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New Development, Trends and in-depth information on selected issues

REITOX

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Summary

1. Drug policy: legislation, strategies and economic analysis

From 2011-2012, new legal provisions mainly focused on local and international trafficking and on the application of law-enforcement policies for narcotics use offences. In terms of demand-reducing policies, lawmaker's concentrated their efforts on involving occupational medicine in preventing use at the workplace on the one hand and on reinforcing follow-ups by healthcare professionals within the scope of drug treatment order on the other hand. The decrees, circulars and orders that were adopted to put laws into effect in 2011 and 2012 were mainly within the scope of the *prévention de la délinquance* (delinquency prevention) law of 5 March 2007, of international framework conventions on cooperating to fight against international trafficking and of the provisions of articles L.5121-1, L.5132-1, L.5132-6, L.5132-7 of the French Public Health Code regarding the use of medications and potentially dangerous substances.

The 2011 national strategies of the governmental policy are set forth by the 2008-2011 government action plan against drugs and drug addiction. The forward-looking 2011 report by the MILDT (*Mission interministérielle de lutte contre la drogue et la toxicomanie*, or the French Interministerial Mission for the Fight Against Drugs and Drug Addiction) revealed that nearly all of the government's objectives had been achieved. Furthermore, between 2011 and 2012, three other national plans integrated and reinforced the health measures set forth in the 2008-2011 drugs plan: the 2009-2012 "hepatitis" plan, the 2009-2013 "cancer plan" and the new 2010-2012 "detainee" plan supervised by the French Ministry of Health and Sports with the participation of the French Ministry of Justice.

Public expenditure on implementing the governmental drug policy and French national health insurance in 2010 was approximately €1,510 M. This estimate does not take into account expenditure attributable to prison administrative services or major hospital or primary care costs. These expense categories have been estimated within the scope of previous studies. Kopp and Fénoglio estimated the costs of treatment attributable to drug-related health problems at €21.58 billion in 2003; prison expenditures were estimated at €219.79 million (Kopp and Fénoglio, 2006b). After inflation, these estimates would have accounted for €26.66 billion and €0.25 billion in 2010 respectively. If we consider these latest categories of expenditure up-dated after inflation, public spending attributable to the drug and addiction prevention policy is somewhere close to €28 billion in 2010 (licit and illicit drugs). This estimate accounts roughly for 1.5 percent of the GDP in 2010 (GDP accounts for €1,931.4 billion in 2010) but also for 6.6 percent of the State's budget which accounts for a spending of €435.37 per habitant.

The profits from the sales of drugs confiscated through drug-related criminal procedures are allocated to a "Narcotics" support fund managed by the MILDT. The fund received contributions of €21 M in 2010 and €23 M in 2011. This support fund represented revenue of €11 M for the MILDT in 2010 and €12 M in 2011. This amount was redistributed to the French ministries responsible for implementing drug policy.

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

The latest data available on the general population are those of the INPES *Baromètre santé* (the health survey of the *Institut national de prévention et d'éducation pour la santé* or the National Institute for Prevention and Health Education) from 2010, as well as surveys conducted amongst adolescent 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 during the last twelve months (at around 8.3%). The "mechanical" increase in cannabis lifetime use of is linked to a "stock" effect of former generations of smokers. Amongst the rarer products, there was a significant increase in cocaine lifetime use and current use (from 2.4% to 3.6% and from 3.8% to 5.2% respectively). The survey furthermore reveals a significant increase in heroin lifetime use (from 0.8% to 1.2%) and mushroom lifetime use (from 2.6% to 3.1%), whereas ecstasy lifetime use is on the decline.

Amongst 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, inhaled products and hallucinogenic mushrooms show the highest lifetime use (by age 17, 9.0%, 5.5% and 3.5% respectively, versus 44.4% 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.

In 2011, at the end of the 2008-2011 governmental "drugs" plan, there were no new developments in terms of prevention. The school setting (and mainly secondary educational environments) remains the primary target for universal prevention, even though the plan has specific measures for the student environment, recreational athletic and cultural environments and so-called "sensitive" neighbourhoods. Tools have also been developed for the occupational environment. Current policy also encourages the development of the role of adult referents in prevention strategies.

The selective prevention of drug use is closely tied to the prevention of drug trafficking and recidivism. Indicated prevention measures largely overlap with the legal provisions aimed at drug users. Awareness-building training courses on the dangers of narcotics can be ordered to people who have been arrested on use charges (please refer to sections 9.1.1 and 9.4.1). *Consultations jeunes consommateurs* (Clinics for Young Users) are dedicated to the needs of young users and their parents.

Finally, the communication strategy of the 2008-2011 governmental plan comprises several media campaigns. Some of the main themes include targeting the role of parents and the family circle in preventing drug use in teenagers, reiterating the illegal nature of drugs and the harm caused to society by use and trafficking.

4. Problem drug use

A new multi-centre "capture/recapture" study was launched at the end of 2010 in six French cities: Lille, Lyons, 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. The different evaluation methods led to a rather wide range of estimates, i.e., 275,000 to 360,000 people. The mean prevalence values for 2011 estimated by different methods seem to be on the rise. Nevertheless, it is difficult to confirm an increase given the wide, overlapping confidence intervals for these two years.

The 2010 ENa-CAARUD study (see appendix IV-F) demonstrated the significant social vulnerability of problem drug users who frequented harm reduction structures in 2010:

- Nearly half of these users experienced unstable housing conditions (i.e., were homeless or living in squats).

- One out of every five users did not have a legal source of income; half lived on welfare ("RSA" or the minimum income provided by the French government for those without an income or with minimal income, and "AAH" or the French government allowance for adult handicapped persons).

- Approximately 15% of problem drug users had been incarcerated at some point during 2010.

One third of problem users had taken heroin in the last month, nearly 40% had taken High-Dose Buprenorphine (HDB) in the last month (75% of these had taken HDB as a substitution treatment) and 46% had taken cocaine in hydrochloride or freebase form in the last month. According to the TREND observation system, there is increasingly widespread use of heroin by inhaling (chasing the dragon), and greater use of freebase cocaine, as well as a greater availability of ketamine.

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

The figures on new patients admitted in outpatient centres in 2011 do not show marked changes in patient characteristics. As in previous years, average patient age has continued to increase, from 28.0 to 30.9 from 2005 to 2011, with significantly more people aged 40 and over and fewer people aged 20-24. The breakdown of the most problematic users by product posing the most problems remained stable. In 2011, 48% of new patients were being treated due to cannabis use, 41% for opiate use and 6.5% for cocaine or crack use.

Nearly 145,000 people received primary care reimbursements for opioid substitution treatments during the second half of 2010, with a clear predominance of HDB reimbursements (75% of the total, a phenomenon specific to France).

6. Health consequences

The number of new AIDS cases amongst injecting drug users (IDUs) has fallen continuously since the mid-1990s. In 2010, 6% of new AIDS cases were diagnosed in IDUs (versus 25% of people diagnosed in the mid 1990s and 8% in 2008).

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 most drug users. However, the reported HCV prevalence amongst IDUs is still high: it was around 40% in the late 2000s, and the percentage of IDUs unaware of their seropositivity is undoubtedly high at present.

According to the most recent data available, the number of deaths by overdose increased again in 2009 (305 deaths in 15-to-49–year-olds) thereby prolonging the upward trend observed since 2003. From 2006 to 2009, the rise in the number of overdoses seemed to be specifically related to an increase in the number of deaths by heroin and/or methadone overdose.

7. Responses to health problems related to drug use

A system of health warnings related to the consumption of psychoactive products was created in 2006. Its purpose is to identify signs indicating the abnormal appearance of acute health problems related to substance use and to disseminate warning messages if such problems are detected. This system has been fully operational since 2008.

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 (OST). Another objective is to encourage people to undergo screening for HIV, HCV and HBV, as well as urging people to get vaccinated against HBV.

In 2008, an estimated 14 million syringes were sold or distributed to drug users. This number has been consistently declining since 1999, suggesting a lower injection frequency. The proportion of drug users who have undergone HIV and HCV screening, which had been on the rise, seemed to stagnate between 2008 and 2010. During this same period, there was better access to treatment for HCV-infected drug users.

8. Social consequences and social reintegration

Indicators in 2011 on the social situation of users admitted to CSAPAs (C*entres de soins, d'accompagnement et de prevention en addictologie*, or National treatment and Prevention Centres for Substance Abuse) and CAARUDs (*Centres d'accueil et d'accompagnement à la réduction de risques pour usagers de drogues*, or Support Centres for the Reduction of Drug-related Harms) seemed to indicate a slight decrease in the precarious lifestyle of users. However, this decline may be the result of an increase in average age and in the proportion of people seen for alcohol consumption in CSAPAs and seen for inclusion difficulties in the survey of the most disadvantaged users in CAARUDs.

In France, there are rehabilitation policies for all disadvantaged people in a situation of exclusion from society. Enabling drug users to benefit from these policies by helping them carry out sometimes-complex administrative procedures is a significant first step in the rehabilitation process.

The issue of employment is the one that most weighs on treatment structures. Some centres implement so-called "occupational" activities as part of workshops that mainly have a therapeutic aim. Professional rehabilitation itself is a problem that is generally addressed through measures that help restore communication and implement coordination and networking between treatment centres and rehabilitation enterprises.

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

In 2011, the number of arrests for narcotics use was slightly over 143,000, which was an increase compared with 2010 (+ 6%). These arrests represent 89% of all drug related offences. The remaining 11% were arrests for use-dealing, international trafficking and local trafficking, which are declining compared with 2010 (- 20% for use-dealing, - 17% for international trafficking and - 16% for local trafficking). Cannabis is the reason for 90% of use arrests and 70% of use-dealing and trafficking arrests.

The number of convictions for drug related offences doubled from 1990 to 2010 to reach 50,000, of which over 28,000 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 annual mean increase).

Convictions for driving under the influence of drugs also rose sharply in recent years (12,428 in 2010 versus 8,988 in 2009 and fewer than 6,600 in 2008), representing a 38% increase over the previous year. Of these convictions 34% resulted in a prison sentence (usually a suspended sentence), nearly half resulted in a fine (a proportion that is rising) and 17% in an alternative sentence (usually driver's licence confiscation).

The range of alternatives to prosecution offered to drug offenders has been expanded since the law of 5 March 2007: people arrested on charges of use or possession may be ordered by the courts to pay for and undergo a drug awareness training course. From 2008 to 2011, 18,000 to 19,000 people took part in such a course.

10. Drug markets

Sales of cannabis, heroin and cocaine are worth, according to some estimates, €3 billion. In 2011, the value of narcotics seized on French soil was approximately €1 billion, representing a 65% increase since 2010.

Some substances, such as heroin and cocaine, were readily available and accessible in 2011. This situation was intensified by the strong presence of networks importing heroin from Afghanistan through the Balkans into Europe and the ongoing switchover of certain trafficking organizations from cannabis resin to cocaine hydrochloride. In addition, the proximity of storage countries (Belgium, Netherlands, Spain) for these two substances enabled a direct supply to border wholesalers. Hundreds of dealing micro-networks mostly run by user-dealers therefore ensured the widespread distribution of cocaine and heroin throughout the whole of France, including rural and periurban areas.

The year 2011 was also characterized by two noteworthy phenomena. The first was the development of "cannabis factories" similar to those in the Netherlands and Belgium. These factories are created when structured criminal organisations begin large-scale cannabis production. The second pertains to the synthetic drug market, which has been shaken up in recent years with the continuous arrival of New Psychoactive Substances (NPS) distributed over the Internet. Since they are sometimes not classified when they appear, these substances are sometimes known as "designer drugs", "research chemicals" or "legal highs".

Selected Issue 1

Given the communal, countercultural spirit of the early 1970s, the authorities were open to new ideas, and residential treatment centres with varying approaches sprung up. These centres became increasingly professionalised in the 1980s, but their missions did not become clear until the early 1990s: a decree indicated that medical, psychological, social and educational treatment must be ensured. These centres, which primarily admitted opiate users who had undergone withdrawal, had been central to drug treatment until now. Changes in use practices amongst relevant populations, the shock of AIDS, the involvement of primary care and the development of substitution treatments changed this situation; outpatient care is now the norm. Residential treatment centres are now driven to become integrated into networks, to become medicalised and to accept the treatment of users receiving substitution treatments, as well as to redefine their actions amongst populations for which outpatient treatment seems to be insufficient. Long term, these changes will require better definitions of the criteria for referring users to residential

treatment structures. The 2000s were characterised by the authorities' consideration of residential treatment needs and resurgence in therapeutic communities, which until then had been subject to suspicion in France following sect-like abuse by a now-defunct association that ran several such communities. In order to meet varying needs, residential treatment programmes have diversified. In addition to group residential treatment programmes (residential treatment centres and therapeutic communities, short-term admission centres for recently released ex-convict drug and alcohol users), there are also individual residential treatment schemes: follow-up therapeutic apartments and foster families.

