ease the coming down from a high.

¹⁰⁸ This problem is taken into consideration by CAARUDs, which are currently experimenting with various solutions for reaching these new populations.

¹⁰⁹ Chasing the dragon consists of inhaling the vapours produced by heating (with a cigarette lighter) heroin placed on aluminium foil. The active substance enters the bloodstream through the pulmonary alveoli, which are highly permeable to gas, and not via the nasal mucosa, like in sniffing. This route of administration increases both the intensity and the rapidity of onset of the effects.

¹¹⁰ A harm reduction tool, which replaces the aluminium foil usually used by users in this practice. The foil releases toxic vapours when it is heated.

Although this phenomenon appeared and developed on the alternative party scene, it is also used by precarious urban users, for whom inhalation started to become an alternative to injection a few years ago. For them, inhaling provides the high without the negative aspects. Hence, the ENa-CAARUD survey conducted in 2012 among the often precarious drug users seen in CAARUDs shows an increasing frequency of MDMA heating and inhalation (11.1% in 2012 versus 3.1% in 2008). The trend continues also for heroin (31.6% in 2012 versus 24.2% in 2008), taking into account that harm reduction facilities encourage injectors to use this route of administration to avoid local injection complications (abscesses, venous obstruction and necrosis). With regard to cocaine, it is inhaled in its freebase form.

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

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

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

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

5.1. Introduction

Definitions

A system for recording treatment demands in compliance with the European protocol (Common Data Collection on Addictions and Treatments or “RECAP”, see Appendix V-RECAP) was introduced in France in 2005 in specialised centres dealing with drug users. These centres, previously known as CSSTs (Specialised Care Centres for Drug Users) were renamed National Treatment and Prevention Centres for Addiction (CSAPAs) in 2010. This term now also covers institutions that provide support both for people with illegal drug or alcohol problems. In accordance with the European protocol, only those persons for whom illegal or psychotropic drugs pose the main problem will be discussed here.

A patient is a drug user having been seen at least once in the year during a face-to-face interview in a treatment centre. A new patient is a drug user seen for the first time by a centre which he has contacted or who returns after a loss of contact of at least six months. A first-time treatment entrant is a drug user who has never before been monitored by an addiction treatment professional for his/her addiction problems.

Data collection tools

RECAP makes it possible to obtain individual data collected on a continuous and theoretically exhaustive basis concerning all patients coming forward to seek aid from the CSAPAs. RECAP replaces the survey carried out on a regular basis between the late 80s and the late 90s on drug users seen by the various types of establishments during the month of November.

The aim of RECAP is to be able to track the characteristics and patterns of use of legal and illegal drug users seen in CSAPAs at both a regional and national level. It is based on the information systems already in place in specialised structures (reception sheets, computerised management of patient files) and a minimum core set of questions to be used by all staff operating in the drug addiction field.

Virtually all structures today manage their patient files using specialised software. A feature included within the software makes it possible to extract RECAP data on patients seen in the last year in an anonymous file in a predefined format. The data, which is sent to the OFDT, is then verified and merged to render it exploitable.

5.2. General description, availability and quality assurance

5.2.1. Strategy and Policy

Background information

The care and treatment policy concerning users of illegal drugs can be characterised by several major distinctive periods in France. Before the 70s, treatment of drug users was mostly conducted in psychiatric hospitals.

The first major turning point dates back to the adoption of the 1970 French law on narcotics¹¹¹. This law stipulated that any drug user could obtain anonymous, free treatment to achieve abstinence. The adoption of this law prompted the development of specialist outpatient centres and residential centres, the latter of which house drug users after withdrawal. Psychiatric institutions proved reticent about accommodating ever-increasing numbers of drug users. In contrast, teams working for related associations volunteered to manage these patients. Subsequently, these patients were accommodated in two different settings (psychiatric hospitals and associations), with the latter option gaining increasingly more significance over time.

The second major milestone was brought about by the rise of the AIDS epidemic. The public authorities only adopted opioid substitution treatments (OST) and harm reduction measures in the early 90s, which was rather late compared with other countries.

In France, it was decided to quickly make high-dose buprenorphine (HDB) substitution treatments widely available. Any practising physician was authorised to prescribe them¹¹². As a result, general practitioners began to play an increasingly important role in treating opioid drug users. At the same time, the rapid spread of AIDS and the adoption of a harm reduction policy (as a direct result of the epidemic) raised the question of admitting drug users to general hospitals as opposed to only psychiatric establishments for their physical health and/or addiction problems. Following the example of the measures adopted for the treatment of alcoholism, liaison teams were established for drug users. Their role was to promote treatment in health care departments and prevent users treated for this type of problem from leaving hospital without a diagnosis and an addiction treatment plan.

As in most developed countries, the care and treatment policy for drug use in France is based on specialised treatment and harm reduction facilities, as well as on general practitioner and hospitals. Above and beyond the effects of publicity and choice of communication tactics, these policies are based in practice on a relatively stable combination of the various sectors and resources available.

The recent drug user treatment policy issued by the public authorities was defined in two plans adopted in 2006 and 2008. The first, the 2007-2011 Plan for addiction treatment and prevention (Ministère de la santé et des solidarités 2006), only focused on treatment and prevention. It was drafted by the French Ministry of Health at the request of the French President. The second, the 2008-2011 government action plan against drugs and drug addiction (MILDT 2008), was produced by the MILDT (Interministerial Mission for the Fight against Drugs and Drug Addiction - see chapter 1). It focused on treatment, prevention and law enforcement. The health aspect incorporated the strategies outlined in the French Ministry of Health Plan whilst outlining new, specific objectives.

The 2007-2011 Plan for addiction treatment and prevention reaffirmed the need for a policy targeting all addictive behaviours: the use of illegal substances, the use of legal substances such as alcohol and tobacco, and non-substance addictions such as gambling. Mainly focused on

¹¹¹ Loi n°70-1320 du 31 décembre 1970 relative aux mesures sanitaires de lutte contre la toxicomanie et à la répression du trafic et de l'usage illicite des substances vénéneuses. JORF du 3 janvier 1971

¹¹² Prescribing methadone treatments was initially authorised only for physicians practising in specialised care centres for drug users. Primary care physicians were only authorised to prescribe this follow-on treatment as a second step. The number of persons receiving methadone substitution treatment has therefore increased far more slowly than the number of persons receiving HDB treatment.

fortifying addiction treatment resources in hospitals, this plan provided for the creation of addiction consultation units or addiction liaison teams in all hospitals with an emergency department. These consultation services or liaison teams would group together all existing smoking cessation, alcohol, and drug addiction units into a single place within a unique department. Addiction services offering simple or complex withdrawal regimes for patients requiring more specific treatment or hospitalisation were to be created during the period covered by this plan (2007-2011). The plan also stipulated that each university hospital (there are 26 establishments) would have an addiction service which would be both an addiction service for patients and a regional reference training and research centre.

This plan reiterated the objectives already outlined in previous plans: incorporating specialised drug and alcohol addiction services into the framework of CSAPAs, expanding residential treatment facilities for illegal drug users through the creation of several multiple therapeutic communities, and involving primary care medicine by strengthening addiction health networks. The plan stated the need for precise frameworks to be established for patient management before, during and after treatment.

All of these objectives were reiterated in the 2008-2011 government action plan against drugs and drug addiction (MILDT 2008), which nevertheless highlighted some of these goals and proposed new ones:

- improving professionals' skills in targeted individual prevention and care through different training programmes;
- improving health and social treatment care for young users of psychoactive substances by increasing the number of clinics for young users (CJC) and, in particular, by making advanced forms of consultation available in generalist centres open to young people;
- creating new therapeutic communities, structures in which the aim of abstinence must be clearly stated;
- developing new treatment measures for cocaine users;
- improving the treatment and continuity of care for incarcerated drug and alcohol users;
- preserving the health of unborn children and their mothers and taking account of the specificities of women who use drugs and alcohol;
- reducing the health risks from drug use;
- reducing morbidity and mortality from hepatitis C in drug users;
- improving the social integration and reintegration of people with addictions;
- reducing the misuse of medications and protecting their therapeutic value.

The OFDT reviewed the 2008-2011 government action plan against drugs and drug addiction, and paid close attention to the treatment and care section of the plan (see chapter 1).

5.2.2. Treatment systems

Two schemes are available for dispensing treatments to illegal drug users: the specialised addiction treatment system (in socio-medical establishments) and the general healthcare system (hospitals and general practitioners).

Treatment via the specialised system

These centres were created in application of the 1970 French law on narcotics. This law included free and anonymous treatment for all illegal drug users wishing to receive treatment. Today almost all of the French departments have at least one of these centres, which are now known as CSAPAs.

These centres were originally government-funded, and since 1st January 2003, have been funded by social insurance bodies as socio-medical establishments. These centres provide medical, social and educational services as well as social integration, among other things.

A circular dated 28 February 2008¹¹³ describes the missions of the CSAPA. CSAPAs are responsible for admitting, informing and ensuring the psychological, medical and social assessment and onward referral of any person with substance related or non-substance related addiction. CSAPAs also ensure medical, psychological and socio-educational treatment and provide harm reduction measures. CSAPA can specialise in treating addictions to illegal drugs or to alcohol.

CSAPAs either provide outpatient services or provide individual or group inpatient services, or both. In 2012, 419 CSAPAs provided outpatient care, but of these, only 190 mainly treated illegal drug users. The other were mostly frequented by people mainly affected by alcohol problems.

Several different types of housing services are provided by CSAPAs. There are:

- Short stays of under three months, which correspond mainly to emergency stays for homeless drug users and transition housing for drug users getting out of prison. This housing can be provided on an individual (nightly) or group basis. In 2011, there were 8 CSAPAs offering this kind of service.
- Medium and long stays, which can be in the form of group housing in a residential treatment centre. This type of structure, formerly known as "aftercare" in France, houses patients who have just gone through withdrawal, are taking OSTs, or more generally, who need a structured solution and a temporary break from their normal environment. These patients are admitted for up to one year. There were 35 such residential treatment centres in 2011. For medium to long term stays, there are follow-up therapeutic apartments housing (ATR) for up to two years. The purpose is to enable patients to regain their independence, re-establish social ties and initiate professional rehabilitation measures. In 2011, 64 CSAPAs provided ATR. There is a third type of medium to long stay structure, which is housing in a host family. This solution provides drug users with

¹¹³ Circulaire DGS/MC2 n°2008-79 du 28 février 2008 relative à la mise en place des centres de soins, d'accompagnement et de prévention en addictologie et à la mise en place des schémas régionaux médico-sociaux d'addictologie. BO Santé, Protection sociale et Solidarité n°3 du 15 avril 2008. (NOR SJSP0830130C)

an environment that is conducive to independence. In 2011, 8 CSAPAs provided housing in host families.

CSAPAs can provide outpatient withdrawal services to drug users. They can also refer and support patients wishing to undergo drug withdrawal in an inpatient setting.

Physicians practising at CSAPAs are entitled to initiate methadone substitution treatments. Like all practising physicians, they can also prescribe high-dose buprenorphine (HDB) treatment for patients.

Some CSAPAs provide services in prison settings. There are fifteen such establishments that are fully dedicated to providing treatment to inmates. Given how few they are, these specialised CSAPAs only cover a very small number of French prison settings. Of the numerous prison establishments that do not have their own CSAPA, a neighbouring CSAPA can treat inmates with drug problems. Although this activity is part of the CSAPA missions, it is an optional activity. Each Regional Health Agency (ARS) in France must appoint a reference CSAPA for each prison setting.

In France, the concept of "drug-free services" is not really used. It is difficult to compare such services into an existing type of structure. However, some "therapeutic communities", the objective of which is to achieve complete abstinence, were recently created. In 2012, there were 10 such communities. These experimental "therapeutic communities" should have become CSAPAs, but none of these structures changed their status in 2012.

In 2004, the public authorities created clinics for young users (CJCs)¹¹⁴ funding projects to open this type of centre. They are intended to deal with young illegal drug (usually cannabis) users or their family circle on an outpatient basis. About 300 such centres are now in operation. Their hours of operation can vary (sometimes half a day each week, sometimes every working day). These CJCs are generally managed by a CSAPA. These CJCs were created to fulfil the need for a specific admission and treatment framework for young users for whom addiction is still mainly inextricably related to adolescence and the psychological problems that tend to accompany this stage of life. The creation of these clinics has probably led to an increase in the number of cannabis users treated in CSAPAs. However, regarding the figures shown in the activity reports generated by these centres since the late 90s, it seems that the proportion of cannabis users among those attending such facilities was already increasing prior to the creation of these CJCs. In 2010, an estimated 20,000 to 25,000 young people were admitted to these CSAPA-managed CJCs.

Treatment via the general healthcare system

The development of the specialised treatment system does not make it possible to meet all of the treatment needs expressed by users of illicit drugs. Since the 90s, there has been a focus on improving how patients suffering from addiction problems are admitted into the general healthcare system (hospitals and general practitioners).

¹¹⁴ Circulaire DGS/DHOS/DGAS n°2004-464 du 23 septembre 2004 relative à la mise en place de consultations destinées aux jeunes consommateurs de cannabis et autres substances psychoactives et leur famille. BO Santé n°2004/42 du 30 octobre 2004. (NOR SANP0430495C)

Hospitals

As mentioned earlier, the Plan for addiction treatment and prevention envisaged a new type of addiction treatment organisation within hospitals. The administrative circulars of 16 May 2007¹¹⁵ and 26 September 2008¹¹⁶ gave precise instructions on the organisation to be established within the hospital system. Hospital addiction treatment is organised into an addiction network involving different components. The aim is to enable anyone with addictive behaviour to gain access to nearby, stepwise general treatment and, if necessary, access to a specialised technical platform. This network has three distinct levels.

Level 1 structures are responsible for simple residential withdrawal cases and for providing liaison and consultation activities. Addiction liaison and treatment teams (ELSA) were established in a circular dated 8 September 2000¹¹⁷. They are generally three-person teams, of which one is a hospital practitioner. Their task involves training and assisting caregivers and medical teams in hospitals. More specifically, this involves creating treatment protocols and working with hospitalised and emergency patients. These liaison teams are responsible for prevention, information and awareness-raising missions within establishments providing treatment. Patients can also be seen in outpatient addiction consultations.

Level 2 structures offer the same services as level 1 structures in addition to providing complex residential care through full or day hospitalisation.

Level 3 structures offer the same services as level 2 structures in addition to providing education, training, research and regional coordination.

The circular of 26 September 2008 also stated that hospital addiction treatment networks must coordinate with the specialised CSAPA and CAARUD structures, primary care physicians and health networks.

General practitioners

General practitioners (GPs) today play a key role in France when it comes to prescribing opioid substitution treatments. Since 1995, they have been able to prescribe follow-on methadone substitution treatment after initiation in a specialist or hospital treatment centre. Since the marketing authorisation for HBD was granted in 1996, GPs can also prescribe this treatment for patients with opioid addiction.

In 2009, half of all general practitioners had seen at least one opioid-addicted drug user per month. GPs treating opioid-addicted drug users saw an average of 3.6 users per month. Of these GPs, the proportion prescribing an OST (90%) did not really change between 2003 and 2009. However, the proportion of GPs prescribing methadone increased from 26% to 38% over this period (Gautier 2011). In 2011, 79% of all prescriptions for reimbursed HDB and 55% of all methadone prescriptions were issued by primary care general practitioners (Brisacier *et al.* in press).

¹¹⁵ Circulaire DGS/6B/DHOS/O2 n°2007-203 du 16 mai 2007 relative à l'organisation du dispositif de prise en charge et de soins en addictologie. BO Santé, Protection sociale et Solidarités n°2007/6 du 15 Juillet 2007. (NOR SANP00730376C)

¹¹⁶ Circulaire DHOS/O2 n°2008-299 du 26 septembre 2008 relative à la filière hospitalière de soins en addictologie. BO Santé, Protection sociale et Solidarité n°2008/10 du 15 novembre 2008. (NOR SJSH0830983C)

¹¹⁷ Circulaire DHOS/O2 - DGS/SD6B n°2000-460 du 8 septembre 2000 relative à l'organisation des soins hospitaliers pour les personnes ayant des conduites addictives. BO Santé n°2000/38 du 18 septembre 2000, p.167-191. (NOR MESH0030387C)

General practitioners are often the first to intervene when patients start to use illegal drugs. The public authorities plan on introducing special training for GPs to enable them to spot these users and familiarise them with the therapeutic solutions best suited to their situation.

Availability and diversity of treatment

Withdrawal

Withdrawal can take place in an outpatient setting, with the patient followed up in a CSAPA or in a hospital addiction unit, or in an inpatient setting. Today, hospital inpatient withdrawal from illegal drugs is infrequent in France. In the past, opioid users were often hospitalised to go through withdrawal. Now, they are mainly treated with opioid substitution treatments.

Opioid substitution treatments (OSTs)

After first being marketed in 1996, HDB very quickly became the leading opioid addiction treatment in France. Since 2006, Subutex® is no longer the only product available. Generics have appeared on the market. In 2013, five HDB generics are available in France: BHD Arrow®, BHD Biogaran®, BHD Mylan®, BHD Sandoz® and BHD Teva®. In 2012, generics made up almost one-third of HDB reimbursements (Assurance Maladie). Generic HDB is prescribed to younger than average users who are more stable and better integrated into a treatment protocol, as demonstrated by the results of the 2011 OPPIDUM survey (CEIP de Marseille 2012), which was conducted mainly in specialised treatment centres (see Appendix V-OPPIDUM). The mean daily dose for patients using generic dosage forms was approximately 2.5mg lower than for other patients.

In January 2012, Suboxone® (a combination product comprised of HDB and naloxone - an opioid antagonist) was launched in a sublingual tablet administration form. The purpose of this combination is to prevent HDB misuse, because HDB also causes withdrawal symptoms when used by the injection route. The number of boxes of Suboxone® reimbursed in 2012 (dispensed in retail pharmacies, general Social Security scheme) represented 0.8% of the total number of HDB boxes reimbursed as OST (Assurance Maladie).

According to the data (*Echantillon Généraliste des Bénéficiaires*) of the *Caisse nationale de l'assurance maladie* (National public health insurance centre - CNAM), from a sample of persons with social security coverage (Brisacier *et al.* in press), in 2011, 152,000 people were reimbursed for OST dispensed in a retail pharmacy, with HDB being dispensed to a clear majority (71% of the total) of people (this is a French phenomenon). Moreover, 20,000 patients received methadone dispensed at a CSAPA in 2010 (Palle *et al.* 2013).

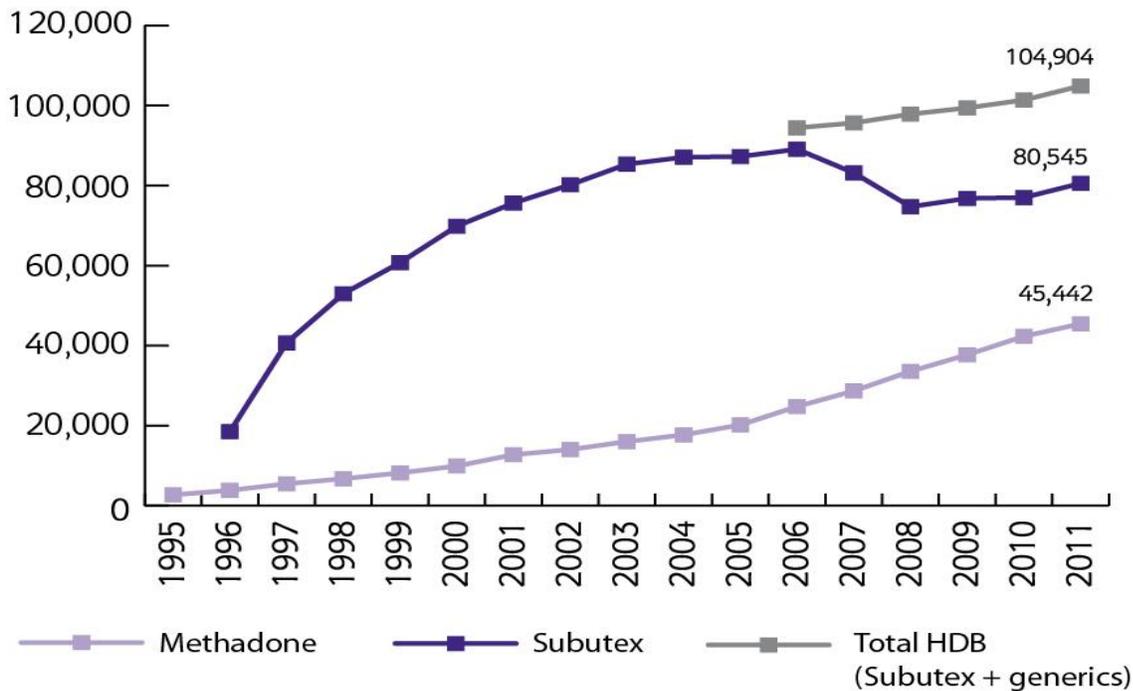
The role of methadone nevertheless continues to increase, understanding that facilitating access to this medication was one of the Consensus Conference (ANAES 2005) recommendations on substitution treatments in June 2004. The 2008 granting of the marketing authorisation for methadone capsules contributed to this increase. In 2011, the liquid (syrup) form was still the predominant form, exclusively prescribed to 58% of the people who were reimbursed for methadone, while the capsule form was exclusively prescribed to 28% of the people who were reimbursed for methadone. Finally, 14% of those reimbursed for methadone were reimbursed for both the syrup and the capsule form (Brisacier *et al.* in press). Figure 5.1 shows the estimated numbers of patients treated with HDB and methadone in France. These data, which are based on sales figures for both drug substitution treatments provided by the GERS (Group for the Production and Elaboration of Statistics), assume a mean daily dose of 8 mg for Subutex® and

60 mg for methadone throughout a year of prescription. The amounts of Subutex® sold in 2011 therefore corresponded to 80,545 theoretical patients, each receiving a daily dose of 8 mg for the entire year. A similar calculation for methadone produced a theoretical 45,442 patients (based on primary care and hospital reimbursement data for the liquid and capsule forms) in 2011.

HDB generics introduced in France since 2006 somewhat offset the actual reduction in the number of patients taking Subutex® since that year. An extrapolation permits to estimate the part of patients benefiting from generic forms. This number increased steadily, reaching approximately one quarter of all patients receiving HDB in 2011 (Figure 5.1). Overall, nearly 105,000 theoretical patients would have received HDB, either in its proprietary or its generic form.

These are theoretical patients, as not all actual patients comply with their treatment protocol and not all patients took their treatment from 1st January to 31st December. Some may stop their treatment and others may start it at any time between those two dates in a given year. The number of people who received at least one prescription for a substitution treatment is therefore logically higher than this theoretical patient number. Moreover, the number of theoretical patients calculated does not include cases of HDB misuse or diversion. Fewer patients are actually receiving OST, although it is still difficult to give a precise figure, since the line between patients following treatment and those receiving HDB prescriptions, but who cannot be considered as following treatment, is unclear.

Figure 5.1: Estimated numbers of patients receiving opioid substitution treatment (Subutex® and generics 8 mg, methadone® 60 mg) between 1995 and 2011 (based on primary care and hospital reimbursements)



Source: SIAMOIS (InVS)

Morphine (generally sustained-release morphine sulphate capsules) is used for substitution purposes in thousands of patients who mainly inject it. However, there is neither a legal prescription framework nor any benefit/risk assessment for the drug as substitution treatment.

Interrupting an opioid substitution treatment

To date, there is no reliable, regularly updated source of information on the number of persons who stop taking OST in the various systems (specialist or generalist). It should be noted that many French addiction specialists and specialised psychiatrists are reluctant to fully withdraw substitution treatment too suddenly given the potential risk of relapse and overdose that may ensue.

HDB misuse and trafficking

Some of the HDB prescribed is misused and is not taken as part of a treatment programme. This proportion has fallen since the National Health Insurance Fund (*Assurance maladie*) introduced a control plan for opioid substitution treatments¹¹⁸: one of the main indicators for HDB misuse (mean daily dose over 32 mg/d¹¹⁹) fell by two-thirds between 2002 and 2007. Six percent of subjects had received over 32 mg/d of HDB in 2002 versus 1.6% in 2007 (Canarelli *et al.* 2009). Since then, this indicator has remained stable (1.7% in 2011) (Brisacier *et al.* in press). Moreover, 73% of patients receiving HDB are receiving regular treatment¹²⁰ and therefore are integrated into a therapeutic process. People who are not regularly receiving these treatments are not necessarily cut off from any treatment strategy, in the same way as users taking this medication as part of a treatment plan are not necessarily exempt from certain forms of misuse (INSERM 2012).

Field observations made on the techno party scene have revealed that this substance is only used marginally and that its availability is also marginal, except at very large dance events.

However, it seems that the measures taken only had a temporary impact on the availability of HDB on the black market in the urban setting (see chapter 10). More organised trafficking has developed in some regions, particularly the Paris and Marseille regions and eastern France, since 2007. At first, fewer users were reselling their surplus, but then better organised National Health Insurance Fund fraud arose through collective “doctor shopping” (e.g., national insurance card theft, recruitment of “fake users”, consultations in several departments) (Cadet-Taïrou *et al.* 2012a).

In 2011, HDB was therefore described as being very readily available and accessible on the black market in cities with a mean national price levelling off just below €5 per 8 mg Subutex® tablet. However, this price was subject to variations, depending on the city and market

¹¹⁸ The French National Health Insurance Fund controls introduced since 2004 primarily aim to identify dealers (“patients” as well as a few GPs and pharmacists) through reimbursement data. These controls red flag users who have at least five different prescribers or dispensing pharmacies, or who are being given a mean dose of more than 32 mg.

¹¹⁹ The HDB maintenance dose is 8 mg/d with a maximal daily dose of 16 mg/d. A mean daily dose of greater than 32 mg/d is an indicator of very suspicious HDB use (dealing and/or resale).

¹²⁰ Patients taking regular HDB treatment are subjects who let at least 35 days go by between prescription refills, or who sometimes wait longer (36-45 days) on at most three occasions. The maximum duration for which prescriptions are legally valid is 28 days.

fluctuations (Cadet-Taïrou *et al.* 2010b). Continued widespread perceived availability could be linked to the reduced demand for HDB as a drug. HDB is subject to competition from heroin, and to a lesser extent, methadone, which is becoming increasingly available. HDB is still the number one opioid for the poorest users. Only the proprietary drug (Subutex®) is available on the black market, since the excipients in HDB generics are said to be more difficult to inject or snort (Cadet-Taïrou 2012). In 2012, the only new phenomenon reported by the Bordeaux TREND site (see Appendix V-TREND) is increased "chasing the dragon"¹²¹ in young, precarious users who use pre-crushed tablets. This is confirmed by an overall upward trend in heating and inhaling drugs (see chapter 4) (Cadet-Taïrou *et al.* 2013b).

Misuse involves three routes of administration: injection, snorting and, to a lesser extent, inhaling. Whereas injection remains the most widely used route of administration when the drug is not used for its therapeutic purpose, snorting is the method used by "long-standing" injectors. Snorting allows these injectors to offset the deteriorating venous access and health complications from their frequent injecting. According to the results of the OPPIDUM survey conducted in 2011 (CEIP de Marseille 2012), 6% of users following a substitution protocol and being seen in a therapeutic framework had injected HDB. In 2010, this figure was 9%. 4% had snorted (this figure was 10% in 2010) and a tiny proportion had inhaled. In 2012, of people seen in CAARUDs, 54.2% of HDB users in the last month, reported having injected (this figure was 50.9% in 2010), i.e., more than the oral route (45.9%). 25.9% stated having snorted, and 5.1% having inhaled. HDB was the most frequently injected substance for 8.2% of CAARUD users who had injected at least once in their lives (Cadet-Taïrou 2012).

Two population groups in particular tended to use HDB as a drug: the first group is comprised of the most disadvantaged drug users, of whom 90% are males, mostly homeless and some are illegal aliens who tend to consume medications and alcohol; the second group is wandering young people, most of whom are polydrug users (INSERM 2012).

In 2011, the French CEIP (Centre for Evaluation and Information on Pharmacodependence) network was alerted by reports of skin lesions - evolving into necrosis in some cases - following the intravenous injection of crushed, diluted sublingual HDB tablets. Of the 27 reported cases, 23 had occurred with Subutex® generics. The members of the *Commission des stupéfiants et des psychotropes* (Narcotics and Psychotropics Substances Commission) voted in favour of implementing additional investigations on the role of HDB excipients in causing lesions when HDB (Subutex® or its generics) is injected (ANSM 2013).

Methadone misuse

Despite the emergence of more visible methadone misuse in parallel to its wider distribution, methadone misuse remains limited compared to that of HDB. In 2012, the syrup form of methadone was still subject to misuse, "spare supply" for the most part, between users helping each other out, or for very small-scale trafficking. There were cases in which precarious eastern European migrant populations injected methadone in its syrup form. There were also cases in which young precarious populations became opioid-addicted, as was reported in Paris and Rennes (see chapter 10). The mean price of a 60 mg bottle varied greatly with geographic area, from €5 in Paris to €20 in Toulouse in 2011. However, the capsule form is still fairly untouched

¹²¹ Chasing the dragon consists of inhaling the vapours produced by heating (with a cigarette lighter) heroin placed on aluminium foil. The active substance enters the bloodstream through the pulmonary alveoli, which are highly permeable to gas, and not via the nasal mucosa, like in sniffing. This route of administration increases both the intensity and the rapidity of onset of the effects.

by the black market: available on the market since 2008, certain TREND scheme sites (Rennes, Lille, Bordeaux, Toulouse and Paris) reported seeing the capsule form circulating on the black market in 2011. However, there were no such observations in 2012. Already reported since 2006, the use of methadone in autosubstitution (use of non-prescribed methadone for substitution purposes) tends to be a generalised practice on all TREND sites (Cadet-Taïrou *et al.* 2013b; Cadet-Taïrou *et al.* 2010b).

Substitution treatment in the inpatient hospital setting

A survey conducted in 2007 by the OFDT (Obradovic *et al.* 2008b) to assess the impact of the circular dated 30 January 2002¹²² on initial methadone prescribing by physicians practising in health institutions (whether hospitals or health units in prisons) demonstrated that accessibility to methadone had increased in these two areas in the six years since this circular was introduced.

The hospital component of this survey showed that general practitioners played an important role in providing access to specialised care for opioid-dependent users. This holds true both early on, when they referred their patients to inpatient settings for treatment initiation, and later, when they took over care from inpatient hospital treatment. This survey also demonstrated how important the relationship between the different partners of the care system was, in preventing interruptions in substitution treatment when patients were discharged from the hospital.

Substitution treatment in prison

The proportion of inmates receiving OST was estimated in 2010 to be 7.9%, or approximately 5,000 people, of whom 68.5% were taking HDB (see chapter 9). The proportion is significantly higher in the female prison population (DGS 2011). The proportion of people under OST is on the rise compared with 1998 and 2004 (when they were 2.2% and 6.6% respectively).

In 2010, the collective expert report of the INSERM on reducing the risk of infection in drug users recommended ensuring equitable access to care and harm reduction measures in and out of prisons (INSERM 2010). OSTs are now accessible in all prison settings, which was not the case in 2003 (Obradovic 2004). Furthermore, for 31% of inmates taking OSTs, treatment was initiated during their incarceration. However, the range of treatments available is lacking: 5% of the prison establishments only offer one of the two medications. Finally, the continuity of care for prisoners who are released needs to be improved by generalising formalised procedures for patients treated with OSTs. Such procedures only exist in 55% of prison establishments (DGS 2011).

The guide to opioid substitution treatments in prisons settings was updated in 2013 (Ministère des affaires sociales et de la santé *et al.* 2013). It is comprised of 14 sections and summarises existing data from 1998-2011, and presents recommendations for best treatment practice.

The viewpoint of patients taking OSTs

A qualitative study of people taking OSTs highlighted the substitution experience (Langlois 2011). The perceptions patients have of opioid substitution medication vary between that of a medicine

¹²² Circulaire DGS/DHOS n°2002-57 du 30 janvier 2002 relative à la prescription de méthadone par les médecins exerçant en établissement de santé, dans le cadre de l'initialisation d'un traitement de substitution pour les toxicomanes dépendants majeurs aux opiacés. BO Santé n°2002/8 du 18 février 2002. (NOR MESP0230029C)

and that of a drug. Their perception can lead patients to doubt the purpose of the treatment: is it a cure or rather a tool of social control? The phenomenon is more marked for HDB than for methadone, whose dispensing is under tighter control, is rarely injected and has a better-established therapeutic image.

In general, the efficacy of treatments in terms of withdrawal symptoms and pain is acknowledged. Once a patient starts substitution, the therapeutic relationship focuses on the issue of dosage. Then, the patient's relationship to treatment evolves and the risk for misuse disappears. Although patients are hoping to stop substitution, this perspective diminishes over time, while some of them no longer even foresee it. In the end, different OST patient profiles, ranging from a more or less conformist attitude to a "deviant" one with respect to the rules governing these treatments can emerge (Langlois 2011; Costes 2010).

5.3. Access to treatment (ST 24 2013)

Total number of patients receiving treatment

Data compatible with the EMCDDA's TDI (Treatment Demand Indicator) protocol are only recorded from people seen in CSAPAs in France. This data collection is not exhaustive, since approximately one-third of CSAPAs did not provide data in 2012. Furthermore, TDI data only concern new patients or people starting or restarting treatment in a centre, thus excluding all those who were monitored continuously in the same centre over the past year. It is therefore necessary to use other sources to provide a quantitative assessment of the total number of people seeking aid from professionals because of their problem with illegal drug use.

On the contrary, we currently have relatively accurate information about the number of people receiving care in specialised centres. CSAPAs are required to provide the administrative authorities with an annual activity report containing certain information about people admitted during the previous year (see Appendix V-CSAPA Activity Reports). The response rate for these reports is close to 90% annually and almost 100% over a two-year period. Based on these activity reports, it is possible to estimate at approximately 109,000 (104,000 after eliminating duplicate cases) the number of people seen in outpatient CSAPAs in 2010,¹²³ for their problem with illegal drugs. Compared to this figure, the number of people housed in a residential treatment centre appeared to be very low, a bit fewer than 2,000 people, some of whom had already been counted among those already seen in an outpatient CSAPA. In fact, these centres send a large number of patients to residential centres where they are then housed. The number of people seen for a problem with illegal drugs in 2010 in prison CSAPAs can be estimated at 5,700.

The only national data available for primary care is for people receiving substitution treatment. In 2010, more than 150,000 people were reimbursed for their substitution treatment by social security organisations. Some of these people may also have been monitored jointly or subsequently by a CSAPA during the year.

National data are available for hospitals from the PMSI¹²⁴ medicalised information system programme about the number of admissions to hospital medicine, surgery and obstetrics with a

¹²³ Last available figures at the time of drafting this report

¹²⁴ <http://stats.atih.sante.fr/mco/catalogmco.php> [accessed 24/09/2013]

primary diagnosis of behavioural disorders related to the use of psychoactive substances excluding alcohol and tobacco (ICD-10 diagnosis: F11 to F16, F18 and F19). There were approximately 7,700 hospitalisations in 2012, of which more than 2,000 involved opioid users, nearly 2,000 involved sedative and hypnotic users, approximately 1,400 involved cannabis users and almost 1,600 involved polydrug users. It should be noted that these data do not include visits to emergency departments or people seen in outpatient hospital addiction units. Overlaps may exist between hospitalised patients and those seen in specialised centres or a primary care setting.

5.3.1. Characteristics of treated clients (TDI data included)

Patients seen in outpatient centres

In 2012, 176 outpatient CSAPAs, or just over two-thirds of CSAPAs mainly seeing illegal drug users, took part in the RECAP survey. **The data shown below pertain to over 45,000 patients (referred to as “new patients”) who started a new episode of treatment in one of these centres in the last year.**

Those patients receiving treatment for the first time in their life (referred to as "first-time treatment entrants") accounted for 31%¹²⁵ of all new patients seen in 2012, and this percentage was lower in women (26% vs. 32% in men). The other patients (the remaining 69%) had previously been monitored for an addiction problem but were about to start a new treatment in a CSAPA. Caution must be exercised when considering the percentage of first-time treatment entrants in relation to the overall number of patients since information relating to the existence of earlier treatments was unknown in 25% of cases.

Socio-demographic characteristics of patients

In 2012, nearly four out of every five (81%) new patients were men. The mean age of these new patients was 30.8 years. Women were slightly older than the men on average (31.4 vs. 30.6). This mean age actually results from the mixing of two subpopulations, cannabis users on one hand, with a mean age between 25 and 26, and opioid and cocaine users on the other hand with a mean age of around 34. The most widely represented age groups among new patients was 20-to-25-year-olds and 25-to-29-year-olds, each representing approximately 20% of new patients. The under 25s represented 33% of the total. A little over 20% of the patients were over the age of 40 (Table 5.1).

Men are slightly more represented among patients seeking treatment for the first time in their lives than among all new patients (83% vs. 81%). First-time treatment entrants were much younger. Their mean age was 25.7. Just over half of these patients were under 25, and 10% were 40 or over.

¹²⁵ Unless stipulated otherwise, all percentages are calculated based on the totals excluding missing responses and “do not know” responses.

Table 5.1: Breakdown of patients by age group (in %), in 2012

Age	New patients (N=44,960)	First-time treatment entrants (N=10,210)
< 20 years old	15.5	32.1
20-24 years old	17.7	24.5
25-29 years old	18.3	16.3
30-34 years old	15.7	10.7
35-39 years old	11.3	6.5
40-44 years old	9.6	4.7
45-49 years old	6.3	2.7
50 years old and over	5.6	2.6
Total	100.0	100.0

Source: RECAP 2012 (OFDT)

New patients mostly approach treatment centres on their own initiative (34%) or following referral by the legal system or law enforcement services (30%) (Table 5.2). Far fewer women were referred by the courts or law enforcement than men (13% vs. 35% respectively). Of first-time treatment entrants, nearly half (47%) were referred in this way. Most of the people referred to a treatment centre by a court of law or law enforcement services were cannabis users.

Table 5.2: Breakdown of patients by treatment origin (in %), in 2012

Origin of the treatment	New patients (N=36,457)	First-time treatment entrants (N=9,526)
Patient's own initiative	34.3	22.4
Family or friends	9.1	10.4
Other specialised centres for drug users	5.7	1.5
General practitioners	6.6	3.9
Hospital or other medical establishment	5.1	3.6
Social services	3.9	3.9
Police, courts or drug treatment order	30.3	47.2
Other	5.1	6.9
Total	100.0	100.0

Source: RECAP 2012 (OFDT)

New patients usually live with their parents or alone (36% and 27% respectively) (Table 5.3) and most often live in stable housing situations (79%) (Table 5.4). Nevertheless, 20% of them stated that they were living in unstable housing conditions. Women lived alone with their child 10 times more often than men (10% vs. 1%), and more often with a partner (18% vs. 11% for men). In contrast, they much less frequently lived with their parents (26% vs. 38% for men). Due to the higher proportion of younger people in this group, first-time treatment entrants were less likely to live alone and more likely (49%) to live with their parents.

Table 5.3: Breakdown of patients by living status (with whom) (in %), in 2012.

Living status (with whom)	New patients (N=35,752)	First-time treatment entrants (N=9,874)
Alone	27.4	20.0
With parents	35.8	49.7
Alone with child	3.0	2.2
With partner but without children	12.2	9.8
With partner and child(ren)	11.6	9.2
With friends	3.5	2.6
Other	6.6	6.6
Total	100.0	100.0

Source: RECAP 2012 (OFDT)

Table 5.4: Breakdown of patients by type of dwelling (in %), in 2012

Type of dwelling	New patients (N=37,530)	First-time treatment entrants (N=9,879)
Stable housing	79.1	86.4
Unstable housing	18.4	11.8
Institutional housing	2.5	1.7
Total	100.0	100.0

Source: RECAP 2012 (OFDT)

The total of all economically inactive people (retired, at home, disabled) and unemployed (Table 5.5) accounts for 45% of new patients. Slightly more than a quarter (27%) had regular employment and 16% were still high school or post-high school students. The percentage of economically inactive patients was clearly higher among women than men (26% vs. 21%). Because they tend to be younger, there were more students and fewer economically inactive people among first-time treatment entrants than among new patients as a whole.

Table 5.5: Breakdown of patients by professional situation (in %), in 2012

Professional situation	New patients (N=35,979)	First-time treatment entrants (N=9,634)
Regular employment	26.7	25.1
Student (high school or post-high school)	15.5	27.3
Economically inactive	21.6	15.4
Unemployed	23.4	18.9
Other	12.9	13.3
Total	100.0	100.0

Source: RECAP 2012 (OFDT)

Nearly two-thirds (61%) of new patients stated having reached secondary school level, 4% had not gotten past primary school level and 34% indicated that they had post-secondary school level (A-level/High School Diploma). A much higher percentage of women had a post-secondary level of education (46% vs. 31%). The breakdown of educational level remained unchanged for first-time treatment entrants.

Drug use

In 2012, almost half of new patients (44%) were admitted to specialised treatment centres for problems associated with cannabis use (Table 5.6). The majority (58%) of them stated using cannabis every day. Fewer women were treated for cannabis use than men (34% vs. 47%). A somewhat lower percentage of men than women used daily (57% vs. 65%).

The proportion of first-time treatment entrants reporting cannabis as primary drug (causing the biggest problem for them) was higher than for all new patients (63% vs. 44%). The breakdown of the frequency of use was similar in both groups. The large number of cannabis users receiving treatment in France was partly the consequence of the large and still increasing number of arrests for cannabis use. In fact, some of the users who are arrested are referred to treatment centres by the courts.

After cannabis, opioids were the second most frequently-cited cause of problems: 43% of new patients fell into this category. Of these patients, 64% stated heroin, 9% methadone and 27% other opioids (primarily HDB)¹²⁶ as being most troublesome. Of these patients, heroin was most frequently snorted (62%), but one of every seven heroin users (14%) had injected. The percentage of injecting drug users in the last month is much higher (19%) among users of other opioids. Among the opioid users, almost 74% consumed these substances on a daily basis and 13% took them regularly (i.e., several times a week).

