Annual reports sent to the EMCDDA (European monitoring center for drugs and drug addiction), giving an overview of the latest developments on the drug problem in France.

National annual reports on drug issues

2016 report

The 2016 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

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The current overarching general principles of French drug policy were stated in a mission letter on 17 October 2012. 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 chairperson of the Interministerial Mission for Combating Drugs and Addictive Behaviours (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 is structured around three main priorities:
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.
This Government Plan also emphasises the need for developing "evaluative" research, preferably in connection with the academic world in order to obtain reliable, independent and useful results for the public authorities to improve the effectiveness of public action. An external evaluation of this Government Plan was entrusted to a Sciences Po research team and will be based on the qualitative analysis of four priority measures. Two actions were evaluated on the implementation period of the first Action plan (2013-2015). The evaluation of two other actions is underway. A final report will be delivered end of 2017.
Specifically concerning the evaluative research which has now been carried out to completion, the researchers examined the relevance of new experimental approaches (peer-led prevention on volunteer university campuses and community action to combat the local narcotics trafficking

problem). As regards the peer-led prevention approach, success is less dependent on the training followed by student liaison officers than other factors, such as the involvement of university staff and their supervisory capacity, the chosen organisational procedures or the quality of partnerships with other professionals working in prevention in the area. Evaluation of the community programme in the southern districts of Marseille highlights several difficulties which the professionals and populations concerned come up against (coordination difficulties, communication problems, quality of partnerships, etc.).
In addition, the evaluation of the degree to which the objectives of the plan have been achieved was entrusted to the OFDT.
In 2014 total drug-related expenditure is estimated to be €1.83 billion. The contribution of the state and the health insurance represented 0.06% of gross domestic product (GDP), with 48% of the total for demand reduction initiatives, 51% for supply reduction activities and 1% allocated for crossed activities (research, training, observation, evaluation, coordination and international cooperation).
The passing of the health law of 26 January 2016 is the most recent major development in terms of public policies in the field of addiction.
This new legislative text prioritises prevention in order to better protect young people from the consequences of substance use and proposes new prevention and harm reduction measures intended for drug users. In this context, it authorises the pharmacy sale of rapid diagnostic tests (RDT) with the aim of improving access to screening for hepatitis C, while trialling drug consumption rooms (DCR). Its provisions also increase legal protection for professionals to ensure that they can carry out their duties, particularly within the scope of trialling DCR. The health law has also made it possible to safeguard the SINTES (National detection system for drugs and toxic substances) monitoring system, French section of the "Early Warning System".

▸ Download Workbook 1.1 : Drug Policy

Legal framework

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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.
The framework of the French policy for combating narcotic use and trafficking is described in the French Penal Code (trafficking, possession, etc.) and the French Public Health Code (notably the provisions relating to illegal use). The general leanings of the penal policy are defined in the directives issued by the French Ministers of Justice tending towards a systematic response from the legal authorities. Thus, during the 2000s, the number of proceedings for simple use increased dramatically; the response to this rapid increase in arrests was the growing recourse to both alternative measures to prosecution and court convictions.
Regarding recent legislative developments, at the beginning of the year, the French National Assembly and Senate passed a law on health system reform. This law has a threefold objective: to promote prevention, facilitate access to care and consolidate the health system. In addition to measures relating to alcohol and tobacco, two major provisions in the field of addiction should be pointed out: the trialling of drug consumption rooms (DCR) for a maximum period of six years and the extension of rapid diagnostic tests (RDT) to personnel in community or prevention facilities having received appropriate training.