There are no good practice guidelines or frameworks recognised by the authorities for implementing medico-social establishment missions. However, at the initiative of the federation of professionals in this sector, these documents are being created. The therapeutic approaches in France are still widely diverse. Each centre defines their project, which must correspond to the essential treatment modalities established by the authorities. They must also specify the chosen therapeutic approaches; some projects are required to define the target population. The renewal in therapeutic communities created an opportunity to reconsider the special type of treatment offered by such institutions: stays are organized according to the residents' progressive ability to manage the tasks with which they are entrusted; the group plays a central role and responsibility is key.

Residential treatment and the organizations that offer it are faced with changes today: the recent spread in France of a concept of addiction that leads those addicted to alcohol and/or illegal drugs to be admitted to the same residential treatment centres; an increase in cocaine, crack and stimulant use that raises questions about the current therapeutic models which are geared mainly towards opiate users; an economic crisis that has made already vulnerable drug using populations even more fragile and has generated over-exclusion. These changes imply a need for residential measures to adapt to the new realities.

Selected Issue 2

This chapter discusses recent trends in public spending (law enforcement and security, treatment and prevention) and specifically addresses the reliability of the collected data. It aims to examine the extent to which the 2007-2009 recession affected public spending on fighting drug use and preventing addictions in France. The first part of the chapter describes the economic context in France at the time the recession started (e.g., sharply declining exports, low levels of private investment, significantly increasing unemployment) as well as how this situation led the government to increase public spending to support activity, thereby further deepening the government’s debt crisis. Next, the chapter reveals the recent trends in public spending on the drug policy in terms of law enforcement and security as well as prevention, focusing particularly on the methods used to estimate the presented data.

The last part of the chapter discusses the change in spending on universal or selective prevention efforts, which were severely curtailed after the crisis. The most significant spending cuts were in prevention, for which 2012 funding was considerably reduced. Increases in spending were recorded for the supply reduction policy. However, even this increase was limited between 2009 and 2010. Finally, the slowdown in public spending has also affected healthcare and indicated prevention.

Part A: New development and trends

1. Drug policy: legislation, strategies and economic analysis

1.1. Introduction

Definitions

A drug user is an individual who consumes a narcotic substance. The legal authorities often liken the possession of small quantities of narcotics to use. They also equate the cultivation of cannabis to use when the substance is intended for personal consumption.

Any drug related offence exposes a person to being arrested by the police, a gendarme or a customs officer and will, in principle, be referred to the judicial system. 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), may decide to take legal action against the offender, to simply close the case or to propose other measures as an alternative to legal proceedings. This principle enables judicial responses to be adapted to each individual situation by providing a progressive response in accordance with the seriousness of the acts committed. It also explains the differences in penal practices employed by the courts.

Data collection tools

The main data collection tools are the French Penal Code, the French Traffic Code, the French Public Health Code, the French Social Action and Family Code and the French Sports Code. The sources used to assess public expenditures on anti-drug policy are the budgets stipulated by the *Loi de règlement des comptes* (the law on actual government income and expenditures for the previous year) and the *Loi de financement de la sécurité sociale* (LFSS, or Social Security Budget Act).

Background

Two types of legislation govern drugs in France. The use, possession and supply of licit drugs (such as alcohol and tobacco) are regulated, but not prohibited. On the other hand, illicit drugs classified as narcotics (heroin, cocaine, cannabis and hallucinogens, for example)[1], are prohibited chiefly by the 31 December 1970 law, the provisions of which have been incorporated into the French Penal Code and the French Public Health Code. The 31 December 1970[2] law cracks down on the use and trafficking of all substances or plants classified as narcotics (regardless of the product). It makes no distinctions between drug users and dealers. The 1970 law considers users to be criminals and to be ill. The regulations ensure free access to specialised structures (CSAPA[3], CAARUD[4] and CT[5]) and to HIV and hepatitis screening

[1] The list of narcotic substances covered by the law was detailed in an order from the French Ministry of Health following a proposal from the General Director of the French Agency for the Safety of Health Products (AFSSAPS) in compliance with international regulations. Since this order was issued, the AFSSAPS has become the ANSM (National Agency of Medicine and Health Products Safety).
[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.
[3] National Treatment and Prevention Centres for Substance Abuse
[4] Support Centres for the Reduction of Drug-related Harms.
[5] Therapeutic Communities.

centres[6] affiliated with healthcare establishments (CDAG[7] and CIDDIST[8]). Since the circular of 9 November 2009[9], drug users are also entitled to receive a Hepatitis B vaccination in CDAGs. People without income or with a low level of income can also receive free primary and hospital medical care.

Since 1999, drug users residing in France are entitled to *Couverture maladie universelle* (CMU, or Universal Medical Coverage). CMU covers people with low levels of income. The care seeker pays medical expenses out-of-pocket and then requests reimbursement. For the most disadvantaged drug users residing in France, free supplemental health insurance exempts the care seeker from paying out-of-pocket medical expenses. Non-residents in France can request *Aide médicale d'État* (state medical assistance for people without residence permits or for people awaiting residence permits).

Hepatitis B vaccination and viral hepatitis screening are free and anonymous[10] when performed in a CSAPA (Art. L.3411-4 of the French Public Health Code). Drug users admitted to CDAGs and CIDDISTs are not required to reveal their identity. Since the French HPST (Hospital, Patients, Health, and Territories) law of July 2009[11] (art. 108) was adopted, in the event that treatment is necessary, a physician in the CDAG or CIDDIST can lift anonymity provided that the express, informed consent of the patient is obtained. The purpose of this provision[12] is to improve support so that healthcare is provided in certain clinical situations (art. L3121-1 of the French Public Health Code). Moreover, drug users who spontaneously approach a healthcare dispensary or establishment are entitled to anonymity upon admission if they expressly request this anonymity.

To maintain the confidentiality of the personal and medical information of a care seeker, professionals of healthcare establishments are required to respect medical and professional confidentiality.

Narcotics use

The legal framework cracking down narcotics use (whether public or private) has not changed since its inception (1970). In 2003, the possibility of a reform aiming to sanction simple use by means of a fine was examined but ruled out by the government in July 2004.

Under the terms of article L.3421-1 of the French Public Health Code (formerly art. L.628), the illegal use of substances listed as narcotics constitutes an offence subject to a maximum punishment of one year's imprisonment and a fine of up to €3,750. However, article L.3411-1 stipulates a specific procedure for "*injonction thérapeutique*" (drug treatment order), which authorises the prosecutor to suspend proceedings against a narcotics user provided that the user agrees to seek treatment.

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[6] 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

[7] Anonymous Free Screening Centre.

[8] Information Screening and Diagnosis Centre on Sexually Transmitted Diseases.

[9] 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, pp. 289-292).

[10] Loi n°2007-1786 du 19 décembre 2007 de financement de la Sécurité sociale pour 2008 (NOR BCFX07663ML), art. 72.

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

[12] 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 (NOR SASP1007832A).

The strategies of penal anti-drug policy have been redefined in various circulars issued by the French Ministry of Justice since the early 1970s. Depending on the period, some focus on improving care, while others emphasise on more efficient cracking down on drug use. The circular of 17 June 1999[13] calls upon public prosecutors of the French Republic "to develop more diverse legal responses" when it comes to dealing with arrested drug users at all stages of criminal proceedings, with prison sentences being reserved for extreme cases and used as a last resort. Subsequently, health alternatives to prosecution were strongly encouraged and better executed: drug treatment orders exclusively for dependent drug users, a warning for occasional users (particularly cannabis users) or dismissal of the case with referral to a health and social care centre for other types of drug-related behaviours.

This *loi de prévention de la délinquance* (delinquency prevention act) of 5 March 2007[14] further reinforces the law enforcement measures against drug users. Firstly, this law enabled judges to deal with drug related offences using a simplified, "fast-track" procedure in order to provide a systematic penal response to narcotics use. It introduced a new, *ad hoc* sanction: a mandatory and subject to charges drug awareness training course (for a fee of up to €450, the same amount as the fine for a 3rd class offence). Provided for in article L 131-35-1 of the French Penal Code and by articles R131-46 and R131-47 of the French Penal Code in application of the decree of 26 September 2007[15], it is intended to make offenders aware of the harmful consequences to human health and to society of using these substances. The course may be proposed by the authorities as an alternative to legal proceedings and to fixed penalty notice. An obligation to complete the 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 13[16].

The 5 March 2007 act also extends the scope of application of drug treatment orders so that they can now be ordered at any stage of legal proceedings: originally conceived as an alternative to legal proceedings (resulting in a suspension of the legal process), drug treatment orders can now be decided as a sentence enforcement measure, including for persons having committed an offence related to alcohol consumption.

The 2007 act reinforces the measures for monitoring the application of drug treatment orders. It introduced the notion of "*médecin relais*" (intermediate doctor), whose task is to assess the medical appropriateness of the measure, inform the doctor chosen by the user of the legal framework in which it is being applied, verify the enforcement of the drug treatment order and inform the legal authorities of changes in the offender's medical situation. To ensure better application of the provisions of March 2007 on the function assigned to intermediate doctors, law 2011-1862 of 13 December 2011 stipulates that any other healthcare professional can give a reasoned opinion to the judicial authorities on the appropriateness of the drug treatment order and ensure the monitoring of the implementation of the drug treatment order (articles L. 3413-1 to L. 3413-4 of the French Public Health Code). These physicians must have the accreditation required by the competent authorities. This accreditation must come from training in addiction medicine or professional experience with addiction patients.

[13] Circulaire du 17 juin 1999 relative aux réponses judiciaires aux toxicomanies (NOR JUSA9900148C).
[14] Loi n°2007-297 du 5 mars 2007 relative à la prévention de la délinquance (INTX0600091L).
[15] 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 (NOR JUSD0755654D).
[16] Circulaire CRIM 08-11/G4 du 9 mai 2008 relative à la lutte contre la toxicomanie et les dépendances (NOR JUSD0811637C).

Narcotics use and road safety

Law enforcement measures against narcotics use are more severe in certain cases, such as when this use affects road safety.

The law of 3 February 2003[17] introduced a new offence concerning any driver whose blood test reveals the presence of narcotics. These drivers risk a sentence of two years' imprisonment and a €4,500 fine, and drivers who simultaneously use narcotics and alcohol risk up to three years' imprisonment and a €9,000 fine. The law of 18 June 1999[18] and its application decree (of 27 August 2001)[19] introduced mandatory drug use screening for drivers involved in a road accident that was immediately fatal or for drivers suspected of narcotics use who were involved in an accident that caused bodily harm. Since the 2011 adoption of the LOPPSI 2 law[20] (*loi d'orientation et de programmation pour la performance de la sécurité intérieure,* which covers French law enforcement activities), and its application circular of 28 March 2011, narcotics screening has become mandatory following road accidents that cause bodily harm, whether such accidents are fatal or not. Moreover, the circular[21] of 28 March 2011 on reinforcing the fight against unsafe road conditions enables, upon requisition of a French public prosecutor, random narcotics controls on all drivers (art. L.235-2 of the French Traffic Code, modified by article 83 of LOPPSI).

Narcotics use in professional environments

The law increases the penal sanctions applicable to employees in a position of public authority (or those carrying out a public service mission or involved in national defence) who are caught committing drug use offences. They now risk a five-year prison sentence and a total maximum fine of €75,000. The staff of public transport companies caught committing drug use offences while on duty are also subject to these penalties as well as to additional sanctions prohibiting them from carrying out their professional activities and requiring them to undergo, at their own cost, a drug awareness training course. Law 2011-867 of 20 July 2011 amends article L. 4622-2 of the French Labour Code on the role of occupational medicine with employers, workers and their representatives, in order to prevent alcohol and drug use.