Women were treated less often than men for cannabis use. However, women were treated far more than men (48% vs. 42%) for their opioid use, regardless of the type of opioid in question. The percentage of first-time treatment entrants reporting opioids as primary drug was far lower than that recorded for all new patients (27% vs. 43%). The breakdown of frequency of use was similar in both groups, although there was a slightly higher proportion of daily use among first-time treatment entrants. Injection in the last month was less frequent in this group (7% versus 14%) than in new patients.

¹²⁶ For methadone and HDB, this means use outside of a therapeutic framework.

Table 5.6: Breakdown (in %) by primary drug, in 2012

Primary drug	New patients (N=34,330)	First-time treatment entrants (N=9,539)
1. Opioids (total)	43.3	27.2
2. Cocaine (total)	5.9	4.0
2.1 cocaine	4.6	3.6
2.2 crack	1.3	0.3
3. Stimulants (total)	1.4	1.3
3.1 amphetamines	0.3	0.2
3.2. MDMA and other derivatives	0.5	0.2
3.3 other stimulants	0.6	0.9
4. Hypnotics and sedatives (total)	2.2	1.4
4.1 barbiturates	0.2	0.1
4.2 benzodiazepines	1.3	0.6
4.3 others	0.8	0.8
5. Hallucinogens (total)	1.5	2.4
6. Inhalants	0.2	0.2
7. Cannabis (total)	44.3	62.5
9. Other substances (total)	1.2	1.0
Total	100.0	100.0

Source: RECAP 2012 (OFDT)

N.B. Details per substance are not indicated for opioids and hallucinogens because of the difficulty in coding following the update of the CSAPA patient record management software.

After cannabis and opioids, cocaine lags far behind as the third most frequently cited reason for seeking treatment; it is listed as the primary drug for just over 5% of patients. Of these patients, the proportion consuming every day was much lower than for opioids (32% vs. 72% for heroin users). Cocaine is mostly snorted (69%) and rarely smoked (18%). Of cocaine users, 12% had injected in the last month. This proportion was virtually identical to that recorded for opioid users. Cocaine was slightly less frequently mentioned among first-time treatment entrants, but the difference was not very significant. Cocaine is also mentioned more frequently as a secondary substance than as a product posing most of the problems. Of new patients for whom product information was available, 15% mentioned the use of cocaine as a secondary substance. Users reporting opioids as the primary drug, report cocaine as the secondary drug in in three-quarters of cases.

Patients seen in residential centres

The number of patients seen in residential treatment centres only represented a very low proportion of the patients seen in all CSAPAs. The influence of the characteristics of these patients on those of all patients was negligible. In 2012, 25 residential centres provided RECAP data on nearly 1,000 patients.

Nearly all of the patients housed in these residential centres had already been helped by a healthcare professional for their addiction. It was rare for the patients themselves to request treatment directly from these centres. In the majority of cases, the patients were referred, at least the first time, by other treatment centres. Two-thirds of those housed in residential centres had been referred by the healthcare sector. One quarter of the patients stated coming on their own initiative.

Patients seen in residential centres were on average older than those seen as outpatients (34.7 years of age vs. 30.8 years of age respectively). These centres tended to treat patients with the

most serious addiction problems. These people were also more often in a situation of social exclusion. This partially explains the very low representation of minors and people under the age of 20, for whom the situation can seem less unfavourable than for older patients from an addiction and social integration standpoint. The lack of sufficient residential treatment for the youngest users is often pointed out by addiction specialists. Minors and adults under the age of 20, whose situation would justify a stay in a residential centre will have considerable difficulty in finding an available spot. Although very few of the youngest users were represented, just over 32% of new patients treated in these centres were under the age of 30.

The most significant evidence of social exclusion in this population was the still-high percentage of patients, in relation to those seen on an outpatient basis, who were living alone (49%), who had unstable housing conditions (46%) or who were unemployed or economically inactive (37% and 34% respectively).

Being older, having more serious addiction problems and experiencing more social exclusion were more often related to opioid and cocaine use in this population than in the population being followed on an outpatient basis (48% for opioid use and 17% for cocaine use among inpatients vs 43.3% for opioid use and 5.9% for cocaine use among outpatients). The percentage of people being followed in these centres for their cannabis use was, in contrast, much lower (24%). Due to the seriousness of their addiction, the proportion of people who had injected in the last 30 days was much higher in this population: nearly 34% in people for whom an opioid was the most problematic product and 24% in people for whom cocaine was the primary drug.

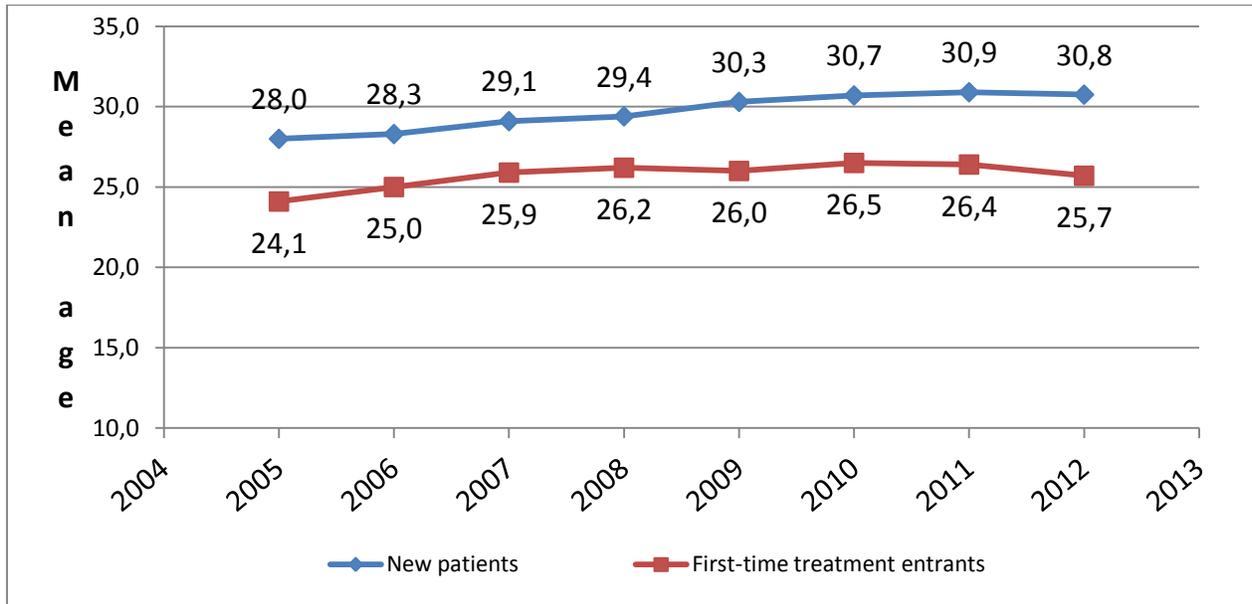
5.3.2. Changes in the characteristics of new patients and first-time treatment entrants managed in CSAPAs

Patient data that are TDI-compatible have only been available in France since 2005. Therefore, changes can only really be followed over a relatively short time period. Major changes in the numbers of patients treated in residential centres, in addition to the highly variable response rates, make it difficult to interpret changes. Consequently, only trends relating to patients seen on an outpatient basis will be considered in this section.

Data for the 2005-2012 period are now available. The first two years (2005 and 2006), however, correspond to a phase during which data collection was being implemented, and there was a rather low participation rate for the period in question (less than 50% in 2005, slightly more than 50% in 2006). The changes observed over these first two years must therefore be interpreted with caution. Over the next six years, the mean level of centre participation in the survey was two-thirds, but the centres responding were not always the same. This situation can cause fluctuations in data levels, which do not necessarily reflect changes in the patients' situation. Attention should therefore only be paid to major trends that remain constant over several years.

Mean patient age rose steadily from 2005 to 2011, from 28 years to nearly 31 years, until it stabilised in 2012 (Figure 5.2).

Figure 5.2: Changes in the mean age of new and first-time treatment entrants managed in CSAPAs, 2005-2012



Source: RECAP (OFDT)

An observation of changes in breakdown by age group (Table 5.7) shows that ageing is essentially due to an approximate 10-point decrease in the proportion of 15-24-year-olds and a near doubling in the proportion of 40-year-olds from 11% in 2005 to over 22% in 2012. Between 2007 and 2012, this decrease was mainly seen in 20-24-year-olds. It is important to bear in mind when interpreting these changes that, according to the activity reports provided by CSAPAs, the number of people admitted has tended to increase annually. A decrease in the proportion of younger people does not necessarily indicate a lower number in absolute terms. From 2011 to 2012, the breakdown by age was rather stable, except for an increase in the proportion of 20-year-olds and a decrease in the number of 20-29-year-olds. In terms of first-time treatment entrants, their mean age remained quite stable between 2008 and 2011, and decreased slightly in 2012 to the levels that were seen in 2007.

Table 5.7: Breakdown of patients by age group (in %), evolution 2005-2012

Age bracket	2005 (N=20,989)	2006 (N=31,674)	2007 (N=41,205)	2008 (N=44,631)	2009 (N=44,339)	2010 (N=45,247)	2011 (N=45,247)	2012 (N=44,960)
>15	0.6	0.8	0.7	1.4	1.2	1.1	1.4	2.0
15-19	16.0	14.8	11.9	11.3	11.4	10.4	12.1	13.5
20-24	24.8	25.2	24.7	23.3	20.4	19.6	18.6	17.7
25-29	19.0	19.4	21.2	21.4	20.2	20.5	19.1	18.3
30-34	16.6	15.4	14.9	14.6	14.8	15.9	15.7	15.7
35-39	12.3	12.3	12.5	12.7	13.4	13.0	11.8	11.3
40-44	6.8	7.1	8.4	8.4	9.3	9.7	10.0	9.6
45-49	2.5	3.2	3.5	4.2	5.4	5.4	6.1	6.3
50-54	0.8	1.2	1.4	1.7	2.3	2.5	3.0	3.2
55-59	0.3	0.5	0.6	0.7	1.0	1.1	1.2	1.4
60-64	0.2	0.2	0.2	0.3	0.4	0.5	0.6	0.6
≥ 65	0.1	0.1	0.1	0.2	0.3	0.3	0.4	0.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

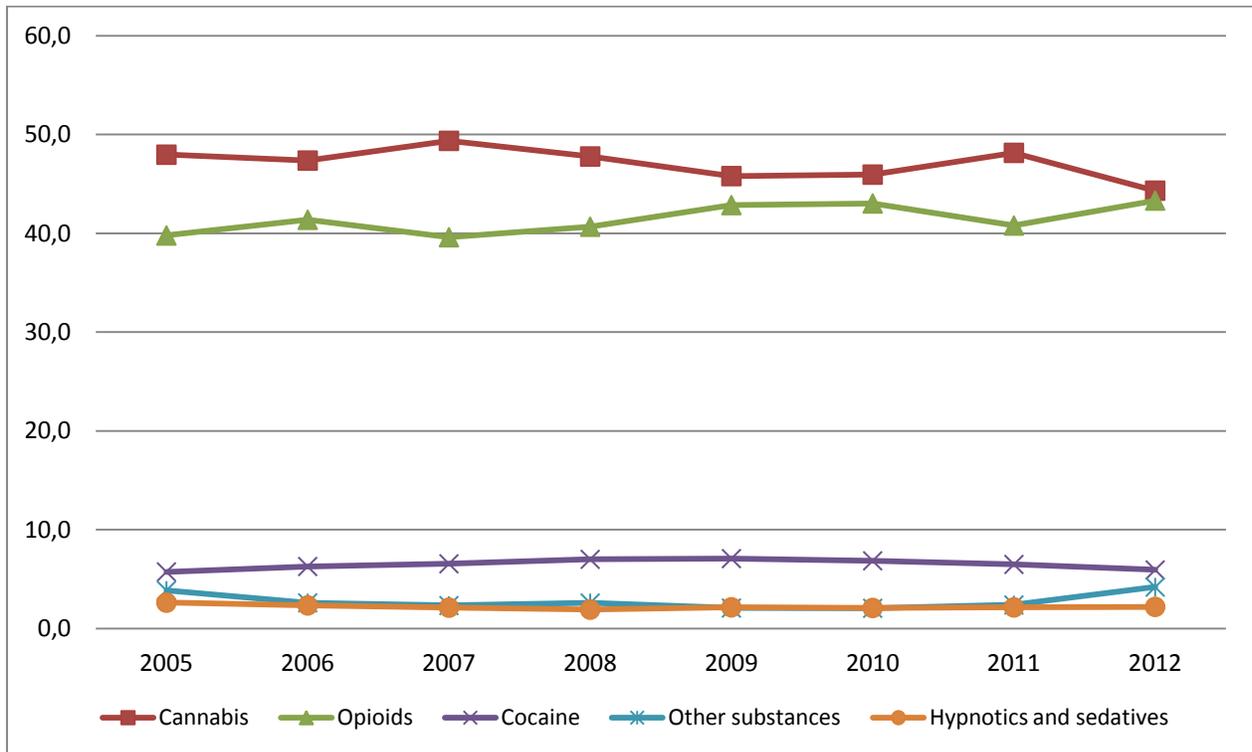
Source: RECAP (OFDT)

The fact that older people are being seen in the centres has repercussions on certain patient characteristics. Thus, in line with the decrease in the number of 15-24 year-olds, the percentage of people living with their parents is constantly declining, falling from 42% to approximately 36%. In contrast, the number of people living alone increased from 25% to 27%. For reasons also associated with changes in breakdown by age group, numbers of high school and post-high school students are also decreasing, falling from 17% in 2005 to 16% in 2012.

Moreover, the proportion of people with stable housing conditions increased slightly from 75% in 2005 to 79% in 2012. It is difficult to know whether or not this change also results from the increase in mean age or if it is related to other factors.

Data on the breakdown by primary drugs for the 2007-2012 period revealed a slight downward trend for cannabis, despite the increase seen in 2011, and a nearly symmetric increase for opioids (Figure 5.3).

Figure 5.3: Breakdown by primary drugs for CSAPA patients (in %), 2005-2012



Source: RECAP (OFDT)

In first-time treatment entrants, the changes seem different: after declining steadily since 2006, the proportion of opioids clearly rose from 20% in 2011 to 27% in 2012. Furthermore, after a six-year rise, in 2012, cannabis fell to its 2006 level (63%).

Changes from 2011 to 2012 should nevertheless be considered with caution. Following changes in the European TDI protocol, changes in the software used by CSAPAs were introduced in 2012. These changes might have interfered with data on certain responses, such as the primary drug.

The data recorded between 2007 and 2011 on routes of administration revealed stability in the percentage of people treated for problems related to opioid use who had injected in the month prior to inclusion (Table 5.8). For these reasons, the 2012 data are clearly inconsistent with those of previous years, and therefore were not produced in this report.

Table 5.8: Percentage of patients who had injected over the last 30 days, by primary drug - changes observed between 2005 and 2011

	2005	2006	2007	2008	2009	2010	2011
1. Opioids (total)	24.8	24.6	20.9	21.2	20.9	20.6	21.2
1.1 heroin	20.6	20.5	17.0	17.8	17.2	17.1	17.6
1.2 methadone	17.4	13.2	11.3	10.3	12.0	14.8	15.6
1.3. other opioids (including HDB)	44.1	44.3	39.6	39.9	39.5	39.0	37.7
2. Cocaine (total)	15.4	16.2	13.1	14.4	13.7	13.7	15.1
2.1 cocaine	18.0	18.1	14.4	15.5	15.2	14.7	17.0
2.2 crack	6.6	8.8	7.8	10.7	9.3	10.7	9.5

Source: RECAP (OFDT)

Interpretation: in 2011, 17.6% of new patients treated for heroin use had injected at least once in the last 30 days. This does not necessarily mean that all of these patients use heroin intravenously. Although it might seldom happens, a user may have injected a substance other than heroin in the last 30 days.

N.B. The injection data for 2012 are not shown here due to the updates in the CSAPA patient record management software.

6. Health correlates and consequences

6.1. Introduction

Drug use can be the direct cause of viral infections (HIV/AIDS and hepatitis), other injection-related infectious pathologies and even disorders related to the use of substances, especially overdoses. Other problems, like tuberculosis, are related to unstable living conditions, a risk-laden lifestyle (sexually transmitted diseases¹²⁷) or the psychiatric and somatic comorbidities that often accompany drug use. Deaths also occur and are recorded and categorised based on a number of information gathering systems in France.

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

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

The reported prevalence of HIV, HBV and HCV: since 2005 (Palle *et al.* 2007), these prevalence numbers have been supplied by the RECAP scheme (of patients seen in CSAPAs) and by surveys of patients seen in so-called, “low-threshold” structures (CAARUDs), particularly the PRELUD (see Appendix V-PRELUD) and ENa-CAARUD (see Appendix V-ENa-CAARUD) surveys.

The biological prevalence of HIV and HCV, determined using blood samples, were collected from the Coquelicot survey (see Appendix V- Coquelicot) (Jauffret-Roustide *et al.* 2006) conducted in 2004. There was a new edition in 2011.

The biological prevalence of HIV and HCV were determined using saliva samples collected from CAARUD clients: these data were collected from volunteers as part of the BioPRELUD¹²⁸ survey conducted by the OFDT in 2006 in five cities. The data helped summarise current psychoactive substance use and practices in a population with a high prevalence of drug use. The analysis of saliva samples, which had been proposed to each surveyed user to identify antibody markers of HIV and HCV infection, provided points of reference for these infections in the target population. The results of the BioPRELUD survey are difficult to compare with those of the Coquelicot survey. The populations were different: the Coquelicot users surveyed were injecting drug users and “snorters” encountered in multiple structures, while BioPRELUD users were encountered exclusively at low-threshold structures. The methodologies were different for both surveys (blood samples vs. saliva samples), and the users surveyed during the BioPRELUD study were five years younger on average. The surveys were also conducted in different cities.

Estimates of the national incidence of AIDS, HIV infection and acute hepatitis B infection were also performed. AIDS case and AIDS death reporting, which has existed since the early 80s, has been mandatory since 1986. A new anonymous reporting method

¹²⁷ In addition to intravenous drug use, at-risk sexual behaviours among injecting drug users increase the risk of sexually transmitted diseases.

¹²⁸ The BioPRELUD survey represents the biological section of the larger PRELUD study, which was conducted among CAARUD users in 9 cities (including the 5 BioPRELUD cities) in 2006. The HIV and HCV prevalence data gathered within the scope of the PRELUD study were declarative data.

implemented in 2003 following a circular issued by the *Direction générale de la santé* (National Health Directorate)¹²⁹ made HIV-infection reporting obligatory as well. This system is combined with HIV virological monitoring (see Appendix V-HIV/AIDS Monitoring System). Reporting of acute hepatitis B infection has been required since 2004 (see Appendix V-Acute Hepatitis B Monitoring System).

Sexually transmitted diseases and tuberculosis

There is no specific French information system that provides details on the reported or biological prevalence of tuberculosis or of sexually transmissible diseases, other than HIV infection, among drug users.

Other infectious diseases

There is no specific French information system that records the reported or biological prevalence of other infectious diseases among drug users.

Behavioural data

In France, quantitative information (ENa-CAARUD and Coquelicot data) and qualitative information (from the TREND scheme - see Appendix V-TREND - and the qualitative section of the Coquelicot survey) provide details on the perceived health status of drug users and their at-risk behaviour (Cadet-Tairou *et al.* 2013b; Jauffret-Roustide *et al.* 2006; Saïd *et al.* in press).

Psychiatric comorbidities

There is no specific French information system that provides details on the prevalence of psychiatric illness among drug users.

Somatic comorbidities

There is no specific French information system that provides details on the prevalence of somatic comorbidities among drug users.

Drug-related deaths

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

The national statistics on the medical causes of death (from the INSERM's CépiDc). This is a registry of information since 1968 from death certificates on all deaths in the past year. Fatal overdoses are those for which the death certificate mentions codes from the International Classification of Diseases (ICD-10) that are on the list of codes (selection B¹³⁰) established by the EMCDDA. Without going into further detail here, this is a group of codes mentioning the use of an illegal substance or certain medications. Some fatal overdoses are nevertheless coded under “deaths with poorly defined causes” and

¹²⁹ 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. BO Santé, Protection sociale et Solidarité n°2003-12 du 17 au 23 Mars 2003. (NOR SANP0330122C)

¹³⁰ Common definition of fatal overdoses for all European countries: <http://www.emcdda.europa.eu/publications/methods/drd-overview> [accessed 24/09/2013]

therefore are not detailed. Furthermore, the substances responsible for death are poorly registered in this source, since the most frequently seen wording is that of polydrug use without any further specifications. These data only become available two years after they are recorded.

The system known as DRAMES (Drug and Substance Abuse-related Deaths - see Appendix V-DRAMES). This information system records deaths that involved legal proceedings and a request for a toxicology analysis and/or autopsy. Toxicological analysts report these cases throughout the French territory on a voluntary basis. Thirty-six experts who performed toxicological analyses within a forensic framework participated in the 2011 edition of the survey. Analyses are performed upon the request of the public prosecutor's office. The definition of overdose used is very similar to the definition accepted by the EMCDDA (illegal substances and opioid substitution treatments). Contrary to the preceding source, DRAMES is not exhaustive. First of all, DRAMES does not cover all toxicology laboratories, and secondly, the system only lists deaths for which the legal authorities requested a toxicological analysis, and such requests are not systematic. Therefore, DRAMES data are mainly useful in determining a breakdown of fatal overdoses according to the substance that caused them.

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

6.2. Drug-related infectious diseases

6.2.1. HIV/AIDS and viral hepatitis B and C (ST 9 2013)

Monitoring system for HIV infection and new AIDS cases

Since HIV reporting became mandatory in 2003, the estimated number of new HIV patients¹³¹ was 61,300 on 31 December 2011¹³², 6,088 of which in 2011. This number is down slightly compared to the annual numbers for the two preceding years: 6,266 in 2010 and 6,372 in 2009).

In 2011, people infected through intravenous drug use represented no more than 1.4% of these new cases of HIV infection (85 on 6,088). The most frequent transmission mode is heterosexual intercourse (57% of cases) followed by homosexual intercourse between men (39%) (InVS 2012). It is still too early to assess the impact of recommendations (generalised screening and repeated screening among exposed populations) of the 2010-2014 French national HIV/AIDS and STI plan (Ministère de la santé et des sports 2010) on HIV surveillance data. In 2008, the incidence of HIV among injecting drug users was estimated at 86 per 100,000 person-years [95% CI, 0-192] (Le Vu *et al.* 2010) (Table 6.1).

¹³¹ People who discovered that they were HIV positive prior to 2003 and those who were unaware of their serological status do not appear in these figures. However, the contamination date might have occurred long before the discovery date during a screening for HIV.

¹³² Data corrected due to reporting delays and under-reporting.

Table 6.1: Number of new HIV infections and incidence among injecting drug users in France in 2008

	New HIV infections [95% CI]	Estimated population of IDUs in the last year	Incidence per 100,000 person-years* [95% CI]
IDUs (all nationalities combined, both sexes)	70 [0-190]	81,000	86 [0-192]

Source: InVS

* The person-years concept expresses an incidence; here, the figure indicates that 86 out of every 100,000 drug users who injected in the last year will contract HIV.

The number of new AIDS cases among injecting drug users (IDUs) has been steadily declining since the mid 90s: they represented one quarter of people diagnosed with AIDS at that time, but only represented 7.4% in 2011 (Table 6.2).

Table 6.2: Total number of new AIDS cases, number of new AIDS cases among IDUs and proportion of IDUs per year of diagnosis from 2001 to 2011

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
IDUs	405	333	286	283	220	185	158	144	96	121	103
Total new AIDS cases	2,343	2,361	2,185	2,081	2,053	2,343	2,361	2,185	2,081	2,053	1,398
IDU proportion (%)	17.3	14.1	13.1	13.6	10.7	10.1	10.1	8.9	6.6	7.2	7.4

Source: Mandatory HIV/AIDS reporting system (InVS)

N.B. Data from 31 Dec. 2011 corrected due to reporting delays and under-reporting.

Hepatitis B monitoring system

The number of acute hepatitis B cases reported between 2003 and 2011 was 1,218; of these, 34 cases (4% of the 715 for whom at-risk exposure was documented) were related to drug use. The rate of coverage for mandatory acute hepatitis B reporting was estimated using national data collected from two random laboratory samples: the rate was 23% in 2005 and 9 to 15% in 2010 (InVS 2013).

Survey of the prevalence of HIV, HCV and HBV among drug users

The prevalence data based on biological samples are only available for 2004 (Coquelicot data) and 2006 (BioPRELUD data) and cannot be easily compared with each other given the significant differences in survey methodology and surveyed populations (see the introduction). The most recent data that can be used to follow the changes in prevalence are declarative data.

Data based on biological samples

The biological (blood) prevalence of HIV infection in drug users who have snorted or injected at least once in their life, as determined during the 2004 Coquelicot survey, was 10.8%. Two percent of users wrongly believed that they were HIV negative. The prevalence was the same whether or not the user injected. The prevalence is higher in older generations: only 0.3% of drug users under the age of 30 were infected.

In this population, nearly all HIV positive drug users were also HCV positive. The biological (blood) prevalence of HCV infection in drug users who had snorted or injected in their life was 59.8%. A significant proportion of drug users (27%) wrongly believed that they were HCV negative (Jauffret-Roustide *et al.* 2009).

The biological (blood) prevalence of HCV infection in drug users who have injected at least once in their life was 73.8%, while that of HIV infection was 11.3% (Table 6.3). There are significant differences in such prevalence figures from city to city, ranging from 1.5% in Lille (in the north of France) to 33.7% in Marseille (south of France).

Table 6.3: Estimated prevalence of HIV and HCV infection from blood samples of IDUs who took part in the Coquelicot survey, by city, in 2004.

	HIV		HCV	
	% infected	Population	% infected	Population
Bordeaux	5.1	97	70.7	97
Lille	1.5	63	60.3	63
Marseille	33.7	106	73.3	106
Paris	10.8	228	76	228
Strasbourg	4.4	109	64.4	109
All five cities	11.3	603	73.8	603

Source: Coquelicot (InVS)

According to the BioPRELUD survey, the prevalence of HIV infection among people encountered in CAARUDs was 8.5% in 2006 (Table 6.4). The proportion of people who tested positive among those who said they were negative was 5.0%.

Table 6.4: Estimated prevalence of HIV infection from saliva samples of CAARUD clients who took part in the BioPRELUD survey (by injection status and age group), in 2006

			Injected at least once during life		Injected and/or snorted at least once during life
			No	Yes	
		All	N = 136	N = 348	N = 467
All	N = 484*	8.5%	9.6%	8.0%	8.8%
< 25 yrs old	N = 134	6.0%	-	5.6%	6.2%
25 to 34 yrs old	N = 211	7.1%	-	5.5%	7.4%
> 34 yrs old	N = 139	13%	-	13%	13%

Source: BioPRELUD 2006 (OFDT)

* Of the 484 users who were tested for HIV, 17 stated that they had never snorted nor injected in their life (while 467 already had).

The BioPRELUD survey in 2006 indicated a hepatitis C prevalence of 32% of all users who accepted to be tested. Estimated prevalence among injectors was 42% (Table 6.5). The proportion of people who tested positive among those who said they were negative was 8.5%, indicating that people were ignorant of their serological status.

Table 6.5: Estimated prevalence of HCV infection from saliva samples of CAARUD clients who took part in the BioPRELUD survey (by injection status and age group), in 2006

		All	Injected at least once during life		Injected and/or snorted at least once during life
			No	Yes	
			N = 138	N = 362	N = 483
All	N = 500*	32%	7%	42%	33%
< 25 yrs old	N = 138	13%	-	15%	14%
25-34 yrs old	N = 214	31%	-	42%	32%
> 34 yrs old	N = 148	51%	-	62%	53%

Source: BioPRELUD 2006 (OFDT)

* Of the 500 users who were tested for HCV, 17 stated that they had never snorted nor injected in their life (while 483 already had).

As mentioned in the introduction, the prevalence figures obtained from these two surveys were difficult to compare to each other. The data based on the saliva samples probably tended to underestimate prevalence values. Furthermore, users surveyed within the BioPRELUD survey were five years younger on average than those surveyed as part of the Coquelicot survey. Nevertheless, both studies showed that prevalence values rose sharply with age. The differences between the cities in which the surveys were conducted also explained the differences in prevalence: the absence in BioPRELUD of Paris and Marseille – cities known for their high prevalence of infectious diseases among drug users – contributes to minimising prevalence figures in this survey; the heavy weight of users in both of these cities in the Coquelicot survey had the reverse effect.

Declarative data

PRELUD data (2003-2006)

The data obtained in the nine PRELUD cities revealed a decline in declared cases of HIV infection from 2003¹³³ (10.2%) to 2006 (6.2%). The reported prevalence of hepatitis C declined from 2003 (43.4%) to 2006 (34%). The decrease was especially marked in people under the age of 25 (from 17.6% in 2003 to 8.4% in 2006).

For the hepatitis B virus, more than a third of users from urban harm reduction low-threshold structures were ignorant of their hepatitis B serological status in 2006, regardless of the users' age. This virus can be transmitted through needle sharing or sexual intercourse. However, far more people over 34 years of age reported being infected (17% compared with 4% of 25-to-34-

¹³³ The latest edition of the “Première Ligne” (Frontline) survey in 2003 replaced in 2006 by the PRELUD survey.

year-olds and 2.1% of under-25s). Of those who reported in 2006 that they had been vaccinated, 45% reported having received three vaccine injections, 25% claimed to have been given two and 28% only one.

ENa-CAARUD data

This national survey, which was conducted for the third time in 2012, questioned 2,905 users seen over the course of a week in 139 CAARUDs¹³⁴. In 2012, the majority of drug users underwent one of these screening tests at least once (91.1% for HIV and 86.7% for HCV).

Of people who had injected at least once in their life and who had been screened, 6.2% stated being HIV positive in 2012. This percentage was 7.2% in 2010, 7.7% in 2008 and 8.7% in 2006. The data obtained from CAARUD clients indicate a decline in reported HIV seropositivity, especially given that the screening rate is stable and the number of tests performed in the last six months increased (48.4% in 2012, 44.7% in 2010 and 41.8% in 2008 in the entire CAARUD population).

Although the data on hepatitis C was declarative, they also suggest a decline in hepatitis C prevalence among drug users. This decrease in reported seropositivity is particularly marked in under-25s who had injected: it decreased from 22.5% in 2006 to 8.5% in 2010 and 7.6% in 2012 (Cadet-Taïrou 2012; Saïd *et al.* in press).

However, of those people who had already injected in their life, 5.7% had never been screened for HIV infection and 7.8% had never been screened for HCV infection (versus 11.9% in 2010 for each viruses).

The vast majority of HIV-positive people (85%) had consulted at least one physician during the previous 12 months for this disease and 73.2% had received treatment over the same period (compared with 74.6% in 2010). Of HCV seropositive subjects, 64.2% had consulted a physician during the same period and 36.2% had received treatment for this pathology (vs. 36.3% in 2010).

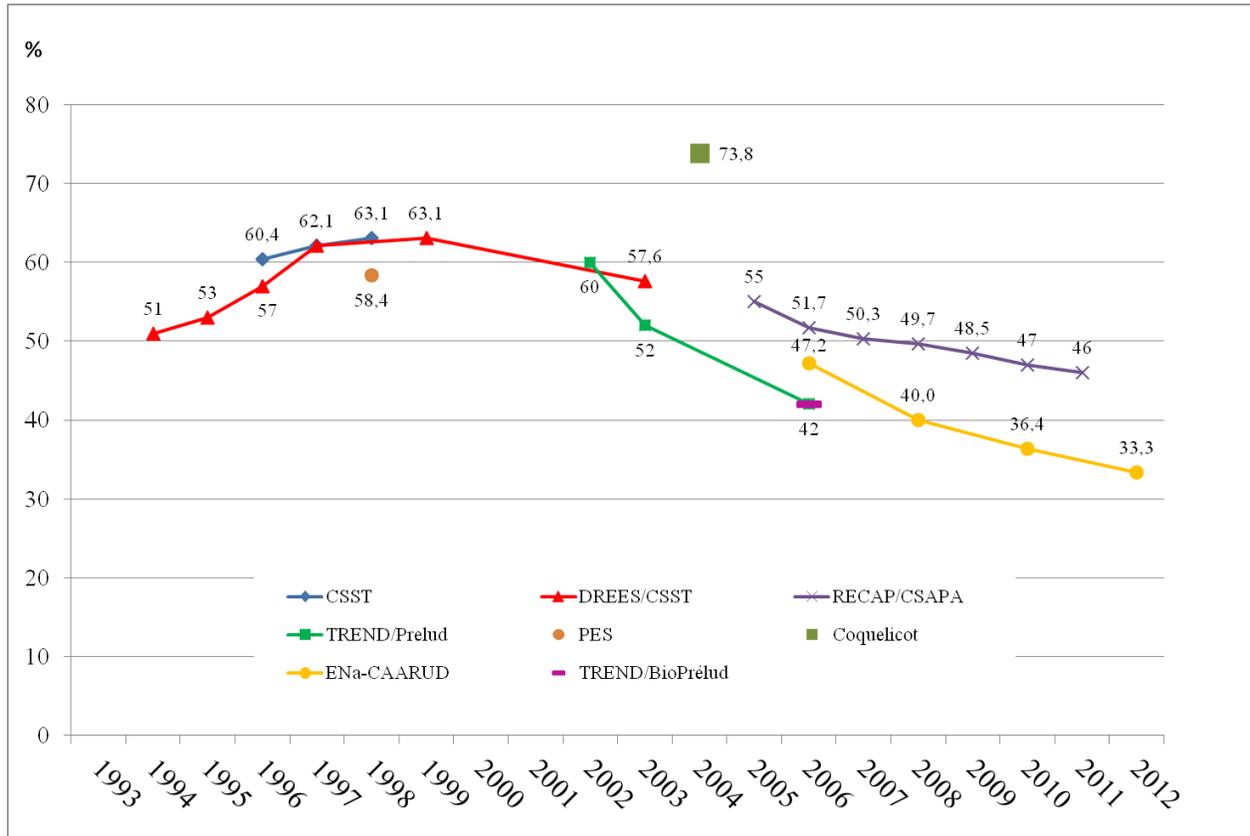
Questions on hepatitis B status were introduced into the ENa-CAARUD 2010 study. They demonstrated that users were ignorant of their serological status. In 2012, 12.4% of users stated already having been hepatitis-B infected, while 74.3% stated never having been infected and 13.3% stated they did not know. Of the users who stated that they had never been infected or did not know, 56.5% stated that they were vaccinated against hepatitis B, 24% stated that they were not vaccinated and 19.4% did not know. However, only 44.2% of users stating that they had been vaccinated were fully vaccinated (three injections), one third (32.1%) had begun the vaccination process (1 to 2 injections) and 23.7% did not know how many injections they had received.

For HIV as for HCV, since the early 2000s there has been a decline in the reported prevalence of these infections in IDUs (Figure 6.1). This trend 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 and changes in drug use practices, (the drop in injection in particular (Cadet-Taïrou 2012; Saïd *et al.* in press).

¹³⁴ The 2010 survey was on 2,505 users recruited in 112 CAARUDs.

Nevertheless, HIV prevalence among IDUs in 2012 was definitely below 10%, and that of HCV was at higher levels, since the reported prevalence clearly seemed to remain below the true prevalence.

Figure 6.1: Change in the prevalence of hepatitis C virus infection among IDUs in France from 1993 to 2012



Sources:

Residential CSSTs: IDUs in residential treatment centres, reported prevalence

DREES: IDUs treated in CSST specialised care centres for drug users, reported prevalence

RECAP: IDUs treated in CSAPA specialised care centres for drug users, reported prevalence

TREND/PRELUD: IDUs seen in low-threshold structures (CAARUDs), reported prevalence

PES: IDUs using a SEP (Syringe Exchange Programme), reported prevalence

Coquelicot: IDUs, biological data

ENa-CAARUDs: IDUs seen in low-threshold structures (CAARUDs), reported prevalence

TREND/BioPRELUD: IDUs seen in low-threshold structures (CAARUDs), biological data

N.B. Injecting drug user (IDU) means a person who has injected at least once in their life.

6.2.2. Sexually transmitted diseases and tuberculosis

There is no specific French information system that provides information on the reported or laboratory prevalence of tuberculosis or of sexually transmissible diseases among drug users.

6.2.3. Other infectious morbidity

Different diseases, particularly infectious ones, may occur with the injection of HDB or other substances. Table 6.6 presents some of these consequences seen among CAARUD clients in 2006.

Table 6.6: Consequences of injection reported by clients of low-threshold drug treatment services in 2006

Injection during the previous month	HDB (n=239)	Other substance(s) (n=232)	Total (n=471)
Injection difficulties	68%*	56%	62%
Skin abscesses	36%*	22%	29%
Venous obstruction, thrombosis, phlebitis	46%*	29%	38%
Swollen hands or forearms	43%*	30%	37%
Swollen feet or legs	16%	12%	14%
“Poussières” ¹³⁵	31%	24%	27%

Source: PRELUD 2006 (OFDT)

* significant difference with a < 1% risk for error between the percentages among injectors of HDB and injectors of other substances

6.2.4. Behavioural data

Whilst most drug users have adopted the concept of not sharing syringes, this does not apply to other ancillary injection equipment. Some users prepare the substance in a group and “pump” it in turn through the filter, each person using their own syringe, which may have been used before. Of recent IDUs seen in CAARUDs in 2012, 8.3% state having shared their syringe in the last month, but one out of five (21.6%) shared at least one other piece of equipment (Table 6.7). The downward trend since 2008 does not appear to be statistically significant.

Table 6.7: Prevalence of injection materials shared by CAARUD clients who had injected in the last 30 days, in 2012

	Men N = 1,061	Women N = 248	All N = 1,311
Syringes	7.5%	11.6%	8.3%
Water for preparation	13.9%	22.0%	15.4%
Water for rinsing	6.3%	11.3%	7.2%
Spoons, containers	13.4%	22.1%	15.0%
Cotton/Filters	10.3%	18.9%	11.9%
All ancillary equipment (except for syringes)	19.7%	29.8%	21.6%
At least one item of equipment	20.7%	30.8%	22.6%

Source: ENa-CAARUD 2012 (OFDT)

¹³⁵ “Poussières” is a French term employed by drug users to refer to a sudden fever with aches, headaches and chills following an injection. Its intensity may vary. It generally results from bacterial contamination of the blood or septicaemia. In English, it is often referred to as “cotton fever”.

It would appear that the younger the users, the more prevalent these sharing practices. In 2012, 36.3% of recent injectors under 25 years of age share at least one piece of injection equipment versus 20.7% of those over the age of 25 ($p < 0.01$) (Saïd *et al.* in press). Moreover, several studies recently identified higher risk practices in women (Cadet-Tairou *et al.* 2010b; Jauffret-Roustide *et al.* 2006), particularly the youngest ones.

Since 2002, several TREND sites have described populations of socially marginalised young people with no family or institutional support and destitute young migrants usually from Eastern Europe. These users most often have extreme use practices (anarchic polydrug use, injection), live in extremely unstable conditions and make little use of treatment systems (see chapter 8). This new generation of precarious users (under 25 years of age) is therefore one with cumulative health risks due to more widespread sharing of injection equipment and a higher prevalence of prostitution (Rahis *et al.* 2010).

In 2012, of the 14.2% of CAARUD clients who had been incarcerated that year, 7.6% stated that they had injected, 38.4% stated that they had snorted and 1.4% stated that they had shared a "syringe"¹³⁶ during their incarceration (Saïd *et al.* in press).

6.3. Other drug-related health correlates and consequences

In 2008, more than a third of CAARUD clients (35% in 2006) felt that they were in poor or very poor physical health. Although morbidity from infection is what is most frequently reported (bronchitis, colds, abscesses), there is also traumatic injury (fractures, wounds and other bodily consequences of violence or accidents), skin problems (mycoses, wounds, ulcers), dental problems (gingivitis, receding gums), digestive issues (constipation or diarrhoea) and cardiac problems (Bello *et al.* 2010). In 2012, 34.8% of CAARUD clients had been hospitalised at least once in the last year.

6.3.1. Non-fatal overdoses and drug-related emergencies

The only data currently available on a regular basis are those of the ENa-CAARUD survey of users frequenting CAARUDs.

In 2012, 6.5% of CAARUD **clients** stated having experienced a non-fatal overdose (loss of consciousness after taking one or more substances) in the 12 months preceding the survey. Alcohol was the drug most often responsible for these overdoses (19.7%), followed by benzodiazepines (15.0%), cocaine (13.9%) and heroin (13.3%).

Psychiatric comorbidities

Almost half of drug users consider that they are in poor psychological health (according to 45% of those seen in CAARUDs in 2006). This impression increased with age (with 38% of those under 25 years of age reporting this compared with 46% of 25-to-34-year-olds and 49% of those

¹³⁶ Since syringes are difficult to obtain in prison, other objects (such as pens) can be used to inject.

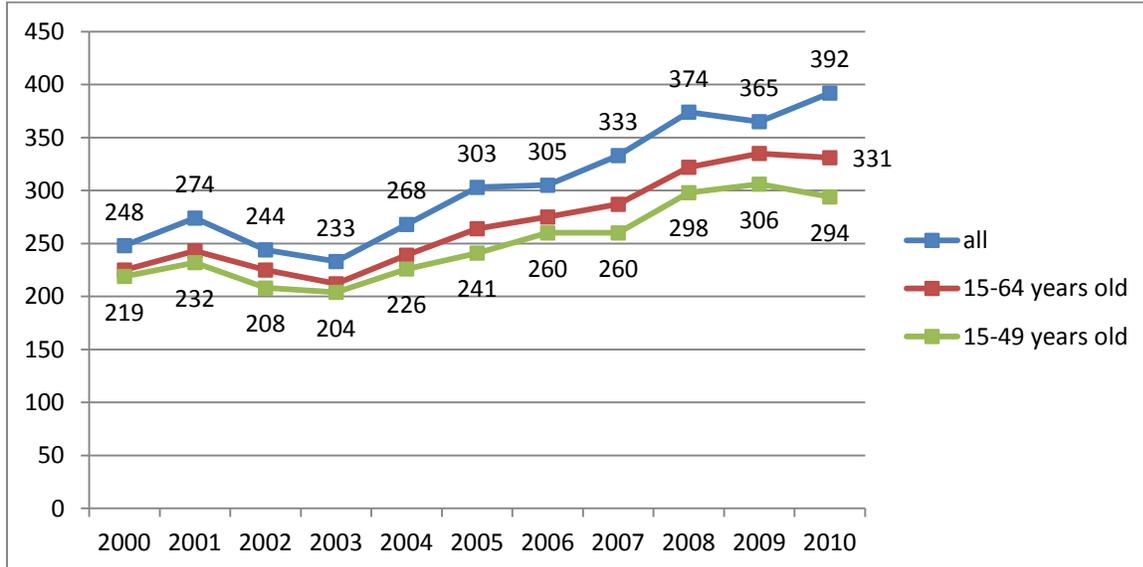
over 35 years of age). Users described symptoms of depression or anxiety, suicidal impulses and even delusional episodes. In 2012, 7.0% of users stated having been hospitalised in the last 12 months for psychological problems not related to withdrawal. Subsequently, nearly one out of five hospitalisations that had occurred in the last 12 months were for this reason. Hospitalisations for withdrawal were more or less at the same level¹³⁷ (Saïd *et al.* in press).