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Drugs

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The main illicit drugs and polydrug use

According to the latest available data (2014), 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 (i.e. 41% of 15 to 64 year-olds). The overall proportion of recent users (in the last month) is 6.6%, and regular use (at least 10 times per month) concerns nearly 1.5 million people in France.
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 – see details in T1.2.3) 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 use has been on the rise since the beginning of the 2010s, 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. 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.
The prevalence of lifetime use of heroin is 1.5% in the entire 18 to 64 year-old population and current use seems very rare (0.2% of those surveyed).
At the same time, the observations carried out as part of the TREND scheme evidence greater visibility of problems related to the development of drug use in rural and periurban areas, whether in a recreational or private setting. A specific investigation conducted between 2012 and 2014 at certain sites of the scheme (Bordeaux, Marseille, Metz, Rennes and Toulouse) provided clearer insight into the populations concerned (Gandilhon and Cadet-Taïrou 2015).
The first group tends to be made up of "neo-rural" individuals, originating from large urban centres. They move to rural areas outside the major urban centres in order to escape situations of extreme social instability. These are individuals involved in considerable drug use (amphetamines, opiates) and often part of the alternative techno subculture. This population also includes "urban" individuals, with few qualifications and looking for seasonal work in rural areas, indulging in more occasional drug use.
They frequent other users, also illegal drug users, directly originating from rural areas. In fact, drug use in the countryside is not limited to an externally imported phenomenon. Hence, in the same way as for French young people, initiation is based on the alcohol-tobacco-cannabis trio (Spilka *et al*. 2015b) and may be extended, particularly in a recreational setting (from village *fêtes* to free parties), to other substances.

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) (Obradovic 2015). 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 (Protais *et al*. 2016).

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Prevention

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Drug use prevention policy in France is coordinated at central level by the Interministerial Mission for Combating Drugs and Addictive Behaviours (MILDECA). The Ministries of National Education, Agriculture (responsible for agricultural education), Health, Interior and Justice are the other main central stakeholders in this field. Since 1999, the French prevention policy embraces all psychoactive substances, both illicit and licit (alcohol, tobacco and psychotropic medicines), and other forms of addiction (gambling, gaming, doping). General goals are not only to prevent first use or delay it, but also to curb use or abuse of these products.
The use of existing guidelines on drug prevention in school settings is strongly encouraged, but is not compulsory. The main focus of the school-based prevention activities, within the area of health education, is to develop students' individual and social skills to resist drug use.
The MILDECA territorial representatives ("*chefs de projet*") coordinate the implementation of the national prevention priorities at the local level (regions, cities). These ones and the independent Regional Health Authorities (ARS) allocate decentralised credits for prevention activities, while the French national health insurance system also provides funding for prevention.
There is no prevention monitoring system in France and therefore information about the scope and coverage of prevention activities remains limited.
• Environmental strategies on alcohol and tobacco use are well developed and have substantial political support.
• At local level, prevention activities are implemented by a large number of professionals. They are mostly universal prevention activities carried out in secondary schools, with school communities involved in commissioning, planning and sometimes in implementing activities. In most cases, external interveners (NGO staff and/or specialised law enforcement officers) address pupils.
• Selective and indicated prevention is mainly the responsibility of specialised NGOs. About 260 Youth Addiction Outpatient Clinics (CJC) deliver 'early intervention' towards young users and their families throughout France in 550 consultation points.
• Community-based prevention is carried out in youth counselling centres. Prevention in the workplace covers both licit and illicit drug use and is primarily in the remit of occupational physicians. Implementation varies across companies/services, according to their sizes (scarcer in small/medium companies) and the lines of business.
National media campaigns to prevent alcohol, tobacco or illicit drugs are regularly issued by the National Institute for Prevention and Health Education (INPES).
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 symbolic sign of this awareness-raising. The strengthening of quality in addictive behaviours prevention through the promotion of evidence-based methods and the professionalization of practitioners results from a quadruple juncture: (i) the evolution of both levels et patterns of use, especially among adolescents; (ii) the improvement of knowledge on harms related to early consumption; (iii) the easier access to substances and synthetic drugs through Internet; (iv) the growing awareness of the gaps and ineffectiveness of a policy that is solely focused on the ban of any drug use so as to prevent addictive behaviours and the related risks.
If young people are definitely the core target public of prevention policies, the two last Government plans (2008-2011, 2013-2017) have clearly set forth priorities towards specific segments of this public, such as youth in deprived neighbourhoods or in contact with the judicial system, or female publics. The current governmental plan also confirms and enhances prevention in occupational settings in both private and public sectors.
Over the last ten years, the most salient engagement of French public authorities in drug prevention

