OBSERVATOIRE FRANÇAIS DES DROGUES ET DES TOXICOMANIES

National annual report on drug issues

Annual report sent to the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) giving an overview of the latest developments on the drug problem in France.

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2017 report

The 2017 report is divided in 10 workbooks: Drug Policy, Legal Framework, Drugs, Prevention, Treatment, Best Practice, Harms and Harm Reduction, Drug Market and Crime, Prison and Research.

Drug policy

top of the page

The current overarching general principles of French drug policy were stated in a mission letter on 17 October 2012 sent by the Prime Minister to the chairperson of the Interministerial Mission for Combating Drugs and Addictive Behaviours. The Government stated its vision for the actions to be taken in this policy area as being of a global and integrated nature, entrusting responsibility for their implementation to the MILDECA. The MILDECA reports to the Prime Minister and is in charge of developing the national strategies and actions plans and coordinating their implementation. France's Government Plan for Combating Drugs and Addictive Behaviours 2013–17 was endorsed by the Interministerial Committee chaired by the Prime Minister on 19 September 2013. Its approach is a comprehensive and global one towards illicit and licit drugs (narcotics, alcohol, tobacco, psychotropic medicines and new synthetic products) and other forms of addictive behaviours (gambling, gaming, doping). The 2013–17 strategy (MILDT 2013a) is structured around three main priorities:

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1. To base public action on observation, research and evaluation.
2. To take the most vulnerable populations into consideration to reduce risks and health and social harm.
3. 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.

Four "flagship" measures of the 2013-2017 plan were selected for external evaluation. The first action ("Student liaison officers on health") was evaluated in a university setting and focused on interventions by students selected and trained by preventive medicine services to work in prevention alongside their peers. The main conclusions of the evaluation centred on the need to improve coordination between the addiction medicine network at national level, perceived by university liaison officers who promote prevention as being fragmented and lacking coordination.
The second action ("Easy money") was evaluated alongside inhabitants in the southern districts of Marseille (mothers, professionals, integrated young people and pre-teens) and local partners (council, police, prevention associations involved, etc.). Certain practical difficulties were identified related to the recent nature of the scheme and the complexity of the trafficking prevention task, together with the cultural differences between the populations involved.
Two other initiatives were evaluated more recently: firstly, the new partnership between MILDECA and the National Family Allowance Fund (CNAF), created to follow on from the main public relations campaign targeting the "general public" as part of the 2013-2017 plan. This was followed by two regional intervention programmes aiming for the prevention and early treatment of foetal alcohol syndrome, one in mainland France and the other in overseas territories (DOM-TOM).

Key indicators for the objectives of the plan were introduced by the OFDT.

The directions of public policy in the field of drugs and addictions are defined by the "Interministerial Committee for Combatting Drugs and Addictive Behaviours", on the authority of the Prime Minister. This committee is made up of ministers and secretaries of State. Prior to this stage, MILDECA is responsible for drafting the decisions of the interministerial committee, then coordinating French government policy for combatting drugs and preventing addictive behaviours, and for ensuring that the decisions of the interministerial committee are implemented. On the authority of the Prime Minister, its scope of action includes prevention, treatment, harm reduction measures, integration, trafficking, law enforcement and research, monitoring and training of staff involved in activities to reduce supply and demand. In 2013, MILDECA drew up the governmental drug action plan and addictive behaviours currently in the process of being implemented. A network of approximately one hundred territorial representatives (project managers) on a national scale guarantees the consistency of supply and demand reduction actions. Eighteen of these are responsible for regional coordination, including thirteen in mainland France.

Concerning the most recent key events in terms of changes in public policy, it should be pointed out that electoral news, particularly the presidential elections in April-May have been a major focus in 2017. The electoral campaign represented a milestone in the stance of most major party candidates regarding the status of cannabis. Only the Front National candidate (extreme right party) advocated the status quo, while the other four main contenders for the presidency of the Republic proposed to revise the 1970 French law on narcotics, after noting the ineffectiveness of the current legal framework in France for combatting cannabis.