6.4. Drug-related deaths and mortality of drug user (ST 5, ST 6 and ST 18 2013)

6.4.1. Drug-induced deaths (overdoses/poisonings)

Data from the mortality register reveal a constant increase in the number of fatal overdoses from 2003 to 2010, with the exception of 2009. If we limit the age range to 15-49-year-olds - the drug-user largest age group - the number of fatal overdoses has stabilised at approximately 300 since 2008 (Figure 6.2).

Figure 6.2: Fatal overdoses in France, according to the mortality register, from 2000 to 2010



Source: CépiDc (INSERM)

N.B. Fatal overdoses listed here correspond to EMCDDA selection B.

DRAMES provides information on the substances that are the main cause of fatal overdoses. In 2011, opioid substitution treatments (OST) were the primary cause of half of all deaths. Illegal substances were the primary cause of 28% of deaths and opioid medications (not including OSTs) nearly 13%. Overall, opioids were chiefly involved in 79% of deaths and cocaine (alone or combined with other substances) in approximately 7%. The proportion illegal substances as the primary cause has declined, while that of OSTs increased from 2009 to 2011 (Table 6.8).

¹³⁷ Out of the 34.8%, or 854 users, who reported having been hospitalised in the last year.

Table 6.8: Substances mainly responsible for fatal overdoses from 2006-2009

	2006		2007		2008		2009		2010		2011	
	N	%	N	%	N	%	N	%	N	%	N	%
Heroin, alone or in combination	59	35.1	69	35.9	79	36.4	103	39.6	79	32.0	43	15.5
Cocaine, alone or in combination	31	18.5	39	20.3	30	13.8	32	12.3	16	6.5	19	6.8
Other illegal substances, alone or in combination	5	3.0	2	1.0	4	1.8	2	0.8	5	2.0	16	5.8
Methadone, alone or in combination	31	18.5	61	31.8	63	29.0	58	22.3	81	32.8	108	38.4
Buprenorphine, alone or in combination	20	11.9	11	5.7	21	9.7	31	11.9	40	16.2	34	12.1
Other opioids, alone or in combination	18	10.7	10	5.2	19	8.8	34	13.1	20	8.1	38	13.4
Others	4	2.4	0	0.0	1	0.5	0	0.0	6	2.4	22	7.9
Total	168	100.0	192	100.0	217	100.0	260	100.0	247	100.0	280	100.0
Number of participating toxicological experts	na		na		19		25		31		36	

Source: DRAMES (ANSM)

na: not available

N.B. Only deaths directly caused by drug use are mentioned.

The qualitative TREND scheme data offer two explanations for the observed trends. Firstly, the black market for methadone is gradually growing as it becomes more accessible as a treatment. However, methadone is far from being as available on the black market as HDB, and is much more a source of self-substitution treatment for opioid users than a drug. In contrast, heroin, which is highly available in France, has been decreasingly pure since about 2011 (see chapter 10) after a period in which very high-dose samples were found to be the cause of an increased number of lethal overdoses (Cadet-Tairou *et al.* 2013a; Cadet-Tairou *et al.* 2013b; Gandilhon *et al.* 2010a).

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

/

6.4.3. Specific causes of mortality indirectly related to drug use

At present, there are no information sources in France to answer this specific question. It should be noted that the main institutions involved seek, above all, to establish a consensus about the direct causes and a uniform measurement of the prevalence of fatal overdoses. However, it should be mentioned that the public authorities wish to assess the number of deaths caused by driving under the influence of narcotics, and cannabis in particular. Since the number of fatal accidents - in which the driver responsible was under the influence of opioids or cocaine - was too low, it was not possible to determine the number of deaths by road accident caused by these substances. However, cannabis use can be deemed to have been responsible for 170 to 190 deaths each year by the end of the 2000s (Van Elslande *et al.* 2011).

7. Responses to drug-related health correlates and consequences

7.1. Introduction

Response measures to drug user health problems over the last two decades have largely been focused on injection-related infectious diseases (HIV and hepatitis) (Bello *et al.* 2010). For this reason, the oldest and best structured programmes are those that fight against these pathologies. There are three levels of prevention¹³⁸: primary prevention with harm reduction, secondary prevention with an encouragement to undergo screening and early treatment, and finally, tertiary prevention, which aims at improving access to treatments and their follow-up for users. Other pathologies related to drug use, psychiatric and somatic comorbidities or acute incidents have not been the subject of specific responses from the public authorities until now.

With the exception of substitution treatments, changes in the supply and availability of treatment and as harm reduction measures have not been closely monitored in France until recently due to the difficulty in gaining access to data. However, a number of indicators exist, making it possible to monitor the geographical coverage of specialised services for drug users. Two surveys conducted by the French National Institute for Prevention and Health Education (the INPES) on a sample of pharmacists and physicians make it possible to measure the number of the health professionals contributing to harm reduction measures or treatments: the *Baromètre santé pharmaciens* (Health barometer for pharmacists) and the *Baromètre santé médecins généralistes* (see Appendix V- Health Barometer - General Practitioners).

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

Up until 2008-2009, no national policy or specific measures existed in France concerning the reduction of serious, acute pathologies and deaths related to drug use. Access to substitution treatments and harm reduction measures (access to sterile injection equipment through pharmacies, syringe exchange programmes, addiction centres and access to health care and social entitlements in so-called "low threshold" structures) offer a number of indirect means of preventing death related to opioid use. The increasingly widespread use, and misuse, of HDB (which causes few overdoses) instead of heroin is considered one of the reasons behind the fall in the number of overdoses recorded between 1994 and 2003 in France.

From 2008-2009 onwards, two specific actions began to emerge:

1) The health warning system, related to the use of psychoactive substances, was launched in 2006 and is now operational and gradually coming on stream.

Nationally, this includes the DGS (the addictions office and the alert management unit), the InVS, the ANSM, the OFDT, the MILDT, the local networks of each of these institutions (hospitals, physicians, specialised treatment centres, regional monitoring units, low threshold services and pharmacists) and their international networks (such as the Early Warning System and the European Centre for Disease Prevention and Control).

¹³⁸ The conceptualisation of the field of prevention is changing with a dissemination of the concepts of universal prevention, selective prevention and indicated prevention (see chapter 3). However, the classification used here always proves to be relevant for describing actions in relation to the various stages of the pathological process.

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

- warning signs related to cases: deaths, unusual symptoms, syndromes or pathologies, possibly occurring together around the same time or in the same locality and having an obvious or suspected link to the occasional or repeated administration of a psychoactive substance or a combination of such substances;
- warning signs related to substances: circulating, seized or already-used psychoactive substances or a combination of substances of an unusual or dangerous nature likely to pose a lethal threat or entail serious health consequences (due to the presence of specific additives, the level of purity, the extent to which the substance or use patterns is new).

Following an analysis of the signs in question, the response can range from simple monitoring to a health alert concerning the toxicity of certain circulating substances or a formal reminder of the dangers of certain "at risk" practices (Lahaie *et al.* 2009).

2) Specific tools aimed at preventing drug-related deaths have been prepared.

The upsurge in drug-related deaths, namely related to heroin use (see chapter 6), has made the health authorities more aware of the gradual spread of heroin to younger sections of the population, who tend to be better integrated socially and, above all, insufficiently informed of the risks of taking opioids and the means available to reduce these risks.

Monitoring

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

The prevention of drug-related infectious diseases

The prevention of drug-related infectious diseases initially targeted only HIV until the 1999-2002 period, when the first national hepatitis C strategic plan was adopted. The prevention measures of this plan chiefly concerned drug users, who account for the vast majority of new cases in France. This plan contained measures for prevention, screening, access to treatment and improvements to treatment. With the decline in HIV infection prevalence in drug users, the fight against viral hepatitis in this group has now become a central issue. The 2002-2005 plan entitled "*Programme national hépatite B et C*" (national hepatitis B and C strategic) plan also includes the fight against hepatitis B. In December 2008, while awaiting the publication of a new plan, measures were taken aimed to raise awareness among health professionals of the need to vaccinate "at risk" individuals, including drug users¹³⁹. The latest plan (2009-2012) (DGS 2009)

¹³⁹ In France, vaccination against hepatitis B has never been compulsory, although a campaign aimed at encouraging vaccination in infants and teenagers existed until 1988. After the end of this campaign, the general vaccination rate declined. Since 2004, the number of infants being vaccinated has increased. The most recent data indicate that 58.2% of infants born in 2009 had received three doses of hepatitis B vaccine by the age of 24 months (Fonteneau *et al.* 2013). Surveys conducted in schools revealed that 46% of 11-year-olds (in year 5 at school in 2007-2008, temporary data) and 42% of 15-year-olds (in year 9 at school in 2003-2004) had been vaccinated (Antona *et al.* 2009).

was based on the same issues, but more generally identified "at-risk" groups to better reach them. Prevention also targeted the most vulnerable and precarious individuals in society, and migrant populations in particular. The plan further stipulated working on preventing experimentation with intravenous drug use. The plan also covered possible contamination by the nasal or inhalation routes, whereas up until now the French prevention measures had scarcely considered this. The 2009-2012 national viral hepatitis B and C strategic plan was evaluated by the High Council for Public Health (HCSP) in 2013 (HCSP 2013). The HCSP does not recommend drawing up a new national plan because there is a lack of clear strategy, of consistency in the measures and in clearly identified and allocated financial resources. However, the HCSP does recommend making hepatitis a priority in the future national healthcare strategy.

The prevention measures used in France are of three types:

1) The harm reduction policy

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

- Distributing and recovering sterile, single-use injection equipment. Syringes and injection kits are sold without restriction in pharmacies (without a prescription since 1987). Injection kits are also distributed by or exchanged within low-threshold structures (CAARUDs), National Treatment and Prevention Centres for Addiction (CSAPAs) or automatic distribution machines. For several years now, the availability of prevention material has gradually been extended to administration routes other than injection, with the distribution of snort kits and basing kits for crack smokers and the distribution of special foils for users who "chase the dragon"¹⁴⁰. Finally, distributing condoms (and encouraging their use) also helps reduce HIV virus contamination.
- The circulation of information on drug-related risks and the promotion of health education.
- The distribution of opioid substitution treatments (OSTs) since 1995, which initially aims to reduce intravenous drug use (preventing the first injection and/or encouraging users to give up the intravenous route) by reducing heroin use, but also by encouraging access to treatment by providing a common objective for both physicians and drug users. This makes it possible to develop a strong therapeutic relationship between them.
- Experimentation with a drug consumption room was authorised by the government in February 2013. The French Interministerial Mission for the Fight against Drugs and Drug Addiction (MILDT) was entrusted by the Ministry of Health to provide support, along with relevant ministries, to the city of Paris, where such an experimental injection room will be established. This drug consumption room is scheduled to open in Paris near the Gare du Nord in 2014. It will offer precarious IDUs a safe environment and acceptable hygiene conditions in which to use their own drugs under the supervision of qualified professionals. In this consumption room, users may meet with physicians, nurses and

¹⁴⁰ Chasing the dragon consists of inhaling the vapours produced by heating (with a cigarette lighter) heroin placed on aluminium foil. The active substance enters the bloodstream through the pulmonary alveoli, which are highly permeable to gas, and not via the nasal mucosa, like in sniffing. This route of administration increases both the intensity and the rapidity of onset of the effects.

social workers who can refer them to substitution programmes, prevention programmes and diagnostic measures, and help them gain access to care and exercise their rights.

The harm reduction system is based essentially on local pharmacies (for the sale of injection equipment and participation in syringe exchange programmes), on the specialised medico-social system (CAARUDs and CSAPAs) and on the non-medical/social services offered by associations. The associations mainly intervene on the party scene and in municipal schemes in charge of syringe dispensing devices. Treatment access points also contribute to reducing risks, either directly (by providing information and equipment) or indirectly (through substitution treatments). General practitioners and pharmacists also contribute to harm reduction measures by prescribing and dispensing HDB. In order to provide OSTs access to the most vulnerable drug-using populations (e.g., pregnant women, inmates), health care professionals can initiate methadone substitution treatment in a hospital or prison setting. Until now, only physicians working in CSAPAs could do this.

2) Encouragement to undergo screening for HIV, HCV and HBV infections and the ease of access to this screening

The 2008-2011 action plan against drugs and drug addiction stipulated carrying out activities more systematically in all structures visited by drug users, as well as providing information on the importance of screening and the efficacy of the treatments available to drug users in areas that generally attract precarious and migrant populations. It also included an information campaign aimed at the general population and health professionals. The aim was to reduce the percentage of cases in which the pathology is already highly advanced by the time it is detected by screening.

The circular of 9 November 2009¹⁴¹ put the provisions of this plan into effect (see chapter 1).

The screening programme is chiefly carried out in anonymous free screening centres (known as CDAGs) (see chapter 1). In 2006 there were 307 CDAGs in France in addition to 73 CDAG units operating in prisons. Users can visit them, and may be referred there or accompanied by CAARUD staff members. There are also local harm reduction or treatment centres that organise the on-site collection of samples for screening purposes. CSAPAs also provide screening free of charge. Finally, access to screening is also possible via the traditional care system. However, whereas the cost of screening for HIV and HCV infections is 100% covered by the French national health insurance scheme, the screening for chronic HBV markers is only reimbursed at a rate of 65%.

3) Encouragement to undergo vaccination against hepatitis B

In addition to continuing to encourage "at risk" people to get vaccinated (in particular in treatment and harm reduction structures), this plan also seeks to encourage vaccination among the general population, infants and teenagers. The hepatitis B vaccine is provided free of charge by CDAGs and CSAPAs. This vaccine is 65% reimbursed by the National Health Insurance Fund (*Assurance maladie*) as part of a general care system.

¹⁴¹ Circulaire DGS/MC2 n°2009-349 du 9 novembre 2009 relative à la mise en œuvre de l'action II-1,3 du plan national de lutte contre les hépatites B et C 2009-2012 ayant pour objectif de permettre aux usagers de drogues de bénéficier d'un service de proximité assurant gratuitement le dépistage de ces hépatites et, le cas échéant, d'une vaccination contre l'hépatite B. BO Santé, Protection sociale et Solidarités n°12 du 15 janvier 2010. (NOR SASP0927192C)

Monitoring

Data for monitoring the quantities of injection equipment delivered to drug users were collected by the OFDT in 2008. The OFDT collects these data from:

- the sale of syringes by *Becton Dickinson* to pharmacies;
- sales of *Stéribox*¹⁴² to pharmacies (System of information on the accessibility of injection equipment and substitution products, see Appendix V-SIAMOIS);
- the information system based on standardised annual reports produced by the CAARUDs (see Appendix V-ASA-CAARUD);
- evaluations produced by various associations distributing syringes.

The information system based on the CAARUD activity reports also makes it possible to monitor activities preventing infectious diseases (number of condoms distributed, mean annual number of acts pertaining to screening for viral disease or hepatitis B vaccination per CAARUD client).

The monitoring of the policy to provide access to screening is chiefly based on the ENA-CAARUD survey (see Appendix V-ENA-CAARUD) among CAARUD clients every two years. The percentage of users having already undergone screening for HIV or HCV is now very high (above 85%). What is important is that this screening needs to be repeated. Therefore, the OFDT also monitors the percentage of users for whom the most recent negative result dates back less than six months.

A number of indicators are not available on a sufficiently regular basis, such as the percentage of HCV- or HIV-infected drug users who are unaware that they are infected. The Coquelicot survey (see Appendix V-Coquelicot) conducted by the InVS in 2004 (and repeated in 2011) found that a large proportion (27%) of HCV-infected drug users were unaware that they were infected (Jauffret-Roustide *et al.* 2006). Similarly, drug users' knowledge of their hepatitis B serological status (vaccinated, infected, cured or not) was assessed in 2006 with the PRELUD survey (see Appendix V-PRELUD) without being subsequently repeated (Cadet-Tairou *et al.* 2008).

Treatment of drug-related infectious diseases

Finally, facilitating access to treatment for infected persons is the main purpose of "treatment" measures, but it is also a public health measure for those users who are not yet infected.

Ministerial measures introduced in December 2005 created "a coordinated treatment process for hepatitis C" organised around hospital reference units. The purpose of this was to improve liaison between primary care and specialised medical services as well as to enhance the quality of treatment offered to patients and their overall quality of life. A "physician's" guide to hepatitis C was produced by the French National Authority for Health (HAS) in 2006 (HAS 2006).

¹⁴² Prevention kits containing 2 1-ml syringes, 1 bottle of sterile water, 1 alcohol wipe, 1 condom with a prevention mention, 2 containers ("cookers") and 2 sterile filters.

Prevention of infectious diseases has also been planned for drug users in prison. The viral hepatitis strategic plan sees prevention in prison as one of five strategic areas for attention. Access to HIV and hepatitis screening is also a main strategy of the 2010-2014 "health/prison" strategic actions plan (Ministère de la santé et des sports *et al.* 2010) (see chapters 1 and 9).

Responses to other health-related consequences of drug use

Other health-related consequences of drug use have not given rise to any specific responses in France. Specialised centres for drug users and harm-reduction structures facilitate access to care, some of which can be administered on-site (such as skin treatments). The activities carried out by the CAARUDs in this particular field can be measured. Furthermore, drug users also utilise the general healthcare system for treatment (emergency departments, hospitals, private practitioners).

For economically disadvantaged population groups, access to care is possible thanks to the CMU¹⁴³. Foreign nationals without papers can benefit from State Medical Assistance (AME) if they request it. Nevertheless, a number of drug users living in extremely unstable conditions no longer have documents entitling them to coverage. Some minors, who are still covered by their parents with whom they no longer have any contact, are also without insurance. Consequently, a small percentage of users frequenting CAARUDs (5.6% in 2012) have no social cover whatsoever (Saïd *et al.* in press).

Treating psychiatric comorbidities in French drug users remains an unresolved problem. Indeed, although addiction medicine is not lacking in psychiatrists and although some psychiatric hospitals have developed drug addiction treatment activities over recent years, these initiatives remain few and far between and insufficient to cover needs. Physicians treating drug addicts experience major difficulties in finding suitable treatment establishments for those requiring residential and often particularly complex treatments.

There are no French indicators for monitoring the treatment of psychiatric comorbidities.

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

In 2010, the health warning system for psychoactive substances improved its organisation by promoting and inciting coordination among players likely to receive, process and respond to warning signs on a regional level¹⁴⁴: Regional Health Agencies (ARS) and Centres for Evaluation and Information on Pharmacodependence (CEIP) of the ANSM network and the OFDT TREND/SINTES sites, if need be. The purpose of these measures is also to inform potential targets (e.g., harm reduction facilities, specialised treatment centres for drug users, networks of physicians specialised in drug addiction, user associations, and hospital emergency departments, etc).

¹⁴³ CMU, or Universal Medical Coverage, is health coverage available to French people who do not make contributions to the Social Security scheme or available to foreigners who have the authorisation to be in France.

¹⁴⁴ A warning sign is likely to be linked to a phenomenon warranting management. It should be evaluated and possibly investigated.

The OFDT SINTES scheme (cf. Annexe V-SINTES) updated the “Methoxetamine” information note on 24 October 2012¹⁴⁵ and the “List of new synthetic drugs identified in France since 2008” on 9 August 2013¹⁴⁶.

7.3. Prevention and treatment of drug-related infectious diseases

Accessibility to harm reduction facilities, screening and treatment will be examined in succession.

Accessibility to harm reduction measures, structures and professionals

In order to guarantee 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 offering. The following indicators are useful to assess the actual coverage of the systems in place.

Level of involvement and location of pharmacy professionals

The INPES has not repeated its *Baromètre* among retail pharmacists. The last data available therefore date back to 2003 (Gautier *et al.* 2005). They can be examined in past French national reports to the EMCDDA.

Another national survey of retail pharmacies was carried out in 2010 by the AFSSAPS (now known as the ANSM): 38% of those pharmacies selected at random took part in the survey. Nearly half (48%, or 769) of the retail pharmacies surveyed stated having provided information on preventing infectious diseases, and 40% confirmed having syringe retrieval services (Lapeyre-Mestre *et al.* 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*^{®147} or *Stéricup*^{®148} units.

Level of professional involvement in primary care

A new edition of the *Baromètre santé médecins généralistes* survey on general practitioners took place in 2009 (Gautier 2011).

Two thirds of general practitioners saw at least one opioid-addicted drug user in the last year. The proportion of those receiving at least one user per month substantially increased to almost 50% (compared to one-third in 2003).

¹⁴⁵ http://www.ofdt.fr/BDD/sintes/ir_methoxetamine_111105.pdf

¹⁴⁶ http://www.ofdt.fr/BDD/sintes/ir_110509_nps.pdf

¹⁴⁷ 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, oedema, phlebitis). For single-use only, this sterile filter aims to prevent injection equipment reuse or sharing.

¹⁴⁸ A sterile aluminium container that diminishes the risks of infection due to the reuse and sharing of injection preparation equipment.

Although the percentage of these GPs prescribing substitution treatment has not significantly changed since 2003, the prescription structure did. More than one-third of these physicians now prescribe methadone (theoretically to provide continuity of care after an initial prescription in a specialised centre in a hospital or a prison), while the percentage prescribing HDB has diminished (Table 7.1). GPs who prescribe OST differ from their colleagues in certain ways. The typical profile is of a male physician in group practice who carries out over 20 procedures a day and for whom at least 10% of his patients have CMU (Universal Medical Coverage). The GPs who prescribe OST feel that they can easily broach the subject of drug use more frequently than other general practitioners. Finally, GPs participating in a network for the treatment of drug addiction, hepatitis or HIV are far more inclined to treat drug users than other physicians (74.8% vs. 47.2%). However, unlike the 2003 situation, the age of the GPs seems to be unrelated to his propensity to treat drug users. Moreover, there are now more GPs treating opioid-addicted people in communities of fewer than 20,000 inhabitants than in more populated communities. This may be due to the increase in drug use outside of major cities.

In 2009, GPs saw an average of 1.8 opioid-addicted drug users per month, which was not significantly different from the number they saw in 2003 (1.6). However, the GPs who saw at least one opioid-addicted patient per month saw 3.6 of them per month, which was significantly lower than in 2003 (4.6).

Table 7.1: Change in involvement of general practitioners in harm reduction between 1999 and 2009

	1998/1999	2003	2009
Proportion of GPs seeing at least one drug user (of opioids) per month	35%	34%	49%*
<i>Of which:</i>			
Proportion of GPs prescribing OST	78.9%	90.3%*	87.2%
HDB (High-dose Buprenorphine)	71.9%	84.5%*	76.9%*
Methadone	12.6%	26.0%*	37.7%*
Other	13.5%	7.4%*	14.9%

Source: Baromètre santé médecins généralistes (Health barometer, General practitioners) (INPES)

* significant difference $p < 0.001$ compared with the previous edition

National coverage of medical-social harm reduction systems

In 2013, medico-social harm reduction systems (CAARUD and CSAPA) covered the majority of the French territory: only 8 departments (out of a total of one hundred or so) do not have a CAARUD, and all departments have CSAPA.

CAARUD harm reduction activities

In 2013, 159 CAARUDs existed throughout France, versus 135 in 2010. These are medico-social establishments funded by the French social security scheme. They operate in various places according to diverse methods. Of these, in 2010, 97% offered stationary admission services, 71% have outreach teams, 47% operated in squats, 33% had mobile units, 56% worked with teams on the party scene and 29% had developed prison activities. They largely contribute to distributing clean injection equipment (4.7 million syringes in 2010) and other preventative equipment (e.g., ancillary injection equipment, condoms, snorting equipment, crack-smoking equipment).

The main actions performed by these structures include providing assistance with hygiene and first aid care, promoting health education, helping people get access to social services, following-up on administrative and legal procedures and seeking out emergency housing.

More specifically, in 2010, CAARUDs distributed the following prevention material:

- syringes: 2.6 million single syringes and 465,000 prevention kits (2 syringes per kit, or approximately 930,000 syringes) were handed over directly to users, 240,000 prevention kits (or 480,000 syringes) were distributed via CAARUD-managed dispensing machines and 297,000 prevention kits (or 594,000 syringes) were distributed through pharmacy Syringe Exchange Programmes¹⁴⁹;
- ancillary injection equipment: 1.1 million filters, 1.2 million containers ("cookers"), 1.6 million water bottles and 2 million alcohol wipes;
- condoms: 754,000, 95% of which were male condoms;
- gel: approximately 289,000 units.

Providing assistance in gaining access to OSTs and general care is one of the CAARUD's primary missions: 79% of CAARUDs reported that they had set up access to OSTs (referral or monitoring).

The role of CSAPAs in harm reduction, which has been one of their missions for the past few years, cannot be quantified in the absence of data.

Actual scope of dispensing machines and operational status

CAARUDs are not the only structures to distribute injection equipment via dispensing machines. Other operators, non-CAARUD-related associations and communities, for the most part, also provide drug users with prevention kits such as the *Stéribox*® kit or *Kit+*¹⁵⁰ via this method. These distribution machines make a substantial contribution to ensuring the accessibility of injection equipment, not only from a quantitative point of view (they distributed just under 10% of all syringes sold or distributed in France) but also in terms of the service they provide (anonymity and around-the-clock access). Furthermore, these dispensing devices enable them to reach a different population from that of other programmes. In 2010, there were 283 dispensers of prevention kits, 201 syringe exchange devices (collecting used syringes for a token) and 70 syringe retrieval devices (collecting used syringes with no exchange of tokens) in 56 departments. These devices distributed over 1.1 million syringes (nearly half by CAARUDs) and retrieved nearly 500,000 used syringes. 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 (Duplessy 2012).

¹⁴⁹ Syringe Exchange Programmes (SEP) provide drug users with free, sterile injection equipment to help limit the transmission of viruses and other infections that can accompany the sharing of equipment. They also offer preparation equipment for injection (filters, water, containers for mixing) or other routes of administration (crack straws/pipes, aluminium foils).

¹⁵⁰ The kits or prevention kits are intended to limit the risks of transmitting infectious diseases among IDUs. 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.

Availability of injection, smoking and snorting equipment

From the different available information sources, we can estimate that approximately 14 million syringes were sold or distributed to drug users in France in 2008. Comparing this number to the number of IDUs (81,000 recent intravenous users) produces a ratio of approximately 170 syringes per user per year (Costes *et al.* 2009). This figure, which only represents an order of magnitude, indicates a rather high accessibility to syringes in France for IDUs. Pharmacies play a key role and are involved in over two-thirds of syringe sales or distribution. However, a reliable evaluation of the needs together with an analysis of the geographic disparities (accessibility of syringes in rural areas in particular) has yet to be carried out.

Since 2008, no complete estimate of the number of syringes distributed or sold could be performed. However, there are some data available for 2010 and 2011. In retail pharmacies, 2.2 million *Stéribox*[®] kits (containing sterile injection equipment) were distributed in 2011, which corresponds to 4.5 million syringes (2 syringes per kit) (Table 7.2). *Stéribox*[®] distribution in retail pharmacies has therefore decreased since 2008. In 2010, CAARUDs distributed nearly 4.7 million syringes (individually or in kits, handed over directly to drug users, through automatic dispensing machines or through pharmacy Syringe Exchange Programmes), which is an increase compared with 2008. Non-CAARUD dispensing machines distributed 600,000 syringes in 2011 according to Safe association data. This figure has remained stable since 2008.

In 2011, the Safe association began experimenting with an alternative equipment access programme through the postal service. Users call or write the association, which assesses user 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 desired or possible. According to initial results, 269 packages were sent to 94 people. The reasons why these users employ this method are structural (geographic distance, poorly-adapted hours of operation, need for specific material - wheel filters¹⁵¹, ascorbic acid¹⁵² - that are not available in CAARUDs) or personal (desire for anonymity, difficulty in admitting to CSAPAs that OSTs are being injected).

¹⁵¹ This type of filter is more effective at trapping impurities than *Stérifilt*[®] filters.

¹⁵² To dissolve heroin or crack, users often add an acidic solution, such as lemon juice or vinegar, to the preparation. These solutions are not adapted to this use and are not sterile. To reduce the risks related to this practice, sterile citric acid packaged into small packets of powder are made available to users needing it.

Table 7.2: Number of syringes dispensed by pharmacies or CAARUDs and dispensing machines according to the latest available data (ST 10 2013)

	Number of syringes sold or distributed (millions)		
	2008	2010	2011
Pharmacy: single syringes	4.3	na	na
Pharmacy: <i>Stéribox</i> [®]	5.2	4.7	4.5
CAARUD: single syringes handed over directly to drug users	2.3	2.6	na
CAARUD: prevention kits handed over directly to drug users	1.0	0.9	na
CAARUD: pharmacy Syringe Exchange Programmes	na	0.6	na
CAARUD automatic dispensing machines	0.4	0.5	na
Non-CAARUD automatic dispensing machines	0.6	0.6	0.6
Total	13.8		

Sources: *Siamois (InVS)*, *Becton Dickinson*, *ASA-CAARUD (OFDT)* and *Safe association*

na: not available

Following a significant increase until the late 90s, syringe sales to drug users in pharmacies have fallen markedly since (last complete estimate was performed in 2008). This significant drop is only partially offset by the increase in the distribution of injection equipment by the CAARUDs. Two hypotheses may be put forth to explain the fall in the number of syringes distributed to drug users in the last ten years.

One optimistic hypothesis is that the number of injections has fallen. This is associated with the fact that new drug users inject less, opting for other routes of administration instead (snorting and smoking). These alternative routes of administration are predominant in drug users who began taking drugs on the party scene and have also been adopted by some vulnerable users.

Hence, in 2010, 34,000 crack mouthpieces were distributed by CAARUDs. Eighty-five percent of these mouthpieces were distributed in structures in Greater Paris. Furthermore, 298,000 snorting items (rolling papers) were also distributed, mostly by CAARUDs working on the party scene (Chalumeau 2010; Dambélé in press).

Another possible explanation may be that drug users are stopping intravenous drug use as a result of the increasingly widespread use of substitution treatments or, for some people, reduced injection frequency with injection becoming only an occasional route of administration. Subsequently, while there was an increase in the number of drug users between 1999 and 2005, the proportion of IDUs appears to have fallen overall, except in some specific groups (Bello *et al.* 2010; Cadet-Taïrou *et al.* 2010b).

One pessimistic hypothesis would be a return to syringe sharing and re-use, observed among some drug users, particularly the most vulnerable ones.

Harm reduction on the party scene

In 2010, nearly 6 out of every 10 CAARUDs had a team that worked on the party scene (Dambélé in press). Other associations carrying out harm reduction activities are not included in the medico-social system. These are mainly certain humanitarian, community health or specialised associations that are not CAARUD-certified. Many of them work on the party scene.

There is no information available to compare the services offered with the needs of users on the party scene. Qualitatively speaking, since the publication of the decree of 2002¹⁵³, which regulates the means by which parties are organised, the TREND scheme has witnessed a fragmenting of the non-commercial party scene. Larger parties are being replaced by smaller, more numerous, and undeclared free parties, in premises advertised at the last minute, and only among intimate circles of regular party-goers. These parties are becoming increasingly inaccessible to harm reduction associations, which cannot be present everywhere.

The methods for intervening on the party scene depend primarily on the type of event organised and on the ability of workers to attend them and organise their services (Table 7.3) (Reynaud-Maurupt *et al.* 2007). Private parties can very easily escape the attention of harm reduction workers. Therefore, it is only when the initiative is taken by the event organisers that the harm reduction associations can intervene and set up specific actions. These actions mainly involve promoting and distributing information material (leaflets on the risks associated with drug use and their prevention) and/or harm reduction tools such as syringes, straws, etc. For public parties, in addition to information and prevention material, food and drink are supplied and areas are set aside where social workers can hold consultations, give counselling, provide reassurance and administer first aid.

Table 7.3: Prevention activities on the party scene

Type of event	Main interventions	Population
Free party: party event with fewer than 500 people or raves with entrance fees (no prefectural authorisation)	Downloadable flyers for participants and organisers and possibility to order harm reduction materials If there is knowledge of such a party: information leaflets and materials (“flyers”)	Techno music regulars, socially integrated people
“Legal” free party: “multi-sound” party event with more than 500 people (2 days)	Stand or “chill out” ¹⁵⁴	Large proportion of Techno scene newcomers (most at risk)
Teknival: party event with more than 50,000 people (several days)	Creation of one or several harm reduction villages: reception, information, equipment, counselling, reassurance, first aid, “testing”	Often young new participants, minority proportion of IDUs
Clubbing or urban parties (free or entry fee)	“Flyers” (information leaflets and materials) or stand for prevention actions	Generally mixed audience, poor hygiene conditions
Town parades, festivals, etc.	Information leaflets and materials (“flyers”), stand or “chill out” area	Many very young people

Source: OFDT from Techno+ activity reports and the 2004-2005 Quanti-festif survey (OFDT/GRVS)

¹⁵³ Décret n°2002-887 du 3 mai 2002 pris pour l'application de l'article 23-1 de la loi n°95-73 du 21 janvier 1995 et relatif à certains rassemblements festifs à caractère musical. JORF n°106 du 7 mai 2002. (NOR INTD0200114D)

¹⁵⁴ Organised, ventilated area, often with rugs and cushions, located at a distance from the speakers and lights to enable participants to relax

Preventing first-time injection

The contexts and circumstances surrounding first injections of psychoactive substances were examined in the "*Priminject*" survey (Guichard *et al.* in press) conducted from October 2010 to March 2011 by the INPES. The on-line questionnaire was filled by 456 IDUs. Then, for analysis, they were classified into subgroups according to the year of first injection (pre-1987, 1988-1995, 1996-2005 and post-2006). The mean age at first injection was 22 years old among respondents who had injected for the first time in a more recent period, versus 19 years old for respondents who had injected for the first time prior to 1987. The increase in age at first injection was related to a lengthening of the duration of reported drug use prior to first injection and to an experimentation with more diverse substances prior to first injection. More users claimed to have injected for the first time alone after 1996, but 70% of more recent IDUs stated having injected with the help or in the presence of another person. The number one injected substance was still heroin, but the proportion of other substances (especially cocaine and Subutex[®]) increased after 1996.

Given this context, the adaptation of the English "Break the cycle" programme provides an additional tool to the range of harm reduction strategies (Guichard 2012). The objective is to work on the attitudes of IDUs towards injection initiation, 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. A training and intervention manual is being created and is currently being tested.

Harm reduction awareness

The TREND scheme reveals that groups of drug users who make little or no use of urban CAARUD services have little knowledge of harm reduction measures. This is especially true for errant young people as well as "socially integrated" users, young people from working class neighbourhoods and younger drug users of the party scene (Cadet-Taïrou *et al.* 2010b).

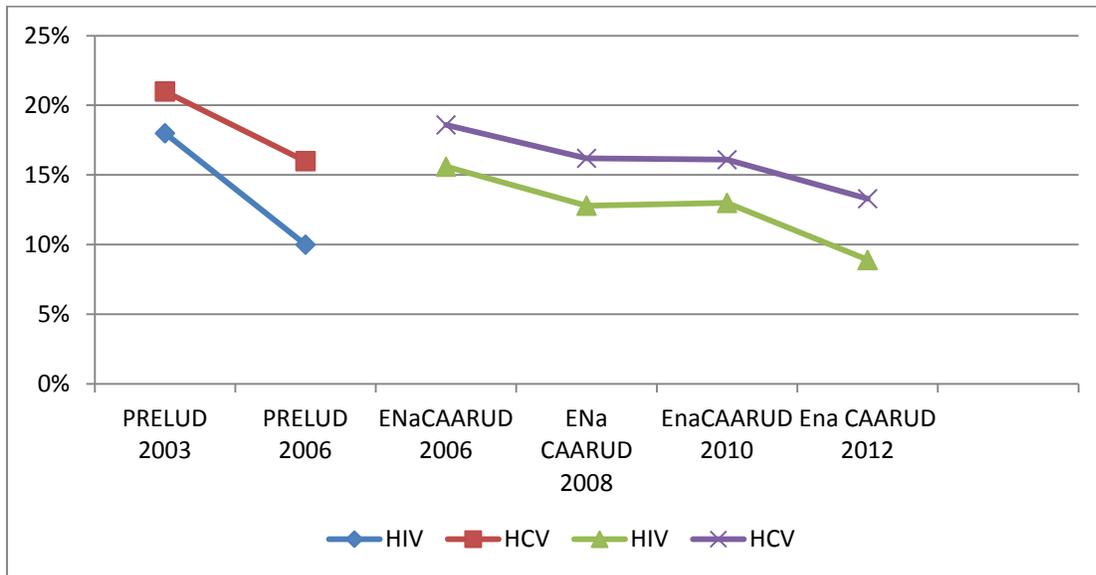
Activity and screening rates for drug users in France

In 2010, of the approximately 60,000 new drug user patient intakes seen, the CAARUDs organised almost 16,000 HBV, HCV or HIV infection screening tests and hepatitis B vaccinations.

Screening rates for drug users in France

The ENa-CAARUD survey showed that the vast majority of drug users frequenting low threshold structures in 2012 had already been screened for HIV and HCV infection (see chapter 6). Only 7.8% of those having already injected at least once in their life had never been screened for hepatitis C, compared to 5.7% for HIV (Saïd *et al.* in press).

Figure 7.1: Proportion of CAARUD clients who have never been screened for HIV or HCV



Sources: Première ligne 2003 (OFDT), PRELUD 2006 (OFDT), ENa-CAARUD (OFDT)

The proportion of CAARUD clients who have never been screened first declined, and then remained stable from 2008 to 2010, before declining once again in 2012 (Figure 7.1).

However, if risky behaviours are persistent, these screening tests rapidly become obsolete. In more than half of the people who had a negative result, the result was at least six months old (Table 7.4). This proportion has been on the decline since 2008 for HIV (59.0% to 51.5% from 2008 to 2012) and for HCV (56.9% to 53.0%).

Table 7.4: HIV and HCV infection screening tests of CAARUD clients, in 2012

	HIV		HCV	
	Population	%	Population	%
Had had the test	2,890	91.1%	2,862	86.7%
Had not had the test	256	8.9%	381	13.3%
Of those with a negative response*, date of last test				
Less than 6 months ago	1,069	48.4%	756	47.0%
6 months to one year ago	528	23.9%	389	24.2%
More than one year ago	610	27.6%	463	28.8%

Source: ENa-CAARUD 2012 (OFDT)

* Declarative results

The proportion of positive users aware of their serological status appeared to be the best indicator of the screening outcome, although this required serologies to be established, which France struggles to do regularly.

In 2004, the Coquelicot survey, conducted in 5 French cities, estimated that 2% of HIV-positive users were unaware of their serological status. The bio-PRELUUD survey conducted in 2006 on also 5 cities estimated this figure to be 5% (Cadet-Tairou *et al.* 2008; Jauffret-Roustide *et al.* 2006). For the HCV, these levels increased to 27% in the Coquelicot survey (2004) and to 8.5% in the BioPRELUUD survey (2006). The difference can be explained, firstly, by the significant difference between the cities. Secondly, Coquelicot measured blood serology and BioPRELUUD saliva serology. In the latter case, only patients whose viraemia was detectable were considered positive; therefore, cured patients were no longer positive. Third and finally, two years passed between these two studies (see chapter 6). In 2006, 36% of CAARUD clients stated that they did not know their hepatitis B status (vaccinated, unvaccinated, uninfected or infected). Finally, a study conducted from the “*pôles de référence pour l’hépatite C*” (hepatitis C reference poles) information system, which treat a portion of patients carrying the hepatitis C virus, made it possible to monitor the proportion of late screening tests conducted in newly treated patients (Brouard *et al.* 2009). A late screening test is defined as one performed in the year the patient started treatment, i.e., the patient is tested when he is at a stage of the disease that already requires treatment. This proportion fell between 2001 and 2007 from 42.7% to 33.4% of the total patient group (regardless of the source of the infection). The proportion of IDUs among these late-tested patients did not change significantly (for men, 39.6% in 2001 compared with 35.5% in 2007 and for women, 15.9% compared with 12.7%). It can be concluded that late screening is falling among drug users in the same way as in all other patients. The same applies to late screening in drug users who exclusively snort.

An evaluation of hepatitis B self-reporting by drug users performed in 2012 in the ENa-CAARUD study revealed that users had poor knowledge of their status (see chapter 6).

Many CAARUD patients underwent Fibroscan^{®155} exams to assess the level of hepatic fibrosis and, if necessary, enable drug users to be referred for more extensive testing. TRODs (rapid diagnostic tests for referral) for HCV are being assessed and recommendations are expected to be issued soon by the French National Authority for Health (HAS). Due to their ease of implementation, the HCV TRODs will use capillary blood or saliva to screen for HCV infection among the most marginalised drug users, whose veins are often in poor shape.

Access to treatment

Data obtained in 2012 from CAARUD clients show that the majority of users who were aware of being HIV-infected were being followed up medically, since 85.8% had had at least one medical consultation for their infection during the year. Only 73.2% were prescribed treatment for the infection. No statistically significant changes can be seen given the small cohort involved.

The same survey showed that two-thirds (64.2%) of people interviewed who had said that they had tested positive for hepatitis C had had at least one medical consultation for their infection in the 12 months before the survey. Slightly over one third (36.2%) were or had been prescribed treatment for this infection (see chapter 6).