Drug-trafficking

Narcotics trafficking law enforcement in France became even harsher in the late 1980s. Circumstances are considered aggravated when committed offences involve minors or take place in teaching, educational or administrative establishments. Subsequently, current legal measures stipulate punishments that differ with the type of trafficking-related offence. Minimal punishments pertain to dealing and sales for personal use (offence created by the 17 January 1986 law)[22]. The maximum penalties can include life imprisonment and a fine of €7.5 million (law

[17] Loi n°2003-87 du 3 février 2003 relative à la conduite sous l'influence de substances ou plantes classées comme stupéfiants (NOR JUSX0205970L).
[18] 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 (NOR EQUX9800010L).
[19] 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 (NOR EQUS0100214D).
[20] Loi n°2011-267 du 14 mars 2011 d'orientation et de programmation pour la performance de la sécurité intérieure (NOR IOCX0903274L).
[21] Circulaire du 28 mars 2011 de la LOPPSI en ce qui concerne l'amélioration de la sécurité routière (NOR IOCD1108865C).
[22] Loi n°86-76 du 17 janvier 1986 portant diverses dispositions d'ordre social.

of 16 December 1992)[23] for certain laundering operations (as defined by the law of 31 December 1987[24]) and be categorised as a criminal offence (by the laws of 23 December 1988[25], 12 July 1990[26] and 13 May 1996[27]).

The law provides for specific, anti-trafficking procedures and instruments, including some that are exceptions to common law. Consequently, the fast-track, immediate court appearance procedure can be used in proceedings against small-scale traffickers following the introduction of the law of 17 January 1986. This law made it possible to immediately judge user-dealers following their arrest, much in the same way as the instigators of organized crime networks. The legal provisions for cracking down on money laundering – provisions that have been in place since the 1990s – also help hunt down drug traffickers by focusing on their visible signs of wealth. As result, the fact that an individual "is unable to account for resources corresponding to his lifestyle when in frequent contact with a drug user or trafficker" is considered an offence under the terms of the law of 13 May 1996, which outlaws "living off the proceeds of drugs".

The law of 9 March 2004[28] allows for reductions in the sentences handed down to offenders for offences if, “after having informed the administrative or legal authorities, the offender has made it possible to put a stop to the offence and possibly identify other guilty parties". This possibility for "criminals-turned-informers" to avoid a sentence for trafficking is a new feature in the French legal process. The law has also extended the special procedural arrangements that already existed for trafficking (including the use of confiscation as a penalty in cases involving the sale or dealing of narcotics) to other offences.

The "delinquency prevention" act 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 in prison and a fine of €300,000). The penalties for offences committed under the influence of a narcotic substance or in a state of drunkenness have also been harshened. Furthermore, the law organises new investigatory measures (searches based on the use of ICTs, deals under surveillance or procedures for determining prior risks).

Finally, law 2010-768 (the so-called “*Warsmann Law*”)[29] established a new criminal procedure for seizing and confiscating the assets of narcotics traffickers under investigation.

Trafficking of chemical precursors used in the manufacture of drugs

The production and sale of "precursor" products that may end up being used for drug extraction or to produce synthetic substances has been controlled ever since the introduction of the law of 19 June 1996[30]. This law falls within the scope of current European regulations on preventing the abuse of raw materials commonly used in the chemicals industry to supply narcotics trafficking networks. The law categorises controlled chemical products into three classes, for

[23] 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 (NOR JUSX9200040L).
[24] Loi n°87-1157 du 31 décembre 1987 relative à la lutte contre le trafic de stupéfiants et modifiant certaines dispositions du Code pénal (NOR JUSX8700015L).
[25] Loi n°88-1149 du 23 décembre 1988 : Loi de finances pour 1989 (NOR ECOX8800121L).
[26] 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 (NOR ECOX9000077L).
[27] 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 (NOR JUSX9400059L).
[28] Loi n°2004-204 du 9 mars 2004 portant adaptation de la justice aux évolutions de la criminalité (NOR JUSX0300028L).
[29] Loi n°2010-768 du 9 juillet 2010 visant à faciliter la saisie et la confiscation en matière pénale (NOR JUSX0912931L).
[30] 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 (NOR INDX9500023L).

which the list is established by decree. The law requires companies involved in producing, selling or transporting controlled chemical products to be authorised by the French Ministry of Industry[31]. The *Mission nationale de contrôle de précurseurs chimiques* (MNCPC, French National mission for the control of chemical precursors) is responsible for granting and renewing authorisations.

Opioid substitution treatments

France was one of the last European countries to introduce OSTs. Methadone only shook off its strictly experimental status in the mid-1990s, when its marketing authorisation was granted in 1995[32]. The methadone marketing authorisation was followed a few months later by the authorisation for HDB in July 1995. Subutex® has been on the market as HDB treatment since February 1996. Generics have been on the market since 2006. Considered safer than methadone (and furthermore, not classified as a narcotic), Subutex® could be prescribed by any physician and outside of specialised treatment centres: This flexible prescription system (methadone was reserved for specialised centres only - at least for the initial treatment phase) has led to a major surge in HDB subscriptions, which today account for approximately 85% of the total "market" for substitution drugs. As a result, a second "doorway" to substitution by means of health establishments was opened with the 30 January 2002[33] circular, which made it possible for any doctor practicing in a health establishment to initiate a substitution treatment using methadone. Until then, this possibility was reserved for physicians in Specialised Care Centres for Drug Users (CSSTs).

Since 1993, several official texts and circulars have been published in order to "balance" the prescription and dispensing of substitution treatments in France. In April 2008[34], the health authorities made prescription and dispensing conditions for buprenorphine and methadone harsher in order to prevent misuse. To obtain reimbursement, patients are now required to provide their physician with the name of the pharmacist who will dispense the medication. The physician must mention this pharmacist on the prescription. Since the decree of 1 April 2008, not only is the pharmacist's name required on prescriptions, but also the establishment of a treatment protocol in the event of misuse. Moreover, the AFSSAPS has implemented a risk management plan for each proprietary HDB product on the market.

The legal framework for harm reduction activities

The harm reduction policy for drug users is the responsibility of the government (article L3121-3 of the French Public Health Code modified by the law of 13 August 2004 - art. 71[35]). This harm reduction policy seeks to prevent the spread of infection, death by intravenous drug overdose and the social and psychological damage caused by narcotics use. The law of 9 August 2004[36], which established CAARUDs, states that, along with other schemes, CAARUDs should be used to contribute to the harm reduction policy (article L3121-5 of the Public Health Code). CAARUDs

[31] 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 (NOR INDD9600699D).
[32] Circulaire DGS/SP3/95 n°29 du 31 mars 1995 relative au traitement de substitution pour les toxicomanes dépendants aux opiacés.
[33] 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 (NOR MESP0230029C).
[34] Arrêté du 1er 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 (NOR SJSP0808150A).
[35] Loi n°2004-809 du 13 août 2004 relative aux libertés et responsabilités locales (NOR INTX0300078L).
[36] Loi n°2004-806 du 9 août 2004 relative à la politique de santé publique (NOR SANX0300055L).

are open to both individuals and groups, provide personalised advice and information to drug users, offer support to help drug users obtain access to treatment (which includes assistance with hygiene and access to basic emergency care), make referrals to specialised or general treatment systems, encourage screening for transmissible infections, help users gain access to entitlements, housing and professional integration or rehabilitation, provide equipment to prevent infection, and intervene locally outside the centre to establish contact with users. CAARUDs[37] provide social mediation to ensure good integration in their neighbourhood and prevent the public disturbances related to drug use. Their coordination with other organisations has been stipulated in a circular[38].

Since May 1987[39], the unrestricted sale of syringes has been authorised in retail pharmacies, pharmacies located inside healthcare establishments and establishments that focus exclusively on selling medical, surgical and dental equipment or that have a specialised department for such equipment. Since March 1995[40], these may be issued free of charge by any non-profit association carrying out AIDS prevention or harm reduction activities among drug users; these associations must meet the French Ministry of Health requirements described in the decree (article D. 3121-27 of the French Public Health Code). Providing syringes and needles to minors is only authorised by prescription (art. D.3121-28 of the French Public Health Code). However, neither pharmacies nor associations are legally bound to ask users to provide their identity or age since the 1987 suspension of the provisions of the 1972 decree.

It is not legal to arrest someone on the sole charge of narcotics use in immediate proximity to a harm reduction or syringe exchange structure (for example, pharmacy SEPs). Furthermore, simply carrying a syringe is not sufficient evidence to justify an arrest.

A national harm reduction standard for drug users has been prepared (art. D. 3121-33 of the Public Health Code) and approved via the decree of 14 April 2005[41]. 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 drugs use or the incitation to use drugs during their work.

Orientations of the national strategy against drugs

The initial interministerial anti-drug plan dates back to 1983. The 2008-2011 “Government Action Plan Against Drugs and Drug Addiction” includes almost 200 measures for prevention, enforcement, health/social care, research, observation, training and international cooperation. Priority is given to preventing people from taking drugs from the get-go, since the age of first-time use is younger and younger. This targets young people and those close to them (such as parents and educators).

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[37] Article R3121-33-1 modifié par le 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 (dispositions réglementaires) (NOR SANP0524015D).

[38] 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 (NOR SANP 0630016C).

[39] Décrets n°87-328 du 13 mai 1987 et n° 88-894 du 24 août 1988 portant suspension des dispositions du décret n° 72-200 du 13 mars 1972 et 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

[40] 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 (NOR SPSP9500414D).

[41] 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 (NOR SANP0521129D).

The Plan mentions several priorities for enforcing the law: alcohol abuse among the youngest users, drug related offences and/or tobacco use in public establishments, cannabis trafficking, seizure and court-ordered confiscation.

It provides for new treatment and social integration modalities, particularly for minors, pregnant women or parents of young children, cocaine or crack users and newly-released convicts. The plan aims to increase housing capacity for addicts in vulnerable conditions.

Finally, with respect to international policy, the 2008-2011 plan has three major objectives:

- reinforcing (within a multilateral, European and bilateral framework) actions deployed at every stage along the trafficking routes (particularly in western Africa and the Mediterranean) in order to choke off the cannabis and cocaine supply sources in Europe and heroin outlets in central Europe and the Balkans;

- setting up of increasing numbers of agreements with the countries concerned in order to simplify international action against the diversion of chemical precursors (particularly in Afghanistan);

- and finally, boosting Mediterranean cooperation to coordinate the fight against drugs in the Mediterranean area.

The 2012 electoral calendar postponed the adoption of the 2012-2015 “Government Action Plan Against Drugs and Drug Addiction”.

The preceding plan (2004-2008) was inspired by a policy that mainly targeted young people and prevention, with a particular focus on “halting the spread of cannabis” among adolescents and young adults. Without abandoning these efforts, the 2008-2011 Plan emphasises enforcing the law through targeted communication campaigns. The government plan can also be seen as a continuation of the French Ministry of Health’s 2007-2011 Plan for the treatment and prevention of addictions, adopted in November 2006[42], which seeks to structure and enhance the availability of existing facilities and programmes (hospitals, health/social care centres and in primary care settings).

Public expenditure and budgets

Since the introduction of the fundamental law relative to the “LOLF” budget laws of 2001, France’s general budget credits allocated to public administrations are now presented on a "per mission" and "per programme" basis. In the fight against drugs, the government runs 30 or so ministerial programmes. Therefore, it is possible to retrace the government’s policy through its primary actions. This includes the credits allocated to the MILDT under the terms of programme 129, "Coordination of governmental work". This is not the case for the expenditure of the French national health insurance scheme, which nevertheless remains identifiable. The contributions of the French national health insurance fund addiction structures and hospitals that treat problem drug users; they also reimburse substitution therapies for people receiving such treatments. Public expenditure on the drug prevention policy, treatment, or drug supply reduction measures have been the subject of numerous studies in France[43]. The most recent assessment of public expenditure attributable to drugs through the use of credits from 2008 to 2010 was performed in 2012 (see 1.4.1. and Selected Issue).

[42] http://www.sante.gouv.fr/htm/actu/plan_addictions_2007_2011/sommaire.htm
[43] http://www.ofdt.fr/ofdtdev/live/publi/pointsur.html

1.2. Legal framework

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

In France, lawmakers' efforts in 2011-2012 were dedicated to fighting against local and international drug trafficking and to reinforcing the application of policies that crack down on narcotics use offences. In terms of drug reduction demand policies, new legislative provisions focused on preventing the use of alcohol and drugs in the workplace and on the involvement of healthcare professionals in drug treatments orders pronounced by the judicial authority.