In terms of public debate, a key event which warrants attention was the organisation of the first public hearing on harm reduction (HR) measures which brought together the main partners in the field in late spring 2016. Further to the presentation of scientific data by specialists and researchers in the field and the discussions, a report was drawn up on trends and guidelines with fifteen proposals for practical measures. These reassert the trends in terms of harm reduction measures,

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falling within the scope of the health system reform law of 26 January 2016, together with the other measures stipulated in the 2013-2017 governmental plan on drugs.
The social cost of drugs in France was estimated at three points, in 1996, 2003 and 2010 (Kopp 2015; Kopp and Fenoglio 2004; Kopp and Fenoglio 2006). The most recent estimate of the social cost of drugs was published by the OFDT in September 2015: hence, for 2010, this cost amounted to EUR 8.7 thousand million for illegal drugs, far behind the amount estimated for alcohol (118 thousand million) and tobacco (122 thousand million).

In 2015, total drug-related expenditure was estimated at EUR 1.83 thousand million. State and National Health Insurance Fund contributions account for 0.05% of gross domestic product (GDP), with 51% of the total for demand reduction initiatives, 48% for supply reduction activities and 1% of resources allocated to cross-disciplinary activities (research, training, monitoring, evaluation, coordination and international cooperation).

▸ Download Workbook 1.1 : Drug Policy

Legal framework

top of the page

In France, the illegal use of any substance or plant classified as a narcotic is an offence punishable by sentences of up to one year in prison and a fine of €3,750 (Article L.3421-1 of the French Public Health Code - CSP). The sentences incurred may be up to five years in prison and a fine of €75,000 when the offence is committed by a public authority, a person responsible for public services or personnel in a company carrying out duties calling into question transport safety. Persons prosecuted for these offences also face additional penalties such as a compulsory awareness course on the dangers of drug and alcohol use, in accordance with the provisions set forth in Article 131-35-1 of the French Penal Code.

Aside from the sentences issued by the courts in compliance with Article L.3421-1 of the CSP, an awareness course may also be proposed by the public prosecutors as an alternative to prosecution or simplified procedure (fixed penalty notice, criminal order). In this context, this measure is particularly intended for occasional narcotics users who do not appear to present health or social integration problems. The course applies to all individuals aged over 13 years. When circumstances show that the respondent requires health care, the legal authorities may require them to undergo court-ordered treatment (Article L.3413-1 of the CSP). Public action is not taken once it has been established that the individual has undergone court-ordered treatment, following the events of which s/he was accused (Article L.3423-1 of the CSP).

Illegal transport, possession, proposal, sale, acquisition or use and the fact of facilitating the illegal use of narcotics are punishable by a maximum of ten years in prison and a fine of €7.5 million (Article L.222-37 of the French Penal Code). The illegal proposal or sale of narcotics to a person with a view to personal use is punishable by five years in prison and a fine of €75,000; however, the prison sentence is extended to ten years when narcotics are proposed or sold to minors, in learning or educational establishments or on government premises, and at or very close to the time when students or the public are entering or leaving these establishments premises, in the vicinity of these establishments or premises (Article L.222-39 of the French Penal Code). The maximum penalties incurred for trafficking are life imprisonment and a fine of €7.5 million (Article L.222-34 of the French Penal Code). The law itself does not distinguish between possession for personal use or for trafficking, nor by type of illegal substance.

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There are no specific laws regulating new psychoactive substances (NPS). The rationale for classifying a NPS on the list of narcotics is both individual (each prohibited substance is named on the list) and generic: it "starts with a basic molecular structure (not necessarily psychoactive) and stipulates the variants affected by the ban" (Martinez 2013).

▸ Download Workbook 1.2 : Legal framework

Drugs

top of the page

The main illicit drugs and polydrug use

According to the latest available data (2016), cannabis is still by far the most widely used illicit substance, both among teenagers and the adult population, with 17 million people having already tried it (42% of 18 to 64 year-olds). In 2014 (latest available data) the overall proportion of recent users (in the last month) is 6.3%, and regular use (at least 10 times per month) is 3.1%.