is the support provided for the development of the Outpatient Clinics for Young Users, so-called CJCs ("Consultations jeunes consommateurs"). These CJCs are the main indicated prevention system in France.
The institutional support for the development of prevention in the workplace is getting important.
In the current Government strategy, priority has been given to drug prevention directed to: young people, especially those in contact with a juvenile court system; pregnant women and female drug-users; and people that are remote from the care system, whether geographically or socially.
The new Government plan requires the reinforcement of the Outpatient Clinics for Young Users (CJCs), in particular through professional training.
The year 2015 has been a favourable context to the development of addictive behaviour prevention: (i) the issue of addictive behaviours and their prevention has been introduced for the first time in the 2016-2020 National Plan for Health at Work, as a priority; (ii) drug prevention is now officially assigned to the remit of drug treatment centres (CSAPA) by the 2016 law on health system reform.
Specific impetus is put on the promotion of quality in prevention, especially through budding governmental initiative to develop evaluation endeavour among practitioners as well as local funders.
Monitoring and evaluation are clearly identified as priorities in the 2013–17 Government plan, at operational and public policy levels. An impetus is also given on training on prevention for people working in contact with young people.
New provisions to restrict tobacco use and packaging (neutral packaging and larger health warnings) and vaping were introduced by the 2016 law on health system reform while the same law has softened alcohol promotion.

▸ Download Workbook 3.1 : Prevention

Treatment

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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 2015, 151,000 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 2012, 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 (60%) and continued to increase between 2014 and 2015, in contrast to the proportion of opiate users. The developments in 2015 reflect an extension of the trends emerging in 2010-2011.
In 2015, 151,000 people received opioid substitution treatment dispensed in community pharmacies: 97,000 were prescribed buprenorphine (Subutex® or generics), 53,000 methadone and 7,000 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.

▸ Download Workbook 3.2 : Treatment

Best practice

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In France, quality assurance in Drug Demand Reduction (DDR - 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. As for risk reduction and treatment, different guidelines exist (on (i) Opiate 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. The addiction treatment services (so-called CSAPA) are marginally impacted by the existing accreditation and certification processes directed to health establishments.
In drug prevention, the National Institute for Prevention and Health Education (INPES) 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.
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.
A growing though still limited number of prevention organisations get involved in implementing international evidence-based programmes in local French contexts. In the recent years, the concern about good practices and evidence-based practices has got higher. This general climate is incentivized by both a political impetus (repeated references to evidence-based approaches in governmental strategies) and professional inspiration.
The Interministerial Commission for the Prevention of Addictive Behaviours (CIPCA) reflects the political will of developing evidence-based prevention knowledge. For the 2015-2017 period, the CIPCA is being funding the impact evaluation of five prevention programmes selected on the basis of a call for tenders. The endeavours started in 2014 to develop training supply on addiction and quality assurance have continued over 2015-2016, especially for professionals working in contact with young people through the training of regional trainers for the certification of competence in preventing addictive behaviours.

▸ Download Workbook 3.3 : Best practice

Harms and Harm Reduction

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The number of overdose deaths in 2013 amounted to 237 among 15-49 year-olds (349 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 more than half of cases in 2014, and heroin in a quarter 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).
In 2014, people infected through intravenous drug use represented only 1.1% of new cases of HIV infection. Furthermore, the biological prevalence of HIV among drug users having injected at least once in their life was 13.3% in 2011, 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.
The number of overdose deaths in the general death register increased in 2013, after declining for two consecutive years, preceded by a rise between 2003 and 2010. However, the fluctuations observed since 2011 should be interpreted with caution due to methodological changes. Between 2010 and 2014, opioid substitution medications were the main substances implicated in overdose deaths, ahead of heroin.
The prevalence of HCV declined, while remaining at a very high level among injecting drug users, although the prevalence of HIV among this population remained stable, at a much lower level, between 2004 and 2011.
The number of HIV seropositive diagnoses associated with drug use remained stable between 2008 and 2014, 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 has been steadily declining since 2003.
The trialling of drug consumption rooms (DCR) falls within the scope of the law reforming the health system. Several cities volunteered to trial these DCR. Drug consumption rooms in Paris and Strasbourg are scheduled to open in autumn 2016, when the work on the facilities has finished. The specifications for these DCR are laid down by a decree, which defines their operating conditions in detail (organisations and populations concerned, location, personnel, etc.). The supporting structures for trialling the DCR in Paris and Strasbourg are described in two decrees.