¹⁵⁵ A non-invasive machine that can instantly detect liver fibrosis and assess its degree of advancement.

7.4. Responses to other health-related consequences among drug users

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

Of the drug users seen at CAARUD centres in 2012, only 5.6% had no medical coverage. More than half (59.2%) had CMU or AME medical coverage and 11.5% had all their costs paid due to a "Long duration" disease (ALD) (Saïd *et al.* in press).

The provision of treatment and access to care ¹⁵⁶ together represented the fourth leading activity of CAARUDs in 2010 after social-integration, harm reduction and hygiene promotion activities (Dambélé in press).

¹⁵⁶ In CAARUDs, the most frequently-provided treatments are nursing care, general medical care, psychological/psychiatric treatment, OST treatment, HBV/HCV/AIDS treatment and dental care.

8. Social correlates and social reintegration

8.1. Introduction

Drug users often encounter difficulties in social integration, professional rehabilitation and relationships. All these problems (unemployment, housing problems, social isolation and criminality) can be grouped together under the term “social harm”. These problems are often analysed as being the consequence of using psychoactive substances. The relationship between social harm and psychoactive drug use is, however, far from one-sided, and social difficulties can create a situation conducive to the development and continuation of drug use. It is also important to be wary of exaggerated viewpoints that link all drug use to social exclusion.

Social integration problems for drug users are described based on the results of surveys carried out among drug users visiting National treatment and prevention centres for addiction (CSAPA) and Support centre for the reduction of drug-related harms (CAARUD).

In order to deal with problems of poverty and social exclusion, the French public authorities are introducing a large number of social policies that focus primarily on health issues, employment, training and housing, but these policies cannot be discussed in detail in this report. Drug users can benefit from these policies in the same way as the general population in France.

Active Solidarity Benefits (RSA)¹⁵⁷, which since 1 June 2009 replaces the Minimum Benefit Income (RMI), ensures minimum income for people without work and provides additional income for people who have very low wages. In 2012, approximately 2.1 million people were receiving RSA benefits.

In 2000, France also established Universal Medical Coverage (CMU) for anyone residing in France who does not have any other coverage, and CMU-C, a free complementary medical insurance coverage. State Medical Assistance (AME) was instituted at the same time. AME entitles illegal aliens residing in France to access to care (see chapter 1).

Thus, in theory, drug users can benefit from numerous programmes introduced for the general French population. In practice, the least socially integrated drug users often find themselves unable to assert their rights, and procedures become too complex for them. Thus, one of the missions of the CSAPAs and CAARUDs, the latter especially, is to help these people assert their rights. More generally, they issue information and perform social assessments, providing guidance to people and their families in addition to social and educational assistance, which includes access to social entitlements and help with integration and reintegration.

8.2. Social exclusion and drug use

The social situation of problem drug users in France is mainly reported through the specialised addiction information systems that glean information from the RECAP survey (see Appendix V-RECAP) of patients seen in CSAPAs as outpatients or residents and the ENa-CAARUD survey (see Appendix V-ENa-CAARUD) in CAARUDs.

¹⁵⁷ Loi n°2008-1249 du 1^{er} décembre 2008 généralisant le revenu de solidarité active et réformant les politiques d’insertion. JORF n°281 du 3 décembre 2008. (NOR PRMX0818589L)

Every year, the OFDT TREND scheme (see Appendix V-TREND) provides information on changes in substance use, types of substances in circulation, routes of administration, relevant populations and contexts. The social situations of users can be discussed within this framework, which also sheds light on specific populations (wandering young or street youths, migrants and women).

8.2.1. Social exclusion among drug users

Users seen in CSAPAs

The indicators available to describe the social situation of people counselled in CSAPAs in 2010 and 2011 are presented in Table 8.1. These indicators illustrate the significant portion of treated people who are in precarious situations. A distinction was made between persons being treated for cannabis use and those being treated for using “opioids, cocaine, alcohol and other drugs” given the marked difference in the characteristics of these two sub-groups (especially in terms of age and number of substances used).

Table 8.1 : Social instability of people treated in CSAPAs in 2010 and 2011

	2010		2011	
	Users of “opioids, cocaine, alcohol and other drugs”	Cannabis users	Users of “opioids, cocaine, alcohol and other drugs”	Cannabis users
Unstable housing ¹⁵⁸	19.6%	13.3%	19.0%	12.9%
Homeless	6.3%	2.1%	5.9%	1.5%
Unstable occupational status ¹⁵⁹	64.6%	50.2%	62.8%	48.6%
Unstable financial resources ¹⁶⁰	41.8%	24.9%	40.7%	24.9%
Educational level below senior high school/upper secondary schooling ¹⁶¹	22.7%	23%	22.7%	23%

Source: RECAP 2010 and 2011 (OFDT)

Interpretation: In 2011, the mean age of users of “opioids, cocaine, alcohol and other drugs” was 37.1, while it was 25.7 years for cannabis users.

Cannabis users have tended to be in stable situations, but the instability of “opioid, cocaine, alcohol and other drug” users seems to have declined since 2005. In 2005, 25.0% of users had unstable housing, 7.5% were homeless, 69.0% had an unstable occupational status and 43.7% had unstable income. This decrease could be only apparent, though, since over the same period, the mean user age increased along with the number of less unstable patients monitored for alcohol problems.

¹⁵⁸ Temporary or institutional residence and inmates

¹⁵⁹ Intermittent paid activities, unemployed persons and other non-workers.

¹⁶⁰ Unemployment benefits, social welfare (RSA, AAH) and other resources (including people without income)

¹⁶¹ Below *baccalauréat* level (roughly equivalent to British 'A' levels) and equivalent, CAP-BEP and equivalent. The unemployment rate in France is inversely proportional to the level of education achieved, which may be used as an indicator of the level of professional qualification, although it does not consider improvements in professional qualification through continuing education and occupational experience.

Users seen in CAARUDs

Drug users counselled in CAARUD low-threshold structures are even more vulnerable. These people are usually not undergoing active treatment or have withdrawn from the care system. Unconditional counselling is fundamental to the work of these structures. In addition to their mission of counselling patients, CAARUDs develop a number of “services” to reach out to the most marginalised drug user populations and those furthest away from health and social services. These services include outreach workers, mobile units, visiting squats and prisons and interventions on the party scene (night clubs, concerts, teknivals).

A "socioeconomic instability" variable¹⁶² was designed to categorise individuals based on their degree of precariousness: low, moderate or high. This classification has been adapted to the population seen in CAARUDs, since this population is in an extremely precarious situation compared with the general population.

Three-quarters (76.2%) of CAARUD clients lived in a situation of moderate to high instability in 2012. After an observed decrease from 2008 to 2010, precariousness once again increased among users surveyed in 2012: the proportion of people in highly unstable situations increased while that of low unstable people decreased (Table 8.2). The lower response rate to the 2010 survey raised the question of whether the selection of users that year was that of people with less precariousness issues. In 2012, the response rate increased, which reduced the possibility of the aforementioned bias occurring. Given the qualitative data available, several phenomena seem to be in play: an increase in the instability of fragile users on the one hand and the extension of CAARUD new patient intakes to socially integrated users (i.e., those with stable employment, usually in the construction, hotel or restaurant industry) on the other hand (Dambélé in press).

Table 8.2 : Instability of CAARUD clients from 2008 to 2012

	2008	2010	2012
Low instability	20.0%	25.7%	23.8%
Moderate instability	47.3%	46.5%	43.0%
High instability	32.6%	27.8%	33.2%

Source: ENa-CAARUD 2008, 2010 and 2012 (OFDT, DGS)

Interpretation: 27.8% of users presented with high instability in 2010 versus 33.2% in 2012.

Under-25s have the highest rate of high instability: 49.1% versus 35.1% of 25-to-34- year-olds and 28.7% of over 35s. The proportion of highly unstable users increased about five points from 2010 to 2012, regardless of the age group. However, the increase varied with geographic location: it was 11 points in Greater Paris versus slightly over 3 points in the rest of the country.

¹⁶² The classification is based on calculating a score (from 0 to 6) obtained by adding the scores of the responses of the following three variables: a) Health coverage: 1- affiliated to a social security scheme with complementary coverage 2- affiliated to a social security scheme (including people with CMU) without complementary coverage 3- no medical coverage or people with AME coverage b) Housing: 1- long-term (independent or long-term with relatives), 2- in an institution or lodging temporarily with relatives, 3- homeless or squatting c) Origin of income: 1- employment income or unemployment benefits, 2- social welfare or funds from third parties, 3- other income (illegal or unofficial) or no income. Score of 0 to 2: low instability; 3-4: moderate instability; 5-6: high instability.

Subsequently, Paris stands apart because it has more high instability than the rest of France (48.3% vs. 27.2%) despite having a smaller proportion of young users.

The vast majority (87%) of users counselled in CAARUDs in 2012 had social security cover. This situation reflects the strength of the French health system, even for the most underprivileged members of the population. More than half of CAARUD clients had national health coverage through the CMU scheme (63.8% in 2012). Nearly one out of eight (13.2%) had 100% medical coverage¹⁶³ due to a long-term illness (ALD). A bit over one third of users (34.6%) had complementary health coverage. For both cases, the numbers had more than doubled compared with 2008 figures (Table 8.3).

Table 8.3 : Social security and healthcare coverage of CAARUD clients from 2008 to 2012

	2008	2010	2012
Health insurance coverage	87.8%	85.3%	87%
With complementary medical coverage	14.4%	25.9%	34.6%
With CMU (Universal Medical Coverage)	50.2%	53.9%	63.8%
With ALD (Long Duration Disease) coverage	6.3%	14.0%	13.2%
No coverage	7.5%	10.8%	9.6%
Without AME (State Medical Assistance) coverage	4.6%	na	5.6%
With AME	2.9%	na	3.6%
Other or does not know	4.8%	3.9%	3.7%

Source: ENa-CAARUD 2008, 2010 and 2012 (OFDT, DGS)

Interpretation: Of users counselled in CAARUDs in 2012, 87% had social cover and 63.8% of all CAARUD clients had CMU.

na: not available

The source of income for CAARUD clients was characterised by an increase in the percentage receiving social welfare from 2008 to 2012 and by a decrease in employment income from 2010 to 2012 (Table 8.4). People under the age of 25 were far more likely to be without any official income (66.6% versus 25.9% for 25-34 year-olds and 19.1% for over-35s). In contrast, older users received more social welfare than the young users: 14.7% for under 25s compared with 58.1% for users 25-to-34-years-old and 64.5% for over 35s. The proportions of users without income increased in each age group: + 8.3 points in the under-25 set, + 6.4 points in the 25-34 set and + 4.8 points in over 35s.

¹⁶³ Only those healthcare expenditures related to the pathology in question are 100% covered.

Table 8.4 : Origin of income for CAARUD clients from 2008 to 2012

	2008	2010	2012
Work-related income	17.8%	22.0%	16.5%
Employment income (including retirement/disability pensions)	13.4%	13.6%	13%
Unemployment benefits	8.4%	9.5%	8.3%
Social welfare / Income from a third party	52.8%	56.0%	56.6%
RMI / RSA	35.2%	40.7%	42.7%
Disability living allowance (AAH)	13.9%	16.6%	16.1%
Other social benefits	2.6%	1.5%	3.5%
Funds from a third party	1.1%	1.7%	1.7%
Other resources (illegal or unofficial)	25.4%	22.0%	26.8%
Other resources (including illegal or unofficial*)	5.4%	8.2%	9.2%
No income (not even from begging)	20.0%	17.5%	18.1%

Source: ENa-CAARUD 2008, 2010 and 2012 (OFDT, DGS)

* Prostitution, dealing, theft and undeclared work are included in this category.

N.B. In 2010 and 2012, the total number of items within each category was greater than the weight of this category because two items were accepted. This was not the case in 2008. Conversely, the total of the percentages of the three main categories was equal to 100%; individuals belonging to two categories were selectively classified in the less unstable of the two.

Finally, in 2012, 46.8% of users seen in CAARUDs lived in temporary housing. The proportion of those living on the street and in squats was 15.2% and 11.9% respectively (Saïd *et al.* in press). There have not been any real changes since 2010. The housing issue remains a problematic one, especially in major cities, and Paris in particular: one quarter of users live "on the streets" in Greater Paris; 27.4% of users live in a squat in certain western regions of France (Aquitaine and Pays de Loire). Moreover, 5% of users live in an institution on a long-term basis and 10.8% live on a temporary basis¹⁶⁴. These data are similar to those of 2010.

8.2.2. Drug use among socially excluded groups

New user groups living in extremely vulnerable conditions have emerged in recent years. These include "street youths" and young men mainly from Eastern Bloc countries who started to use drugs before immigrating to France. In addition, the presence of women under the age of 25 in harm reduction facilities has required more involvement from drug workers because of the extreme practices and persistent high risk drug use of these women (Rahis *et al.* 2010).

"Street youths" (younger, marginalised individuals characterised by extreme social difficulties and health problems) tend to be polydrug users, and users of intravenously-administered opioids in particular. Nevertheless, in an attempt to move away from the typical image of problem drug

¹⁶⁴ The survey was conducted in the winter - a time period during which great efforts are made to provide temporary solutions to homeless people.

users, they tend to make use of harm reduction measures, although in an apparently more occasional manner directed towards meeting their immediate needs (showers, laundry) rather than treatment needs. Their precarious lifestyle and “resourcefulness” gives them an illusion of paradoxical, alternative integration.

“New migrants” are mainly from Central and Eastern Europe, Asia (and China in particular) and the African continent (North Africa and Sub-Saharan Africa) (Rahis *et al.* 2010). Whilst Paris brings together people of very diverse origins, other parts of France see mostly immigrants from former Soviet Bloc countries (Russia, Bulgaria, Georgia, Ukraine, Belarus, Romania, Moldavia and former Yugoslavia) (Rahis *et al.* 2010).

These populations live in very precarious conditions worsened by the illegal nature of their residence in France. They are mostly heroin and amphetamine IDUs who also misuse legal medications (particularly HDB). CAARUD workers are striving to make these populations aware of the risk of viral (HIV and hepatitis) infection transmission as a result of their living conditions and the disapproval of injection within the groups to which they belong. Major tension has been reported between these groups and the other more “historical” beneficiaries of harm reduction facilities.

8.3. Social reintegration

Social support for drug users in France is mainly provided by specialised structures, (CSAPA and CAARUD), through targeted projects and programmes or acting as relays towards the general healthcare system.

CAARUD annual activity reports (see Appendix V-ASA-CAARUD) provide information on the number and type of actions undertaken by these structures. Rehabilitation measures, such as access to entitlements, housing, training or employment, are developed. However, these only represent a small part of these structures' total activity, which is primarily centred on first line intervention (providing “shelter”, food and basic hygiene), harm reduction and nursing or general medical care. In 2010, only 15% of the activities of these structures pertained to providing access to administrative and social entitlements. Of these entitlement-related actions, 23.5% pertained to housing measures. Activities pertaining to job-seeking, job-keeping and training only represented 10% of all entitlement-related actions (Dambélé in press).

Apart from the CAARUD activity reports, there are no tools available to precisely trace the measures undertaken to address the various aspects of social integration for people receiving treatment. Furthermore, these activity reports only provide a short description of these kinds of actions and programmes.

8.3.1. Housing

The main alternatives available for drug users with housing problems are **social housing, emergency housing, integration housing** and **residential treatment**.

Social housing facilities in France are essentially comprised of "HLM" housing (low-rent social housing). In 2010, 10 million people lived in 4.5 million HLM homes. However, the waits to get such housing can be from several months to several years, depending on the region since the number of available housing units is far lower than demand. Whilst addicts receiving treatment are not subject to any demonstrable discrimination in terms of housing allocation, they too suffer from the effects of this shortage unless they fulfil certain conditions that give them priority status (they live in unhealthy housing, have serious health problems or have experienced domestic violence, for example).

Some structures (CSAPAs mainly) are developing services to facilitate access to individual housing:

- "sliding leases", in which the CSAPA initially rents housing belonging to private or public owners, and then legally sublets to the tenant. The structure signs the inventory of fixtures and the lease and pays rent to the owner. The housing allocation of the user in question is paid directly to the structure and the remaining rent (rent minus housing allocation) is paid for by the sublessee. After a probationary period, which may range from six months to a year, the lease "slides" over to the sublessee, who then becomes the official tenant of the premises.
- "educational" rental support: to help tenants optimise their budget and complete administrative tasks such as paying bills and purchasing furniture, etc.

There are no data on the frequency or volume of these programmes.

Specialised structures may make use of **emergency housing**, which accepts lodgers unconditionally (i.e., without discrimination), but only for a limited duration. The main structures and facilities that provide emergency social housing are:

- social housing centres (CHRS): one third of the 924 CHRS centres have an emergency section with 15 beds on average (Mainaud 2012);
- overnight hotel stays;
- night accommodation centres, sometimes in dormitories and sometimes more individual in nature;
- centres that operate throughout the day and offer housing either for very short periods (a few nights) or in a manner similar to CHRS centres (usually 6 months, renewable);
- accommodation centres intended exclusively for drug users. Three cities in mainland France (Paris, Lille and Marseille) in addition to Cayenne (French Guiana) have this type of structure.

Apart from the latter accommodation centres, emergency housing centres prefer admitting “stabilised” people who do not present any behavioural disorders. This may tend to exclude a number of drug users. Residents in all these structures are asked to comply with the various in-house rules and regulations (no alcohol or drug use and no physical or verbal abuse).

Integration housing is selective in terms of its residents and offers longer-term counselling and integration measures. A team of professionals is present at all times. The main social integration housing structures are:

- social housing centres (CHRS), whose aim is to enable the people admitted to become personally and socially independent. They provide accommodations, counselling (particularly in emergency situations), social assistance and support, and aid in adapting to working life as well as in social and occupational reintegration. The CHRS population can be varied. It includes people or families in serious difficulty (financial, family, health or integration difficulties) particularly because of a lack of housing or poor housing conditions, domestic violence, alcoholism and other drug addictions, or recent release from prison. The categories of people admitted may differ from one centre to the next. In 2008 in France, there were 41,000 CHRS beds and approximately 40,000 people were admitted for a mean duration of 7 months (Mainaud 2012).
- halfway houses: these are small social residences, each with 10 to 25 lodgings intended for extremely marginalised people. Halfway houses offer them independent housing without length-of-stay conditions, common areas and increased assistance with activities of daily living (health-, hygiene- and food-related activities). Their aim is to be fully integrated into the local environment.
- social residences: these offer a furnished transitional housing solution to households with limited income or with difficulties in accessing ordinary housing for financial or social reasons, and who may require social support.

Despite the major efforts made by specialised structures and the “general” social housing sector to offer solutions to people receiving treatment, various field workers have reported that people have significant access difficulties. To improve this situation, the 2008-2011 governmental action Plan against drugs and drug addiction aimed to promote partnerships and interaction between both types of structures: subsequently, 30 projects selected through a bidding process were funded.

Finally, several specialised **residential treatment facilities** dedicated specifically to people receiving treatment are available in France. All of these establishments are managed by CSAPAs:

- Addiction follow-up and rehabilitation centres (CSSRAs) receive usually after detoxification, addicted people who express a need to consolidate their abstinence in a protected environment. The length of stay varies from 1 to 3 months, and exits and visits are controlled.
- Residential treatment centres (CTRs), also called *postcure* centres in France, are treatment centres with community housing that admit any drug addict voluntarily undergoing a treatment process. CTRs can admit up to 20 people. The initial length of stay is approximately six months, and this period can be renewed. Some CTRs have long waiting times.

- Community treatment centres (CTCs), also called "therapeutic communities", are treatment centres with community housing. Therapeutic communities are similar to a structured, hierarchical, organised family unit. Each resident belongs to a group, and each group has a group leader. Each group is responsible for different tasks, such as cleaning, cooking, gardening and household maintenance. CTCs can admit up to 50 people.
- Follow-up therapeutic apartments housing (ATRs): these are individual or community apartments that are made available to former drug users who have begun a treatment process. The absence of permanent staff limits admission to these centres to people able to live on their own. Some apartments are available for couples and people with children.
- Temporary or emergency housing is offered to addicted or formerly addicted person who is between two periods of treatment or in a "transition period": before withdrawal; during stabilisation of withdrawal or substitution treatment; waiting for admission into a CSSRA or a CTR or stable housing. This period can be adjusted according to a person's health and social needs. During this short stay (1 to 4 weeks), the person is accommodated in an individual or community apartment, and sometimes in a hotel room.
- A foster family network is a group of professionally trained and organised families who volunteer to take in a person being treated for a period of time. Foster families offer a drug addict a personalised relationship in a family environment. The families are paid according to the actual time a person spends with them.

Despite this range of residential treatment programmes, the overall service offer is still inadequate according to the field professionals.

8.3.2. Education and training

People undergoing treatment in CSAPAs do not have any specific programmes or measures for training or for basic education available to them. Like the general population, and particularly those looking for work, they can however rely on public and private occupational training organisations.

An identical situation exists for vocational skills training. The relevant measures are incorporated into the employment policy, the main operator is the National agency for employment (*Pôle emploi*). Referrals and funding for training are part of its missions. There is no specific training dedicated to vulnerable populations. However, three priority populations have been identified: people who have been out of work for an extended period of time, young people and immigrants (and immigrant women in particular). The VAE (Validation of acquired experience) process and traditional vocational skills training are the two main measures used.

8.3.3. Employment

There are no particular administrative barriers (screening or discriminatory medical situations) in France to gaining access to employment on the “open job market” for people receiving treatment¹⁶⁵, although it may be assumed that employers are reluctant to employ such people. The high observed rate of unemployment should be considered within the context of minimal training, an often chaotic career path and a very strained job market (over 10% unemployment on a national level in France in 2013).

Moreover, in France, there is an "intermediary job market" that covers various measures targeting young people and adults encountering difficulties in entering the job market or needing special social support. These channels include measures to help reintegrate people through work (Integration through economic activity, IAE) and “assisted contracts” (reducing the wage bill for the employer). In 2013, the French government announced the creation of 470,000 such assisted contracts in 2013.

Some specialised structures have developed their own occupational integration schemes or promote reorientation pathways and cooperation¹⁶⁶ given the difficulties encountered in assisting their "beneficiaries" in finding employment (Maguet *et al.* 2009). In 2011, a non-exhaustive inventory of these measures was conducted as part of the "*Pratiques en réseaux et insertion par l'emploi d'usagers de drogues*"¹⁶⁷ project. The report published on this work (Calderon *et al.* 2011) detailed some of these occupational integration initiatives and formulated recommendations (Dambélé 2012).

¹⁶⁵ However, for certain public servant jobs or "sensitive" positions (security jobs, jobs working with young children) employers may require a candidate to prove that they do not have a criminal record.

¹⁶⁶ Professional activities should be dissociated from integration/employment-seeking activities, but offer an initial experience that can lead to traditional employment.

¹⁶⁷ The purpose of this project, which was launched in 2009 and incorporated four other European countries (Portugal, Italy, Greece and Lithuania) was to create a network of French and European schemes to enable the sharing of professional practices and public policies and promote the occupational rehabilitation of drug users.

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

9.1. Introduction

Definitions

According to French law, anyone who uses and/or possesses substances classified as narcotics runs the risk of imprisonment (with or without a suspended sentence) and a fine. Ever since the criminality prevention act of 5 March 2007¹⁶⁸, persons arrested for possessing and using narcotics may be sentenced to undergo “awareness-building training courses on the dangers of narcotics use”. This new measure is therefore part of a wide range of penal responses available to sanction narcotics use. Inspired by road awareness-building training course, this monetary sanction (because it must be paid by the offender) is educational and aimed at occasional, non-addicted narcotics users in an attempt to dissuade them from reverting to drug use by making them aware of the consequences of their use. Simple drug users may therefore face arrest and possible conviction, which may lead to imprisonment (see chapter 1).

According to penal procedure, all arrests must be referred to the Public Prosecutor, who then has the option of closing the case, ordering an alternative to prosecution (such as a warning or drug treatment and testing order) or to begin legal proceedings. In the latter case, the offender who has been arrested is seen by a judge, who may hand down a sentence: a fine, an alternative to imprisonment or imprisonment (with or without a suspended sentence). The significant increase in arrests for narcotics use in France has been accompanied by the handing down of more systematic penal sanctions, since the courts have been tending towards alternatives to prosecution.

As of 1 January 2012, France had 191 prison establishments with a total operational capacity of 57,236. These establishments include:

- 99 remand centres and 42 remand wings (located in penal institutions) holding pre-trial detainees (remand inmates), inmates with less than 1 year of their sentence left and newly convicted inmates awaiting transfer to another prison setting (detention centre or high security prison)
- 85 prisons for convicted inmates (with several wings), i.e.:
- 43 penitentiaries including at least two wings for inmates of a different detention status (remand centre, detention centre and/or high security)
- 25 detention centres and 37 detention centre wings holding those convicted adults with the best prospects for social reintegration. Their detention programme is chiefly aimed at "re-socialising" inmates;
- 6 high security prisons and 6 high security wings
- 11 semi-custodial centres and 7 semi-custodial wings housing convicted offenders who have been referred there by a judge responsible for the execution of sentences with an

¹⁶⁸ Loi n°2007-297 du 5 mars 2007 relative à la prévention de la délinquance. JORF n°56 du 7 mars 2007. (INTX0600091L)

outside placement without monitoring or an open prison regime, and 6 resettlement prison wings, which are located in penitentiaries

- 6 prison settings for minors, which are provided for in the French law of September 2002 on the orientation and programming of the justice system¹⁶⁹. The first of these was opened in mid-2008.
- 50 outsourced centres out of 191.

Data collection tools

Police statistics on drug-related offences from the police or court system have the advantage of being regular, sufficiently historical and easily accessible. However, these data may be subject to breaks in the statistical series when there is an organisational change within ministries responsible for following the annual indicators. For example, in the last two years, the OCRTIS (Ministry of the interior) has not been able to collect data from the *gendarmerie*: in 2011 and 2012, the OCRTIS figures have therefore only included data from the police service, meaning that a large part of arrests, particularly those in rural areas (which are under the jurisdictions of *gendarmeries* in France), were ignored. Likewise, within the Ministry of Justice, the overhaul of the penal procedure information system (known as Cassiopée), which started in 2013 and should enable cases handled in all jurisdictions to be monitored according to common indicators, led to an interruption in the flow of data from the "*Nouvelle chaîne pénale*" information centre. Moreover, these data do not provide a complete overview of the manner in which offences are handled from arrest through to conviction and sentence enforcement. There are several reasons for this.

The first is related to different classification systems: Arrests for drug-related offences are classified into one of two major categories: simple use and dealing (which is further broken down into use-dealing, local trafficking and international trafficking). These data have been available since 1971. The sentences recorded by the French National Criminal Record (CJN in French, see Appendix V-CJN), which has been computerised since 1984, contain details of court orders handed down against persons brought before the courts for drug-related offences. Consequently, we have access to a homogeneous statistical processing system that enables us to monitor changes in these sentences, both in terms of volume and structure, from 1984 to 2010. As changes in the narcotics legislation during this period were limited, this offers a satisfactory degree of comparability to analyse changes in sentences issued by the courts during this period.

The second reason is related to the difficulty in isolating the type of penal response to each type of drug-related offence. A conviction can cover several offences but convictions are usually listed based on the main offence. The statistical categories used are as follows: the illegal use of narcotics, aiding and abetting a narcotics user, possession/acquisition, manufacturing/use/transport, dealing and selling, importing/exporting and other drug-related offences.

¹⁶⁹ Loi n°2002-1138 du 9 septembre 2002 d'orientation et de programmation pour la justice. JORF du 10 septembre 2002. (NOR JUSX0200117L)

- Until 2003, it was the statistical processing of the data contained in the National Register of Prisoners (FND in French) that made it possible to analyse prison population flows and to track inmates (whether incarcerated for drug-related offences or other offences).
- Since 2003, the FND has been receiving data from the GIDE (computerised inmate management application). All offences resulting in a conviction are now recorded (whereas previously, only the main offence had been recorded). However, the current version of the FND database does not tell us the ranking of the offence (i.e., whether it is the main offence or a subsidiary offence), and consequently does not make it possible to identify those cases for which a drug-related offence was the main reason for incarceration. This limitation is particularly acute for narcotics use as these cases are often accompanied by more serious offences possibly constituting grounds for incarceration.

Over and above these regular activity indicators, the French framework for the production of knowledge on drug-related crimes also includes data specifically collected in the prison setting:

- Institutional surveys: initiated, designed and deployed by the governing authorities (e.g., the Ministry of Health or the Ministry of Justice), the results are published by these authorities. They often comprise follow-up analyses of existing data (e.g., health forms for newly inmates, the number of substitution treatments prescribed in prison, data derived from prison CSAPA activity reports). The samples involved are large and seek to be as representative as possible of the prison population. The frequency of the surveys is irregular, as is the survey on the health of new inmates (see Appendix V- Prison Entrants Health Survey). Of the surveys carried out by the various ministry research departments, we should mention the DREES (French Directorate for Research, Studies, Assessment and Statistics of the Ministry of Health) surveys conducted in 1997 (Ministry of Employment, Labour and Social Cohesion) and 2003 (Ministry of Solidarity, Health and the Family). These surveys provide data for analysing the profile of new inmates (use of psychoactive substances, substitution treatments, risk factors and observed pathologies). This data is recorded during the initial medical examination when inmates arrive at a penitentiary remand centre or remand wing.

Similarly, the data supplied by the DGS-DHOS survey between 1999 and 2004 on substitution treatments in prison environments enables us to track changes in the number of treatments (ongoing or new treatments) and the type of treatment (methadone, Subutex®) during this period. The surveys carried out by the DHOS (French Directorate for Hospitalisation and Organisation of Care) "on a given day" among detainees known by prison medical teams to be infected by HIV or hepatitis C (from 23-27 June 2003, for example) describe the profile of known HIV- and HCV-positive patients seen by the prison-based hospital healthcare units (UCSAs) operating in prison establishments. These "substitution" and "HIV-HCV" surveys, previously conducted by the Ministry of Health have been grouped together within the PREVACAR (*PREVA*lences en milieu *CAR*céral – prevalence in prison settings) survey (see Appendix V-PREVACAR), now jointly designed and implemented by the National Health Directorate or DGS (sponsor) and the National Institute for Public Health Surveillance or InVS (scientific co-ordination).

- Epidemiological surveys: often backed by research institutes (for example, the INSERM (Lukasiewicz *et al.* 2007; Vernay-Vaisse *et al.* 1997; Rotily *et al.* 1997) or the InVS (Jauffret-Roustide *et al.* 2006)), these are local or national and are also based on pre-existing data.
- Qualitative sociological research and studies: based on qualitative interviews with small samples, these surveys seek to describe user profiles and their drug addiction and incarceration histories. These data are collected outside the period of incarceration.
- Studies conducted on the practices of treatment professionals working in prison settings: quantitative or qualitative studies, such as the PRI2DE survey (research and intervention programme to prevent infection among inmates) conducted by the French National AIDS and Viral Hepatitis Research Agency (ANRS) (Michel *et al.* 2011b). They allow the viewpoints and experience of professionals to be known.
- Official reports: motivated by legal or regulatory changes, by current political issues or by an official appraisal or inspection role, their purpose is to put forward recommendations based on observations and assessments documenting the subject.
- NGO publications: in terms of content, they are similar to official reports (observations and recommendations) but they have a more flexible format. More rarely, they may be based on a collection of data (OIP (Observatoire International des Prisons) 2005).

To these sources should be added a number of more general documents concerning prisons, mainly sociological or demographic works that elucidate the general context of the prison environment. Additionally, we should mention the use of various articles and documents that are often summaries of other works.

Background information

Criminality and drug use

The numerous surveys conducted on the relationship between criminality and drug use have shown that drug users are more frequently responsible for offences, the number of which tend to increase as the frequency of psychotropic substance use increases.

The link observed between drug use in young people and problem behaviour (e.g., "acquisitive" criminality, absenteeism and expulsion from school, involvement in fights or acts of vandalism) has also been established (Barré *et al.* 2001).

In France, the survey carried out since 1998 at the request of the Ministry of Justice and involving youngsters aged 14 to 21 going through the juvenile court system (Judicial youth protection service or PJJ in French) has revealed high prevalence levels as follows: 60% of these youngsters had already used cannabis (Choquet *et al.* 1998).

However, a distinction should be made between drug-related offences in the strictest sense of the word, crimes and offences indirectly attributable to the abuse of psychoactive substances and all other lifestyle factors common to these types of deviant behaviour characterised by substance abuse and criminality.

- The first of these three categories, and the easiest to understand, includes all crimes and offences directly related to drugs, such as the use, possession, trafficking or manufacturing of illegal substances, all of which represent drug-related offences. To this, we can add cases involving driving, accidents and violence under the influence of narcotics.
- The second group of offences indirectly attributable to the use of psychoactive substances includes acts of criminality when these are associated in one form or another with the use of psychoactive substances without this use constituting an aspect of their definition (so-called "acquisitive" criminality carried out in order to obtain the money needed to buy drugs).
- The third and final category (and the category most likely to highlight the complex relationship between drugs and criminality): addictive and delinquent behaviour can be seen as two joint aspects of a deviant form of socialisation and lifestyle (Joubert *et al.* 1995). From this virtually ethnological viewpoint, the use of psychoactive substances should be seen as one of several factors contributing to the risky behaviour pursued by the individuals in question. Most of the epidemiological and sociological research in France tends to favour this approach.

Drug use in prison

With 14,725 prison sentences, some partially suspended, in 2011, drug-related offences led to nearly 12.3% of sentences involving imprisonment. Imprisonment represents 30% of drug-related offence sentences. This does not necessarily mean that those being incarcerated use drugs (sometimes they are incarcerated for possession or trafficking). Furthermore, people imprisoned for non drug-related offences may be drug users. Therefore, it is difficult to precisely determine the proportion of inmates who use drugs. According to the report issued by the French Senate survey committee and published in 2000, almost 40,000 of the 68,765 (58%) people incarcerated in 2000 were regular or occasional drug users, and they were incarcerated either as a result of direct involvement in narcotics trafficking or because of an offence related to drug use or acquisition (e.g., theft) (Hyst *et al.* 2000).

In France, epidemiological data relating to drug use in prison were relatively old: the last survey on the prevalence of drug use in prison among "new offenders" was carried out by the DREES in 2003. Moreover, the proportion of injecting drug users (IDU) with a history of incarceration was estimated at 43% or 61%, depending on the survey. According to the RECAP survey conducted in 2011 (see Appendix V-RECAP), 43% of drug users seen in a CSAPA for a problem involving the use of an illegal drug other than cannabis had already been incarcerated; three out of every five had even been incarcerated several times. The 2004 Coquelicot survey (see Appendix V-Coquelicot) revealed that 61% of drug users who had snorted or injected drugs at least once in their lives had already been imprisoned (Jauffret-Roustide *et al.*). Of the users seen in low-threshold structures (CAARUDs) in 2012, 14.2% had been incarcerated in the last year (Saïd *et al.* in press). Polydrug use was also established, since in 2003, one quarter of "new offenders" admitted to using at least two psychoactive substances (Mouquet 2005).

The existing studies show that all substances smoked, snorted, injected or swallowed prior to incarceration continue to be used (albeit in reduced proportions) during incarceration (Rotily 2000). Furthermore, the use of more easily accessible substances (such as medicines) tended to develop in prison environments. Generally speaking, there is an observed relative transfer of use from rarer illegal drugs to medications (Stankoff *et al.* 2000).

This use of narcotics, whether initiated or continued in prison, can seriously affect the health of the individuals concerned, by causing serious abscesses, accidents when combining medicines and other substances, severe and longer cravings, and the onset or worsening of psychological or psychiatric disorders (Obradovic *et al.* 2011). Moreover, detainees constitute a population group with numerous, cumulative risk factors considering the health and social consequences of drug use. The low levels of access to care for this population group, and more fundamentally, the unstable and marginal situations often faced before incarceration (including a lack of stable housing or social security coverage) all contribute to explaining the prevalence of "at risk" use behaviour among new inmates.

The prevalence of injection therefore appears to be higher among this unstable population group, although the number of injecting drug users seems to be declining: 6.2% of the newly sentenced inmates reported use of intravenous drugs during the year preceding their incarceration in 1997 (Mouquet *et al.* 1999); in 2003, only 2.6% of them reported injection (Mouquet 2005). According to studies, between 60 and 80% of inmates stop injecting during their incarceration (Stankoff *et al.* 2000). The 20 to 40% who carry on injecting tend to reduce the frequency of their injections but increase the quantities injected. They also tend to be more often affected by HIV and/or HCV, with a high risk of contamination from shared equipment, unprotected sex and tattooing (Rotily *et al.* 1998). People who have already been incarcerated at least once have a prevalence of hepatitis C that is nearly 10 times higher than that of the general population (7.1% versus 0.8%), as shown by the data of the Coquelicot survey (2004).

Inmates appear to have greater rates of infectious disease than the general population (DGS 2011; DHOS 2004; Sanchez 2006): in 2011, the HIV prevalence was 2% and HCV prevalence was 4.8%. As in the general population, however, the prevalence of HIV declined in prison while that of hepatitis C sharply increased.

The proportion of people receiving opioid substitution treatment (OST) was 7% to 9%, depending on the survey. Based on the more recent PREVACAR (Chemlal *et al.* 2012) and PRI2DE (Michel *et al.* 2011b) surveys 8% to 9% of detainees receive OST. According to the oldest DREES study, on arrival to prison, approximately 7% of newly incarcerated inmates stated they were taking an OST, e.g. Subutex® in 8 out of 10 cases (approximately 85% of the total OST-taking population) (Mouquet 2005). During incarceration this figure tends to decrease because in a certain number of establishments the treatments are not continued despite the stipulations of the 18 January 1994 law¹⁷⁰ (which introduced an obligation to treat incarcerated patients in the same way as non-incarcerated patients). The level of interrupted courses of treatment fell sharply between 1998 and 2004, but nevertheless concerned more than one out of 10 treatments (DHOS 2004). A survey conducted by the OFDT showed that access to methadone rose in prison settings: among opioid-dependent inmates, 35% were treated with methadone-based opioid substitution treatment in 2006 (Obradovic *et al.* 2008b; Obradovic *et al.* 2008a) compared with 22% in 2004 (DHOS 2004). A third of establishments today have more than 50% of their patients undergoing methadone substitution (although there are major disparities). The mean initial prescription levels in prison settings are now similar to the levels seen outside of prisons (i.e. in hospitals), which is between 23 (minimum) and 76 (maximum) mg per day. The OFDT has also established that initial methadone prescriptions by UCSAs (now

¹⁷⁰ Loi n°94-43 du 18 janvier 1994 relative à la santé publique et à la protection sociale. JORF n°15 du 19 janvier 1994. (NOR SPSX9300136L)

known as healthcare units operating in prisons) was also up (28% vs. 72% of ongoing methadone treatments for inmates (Obradovic *et al.* 2008b).

Since the law of 18 January 1994, which transferred the responsibility for health in prisons from the Ministry of Justice to the Ministry of Health - with the creation of prison-based hospital healthcare units (UCSAs) which are link to local hospitals and intervene in all prison settings - the treatment of addiction in prison settings is now based on a three-tiered system: UCSAs, which are responsible for monitoring the physical health of inmates, Regional Medico-Psychological Hospital Services (SMPRs) established in each of the 26 French regions handle the mental health aspects of drug addicts in establishments where no local units exist, and finally, since 1987, “local addiction units” have been established in the 16 largest establishments in France (and cover approximately a quarter of the incarcerated population). This general scheme is also accompanied by another, set up on an experimental basis: UPSs, or care units for prison leavers, exist in 7 establishments.

At the same time, the legal framework of the prison harm reduction scheme also offers various possibilities for providing access to care for drug addicted inmates (circular of 5 December 1996¹⁷¹):

- Screening for HIV and hepatitis is theoretically offered upon arrival (CDAG - Anonymous Free Screening Centre) but is not systematic for hepatitis C. (POPHEC - First hepatitis C prison's observatory - data)
- Prophylactic measures (hygiene measures and the provision of post-exposure treatments for both staff and inmates)
- The availability of condoms with lubricant (theoretically accessible via UCSAs)
- Access to OSTs and the availability of bleach to disinfect equipment in contact with blood (injection, tattooing and body piercing equipment).

France does not offer syringe exchange programmes in prisons. This was considered a “premature” initiative by the Health-Justice mission of 2000 before becoming the subject of new recommendations within the scope of the INSERM collective expert evaluation conducted in 2010 (INSERM 2010). There was also no specific programme in prisons to provide information on how contamination occurs through injection practices.

¹⁷¹ Circulaire DGS/DH/DAP n°96-739 du 5 décembre 1996 relative à la lutte contre l'infection par le virus de l'immunodéficience humaine (VIH) en milieu pénitentiaire : prévention, dépistage, prise en charge sanitaire, préparation à la sortie et formation des personnels. BO Justice n°96/52, Tome II du 25 janvier 1997. (NOR TASP9630649C)

9.2. Drug-related crime

9.3. Drug law offences (ST 11 2013)

Arrests for drug-related offences

According to the most recent figures available from the OCRTIS, in 2010, there were 157,341 arrests for drug-related offences recorded by the police services, *gendarmerie* and customs (see ST11 2013), and of these, 135,447 arrests (86% of drug-related offences) were for simple use. Arrests for narcotics use increased 60-fold in the span of 40 years. In the last two decades, they increased five-fold (Table 9.1). The number of arrests for drug use increased twice as fast as for trafficking or use-dealing (Obradovic 2012b).