Among last year users aged 18 to 64 years, according to the 2014 Health Barometer Survey of *Santé publique France*, the proportion of those at high risk of problem cannabis use (according to the Cannabis Abuse Screening Test, CAST) is 21%, i.e. 2.2% of the French population aged 18 to 64 years. Cannabis is also the most frequently reported substance mentioned as the principal reason for entering drug treatment (CSAPA). As far as synthetic cannabinoids are concerned, 1.7% of adults aged 18 to 64 state that they have already used such substances. Their use levels are similar to heroin or amphetamines.

Cannabis stands out as the illicit substance most widely used between the ages of 11 and 16 years, particularly among boys. In terms of lifetime cannabis use, it was extremely rare among 11 year-olds, it was found in 5.6% of 13 year-olds and 28.3% among 15 year-olds (data from the 2014 HBSC survey). These proportions are stable when compared to 2010. According to the latest ESPAD survey, in 2015, 32% of the students aged 16 have used cannabis at least once during their lifetime (29% of girls and 24% of boys). This represents a decrease compared with the previous 2011 ESPAD survey (39% of the students).

Cannabis use rose between 2010 and 2014 and has since remained at high levels, regardless of age group and frequency of use: this rise is part of a context of a marked increase in cannabis supply in France, particularly home cultivation and local production of herbal cannabis, while the cannabis resin market is still very dynamic (see workbook Drug Market and Crime).

The use of cocaine, the second most frequently used illicit substance, is far below that of cannabis and concerns approximately one tenth the number of people, either in terms of lifetime use or use in the past year. However, the proportion of lifetime cocaine users aged 18 to 64 has increased four-fold in two decades (from 1.2% in 1995 to 5.6% in 2014), as had the proportion of cocaine users within the year between 2000 (0.3%) and 2014 (1.1%). This variation indicates the wider diffusion of a substance once limited to well-off categories, and affecting all social groups in recent years. The levels of lifetime use for synthetic drugs such as MDMA/ecstasy and amphetamines are 4.3% and 2.3%, respectively. The proportion of current MDMA/ecstasy users increased significantly between 2010 and 2014 (from 0.3% to 0.9%), thus reaching a peak since the last decade. Among 18-25 year olds, the use of this product exceeds that of cocaine.

The prevalence of lifetime use of heroin is 1.5% in the entire 18 to 64 year-old population and

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current use seems very rare2 (0.2% of those surveyed).

The latest ENa-CAARUD survey, conducted at the end of 2015 in support centres for the reduction of drug-related harms (CAARUDs), validated the qualitative findings of the TREND system on the changes in this problem drug user population: the most disadvantaged users turning to less expensive substances, medications and crack when available (Cadet-Taïrou et al. 2014; Lermenier-Jeannet et al. 2017).

Overall, substance use in the past 30 days before the survey did not show any major changes in terms of structure. Nevertheless, certain changes can be observed since 2008. As regards opioids, in compliance with qualitative findings, the use of buprenorphine has declined steadily (since 2010) (40% vs. 35%), in favour of methadone (24% in 2008 vs. 34% in 2015), which is more widely prescribed, and morphine sulphate, which is more frequently misused (15% in 2010, 19% in 2015). The use of substances containing codeine has been gradually increasing since 2010, when this was measured for the first time (5% vs. 10%), whereas the use of other opioid medications (for instance, fentanyl), studied for the first time, reached 8%.

As regards stimulants, the proportion of CAARUD clients having taken freebase cocaine (crack or freebase) continued to increase steadily (22% in 2008, 32% in 2015). Only 5% of users took diverted methylphenidate, although this situation was highly concentrated geographically. No changes were observed for hallucinogens exclusively used by a subgroup of this population (15%).