Law enforcement policies for narcotics use offences

Since the adoption of **law 2011-1862 of 13 December 2011**[44], the French Code of Penal Procedure has enabled public prosecutors to institute simplified proceedings for narcotics use offences. However, the public prosecutor must ensure that the alleged offences for which an accused is being held in custody are simple and have been established by police investigation, and that, given the minor nature of the offences, it does not seem necessary to order a sentence of imprisonment or a fine of up to €3,750 (fine stipulated in article L.3421-1 of the French Public Health Code). In the event of a simplified procedure, the arrested person may be ordered to pay a fine of up to €1,875 in compliance with article 495-1 of the French Code of Penal Procedure. If the judge presiding over the case deems that imprisonment should be ordered, the judge refers the case to the public prosecutor.

In addition to applicable punishments, lawmakers also came to a decision on the new policy for carrying out sentences applicable to *cours d'appel* (courts of appeal) and *tribunaux de grande instance* (high courts). **Law 2012-409 of 27 March 2012**[45] thereby establishes a new strategic framework for law enforcement jurisdictions. This law has three main objectives:

- To ensure swiftness in executing the sentences that are handed down, particularly for prison sentences;
- To reinforce efforts to prevent recidivism;
- To improve how delinquent minors are handled.

Among other measures, the 27 March 2012 law provides for files to be in electronic form and for improved information transfer between parties working throughout the penal process. This will enable the penal process to become more reactive and for information transfer to become more secure. Nearly €284 million in investment credits has been allocated to fund these different projects.

[44] Loi n°2011-1862 du 13 décembre 2011 relative à la répartition des contentieux et à l'allégement de certaines procédures juridictionnelles (NOR JUSX1002218L).
[45] Loi n°2012-409 du 27 mars 2012 de programmation relative à l'exécution des peines (NOR JUSX1128281L).

Simplified information exchange between law enforcement authorities of the EU Member States

Order n°2011-1069 of 8 September 2011[46] transposed Council framework decision 2006/960 on simplifying the exchange of information and intelligence between law enforcement authorities of the Member States of the European Union. The purpose of this legislation is to simplify information transmission as well as to expedite evidence collection and perpetrator searches in relation to offences committed on European territory.

Reinforcement of intelligence in the fight against local trafficking

National security was another field of action for lawmakers during this period. **Order n°2012-351**[47] therefore targeted narcotics trafficking. Since the adoption of this order, public authorities with jurisdiction in areas that are highly exposed to the risks of narcotics trafficking have been authorised to record video surveillance images in public places.

Prevention of alcohol and drug use in the workplace

Law n°2011-867 of 20 July 2011[48] established the operational framework for occupational health services. This law amends article L. 4622-2 of the French Labour Code on the role of occupational medicine with employers, workers and their representatives in preventing alcohol and drug use.

Involvement of any qualified healthcare professional in monitoring drug treatment orders

By creating the function of *médecin relais* (intermediate doctor), the delinquency prevention law of 5 March 2007 reinforced the provisions for monitoring the enforcement of drug treatment orders stipulated in articles L. 3413-1 to L. 3413-4 of the French Public Health Code. To ensure better application of the provisions of March 2007 on the function assigned to intermediate doctors within the scope of drug treatment order, **law n°2011-1862 of 13 December 2011** stipulates that any other healthcare professional can give a reasoned opinion to the judicial authorities on the appropriateness of the drug treatment order and ensure the monitoring of the implementation of the drug treatment order. The professional assigned by the regional health agency must have the accreditation required by the competent authorities. This accreditation must come from training in addiction science or professional experience with addiction patients. The accredited healthcare professional is now responsible for conducting a psychosocial assessment of the patient, justifying the appropriateness of the drug treatment order, monitoring its implementation, suggesting modalities and controlling follow-up. Moreover, since December 2011, judicial authorities can instruct regular and excessive alcohol users to submit to drug treatment order in compliance with articles L. 3413-1 to L. 3413-4.

1.2.2. Law implementation

The decrees, circulars and orders that were adopted to put laws into effect in 2011 and 2012 were mainly within the scope of the delinquency prevention law of 5 March 2007 on the new

[46] Ordonnance n°2011-1069 du 8 septembre 2011 transposant la décision-cadre 2006/960/JAI du Conseil du 18 décembre 2006 relative à la simplification de l'échange d'informations et de renseignements entre les services répressifs des États membres de l'Union européenne (NOR IOCD1114994R).

[47] Ordonnance n°2012-351 du 12 mars 2012 relative à la partie législative du Code de la sécurité intérieure (NOR IOCD1129997R).

[48] Loi n°2011-867 du 20 juillet 2011 relative à l'organisation de la médecine du travail (NOR ETSX1104600L).

criminal policy strategies for narcotics use offences; within the scope of international framework conventions on cooperation and the fight against international trafficking; within the scope of the provisions of articles L.5121-1, L.5132-1, L.5132-6, L.5132-7 of the French Public Health Code related to the use of medications and potentially dangerous substances.

New criminal policy strategies for drug use

The **16 February 2012**[49] circular established new criminal policy strategies to be adopted by the judicial authorities. While reiterating the need to consider investigative elements that suggest simple use or narcotics addiction and the principle of proportionality with respect to the seriousness of the alleged offence, the February 2012 circular emphasises the need for systematic penal responses and increasingly effective judicial measures. Jurisdictions are encouraged to implement primarily educational measures for initial simple use offences. Examples of these measures include drug awareness training course and health/social strategies for addicted users (drug treatment order). Responses to minors should be limited to educational and health measures. The circular also encourages courts and courts of appeal to develop partnerships with associations to ensure the efficacy of educational and health/social measures.

Reinforcement of international cooperation for national security

In terms of international cooperation, the French government signed the following two agreements in 2011 and 2012: one was with the Greek government in September 2011[50] and the other was with the government of Tajikistan in February 2012[51]. The purpose of these agreements is to heighten cooperation and provide mutual technical assistance to more effectively combat various forms of crime, particularly in the area of the trafficking of narcotics and psychotropic substances.

Vigilance of the authorities on the appearance of potentially dangerous substances

Since the second half of 2011, the French Ministry in charge of health and the French Agency for the Safety of Health Products (AFSSAPS) have adopted the following two decrees to integrate “mequitazine” into the list of dangerous substances and to classify all pharmaceutical forms of “phentermine” as narcotics:

- **Decree of 25 July 2011**[52], which classifies “mequitazine” on the poisonous substances list due to its psychoactive effects

- **Decree of 14 February 2012**[53] relative to the classification of all “phentermine” products as narcotics. Phentermine or α, α-Dimethyl-2-phenylethylamine, is a

[49] Circulaire CRIM 2012-6/G4 du 16 février 2012 relative à l'amélioration du traitement judiciaire de l'usage de stupéfiants (NOR JUSD1204745C).
[50] Décret n°2011-1123 du 19 septembre 2011 portant publication de l'accord entre le Gouvernement de la République française et le Gouvernement de la République hellénique relatif à la coopération en matière de sécurité intérieure, signé à Paris le 19 mai 2008 (NOR MAEJ1123344D).
[51] Décret n°2012-267 du 24 février 2012 portant publication de l'accord entre le Gouvernement de la République française et le Gouvernement de la République du Tadjikistan relatif à la coopération en matière de sécurité intérieure, signé à Paris le 6 décembre 2002 (NOR MAEJ1201957D).
[52] Arrêté du 25 juillet 2011 portant classement sur les listes des substances vénéneuses (NOR ETSP1120711A).

phenylethylamine derivative, whose structure is very similar to that of amphetamine. It was commercialised in France as an appetite suppressant from 1962 to 1988. Injectable phentermine was already on the narcotics list and oral phentermine was classified as a psychotropic. Due to the potential for abuse, addiction and misuse of this substance and its amphetaminic profile, phentermine (in all forms) is now listed as a narcotic.

Since the second half of 2011, and within the scope of its addiction vigilance mission, the AFSSAPS has adopted several decisions that aim to control the conditions for prescribing and dispensing certain medications at risk for abuse:

- **Decree of 24 August 2011**[54], which subjected orally-administered medications derived from "clonazepam" to special prescription and dispensing conditions. This decision was propelled by the risk of drug addiction, abuse and misuse of this medication (repealed by the decree of 9 March 2012[55]).

- **Decree of 9 March 2012**[56], which aimed to harmonise the prescription and dispensing conditions for medications subject to narcotics regulations. This pertains to orally-administered medications derived from flunitrazepam (Rohypnol®), buprenorphine (Subutex® and its generics / Suboxone® / Temgesic®), clonazepam (Rivotril® tablets and drops) and certain orally-administered, clorazepate dipotassium-based medications (Tranxene® 20 mg). This decree also aimed to clarify these measures scope of application.

- **Decree of 16 April 2012**[57] published in the French *Journal Officiel* (official gazette) of 28 April 2012 subjecting orally-administered medications derived from "midazolam" to special prescription and dispensing conditions. In 2011, the Agency had examined the legal resources for controlling and regulating the public sale of "gamma-butyrolactone" (GBL), whose sale was unrestricted for domestic use. In effect since 8 September 2011, **the decree of 2 September 2011**[58] banned the distribution and public sale of GBL as well as the commercialisation of 1,4 BD and of products containing this compound due to the high risk of addiction and abuse related to this molecule.

To combat the spread of new drugs on the Internet, the ANSM (National Agency of Medicine and Health Product Safety, former AFSSAPS) seriously examined the possibility of establishing a classification for all "substituted cathinones". In 2012, the ANSM submitted a draft decree to

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[53] 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 (NOR ETSP1204444A).

[54] Arrêté du 24 août 2011 portant application de la réglementation des stupéfiants aux médicaments à base de clonazépam administrés par voie orale (NOR ETSP1123702A).

[55] 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 (NOR ETSP1207340A).

[56] 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 (NOR ETSP1207340A).

[57] Arrêté du 16 avril 2012 portant application de la réglementation des stupéfiants aux médicaments à base de midazolam administrés par voie orale (NOR ETSP1220641A).

[58] 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 (NOR ETSP1124197A).

the French Ministry of Health. The electoral calendar postponed its consideration. In contrast, the plan to classify new drugs into families was abandoned.

Finally, due to their adverse health effects, preparations containing one of the following substances were subjected to commercialisation and sales restrictions following directives from the French Ministry of Social Affairs: 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 (date on which **both 12 April 2012 decisions**[59] of the French Ministry of Social Affairs and Health were published in the *Journal officiel*). Published in the *Journal officiel* on the same day, a third **12 April 2012 decision**[60] totally banned preparations containing clonazepam, meprobamate and synephrine.

1.3. National action plan, strategy, evaluation and coordination

1.3.1. National action plan and/or strategy

France-wide, the interministerial anti-drug strategies implemented in 2011 by the government are those established by the 2008 governmental "drugs" plan (Rapport National France, 2008). This plan's "health" section reiterates the measures adopted by the French Ministry of Health in its 2007-2011 plan for addiction treatment and prevention (Rapport national France, 2007). Two other long-term plans that are also being supervised by the health authorities recently strengthened the health section of the governmental hepatitis prevention and treatment plan.

2009-2012 "Hepatitis" plan

In preparation since 2007, the **National hepatitis B and C strategic plan** was released on 24 February 2009 by the French Ministry of Health. A four-year scheme (2009-2012), the hepatitis strategic plan follows the National hepatitis C plan (1999-2002), the national hepatitis B and C strategic plan (2002-2005) and the measures taken on 8 December 2005. Included in the plan's priority populations were drug users, and intravenous drug users in particular. In fact, drug use is considered to be the primary means of HCV transmission. Other people targeted by the plan include those engaging in risky behaviours (e.g., with multiple sexual partners), those in unstable situations and those in prison.

The plan is also consistent with the observations made in the 2004 Public Health Law assessment report drafted by the *Haut conseil de la santé publique* (HCSP, French High Council

[59] 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, chlordiazépoxide, duloxétine, naltrexone, pirfénidone, roflumilast ou venlafaxine (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 (NOR AFSX1224673S).