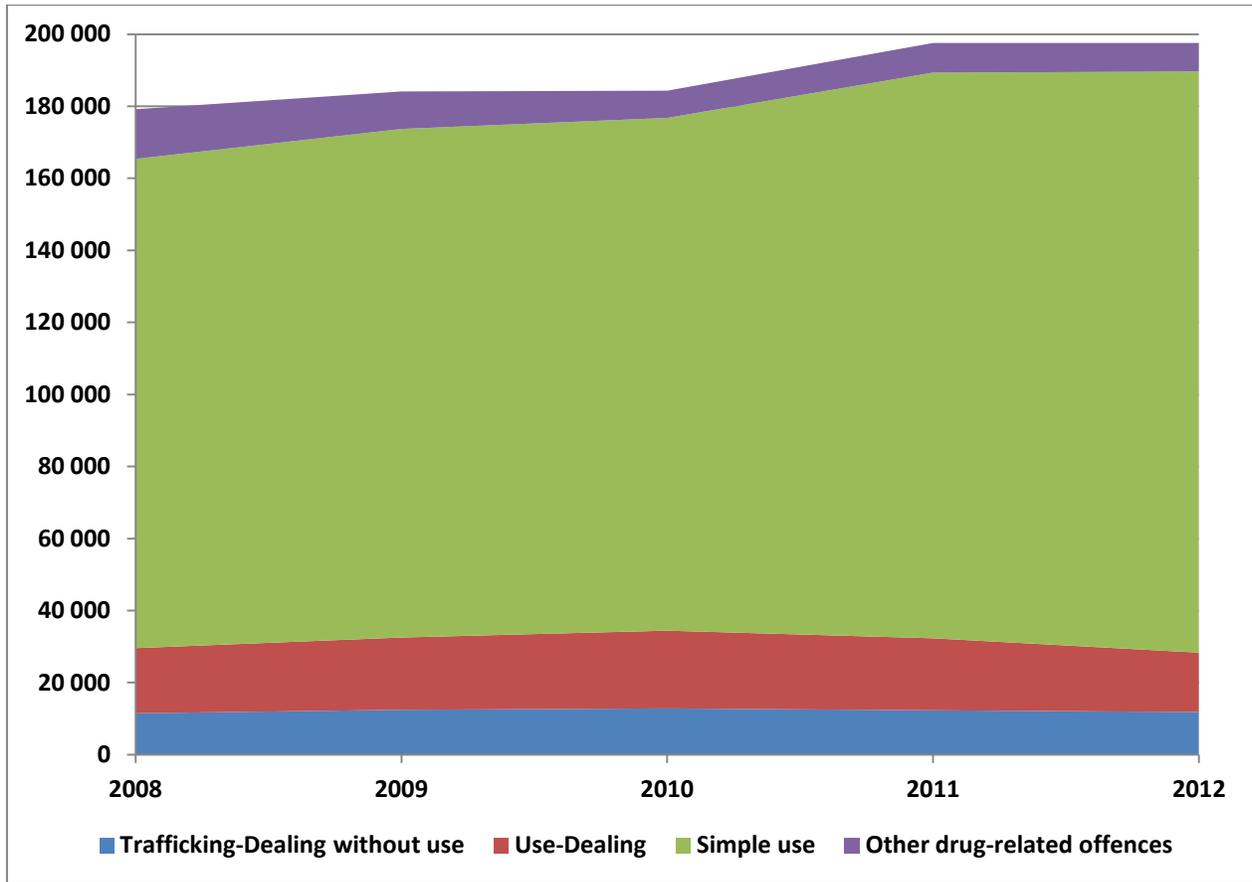
Reasons for arrests

Simple use is by far the number one reason for drug-related offence arrests. In 2012, the number of people accused by police services for simple use was five to six times higher than for all other drug-related offences (119,185 versus 21,017 for use-dealing, trafficking-dealing without use and other drug-related offences).

For the last 40 years, the proportion of use in drug-related offences increased steadily, from 75% right after the 1970 French law on narcotics¹⁷² to 86% today (Obradovic 2012b) and is continuing its rise (Figure 9.1).

¹⁷² Loi n°70-1320 du 31 décembre 1970 relative aux mesures sanitaires de lutte contre la toxicomanie et à la répression du trafic et de l'usage illicite des substances vénéneuses. JORF du 3 janvier 1971

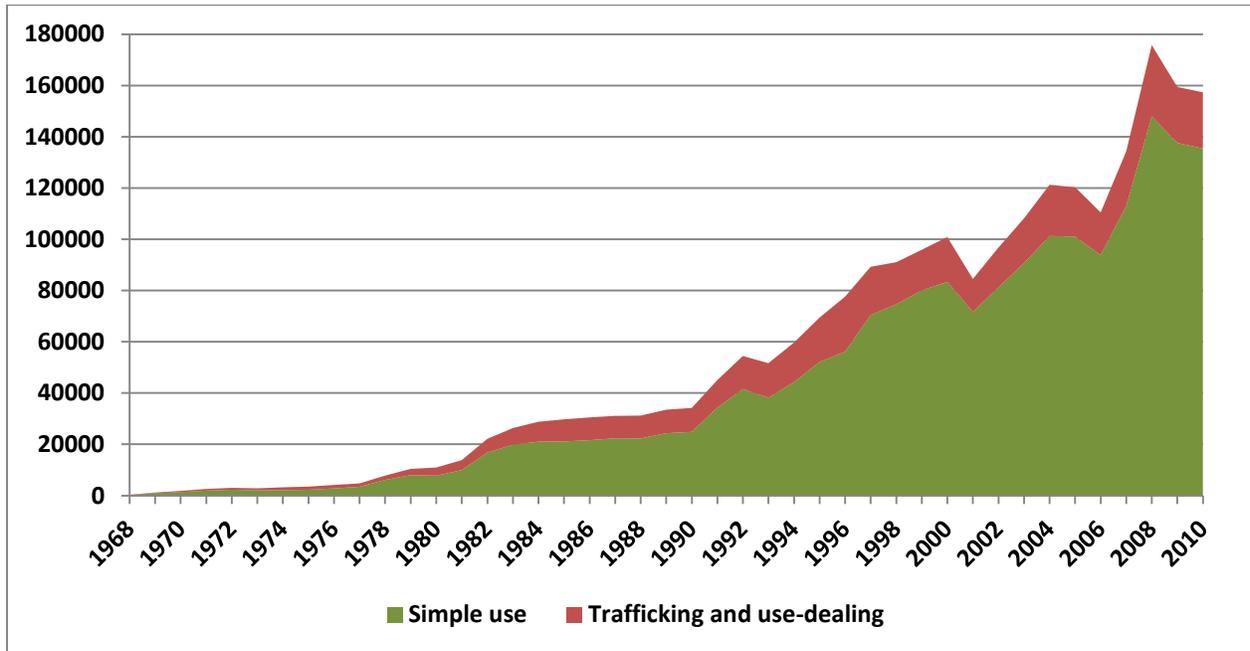
Figure 9.1: Change in the number of people accused by law enforcement services of committing drug-related offences, by type of offence, from 2008 to 2012



Source: État 4001 (SDRES/DEP – Ministry of the Interior)

There was a corresponding decline in the proportion of arrests made for use-dealing and trafficking. For a long time (from 1976 to 1996 notably), the number of arrests for use-dealing and trafficking increased yearly and represented one quarter and one third of drug-related offences respectively (Figure 9.2). Since the late 90s, the proportion of arrests for use-dealing and trafficking dropped below 20% and has been dropping one point every two to three years on average.

Figure 9.2: Change in the number of arrests for simple use and for trafficking and use-dealing from 1968 to 2010



Source: OSIRIS (OCRTIS) – see Appendix V-OSIRIS

Substances involved in drug-related offences

More than nine out of every 10 arrests for use are of users of cannabis, which is the number one substance involved in use arrests (Table 9.1). The preponderance of cannabis arrests has strengthened over time: in the early 1990s, cannabis was involved in seven use arrests out of every 10.

Way behind cannabis, heroin and cocaine are the main substances involved in drug-related arrests (accounting for 5.4% and 3.5% of usage-related arrests respectively). Cocaine's has become increasingly involved in use arrests in the last 20 years.

Table 9.1: Arrests for narcotics use and changes per substance from 1990 to 2010

	Number of arrests		Breakdown per substance		Change from 1990 to 2010
	1990	2010	1990	2010	
Cannabis	17,736	122,439	71.4%	90.4%	+ 590.3%
Heroin, Opioids	6,522	7,287	26.2%	5.4%	+ 11.7%
Cocaine/Crack	388	4,679	1.6%	3.5%	+ 1,105.9%
Amphetamines	49	290	0.2%	0.2%	+ 491.8%
Ecstasy	24	203	0.1%	0.1%	+ 745.8%
LSD	60	59	0.2%	0.0%	-1.7%
Other	77	114	0.3%	0.1%	+ 48.1%
Total	24,856	135,447	100.0%	100.0%	+ 449%

Source: OSIRIS (OCRTIS)

Data from the Ministry of Justice: convictions

The sentences handed down for drug-related offences (as the main or ancillary offence) represented 9% of all convictions for an offence, or 50,092 convictions. These offences are broken down as follows: use (29,202 or 58%), possession-acquisition (10,173 or 20%), commerce-transport (7,045 or 14%), import-export (1,449 or 3%), dealing and selling (2,107 or 4%), aiding and abetting, which may comprise incitement to use and facilitate use (27 cases) and other (89 cases). Prison sentences, some partially suspended, are handed down in 30% of the convictions for illegal drug use.

An examination of the figures issued by the Ministry of the Interior and Ministry of Justice reveals that the ratio of convicted users to arrested users has decreased from 30% in 1990 to 21% in 2010, indicating that prosecution of drug users is becoming less systematic. However, the criminalisation of narcotics use has not disappeared, it has been transformed (Obradovic 2012b). It has greatly diversified, and today is at a never-before-reached level due to the more systematic use of alternatives to prosecution by the courts. The penal response rate to drug use offences rose from 70% at the beginning of the last decade to 90%. There are two different types of penal response to drug-related offences: alternatives to prosecution (i.e., in three quarters of the cases) and legal proceedings that may end in a conviction by a judge (one quarter of the cases).

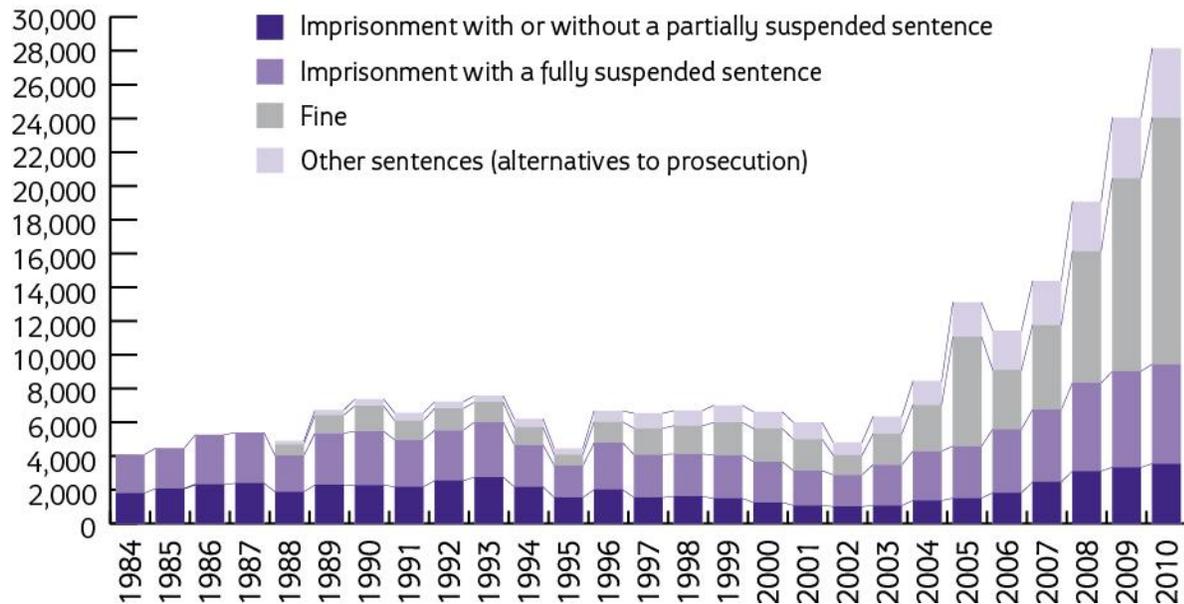
Resorting to alternative measures is encouraged by political circulars as well as by lawmakers to intensify penal responses without increasing the number of prosecutions and backing up the courts. For example, since 5 March 2007, occasional illegal drug users can be required to undergo awareness-building training course on the dangers of narcotics use. Such training must be paid for by the users (up to €450), may last up to two days, and is often used as an alternative to prosecution) (Obradovic 2012c).

The structure of alternatives to prosecution ordered for drug users has evolved. Although the proportion represented by drug warnings (in which the offender is summoned by the Deputy Prosecutor and accused) is the most widely used alternative measure (77% in 2010), its use is on the decline and being replaced by health measures: drug treatment orders and referrals to medico-social structures. Today, the latter alternatives represent 20% of the alternatives prescribed to sanction drug use offences. The pronouncement of health measures as a penal response is in part related to the 2004 establishment of counselling clinics for young users (CJCs) throughout the territory. These were rapidly identified by Public Prosecutors as an appropriate referral measure (Obradovic 2009).

In addition to developing alternatives to prosecution, penal responses to narcotics use cases are also increasingly characterised by convictions. Of course, the rise in convictions increased less rapidly than that of arrests, but they nevertheless increased fourfold since 1990. Today, nearly 60% of drug-related offence convictions are handed down against users (with use as the primary offence, either alone or in conjunction with other offences): the proportion of such drug-related offence convictions reached a record level that was twice the level it was in 2000. The proportion of those convictions sanctioning use only, to the exclusion of any other offences, was 44.8% in 2011. This increase is in part related to recidivism, which leads to more severe convictions each time the offender is brought before the courts.

The nature of the convictions handed down to sanction use has transformed in the last two decades. Exclusively focused on imprisonment in the mid 80s, the courts' response to use offences has become progressively stricter, and fines are now the leading penal method applied to users seen in the court system (Figure 9.3).

Figure 9.3: Changes in legal convictions handed down for narcotics use as the main offence from 1984 to 2010



Source: *Casier judiciaire national (French national criminal record) (Ministry of Justice)*
 N.B. The decreases identified in 1988, 1995 and 2002 correspond to presidential amnesty years

Data from the Ministry of Justice: imprisonment

Of the 82,725 new inmates incarcerated in 2010, approximately 14% were imprisoned for a drug-related offence. The proportion of people incarcerated for drug-related offences is approximately 5% (compared to 2.5% in 2006).

9.4. Other drug-related crime

Current legislation

Since the law of 18 June 1999¹⁷³ (and its application decree dated 27 August 2001¹⁷⁴), all drivers involved in traffic accidents resulting in an immediate death are automatically screened for narcotics use. In the event that screening results reveal narcotics in the blood, the users are subject to a maximum sentence of two years imprisonment and a fine of up to €4,500 according to the 3 February 2003 law¹⁷⁵. These sanctions may reach 3 years' imprisonment and a fine of €9,000 if alcohol has been consumed in addition to illegal drugs. The French LOPPSI 2 law

¹⁷³ Loi n°99-505 du 18 juin 1999 portant diverses mesures relatives à la sécurité routière et aux infractions sur les agents des exploitants de réseau de transport public de voyageurs. JORF n°140 du 19 juin 1999. (NOR EQUX9800010L)

¹⁷⁴ Décret n°2001-751 du 27 août 2001 relatif à la recherche de stupéfiants pratiquée sur les conducteurs impliqués dans un accident mortel de la circulation routière, modifiant le décret n°2001-251 du 22 mars 2001 relatif à la partie réglementaire du Code de la route (décrets en Conseil d'État) et modifiant le Code de la route. JORF n°198 du 28 août 2001. (NOR EQU0100214D)

¹⁷⁵ Loi n°2003-87 du 3 février 2003 relative à la conduite sous l'influence de substances ou plantes classées comme stupéfiants. JORF du 4 février 2003. (NOR JUSX0205970L)

(Homeland Security Performance Planning Act) adopted on 14 March 2011¹⁷⁶ provided for an additional sanction of vehicle confiscation, which is obligatory in some cases, notably for repeat offenders with a prior conviction for driving under the influence of alcohol or narcotics. The law also created an additional sentence after driving under the influence of alcohol or narcotics in the form of a five-year prohibition to drive any vehicle that is not fitted with an accredited anti-start system based on an electronic breath analyser.

For a number of years, a special drug screening procedure has been performed on roads: saliva testing devices for the on-site screening of drivers suspected of having taken drugs have been authorised since 2005, but they have only actually been used since 2008¹⁷⁷. Until then, the screening procedure had been performed with roadside urine tests, in the presence of a physician. This procedure was considered to be too complicated and too costly given the results obtained. The first operational deployment phase for the use of saliva screening kits by police law enforcement services is therefore recent (October 2008): an initial evaluation carried out in mid-March 2009 registered 52,000 saliva kits deployed in virtually all French departments and 7,588 tests that were conducted¹⁷⁸. Of the tests that were conducted, 37.4% were positive in the geographical areas covered by the French police and 29.6% in the areas covered by the *gendarmerie*.

In February 2010, the Interministerial Road Safety Committee announced an increase in the number of saliva tests performed on the roadside. The new measures approved in 2010 have increased the number of narcotics checks to almost 100,000 per annum (versus 10,000 in 2003). However, the results of this policy have not been accurately evaluated to date. According to the traffic safety evaluation undertaken in 2011 by the French National Interministerial Observatory for Road Safety (ONISR 2012), the “drugs” heading on the accident form could not be used in 2011 since it was only completed in one in ten cases (tests are seldom carried out and the test results are submitted too late to be recorded). The report stated that 1,832 cases of bodily injury were recorded in 2011, 455 of which were fatal, and that in these cases at least one driver had tested positive (regardless of whether or not said driver was deemed to be responsible for the accident). These accidents confirmed that cannabis use had triggered 499 deaths (i.e. 12.6% of road traffic deaths) but not all were attributable to cannabis (directly or indirectly).

Narcotics checks in 2011

In 2011, 98,100 narcotics screening procedures (preventive and obligatory) were carried out by the police and *gendarmerie*, representing a 45% increase compared with the previous year (see Appendix V- Road Traffic Violations Record). Of these procedures, 4,600 were performed following a fatal traffic accident. Since 2004, the first year of application of the law against drug-related traffic offences¹⁷⁹, the number of screenings performed following a fatal accident varied from 4,000 to 5,250, depending on the year (4,600 in 2011). This relative stability can be partially

¹⁷⁶ Loi n°2011-267 du 14 mars 2011 d'orientation et de programmation pour la performance de la sécurité intérieure. JORF n°62 du 15 mars 2011. (NOR IOCX0903274L)

¹⁷⁷ The decree of 30 July 2008 amends several articles of the Traffic Code to enable law enforcement services, during traffic controls, to screen drivers for narcotics use with saliva tests. Décret n°2008-754 du 30 juillet 2008 portant diverses dispositions de sécurité routière. JORF n°178 du 1 août 2008. (NOR DEVS0810101D)

¹⁷⁸ French national assembly: answer to written question 38796 from M. Marc Le Fur published in the 21 September 2009 Official journal (<http://questions.assemblee-nationale.fr/q/13/13-38796QE.htm> [accessed 24/09/13])

¹⁷⁹ Loi n°2003-87 du 3 février 2003 relative à la conduite sous l'influence de substances ou plantes classées comme stupéfiants. JORF du 4 février 2003. (NOR JUSX0205970L)

explained by the fact that such screening in the event of a fatal accident was not systematic, despite what was stipulated by the law: narcotics screening was performed for only 57% of drivers involved in fatal accidents, three times more than for accidents involving bodily injury in which the presence of narcotics was only sought in 17% of the cases (ONISR 2012). Nevertheless, the implementation of the decision to make drivers pay for their screening tests if they tested positive is part of LOPSSI 2 law, and could make the difference in the years to come.

The rate of positive drug tests following a fatal accident has steadily declined since 2008. The presence of narcotics use has nevertheless been observed in 11% of fatal accidents that are followed by screening (Direction de la modernisation et de l'action territoriale *et al.* 2012), which confirms that narcotics use is related to traffic fatalities, although to a lesser extent than alcohol. Since the simultaneous use of alcohol and narcotics is not assessed during traffic controls, it is difficult to identify the number of fatal traffic accidents related solely to alcohol or narcotics. The road safety epidemiological survey on narcotics and fatal road accidents (SAM) carried out in 2001 and 2003 by the OFDT and IFSTTAR¹⁸⁰ nevertheless highlight the fact that alcohol increases the risk of fatal accidents by a factor of 8.5 while cannabis does so by a factor of 1.8. Moreover, combining alcohol and cannabis is particularly dangerous, since it increases the risk of fatal traffic accidents by a factor of 14 (Laumon *et al.* 2005).

Convictions in 2011

Drug-related traffic offences are broken down as follows: 24,787 for driving a vehicle under the influence of narcotics (97% of drug-related traffic offences) and 638 refusals to undergo narcotics screening (3%), an offence that rose sharply (+10.4%) between 2010 and 2011. The number of drug-related traffic offences has doubled (12,994 offences) since saliva testing was implemented by law-enforcement services in 2008.

Furthermore, 3,397 narcotics- and alcohol-related traffic violations were recorded in 2011. This represents a 15% decrease compared with 2010. This decrease is in contrast with the significant increase observed in the previous year. From 2007 to 2010, this kind of offence increased in frequency by a factor of 2.4 (4,002 offences in 2010 versus 1,633 in 2007) and the increase in this type of behaviour seems to be accelerating.

The number of convictions for driving after narcotics use increased rapidly in the last few years: it increased fivefold from 2005 to 2011, from 2,976 to 16,264, a number that includes fixed penalty notices. Of the convictions for driving under the influence of narcotics (excluding fixed penalty notices), 77% committed just this one offence whereas 23% were associated with one or more other offences. More than one-third of convictions led to imprisonment (34%, of which less than 1 out of 5 were non-suspended sentences); half were fined (49%) and approximately 17% were given an alternative sentence (most often a driving licence revocation or suspension).

Punishments tended to be less severe for driving under the influence of narcotics alone or for refusing to cooperate. However, sanctions tended to be more severe in the case of bodily injury (8 out of 10 sentences led to imprisonment) and particularly in the case of homicide, where most convictions led to imprisonment without parole (Obradovic 2013).

The increase in the number of drug-related convictions is the result of several factors. Firstly, it reflects the attention placed by the public authorities on preventing traffic offences since 2002,

¹⁸⁰ French Institute of Science and Technology for Transport, Development and Networks (IFSTTAR)

when road safety became a public policy priority given the high levels of fatality. Therefore, traffic safety policies are enforced by creating new offences (driving under the influence of narcotics, refusal to undergo narcotics screening), which gives rise to increasingly systematic sentences. These policies are also used to develop prevention, which mechanically leads to an increase in convictions.

The structure of the sentences handed down has been following an obvious trend for several years: there has been an increasing number of fines and a decreasing number of convictions with fully suspended prison sentences. Subsequently, in the event of driving under the influence of narcotics, the proportion of fines increased from 35.6% to 48.9% from 2005 to 2010, while the proportion of fully suspended prison sentences decreased from 43.2% to 27.8%. This trend can be explained by an increasing number of simplified penal procedures (fixed penalty notice, simplified sentencing for lesser offences where the defendant is not obliged to be present), which are not compatible with imprisonment. At the same time, drug-related traffic offences have been increasingly sanctioned by imprisonment with only a partially suspended sentence: this proportion increased from 4.1% to 6.2% from 2005 to 2010.

9.5. Prevention of drug-related crime

According to the terms of the 1970 French law on narcotics, the French criminal justice system presents an array of court-ordered treatment options for drug users. These treatment referrals can be ordered by the Public Prosecutor (case dismissal after referral to a treatment or social structure, drug treatment order) or by the judge (bail conditional upon drug treatment order, mandatory withdrawal, a warning possibly associated with court ordered treatment). Since the law dated 5 March 2007, the scope of drug treatment orders has been extended, such that this measure can, from now on, be adopted at all stages of criminal proceedings¹⁸¹ as an alternative to prosecution, a settlement or as a way of enforcing the sentence (especially in the case of a suspended sentence with court-ordered supervision) for all narcotics users aged 13 years and above (see chapter 1).

Examination of penal cases recorded in the Paris area (which represents 25% of all French drug-related offences) reveals an increase in the number of narcotics use cases handled by the courts over the decade beginning in 2000: this figure doubled, increasing from 10,261 in 2001 to 22,663 in 2011. At the same time, the proportion represented by case dismissals of all decisions fell and, in contrast, the proportion of alternative to prosecutions increased. Alternatives to prosecutions now make up 70% of the decisions handed down for drug users, whereas the range of alternative to prosecutions applied has diversified (Obradovic 2010).

Counselling clinics for young users (CJCs), which were established in 2004, represent the most recent healthcare referral system example. Half of all outpatients received in these structures (for screening or brief intervention), and men and young adults in particular, were referred by the courts (Obradovic 2009).

Since the law of 5 March 2007 and the decree of 16 April 2008¹⁸², individuals over the age of 13 arrested for use or drug possession may be ordered to pay for and attend an awareness-building

¹⁸¹ Articles L3413-1 to L. 3413-4 and L3423-1 and following of the Public Health Code (CSP).

¹⁸² Décret n°2008-364 du 16 avril 2008 relatif au suivi des mesures d'injonction thérapeutique et aux médecins relais. JORF n°92 du 18 avril 2008. (NOR SJSP0769782D)

training course on the risks associated with the use of narcotic substances. These awareness-building training courses have an educational objective: users are informed of the risks relating to drug use, drug-related policies and legislation currently in force as well as the health and social consequences of drug use.

Based on a first evaluation implemented by the OFDT at the request of the Ministry of Justice, 1,800 to 1,900 collective awareness-building training courses on the dangers of narcotics use have been introduced in mainland France and the overseas French departments since the 2007 law, by 101 approved associations under the jurisdiction of 35 courts of appeal. At least one awareness-building training course provider comes under the jurisdiction of each court of appeal. With ten trainees on average, the courses have been attended by 18,000 to 19,000 people since 2008 (96% of whom were cannabis users), i.e., approximately 4,500 trainees per year - a figure that is rising steadily (Obradovic 2012a).

Nine out of ten awareness-building training courses are introduced as an alternative to prosecution (50% as alternatives to “traditional” prosecution and 39% as fixed penalty notice). The average age of the mostly male (93%) trainees is 25 years. This population is characterised by a preponderance (64%) of young adults compared with the number of minors, who account for only 3% of the training course cohort. Nine out of every ten trainees were arrested for cannabis possession or use. More specifically, 68% of trainees had been arrested for cannabis use without any other related offence. For two-thirds of these users, it was their first arrest. Furthermore, 11% of the people enrolled in the training had been arrested for a driving offence (e.g., driving under the influence of narcotics or alcohol or a speeding offence).

Four out of ten trainees used cannabis occasionally, i.e., fewer than 10 times per month, 30% used it regularly (but not every day) and 29% were daily cannabis smokers. More than 60% of trainees usually smoked in a festive or recreational setting (62%) and 8 out of 10 smoked at home or at a friend's house.

9.6. Interventions in the criminal justice system

People found guilty of a drug-related offence by the criminal court may receive alternative sentencing, thus avoiding imprisonment. These alternatives to imprisonment may take various forms: community service, ‘*jours-amendes*’ penalties (day-fines, literally, corresponding to the number of days in prison paid off by fines), or other types of sanctions. Although the national data on this topic are fragmented, they show a rise in the numbers and proportions of these measures applied to simple drug users.

9.7. Drug use and problem drug use in prisons

With 64,787 inmates as of 1st January 2012 for 57,236 operational places, there are 113 inmates for every 100 prison places in France. Overcrowding, in addition to poor inmate conditions, is one of the distinctive characteristics of French prisons regularly denounced by various

international bodies¹⁸³. This helps account for some of the difficulties encountered in accessing care.

There are more mental health and addiction-related problems in the incarcerated population than outside of prison. The first large-scale epidemiological survey of mental health in prisons was conducted in 2003-2004, and it showed that 80% of male inmates and 70% of female inmates had at least one psychiatric problem, and that the great majority were suffering from more than one (Rouillon *et al.* 2007). This study also showed that nearly 40% of the inmates incarcerated in the last six months were addicted to illegal substances and 30% were alcohol-dependent.

A 2003 inquiry into the health of newly-arrived inmates conducted by the DREES confirms the overrepresentation of addictions in the prison setting (Mouquet 2005). One-third of new inmates state having engaged in long-term, regular use of illegal drugs during the year preceding their incarceration (see ST 12 2013): cannabis (29.8%), cocaine and crack (7.7%), opioids (6.5%), misused prescription drugs (5.4%), and other substances: (LSD, ecstasy, glues, solvents, 4.0%). Nearly 11% of inmates stating that they used illegal drugs on a regular basis used multiple substances before their incarceration. This high prevalence of psychoactive substance use should be linked to the prevalence of imprisonment due to drug-related offences¹⁸⁴ because, with the exception of cannabis, the reported use of illegal drugs is marginal in the general population.

According to the unpublished, preliminary results of the PREVACAR survey (DGS 2011) (DGS/InVS), 2% of inmates are HIV-positive, i.e. fewer than 1,220 inmates, three-quarters of them being immunodeficient (with a CD4 count of under 350). The prevalence of HIV infection is comparable in men and women (2.5% vs. 2.0%). HIV-positive inmates were characterised by long-standing infection (diagnosed nine years ago on average). HIV infection was discovered in prison in one out of every four inmates, and one-third of them were suffering from full-blown AIDS. In addition, 72% of HIV+ inmates are receiving treatment. Moreover, it is believed that 4.8% of inmates carry HCV (i.e. fewer than 3,000 detainees), with a higher proportion of women infected: 11.8% of female inmates were HCV-infected vs. 4.5% of male inmates: drug abuse is the most common transmission mode (70%). Older figures showed that the risk of viral transmission in prison is higher since injecting drug users there tend to share equipment (Ben Diane *et al.* 2001).

9.7.1. Illegal drug market in prison

Although it is known that illegal drugs are available in French prisons, it is difficult to define the magnitude of the problem. In France, the sparse official information available on the subject goes back to 1996: 75% of French prison settings were concerned by drug trafficking. In 80% of cases, the illegal substance seized was cannabis, a prescription drugs was confiscated in 6% of cases, and heroin or another drug in the rest (Senon *et al.* 2004).

¹⁸³ On several occasions, the European Committee for the Prevention of Torture (CPT) condemned France for the state of its prisons (overcrowding, insalubrity) and the “inhuman and degrading treatment” of the inmates.

¹⁸⁴ In fact, thanks to the French Prison Authorities' statistics, approximately 15% of convictions are known to be primarily linked to drug-related offences.

Fifteen years later, the evidence suggests that little has changed and that cannabis remains the most trafficked substance. This is probably truer than ever before, because since the introduction of opioid substitution therapy into prisons in 1996 the demand for heroin has decreased substantially (Gandilhon 2010). Moreover, as is the case outside prison, in some centres the distribution of HDB has triggered the trafficking of tablets that are highly sought after for their sedative properties.

Although cannabis is the most widely trafficked illegal substance within French prisons, the trafficking of cocaine hydrochloride is also increasing. This phenomenon is logical and, in the end, is only a reflection of what is happening in society in general with a marked increase in consumption observed in France over the last fifteen years - largely due to expansion of supply.

In terms of supply, the fact that on its way to the major European market, cocaine is passing increasingly via West and North Africa, i.e., the traditional routes for cannabis resin (Gandilhon *et al.* 2010b) means that this substance is increasingly becoming part of the contraband sold by city dealers, who are highly present in prisons. These networks are generally run by North African crime bosses who reproduce their urban housing estate gangs in prisons (Gandilhon 2010). Although it is difficult to quantify this phenomenon because of the lack of data, it nevertheless seems to be a major problem, notably in the French prison establishments close to the main French urban centres, in which the percentage of persons jailed for drug-related offences can reach 40 to 50% of the inmate population.

In countries like Brazil and Mexico, criminal organisations have effectively taken control of certain prisons, using their ability to intimidate and corrupt the prison service. Although it is not the same in French prisons, hierarchies nevertheless exist in which a certain caste reigns supreme. These individuals, who in general do not use drugs themselves, rule a band of addicts who have been imprisoned for drug use/dealing. The development of new information technology tools, notably in the form of mobile telephones, makes it possible to direct networks outside from a prison cell and supply the prison on a just-in-time basis depending on inmates' needs.

9.8. Responses to drug-related health issues in prisons

Regularly, data emerge showing how difficult it is to provide inmates with personalised treatment against a background of overcrowded prisons.

All inmates must have a medical visit when they enter prison. This visit is performed by prison-based hospital healthcare units, which can screen for infectious diseases. To guarantee the application of harm reduction measures, now embodied in legislation¹⁸⁵, two main ways of preventing the spread of infectious diseases have been implemented in prison settings since 1996¹⁸⁶. The 5 December 1996 circular¹⁸⁷ first and foremost stipulates access to OST in prison:

¹⁸⁵ Loi n°2004-806 du 9 août 2004 relative à la politique de santé publique. JORF n°185 du 11 août 2004. (NOR SANX0300055L). This law proposes an official definition of the harm reduction policy ("the policy of harm reduction for drug users aims to prevent the transmission of infection, death by intravenous drug overdose and the social and psychological harm related to abuse of drugs classified as narcotics", art. L. 3121-4) and places the responsibility for defining this policy with the French government(art. L. 3121-3).

¹⁸⁶ As one of the primary objectives of the public authorities since 1994 (Bergeron 1999; Coppel 2002), harm reduction measures have been prescribed by a 1996 circular for the prison environment: Circulaire DGS/DH n°96-239 du 3 avril 1996 relative aux

inmates receiving OST must not only be able to continue their treatment in prison, but should also be able to initiate treatment if they wish, and especially HDB therapy. Since 2002, methadone OST can also be initiated¹⁸⁸. There is no medicalised heroin programme in prison, unlike outside of prisons.

In addition to substitution, prison establishments offer prevention and decontamination tools for fighting against HIV: in accordance with the recommendations of the Gentilini report (Gentilini *et al.* 1996), periodically distributing bleach in set quantities and concentrations became generalised in prison in order to clean any equipment that comes into contact with blood (such as injection, tattooing and piercing equipment). Distributing bleach chlorometrically titrated to 12° has occurred systematically since the Health-Justice circular of 5 December 1996 and since the Health/Justice memorandum dated 9 August 2001¹⁸⁹, prison administrations have been encouraging health personnel to inform inmates on how to use bleach as a product to disinfect injection equipment. The legal measures implemented by the 5 December 1996 circular to fight against the spread of HIV also stipulate making NF-compliant condoms available free of charge with lubricants (theoretically obtainable through prison-based hospital healthcare units): inmates can keep these items on their person or in their cell. Access to prophylactic antiretroviral therapy after accidental exposure to blood is also available for health and prison staff as well as for inmates. Subsequently, for injecting drug users, the only current way to protect themselves against AIDS, other than through post-exposure antiretroviral prophylaxis and access to condoms and lubricants in the event of sexual relations, is to disinfect syringes with bleach. These measures for cleaning injection equipment with bleach have been proven acceptable in eliminating HIV: however, it has been established that these measures are not sufficiently effective in combating the hepatitis C virus (Crofts 1994). Outside of the prison setting, messages on disinfecting with bleach have furthermore been largely abandoned in favour of messages on refraining from reusing injection equipment ("*A chaque injection, du matériel neuf*" / "New equipment for each injection").

In contrast to the situation outside prisons, support for drug users is limited in the prison setting (counselling, peer education, primary health care) and access to sterile injection equipment (alcohol wipes, bottles of sterile water, sterile containers "cookers", sterile syringes), which has been authorised in the general population since 1989, is absent from all prison settings.

Despite the World Health Organisation's repeated recommendations since 1993, incarcerated injecting drug users in France do not benefit from access to sterile injection equipment. The principle of equivalence of care for both incarcerated patients and the general population, embodied in the Law of 18 January 1994¹⁹⁰, is therefore not applied to the letter in France. However, various action plans are designed to improve access to care. The 2010-2014

orientations dans le domaine de la prise en charge des toxicomanes en 1996. BO Affaires Sociales n°96/16 du 25 mai 1996. (NOR TASP9630145C)

¹⁸⁷ Circulaire DGS/DH/DAP n°96-739 du 5 décembre 1996 relative à la lutte contre l'infection par le virus de l'immunodéficience humaine (VIH) en milieu pénitentiaire : prévention, dépistage, prise en charge sanitaire, préparation à la sortie et formation des personnels. BO Justice n°96/52, Tome II du 25 janvier 1997. (NOR TASP9630649C)

¹⁸⁸ Circulaire DGS/DHOS n°2002-57 du 30 janvier 2002 relative à la prescription de méthadone par les médecins exerçant en établissement de santé, dans le cadre de l'initialisation d'un traitement de substitution pour les toxicomanes dépendants majeurs aux opiacés. BO Santé n°2002/8 du 18 février 2002. (NOR MESP0230029C)

¹⁸⁹ Note interministérielle MILDT/DGS/DHOS/DAP n°474 du 9 août 2001 relative à l'amélioration de la prise en charge sanitaire et sociale des personnes détenues présentant une dépendance aux produits licites ou illicites ou ayant une consommation abusive

¹⁹⁰ Loi n°94-43 du 18 janvier 1994 relative à la santé publique et à la protection sociale. JORF n°15 du 19 janvier 1994. (NOR SPSX9300136L)

“health/prison” strategic actions plan on health policy for inmates (Ministère de la santé et des sports *et al.* 2010) stipulates acting on inmates' health determinants (practices exposing them to a risk for infection) and making screening programmes available for inmates. It provides for the establishment of suitable harm reduction measures that can be applied in prisons to remedy the shortcomings observed in France : these measures include distributing bleach with instructions for use, providing access to condoms, taking into consideration the infection risk of certain behaviours (e.g., snorting, tattooing, injections), providing access to sterile drug-use related harm reduction equipment, providing access to Fibroscan®¹⁹¹ testing in prison, improving prevention measures (inviting professional tattoo artists to prisons) and screening (developing screening during incarceration). The strategies of this plan are to improve treatment and bolster the objectives of the 2009-2012 national viral hepatitis strategic plan (DGS 2009), which defines a general framework for actions in prison settings, limiting itself to encouraging new inmates to undergo screening for hepatitis and assessing the Health/Justice memorandum of 9 August 2001. The 2007-2011 government action plan for the treatment and prevention of addictions (Ministère de la santé et des solidarités 2006) provides no specific actions for prison settings.

9.8.1. Drug treatment (including number of inmates receiving opioid substitution treatment)

Between 8% and 9% of inmates receive substitution treatment (Michel *et al.* 2011a). The predominance of HDB over methadone OST is as high in prison than in the general population: 68.5% HDB in the prison population vs. 62% in the general population.

In 2010, 100% of prison-based hospital healthcare units provided access to at least one of these two types of OST. However, a few establishments only offered one type of treatment: HDB only was offered in four establishments and methadone only in four others. Continuity of OST care upon release is only ensured by half of the establishments (55%), and 38% of the establishments stated that they did not have a formalised procedure.

In accordance with the provisions of the 2008-2011 government action plan against drugs and drug addiction, a professional best practices guide (concerning opioid substitution treatments in particular) was drafted under the auspices of the MILDT (French Interministerial Mission for the Fight against Drugs and Drug Addiction) (Ministère des affaires sociales et de la santé *et al.* 2013).

Regarding harm reduction services, 18% of prison-based hospital healthcare unit teams were aware that there were used syringes in the establishment and 29% in the establishments with fewer than 500 inmates. The discovery of syringes mostly involves large-capacity establishments with over 150 places.

Although we do not know how many inmates began OST during their incarceration, we do know that the Subutex® proportion (70%) tends to decline as a proportion of treatments initiated in prison, which is explained in part by the risks associated with taking this treatment¹⁹². The survey

¹⁹¹ A non-invasive machine that can instantly detect liver fibrosis and assess its degree of advancement.

¹⁹² Although high dose buprenorphine is the main treatment prescribed in community practices (Canarelli *et al.* 2009), in the prison setting, it is “relatively easy to misuse” (Pradier, 1999) and can be “injected” or “snorted”. Since the method for dispensing methadone (as an oral solution to be taken daily in front of the treatment personnel at the dispensing medical centre) is not

conducted in 2007 of UCSAs and SMPRs (with a 65% response rate) revealed a remarkable progression in access to methadone. In 2006, 35% of opioid-addicted inmates were being treated with methadone maintenance treatment vs. 22% in 2004 (DHOS 2004; Obradovic *et al.* 2008b), representing 40% of the entire opioid-dependent prison population. In 2010, this percentage remained stable: two-thirds of OST-receiving inmates received HDB and one-third received methadone (Michel *et al.* 2011a). Changes in medical practices were evidenced by a second figure: approximately 70% of the establishments surveyed stated that they had at least one initial methadone prescription during the second half of 2006 (most often among the large remand centres, where the organisation of health care was simplified with a single prescription service). However, in 2010, 13% of the establishments that had responded to the PRI2DE inventory stated that they never initiate substitution treatment (Michel *et al.* 2011a). Moreover, although the rules for organising prescriptions were heterogeneous, the medical practices for dispensing and monitoring showed little variation from one establishment to another (Obradovic *et al.* 2008a).

9.8.2. Prevention and reduction of drug-related harm

Harm reduction strategies are directed towards reducing harm, in many cases by altering behaviour associated with drug use and drug effects (acquisition, drug use, and withdrawal). A number of strategic documents (2008-2011 government action plan on drugs and drug addiction (MILDT 2008), 2010-2014 “health/prison” strategic actions plan on the health policy for inmates (Ministère de la santé et des sports *et al.* 2010)) address the public problems encountered at three different levels of drug-related harm:

- Drug acquisition harm (*acquisitive crime*) may be related to the risks of being exposed to high-risk situations, such as criminality (either being exposed to or conducting criminal acts such as drug dealing and robbery).
- Drug use harm related to the drug used, the amount consumed, and the route of administration, generating pharmacological effects and consequences on an individual’s health (for example, using intravenous drugs may lead to vein problems, abscesses, skin breakdown, HIV and other infectious diseases when sharing needles and injection equipment, and, of course, the risk of overdose).
- Drug withdrawal harm related to the effects of reducing or eliminating drug use that may impair an individual’s work and social functioning.