However, benzodiazepine use rose sharply between 2012 and 2015 (30.5% vs. 40%).

The use of illicit drugs with alcohol, tobacco and prescription drugs

In the *Santé publique France* Health Barometer (adult population), like in the OFDT ESCAPAD survey (17 year-olds), polydrug use is discussed through regular use (at least 10 uses in the month, and daily tobacco) of at least two of three substances, alcohol, tobacco and cannabis, without being able to determine whether this involves concomitant use. In 2014, this type of practice is still uncommon since it only concerns 9.0% of the adult population. It reaches a peak among 18 to 25 year-olds, who are one of the age groups with the highest tobacco and cannabis use (13.2%). Regular polydrug use of three substances is rare since this concerns 1.8% of males and 0.3% of females aged 18 to 64.
In 2014, regular polydrug use of alcohol, tobacco or cannabis concerns 12.8% of 17-year old teenagers. Cumulative regular tobacco and cannabis use is more widespread (5.0%) than in 2010, slightly ahead of cumulative regular tobacco and alcohol use (4.5%). Cumulative regular use of the three substances concerns 3.0% of 17 year-olds.
Between 2011 and 2014, regular polydrug use rose by 3 points. This concentration of regular use has become more pronounced among young girls, with polydrug use practically increasing by half relative to 2011, from 5.8% to 8.4%.
Regarding the public received in Youth Addiction Outpatient Clinics (CJC), outpatients seeking help for cannabis use were also tobacco users (87% of daily smokers) and subject to frequent or massive alcohol consumption. Thus, one outpatient out of five stated drinking alcohol often to get drunk, especially among young adults (19% of minors, 26% of 18-25 year olds, 16% over 25 years). About 10% of these "cannabis outpatients" are regular drinkers. Almost a quarter (22%) declared at least three heavy episodic drinking (HED) in the last month.

As regards clients attending CAARUDs in 2015, refer to T0.1.1 for medication use.

Alcohol use also appears to be predominant: while 69% of CAARUD clients reported last-month alcohol use, 33%, i.e. nearly half of recent alcohol users, claimed to have drank the equivalent of at

least 6 glasses on a single occasion, every day or nearly every day in the past year (Lermenier-Jeannet et *al*. 2017).

▶ Download Workbook 2 : Drugs

Prevention

top of the page

Policy and organization: In France, drug prevention falls under the addictive behaviour prevention policy referring not only to illicit or licit (alcohol, tobacco and psychotropic medicines) psychoactive substances, but also other forms of addiction (gambling, gaming, doping). This strategy is a State responsibility, coordinated at central level by the Interministerial Mission for Combating Drugs and Addictive Behaviours (MILDECA) and implemented at local levels by deconcentrated services. General goals are not only to delay if not to prevent the onset of use, but also to curb addictive practices and the related abuses and risks.

The MILDECA territorial representatives (“chefs de projet”) coordinate the implementation of the national prevention priorities at the local level (regions, counties, cities). They allocate credits for prevention activities, raised by a fund fed by confiscated proceeds of drug trafficking. Funding for prevention arises from the independent Regional Health Authorities (ARS), a specific fund of the French national health insurance system and, especially for a couple of years, from the Interministerial Fund for Crime Prevention (FIPD).

At local level, school prevention activities are implemented by a range of professionals. Within the area of educative health pathway for pupils, school stakeholders are involved in commissioning, planning and implementing activities. In many cases, external interveners (NGO staff and/or specialised law enforcement officers) are solicited to address pupils. School-based prevention mainly aims to develop pupils’ individual and social skills to resist drug use.

Prevention interventions: School-based universal prevention mostly in secondary schools and indicated prevention through the Youth Addiction Outpatient Clinics (CJC) which deliver ‘early intervention’ towards young users and their families (in 550 consultation points throughout France) are two pillars of the public responses. Hence over the 2010’s preventive responses were enhanced towards priority publics, like female users, youth in deprived urban areas, youth in contact with the judicial system. Major efforts have been made to develop collective prevention measures in the workplace as well (primarily in the remit of occupational physicians). Environmental strategies to curb alcohol and tobacco use are well developed and have substantial political support. National media campaigns to prevent alcohol, tobacco or illicit drugs are regularly issued.