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Drug market and crime

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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 Guyana) close to the major cocaine production and transit zones (Colombia, Venezuela). Also, like many developed countries, where the population has strong purchasing power, France has significant levels of use (for some of these substances), making it a strategic market for drug traffickers. In recent years, the major changes in terms of supply have concerned cannabis, cocaine and MDMA/ecstasy. These changes notably provide insight into why the levels of prevalence for use of these three substances are showing such a significant increase, as supply dynamics are partly able to explain the dynamics of demand.

Over the past few years, the cannabis market in France has been in upheaval, like other European countries, with herbal cannabis increasingly competing against cannabis resin produced in Morocco. While the cannabis resin market is still superior, the herbal cannabis market is becoming increasingly dynamic, driven by protagonists sharply contrasting with the usual profiles. Hence, alongside home-grown cannabis growers with a marginal role on the market, herbal cannabis factories have emerged, cultivating hundreds or, indeed, thousands of plants. Among the latter, two types of groups can be distinguished. Vietnamese criminal gangs, long having specialised in this illegal segment, particularly in Britain, who are becoming established in France, drawn by the dynamic market and prospects in terms of profit, and private individuals, a priori not connected to the traditional criminal scene, who are turning to large-scale illegal commercial cultivation for the same reasons. A third group is in the process of emerging, also made up of "housing estate" dealers, specialising in the resale of cannabis resin and moving into production more suited to the new reality of demand.

The second largest illegal market, cocaine, has also been affected by changes in supply. These changes do not concern those involved in importing the substance into France, whether traditional organised crime networks (Corsican and North African) or the lower spheres of minor trafficking, or "small-time drug runners" in police jargon. The changes supposedly affect major trafficking channels, notably with the increasing role of French overseas departments. This phenomenon, which started to grow in amplitude from 2011, should be connected with the recent reopening of cocaine routes in the Caribbean headed to the United States and Europe, further to the security crisis in Venezuela which has become a major transit country for Colombian cocaine.

Lastly, the MDMA/ecstasy market has experienced renewed dynamism as before its shortage in 2009. The availability of powder and crystal forms has increased with high purity levels, while the tablet form has been on the rise since 2013, particularly in the recreational setting, with high MDMA potency. Furthermore, dealers' attention to tablet appearance (bright colours, 3D forms, etc.) has boosted their appeal to young users.

A recent analysis of the situation in French departments in the Americas (DFA: Martinique, Guadeloupe and French Guyana) offers an up-to-date perspective on international trafficking, although the developments described do not only cover 2015 and are the result of prior changes. Martinique and Guadeloupe are not only areas of freebase cocaine (crack) consumption, but now play an increasingly important role in supplying the metropolitan market. The police services, in fact, estimate that between 15% and 20% of annual seizures throughout French could originate from these two departments.

Cocaine trafficking is intensifying in French Guyana, a department bordered by Suriname and Brazil, with a long coastline running along the Atlantic. As for Martinique and Guadeloupe, cocaine trafficking destined for Europe slowly developed from the beginning of the 1990s, and has literally rocketed in the past five years. This appeal has been confirmed by the substantial and consistent increase in seizures conducted both locally and in metropolitan France.