[60] 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 homépathiques, contenant du clenbutérol, du clonazépam, de l'exénatide, du liraglutide, du méprobamate, de l'orlistat ou de la synéphrine (NOR AFSX1224680S).

for Public Health) (Salamon *et al.* 2010). The five-year law of 9 August 2004[61] set a general goal of reducing deaths from chronic hepatitis by 30% by reducing the number of infected patients from 10-20% to 7-14% in 2008. It does not appear particularly relevant to monitor death rates over a five-year period for a disease with a long clinical course and the HCSP experts therefore decided to place more emphasis on the prevention of viral hepatitis.

The strategy entailed a combination of improved prevention and more accessible screening, while improving access to effective treatments and to care. The priorities of the new hepatitis plan are: reducing HCV and HBV transmission, increasing screening frequency and access to care and introducing additional measures suitable for prisons. The plan pays particular attention to the quality of care and quality of life of people suffering from chronic hepatitis B and C.

The 2004 public health law set other, more specific objectives for combating hepatitis: reach a coverage level of 80% for initial hepatitis B vaccinations in children and 75% in teens 15 years of age; increase by 25% the proportion of hepatitis-infected people screened and decrease by at least 20% in 5 years the prevalence of HCV infections among illicit substance users under the age of 25. The HCSP assessment report also examined the achievement of these objectives. The conclusions and proposals will serve to devise the next public health law, which will determine health authority policy, including addictions policy. The hepatitis plan also envisages an interorganisational monitoring committee responsible for the plan's assessment. This task will be given to an external assessor and is intended to be in operation in 2012.

2009-2013 "Cancer" plan

Adopted in 2009, the **2009-2013 cancer plan** launched by the President of France on 2 November 2009 comprises measures for the fight against hepatitis. A budget of €732.65 M was allocated to enable the plan's 118 actions programmed over a five-year period to be followed-through. The 2009-2013 cancer plan was based on the report by Prof. Jean-Pierre Grünfeld (Grünfeld 2009). It is a continuation of the preceding cancer plan (2003-2007) and capitalises on experience and follows new directions, particularly regarding three new challenges addressed by three multidisciplinary, priority themes of the plan:

- greater consideration for health inequalities to improve the equity and effectiveness of care in all measures to combat cancer;
- the analysis and consideration of individual and environmental factors in order to customise treatment before, during and after the disease;
- to strengthen the role of the attending physician at all treatment steps, in particular to help to improve life during and after the disease.

The 2010-2014 "Health/Prison" Plan

In 2010, the French Ministry of Health and Sports, with the help of the French Ministry of Justice and Liberties, devised a strategic action plan[62] that, for the period 2010-2014, determined a health policy for people going through the justice system. This was the first national plan for

[61] Loi n°2004-806 du 9 août 2004 relative à la politique de santé publique (NOR SANX0300055L).
[62] 2010-2014 Strategic Action Plan: Health policy for people placed in the French justice system, French Ministry of Health and Sports and French Ministry of Justice and Liberties

improving the health of detained people. The relevant central administration[63] departments, the *Institut national de prévention et d'éducation pour la santé* (INPES, or French National Institute for Prevention and Health Education), the *Institut de veille sanitaire* (InVS, or the French National Institute for Public Health Surveillance), the *Agence des systèmes d'information partagés* (ASIP Santé, or the Shared Healthcare Information Systems Agency) and a general advisor for health establishments were involved in preparing this "Health/Prison" Plan. This plan addresses aspects of prison health policy through programmes to improve the government's awareness of detainee's state of health, to strengthen the existing health systems and to provide for reinforced measures for certain detainee categories (especially prisoners with addictive disorders). The plan emphases the importance of continuity of care after release. Against this background, the three "key" measures of the Plan are as follows: create a large number of therapeutic coordination apartments or *halte-soins-santé* beds (for very unstable people); improve coordination between involved services to facilitate access to housing for people being released from prison and ensure the continuity of care post-incarceration; implement joint frameworks and joint training. An institutional supervisory committee is responsible for monitoring action plans and preparing an annual progress report. The French Ministry of Health and Sports is responsible for assessing the plan.

The 2008-2011 governmental "drugs" plan supervised by the MILDT provides for the cascading of its national strategic directions down into interministerial departmental "drugs" plans. Departmental project managers, working under the authority of the Prefect of the department, are responsible for drafting the local departmental drug plans[64]. The project manager takes the national policy and adapts it to local situations and characteristics. These plans are produced in a local steering committee, which brings together the different State services. The monitoring committee is also responsible for seeking consistency with the specific departmental plans (social cohesion contracts, road safety plans, delinquency prevention measures, city contracts, public health programmes, regional ambulatory and hospital care organisation and regional medico-social care services and facilities). Departmental plan measures that fall within the scope of the usual activities of decentralised services or the French national health insurance scheme are funded from their respective budgets. The experimental actions of the interministerial projects are financed using credits delegated by the MILDT (€15 M in 2009, €13 M in 2010 and €11 M in 2011). These experimental actions gather decentralised services around joint objectives, such as interministerial training, joint information and prevention or awareness-raising tools for all services. **The MILDT memo of 4 November 2009[65] to departmental drug project managers** reaffirmed their legitimate right to stimulate the local activities of administrative and institutional organisations and provided guidance for actions taken in 2010-2011:

- **Prevention: Priority should be given to local actions** that relay the messages of the national communication campaigns conducted in 2009 and 2010 on the danger of products, the legal status of substances and the role of parents. Furthermore, a primary objective of the departmental plan is to mobilise the departmental social partners to launch occupational prevention actions and implement measures to involve adults in the prevention of use. In continuation of the strategic directions of 2008 and 2009, the project managers are responsible for developing preventive

[63] Direction générale de l'offre de soins (DGOS, or General Healthcare Services Directorate), Direction générale de la santé (DGS, or the National Health Directorate), Direction de la sécurité sociale (DSS, or the Social Security Directorate), Direction générale de la cohésion sociale (DGCS, or the General Directorate for Social Cohesion).

[64] Note no. 578 of 18 September 2008 from the President of the MILDT for the attention of departmental project managers under the supervision of departmental Prefects.

[65] Note no. 683 of 4 November 2009 from the President of the MILDT for the attention of departmental project managers under the supervision of departmental Prefects.

activities in schools and universities, recreational environments and in populations being followed by the judicial system. As part of the delinquency prevention policy driven by the governmental plan, developing drug awareness training courses on the dangers of illicit drug use for occasional users is strongly encouraged.

- **Regarding addiction health policy**, the plan encourages departmental project managers to coordinate with regional project managers, the preferred liaisons for the "A*gences régionales de santé*" (ARS, or Regional Health Agencies). Since the HPST[66] (Hospital, Patients, Health, Territories) law of July 2009, which established the principle of regionalising care systems, health actions must be planned and assessed regionally. On this scale, the departmental project manager ensures that local health actions provided for in the regional programme meet the needs of the users of the department in terms of health education, available healthcare, social support and harm reduction.

- The departmental plan must comprise **actions to fight against local trafficking**. More specifically, it must help identify typical places for minor dealing, which feeds into the black market and generates significant social disturbances, particularly around school establishments. The project manager mobilises the efforts of local and regional players to fight against drug trafficking and criminal assets.

The 2008-2011 governmental plan had an implementation period of four years. The 2012 general elections postponed the adoption of the next governmental drug and addiction treatment strategy, which initially was supposed to take place in 2012.

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

In June 2011, the MILDT announced that nearly all of the 193 actions of the 2008-2011 governmental plan had been carried out.

Information, communication, prevention

The most recent national "general public" information and communication campaign took place in December 2010 (see chapter 3). The "Everyone can fight against drugs" campaign targeted adults so that they could examine their role in preventing drug use in children. It followed on from the campaigns of 2009: The October 2009 "*Drogue, ne fermons pas les yeux*" campaign ("Don't ignore drugs") and the November 2009 "*La drogue, si c'est interdit, ce n'est pas par hasard*" campaign ("Drugs, there's a reason they are illicit") (see chapter 3).

The governmental plan intended to mobilise parents and social partners involved in addictions at the workplace to help prevent addictive behaviours. Two national conferences were organised by the MILDT in 2010: one on parenting was held on 6-7 May 2010, and the other, on addictions in the workplace, in June 2010. The purpose of the national conferences was to provide an image of the current main problems and make recommendations (see chapter 3).

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

Law implementation and combating trafficking

The drug awareness training courses adopted by the "delinquency prevention act" of 5 March 2007[67], intended for occasional illicit drug users within the scope of their arrest, continued to strengthen after a series of awareness-raising activities by public prosecutors. The MILDT's report announced that this measure was used in more than 70% of jurisdictions. The Ministry of Justice entrusted the assessment of the measure to the OFDT. The results of this assessment are presented in chapter 9.

International cooperation in the fight against drug trafficking was reinforced by using joint investigatory teams in the fight against cross-border crime. The MILDT identifies 24 international teams in mid-2011 (in France, Spain, Belgium, Holland, Germany and Romania). In 2009, two platforms for European liaison officers in West Africa (Dakar and Accra) were created to facilitate the exchange of operational information on international narcotics trafficking cases.

Targeted, drug-related anti-money laundering actions were pursued: organisational measures, training for the "*Groupements d'intervention régionaux*" (GIR, or Regional Intervention Groups) aiming to improve measures for seizing criminal assets, actions to raise awareness in law enforcement agents, sponsorships of countries classified as sensitive in the fight against narcotics trafficking. The MILDT credits enabled a new GIR to be established in Guadeloupe, and branches to be established in Nice and Bastia. An information and strategy division, funded mainly by the MILDT, was created at the *Office central de répression du trafic illicite de stupéfiants* (OCRTIS, Central Office for the Repression of Illicit Narcotics Trafficking) in order to assess the extent of drug trafficking and its development. "Cyberpatrols" were created within law enforcement agencies to fight against cybercriminality, and good practice was formalised in collaboration with internet service providers. Finally, new detection tests were launched to fight against chemical precursors.

Treatment for drug users

In 2009 and 2010, the MILDT and the health authorities funded experimental programmes within the medico-social system for particularly vulnerable members of the public (e.g., young people in difficulty, detainees, pregnant women and parents with children and people experiencing social difficulties). These programmes provide for the creation of gateways between the medico-social sector and judicial youth protection structures or youth support centres, and even social structures collectively referred to as "common law " measures intended to promote the social integration and rehabilitation of people with addictions (see 1.4.1.2. on French national health insurance credits). Promoting the quality of professional practices is also one of the priorities of the governmental plan. Subsequently, in cooperation with the French Ministry of Health, the MILDT mobilised professionals concerned by the importance of improving professional practices within the scope of *Consultations jeunes consommateurs* (CJCs, or Clinics for Young Users). Numbers of this type of facility are still on the rise (38 new CJCs have been created since 2008; the overall budget for the duration of the Plan was €627,000).

In 2010, the *Haute autorité de santé* (HAS, or the French National Authority for Health) published recommendations for treating cocaine users. They were integrated into the call for tenders opened to CSAPAs and in particular were taken into consideration in the treatment of crack users. It was agreed to promote integrated healthcare practices for patients presenting with comorbitities, both somatic and psychiatric, coordinated between various services of the same hospital establishment as well as between CSAPAs and hospitals. The MILDT supports

[67] Loi n°2007-297 du 5 mars 2007 relative à la prévention de la délinquance (NOR INTX0600091L).

this measure for improving hepatitis C treatment for patients followed in CSAPAs and CAARUDs and in *Unités de consultations et de soins ambulatoires* (UCSAs, or Prison-based Hospital Healthcare Units) in the prison setting. The MILDT subsequently funds a dozen Fibroscans (€500,000 budget out of the 10% of the support funding earmarked for prevention) within the scope of quantitative and qualitative clinical research on the development of units for hepatitis prevention, care and harm reduction.