Trends & Quality assurance: Over the 2010’s, there has been a growing concern among practitioners and decision makers to enhance quality in the delivered prevention programmes and services. The creation of the Interministerial Commission for the Prevention of Addictive Behaviours (CIPCA), in 2014, is a sign of this willingness. Still, prevention stakeholders are encouraged but free to refer to guidelines on drug prevention in school or other settings. The ASPIRE toolkit (Appreciation for the Selection of Prevention programmes Issued from the Review of EDPQS) has been adapted from the EDPQS material to promote quality prevention. It shall be piloted by MILDECA territorial representative in four regions.

New development: No major new development but several interesting novelties are reported throughout the workbook. Still, there is no prevention monitoring system in France and therefore

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information about the scope and coverage of prevention activities is still partial.

▸ Download Workbook 3.1 : Prevention

Treatment

top of the page

There are two schemes available for dispensing treatments to people using illicit drugs: the specialised addiction treatment system (in socio-medical establishments) and the general healthcare system (hospitals and general practitioners). Approximately 132,000 individuals were received in outpatient CSAPA (specialised addiction treatment centres) in 2014 for problems with illegal drugs or diverted psychotropic medications.

OST is mainly prescribed in a primary care setting by general practitioners, and is usually dispensed in community pharmacies. In 2016, 151,500 persons received opioid substitution treatment dispensed in community pharmacies and 22,900 patients received treatment dispensed in a CSAPA.

In terms of outpatient treatment provision, the public authorities developed specific healthcare for young users by creating youth addiction outpatients clinics (CJC) in 2004. Presently, approximately 540 clinics have opened. Although no national "programmes" intended for other target groups exist, some CSAPA have specialised in healthcare adapted to specific populations (women with children, offenders, etc.).

Among those overseen for the first time in the specialised addiction treatment structure, the proportion of cannabis users is tending to increase whereas the proportion of opioid users is declining. In 2015, this population, with an average age of 27, comprises nearly 75% cannabis users and 15% opioid users.

As regards all treatment entrants, the distribution according to substances seems fairly stable up to 2010, with a slight downward trend in the percentage of cannabis users. However the share of these users increases then sharply and amounts to 60% in 2015. The evolution of the share of opiate users is roughly symmetrical to that of cannabis users.

Furthermore, since 2013, the number of persons receiving OST has remained stable, after increasing constantly since this type of treatment was first introduced. The number of persons treated with buprenorphine decreased slightly over this period, in favour of patients treated with methadone, in keeping with sales data for these opioid substitution medications.

The proportion of new patients treated for a cannabis problem is high (62%) and continued to increase between 2015 and 2016, in contrast to the proportion of opiate users. The developments in 2016 reflect an extension of the trends emerging in 2010-2011.

In 2016, 151,500 people received opioid substitution treatment dispensed in community pharmacies: 95,000 were prescribed buprenorphine (Subutex® or generics), 56,000 methadone and 7,500 buprenorphine in combination with naloxone (Suboxone®). Furthermore, 22,900 patients were dispensed opioid substitution medications in CSAPA (19,200 methadone and 3,700 buprenorphine) in 2014.

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Best practice

top of the page

The Government Plan for Combating Drugs and Addictive Behaviours 2013–17 (MILDT 2013) address quality assurance as it aims at basing public action on observation, research and evaluation and reinforcing training strategy. Under the prevention and care strategical pillars, it defines quality assurance objectives: “Promoting Evidence-Based Preventive Strategies”, especially through the creation of an Interministerial Commission for the Prevention of Addictive Behaviours (CIPCA), and “Improving the Quality of Healthcare for Patients receiving Opiate Substitution Treatment and Increasing the Accessibility”.