In terms of prevention, inmates have access to bleach, but it is not systematically distributed and is, in most cases, not accompanied by useful harm reduction information (INSERM 2010). Moreover, under illegal conditions of use, bleach is considered to be a poor HIV decontamination solution (WHO *et al.* 2004), and a very poor HCV decontamination solution (Hagan *et al.* 2003). Finally, imprisoned drug users do not benefit from all the harm reduction measures that are available outside prison, especially Syringe Exchange Programmes (CNS (Conseil national du sida) 2009; CNS (Conseil national du sida) 2011).

conducive to this kind of abuse, the French Ministry of Health authorised initial methadone prescriptions in all health establishments, including UCSAs and SMPRs, in 2002.

9.8.3. Prevention, treatment and care of infectious diseases

Infectious diseases are more prevalent among inmates than among the general population. The prevalence of HIV in the prison population is three to four times higher than in the general population, and that of hepatitis C is four to five times higher.

Newly-arrived inmates are screened for health problems related to substance abuse. Upon their arrival in prison, all inmates are offered a medical visit provided by a prison-based hospital healthcare unit. The screening includes, along with tuberculosis testing, a voluntary HIV test free of charge and, more recently, screening for Hepatitis C as well as a Hepatitis B vaccination. Regional Medico-Psychological Hospital Services (SMPRs) are responsible for psychiatric care in 26 penal institutions (larger prisons in general), while the prison-based hospital healthcare units deal with physical care. The 2008-2011 government action plan against drugs and drug addiction set an objective of improving "the treatment and continuity of care provided to incarcerated drug and alcohol users in order to reduce associated risks and prevent relapse", considering that the resources offered within the existing system were insufficient to control these problems. The plan subsequently proposed to change the regulations such that prison-based hospital healthcare units (UCSAs), could define the treatment objectives to be achieved for addicted persons and to increase the financial resources for these services. The plan also called for the introduction of a 'genuine prison addiction plan', including in particular the establishment of addiction and hepatology visits, including Fibroscan® testing, addiction and hepatitis training for health professionals and information about hepatitis C for drug users.

In terms of information and prevention, the PREVACAR survey conducted in 2010 (DGS 2011) showed that three-quarters of UCSAs provided health information and conducted prevention campaigns for inmates, but that only one-third had done so in the preceding six months. The survey also showed that screening for infectious diseases had improved in the last decade: HIV, HCV and HBV screening is almost systematic in prisons, and 93% of UCSAs provide this screening, although only one out of two offers repeated screening. Furthermore, just over half of UCSAs (52%) offer specialist HIV visits, and these are mainly conducted in the largest prison settings. A slightly greater proportion (57%) of UCSAs offer a specialist hepatology visits for inmates. In terms of HCV treatment in prison, 50% of UCSAs perform HCV screening and antibody testing.

However, little data exist on the access to tritherapy provided to HIV-positive inmates and the existence of special diets for patients suffering from hepatitis.

9.8.4. Prevention of overdose risk upon prison release

Release from prison is linked to a high risk of relapse, which is sometimes fatal, for inmates with a history of opioid addiction (Harding-Pink 1990; Marzo *et al.* 2009; Seaman *et al.* 1998). According to a study conducted in 2001 on inmates released from the Fresnes Remand Centre, the risk of fatal overdose in former inmates was more than 120 times that of the general population (Prudhomme *et al.* 2001; Verger *et al.* 2003). This same study established a particularly high rate of fatal overdose among newly-released inmates under the age of 55.

The continuity of care for drug addicts released from prison is deemed a "fundamental" issue in all the legislation organising care in prisons since the act of 18 January 1994. For example, a *Guide méthodologique relatif à la prise en charge sanitaire des personnes détenues* (methodological guide relating to the health care management of inmates) was established by

the Directorate for hospitalisation and organisation of care (DHOS) to help professionals (Ministère de la justice *et al.* 2012). The guide clearly summarises the specific conditions for providing health care to inmates at various stages of their incarceration. It specifies that the modalities for release need to be planned sufficiently early, before the definitive release date. Therefore, theoretically, upon release, a prescription for methadone or HDB substitution treatment needs to be provided to the inmate in order to avoid any interruption in treatment while awaiting a follow-up visit.

In practice, the recommendations are not systematically followed and the health care treatment of newly-released inmates is often insufficient. More recently, the assessment of initial methadone prescriptions given by UCSAs revealed that in 2007, UCSA professionals deemed that the continuity of care was correctly carried out for patients under methadone treatment, most often in the form of post-prison referrals to an outside CSAPA, to a general practitioner or, far less frequently, to a hospital (Obradovic *et al.* 2008a). More recently, the 2010 PREVACAR survey showed that only 52% of UCSAs have established a formal procedure to ensure continuity of care upon release from prison.

9.9. Reintegration of drug users after release from prison

The 2008-2011 government action plan against drugs and drug addiction also envisaged the creation of 'short and quick access reception programmes for released inmates, within existing structures affiliated with hospitals associated with the prison', highlighting 'difficulties with accommodation upon release from prison'. A call for national bids helped create three programmes and a dozen or so places in CSAPAs for newly-released inmates (two in 2009 and one more in 2010).

10. Drug markets

10.1. Introduction

Understanding the market for illegal drugs requires assessing the *availability* and *accessibility* of a given substance, the changes in the quantities seized and the changes in street price.

Monitoring drug supplies also means tracking the composition (purity and cutting agents) of the substances in circulation.

Availability and accessibility

The *availability* of a drug can be defined as the overall presence of a substance in a given geographical area. This availability is “perceived” to the extent that it is determined by “sentinels” devoted to observing what is obtainable.

Accessibility refers to the degree of effort required by an average user with the necessary financial resources to obtain the substance they are seeking. A substance may well be available but not particularly accessible. There are several degrees of accessibility and they can be measured based on factors such as the time needed to gain access to the substance, the location (public/private) of the sourcing, the time (night or day) of procurement and the type of supply network involved.

The main source of information in this area is provided by the ongoing Emerging Trends and New Drugs survey (see Appendix V-TREND), which, since 1999, has been providing chiefly qualitative information (accessibility, availability and price) on users and the various key players in the fields of prevention, treatment and law enforcement.

The product analysis scheme referred to as the National Detection System of Drugs and Toxic substances (SINTES, see Appendix V-SINTES), an integral part of the TREND survey, provides information on the circulation of rare and emerging substances.

General population surveys on the perceived accessibility, supply and availability of various illegal substances can also provide us with data on the most widely available substances.

Seizures and the structure of trafficking activities

France is a transit country particularly for substances destined for the Netherlands, Belgium, the United Kingdom, Italy and beyond. Therefore, it is difficult to distinguish between the quantities of drugs intended for the French market and those that are only in transit. Trafficking in France must therefore be assessed based on the substances encountered, since countries of acquisition and destination vary depending on the drug in question.

In France, there are three main types of supply networks for illegal substances:

- Networks linked to major criminal organisations are often encountered at the "wholesale" or "semi-wholesale" sale stage.
- "Retailer" networks are based on a strict organisational structure (manager/dealer/tout/lookout).
- "Micro-networks" include user-dealers.

The main source of information is data from law enforcement services (police, customs and *gendarmerie*) produced and published on an annual basis in the form of a report under the responsibility of the OCRTIS (the Central Office for the Repression of Drug related Offences). This report includes, among other things, the quantities of illegal drugs seized in France, the number of arrests (for use, use-dealing and trafficking) related to drug-related offences, the prices involved and any information on the structure of the trafficking networks.

Additionally, the TREND scheme provides qualitative information on methods for gaining access to products and on micro-trafficking.

Prices

Two resources make it possible to collect unit sale prices of illegal substances:

- A periodic OCRTIS survey based on data collected at 69 sites throughout metropolitan France records the median semi-wholesale and retail prices of certain illegal substances (heroin, cocaine, cannabis and ecstasy).
- The TREND network uses qualitative questionnaires that are completed by CAARUD harm reduction facilities and people working on the techno party scenes near each TREND site. For each substance under consideration (whether illegal drugs or misused legal medications), the retail price is requested, as well as an estimate of the lowest price, the highest price and the usual price. In 2011, at the request of the MILDT (French Interministerial Mission for the Fight against Drugs and Drug Addiction), the collection of information on prices was reinforced by data collected from the seven TREND sites every six months, and since 2012 every year. The illegal substances in question were cannabis (herbal, resin), heroin, MDMA (tablets, powder, crystal) and cocaine (for which the prices were collected in both urban areas and on the party scene).

Substance composition and purity

The composition of a product refers to all of the substances present in a sample of that product.

The purity, or potency, represents the percentage of the psychoactive substance found in the product.

The product samples also include cutting agents or additives. These terms refer to any substance added to the main product. They may or may not be pharmacologically active.

The detection threshold is the minimum quantity needed of a substance to identify it in a sample.

The quantification threshold is the minimum quantity needed of a substance to determine its dosage in a sample.

Two further information sources are used by the OFDT to document the composition of substances in circulation:

- Analyses are performed on substances seized by law enforcement services. These data are supplied by law enforcement laboratories and are grouped together in the report from the OCRTIS.
- Analyses are also performed on drug user data collected as part of the OFDT's SINTES system.

Analyses of seizures

Analyses of seizures by law enforcement service laboratories provide the main source of information on the composition of illegal substances in France. The annual OCRTIS report provides a summary of all of the data on the composition of illegal substances seized and analysed by all French law enforcement services (customs, police and *gendarmerie*) during the year for the whole country. The data represents the results of analyses of seizures without regard for the volume of each seizure, with the exception of cocaine, for which a distinction is made between airport seizures and street seizures.

The content of the main psychoactive substance is determined; with few exceptions, the other substances in the product are simply identified.

The exchange of information between the Early Warning System (EWS) - the EMCDDA's European alert system - and SINTES - the EWS's national correspondent - also helps identify new molecules.

Finally, SINTES is also in contact with the laboratories of law enforcement services through an agreement that officially establishes and authorises an exchange of information on substances in circulation. Following a specific request from the OFDT, these entities provide information on the nature and composition of substances that have been recently seized or that attract special attention from the OFDT and/or the EMCDDA.

The SINTES scheme

The SINTES scheme is based on collecting samples of illegal and legal substances directly from drug users. The substances collected are forwarded to a toxicological analysis laboratory, which determines their composition. At the same time, drug users are asked to complete a questionnaire on the context of use for the substance and its purchase price. This makes it possible to directly correlate the price and purity of a given substance. SINTES has two sections:

- The *observation* section provides an annual overview of the composition of a particular illegal product (2006 - cocaine, 2007-2008 - heroin, 2009 - synthetic substances, 2011 - heroin, 2012 - cannabis, both herbal and resin). The SINTES observation scheme relies primarily on the French TREND network. "Collectors" are selected and trained according to their networks and skills by the regional coordinator under the responsibility of the OFDT, which then provide collectors with their collector card. In total, the network has approximately 90 collectors. Each year, about 350 to 450 samples of the substance being

studied are collected from as many different users. This is consequently the main focus of the SINTES scheme: obtaining details on the composition of a given substance on a national basis for a given year.

- The *monitoring* section is more specific to the health alert system. Any professional working with drug users may ask the OFDT for authorisation to collect an illegal substance as long as it has generated undesirable and unusual effects in users or if it is new in some way. The annual number of samples collected is generally between 60 and 100. The contributions made in this section are limited exclusively to the identification of newly circulating molecules and up-to-date information on the composition of certain substances at a given moment and in a given location.
- Since 2010, SINTES has been exploiting the Internet to monitor for new psychoactive substances (NPS) and document them. In April 2013, the official launch of the European I-TREND project coordinated by the OFDT will help design and implement tools for observing NPS sold on the Web and their use.

All pharmacologically active substances are identified provided that they are included in the laboratory database. However, only the main psychoactive substance in a product undergoes content analyses, unless requested otherwise.

10.2. Availability and supply

10.2.1. Perceived availability of drugs, exposure, access to drugs

Cannabis

Cannabis is the most frequently used narcotic substance in France. According to data from 2007, the estimated market value of resin and herbal cannabis combined is €832 million (Costes 2007).

Due to well-established French drug networks, which import the substance either directly from Morocco or indirectly from Spain, cannabis resin is still widely available regardless of the fluctuations that can arise on certain local markets. Furthermore, in France and the rest of the European continent, users are becoming increasingly enthusiastic about herbal cannabis, which seems to be ever more available. Over 40% of the cannabis used is in herbal form and 12% (or 32 tonnes) of this herbal cannabis was produced in France according to a study from 2005 (Ben Lakhdar 2009). Since then, the phenomenon has intensified. This cannabis is mainly cultivated by an estimated 80,000 small-scale growers¹⁹³. In the overwhelming majority of cases, these small-scale growers aim to supply their own personal use. However, several things demonstrate that this fragmented image of herbal cannabis supply is changing. There was an emergence of *cannabis social clubs* (see box) in 2011, while some TREND sites reported an increase in commercial *indoor* growing by individuals. Furthermore, it seems that some criminal circles, especially those of Asian origin, are becoming more interested in intensive cannabis production.

¹⁹³ In 2010, 2% of people aged 18 to 64 ans who had used cannabis in the last year (80,000 people) stated having used only cannabis that they had grown themselves. The 2005 data cannot be directly compared: 5% of these people (200,000 individuals) had stated using cannabis they had grown themselves on occasion (OFDT 2013).

Cannabis social clubs

The cannabis social clubs phenomenon was first seen in France in 2011, when certain people used the media to openly demand changes in French cannabis legislation (decriminalisation of use and legalisation of production). Cannabis social clubs, which are inspired by the Spanish model, are based on putting local producers into contact to mutualise their resources. In 2012, a non-profit association whose objective is to unite producers on a national level was created in Tours in accordance with the French law passed in 1901. It was dissolved by the *Tribunal de grande instance* (District Court) of Tours on 20 June 2013, while just a few weeks earlier, the association's spokesperson had been condemned to a suspended eight-month prison sentence and a €2,500 fine.

The development of various forms of cannabis cultivation ("closet" cannabis growing, cannabis social clubs) is based on demand for "organic" and high quality product. However, the increasing desire by users to avoid the black market should be taken into consideration. Issues of safety are raised, as are ethical concerns by users who do not want to feed into criminal networks. These are the arguments put forward by the leaders of the cannabis social club movement.

Heroin

In France, heroin is available in two chemical forms: the "white" hydrochloride form and the "brown" freebase form. The white form accounts for a very small share of the black market. It only circulates through highly specific channels, such as in certain sections of the Asian immigrant community (the Chinese community in particular) and among Greater Paris-based users, who by their very nature are not particularly visible. In contrast, the freebase form dominates the market.

After a period of decline following the introduction of substitution treatments in France in the second half of the 90s, observers of drug markets as well as drug trafficking and drug use-related law enforcement services noted that brown heroin has become more available since 2006. This has been taking place in a context in which the price has stabilised at a fairly low level of about €35-40 in 2012 compared with the early 2000s, when the price reached €60 or even €70. This increase in availability was seen both among the most marginalised users frequenting CAARUD or CSAPA and in certain alternative and underground techno party scenes (Cadet-Tairou *et al.* 2010b).

In France, with the exception of Marseille, heroin is still very available in the territories within the scope of the TREND scheme in France. In 2011, the TREND sites even reported an increase in availability and no shortage periods - even limited or occasional - of the substance. These observations were confirmed by those of the OCRTIS, which mentioned "*an increase in the availability of the substance*". Furthermore, 71% of users questioned during the SINTES/heroin 2011 survey stated that they had no difficulty in procuring heroin (Lahaie in press).

In 2012, according to initial feedback from TREND sites, the situation has not really changed. In Toulouse and Metz, heroin use is even becoming, once again, of significant concern to the public authorities and entities involved in harm reduction. This constant availability of heroin was also observed by the OCRTIS, which reported that the substance is still readily available, especially in eastern and north-eastern France (OCRTIS 2013).

Cocaine

According to a study published by the OFDT in 2011, cocaine sales in France were approximately €900 million, representing domestic use of about 15 tonnes (Ben Lakhdar 2012).

According to all TREND sites, in 2011 and 2012 cocaine hydrochloride remained readily available even though cocaine seizures in France reached an historic high of 11 tonnes in total in 2011. This phenomenon is characterised by a real diversification of the ways in which the drug is supplied. In 2011, certain sites (Metz, Toulouse) emphasised expanded supply from disadvantaged areas with *modi operandi* similar to those used for cannabis resin: deals in public areas (stairwells, building hallways) and vertically-structured organisations (people stashing away the drugs, lookouts, dealers). Nevertheless, despite what was believed a few years ago, it would seem that networks that import and deal cannabis resin are not the same as those that supply France with cocaine. There is a separation between the activities: *"there are clearly-established, specific trafficking networks established in the aforementioned neighbourhoods. Some networks are well-structured and run by families who make cannabis resin available on the market. Others are more traditional, created around teams that use go-fasts or go-slows and ensure that cocaine is readily available"* (Sudérie 2013). However, this cocaine distribution method is still not very widespread compared with small user-dealer networks that procure directly from the Netherlands or Spain or, as reported in 2011, traffic via post.

According to the OCRTIS, the availability of cocaine in 2012 was "high or fairly high throughout much of France", with the exception of rural departments in the centre of France. It is in the major urban areas of Lille, Paris, Lyon and Marseille that the substance is most available (OCRTIS 2013).

In contrast, the availability of crack (cocaine sold in its based form and in very small quantities to a primarily precarious clientele) remains characteristic of northeastern portions of Greater Paris, the Antilles and French Guyana. The micro-markets that sporadically crop up in provincial cities are very short-lived.

Crack and freebase: what is the difference in France?

Both of these correspond to cocaine hydrochloride converted to "freebase" form by dissolving the hydrochloride form in water and adding a basic reagent: the use of bicarbonate produces "crack", and that of ammonia produces "freebase", although the active substance remains the same. However, given how these methods arrived in France, it is mainly the context that determines whether users indulge in "crack" or "freebase": while crack is sold already prepared in the form of a rock, freebase is often prepared by users themselves after purchasing hydrochloride in powder form.

Until recently, even though crack and freebase cocaine are the same product (based cocaine), their routes of administration and social environments of use were vastly different. Crack was, and still is, used by extremely marginalised users in Greater Paris (particularly the north of the city and the Seine-Saint-Denis department). Crack users get their product from "professional" dealers, while freebase tends to be consumed by people in the alternative party scene who use cocaine to prepare the product themselves. Even though this is still mainly true, it seems that in certain areas, the situation has changed in several ways. In Paris, ethnographic observations over the last few years have demonstrated that there is more free movement between these social milieus, and that the crack scene in northern Paris is increasingly frequented by people with unusual profiles (Cadet-Tairou *et al.* 2012b). The presence of young people who frequent the alternative party scene or of socially integrated adults is increasingly visible. This presence is

related mainly to the difficulties users have in collecting enough money to purchase a gram of cocaine (which costs about €70) to be based, while crack can be sold in smaller quantities (from 50 to 200 mg) for a more easily accessible price of approximately €20. This demand for freebase cocaine, which exceeds that of the traditional crack/freebase dichotomy, seems to be making specific demand emerge. In Paris, ethnographic and law enforcement service data reveal that, in certain housing estates ("*cités*") to the north of the city, freebase cocaine networks are modelled after cannabis resin distribution networks. Rocks of crack are produced in Seine-Saint-Denis, then moved to the capital to be dealt.

At the same time, it seems that the semantic crack/freebase distinction is less frequently made as increasing numbers of users realise they are using the same substance despite the two different names or other criteria for the crack/freebase dichotomy. In Toulouse, users of based cocaine speak more frequently of "crack" to describe the substance that they use and/or buy already based, whether these users are marginalised or socially integrated party goers.

However, although the prices on the Bordeaux market are similar to those of the Parisian market, the Toulouse market sells crack by the gram, which may prevent more widespread diffusion to highly marginalised populations. Nevertheless, in 2012, 57.7% of cocaine/crack users surveyed in CAARUDs stated that they had smoked cocaine (crack or freebase) in the last month, while this figure was 47.9% in 2008 (Saïd *et al.* in press).

Beyond the simple semantics, these trends are of interest due to their potential continuity resulting from a trivialisation of crack and an increase in the accessibility of low-cost cocaine to larger populations.

Ecstasy and amphetamines

To correctly understand the current ecstasy market and supply, a distinction needs to be made between the drug's different forms: tablets, capsules, powder and crystal. Although the tablet is the most widespread administration form in France, its market is far less dynamic than it was when the techno movement was developing in the mid 90s. After a year 2009 characterised by a drop in the availability of MDMA-containing tablets, it seems that this ecstasy, under the same galenic form, is once again present on the party scene. In 2011 and 2012, this trend was confirmed by the monitoring portions of SINTES and OCRTIS, and the tablets that were present on the market contained very high doses.

For several years now, the MDMA powdered form has become increasingly available in various party settings. This form benefits from the growing appeal of cocaine hydrochloride, to which it is frequently assimilated, and from the growing popularity of "snorting". Given its relatively high price, it is only used by a special subpopulation of party goers (those who frequent discothèques and nightclubs). However, its price has clearly been falling over the last few years, from €80 in 2009 to €55-60 in 2012. Moreover, it would seem that, in response to the increase in demand, a more organised supply network is being established. For example, law enforcement services in Paris and Rennes are observing an emergence of professionalised, organised networks that are sourcing from the Netherlands and Belgium.

Amphetamine (speed) supply remains dynamic and targets a specific, clearly identified segment of users who view speed as a cheap alternative to cocaine because it is available in powdered form and is snorted. This substance is predominantly available in the alternative environments of the techno party setting, but also appears to be gaining ground in nightclubs and discotheques as increasing numbers of users have become dissatisfied with ecstasy tablets.

Even though methamphetamine is rarely seen in France, it should be carefully monitored due to its intrinsic danger and its availability in certain European countries (the Czech Republic, the Slovak Republic), which makes its potential for circulation in France real. Like in preceding years, in 2011 and 2012, several sites like Rennes, Paris and Toulouse reported methamphetamine use in certain circles, like the gay community or Southeast Asian immigrant communities. Of the so-called methamphetamine samples collected, analyses showed that the majority of the samples actually did not contain any. Methamphetamines were determined to be present by three analyses over the last three years: in Toulouse in 2010 (brought into France from abroad by the user), in Paris in 2011 (from a user who employed it in a sexual context) and in Toulouse once more in 2013. The customs department also reported seizures of methamphetamines intended for the French market in greater quantities than in the past: up to 2.6 kg during a seizure at Roissy in 2011¹⁹⁴ and nearly 1 kg in a vehicle in Marseille, intended for the local market, in early 2013. Moreover, a case of problem use (validated by biological analyses) was reported by the Paris site: the user in question, who was fully socially integrated, had been smoking the product for over a year, but suffered serious consequences from this use according to the treatment system. Regardless of the situation, and despite the interest in this substance and the fascination it generates, its use remains very discreet.

Other synthetic drugs: new psychoactive substances (NPS)

NPS are synthetic substances that are accessible for sale on the Internet and whose effects are similar to those of already known substances, such as cannabis, khat or MDMA.

Since the discreet arrival of NPS in France in 2008 (Lahaie *et al.* 2013), 60 new substances¹⁹⁵ have been identified by toxicological analyses laboratories, which have detected increasing numbers of such drugs since 2010. Today, one new substance is analysed every month. The vast majority of these substances belong to the synthetic cannabinoids (18 from 2008 and 2012) and cathinones (15 from 2008 to 2012) families. The majority of NPS sales are through the Internet with an increase in the number of European sites: approximately 700 online sales sites were identified by the EMCDDA in 2011 (EMCDDA 2012), and about thirty of these were listed by the OFDT and were in French. However, "real live" sales are increasingly seen on the alternative techno scene by several TREND sites (Bordeaux, Metz and Lille, especially on the other side of the Belgian border). These sales do not occur in organised networks, but rather through users or isolated dealers who obtained the substance through the Internet and micro-traffic while also sharing with friends.

The "dealer" prices seem to be much higher than those practised on the web. In 2011, NPS "street" prices were three times higher on average than those online. However, the prices are still competitive compared with "traditional" drugs, and NPS are often sold as traditional drugs. The circulation of so-called "new" or "unknown" products, described only by quirky names or supposed or experienced effects, is seen more regularly on the party scene. The same holds true for substances sold as cocaine, ketamine or "PCP" (phencyclidine)¹⁹⁶, whose effects have little to do with the claimed substance. The Metz site also reported "street sales" in the city centre, but this phenomenon is still rather limited.

¹⁹⁴ Seizures of methamphetamines at airports never used to exceed 100 g.

¹⁹⁵ From 2008 to 2012

¹⁹⁶ A dissociative (i.e., leading to a feeling of dissociation between the body and the mind) synthetic substance that has both psychotropic and hallucinogenic effects. Although users sometime mention having purchased PCP, there is practically no data (seizures, intoxication, death) bearing witness to the drug's circulation in France or the European Union.

NPS use seems to be somewhat limited compared with "traditional drugs", which are still preferred, at least outside of circles of experienced users. Nevertheless, NPS are being used more frequently in a sexual context among certain gay communities. The slamming (injecting in a sexual context) of NPS often takes place in "hardcore" contexts. Reports of health problems after NPS use also demonstrates that their use is on the rise, even though this is very difficult to determine using traditional observation methods since the supply and use of such drugs remains totally private.

MXE: the NPS of 2012?

Although not examined closely, the life cycle of an NPS can be clearly distinguished from that of traditional substances due to the speed with which they develop and the rapid disinterest in the majority of them. In 2011 and 2012, MXE (methoxetamine) stood out due to the increasing interest it generated among Web surfers¹⁹⁷. Today, it can be seen on the party scene at a number of sites (Bordeaux, Toulouse, Paris and Metz). The effects are similar to those of ketamine, the name under which it is often distributed. It seems that the new MXE drug is benefiting from the current infatuation for ketamine, which is often in short supply on the techno party scene (Martinez *et al.* 2013). Since the effects of MXE are more powerful and last longer than those of ketamine, which is difficult to dose, this substitution often causes complications (malaise and psychological or psychiatric disturbances, for example).

Hallucinogens

The market for hallucinogens is divided into two submarkets: one for synthetic substances such as LSD and the other for natural products such as hallucinogenic mushrooms or *Salvia divinorum* (Seer's sage).

For about 10 years, the LSD market in France has been extremely volatile due to the ups and downs of a supply that depends greatly on law enforcement service activities in the countries that produce this substance, such as Belgium or the Netherlands. Consequently, some years, observers within the TREND network reported virtually zero availability, while at other times, LSD appeared to have been extensively present on the market. Since 2006, the supply of LSD seems to have experienced no major interruptions and the drug has been mainly available at *free parties* and teknivals, where the drug appears to be actively sought by a fringe group of consumers comprised of young thrill seekers.

Since 2009, ketamine has become a more permanent fixture among the range of substances generally used on the alternative party scene. In 2011-2012, although its availability varied, its presence increased in Rennes, Bordeaux and Toulouse following a shift to the west/southwest of France. The increase was less marked in parties that took place in Metz, Paris, Marseille and Lille, even though the substance is sought there. However, the market remains unstructured and fairly artisanal. The price per gram of ketamine (€40 on average) seems to vary significantly (from €20 to €60) with time and place.

New users are mainly young polydrug users from the alternative party scene who tend to focus on this substance. In Toulouse, Bordeaux and, to a lesser extent, Metz, ketamine is also consumed by unstable drug users seen in urban areas, and mainly, although not only, wandering street youths.

¹⁹⁷ See the SINTES memorandum (in French) updated 24 October 2012 on this substance: http://www.ofdt.fr/BDD/sintes/ir_methoxetamine_111105.pdf

Although use practices and sought effects generally have been described in preceding TREND reports (Cadet-Taïrou *et al.* 2010b), some elements are worth mentioning.

One example is the development of ketamine's image and the many messages this drug generates. Its more widespread image as the "horse tranquillizer" - a dangerous substance with uncontrollable effects - is slowly being replaced among users by a lighter, festive, recreational image that is now associated with the term "pony" in a variety of expressions ("pony generation", "riding the pony"). This playing down of the drug's image is linked directly to a more banal use of the drug by certain users, who have succeeded in controlling their doses.

Moreover, ketamine is considered by many users to be an uncut substance. These users also mention time-limited effects (20 to 30 minutes) that are not followed by a down phase, the fact that users can drive, can avoid drug screening detection (ketamine cannot be detected by drug screening kits) and can be in decent shape the next day (although some state that they are "exhausted" after using). Users also consider the drug as being easily combined with other substances, and use it with alcohol, cocaine (known as "Calvin Klein"), MDMA and LSD. Its quality, the way it is prepared and the related urological problems regular use seems to generate are just some of the hot topics of discussion (Hanna 2010).

In 2012, two sites - Paris and Marseille - reported very high, voluntarily-taken doses in people searching for the K-Hole¹⁹⁸, or a stronger ketamine experience. The Parisian site also mentioned users seeking the "Rocketta effect", which involves taking as much alcohol as possible, and then taking ketamine.

Despite positive messages, users and professionals have been reporting significant and rapid tolerance with a supposed risk of chronic use and addiction, in addition to the aforementioned risks.

GBL (the precursor of GHB) can be easily obtained on the Internet and in certain automotive supply stores, even though in 2011 its sale to the public was banned (see chapter 1). Until 2007, its consumption was mainly limited to the gay party scene. However, thereafter use spread from Paris out to other areas of France, and from sites of private use to clubs. Around 2009, use spread to clubs and discotheques mainly in the cities of southern France (Toulouse, Bordeaux, Montpellier, Aix en Provence), thereby extending beyond the gay party scene to a young club-going population. In 2011, use by the gay party scene was once again confined to the private sphere, and it seems that use in the young population once again became rather discreet.

As for herbal cannabis, demand for natural hallucinogens has risen sharply. This supply has been boosted by a strong demand for so-called organic substances with high "mystical" content, such as herbs used in traditional societies for inducing shamanic trance states, like *Salvia divinorum* or *Datura* (Reynaud-Maurupt 2006). Furthermore, supply has been encouraged by the use of the Internet, allowing users to procure substances, generally from the Netherlands and the United Kingdom, without taking major risks.

¹⁹⁸ The K-Hole or "black hole" experience refers to the intense, and sometimes anxiety-provoking effects of taking high ketamine doses: loss of temporospatial orientation, hallucinations, mind and body dissociation and distorted perception.

10.2.2. Drug origin: national production versus imported production

Herbal cannabis is the only illegal substance produced in France by individuals at home and on a very small scale.

This phenomenon is related to several factors. First, there is the development of a trend in which people are opting to use “organic” products, which are reputed to be of higher quality. The second is the increasing desire by users to protect themselves from the risk of getting arrested by avoiding frequenting black markets and dealers.

The phenomenon appears to have increased sharply over the last decade. In 2005, domestic cannabis production was estimated to be 30 tonnes (Ben Lakhdar 2009).

Various drug-trafficking repression services have noted an increase in the cross-border dealing of herbal cannabis from Belgium and the Netherlands. For these two countries, whose combined production is estimated to be approximately 1,000 tonnes, cannabis production expanded dramatically due to the involvement of organised crime in large-scale production (Weinberger 2011), and it seems that the lion's share of this production is intended for export. It would seem that France, like other countries, has not been spared from this phenomenon for the last few years.

Since 2007, many cases revealed by the OCRTIS narcotics law enforcement office have helped dismantle production cooperatives involving people from the Netherlands. In the Parisian suburbs in 2011, investigators from OCRIEST (Central office on illegal immigration and employment) and the OCRTIS seized 700 cannabis plants in a clandestine *indoor* plantation employing illegal Vietnamese immigrants. This *cannabis factory* was capable of annually producing 100 kg of sinsemilla¹⁹⁹, representing €400,000 in annual sales (Weinberger 2011).

In 2012 and 2013, new cases in which cannabis factories were dismantled in Greater Paris and in the Lorraine region confirmed that this method of herbal cannabis production exists in France.

10.2.3. Trafficking patterns, national and international drug flows, trafficking routes, *modi operandi* and organisation of domestic drug markets

Cannabis

The cannabis resin consumed in France comes from Morocco and usually transits through Spain. It is imported by well-organised cross-border criminal networks that are often established in tense housing estates located on the periphery of major French cities, where the networks are in close proximity with the country of production. The cannabis resin trafficking network in France is comprised of three major types of dealers:

- The first type is comprised of wholesalers in southern Spain or Morocco. These traffickers can import cannabis resin by the tonne. According to certain law-enforcement services, there are approximately sixty such networks using about one thousand people in total.

¹⁹⁹ Sinsemilla (which means without seeds in Spanish) is a type of cannabis that appeared in California in the 1960s. It is obtained through a special technique based on genetically crossing different varieties and uprooting male plants, thereby enabling female plants to develop maximal THC potency (upwards of 20%, and sometimes reaching 35%).

- There are also intermediaries (semi-wholesalers), who regularly transport cannabis resin from Spain or the Netherlands to France. These are very structured groups that primarily import a single substance, although they may also import other illegal substances (cocaine, heroin). There are an estimated 689 to 1,504 semi-wholesalers (Ben Lakhdar 2007).
- Finally, we observe local dealers who oversee a network of dealers in charge of selling the substance in a given territory.

Today, the cannabis resin market seems to be less dynamic and less profitable. There are several reasons for this. On the one hand, there is increasingly stiff competition from cannabis grown in France and elsewhere in Europe. On the other hand, law-enforcement efforts by the police, customs and *gendarmerie* oblige dealers to have multiple storage areas thereby fragmenting their deliveries. This automatically leads to an increase in prices and a decline in profitability.

In 2012, what stood out in terms of supply was the availability of cannabis resin from Afghanistan, a country that has become the world's leading producer of this substance. For the time being, this phenomenon seems to be marginal - a few dozen kilos were seized in France in 2012 - and the information on the import networks is still highly fragmented.

Heroin

The trend towards increasing heroin availability on the French market is encouraged both by a renewed dynamism of supply over the last decade in Afghanistan, the source country for 90% of the heroin consumed in France, and by higher demand in recent years (Cadet-Tairou *et al.* 2012a).

The rise in opium and heroin production (Chouvy 2013) has encouraged the development of criminal organisations (particularly Turkish and Albanian) that import heroin through the Balkans²⁰⁰ onto French soil.

This importation occurs through one of two major circuits. One circuit receives the heroin directly on French territory (Eastern France and the Rhône-Alpes region), while another, indirect circuit acquires heroin by implanting stores of the drug intended for the French market in border countries, such as Belgium, the Netherlands and Germany. This indirectly supplied heroin is sold on a semi-wholesale or wholesale basis to networks of retailers. These networks are based in housing estates surrounding major French cities, where they control the traffic of cannabis resin imported from Spain or Morocco.

Alongside these networks, which are controlled by organised crime, we also find what the police refer to as *secondary* networks, i.e., small-scale organisations chiefly comprised of user-dealers. They obtain heroin in countries bordering France, such as Belgium and the Netherlands. These two countries are the customary storage sites for heroin arriving *via* the Balkan route (OCRTIS 2009). All of these factors contribute to the increasingly widespread presence of the substance in France.

²⁰⁰ According to the UNODC 80% of Afghan heroin intended for the European market transited through the Balkans (UNODC 2012).

High dose buprenorphine (HDB)

Ever since its 1996 launch, the high-dose buprenorphine (HDB) prescribed for opioid substitution treatment has been the subject of trafficking on the urban black market, and often targets extremely marginalised drug users (Toufik *et al.* 2010). This trafficking is organised by two types of groups.

- The first type, which displays a certain degree of organisation, obtains major quantities of tablets available for sale on the black market by falsifying prescriptions and obtaining multiple prescriptions from people not dependent on opioids.
- The second type is chiefly comprised of users receiving the substitution treatments themselves and carry out small-scale dealing in the products.

In 2010, within the scope of reported cross-border trafficking from eastern France to Germany, the 8 mg tablet could be sold at a price of €25 to €50 instead of the average €5 price per tablet in France. In 2011, it appeared that despite the enhanced monitoring and control methods employed by French national health insurance on a regional level, French demand remained high, even though occasional shortages occurred in certain cities. The medication was therefore highly available and accessible. In stark contrast to the situation with illegal substances such as heroin or cocaine, an open drug scene for the sale of HDB drugs exists in many French cities.

Methadone

For several years now, the "syrup" oral form has been subject to misuse in the same way it was in preceding years. In other words, for the most part, it was used for "temporary fixes" or by micro-traffickers who never go beyond the micro level, even though they are increasingly visible each year. In 2011, certain TREND sites (Rennes, Lille Bordeaux, Toulouse and Paris) reported that methadone capsules were circulating outside of their therapeutic framework. However, like for the syrup form, it seems that the capsules are not part of organised trafficking, but rather serve as supply for "temporary fixes" among users. Although methadone is misused by certain groups for "getting high", it is mainly taken by users for substitution purposes, and its image is still that of a medication. Users who have requested treatment and often already self-substituted with "street" methadone are becoming common. The Paris, Marseille and Rennes²⁰¹ sites are still reporting cases in which unstable eastern European migrant populations injected methadone in its syrup form after simply diluting it and using 10 ml or even 30 ml syringes. There were also cases in which young unstable populations became opioid-addicted by using this medication. Given this background, the capsules do not seem to be subject to any particular preferences. There are no reports of injecting the contents of capsules. Therefore, these phenomena should be closely monitored given the rise, since 2009, in fatal methadone overdoses in France with a concurrent decline in heroin as a cause of such deaths: according to the DRAMES data collected in 2011, methadone alone or in combination was allegedly responsible for 38% of drug overdoses for that year in contrast with 22% in 2009²⁰² (see chapter 6) (Brisacier 2013).

²⁰¹ As well as a CAARUD in Lyon in 2010.

²⁰² In contrast, from 2007 to 2009, an increase in the proportion of heroin was observed.

Cocaine

Today, there are three major types of cocaine distribution networks in France:

- There are networks related to organised crime in France and elsewhere; these networks specialise in wholesale.
- There are so-called “housing estate” networks, which are established in neighbourhoods located at the periphery of major cities; these networks deal either in wholesale or in retail sales.
- Finally, there are user-dealers of varying reach.

Although the organised crime networks represent a minority in terms of quantity, they play an important role in determining the availability of the substance. These organised crime networks can be divided into two subgroups:

- There are foreign dealers operating in countries that receive cocaine arriving to Europe, particularly in southern Spain. These dealers operate by directly selling large quantities of product to all types of potential importers in France.
- There are also local or regional French wholesalers, who sell product obtained mainly from the organisations mentioned in the first group and sell to more or less organised retailer networks.

In contrast with French wholesalers, the first group is in direct contact with European crime organisations, mainly Italian or British, or non-European structures, such as Colombian or Mexican cartels (Olvera *et al.* 2012). They are capable of importing hundreds of kilos of cocaine (mainly by sea) and are developing internationally by establishing operations in Latin America (Venezuela, Brazil), the Antilles (Guadeloupe, Martinique, the Dominican Republic), and more recently, West Africa.

Within networks of dealers who source abroad, the aforementioned “housing estate” organisations are well represented due to their decades-long experience in importing cannabis resin. They generally have close ties with organised crime networks due to business relationships and a certain exchange of movement between the two circles: the more dynamic members of these networks can join the upper echelons of organised crime.

Several factors explain the increasing involvement of “housing estate” networks in cocaine trafficking: there is very dynamic demand and a higher profitability for cocaine trafficking than for cannabis resin trafficking.

Cocaine use is developing among the working-class, and this development is in turn driving the growth of immigrant-populated housing estate networks, where this working class often has social ties. In the past ten years, the retail per-gram price dropped from €150 in the late 90s to €60 or even €50, which has facilitated access to the substance by lower-income populations within a context characterised by transformations in social representations of so-called “hard” drugs. It seems that in the working-class suburbs, which were affected in the late 70s by the heroin epidemic, the taboos related to the use of illegal substances such as heroin and cocaine

are fading. This promotes the emergence of demand inherent to the estates, which in turn is feeding an increasingly structured local supply.

The higher profitability that comes from selling retail cocaine compared with selling retail cannabis resin also encourages dealers to shift towards cocaine. Given the wholesale prices, every gram of cocaine sold retail provides a margin of about €30 vs. barely €3 for cannabis resin.

The third major organisational structure is that of micro-trafficking, in which user-dealers operate for the most part. In general, these users begin dealing as a way to lower the costs related to their personal use; a gram of cocaine purchased wholesale is, on average, half the price of a gram of retail cocaine. As a result, users buy cocaine from a wholesaler or a semi-wholesaler and end up creating micro-networks of a few regular customers.

Due to the method of procurement, these micro-networks reveal the extent of cross-border movement in French trafficking, i.e., when French user-dealers do not have local wholesalers, they do not hesitate to cross borders to source cocaine and even heroin (from Belgium, the Netherlands or Spain). This type of network, which is based on the movement of small-time drug runners, is likely predominant in France compared with organised crime networks and professionalised dealer groups. On their level, these networks contribute to making cocaine highly available in France. Furthermore, the 2004-2005 study on arrests for cocaine use-dealing revealed the relative ease with which these types of organisations can form (Gandilhon 2007).

These micro-networks are encouraged by the high number of well-established Belgian, Dutch and Spanish wholesalers and semi-wholesalers, who know how to deal with “drug tourists”. Moreover, for the most organised networks, the prospect of quick, significant profit further encourages the process: importing a few dozen grams each month and selling them to a small clientele is enough to procure several thousand Euros in income. This is particularly attractive considering that many user-dealers come from socially and professionally unstable environments. In any event, according to the increasing number of arrests and the TREND system observations, this cross-border, micro-network phenomenon seems to have steadily grown in recent years. This even holds true in the West and the Centre of France, which are much further from the countries in which the cocaine intended for the European market is stored.

Crack and freebase

A second type of cocaine found in the French market is known as “crack” or “freebase”. These two different expressions actually refer to one substance that is used by two very different client groups.

Unlike cocaine hydrochloride, the distinctive feature of crack cocaine is that it is found in highly specific markets in particular geographical areas. Crack is overwhelmingly intended for a minority clientele (15,000 to 20,000 people in mainland France according to some estimates) comprised of highly marginalised users (Janssen 2012). The users are chiefly found in Paris and in the French overseas departments of French Guiana, Guadeloupe and Martinique (Merle *et al.* 2010), even though this product has been sporadically reported at other TREND scheme sites, such as Toulouse in 2010 and 2011. It has been confirmed that part of the Parisian crack supply chain is being increasingly handled by networks of individuals specialised in dealing cannabis resin to the detriment of traditional dealers, who are usually from West Africa and particularly from Senegal.