As departmental strategies of the anti-drug policy, the MILDT memo of 4 November 2009[68] to the departmental drug project managers reiterated the merits of **assessing innovative projects** so that they could continue long-term or so that new projects could be adopted. **The task of assessing activities conducted in 2009 was entrusted to a commission working under the Prefect**. It delegates the assessment mission to a specialised sub-committee that, moreover, since January 2010 has been defining the territorial strategies and projects to be executed. The 2009 MILDT memo reiterates the creation in each region of a system for providing methodological support to project managers. The purpose of this support is to elucidate the project manager's strategic choices and to define relevant indicators for assessing their effectiveness. This system integrates the methodological advice and observation work of the *Centres d'information régionaux sur les drogues et les dépendances* (CIRDDs, or Regional information Centres on Drugs and Drug Addiction) established by the MILDT in 2005. **The MILDT memo of 28 July 2009[69] intented for regional project managers** renewed the former regional support system provided by the associations in order to move from an associative network subsidy process to a project funding system and to strengthen the interministerial nature of the system. It stipulates that the MILDT shall provide subsidies to regional project managers. These subsidies will fund the organisation that wins the bidding process and signs a service agreement. In 2009, the CIRDD budget was €2.8 million. In 2010, the amount of the regional subsidy for tenders remained unchanged.

1.3.3. Other drug policy developments

A joint drug addiction information mission grouping delegations from the French Senate and the French National Assembly (30 members of French Parliament in total) was implemented in late 2010. After interviewing relevant professionals, associations and ministerial departments, as well as offsite interviews, the parliamentary mission finally issued its report on 29 June 2011. This report excluded any notion of decriminalisation, characterised as "*an ethical and judicial* impasse*",* but provides for the implementation of a fine in the event of an initial arrest for simple use. Furthermore, the report characterises the concept of opening supervised injection rooms as a "**dangerous option**"*.*

A few weeks before the publication of this parliamentary report, Deputy Daniel Vaillant (who is also a member of the joint mission) told the press that he supported the idea of the controlled legalisation of cannabis, thereby triggering a vigorous public debate.

Subsequently, these questions were sporadically discussed during the 2012 French presidential campaign.

[68] Memo no. 683 of 4 November 2009 from the President of the MILDT for the attention of departmental project managers under the supervision of departmental Prefects.
[69] MILDT note no. 451 of 28 July 2009 for the attention of the regional project managers overseeing the fight against drugs and drug addiction under the supervision of regional Prefects, with respect to the reform of the regional support system.

As for the MILDT, in the fall of 2011, the political alternation in the French Senate gave rise to a symbolic vote. Within the scope of the discussion of the 2012 budget bill, the Senate Commission on Social Affairs rejected the adoption of the credits of the mission following the advice of spokesperson, Laurence Cohen. These credits were deemed insufficient and poorly distributed because they were too focused on law enforcement. This rejection was not ratified by the National Assembly, and therefore had no impact.

1.3.4. Coordination arrangements

National interministerial coordination

In order to improve the central coordination of interministerial actions, the State, through article 138 of the amended budget law for 2008[70], provided the MILDT with a permanent supervisory instrument for the drug and drug addiction policy: the first version of the *Document de politique transversale* (DPT, for Transversal Policy Document) was produced in 2009 within the scope of the 2010 budget law. The "drugs" DPT is written every year by the MILDT with the support of relevant senior ministerial officers and serves as an organisational tool for mobilising ministerial players. It was produced using the *Projets annuel de performance* (PAP, or annual project performance indicators) for ministerial programmes.

Territorial interministerial coordination

Despite the reforms introduced by the HPST law conferring upon the region the health policy supervision, and despite the desire of MILDT to keep its new "drugs" support system on a regional level, the administration of the governmental drug policy on a departmental level was not questioned. The legitimate right of the local drug project manager to boost the administration's territorial actions was reaffirmed in the MILDT memo of 4 November 2009[71] to departmental project managers. Coordination is provided by the departmental project manager within the monitoring committee, which ensures that the local health activities stipulated in the regional plan meet users needs in the department (see 1.3.1.).

1.4. Economic analysis

1.4.1. Public expenditure

The budget resources allocated to combat drugs and drug addiction come mostly from the State and the French national health insurance fund. The latest data available on "drug" credits used by administrations are from 2010 (RAP, or Annual Performance Report 2010 annexed to the 2010 *loi de règlement des comptes* (PLFR or Amended Initial Budget Act) and the drug and drug addiction *DPT* for 2012). With respect to national health insurance spending in the area, the funding of addiction treatment structures (CSAPAs, CAARUDs and CTs) represents the area of highest expenditure. The most recent official data for this expenditure category also comes from 2010. The following table presents 2010 expenditures that may be attributed to the joint contributions of the French government and French national health insurance. The healthcare

[70] Loi n°2008-1443 du 30 décembre 2008 de finances rectificative pour 2008 (NOR BCFX0826279L).
[71] MILDT note no. 451 of 28 July 2009 for the attention of the regional project managers overseeing the fight against drugs and drug addiction under the supervision of regional Prefects, with respect to the reform of the regional support system.

expenditures on the direct healthcare costs of primary care and hospital care are not considered in the estimates performed for 2010.

Table 1-1: Total public expenditure attributable to the 2010 drug policy (in € million)

	Sector	Cofog1	2010
Spending on Defence, Public order& Safety and customs departments and indirect taxes to fight against narcotics trafficking and the black market for drugs	S1311	Gf02 Gf03 Gf04	685.98
Spending on universal prevention and selective prevention	S1311	Gf09 Gf07	332.97
Spending on healthcare and indicated prevention	S1311	Gf07	369.53
Spending on Research & Development	S1311	Gf07	11.47
Spending on training	S1311	Gf02 Gf03 Gf04 Gf07 Gf09	11.51
Spending on the coordination of the drug policy	S1311	Gf03 Gf07 Gf09 Gf10	2.58
Spending on observation and assessment (OFDT and DAR)	S1311	Gf03 Gf07 Gf09 Gf10	5.88
Total			1419.93

Source: Table created by the OFDT using RAP and DPT data from 2010, 2011 and 2012.
Note: The latest year available for medication reimbursement amounts from the ADELI list of health professionals is 2009. The amount of OST medications reimbursed by the national health insurance scheme in 2009 was €88.87 million
Cofog: United Nations Classification of Government Functions.

Public expenditure on implementing the governmental and French national health insurance drug policy in 2010 was in the region of €1,420 million. Since the data is not available, this estimate does not include French national health insurance expenditure on reimbursing OSTs. In 2009, the amount reimbursed by the national health insurance scheme was €88.87 million. Assuming that the difference between reimbursed amounts in 2009 and 2010 will be minimal, the 2009 reimbursements can be used indicatively to establish a forecasted amount for OST medication reimbursement in 2010. This assumption is based on qualitative data collected within

the scope of the TREND survey. These data support the idea of an emerging "saturation" effect on treatment demand by users and greater accessibility to heroin on local markets. By integrating the 2009 reimbursements, public spending attributable to the drug policy reaches €1,510 million in 2010. Moreover, the two main limitations of this estimate pertain to the failure to take into consideration the main expenditure areas of prison administration and health services (direct costs of providing primary care and hospital care in the field). These categories of expenditures have been estimated for 2003 by Kopp and Fénoglio (Kopp *et al.* 2006b). The cost of treatment for the illicit drugs was estimated at somewhere between €573 and €632 million. Expenditures for alcohol-related treatments were estimated between €5,467 million and €6,156 million. Treatment costs of tobacco-related health problems were estimated in the range of €15,537 and €18,254 million. Taking into account inflation since 2003, such estimates on expenditures in health-related problems would have reached €689.50 million for illicit drugs, €6,646.50 million for alcohol and €19,322.50 million for tobacco, in 2010. In the area of prison, Kopp and Fénoglio (Kopp *et al.* 2006b) referred to €219.79 million in 2003, of which €200.49 accounts for illicit drug-related convictions, and €19.30 million for drink driving convictions. After inflation since 2003, such estimates on incarceration spending would have reached €229 million and €22 million in 2010, respectively. Including these estimates on health and prison services, updated after inflation, the total spending will be somewhere close to €28 billion in 2010 (licit and illicit drugs). This estimate accounts roughly for 1.5 percent of the GDP in 2010 (GDP accounts for €1,931.4 billion in 2010) or 6.6 percent of the State's budget which accounts for a spending of €435.37 per habitant.

1.4.2. Budget

The funding presented here comes from the "Narcotics" support fund. The proceeds from the sale of assets confiscated within the scope of criminal proceedings for narcotics cases in 2011 were €22.76 million. Of this amount, €18.81 € was redistributed by the MILDT in 2011 to the French ministries responsible for implementing the drug policy.

This "Narcotics" support fund was created in March 1995[72] at the initiative of the 1993 Interministerial Committee Against Drugs and Drugs addiction. The management of the allocation of the proceeds of assets confiscated from drug dealers remains the responsibility of the MILDT. Preparatory work for the 17 March 1995 decree revealed that the distribution to the various relevant ministries of the allocated amounts from the support fund is established as follows: 90% of the amount should be redistributed to the ministries in charge of fighting against trafficking and enforcing the law to fund the acquisition of equipment or services intended for the fight against drugs; the remaining 10% can be used to fund prevention activities carried out by the relevant ministries.

Since the 9 July 2010[73] law that entrusted the centralised management of amounts seized to a public establishment to which jurisdictions should refer (AGRASC), contributions to the "Narcotics" support fund have only risen.

[72] 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 (NOR BUDB9560005D) et 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 (NOR SANG9502738A).
[73] Loi n° 2010-768 du 9 juillet 2010 visant à faciliter la saisie et la confiscation en matière pénale (NOR JUSX0912931L).

1.4.3. Social costs

For the last ten years, the *Observatoire français des drogues et des toxicomanies* (OFDT, or the French Monitoring Centre for Drugs and Drug Addiction) has repeatedly worked on estimating the social cost of licit and illicit drugs. The first study (Kopp *et al.* 1998) dates back to the 1990s and examined the possible calculation methods. The initial estimates were presented in the Kopp and Fénoglio report (Kopp *et al.* 2000) on *Le coût social des drogues* (the social cost of drugs). This initial work estimated the annual costs of the illicit drugs to society to be €2,035.24 million. Regular estimates have been carried out since then. There are two reasons for the need to continually re-estimate these figures: the appearance of new data that were initially unavailable (e.g. treatments for certain diseases) and the need to consider new calculation methods. Hence, the 2006 study assessed the social cost of illegal drugs to be €2,824.44 million in 2003 (Kopp *et al.* 2004). Compared to the 2000 estimate, the social cost of illicit drugs was only multiplied by a factor of approximately 1.39.

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;
- 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.

In addition, they enable survey results to be more detailed by distinguishing between the different types of use (recent use, regular use, daily use, etc.).

The use of various other additional observational tools such as the TREND (see Appendix IV-U) and SINTES (see Appendix IV-R) 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 TREND and SINTES systems are primarily used to collect qualitative data.

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 of a randomly selected individual 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 IV-A). 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, see Appendix IV-J)-) 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 amongst this population using the most suitable collection method, a self-completed paper questionnaire. The Health Behaviour in School-aged Children Survey (HBSC), conducted in 41 countries or regions, questions 11, 13 and 15 year-old youngsters, still at school. 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. However, it's at the end of adolescence (17 years old) that the distinction between individuals actually involved in drug and alcohol use and those who are not, can be made

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:
Experimentation: 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 (see 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 consumption in the over 50 year-olds.

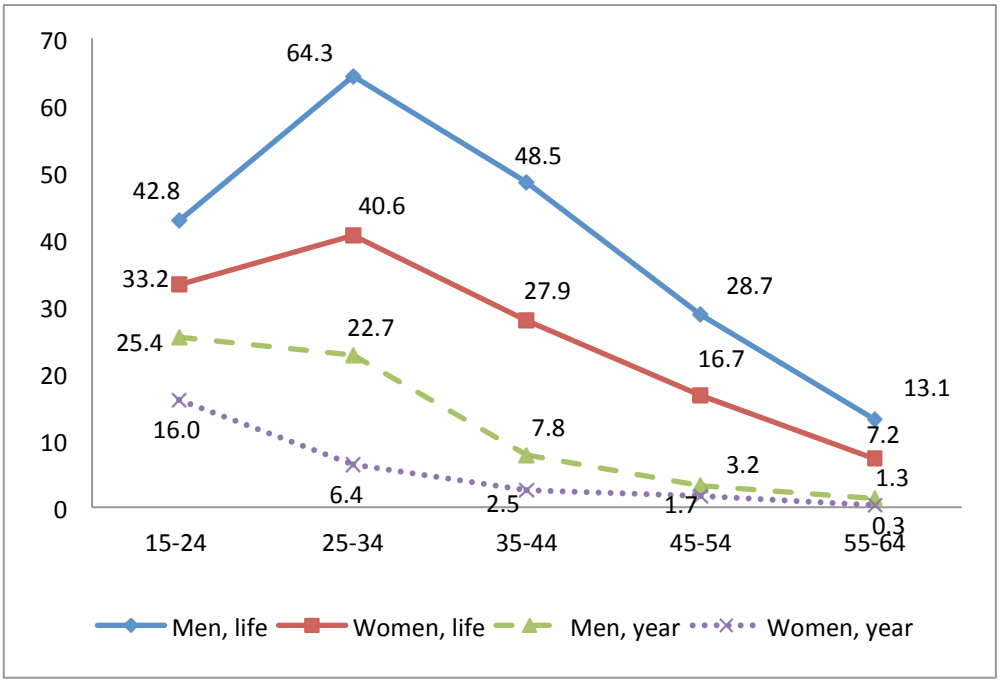
Thus 20.8% of 15-24 year-olds were implicated in cannabis use over the twelve-month period preceding the survey.