In France, quality assurance in Drug Demand Reduction (prevention, risk reduction, treatment and rehabilitation) builds on specific advocacy, guidelines or trainings from professional societies or organisations or public health institutions but it is not strongly institutionally structured nor imposed. Promoting quality assurance is in the remits of institutions: (i) the Health Promotion and Prevention Division within the National Public Health Agency (formerly the INPES), (ii) The French National Authority for Health (Haute autorité de santé - HAS). As for risk reduction and treatment, different guidelines exist on: (i) Opioid Substitution Treatment, (ii) Early intervention and risk/harm reduction for crack or free base users, (iii) Clinics for young drug users and (iv) Treatment of cocaine users. However their implementation is not compulsory: there is no formal prerequisite of fulfilling guidelines to get support or subsidies. The compliance to these guidelines is not as a label. Professional federations are also engaged in developing quality and professional supports: the new portal on addictions for health professionals is an example: https://intervenir-addictions.fr.

In drug prevention, the Health Promotion and Prevention Division within the National Public Health Agency distributes information on evidence-based prevention methods. However, there is no specific drug use prevention protocol for prevention providers, public servants or associative workers to follow. The Interministerial Commission for the Prevention of Addictive Behaviours (CIPCA) reflects the political will of developing evidence-based prevention knowledge. Within the framework of the CIPCA, a quality assurance tool inspired from the EDPQS was issued in January 2017: the ASPIRE toolkit. In the 2010’s, although many resource services in prevention engineering have collapsed at local level, there is a noticeable willing at national level to enhance quality in the programmes and services delivered, especially in prevention.

The addiction treatment services (so-called CSAPA) are marginally impacted by the existing accreditation and certification processes of the HAS (French National Authority for Health) directed to health establishments.

The National Institute for the Training of the National Police (INFPN) is the unique service for initial and continuing education for the Police and Gendarmerie drug Prevention officers. Over the last five years, several initiatives were endeavored to develop knowledge and competence on addictions in medical study curricula and continued training for health professionals, prevention or treatment practitioners, etc.

▸ Download Workbook 3.3 : Best practice

Harms and Harm Reduction

top of the page

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The number of overdose deaths in 2014 amounted to 241 among 15-49 year-olds (370 in total) according to the general death register (for which the data availability period is 2 years). According to the specific overdose death register (DRAMES scheme), opioid substitution medications were implicated in 41% of cases in 2015, and heroin in 30% of cases. The mortality cohort study included 1,134 individuals, and for 955 (or 84%) of these subjects, the vital status was checked in December 2015. For men, the standardised mortality ratio was 5.6. For women, it was much higher (18.5).

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

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

In 2015, people infected through intravenous drug use represented only 1.5% of new cases of HIV infection. The number of HIV seropositive diagnoses associated with drug use remained stable between 2008 and 2015, following a steady decline between 2003 (date on which monitoring of this indicator began) and 2008. The number of new AIDS cases related to drug use remained stable in 2014, after steadily declining between 2003 and 2013.

Furthermore, between 2012 and 2015, the reported prevalence of HIV and HCV remained stable, both in the CAARUD and CSAPA context. This stability highlights the end of the declining prevalence of HCV among injecting drug users (IDU) observed since the beginning of the 2000s. The most recent data on biological prevalence are from 2011. The biological prevalence of HIV among drug users having injected at least once in their life was 13.3%, while the biological prevalence of HCV in this population reached 63.8%. The seroprevalence of AgHB (which indicates chronic hepatitis B virus infection) was 2.1% among male drug users surveyed in Paris during the period from 2011 to 2013.

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

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

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

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

Updated guidelines on the management of HCV-infected individuals, and on the HIV screening strategy urge the continuation and consolidation of action already taken along these lines, particularly among injecting drug users. In 2014 and 2015, 22,600 patients suffering from chronic hepatitis C were thus treated with direct-acting antivirals. Since June 2016, the treatment of hepatitis C with direct-acting antivirals has been 100% reimbursed by the National Health Insurance Fund for drug users who exchange their equipment (irrespective of their stage of fibrosis).