These developments can be explained by two key changes. Firstly, at the end of the 1990s, the emergence of the West African route to Europe via French Guyana, aiming to circumvent the security systems set in place by the European Union. Secondly, the intensified control of the air route connecting Paramaribo, the capital of Suriname, and Amsterdam. Owing to more vulnerable security systems, French Guyana represents a strategic point for organised crime in Suriname, in

terms of cocaine exports, via Cayenne and its international airport.
Nevertheless, in the past few years, criminal gangs in French Guyana have become more empowered. They recruit French "mules" to travel to Paris, so as to set down roots in small and medium-sized metropolitan cities. The cocaine which passes via French Guyana is of equivalent quality (at least 70% purity) but half the cost (5,000 euros per kg on average) as that purchased in the West Indies or in the Dominican Republic. In view of the price and poverty faced by the inhabitants, Guyanese channels could increase in scale in the next few years. Similar phenomena to those observed in Martinique currently in play, with the emergence of a local market and bartering of cannabis resin for cocaine.
Furthermore, the port of Le Havre, owing to its connection with the port of Fort-de-France in Martinique and its status as a leading French port for container traffic, is increasingly used as a major doorway for cocaine into the French and European markets, like other major ports in northern Europe, such as Rotterdam and Antwerp.
In 2014-2015, according to the TREND scheme observation sites, heroin was very widely available in northern and eastern France although it still had limited visibility in the south where its accessibility is reduced. The surviving trafficking is due to small networks of users who obtain their supplies in Spain, or, indeed, in the Netherlands or Belgium. In the Paris region, the law-enforcement services (police) have reported a strong increase in seizures in the areas around Paris, indicating high availability of the substance, and which could foreshadow its major return to the streets of the capital. Furthermore, a number of problems have been observed related to the diversion and abuse of opioid medications, prescribed for the treatment of pain or obtained via the Internet.
As regards new psychoactive substances (NPS), the total number of seizures fell between 2014 and 2015 (865 *vs*. 1,200) and involved fewer agents (111 *vs*. 131). This decline is difficult to interpret; however, there are more personal seizures than previously, which could be the result of the growth in retail resale activities, not on the Internet but between individuals.
Synthetic cannabinoids still play a key role in the semi-wholesale market (large quantities of powder, at least one or more kg) and among substances presented in commercial forms (small quantities). This market, borne more by supply rather than demand, concerns agents usually sold with brand names or instead of a "conventional" illegal substance, such as alpha-PVP and similar products, methylone, or synthetic cannabinoids in the JWH series, AB-FUBINACA and AB-CHMINACA. Commercial efforts are especially evident with the plant/herbal form (43.9% of seizures in 2014, 34.7% in 2015) in which artificial flavourings (strawberry, vanilla) have been identified for the first time in France.
In contrast to the retail market, the activity of the wholesale or semi-wholesale market is characterised more by shortages, with the practical disappearance of certain agents (such as chloromethcathinone), new arrivals (clephedrone seized for the first time in France in 2015) and substantial seizures (more than 10,000 tablets in the same single seizure).

▸ Download Workbook 4 : Drug Market and Crime

Prison

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As of 1st January 2015, France had 188 prison establishments with a total operational capacity of 57,841. With 66,270 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. The prevalence of injection is high in prisons: in the year preceding imprisonment, 2.6% of new inmates were concerned in 2003. 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.
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.
As part of the 2013-2017 governmental action plan, several measures specific to the prison populations are expected in the 2016-2017 action plan:
- To strengthen the reference CSAPA by drawing up a guide and by presenting these facilities during prison health conferences;
- To develop action-research on screening activities for individuals in custody;
- To support the development of a health data collection application for new inmates;
- To organise the coordination of health workers in a prison, legal and association context, led to care for individuals referred by the justice system.
Furthermore, the health system reform law of 26 January 2016 has also reasserted the need for the diffusion of harm reduction measures in the prison setting and reiterates the principle that inmates should be offered a health assessment on the use of psychoactive substances (including legal ones), stating that this should be performed from the start of imprisonment.

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Research

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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 (MILDT 2013), 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.
View 'Drug-related research' for additional information.
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.

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