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.

Graph 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 cocaine[74], 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 (0.8% of the general population), 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 nevertheless 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

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

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 use[75]. 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%).

Geographically, in 2010, the Mediterranean regions and Brittany had the highest percentage of users with a greater distribution in rural areas and small urban zones, as confirmed by multivariate analysis.

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 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

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

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.

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 various legislative procedures in recent years, ranging from licit to illicit drugs. Some forms are currently licit.

Table 2-2: Trends in lifetime use and substances use during the last 12 months (current) 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) 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 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

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

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1: Relative change recorded with exact figures.
2: Absolute change recorded with exact figures.
Source: ESCAPAD 2011 OFDT

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 events[76] 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 (Pfau A paraître).

[76] 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 principles and references

The drug use prevention policy in France is based on early intervention aimed at youngsters in order to delay the mean age of first drug use. Since 1999, its scope has been expanded to include legal psychoactive substances (such as alcohol, tobacco and psychotropic medicines) and the concept of abuse in addition to the concept of use. These principles are introduced and disseminated through the "Parquet" report (Parquet 1997), which constitutes the main theoretical reference for prevention in France. In schools, the general framework for intervention is that of preventing addictive behaviour, which more generally falls within the province of health education.

The policies on legal and illegal drug use are defined within the scope of long-term plans.

The principles and strategies of these various documents are evidenced in a more practical way in the *Guide de prevention des conduites addictives en milieu scolaire (A guide on preventing addictive behaviour in schools)*, issued in 2005 by the French Ministry of National Education and the MILDT, and updated in 2010 (DESCO (Direction générale de l'enseignement scolaire) *et al.* 2005; DGESCO (Direction générale de l'enseignement scolaire) *et al.* 2010). The INPES also summarised the evidence-based methods of prevention in its *Référentiel de bonnes pratiques*. *Comportements à risques et santé : agir en milieu scolaire (Good practice guidelines for addressing health and risky behaviour in schools)* (Bantuelle *et al.* 2008). Although these documents represent the only national references in terms of prevention, they are for information purposes only. There is no specific protocol for specialised structures, whether governmental or associative.

The notions of universal prevention, selective prevention or indicated prevention[77] are not yet in widespread use, even though they are increasingly present in professional and institutional circles. Reference to "primary prevention"[78] persists even though comprehension of the notion has had to evolve since actions targeting young people also began focusing on preventing abuse. Consequently, discourse increasingly refers to targeted types of use (e.g., "simple" use, abuse, binge drinking, etc.) or on the status of those populations targeted by prevention actions (pupils and students, workers, or people referred by the justice system).

Universal prevention of legal and illegal drug use is the main approach developed in French schools.

77 Established by the Institute of Medicine of Chicago in 1990, this classification is based both on the target population and the level of risk in terms of a given pathology or behaviour. In outline, universal prevention concerns the general population, selective prevention concerns at-risk groups and indicated prevention concerns those groups exhibiting the early stages of problem-behaviour (recent users, first-time offenders, etc.).

78 The WHO suggests a classification based on the stage of disease (1948). Hence, primary prevention is defined as all activities aimed at reducing the incidence of a disease, and therefore reducing the risks of new cases. Secondary prevention aims to reduce the prevalence of disease in a population. Subsequently, this type of prevention covers activities instituted when a disorder or pathology appears to prevent its development or activities instituted to eliminate risk factors. Tertiary prevention aims to decrease the prevalence of chronic disablement or recidivism in a population and to reduce the complications, disabilities or relapses of a disease.

Despite the lack of national data on prevention practices, certain trends can be pointed out. Thanks to the efforts made since 1999 to professionalise and harmonise the range of preventive initiatives, several principles appear to be prevalent today: for example, the limits of a purely informative approach alone and the relevance of the preventive role played by parents, of an interactive approach or of the development of psychosocial skills, are currently well-known. Nevertheless, putting these interventional principles into practice remains difficult for many actors involved.

The general context and key players

Drug use prevention is within the competence of the State and can be delegated to associations when a local approach is more appropriate.

The actions that target young populations are most often organised within the scope of secondary education where the education community is widely involved, both for coordination and execution purposes. Three major categories of key players are involved among youth: people involved in associations that focus on prevention or health education, specialised *gendarme* (FRAD) or police force (PFAD)[79] agents, and school educational, health and social personnel.

In secondary education

In secondary schools, each principal, as chairperson of a *Comité d'éducation à la santé et à la citoyenneté* (CESC, or Health and Citizenship Education Committee) defines the prevention activities to be carried out each year among students. The CESCs bring together the educational community and qualified external partners to define and coordinate drug use prevention policy in secondary schools. Head teachers receive recommendations from their local administrative authorities which, in turn, are based on ministerial guidelines. However, the establishments enjoy a high level of independence in this area.

Since 2006, prevention of addictive behaviour has been given a new foothold in the basic missions of the French education system through the adoption of the "*socle commun de connaissances et de compétences*" ("common base of knowledge and skills"), i.e. the set of knowledge, skills, values and attitudes that all students must master by the end of mandatory schooling for their life as future citizens[80]. The "social skills and civics" and the "independence and initiative skills" subsets (skill subsets 6 and 7 respectively) illustrate the French education system's academic contribution to the development of the individual and social skills generally associated with life skills, and which may be used by students when they are offered drugs.

Agricultural secondary and higher education establishments are also relatively free to define their commitment to prevention, but are largely encouraged by the supervising Ministry of Agriculture to invest in such efforts. Since 2001, professionals of agricultural education have enjoyed access to the *Réseau d'éducation à la santé, l'écoute et le développement de l'adolescent* (*Reseda* or the Health Education, Counselling and Adolescent's Development Network), which encourages dialogue, training and resource distribution on drug prevention, and also organises tenders in the field of health education.

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[79] FRAD: *Formateurs relais anti-drogue* (Anti-drug liaison trainer of the French *gendarmerie nationale*; PFAD: *Policiers formateur anti-drogue* (Anti-drug police trainer)

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 (NOR: MENE0601554D).

In higher education

Actions among students (in establishments of higher education) are organised by the *Services (inter)universitaires de médecine préventive et de promotion de la santé* (S[I]UMPPS, or [Inter] University Preventive Medicine and Health Promotion Service). Several associations or complementary student health insurance companies also participate in this area.

In the workplace

In the workplace, the prevention of alcohol, drug or psychotropic medication use is governed by the French Labour Code. Occupational health services are responsible for preventing the use of alcohol and drugs in the workplace. Specialists of the gendarmerie/police forces and associations can be called upon to deliver preventive communication in the workplace.

Prevention targeting "at risk" populations (selective prevention) or drug users (indicated prevention) is handled mainly by specialised associations, particularly when implemented outside of the school environment, in communities (in underprivileged neighbourhoods) or in judicial settings. This is the case with *Consultations jeunes consommateurs* (CJC, or clinics for young users) and drug awareness training courses (see chapter 9).

Observation system

Since 2006, the OFDT has been working on a national observation system for universal or selective prevention practices related to the use of both legal and illegal drugs in France. RELIONPREDIL (*Recueil d'indicateurs pour l'observation nationale des actions de prévention liées aux drogues illicites* ou *licites* or the Survey for the monitoring of prevention actions related to illicit or licit drugs, see Appendix IV-W) aims to document and track the key theoretical and practical components of local prevention actions. Its steering committee is comprised of ministerial and associative representatives in the field. Its specificity mainly lies in the coverage of numerous sectors (such as education, the workplace, the judicial system, and the community) and its ability to include actions independently of their funding source (including those performed free of charge). The initiative has had three phases of local experimentation, the last of which took place in 2011, with adjustments that were methodological in nature or concerned the changes in the resources employed. The complexity of the field of prevention (e.g., unstable principles of intervention and concept, numerous stakeholders) and the difficulty in eliciting a satisfactory response rate (weariness of field actors, lack of time or resources in face of information requests) explain the difficulty in implementing this type of system and the need to develop new approaches to continue exploring this field.

Consequently, the description of prevention actions conducted in France is not available at this time.

The legislative framework

The foundations of illegal drug use prevention measures are rarely found in legislation. The French *loi de santé publique* (Public Health act) of 2004, which was incorporated into the French Education Code, sets a minimum target of one annual information session per uniform age group to provide information on "the consequences of drug use on health, and particularly the neuropsychological and behavioural effects of cannabis, in secondary schools (...)". With regard to prevention of tobacco and alcohol use, legislation governs the advertisement, accessibility and use of these substances in public places. Taxation policy also helps limit use.

National and local coordination and financing

The policies for the prevention of legal or illegal drug use are established by 3-year government plans and coordinated by the MILDT. They can reflect or be completed by ministerial programmes or national plans on related themes (e.g., cancer, hepatitis) covered by National Education or Health Departments.

The adaptation of national strategies to the local level is entrusted to departmental programmes to fight against drugs and addictions. It is supervised by "drug and addiction" project managers (appointed within prefects) and local MILDT representatives in regions and *départements* (sub-regional administrative territories). More generally, it is based on the decentralised services of the State Project managers have specific credits available to subsidize addiction prevention actions and professional training.

Since 2007, sales of assets seized during efforts to crack down on illegal drug trafficking have been turned over to the MILDT-managed drug support fund (*fonds de concours drogues*). Of the money in this fund, 90% is allocated to the fight against drug trafficking and 10% (or 2.2 million Euros in 2011) is allocated to prevention efforts. The French national health insurance system also subsidises prevention activities through tenders issued by the *Fonds national de prévention, d'éducation et d'information sanitaire* (FNPEIS, or French National Fund for Prevention, Education and Health Information). Various cross-disciplinary local programmes (concerning health, social exclusion, law and order, 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 to 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).

The *Commission de validation des outils de prévention* (Committee for the validation of prevention tools, coordinated via the MILDT) issues its opinion on the quality and relevance of the tools submitted to it.

In order to be fully represented in public debates and to encourage professional dialogue, the specialised associations are assembled into federated organisations[81]. These organisations implement training, conference cycles and think tanks on reducing the drug demand.

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

[81] FNES: *Fédération nationale des comités d'éducation pour la santé* (French national federation of health education committees); Fédération Addiction, which is the merger of Anitea (Asso*ciation nationale des intervenants en toxicomanie et addictologie*/the French national association of drug abuse and addiction workers) and of F3A (*Fédération des acteurs de l'alcoologie et de l'addictologie*/the French Federation of alcohol and drug addiction stakeholders) (www.anitea.fr); FFA: Fédération française d'addictologie (French federation of addictology, www.addictologie.org); CRIPS: Regional AIDS information and prevention centres (www.lecrips.net/reseau.htm).

National and local media campaigns

The media campaigns on illegal drugs run by the public authorities seek to inform and/or warn the public of the dangers of using such substances.

For about a decade, these campaigns have been conducted by the MILDT, often with the INPES and relevant ministries (Health, Justice).

These media activities are carried out at varying intervals and frequencies. Similarly, the nature of the drug prevention messages, the substances mentioned (depending on whether a global or another approach has been adopted) and the population groups targeted as a priority (young people, parents, the whole population and also, occasionally, professionals) vary according to the guidelines of the governmental drug plan.

The media used to carry these messages are just as diverse and can include: the press, outdoor displays, radio and television, as well as (and increasingly so) the Internet. Finally, the budget allocated to such activities can vary from campaign to campaign.