As regards the implementation of a naloxone distribution programme (antidote to opioid overdose) in France, a proprietary medicinal product containing naloxone for nasal use obtained a cohort temporary authorisation for use in November 2015. It has been available since July 2016. Priority users are newly released inmates together with users after opioid withdrawal. Since May 2017, CAARUDs have been authorised to dispense naloxone kits, which had previously been limited to hospital pharmacies and hospital CSAPAs. The proprietary medicinal product Nalscue® obtained marketing authorisation in July 2017.

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

▸ Download Workbook 3.4 : Harms and Harm Reduction

Drug market and crime

top of the page

Domestic drug market (domestic production/cultivation; trafficking routes for imported drugs)

Herbal cannabis is the only illegal substance for which production is seen in France. It is mainly cultivated by individuals at home and on a very small scale, but, starting in 2011, “cannabis factories” overseen by organised crime has begun to appear.

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. This is also the case due to its overseas departments on the American continent (Guadeloupe, Martinique and French Guiana) close to the major cocaine production and transit zones (Colombia, Venezuela).

Cannabis resin smoked in France comes from Morocco and usually transits through Spain while herbal cannabis comes mainly from Spain, Belgium and Netherland. New trafficking routes emerges, through Lybia for cannabis resin and from Albania for herbal cannabis.

The cocaine used in France mainly comes from Colombia. It mainly passes through the south via Spain and the north via the Netherlands (Rotterdam) and Belgium (Antwerp). Over the past few years, cocaine, transiting through Venezuela then via the French West Indies, has been entering the European continent through the port of Le Havre. There has also been a major increase in air trafficking by mules between Guiana and mainland France in the past two years.

The heroin used in France mainly comes from Afghanistan (brown heroin) and passes via the Balkans (Turkey, Greece, Albania). The Netherlands, ahead of Belgium, is the main platform which

supplies French dealers. Synthetic drugs (MDMA/ecstasy, amphetamines) used in France also mainly come from the Netherlands,

National drug law offences (main drugs linked to offences; distinguishing between possession/use, trafficking, cultivation/production)

In 2016, the total number of persons accused of narcotic use in France is about 160,000. Aside from these drug use offences (83% of the total), the police services and French Gendarmerie accused 16,487 individuals of drug use-resale and 13,515 of trafficking-resale without the use of narcotics. In 2010, 90% concerned simple cannabis use, 5% heroin use and 3% cocaine use.

Key drug supply reduction activities

The 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours (MILDT 2013), and its subsequent 2016-2017 Actions Plan (MILDECA 2016), include a line of action for stepping up measures against trafficking, with the following objectives: Acting at pre-trafficking stages: notably by strengthening international cooperation and capabilities for control, and by sharing information; reinforcing anti-money laundering measures and an asset-based approach to legal investigations; step up measures against in-door cannabis growing; increase the monitoring of the use of Internet and the fight against the online supply of illicit substances; cut off international cannabis and cocaine trafficking routes in the Mediterranean and Caribbean sea.

▸ Download Workbook 4 : Drug Market and Crime

Prison

top of the page

As of 1st January 2016, France had 187 prison establishments with a total operational capacity of 58,561. With 66,678 inmates, there are 114 inmates for every 100 beds in France. Studies conducted about a dozen years ago demonstrated that one third of new inmates stated prolonged, regular use of illegal drugs in the year prior to entering prison. Nearly 11% of inmates stating that they used illegal drugs on a regular basis used multiple substances prior to their imprisonment. 10% of inmates were addicted, but the total number of problem drug users (PDU) in prison settings is not quantified in France. Injecting appears to be fairly widespread among new inmates: in the year prior to imprisonment, this concerned 2.6% in 2003. Limited studies provide data on use in prisons. The only recent surveys on the subject merely provide preliminary data. Inmates have greater rates of infectious disease than the general population: although declining, HIV infection prevalences vary, depending on the source, from 0.6% to 2.0% (three to four times the prevalence in the general population), while prevalences of HCV are from 4.2% to 6.9% (four to five times higher).