Unlike crack, freebase is not sold via a dealer system structured by organised networks.

Ecstasy

It appears that the low level of demand for ecstasy in its tablet form has caused French criminal organisations to lose interest in this substance (Girard *et al.* 2010). In 2011, most of the supply found on the French market came through micro-networks that sourced abroad (from Belgium, the Netherlands or Germany) and less commonly through Eastern Europe's organised crime networks.

NPS and their development on the Internet

Since 2009, the number of online retail websites for psychotropic substances has increased. SINTES has determined a typology for the market. Four market segments have been identified. The first two – the “informed public” segment and the “commercial” segment – can both be targeted by a single website or each be targeted by specialised sites. The latter two segments – “deep web”²⁰³ and “classified ads” – are only accessible in specialised areas.

The "informed public" segment

The first segment of the NPS market is transparent and relatively easy to understand, and seems to be the oldest of the segments. The websites that target this segment are usually understated and fewer in number than the more commercial websites. The chemical names of the molecules are displayed. The substances are sold in plastic sachets without any specific marketing. The products are for a target clientele able to link the effects to the names of the molecules and able to understand the doses.

The "commercial" segment

In contrast, the second market segment is more commercially oriented. The sites or portions of websites targeting this segment are often more attractive than the websites that target the first segment. Product packaging is colourfully designed. The websites sometimes expressly aim their advertising messages at a young target, particularly when it comes to marketing synthetic cannabinoids.

Molecules or combinations of molecules are sold under brand names. There is no mention of the active ingredient content in the wording presenting the substance or on the packaging. In general, the substances sold are rarely presented in powder form; rather they are packaged in tablet form, especially the stimulants. This format may imply to users that the dosing is prepared by the manufacturer. The presentation or product appearance does not encourage users to seek information on the chemical composition of the product and/or the dosages.

Moreover, these websites raise doubts as to the psychoactive nature of the substances being sold. For example, synthetic cannabinoids, invisible to the naked eye, are sometimes presented on plant-based fragments on which they are deposited. This presentation may lead users to believe that they are consuming a plant rather than a synthetic substance. For the first market

²⁰³ In general, the “deep web” segment is comprised of directory pages or internal pages of websites. Nevertheless, there are websites launched by a server specifically designed not to be picked up by traditional Internet protocols.

segment, this presentation “effort” is not made, since cannabinoids can be sold directly in powder, tablet or paste form.

These websites can also offer “complementary” items similar to those sold in the “smart shops” of the Netherlands and some Eastern European countries. These complementary items include energy drinks, equipment for use by inhalation, toxicological testing kits and so on.

This more commercial market segment seems to be bigger than the “informed public” market segment. Subsequently, in 2011 the OFDT recorded 32 retail websites²⁰⁴. Some of these websites only focused on one of the two aforementioned markets, while others targeted both. It appeared that there were three times as many “commercially-packaged” products that did not mention the contents than there were chemically identified molecules. There were 63 of the latter.

It also seems that the websites or sections of websites exhibit other differences that target either an “informed public” or a “commercial” segment. As a result, seizures and SINTES data collection reveal that “commercial packaging” for NPS products contains more molecules than the bags sold on the “informed public” sites. The analyses performed by the Customs Joint Laboratories Department (SCL) on several commercially packaged products with the same name revealed combinations of as many as five different synthetic cannabinoids²⁰⁵. Conversely, analyses performed in 2011 by SINTES on 16 bags with the chemical name of one single molecule sold on websites for the “informed public” segment demonstrated that the molecules were indeed present and unique. These initial observations should be confirmed by other analyses.

The “deep web” segment

The third market segment is that of people who purchase on websites that are not referenced by search engines. Two such websites were closed down by the American DEA (Drug Enforcement Administration) between the summer of 2011 and March 2012.

The specificity of this segment comes from the confidential way in which it is reached: Web surfers can only access “deep web” sites if somebody has given them the address. These sites can be used to sell psychoactive substances to people with virtual money. On these sites, it is possible to find products categorised as narcotic substances, prescription-only drugs and NPS.

Other, similar sites put buyers and sellers in a given geographic location in contact with each other. This trend seems to be marginal since users need to be part of a network with extensive information technology know-how.

²⁰⁴ The websites were selected using “snapshot” methodology, i.e., by using the relevant results of the first 100 pages found by a search engine, after a search using a combination of key words.

²⁰⁵ Synthetic cannabinoids are molecules that are chemically similar to Δ^9 -tetrahydrocannabinol.

The "classified ads" segment

Finally, one of the final segments of the market is users who purchase through classified ads. In 2010, the OFDT performed research on the "certification"²⁰⁶ of Web-based drug information in general. The work led to a classification of online NPS websites (Delprat 2011) referenced by search engines. Subsequently, the majority of today's leading substances appeared to be available in classified advertisements listed under general categories. The majority of the ads refer people to addresses in Africa (Nigeria, Cameroon) or in China. User websites reacted by listing fraudulent addresses and e-mails.

The limited qualitative information collected on user purchasing behaviour seemed to demonstrate that few consumers really use this supply mode. Nevertheless, the persistent, overwhelming presence of classified ad listing sites warrants further investigation.

The communication strategy of vendors

Vendors develop relatively sophisticated communication strategies. Social networks like Facebook and YouTube serve as advertising platforms for products and sites. Twitter is employed as well.

Blogs dedicated to social, volunteer article-writing, called "webzines", can be used to write articles that seem to have journalistic integrity, but really only serve to inform the reader of the availability of a substance.

Other sites that sometimes come from public institutions can be "cannibalised". This means that areas open to the public to edit videos or personal documents may be used to post video clips and advertisements that announce the opening of online retail sites.

Finally, general, unspecialised forums on products or IRC platforms²⁰⁷ are also places where information may be exchanged. This method of communication requires new users to be accepted by other users before being able to access and share information.

10.3. Seizures

10.3.1. Quantities and numbers of seizures of all illicit drugs (ST 13 2013)

Given France's geographic position at the heart of Western Europe, it is a transit area for the main illegal substances (cannabis, cocaine, heroin and synthetic drugs) produced worldwide. Like many developed countries, where the population has high purchasing power, France is also a country where there are high levels of use, making it a strategic market for drug dealers.

In 2011, the number of narcotics seized by law enforcement services (police, customs, *gendarmerie*)²⁰⁸, all substances combined, was 157,395, representing an increase of nearly 20%

²⁰⁶ As it is used here, the term has a specific meaning with respect to electronic publishing. It indicates the process by which website referencing is increasingly recognised and seen as an authority in the area in question.

²⁰⁷ Internet Relay Chat is an instant, text-exchange protocol that uses "rooms" or "channels" for themed discussions.

²⁰⁸ We do not have data on the number of seizures performed for each of the illegal substances in question.

compared with the previous year. This level is the highest it has been in a decade, and demonstrates the dynamic nature of the French drug market. Data are not available for 2012.

Cannabis

The downward trend observed for cannabis resin since 2004, which marked the all-time high level for cannabis resin seizures in France (about 100 tonnes) continued in 2012, with an 8% decline since 2011 (Table 10.1). This trend may be explained by a fragmenting of cannabis resin storage facilities and transport, which led to more deliveries, each of which contained less merchandise. Therefore, the so-called *go fast* road convoys intercepted in 2011 were transporting an average of 400 kg, whereas such convoys were transporting an average of 600 kg in 2010. Furthermore, for the last few years, a more discreet method, called *go slow* has appeared. This method employs more traditional cars that transport smaller quantities and take secondary roads. Another phenomenon observed by law enforcement services was the fragmenting of import channels, making the dismantling of networks more difficult.

From 2011 to 2012, the upward trend in herbal cannabis seizures being observed for several years ended. Seizure during that period fell by 40%.

Table 10.1 : Quantities of drugs seized (in kilograms), from 2007 to 2012 and changes from 2011 to 2012 (%)

Drugs seized	2007	2008	2009	2010	2011	2012	Change from 2011 to 2012
Cannabis: resin	34,182	71,075	56,073	52,795	55,641	51,118	-8.8
Cannabis: herbal	3,047	3,422	3,495	4,564	5,450	3,270	-40
Cannabis: seeds	51	30	45	22	na	13	na
Heroin	1,035	1,117	970	1,087	883	701	-20
Cocaine	6,578	8,214	5,211	4,125	10,834	5,602	-48
Crack	6	12	12	14	13	14	+7.6
Amphetamines	307	10	564	176	601	279	-53.1
Ecstasy (tablets)	1,359,912	342,923	106,597	663,595	1,510,500	156,337	-90
LSD (blotter)	13,107	90,021	10,209	28,411	na	4,135	na
Ketamine	2	65	3	14	na	4.6	na

Source: OSIRIS (OCRTIS)

na: not available

Heroin

Heroin seizures in 2012 declined sharply, confirming the trend that has been observed over the last few years. However, the 2012 seizures remained high compared with those of the 2000s - 2012 quantities were three times what they were in France from 1999 to 2001. The fragmenting of heroin trafficking, which is now dispersed among many minor structures that distribute smaller quantities of substances, may explain the contrast between a steady decrease in seizures and the certain availability of the substance in France.

Cocaine

Cocaine seizures in 2012 declined sharply compared with 2011, which was an exceptional year in which the symbolic threshold of 10 tonnes was exceeded due to substantial maritime seizures in the Antilles (Guadeloupe, Martinique) and the increase in seizures at French airports. Nevertheless, these results are the norm: while in the 90s, the average French seizure was approximately one tonne, since the early 2000s, this average has regularly exceeded five tonnes (Gandilhon 2012).

Crack seizures have been erratic since the early 2000s. Although they are up since 2007, it is difficult to discern a long term pattern.

Ecstasy

In 2012, ecstasy tablet seizures fell by 90% and returned to the levels seen in 2009, which was an exceptionally low year due to an MDMA shortage following the massive destruction in Cambodia of a precursor required for the drug's production. However, contrary to the 2009 situation, this significant decrease was not due to a shortage, but rather due to the very random seizures in France resulting from the fragmentation of the drug's trafficking network.

Other synthetic drugs: new psychoactive substances (NPS)

From 2008 to 2011, the number of NPS seized increased sixfold, from 21 to 133. In the first half of 2012 alone, there were 83 NPS seizures (Lahaie *et al.* 2013). At the end of the same year, French customs officers intercepted packages weighing as much as two kilograms. This is much heavier than the several grams that had customarily been transferred, indicating likely purchasing for trafficking purposes.

10.3.2. Quantities and numbers of seizures of chemical precursors used in the manufacture of illicit drugs

There is no data on seizures of precursor chemicals because France is currently not (or is only marginally) an illegal drug-producing country.

10.3.3. Number of illicit laboratories and other production sites dismantled and precise types of illicit drugs manufactured there

The last dismantlement of a clandestine production laboratory in France was in 2005. It was a cocaine production unit in the community of Perreux in the Val-de-Marne region of France.

10.4. Price/Purity

10.4.1. Price of illicit drugs at retail level (ST 16 2013)

Cannabis

According to OCRTIS (OCRTIS 2013), the median price for herbal cannabis in 2012 was approximately €8 per gram and ranged from €6.60 to €10 per gram. This price was up compared with previous years (€6.50 in 2009 and €7.00 in 2010). According to the TREND scheme's price barometer, the median price for herbal cannabis is around €10 (Gandilhon *et al.* 2011). This upward phenomenon is explained by the fact that an increasing percentage of users appear to display a marked preference for "high-quality" products.

The wholesale price, as determined by law enforcement, stands at €3,625 per kilogram.

For the OCRTIS, the median price of cannabis resin is on the rise. In 2012, it was €6 per gram. This observation was confirmed by the TREND scheme, since the median price per gram according to this network was approximately €7 (Table 10.2). The wholesale price of cannabis resin for the same year was €2,000 per kilogram.

Heroin

According to the OCRTIS in 2012, the median price for a gram of brown heroin was approximately €35, down more than 10% compared with 2010. If this downward trend continues, this would indicate a certain trend reversal since the price per gram had been stable since 2007. Nevertheless, over the longer term, the trend is clearly downward since the price of a gram of heroin in the early 2000s was approximately €60. For 2012, the TREND system reported a stabilisation of the price at around €40.

The wholesale price for brown heroin has also decreased to approximately €9,000 per kilogram.

Misuse of substitution medications

Since 2008, the price per 8 mg tablet of HDB marketed as Subutex[®], the only (or almost only) form available on the black market in major urban centres, rose slightly to €5.50-5.60 in 2011 compared with the €4 price of previous years (Cadet-Taïrou *et al.* 2010b). This price increase is believed to be related to difficulties in keeping the market supplied due to the strict prescription control measures put in place by health authorities.

The price of a 60 ml vial of methadone ranges from €5 to approximately €20, depending on the location.

Cocaine

The price per gram of cocaine hydrochloride has remained stable for five years after having been halved compared with the late 90s. According to the OCRTIS, the median price of cocaine in 2012 rose markedly to approximately €65. The TREND system observed the exact same phenomenon, with an increase hovering between €70 and €75. Moreover, whereas until recently, prices were higher on the party scene than they were in urban areas, they are now aligning. This general increase in cocaine prices is to be confirmed in 2013.

The wholesale price, which also remained stable, was €30,000 per kilogram.

Table 10.2 : Change in median drug prices (in Euros) since 2000

	TREND*				OCRTIS**	
	2000	2010	2011	2012	2011	2012
Heroin	59	42	40	41	40	35
Cocaine	84	67	68	76	60	65
Ecstasy (tablets)	15	7.7	7	10	6	7.5
Cannabis resin	NA	5	5.4	7	5	6
Herbal cannabis	NA	8	8	10	7.5	8
Amphetamines	15	16	15.5	na	na	na
LSD (blotter)	8.5	10	10	na	na	na
HDB/Subutex [®] /8mg	6.3	5	4.8	na	na	na

Source:

* Half-yearly TREND (OFDT) price analysis for heroin, cocaine, ecstasy tablets, cannabis resin and herbal cannabis; TREND ethnographic observations for amphetamines, LSD and HDB.

** Baromètre prix OCRTIS

na: not available

Ecstasy

It is necessary to indicate the galenic form in which the substance is sold: tablets, powder or crystal.

According to the OCRTIS, the 2012 price of a tablet of ecstasy was €7.50, indicating a relative increase compared with previous years. However, this retail price does not fully reflect the reality of the retail market since users tend to buy several dozens of tablets at once to lower the unit price they pay. By doing so, consumers can lower the unit price of a tablet to €2.50.

For the TREND scheme, the median price of a tablet was also on the rise, hovering at around €10, while the powder (MDMA) and crystal forms were approximately €60 per gram. For the latter two forms, the price is experiencing a downward trend.

10.4.2. Purity/potency of illicit drugs (ST 14 2013)

Cannabis

The increase in mean THC potency seen since the 2000s continued in 2012. THC levels in resins increased sharply, from 12% in 2011 to 16% in 2012. For resins, this was due primarily to the increase in the circulation of high-dose resins (>15%) and the concomitant decrease in the circulation of low-dose resins (< 2%). The maximum THC content observed in resin was 38% in 2012 (INPS (Institut national de police scientifique) 2013).

The THC potency in herbal cannabis rose from 10% on average in 2010 to 11% in 2011. This trend can also be explained by an increase in high-dose (>15%) herbal cannabis. The maximal THC potency found in herbal cannabis in 2011 was 34%.

Heroin

Data from the INPS (the National Forensic Science Institute) clearly show a decline in mean street heroin potency from 13% in 2010 to 8% in 2011, then to 7% in 2012, the lowest potency levels seen in 12 years. The SINTES-Heroin study conducted in 2011 indicated that the mean potency of samples of heroin bought by users halved from 12% in November 2010 to 6% in December 2011 (Lahaie in press). Moreover, the further the heroin was found from the borders of Belgium and the Netherlands, the two main storage and secondary redistribution countries for western Europe, the lower the potency of the drug.

Cocaine

In 2012, cocaine potency in seized street samples (i.e., weighing under 10g) stabilised. The majority of samples had a potency of 10% to 20%, versus 10% to 40% in 2010.

Ecstasy

The purity of MDMA powder, the administration form that is becoming increasingly present on the French market, is continuing its increase, from 47% in 2009 to 55% in 2011 and to 63% in 2012). This increase in purity was also seen in ecstasy tablets (21% in 2009, 23% in 2011 and 35% in 2012). In 2012, analyses of samples collected through SINTES revealed the presence of sometimes very high dose tablets on the market (up to 90% in Lille).

10.4.3. Composition of illicit drugs and drug tablets (ST 15 2013)

Heroin

Since the early 2000s, more than nine out of every ten heroin samples have been found to contain a mixture of caffeine (20% to 40%) and paracetamol (40% to 60%) (Lahaie *et al.* 2010). Therefore, this combination represents the cutting agent of choice. The remainder is comprised of inactive products such as sugars and mannitol.

Pharmacologically active adulterants, such as diazepam, phenacetin, dextromethorphan and alprazolam, were identified in a few samples in 2011 (Lahaie in press).

Cocaine

When cocaine arrives in France, it has already been cut using psychoactive substances such as levamisole, hydroxyzine and diltiazem (Lahaie 2011). Its mean purity is up to 63%, which double the level of street cocaine. It is then re-cut with other psychoactive substances such as phenacetin, lidocaine and sugars (mannitol, inositol and glucose) before being dealt on the street.

Levamisole remains the most frequently found adulterant (present in more than half of samples, representing an increase since 2010) although its potency is low (mean of 10% of the total volume of a sample). Phenacetin is still the second most frequently seen adulterant in cocaine samples (approximately 40%). At approximately one third of the total volume of a sample, it is present in higher levels than levamisole, and nearly at the same levels as the cocaine itself.

Ecstasy

In 2011, caffeine was the ingredient most often combined with MDMA. The presence of mCPP has become very rare since 2009.

Part B: Bibliography

Alphabetic list of bibliographic references

- ANAES (2005). Conférence de consensus, Lyon, 23-24 juin 2004. Stratégies thérapeutiques pour les personnes dépendantes des opiacés : place des traitements de substitution. Textes des recommandations. ANAES, Saint-Denis.
- ANSM (2013). Compte rendu de la séance n°1 du 21 mars 2013 de la Commission des stupéfiants et des psychotropes [online]. Available: [http://ansm.sante.fr/L-ANSM2/Commissions-consultatives/Commission-des-stupefiants-et-des-psychotropes/\(offset\)/3](http://ansm.sante.fr/L-ANSM2/Commissions-consultatives/Commission-des-stupefiants-et-des-psychotropes/(offset)/3) [accessed 07/06/2013].
- Antona, D., Letort, M.J. and Lévy-Bruhl, D. (2009). Estimation du nombre annuel de nouvelles infections par le virus de l'hépatite B en France, 2004-2007. BEH - Bulletin Epidémiologique Hebdomadaire (20-21) 196-199.
- Assurance Maladie Medic'AM 2008-2012 [online]. Available: <http://www.ameli.fr/l-assurance-maladie/statistiques-et-publications/donnees-statistiques/medicament/medic-am-2008-2012.php> [accessed 07/06/2013].
- Bantuelle, M. and Demeulemeester, R. (2008). Référentiel de bonnes pratiques. Comportements à risque et santé : agir en milieu scolaire. Programmes et stratégies efficaces. INPES, Saint-Denis.
- Barré, M.C., Pottier, M.L. and Delaitre, S. (2001). Toxicomanie, police, justice : trajectoires pénales. OFDT, Paris.
- Beck, F., Guignard, R., Richard, J.B., Tovar, M.L. and Spilka, S. (2011). Les niveaux d'usage des drogues en France en 2010. Exploitation des données du Baromètre santé 2010 relatives aux pratiques d'usage de substances psychoactives en population adulte. Tendances (76) 1-6.
- Bello, P.Y., Cadet-Taïrou, A. and Halfen, S. (2010). L'état de santé des usagers problématiques. In: Costes, J.M. (Ed.) Les usages de drogues illicites en France depuis 1999 vus au travers du dispositif TREND. OFDT.
- Ben Diane, M.K., Rotily, M. and Delorme, C. (2001). Vulnérabilité de la population carcérale française face à l'infection VIH et aux hépatites. In: Joubert, M., Chauvin, P., Facy, F. & Ringa, V. (Eds.) Précarisation, risque et santé. Inserm, Paris.
- Ben Lakhdar, C. (2007). Le trafic de cannabis en France. Estimation des gains des dealers afin d'apprécier le potentiel de blanchiment. OFDT, Saint-Denis.
- Ben Lakhdar, C. (2009). La culture du cannabis en France : implication, volume et quantités. Alcoologie et Addictologie 31 (2) 121-127.
- Ben Lakhdar, C. (2012). Taille du marché de la cocaïne en France. In: Pousset, M. (Ed.) Cocaïne, données essentielles. OFDT, Saint-Denis.
- Bergeron, H. (1999). L'Etat et la toxicomanie : histoire d'une singularité française. PUF, Paris.
- Böhning, D. and Del Rio Vilas, V.J. (2009a). On the question of proportionality of the count of observed scrapie cases and the size of holding. BMC Veterinary Research 5 (17) 1-11.
- Böhning, D. and van der Heijden, P.G.M. (2009b). A covariate adjustment for zero-truncated approaches to estimating the size of hidden and elusive populations. Annals of Applied Statistics 3 (2) 595-610.
- Botvin, G.J. and Griffin, K.W. (2002). Life skills training as a primary prevention approach for adolescent drug abuse and other problem behaviors. International Journal of Emergency Mental Health 4 (1) 41-47.
- Brisacier, A.C. (2013). Morbidité et mortalité liées aux drogues illicites. In: OFDT (Ed.) Drogues et addictions, données essentielles. OFDT, Saint-Denis.

- Brisacier, A.C. and Colin, C. (in press). Données récentes relatives aux traitements de substitution aux opiacés. Analyse des remboursements concernant l'échantillon généraliste des bénéficiaires en 2011. OFDT ; ANSM, Saint-Denis.
- Brouard, C., Delarocque Astagneau, E., Meffre, C., Pioche, C., Silvain, C., Larsen, C. *et al.* (2009). Évolution du dépistage de l'hépatite C en France à partir des systèmes de surveillance Rena-VHC et des pôles de référence, 2000-2007. BEH - Bulletin Epidémiologique Hebdomadaire (20-21) 199-204.
- Cadet-Taïrou, A., Gandilhon, M., Toufik, A. and Evrard, I. (2008). Phénomènes émergents liés aux drogues en 2006. Huitième rapport national du dispositif TREND. OFDT, Saint-Denis.
- Cadet-Taïrou, A., Coquelin, A. and Toufik, A. (2010a). CAARUD : profils et pratiques des usagers en 2008. Tendances (74) 1-4.
- Cadet-Taïrou, A., Gandilhon, M., Lahaie, E., Chalumeau, M., Coquelin, A. and Toufik, A. (2010b). Drogues et usages de drogues en France. État des lieux et tendances récentes 2007-2009. Neuvième édition du rapport national du dispositif TREND. OFDT, Saint-Denis.
- Cadet-Taïrou, A. (2012). Résultats ENa-CAARUD 2010. Profils et pratiques des usagers. OFDT, Saint-Denis.
- Cadet-Taïrou, A., Gandilhon, M. and Lahaie, E. (2012a). Phénomènes marquants et émergents en matière de drogues illicites (2010-2011). Tendances (78) 1-6.
- Cadet-Taïrou, A. and Janssen, E. (2012b). Les usagers précaires de cocaïne et de crack. In: Pousset, M. (Ed.) Cocaïne, données essentielles. OFDT, Saint-Denis.
- Cadet-Taïrou, A. and Dambélé, S. (2013a). Héroïne et autres opiacés. In: OFDT (Ed.) Drogues et addictions, données essentielles. OFDT, Saint-Denis.
- Cadet-Taïrou, A. and Gandilhon, M. (2013b). Marchés, produits, usagers : les tendances récentes (2011-2012). Observations au plan national du dispositif TREND en matière de psychotropes illicites ou détournés de leur usage. Tendances (86) 1-8.
- Calderon, C., Lagomanzini, P., Maguet, O., Menneret, F., Drogues et Société, CIRDD Rhône-Alpes *et al.* (2011). Insertion sociale et par l'emploi des usagers de drogues. Recommandations pour un accompagnement individuel et collectif. CIRDD Rhône-Alpes, Lyon.
- Canarelli, T. and Coquelin, A. (2009). Données récentes relatives aux traitements de substitution aux opiacés. Premiers résultats d'une analyse de données de remboursement concernant plus de 4 500 patients en 2006 et 2007. Tendances (65) 1-6.
- CEIP de Marseille (2012). OPPIDUM, principaux résultats de l'enquête n°23, 3-30 octobre 2011. ANSM, Saint-Denis.
- Chalumeau, M. (2010). Les CAARUD en 2008. Analyse nationale des rapports d'activité ASA-CAARUD. OFDT, Saint-Denis.
- Chemlal, K., Bouscaillou, J., Jauffret-Roustide, M., Semaille, C., Barbier, C., Michon, C. *et al.* (2012). Offre de soins en milieu carcéral en France : infection par le VIH et les hépatites. Enquête Prévacar, 2010. BEH - Bulletin Epidémiologique Hebdomadaire (10-11) 131-134.
- Choquet, M., Ledoux, S., Hassler, C. and Pare, C. (1998). Adolescents (14-21 ans) de la protection judiciaire de la jeunesse et santé. INSERM, Paris.
- Chouvy, P.A. (2013). L'opium Afghan : 20 ans de suprématie mondiale. Drogues, enjeux internationaux (5) 1-5.
- CNS (Conseil national du sida) (2009). Note valant avis sur l'expérimentation des programmes d'échange de seringues dans les établissements pénitentiaires, 10 septembre 2009.
- CNS (Conseil national du sida) (2011). Note valant avis sur l'impact des politiques relatives aux drogues illicites sur la réduction des risques infectieux, 20 janvier 2011.

- Coppel, A. (2002). Peut-on civiliser les drogues ? De la guerre à la drogue à la réduction des risques. La Découverte, Paris.
- Costes, J.M. (2007). Cannabis, données essentielles. OFDT, Saint-Denis.
- Costes, J.M., Vaissade, L., Colasante, E., Palle, C., Legleye, S., Janssen, E. *et al.* (2009). Prévalence de l'usage problématique de drogues en France - estimations 2006. OFDT, Saint-Denis.
- Costes, J.M. (2010). Les usages de drogues illicites en France depuis 1999 vus au travers du dispositif TREND. OFDT, Saint-Denis.
- Crofts, N. (1994). Hepatitis C infection among injecting drug users: where do we go from here? Drug and Alcohol Review 13 (3) 235-237.
- Currie, C., Zanotti, C., Morgan, A., Currie, D., De Looze, M., Roberts, C. *et al.* (2012). Social determinants of health and well-being among young people. Health Behaviour in School-aged Children (HBSC) study: International report from the 2009/2010 survey. WHO Regional Office for Europe, Copenhagen.
- Dambélé, S. (2012). Social correlates and social reintegration. 2012 National report (2011 data) to the EMCDDA by the Reitox National Focal Point France. New development, trends and in-depth information on selected issues. OFDT, Saint-Denis.
- Dambélé, S. (in press). Les CAARUD en 2010. Analyse nationale des rapports standardisés d'activité ASA-CAARUD. OFDT, Saint-Denis.
- Delprat, T. (2011). L'accréditation des informations liées à l'usage de nouvelles drogues de synthèse. Une étude à partir des dispositifs de médiation en place sur le web. Master professionnel Information et Communication, spécialité « Web éditorial » - Mémoire de fin d'études. Université de Poitiers.
- DESCO (Direction générale de l'enseignement scolaire) and MILDT (2005). Prévention des conduites addictives. Guide d'intervention en milieu scolaire. CNDP, Paris.
- DGESCO (Direction générale de l'enseignement scolaire) and MILDT (2010). Prévention des conduites addictives. Guide d'intervention en milieu scolaire. CNDP, Paris.
- DGS (2009). Plan national de lutte contre les hépatites B et C 2009-2012. Ministère de la santé et des sports, Paris.
- DGS (2011). Enquête Prevacar - Volet offre de soins - VIH, hépatites et traitements de substitution en milieu carcéral. DGS, Paris.
- DGT-MILDT (2012). Repères pour une politique de prévention des risques liés à la consommation de drogues en milieu professionnel. La documentation française.
- DHOS (2004). Enquête "un jour donné" sur les personnes détenues atteintes par le VIH et le VHC en milieu pénitentiaire : résultats de l'enquête de juin 2003. Direction de l'hospitalisation et de l'organisation des soins, Paris.
- Díaz Gómez, C., Mutatayi, C., Milhet, M. and Obradovic, I. (2011). Bilan d'évaluation du plan gouvernemental 2008-2011 [Non publié]. OFDT, Saint-Denis.
- Direction de la modernisation et de l'action territoriale and Ministère de l'intérieur (2012). Le comportement des usagers de la route. Bilan statistique de l'année 2011. Ministère de l'Intérieur, Paris.
- DJEPVA-MILDT (2012). Prévention des conduites addictives et animation. DJEPVA.
- Duplessy, C. (2012). Résultats de l'enquête nationale sur le dispositif d'automates d'échange de seringues. Enquête menée en 2011 sur les résultats de l'année 2010. Safe, Paris.
- EMCDDA (2012). Rapport annuel 2012 : état du phénomène de la drogue en Europe [EMCDDA 2012 Annual report on the state of the drugs problem in Europe]. Publications Office of the European Union, Luxembourg.
- Fonteneau, L., Guthmann, J.P. and Lévy-Bruhl, D. (2013). Estimation des couvertures vaccinales en France à partir de l'Échantillon généraliste des bénéficiaires (EGB) : exemples de la rougeole, de l'hépatite B et de la vaccination HPV. BEH - Bulletin Épidémiologique Hebdomadaire (8-9) 72-76.

- Foureur, N., Fournier, S., Jauffret-Roustide, M., Labrouve, V., Pascal, X., Quatremere, G. *et al.* (2013). SLAM - Première enquête qualitative en France. AIDES, Paris.
- Gandilhon, M. (2007). Le petit trafic de cocaïne en France. Tendances (53) 1-4.
- Gandilhon, M. (2010). L'institution carcérale en France au miroir des drogues illicites. Cahiers de la Sécurité (12) 153-161.
- Gandilhon, M., Cadet-Taïrou, A., Lahaie, E. and Chalumeau, M. (2010a). Drogues illicites : les observations du dispositif TREND en 2009. Tendances (73) 1-6.
- Gandilhon, M. and Hoareau, E. (2010b). Les évolutions du petit trafic d'héroïne et de cocaïne en France. In: Costes, J.M. (Ed.) Les usages de drogues illicites en France depuis 1999 vus au travers du dispositif TREND. OFDT, Saint-Denis.
- Gandilhon, M., Cadet-Taïrou, A. and Lahaie, E. (2011). Les prix de détail des principales substances psychoactives circulant en France au premier semestre 2011. Note n°2011.18 à l'attention de la MILDT. OFDT, Saint-Denis.
- Gandilhon, M. (2012). Les trafics de cocaïne en France. In: Pousset, M. (Ed.) Cocaïne, données essentielles. OFDT, Saint-Denis.
- Gautier, A., Balinska, M.A., Baudier, F., Bourdessol, H., Buttet, P., Collin, J.F. *et al.* (2005). Baromètre santé médecins/pharmaciens 2003. INPES, Saint-Denis.
- Gautier, A. (2011). Baromètre santé médecins généralistes 2009. Inpes, Saint-Denis.
- Gentilini, M. and Tcheriatchoukine, J. (1996). Infection à VIH, hépatites, toxicomanies dans les établissements pénitentiaires et état d'avancement de l'application de la loi du 18 janvier 1994. Rapport au garde des Sceaux et au secrétaire d'Etat à la Santé. DGS (Direction Générale de la Santé), Paris.
- Girard, G. and Boscher, G. (2010). L'ecstasy, de l'engouement à la "ringardisation". In: Costes, J.M. (Ed.) Les usages de drogues illicites en France depuis 1999 vus au travers du dispositif TREND. OFDT, Saint-Denis.
- Guichard, A. (2012). Adaptation du programme Break the cycle au contexte français. Protocole. INPES, Saint-Denis.
- Guichard, A., Guignard, R., Michels, D., Beck, F., Arwidson, P., Lert, F. *et al.* (in press). Changing patterns of first injection across key periods of the French Harm Reduction Policy: Priminject, a cross sectional analysis. Drug and Alcohol Dependence.
- Hagan, H. and Thiede, H. (2003). Does bleach disinfection of syringes help prevent hepatitis C virus transmission? Epidemiology 14 (5) 628-629.
- Hanna, J. (2010). KLUTS: Ketamine and Lower Urinary Tract Symptoms. Erowid Extracts (19) 12-14.
- Harding-Pink, D. (1990). Mortality following release from prison. Medicine, Science, and the Law 30 (1) 12-16.
- HAS (2006). Hépatite chronique C. Guide - Affection de longue durée. Haute Autorité de santé, Saint-Denis.
- HCSP (2013). Evaluation du Plan national de lutte contre les hépatites B et C 2009-2012. Haut Conseil de la santé publique, Paris.
- Hibell, B., Guttormsson, U., Ahlström, S., Balakireva, O., Bjarnason, T., Kokkevi, A. *et al.* (2012). The 2011 ESPAD report - Substance use among students in 36 European countries. CAN (The Swedish Council for Information on Alcohol and other Drugs), Stockholm.
- Hyst, J.J. and Cabanel, G.P. (2000). Rapport de la Commission d'enquête sur les conditions de détention dans les établissements pénitentiaires en France, créée en vertu d'une résolution adoptée par le Sénat le 10 février 2000. Tomes I et II. Sénat, Paris.
- INPS (Institut national de police scientifique) (2013). Données issues de fichiers STUPS 2012.
- INSERM (2010). Réduction des risques infectieux chez les usagers de drogues. INSERM, Paris.
- INSERM (2012). Médicaments psychotropes : consommations et pharmacodépendances. INSERM, Paris.

- InVS (2012). Découvertes de séropositivité VIH et diagnostics de sida 2003-2011. Réunion des Associations, 20 novembre 2012 [online]. Available: http://www.invs.sante.fr/surveillance/vih-sida/PDF/DO_VIH_sida_2011.pdf [accessed 10/06/2013].
- InVS (2013). Hépatite B aiguë [online]. Available: <http://www.invs.sante.fr/Dossiers-thematiques/Maladies-infectieuses/Hepatites-virales/Hepatite-B/Infection-aigue-symptomatique-par-le-virus-de-l-hepatite-B/Donnees-epidemiologiques> [accessed 10/06/2013].
- Janssen, E. (2012). Estimation du nombre d'usagers de crack en France métropolitaine. In: Pousset, M. (Ed.) Cocaïne, données essentielles. OFDT, Saint-Denis.
- Jauffret-Roustide, M., Couturier, E., Le Strat, Y., Barin, F., Emmanuelli, J., Semaille, C. *et al.* (2006). Estimation de la séroprévalence du VIH et du VHC et profils des usagers de drogues en France, étude InVS-ANRS Coquelicot, 2004. BEH - Bulletin Epidémiologique Hebdomadaire (33) 244-247.
- Jauffret-Roustide, M., Le Strat, Y., Couturier, E., Thierry, D., Rondy, M., Quaglia, M. *et al.* (2009). A national cross-sectional study among drug-users in France: epidemiology of HCV and highlight on practical and statistical aspects of the design. BMC Infectious diseases 9 (113) 1-12.
- Joubert, M., Weinberger, M., Aquatias, S., Khedim, H., Bouhnik, P. and Touze, S. (1995). Trafics de drogues et modes de vie. Revue Toxibase (4) 1-29.
- Kopp, P. and Palle, C. (1998). Vers l'analyse du coût des drogues illégales. Un essai de mesure du coût de la politique publique de la drogue et quelques réflexions sur la mesure des autres coûts. OFDT, Paris.
- Kopp, P. and Fenoglio, P. (2000). Le coût social des drogues licites (alcool et tabac) et illicites en France. OFDT, Paris.
- Kopp, P. and Fenoglio, P. (2006a). Le coût social des drogues en 2003. Les dépenses publiques dans le cadre de la lutte contre les drogues en France en 2003 (Réactualisation du rapport OFDT, mai 1998). OFDT, Saint-Denis.
- Kopp, P. and Fenoglio, P. (2006b). Le coût des traitements et de la mise en œuvre de la loi dans le domaine des drogues. OFDT, Saint-Denis.
- Lahaie, E. and Cadet-Taïrou, A. (2009). The SINTES monitoring system, OFDT Contribution to the National Alert Unit in France. EMCDDA, Lisbon.
- Lahaie, E., Cadet-Taïrou, A. and Janssen, E. (2010). Composition de l'héroïne et connaissance des usagers. Résultats de l'enquête SINTES Observation (mars 2007 à juin 2008). OFDT, Saint-Denis.
- Lahaie, E. (2011). Enquête SINTES 2009 sur la composition des produits de synthèse. OFDT, Saint-Denis.
- Lahaie, E., Martinez, M. and Cadet-Taïrou, A. (2013). Nouveaux produits de synthèse et Internet. Tendances (84) 1-8.
- Lahaie, E. (in press). Héroïne : compositions, prix, connaissance des usagers, à partir des résultats de l'enquête nationale SINTES (novembre 2010-décembre 2011). OFDT, Saint-Denis.
- Langlois, E. (2011). Les traitements de substitution vus par les patients. Quels sont les enseignements de leur expérience ? OFDT, Saint-Denis.
- Lapeyre-Mestre, M. and Boeuf-Cazou, O. (2011). Rôle du pharmacien dans la réduction des risques liés à la toxicomanie. Point de vue des patients sous médicaments de substitution aux opiacés (MSO) et des usagers de drogues. U1027 INSERM - Unité de Pharmacopépidémiologie de Toulouse - AFSSAPS-CEIP.
- Laumon, B., Gadegbeku, B., Martin, J.L., Biecheler, M.B. and The Sam Group (2005). Cannabis intoxication and fatal road crashes in France: population based case-control study. British Medical Journal 331 (7529) 1371-1374.

- Le Vu, S., Le Strat, Y., Barin, F., Pillonel, J., Cazein, F., Bousquet, V. *et al.* (2010). Incidence de l'infection par le VIH en France, 2003-2008. BEH - Bulletin Epidémiologique Hebdomadaire (45-46) 473-476.
- Lermenier, A. (2013). Le marché du tabac. In: OFDT (Ed.) Drogues et addictions, données essentielles. OFDT, Saint-Denis.
- Lukasiewicz, M., Falissard, B., Michel, L., Neveu, X., Reynaud, M. and Gasquet, I. (2007). Prevalence and factors associated with alcohol and drug-related disorders in prison: a French national study. Substance Abuse Treatment, Prevention, and Policy 2 (1) 1-10.
- Maguet, O., Calderon, C., Dorso, V., Menneret, F. and Lagomanzini, P. (2009). Insertion par l'emploi des usagers de drogues. Territoires en réseaux. Commission Européenne, Bruxelles.
- Mainaud, T. (2012). Les établissements d'hébergement pour adultes et familles en difficulté sociale. Activité, personnel et clientèle au 15 décembre 2008. DREES, Paris.
- Martinez, M. and Lahaie, E. (2013). Nouveaux produits de synthèse. In: OFDT (Ed.) Drogues et addictions, données essentielles. OFDT, Saint-Denis.
- Marzo, J.N., Rotily, M., Meroueh, F., Varastet, M., Hunault, C., Obradovic, I. *et al.* (2009). Maintenance therapy and 3-year outcome of opioid-dependent prisoners: a prospective study in France (2003-06). Addiction 104 (7) 1233-1240.
- Merle, S. and Vallart, M. (2010). Martinique, Guyane : les spécificités de l'usage ultra-marin. In: Costes, J.M. (Ed.) Les usages de drogues illicites en France depuis 1999 vus au travers du dispositif TREND. OFDT, Saint-Denis.
- Michel, L., Jauffret-Roustide, M., Blanche, J., Maguet, O., Calderon, C., Cohen, J. *et al.* (2011a). Limited access to HIV prevention in French prisons (ANRS PRI²DE): implications for public health and drug policy. BMC Public Health 11 (400).
- Michel, L., Jauffret-Roustide, M., Blanche, J., Maguet, O., Calderon, C., Cohen, J. *et al.* (2011b). Prévention du risque infectieux dans les prisons françaises. L'inventaire ANRS-PRI²DE, 2009. BEH - Bulletin Epidémiologique Hebdomadaire (39) 409-412.
- MILDT (2008). Plan gouvernemental de lutte contre les drogues et les toxicomanies 2008-2011. La Documentation française, Paris.
- Ministère de l'Economie et des Finances (2012). Politique de lutte contre les drogues et les toxicomanies. Document de politique transversale - Projet de loi de finances pour 2013. République française, Paris.
- Ministère de la justice and Ministère des affaires sociales et de la santé (2012). Prise en charge sanitaire des personnes placées sous main de justice. Guide méthodologique. Ministère de la Justice, Ministère des affaires sociales et de la santé, Paris.
- Ministère de la santé et de la protection sociale and Ministère de la justice (2004). Guide méthodologique relatif à la prise en charge sanitaire des personnes détenues. Ministère de la santé et de la protection sociale, Paris.
- Ministère de la santé et des solidarités (2006). La prise en charge et la prévention des addictions : plan 2007-2011. Ministère de la santé et des solidarités, Paris.
- Ministère de la santé et des sports (2010). Plan national de lutte contre le VIH/SIDA et les IST 2010-2014. Ministère de la santé et des sports, Paris.
- Ministère de la santé et des sports and Ministère de la justice et des libertés (2010). Plan d'actions stratégiques 2010-2014. Politique de santé pour les personnes placées sous main de justice.
- Ministère des affaires sociales et de la santé and MILDT (2013). Guide des traitements de substitution aux opiacés en milieu carcéral.
- Mouquet, M.C., Dumont, M. and Bonnevie, M.C. (1999). La santé des entrants en prison : un cumul de factures de risque. Etudes et résultats (4) 1-10.
- Mouquet, M.C. (2005). La santé des personnes entrées en prison en 2003. Etudes et résultats (386) 1-12.

- Mutatayi, C. (2012). RELIONPREDIL 2011. Actions de prévention des usages de drogues illicites et licites en Rhône-Alpes. OFDT, Saint-Denis.
- Mutatayi, C. and Obradovic, I. (in press). Évaluation des mesures expérimentales du plan gouvernemental 2008-2011. OFDT, Saint-Denis.
- Obradovic, I. (2004). Addictions en milieu carcéral. Enquête sur la prise en charge sanitaire et sociale des personnes détenues présentant une dépendance aux produits licites ou illicites ou ayant une consommation abusive. Rapport, 2003. OFDT, Saint-Denis.
- Obradovic, I. and Canarelli, T. (2008a). Primoprescription de méthadone en établissement de santé. Tendances (60) 1-4.
- Obradovic, I. and Canarelli, T. (2008b). Initialisation de traitements par méthadone en milieu hospitalier et en milieu pénitentiaire. OFDT, Saint-Denis.
- Obradovic, I. (2009). Caractéristiques du public reçu dans les Consultations jeunes consommateurs pour un problème d'addiction, 2005-2007. BEH - Bulletin Épidémiologique Hebdomadaire (30) 332-336.
- Obradovic, I. (2010). La réponse pénale à l'usage de stupéfiants. Tendances (72) 1-6.
- Obradovic, I., Bastianic, T., Michel, L. and Jauffret-Roustide, M. (2011). Politique de santé et services de soins concernant les drogues en prison (thème spécifique 1) [Drug-related health policies and services in prison (Selected issue 1)]. In: OFDT (Ed.) 2011 National report (2010 data) to the EMCDDA by the Reitox National Focal Point France. New development, trends and in-depth information on selected issues. OFDT, Saint-Denis.
- Obradovic, I. (2012a). Évaluation des stages de sensibilisation aux dangers de l'usage de stupéfiants. OFDT, Saint-Denis.
- Obradovic, I. (2012b). La pénalisation de l'usage de stupéfiants en France au miroir des statistiques administratives. Enjeux et controverses. Déviance et Société 36 (4) 441-469.
- Obradovic, I. (2012c). Les stages de sensibilisation aux dangers de l'usage de produits stupéfiants. Évaluation de la mise en oeuvre du dispositif quatre ans après sa création. Tendances (81) 1-6.
- Obradovic, I. (2013). Contrôles et délits routiers. In: OFDT (Ed.) Drogues et addictions, données essentielles. OFDT, Saint-Denis.
- OCRTIS (2009). Usage et trafic des produits stupéfiants en France en 2008 - Stups - Osiris. Ministère de l'Intérieur, de l'Outre-Mer et des Collectivités territoriales, Direction Générale de la Police Nationale, Direction Centrale de la Police Judiciaire, OCRTIS, Paris.
- OCRTIS (2013). Les prix des stupéfiants en France. La photographie au 4ème trimestre 2012. OCRTIS, Nanterre.
- OFDT (2012). Rapport national 2012 (données 2011) à l'OEDT par le point focal français du Reitox. Nouveaux développements, tendances et information détaillée sur des thèmes spécifiques [2012 National report (2011 data) to the EMCDDA by the Reitox National Focal Point France. New development, trends and in-depth information on selected issues]. OFDT, Saint-Denis.
- OFDT (2013). Drogues, chiffres clés (5e édition). OFDT, Saint-Denis.
- OIP (Observatoire International des Prisons) (2005). Les conditions de détention en France. Rapport 2005. La Découverte, Paris.
- Olvera, J.C. and Gandilhon, M. (2012). Les cartels mexicains : de l'Amérique latine à l'Europe. Drogues, enjeux internationaux (3) 1-5.
- ONISR (2012). La sécurité routière en France. Bilan de l'année 2011. La Documentation française, Paris.
- Palle, C. and Vaissade, L. (2007). Premiers résultats nationaux de l'enquête RECAP. Les personnes prises en charge dans les CSST et les CCAA en 2005. Tendances (54) 1-6.
- Palle, C. (2013). Le poids économique de l'alcool. In: OFDT (Ed.) Drogues et addictions, données essentielles. OFDT, Saint-Denis.

- Palle, C. and Rattanatray, M. (2013). Les centres de soins, d'accompagnement et de prévention en addictologie en 2010. Situation en 2010 et évolutions sur la période 2005-2010. OFDT, Saint-Denis.
- Pfau, G. (in press). Etat des lieux de la toxicomanie et phénomènes émergents liés aux drogues à Paris en 2011.
- Prudhomme, J., Ben Diane, M.K. and Rotily, M. (2001). Evaluation des unités pour sortants (UPS). ORS PACA, Marseille.
- Rahis, A.C., Cadet-Taïrou, A. and Delile, J.M. (2010). Les nouveaux visages de la marginalité. In: Costes, J.M. (Ed.) Les usages de drogues illicites en France depuis 1999. OFDT, Saint-Denis.
- Reynaud-Maurupt, C. (2006). Usages contemporains de plantes et champignons hallucinogènes - Une enquête qualitative exploratoire conduite en France. OFDT, Saint-Denis.
- Reynaud-Maurupt, C., Chaker, S., Claverie, O., Monzel, M., Moreau, C., Evrard, I. *et al.* (2007). Pratiques et opinions liées aux usages des substances psychoactives dans l'espace festif "musiques électroniques". OFDT, Saint-Denis.
- Rotily, M., Vernay-Vaisse, C. and Bourlière, M. (1997). Three quarters of one French prison population needed immunisation against hepatitis B [Letter]. British Medical Journal 315 (7099) 61.
- Rotily, M., Delorme, C. and Ben Diane, M.K. (1998). Réduction des risques de l'infection à VIH et des hépatites en milieu carcéral : prévalence des pratiques à risques et analyse des contraintes et de la faisabilité des programmes de réduction des risques en milieu carcéral. Rapport final. ORS PACA, Marseille.
- Rotily, M. (2000). Stratégies de réduction des risques en milieu carcéral. Rapport de la mission santé-justice. Ministère de la justice ; ORS PACA, Paris.
- Rouillon, F., Duburcq, A., Fagnani, F. and Falissard, B. (2007). Etude épidémiologique sur la santé mentale des personnes détenues en prison conduite entre 2003 et 2004. Inserm, Paris.
- Saïd, S., Cadet-Taïrou, A. and Martinez, M. (in press). Résultats ENa-CAARUD 2012. Profils et pratiques des usagers. OFDT, Saint-Denis.
- Sanchez, G. (2006). Le traitement du VHC en prison : le foie, une bombe sous les barreaux. Journal du Sida (185) 9-12.
- Seaman, S.R., Brettell, R.P. and Gore, S.M. (1998). Mortality from overdose among injecting drug users recently released from prison: database linkage study. British Medical Journal 316 (7129) 426-428.
- Senon, J.L., Méry, B. and Lafay, N. (2004). Prison. In: Richard, D., Senon, J.L. & Valleur, M. (Eds.) Dictionnaire des drogues et des dépendances. Larousse, Paris.
- Spilka, S., Le Nézet, O. and Tovar, M.L. (2012). Les drogues à 17 ans : premiers résultats de l'enquête ESCAPAD 2011. Tendances (79) 1-4.
- Spilka, S., Le Nézet, O., Godeau, E. and Beck, F. (2013). La consommation d'alcool parmi les collégiens en 2010 et les lycéens en 2011, en France. BEH - Bulletin Epidémiologique Hebdomadaire (16-17-18) 168-171.
- Stankoff, S., Dherot, J., DAP (Direction de l'administration pénitentiaire) and DGS (Direction générale de la santé) (2000). Rapport de la mission santé-justice sur la réduction des risques de transmission du VIH et des hépatites en milieu carcéral. Ministère de la Justice, Paris.
- Sudérie, G. (2013). Phénomènes émergents liés aux drogues sur le site de Toulouse. Rapport TREND Toulouse. Graphiti-CIRDD Midi-Pyrénées, Toulouse.
- Toufik, A., Escots, S. and Cadet-Taïrou, A. (2010). La transformation des usages de drogues liée à la diffusion des traitements de substitution aux opiacés. In: Costes, J.M. (Ed.) Les usages de drogues illicites en France depuis 1999 vus au travers du dispositif TREND. OFDT, Saint-Denis.

- UNODC (2012). World drug report 2011. United Nations, New York.
- Vaissade, L. and Legleye, S. (2009). Capture-recapture estimates of the local prevalence of problem drug use in six French cities. European Journal of Public Health 19 (1) 32-37.
- Van Elslande, P., Jaffard, M., Fournier, J.Y., Fouquet, K., Nussbaum, F., Perez, E. *et al.* (2011). Stupéfiants et accidents mortels (projet SAM) : Analyse accidentologique des défaillances de conduite sous l'influence de l'alcool et/ou du cannabis. OFDT, Saint-Denis.
- Verger, P., Rotily, M., Prudhomme, J. and Bird, S. (2003). High mortality rates among inmates during the year following their discharge from a French prison. Journal of Forensic Sciences 48 (3) 614-616.
- Vernay-Vaisse, C. and Rotily, M. (1997). Epidémiologie des hépatites virales B et C : évaluation d'un programme de dépistage et de vaccination au centre pénitentiaire de Marseille. Revue d'Epidémiologie et de Santé Publique 45 (Suppl.1) S42-S43.
- Weinberger, D. (2011). Réseaux criminels et cannabis indoor en Europe : maintenant la France ? Drogues, enjeux internationaux (1) 1-6.
- WHO, Wodak, A. and Cooney, A. (2004). Effectiveness of sterile needle and syringe programming in reducing HIV/aids among injecting drug users. World Health Organisation, Geneva.

Alphabetic list of relevant databases available on Internet

BDSP (Banque de données en santé publique). Bibliographic database
<http://www.bdsp.ehesp.fr/Base/SearchForm>

INSERM. CépiDc - Centre d'épidémiologie sur les causes médicales de décès. National statistics on the medical causes of death
<http://www.cepidc.inserm.fr/site4/>

IREB (Institut de recherches scientifiques sur les boissons). Bibliographic database
<http://doc.ireb.com/>

OFDT. ODICER - Observation des drogues pour l'information sur les comportements en régions
<http://www.ofdt.fr/ofdtdev/live/donneesloc.html>

OFDT. Répertoire des sources statistiques
<http://www.ofdt.fr/ofdtdev/live/donneesnat/sources.html>

OFDT. Statistical series
<http://www.ofdt.fr/ofdtdev/live/donneesnat/series.html>

Alphabetic list of relevant Internet addresses

AFR (Association française pour la réduction des risques)

<http://a-f-r.org>

ANPAA (Association nationale de prévention en alcoologie et addictologie)

<http://www.anpaa.asso.fr>

ANSM (Agence nationale de sécurité du médicament et des produits de santé)

<http://ansm.sante.fr/>

ASUD (Autosupport et réduction des risques parmi les usagers de drogues)

<http://www.asud.org>

CRIPS (Centres régionaux d'information et de prévention du sida)

<http://www.lecrips.net>

Fédération addiction

<http://www.federationaddiction.fr/>

FNORS (Fédération nationale des observatoires régionaux de la santé)

<http://www.fnors.org/index.html>

Hôpital Marmottan

<http://www.hopital-marmottan.fr>

INPES (Institut national de prévention et d'éducation pour la santé)

<http://www.inpes.sante.fr>

MILDT (Mission interministérielle de lutte contre la drogue et la toxicomanie)

<http://www.drogues.gouv.fr>

OFDT

<http://www.ofdt.fr>

SFA (Société française d'alcoologie)

<http://www.sfalcoologie.asso.fr>

Annexes

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Appendix IV - List of abbreviations

AAH	Allocation adulte handicapé	Disability Living Allowance
ABV	Alcohol By Volume	
AFSSAPS	Agence française de sécurité sanitaire des produits de santé	(French) Agency for the Safety of Health Products (now ANSM)
AIDS	Acquired Immuned Deficiency Syndrome	
ALD	Affection de longue durée	Long Duration Disease
AME	Aide médicale d'État	State Medical Assistance (for foreigners without medical coverage)
AMELI	Assurance maladie en ligne	National file of the national health insurance
AMM	Autorisation de mise sur le marché	Marketing Authorisation
ANAES	Agence nationale d'accréditation et d'évaluation en santé	(French) National Agency for Accreditation and Evaluation of Health Care
ANRS	Agence nationale de recherche sur le sida et les hépatites virales	(French) National AIDS and viral hepatitis research agency
ANSM	Agence nationale de sécurité du médicament et des produits de santé	(French) National Agency for Medicines and Health Products Safety
ARS	Agence régionale de santé	Regional Health Agency
ASA-CAARUD	Analyse nationale des rapports d'activités des CAARUD (OFDT)	National analysis of CAARUD activity reports (OFDT) (<i>see list of sources</i>)
ATR	Appartement thérapeutique relais	Follow-up therapeutic apartment housing
BAFA	Brevet d'aptitude aux fonctions d'animateur	Certificate for activity leaders in a holiday camp
BEP	Brevet d'étude professionnelle	Professional training diploma
CAARUD	Centre d'accueil et d'accompagnement à la réduction des risques des usagers de drogues	Support Centre for the Reduction of Drug-related Harms (low-threshold structures)
CAP	Certificat d'aptitude professionnelle	Vocational Training Certificate
CCNE	Comité consultatif national d'éthique pour les sciences de la vie et de la santé	National Ethics Advisory Committee for the life sciences and health

CD4	CD4 cells send signals to activate our body's immune response to fight viruses or bacteria. A CD4 count of fewer than 200 cells/mm ³ is one of the qualifications for a diagnosis of AIDS.	
CDAG	Centre de dépistage anonyme et gratuit	Anonymous Free Screening Centre
CECLAD-M	Centre de coordination de lutte anti-drogue en Méditerranée	Mediterranean anti-drug coordination centre
CEIP	Centre d'évaluation et d'information sur la pharmacodépendance	Centre for Evaluation and Information on Pharmacodependence
CépiDc	Centre d'épidémiologie sur les causes médicales de décès	Centre for epidemiology of the medical causes of death
CESC	Comité d'éducation à la santé et la citoyenneté	Health Education and Citizenship Committee
CHRS	Centre d'hébergement et de réinsertion sociale	Social Housing Centre
CI	Confidence Interval	
CIDDIST	Centre d'information, de dépistage et de diagnostic des infections sexuellement transmissibles	Centre for providing information, screening, diagnosing and treating sexually transmitted diseases
CJC	Consultation jeunes consommateurs	Counselling Clinics for Young User
CJN	Casier judiciaire national	National Criminal Record
CMU	Couverture maladie universelle	Universal Medical Coverage
CMU-C	Couverture maladie universelle complémentaire	Complementary Medical Insurance Coverage
CNAM	Caisse nationale de l'assurance maladie	(French) National public health insurance centre
CNS	Conseil national du sida	(French) National AIDS Council
CPT	Comité de prévention de la torture	European Committee for the Prevention of Torture
CRIPS	Centre régional d'information et de prévention du sida	Regional AIDS Information and Prevention Centre
CSAPA	Centre de soins, d'accompagnement et de prévention en addictologie	National Treatment and Prevention Centre for Addiction
CSP	Code de la santé publique	Public Health Code

CSSRA	Centre de soins de suite et de réadaptation en addictologie	Addiction Follow-up and Rehabilitation Centre
CSST	Centre spécialisé de soins pour toxicomanes	Specialised Care Centre for Drug Users
CT	Communauté thérapeutique	Therapeutic Communities
CTC	Centre thérapeutique communautaire	Community treatment centres, also called "Therapeutic Communities"
CTR	Centre thérapeutique résidentiel	Residential Treatment Centre
DAP	Direction de l'administration pénitentiaire (ministère de la Justice)	Prisons Administration Directorate (Ministry of Justice)
DEA	Drug Enforcement Administration	
DESCO / DGESCO	Direction de l'enseignement scolaire (ministère de l'Éducation nationale)	National Directorate on School Teaching (Ministry of National Education)
DGAS	Direction générale de l'action sociale (ministère des Affaires sociales et de la Santé)	General Directorate for Social Action (Ministry of Social affairs and Health)
DGCS	Direction générale de la cohésion sociale (ministère des Affaires sociales et de la Santé)	General Directorate for Social Cohesion (Ministry of Social affairs and Health)
DGDDI	Direction générale des douanes et droits indirects (ministère de l'Économie et des Finances)	French customs (Ministry of Economy and Finances)
DGOS	Direction générale de l'offre de soins (ministère des Affaires sociales et de la Santé)	General Directorate for the Provision of Care (Ministry of Social affairs and Health)
DGS	Direction générale de la santé (ministère des Affaires sociales et de la Santé)	National Health Directorate (Ministry of Social affairs and Health)
DGT	Direction générale du travail (ministère du Travail et de l'emploi)	General Directorate for Labour (Ministry of Labour and Employment)
DHOS	Direction de l'hospitalisation et de l'organisation des soins (ministère des Affaires sociales et de la Santé)	Directorate for Hospitalisation and Organisation of Care (Ministry of Social affairs and Health)
DJEPVA	Direction de la jeunesse, de l'éducation populaire et de la vie associative (ministère des Sports et de la Jeunesse)	Directorate of Youth, Popular Education and Community Life (Ministry of Sports and Youth)
DOM	Département d'outre-mer	French overseas departments

DPJJ	Direction de la protection judiciaire de la jeunesse (ministère de la Justice)	Judicial Youth Protection Directorate (Ministry of Justice)
DPT	Document de politique transversale	Transversal Policy Document
DRAMES	Décès en relation avec l'abus de médicaments et de substances (ANSM)	Drug and substance abuse-related deaths (ANSM) (<i>see list of sources</i>)
DREES	Direction de la recherche, des études, de l'évaluation et des statistiques (ministère de la Santé)	(French) Directorate for research, studies, assessment and statistics (Ministry of Health)
ELSA	Equipe de liaison et de soins en addictologie	Addiction liaison and treatment team
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction	
ENa-CAARUD	Enquête nationale auprès des usagers des CAARUD (OFDT)	National survey of CAARUDs low-threshold structures (OFDT) (<i>see list of sources</i>)
EROPP	Enquête sur les représentations, opinions et perceptions sur les psychotropes (OFDT)	Survey on representations, opinions and perceptions regarding psychoactive drugs
ESCAPAD	Enquête sur la santé et les consommations lors de l'appel de préparation à la défense (OFDT)	Survey on Health and Use on National Defence and Citizenship Day (OFDT) (<i>see list of sources</i>)
ESPAD	European School Survey Project on Alcohol and other Drugs (INSERM - OFDT - MJENR) (<i>see list of sources</i>)	
EU	European Union	
EWS	Early Warning System	
FFA	Fédération française d'addictologie	French Federation of Addictology
FND	Fichier national des détenus (ministère de la Justice)	(French) National Register of Prisoners (Ministry of Justice)
FNES	Fédération nationale des comités d'éducation pour la santé	(French) National Federation of Health Education Committees
FNPEIS	Fonds national de prévention, d'éducation et d'information sanitaire	(French) National Fund for Prevention, Education and Health Information
FRAD	Formateurs relais antidrogues (gradés de la Gendarmerie nationale)	Anti-drug liaison trainer (of the French <i>Gendarmerie Nationale</i>)
GBL	Gamma-butyrolactone	
GERS	Groupement pour l'élaboration et la réalisation de statistiques	Group for the Production and Elaboration of Statistics

GHB	Gamma-hydroxybutyrate	
GIDE	Gestion informatisée des détenus en établissement	Computerised Inmate Management Application
GP	General Practitioner	
HAS	Haute autorité de santé	(French) National Authority for Health
HBSC	Health Behaviour in School-aged Children	
HBV	Hepatitis B Virus	
HCSP	Haut conseil de la santé publique	High Council for Public Health
HCV	Hepatitis C Virus	
HDB	High-Dose Buprenorphine	
HIV	Human Immune deficiency Virus	
HLM	Habitation à loyer modéré	Low-rent Social Housing
HPST	(Loi) Hôpital, patients, santé, territoires	Hospital, Patients, Health and Territories (French) law of July 21, 2009
IAE	Insertion par l'activité économique	Integration through economic activity
ICD	International Classification of Diseases	
IDU	Intravenous Drug User or Injecting Drug User	
IFSTTAR	Institut français des sciences et technologies des transports, de l'aménagement et des réseaux	French Institute of Science and Technology for Transport, Development and Networks
INPES	Institut national de prévention et d'éducation pour la santé	(French) National Institute for Prevention and Health Education
INPS	Institut national de police scientifique	(French) National Forensic Science Institute
INSERM	Institut national de la santé et de la recherche médicale	(French) National Institute for Health and Medical Research
InVS	Institut national de veille sanitaire	(French) National Institute for Public Health Surveillance
IRC	Internet Relay Chat	
IUFM	Institut universitaire de formation des maîtres	University institute for teacher training
JAPD	Journée d'appel de préparation à la défense	National defence and preparation day

JDC	Journée défense et citoyenneté	National defence and citizenship day
JO / JORF	Journal officiel de la République française	Official Journal of the French Republic
LOLF	Loi organique relative aux lois de finances	Constitutional bylaw on budget acts
LOPPSI	Loi d'orientation et de programmation pour la performance de la sécurité intérieure	Homeland security performance planning act
LSD	Lysergic Acid Diethylamide	
M€	Million of euros	
mCPP	Metachlorophenylpiperazine	
MDMA	3,4-methylene-dioxymethamphetamine	
MILDT	Mission interministérielle de lutte contre la drogue et la toxicomanie	(French) Interministerial Mission for the Fight against Drugs and Drug Addiction
MNCPC	Mission nationale de contrôle des précurseurs chimiques	(French) National Mission for the Control of Chemical Precursors
MXE	Methoxetamine	
NEMO	Nouvelle étude multicentrique sur les estimations locales de la prévalence de l'usage problématique de drogues (OFDT)	New multicentre study on local estimates of problem drug use prevalence (OFDT) (<i>see list of sources</i>)
NF	Norme française	French certification
NGO	Non-Governmental Organisation	
NPS	New Psychoactive Substance	
OCRIEST	Office central pour la répression de l'immigration irrégulière et de l'emploi des étrangers sans titre	Central office on illegal immigration and employment
OCRTIS	Office central pour la répression du trafic illicite de stupéfiants	Central office for the repression of drug-related offences
OFDT	Observatoire français des drogues et des toxicomanies	French Monitoring Centre for Drugs and Drug Addiction
OIP	Observatoire international des prisons	International observatory on prisons
ONISR	Observatoire national interministériel de la sécurité routière	French National Interministerial Observatory for Road Safety
OPPIDUM	Observation des produits détournés de leur utilisation médicamenteuse (CEIP)	Observation of illegal drugs and misuse of psychotropic medications (CEIP) (<i>see list of sources</i>)

OST	Opioid Substitution Treatment	
PAP	Projet annuel de performance	Annual performance project
PCP	Phencyclidine	
PDU	Problem Drug User	
PFAD	Policier formateur antidrogue	Anti-drug police trainer
PJJ	Protection judiciaire de la jeunesse	Judicial Youth Protection Service
PLFSS	Projet de loi de financement de la Sécurité sociale	Provisional project for the social security budget act
PMSI	Programme de médicalisation des systèmes d'information	Medicalised information system programme
POPHEC	Premier observatoire en prison de l'hépatite C	First hepatitis C prison's observatory
PRELUD / BioPRELUD	(Enquête) Première ligne usagers de drogues (OFDT)	Survey among drug users seen in harm reduction facilities (OFDT) (<i>see list of sources</i>)
PREVACAR	Prévalences en milieu carcéral (DGS/InVS)	Prevalence in prison settings (DGS/InVS) (<i>see list of sources</i>)
PRI2DE	Programme de recherche et d'intervention pour la prévention du risque infectieux en détention	Research and intervention programme to prevent infection among inmates
RECAP	Recueil commun sur les addictions et les prises en charge (OFDT)	Common Data Collection on Addictions and Treatments (OFDT) (<i>see list of sources</i>)
RELION-PREDIL	Recueil d'indicateurs pour l'observation nationale des actions de prévention liées aux drogues illicites et licites (OFDT)	Survey for the monitoring of prevention actions related to licit and illicit drugs (OFDT) (<i>see list of sources</i>)
RESEDA	Réseau d'éducation à la santé, l'écoute et le développement de l'adolescent	Health Education, Counselling and Adolescent Development Network
RMI	Revenu minimum d'insertion	Minimum Benefit Income
RSA	Revenu de solidarité active	Active Solidarity Benefit
S[<i>I</i>]UMPPS	Service [<i>inter</i>] universitaire de médecine préventive et de promotion de la santé	[<i>Inter</i>]-University Preventive Medicine and Health Promotion Service
SAM	Enquête « Stupéfiants et accidents mortels de la circulation routière » (DGS/OFDT/IFSTTAR)	Road safety epidemiological survey on narcotics and fatal road accidents (DGS/OFDT/IFSTTAR)) (<i>see list of sources</i>)

SCL	Service commun des laboratoires	Customs Joint Laboratories Department
SEP	Syringe Exchange Programme	
SIAMOIS	Système d'information sur l'accessibilité au matériel officinal d'injection et de substitution (InVs)	System of information on the accessibility of injection equipment and substitution products (InVs) (<i>see list of sources</i>)
SINTES	Système d'identification national des toxiques et des substances (OFDT)	National Detection System of Drugs and Toxic Substances (OFDT) (<i>see list of sources</i>)
SMPR	Services Médico-psychologiques régionaux	Regional Medico-Psychological Hospital Services
SQ	Standard Questionnaire	
ST	Standard Table	
STI	Sexually Transmitted Infection	
TDI	Treatment Demand Indicator	
THC	Δ^9 -Tetrahydrocannabinol	
TREND	Tendances récentes et nouvelles drogues (OFDT)	Emerging Trends and New Drugs (OFDT) (<i>see list of sources</i>)
TROD	Test rapide d'orientation diagnostique	Rapid Diagnostic Test for Referral
UCSA	Unité de consultation et de soins ambulatoires	Prison-based Hospital Healthcare Unit
UNODC	United Nations Office on Drugs and Crime	
UPS	Unité de préparation à la sortie	Care Unit for Prison Leavers
VAE	Validation of Acquired Experience	
VAT	Value Added Tax	
WHO	World Health Organisation	

Appendix V - List of sources

Acute Hepatitis B Monitoring System

French National Institute for Public Health Surveillance (InVS)

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

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

ASA-CAARUD: National analysis of CAARUD activity reports

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

In addition to the ENa-CAARUD study, the OFDT implemented another epidemiological data collection tool in **low-threshold structures (CAARUDs)**: the standardised annual activity report. This report, which is called ASA-CAARUD, provides information about the type of activities developed in these structures.

Each CAARUD provides quantitative and qualitative information on its activity, the users seen and their practices, as well as on the substances being used. The most recent overall analysis was on 118 reports (from a total of 133 CAARUDs, or 89%) in 2010. Despite the differences that exist from one CAARUD to the next, the analyses described the network from a national and regional point of view, the clients admitted and the main interventions carried out by the CAARUDs.

CJN: National Criminal Record

Sub-Directorate for Statistics and Studies (SDSE) of the Ministry of Justice

Information on convictions has been obtained since 1984 through the use of the National Criminal Record. This information describes the different offences for which convictions have been handed down by judges, the type of procedure, the nature and duration of the sentence, and if applicable, the specific characteristics of convicted offenders (age, sex and nationality).

Since people may be convicted for several offences at once, the main offence is what is most frequently used in the statistics of the Ministry of Justice. Other concepts can be used to refine analyses, such as an isolated offence versus an associated offence. Convictions should not be confused with offenders: a person who has been convicted twice will be counted as two convictions, not one.

Coquelicot: a multi-centre, multi-site survey on the frequency and determining factors in practices that lead to a high risk of HIV and HCV transmission in drug users

French National Institute for Public Health Surveillance (InVS)

The purpose of this survey is to measure the prevalence of HIV and HCV infection in drug users through an epidemiological section (which includes blood testing) and a qualitative section that employs user interviews to identify the determining factors in at-risk practices. The survey focuses on users' perceptions of their health and healthcare, use practices (products 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 survey 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. These people were recruited in various structures (CSAPAs, CAARUDs, housing structures, general medicine practices). Of the 2,389 surveyed drug users, 1,462 (61%) agreed to participate. Of these users, 79% agreed to provide a blood sample from their finger. A new Coquelicot survey was conducted in 2011.

CSAPA Activity Reports: use of activity reports from National Treatment and Prevention Centres for Addiction (CSAPAs)

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

Since 1998, CSSTs (Specialised care centres for drug users), and then the CSAPAs that followed them, have been annually completing a standardised activity report and submitting it to their Regional Health Agency (ARS). These reports are then sent to the DGS, which processes them with the assistance of the OFDT. The aim of this data collection exercise is to monitor the activity of the centres and the number and characteristics of the patients received. Epidemiological data are not recorded patient by patient, but rather for all people received in the centre. For 2010, the reports from the 348 outpatient CSAPAs and 10 prison-based CSAPAs were analysed. The respective response rates were 83% and 67%.

DRAMES: Drug and Substance Abuse-related Deaths

French National Agency for Medicines and Health Products Safety (ANSM)

Implemented in 2002, this survey uses a continuous method for collecting data in mainland France and was set up in order to obtain the most exhaustive data possible on deaths occurring from use of psychoactive substances in the context of drug abuse or addiction. The survey also aims to describe the circumstances under which the body was discovered, the level of abuse at the moment of death and the results of the autopsy, as well as to identify and quantify the substances involved, through blood testing.

Thirty-six toxicological experts performed forensic analyses for the 2010 edition of the survey. DRAMES includes drug-related deaths (the definition of which is similar to that of the European Monitoring Centre for Drugs and Drug Addiction) for which toxicological analyses were performed by experts who took part in the study.

ENa-CAARUD: National survey of low-threshold structures (CAARUDs)

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

Conducted every two years since 2006 in all CAARUDs (on mainland France and in French overseas departments), this survey determines the number of users seen in these structures, the characteristics of these users and their use patterns. Each user who enters into contact with the structure during the survey undergoes a face-to-face interview with someone working at the structure. The questions asked are on use (frequency, age of experimentation, administration route), use-related behaviour (injection, equipment-sharing), screening (HIV, HBV and HCV) and social situation (social coverage, housing, level of education, support from friends and family).

The 2012 survey was conducted from 26 November to 7 December: 4,241 completed or "non-responder" questionnaires were conducted in 142 CAARUDs. After eliminating duplicates (299) and "non-responders" (1,037), 2,905 individuals (in 139 CAARUDs) were included in the analysis.

ESCAPAD: Survey on Health and Use on National Defence and Citizenship Day

The French Monitoring Centre for Drugs and Drug Addition (OFDT) and the National Service Directorate (DSN) of the Ministry of Defence

Originally conducted on an annual basis from 2000 to 2003, the ESCAPAD survey has been organised on a triennial basis since 2005. It takes place on the National Defence and Citizenship Day (JDC), which has existed since obligatory military service was eliminated in France. Young people participating in a JDC session fill out an anonymous, self-administered questionnaire about their use of legal or illegal psychoactive substances and their health and lifestyle.

In 2011, 200 national armed services centres in mainland France and in overseas French departments conducted the survey for a week and a half in April. In total, 32,249 individuals were surveyed and 29,143 questionnaires were analysed. These mainly 17-year-old French nationals were still in higher education or in training, for the most part. On a given day, JDC participation is 90%, but the coverage rate is much higher (people can be summoned on different days because participation is quasi-compulsory to be allowed to register later on for examinations such as university diplomas and the driver licence).

ESPAD: European School Survey Project on Alcohol and Other Drugs

French Monitoring Centre for Drugs and Drug Addiction (OFDT) / Ministry of Youth, National Education and Research (MJENR) / General secretariat of Catholic Education / French National Institute for Health and Medical Research (INSERM U669 / French National Institute for Prevention and Health Education (INPES)

This survey was initiated Europe-wide in 1995 by the Swedish council for information on alcohol and other drugs with the support of the Council of Europe. It takes place every four years in school settings and targets students aged 16 years - the age at which mandatory schooling is over in the majority of European countries. Data collection takes place in the second quarter of the year of the survey.

The 2011 survey took place in 36 countries, including France for the fourth consecutive year. There was one common questionnaire that focused on use, attitudes and opinions related to

drugs. In France, a total of 2,572 students born in 1995, i.e., 15-16 years of age when the 2011 survey was conducted, answered a self-administered questionnaire in a classroom setting in the presence of a health professional.

HBSC: Health Behaviour in School-aged Children survey

University of Edinburgh (CAHRU) for the HBSC network / Medical department of the Toulouse school district for the survey in France / French Monitoring Centre for Drugs and Drug Addiction (OFDT) / French Institute for Prevention and Health Education (INPES)

This is an international survey being conducted every four years since 1982 under the auspices of the European office of the World Health Organisation (WHO). Currently, over 41 countries (including France since 2002) or regions, mainly in Europe, take part and collect standardised information on behaviours that are detrimental to or positive for health in students aged 11, 13 and 15 years. The HBSC survey is self-administered, strictly anonymous and conducted in class under the supervision of a specially trained investigator.

In 2010, 11,754 school-age students from the last year of primary school to the first year of high school were surveyed in public or private establishments in mainland France under contract with the French national education authority. A total of 11,638 questionnaires were analysed.

Health Barometer

French National Institute for Prevention and Health Education (INPES)

The health barometer is a telephone health survey of a representative sample of the population of mainland France: nearly 27,700 individuals aged 15 to 85 years took part in the 2010 edition. Conducted from October 2009 to July 2010, this survey was the most recent in a series of five, entitled, "Adult health barometers", conducted in 1992, 1993, 1995, 2000 and 2005. The survey collects information on various health behaviours and attitudes among French people (such as those pertaining to the use of treatments, depression, vaccination, screening practices, physical activity, violence and sexuality). The survey also broaches the subject of legal and illegal drug use.

Health Barometer - General Practitioners

French National Institute for Prevention and Health Education (INPES)

Since 1992, the INPES has conducted six surveys of general practitioners (1992, 1993/1994, 1994/1995, 1998/1999, 2002/2003 and 2008/2009) and two surveys of retail pharmacists (1998/1999, 2002/2003) using the same methodology developed for the "Health barometer" surveys.

The most recent survey, which was conducted from 6 November 2008 to 31 January 2009, questioned 2,083 general practitioners in private practice, representing one in 30 physicians. These practitioners were questioned on their behaviours, attitudes and opinions regarding their medical practice, and addiction treatment in particular.

HIV/AIDS Monitoring System

French National Institute for Public Health Surveillance (InVS)

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

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

NEMO: National estimate of the number of problem drug user

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

The "capture-recapture" method, which is particularly useful for difficult-to-access populations, provides local estimates of numbers of problem drug users in several cities in France. This method involves cross-checking groups of users surveyed at different observation sites (CSAPAs, CAARUDs, hospitals) to estimate the number of people who are absent. The total number of users encountered and the calculation of the number of those who are absent provides an estimate of the number of problem drug users in each city.

These local prevalence estimates can then be used to perform a national extrapolation. The OFDT subsequently obtains an estimate of the number of problem drug users in France by comparing the number of known drug users treated in the French system to the locally-estimated number.

OPPIDUM: Observation of illegal drugs and misuse of psychotropic medications

Centre for Evaluation and Information on Pharmacodependence (CEIP)

This epidemiological system for monitoring narcotic and psychotropic drug use (illegal or misused substances), through an annual multi-centre study of structures that admit and treat drug users, has existed at national level in France since 1995. Any patient addicted to or abusing psychoactive substances or taking substitution treatment presenting to these structures in the month of October of any given year is included in this study.

The information collected includes the characteristics of individuals and each of the substances used in the last week (description, how it was procured, use, sought effect and signs of addiction). In 2011, 137 centres (or 5,189 patients) took part in the survey. The majority (61%) of patients had been seen in outpatient CSAPAs, but some had been seen in prison-based hospital healthcare units (UCSA) and CAARUDs).

OSIRIS: Statistical information and research tool for drug-related offences

Central office for the Repression of Drug-related Offences (OCRTIS)

All drug-related offence procedures established by the police, *gendarmerie* or customs on French territory (including overseas departments) are registered in the OSIRIS database. It contains information about arrests (classified as simple use, possession, local trafficking, international trafficking) and seizures. However, the least serious cases of narcotics trafficking and those that are settled through a customs transaction are not always registered.

The substance listed is the “dominant drug”, i.e., the substance primarily consumed by the user or the substance held in the largest amount by the dealer. When this rule cannot be used, the “strongest” substance (in this order, heroin, then cocaine, then cannabis) is recorded.

PRELUD: Survey among drug users seen in harm reduction facilities

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

This quantitative survey, conducted annually from 2000 to 2003, and then repeated in 2006, was designed to obtain knowledge about and monitor users of psychoactive substances and their practices. The population studied consists of users attending frontline facilities that provide support to drug users: harm reduction facilities (shops, syringe exchanges) and so called “low-threshold” structures, including “low threshold” methadone distribution centres. People interviewed are not necessarily representative of users attending these centres, as participation in the survey is voluntary.

The BioPRELUD survey represents the biological section of the larger PRELUD survey, which was conducted among CAARUD users in five cities. The prevalence of HIV and HCV observed is reported (declarative data). BioPRELUD gathered biological data (saliva samples).

PREVACAR: Survey on HIV and HCV prevalence in prison settings

National Health Directorate (DGS) / French National Institute for Public Health Surveillance (InVS)

Conducted in June 2010, this survey determined the prevalence of HIV and HCV infection and the proportion of people receiving opioid substitution treatment (OST) in prison settings. The survey also comprises a section on health care delivery in prison settings: screening organisation and practices, treatment of HIV- and hepatitis-infected individuals, access to OSTs and harm reduction.

For the "prevalence" section, data were collected through an anonymous questionnaire completed by the supervising physician. For the "health care delivery" section, a 35-item questionnaire was sent to all 168 prison-based hospital healthcare units (UCSAs): 145 of them sent them back to the DGS, (86% response rate), representing over 56,000 inmates, or 92% of the incarcerated population, on 1st July 2010.

Prison Entrants Health Survey

French Directorate for Research, Studies, Assessment and Statistics (DREES) of the Ministry of Health

This survey was conducted for the first time in 1997 in all remand centres and remand wings within prison settings. The last survey was conducted in 2003. It collects information during the admission medical visit about risk factors for the health of entrants as well as observed pathologies, which are mainly identified from ongoing treatments. Declared use of psychoactive substances included daily smoking, excessive alcohol consumption (more than 5 glasses per day) and “prolonged regular use during the 12 months before imprisonment” of illegal drugs.

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 2011, approximately 96,000 patients seen in 160 outpatient CSAPAs (75%), 18 residential treatment centres (nearly 50%) and 11 prison based CSAPAs (69%) were included in the survey.

RELIONPREDIL: Survey for the monitoring of prevention actions related to licit and illicit drugs

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

The purpose of this survey is to describe the main characteristics of the actions undertaken to prevent licit and illicit drug use at local level. It does not pertain to training, or to the standing counselling, support and consultation activities of specialised structures. The survey is on **actions aimed directly at a subpopulation, the general population or an at-risk group to help prevent new or repeated harmful use practices.**

The RELIONPREDIL survey on the actions undertaken between January and December 2010 was conducted in the Rhône-Alpes region from 3 January to 15 March 2011. The 112 responses collected describe a total of 487 actions undertaken in as many different locations. The limited response rate for certain respondent categories, particularly schools and specialised associations, explains why the overall response rate was only 17%.

Road Traffic Violations Record

Directorate of modernisation and territorial action (Sub-directorate of traffic and road safety) of the Ministry of the Interior

This registry records all road traffic-related offences booked by law enforcement services (Police, Paris prefect police, *gendarmerie*) and classified as speed limit offences, specific controls (helmet, seatbelt, red-lights, stop signs) and the results of alcohol and narcotics blood testing on drivers. Each year, a report is written on this information. This report (*Bilan du comportement des usagers de la route*) is made available to the general public on the website of the Ministry of the Interior: <http://www.interieur.gouv.fr/Publications/Statistiques/Securite-routiere/Bilan-du-comportement-des-usagers-de-la-route>.

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

French National Institute for Public Health Surveillance (InVS)

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. These data are submitted to the InVS by the GERS (Group for the Production and Elaboration of Statistics). They are collected from 509 geographical analysis units that provide regional and departmental information, although information on a lower level is difficult to obtain. This system, along with the national health insurance fund reimbursement data, is used to estimate the number of drug users being treated with opioid substitution medications.

SINTES: National Detection System of Drugs and Toxic Substances

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

The SINTES scheme is intended to document the toxicological composition of illegal substances in circulation in France. The information incorporated in this system comes from two sources:

- the submission to the OFDT of the results of toxicology tests performed on seizures by law enforcement laboratories (French National Forensic Science Institute, Forensic Sciences Institute of the French *gendarmerie* and Customs laboratories)
- investigations conducted by the OFDT on samples of substances obtained directly from users. These collections are governed by a strict regulatory framework and obtained by specifically trained survey workers.

TREND: Emerging trends and New Drugs

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

The aim of the TREND scheme, which was established in 1999, is to provide information about illegal drug use and users, and on emerging phenomena. Emerging phenomena refer either to new phenomena or to existing phenomena that have not yet been detected by other observation systems. The observations are conducted in two social settings chosen due to the high likelihood of finding new or not as yet observed phenomena, even though these do not necessarily reflect the entire reality of the drug use in France:

- urban areas, as defined by TREND, mainly cover low-threshold structures (CAARUDs) and open sites (street, squats). Most of the people met and observed in these settings are problem users of illegal drugs living in particularly precarious conditions.
- Techno party settings refer to places where events are organised around techno music. These include so-called “alternative” techno settings (free-party, teknivals) and techno events in clubs, discothèques and private parties.

The system is based on data analysed by seven local coordinating sites (Bordeaux, Lille, Marseille, Metz, Paris, Rennes and Toulouse) that produce site reports, which are then extrapolated to a national level:

- continuous qualitative data collection by the local coordination network, which has a common data collection and information strategy
- the SINTES scheme, an observation system geared towards detecting and analysing the toxicological composition of illegal substances
- recurring quantitative surveys, particularly among CAARUD users (ENa-CAARUD)
- partner information system results
- thematic quantitative and qualitative investigations that aim to gather more information about a particular subject.