Since 1994, the Ministry of Health is responsible for health in prisons and the treatment of addiction in prison settings is based on a three-tiered system: prison-based hospital healthcare units (UCSAs - now called health units in prison setting: USMP), which are responsible for monitoring the physical health of inmates; Regional Medico-Psychological Hospital Services (SMPRs) established in each French regions handle the mental health aspects of drug addicts in establishments where no national treatment and prevention centre for addiction (CSAPA) for prison exist, and finally, CSAPAs for prison have been established in the 16 largest establishments in France (and cover approximately a quarter of the incarcerated population). Furthermore, a reference CSAPA is appointed for each prison so as to offer support for inmates with addiction problems, particularly after their release.

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To guarantee the application of harm reduction measures, two main ways of preventing the spread of infectious diseases have been implemented in prison settings since 1996. First, 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. In addition to substitution, prison establishments offer prevention and decontamination tools for fighting against HIV and hepatitis's.

Since 2009, different laws have proposed to step up harm reduction measures in prison. The main lines of improvement concern the increased scope and role of the reference CSAPA, routine implementation of screening tests, and widespread access to all existing harm reduction measures, including needle and syringe exchange programmes. These objectives are reasserted in the 2016 health reform law. Its implementing decree is planned for late 2017, early 2018.

The report on the evaluation of interdepartmental policies on the integration of individuals placed in the hands of the prison authorities by the legal authorities, published in July 2016, issued a number of recommendations on the reintegration of inmates displaying addictive behaviour:
- the increasing number of alternative programmes to custody in the event of offences related to addictions based on the Bobigny system model.
- The development of treatment units in custody committed to fighting addictions similar to existing programmes abroad, based on the drug user rehabilitation unit (URUD) that has been implemented experimentally in one prison with the OFDT in charge of its evaluation.
- the routine implementation of a treatment and follow-up programme following custody, for all individuals suffering from addictions.

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Research

top of the page

In France, the Ministry of National Education, Higher Education and Research (MENESR) designs, coordinates and implements national policy on research and innovation. Two primary academic organisations, the National Centre for Scientific Research (CNRS) and the National Institute for Health and Medical Research (INSERM), cover a wide range of research areas, from neurosciences, through public health and clinical research to social sciences. The French National Focal Point (OFDT) is the main body involved in drug-related data collection, studies and network development. It collaborates extensively with national and European drug-related research teams. Dissemination of data and research results are also part of its mandate, together with publishing in national and international scientific journals, and promoting the use of research results in practice and policymaking. The Interministerial Mission for the Fight Against Drugs and Addictive Behaviours (MILDECA) is the central structure responsible to the Prime Minister for coordinating governmental action in the drugs field. Part of its role is to promote and fund drug-related research. In line with the Government Plan for Combating Drugs and Addictive Behaviours 2013–17, the MILDECA supports calls for proposals and extended collaboration with research organisations/universities and with the French Research Agency (ANR). It also promotes clinical research networks and dissemination initiatives towards the scientific community and policymakers. Today, research on drugs and addictive behaviours is also on the agenda of the strategic priorities of thematic research alliances.

Like previous ones, the 2013-2017 government plan reiterates the will to base the fight against drugs and addictive behaviours on research and training. Public authorities are committed to supporting research and monitoring and identified the following key priorities:

- to progress in the understanding of addictive behaviours: supporting multidisciplinary work, epidemiological research on health and social effects of use among young people in France, by strengthening monitoring schemes and surveillance networks on addictive behaviour.
- to strengthen clinical research in the field of addictions, in particular the work on innovative drug treatments and new therapeutic strategies.
- to develop research on prevention.
- to develop evaluation research.
- to improve the interface between researchers and policymakers.

▸ Download Workbook 5.2 : Research

All reports :