These campaigns are most often subject to pre-tests, and sometimes to post-tests: the purpose of these tests is to assess the impact of the campaigns in respect to audience, message retention and approval, allowing for a number of comparisons to be made.

3.2. Environmental prevention

Environmental prevention policies for alcohol and tobacco use

The governmental strategy to prevent legal drug use is defined by the governmental drug plans or cancer plans. The last governmental plan (2008-2011) emphasised binge drinking, especially in young people, and the issue of alcohol use in the workplace to reduce work-related accidents, absenteeism and other associated risks. This plan aims to modify the French social perceptions of alcohol in a context of diminishing global alcohol use per inhabitant. However, the plan does not specifically address the issue of preventing tobacco smoking, since this is more specifically addressed by the 2009-2013 cancer Plan. The latter aims to reduce the attractiveness of tobacco products, to ensure the efficacy of the measures to protect minors from tobacco use that were adopted in the “Hospital, Patients, Health and Territories” law (so-called *loi HPST*) and to succeed in banning the sale of tobacco products on the Internet.

The commerce, distribution and use of alcohol and tobacco have well-established controls that are regularly reinforced.

For several centuries, French legislation has regulated the commerce and distribution of alcohol, and originally did so for tax purposes and for maintaining law and order. Since the 1960s, consideration for public health began influencing legislation. The so-called “*Loi* Évin” law of 10 January 1991[82], the 21 July 2009 reform law on “Hospital, Patients, Health and Territories [83] (the "*Loi* HPST") and the French Code of Public Health, which was amended by the aforementioned laws, are today the primary legislative texts restricting access to alcoholic beverages or laying down the main, related principles of prevention and social/health treatment.

[82] Loi n° 91-32 du 10 janvier 1991 relative à la lutte contre le tabagisme et l'alcoolisme (NOR SPSX9000097L).
[83] Loi n° 2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires (NOR SASX0822640L).

The first French law on tobacco use, adopted on 9 July 1976 (the "*Loi* Veil")[84] mainly regulated advertisements and sport sponsoring, and banned smoking in public places where it could have harmful health consequences. Besides, the law stipulated measures for informing smokers about the tobacco related risks. In 1991, the Évin law reinforced the restrictive nature of the 1976 law concerning the use, manufacture or promotion of tobacco products. Since then, even though there have been several measures to relax legislation in terms of tobacco promotion, restrictions on use have been reinforced in the last decade, and especially with regard to young people.

Taxation

The tax scheme applied in France to alcohol and alcoholic beverages complies with the minimal taxation level determined by the Council of Europe[85].

Hence, all alcoholic beverages are subject to 19.6% VAT. In addition to the VAT are excise duties (consumption or circulation taxes) of €1.25 to €1,514.47 per hectolitre, depending on the type of product and the degree of alcohol. By virtue of specific public health objectives, certain alcoholic drinks are subject to additional taxation. This is the case for Premix taxes, which are established at €11 per decilitre of pure alcohol (art. 1613 of the French General Tax Code). In 2009, the Social Security budget law established a social contribution applicable to alcoholic beverages containing over 25% alcohol by volume. In December 2011, the 2012 Social Security budget law[86] used taxation as a lever to increase the price of alcoholic beverages (since the price levels were estimated to be 10% lower than the European Union average) and contribute to measures to fight against excessive alcohol consumption, especially among young people. Among others, the law expanded the application of the social contribution to include drinks with over 18% alcohol by volume. The total amount generated through excise duties and social contributions on alcohol goes to finance healthcare and ageing branches of the social security scheme of farmers (**3.3 billion Euros** in 2011). In total, these new measures should generate **340 million Euros**.

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

Tobacco products are subject to *ad valorem* tax: VAT of 19.6% and consumption duties in proportion to the retail selling price of products except cigarettes. For cigarettes, duties are broken down into a specific part per 1,000 cigarettes (€27.58) and a part proportional to the retail selling price (54.57 %). These parts are calculated based on the reference retail selling price of cigarettes of the class (currently €5.70 in France).

[84] Loi n°76-616 du 9 juillet 1976 relative à la lutte contre le tabagisme.
[85] Directive n° 92/83/CEE et n° 92/84/CEE du Conseil du 19 octobre 1992.
[86] Loi n° 2011-1906 du 21 décembre 2011 de financement de la sécurité sociale pour 2012 (NOR BCRX1125833L).

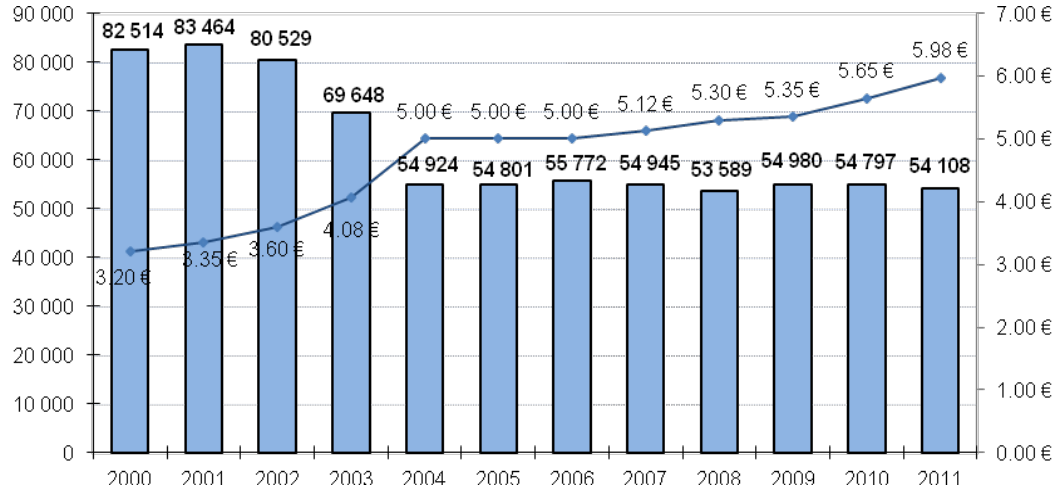
Table 3-1: Consumption tax as per article 575 A of the French General Tax Code

Product group	Applicable tax
Cigarettes	64.25 %
Cigars	27.57 %
Finely-cut tobacco intended for rolled cigarettes	58.57 %
Other smoking tobaccos	52.42 %
Snuffs	45.57 %
Chewing tobaccos	32.17 %

The retail price of tobacco products (expressed per 1,000 units or per 1,000 g) is the same for the entire country. 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.

After sharp rise in tobacco prices in 2003 (successive increases of 8% in January and 18% in October) and in 2004 (+ 9%), the latest increases occurred in November 2010, bringing the price of a pack of the most popular brand from € 5.60 to € 5.90 (+ 6%), and in January 2011 (+ 6%). Despite this, cigarette sales have remained relatively stable since 2004.

Graph 3-1: Cigarette sales (in millions of units) and annual average price per pack of the most widely sold brand



Source: Altadis / DGDDI (French customs and duties department)

Control of sales (composition, packaging)

Given the regulations on the manufacture, sale and consumption of beverages, they are broken down into five groups, four of which contain alcoholic beverages.

The sale of alcohol is subject to authorisation[87]. There are four different licence types for on-licence drinking establishments depending on the type of beverages sold. Only licence IV authorizes the sale of any type of alcoholic beverage (see the table below).

Table 3-2: Legal classification of drinks and drinking establishments

Beverage classifications		Drinking establishment classifications	
Groups	Type of drinks	On-licence	Off-licence
1st group	Non-alcoholic beverages of less than 1.2° alcohol	Licence I: Non-alcoholic beverage licence	Small off-licence (group 1 and 2 beverages)
2nd group	• Wines, ciders, beers • Lightly fortified wines subject to the wine taxation scheme (Banyuls, Rivesaltes, Frontignan) • Crèmes de cassis and fermented fruit or vegetable juices that are 1.2 to 3 degrees alcohol	Licence II: Undistilled fermented beverage licence (group 1 and 2 beverages)	
3rd group	• Lightly fortified wines other than those in group 2 • Fortified wines (Porto, Malaga, Pineau) • Wine-based aperitifs (Byrrh, Martini, Dubonnet …) • Liqueurs of less than 19°	Licence III: Restricted licence (including intermediate alcoholic products) (group 1, 2 and 3 beverages)	Off-licence (all 5 beverage groups)
4th group	• Rums, Tafias, Brandies • Cognac, Armagnac • Other liqueurs (Bénédictine, Cointreau, Chartreuse) • Alcohols produced by distilling wines, ciders, berries or fruits[88]	Licence IV: major licence (for spirits and alcoholic beverages)	
5th group	All other beverages, including grain alcohols other than those in group IV (aniseed, gin, whisky, vodka…) and Premixes		

Several legal provisions govern the packaging or composition of tobacco products, and especially those tobacco forms that appear to be the most attractive to young people. Hence, the sale of packs of fewer than 20 cigarettes[89] and the sale of cigarettes presented in attractive colours with sweet flavours and aromas is prohibited.

Cigarette packaging and tobacco product packets must display the "Seriously harmful to your health" warning, the composition of the product and the average tar, nicotine and carbon monoxide content. Since 20 April 2011[90], cigarette packs must, in addition to the text warning on

[87] Loi du 24 septembre 1941 modifiant la loi du 23 août 1940 contre l'alcoolisme.
[88] Not containing any added essences as well as liqueurs sweetened with at least 400 grams of sugar, glucose or honey per litre for aniseed liqueurs and 200 grams for other liqueurs and not containing over a half gram of essence per litre.
[89] Loi n°2003-715 du 31 juillet 2003 visant à restreindre la consommation de tabac chez les jeunes. (NOR SANX0306354L).
[90] Arrêté du 15 avril 2010 relatif aux modalités d'inscription des avertissements de caractère sanitaire sur les unités de conditionnement des produits du tabac (NOR SASP0931273A).

the front, display a health message with a captioned photograph that covers 40% of the back as well as the abbreviated telephone number for the Tobacco information service telephone helpline. This measure will be expanded to include all tobacco products (including rolling tobacco, cigars and cigarillos) on 20 April 2012. Moreover, tobacco product packaging cannot display text or figures that indicate diminished harmfulness compared to other tobacco products.

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

Protected areas and restricted distribution sites

Since the adoption of the *Loi* Évin, on-licences cannot operate within "protected areas" likely to be frequented by minors, and no new establishment can set up in such areas (except in the event of a transfer). These protected areas include "public and private educational establishments and all training and recreation establishments for young people" (art. L3335-1 of the French Public Health Code).

Public intoxication is currently subject to a 2nd class fine (€150). The offender may be detained at the closest police station until reasonably sober. Intoxication **at sport events** is an offence punishable by imprisonment, especially in the event of violence (law of 6 December 1993[91]). However, stadium refreshment stands, which were banned in 1991, were reintroduced by the law of 30 December 1998[92].

Since 1 February 2007, it is illegal to smoke in France in any enclosed, covered public areas or in the workplace, in healthcare establishments, in public transport, and in public and private schools, as well as in establishments where minors are trained or housed (including open areas, such as school courtyards)[93]. A year later (1 January 2008), the same decree extended this ban to include drinking establishments such as on-licences, hotels, restaurants, tobacco shops, casinos, game tables and discotheques. Smoking areas can be installed, except in health establishments and establishments frequented by minors.

Provisions that target young people

The sale of alcohol to minors is subject to special provisions. The ban on sales to minors was established in 1914 and encompassed two minimum ages (16 and 18 years), two sales methods (on- and off-licence) and two product categories (2nd group beverages on the one hand and 3rd to 5th group beverages on the other hand). Since 1991, the *Loi* Évin has banned the sale AND the (free) supply of alcohol to minors under the age of 16, regardless of the alcoholic beverage type. Since then, drinking establishments are no longer authorised to let minors under the age of 16 enter unless accompanied by a person aged 18 or over who is responsible for or will monitor that minor. In 2009, the Loi HPST modified the regulations, and particularly the French Public Health Code, on alcohol and tobacco to limit at-risk use, especially in young people.

It expanded the scope of the ban on alcohol sales to minors at all places of business or public places, regardless of the method of sale (on- or off-licence) or the category of alcoholic

[91] Loi n°93-1282 du 6 décembre 1993 relative à la sécurité des manifestations sportives (NOR MJSX9300141L).
[92] Loi de finances rectificative pour 1998 (n°98-1267 du 30 décembre 1998) (NOR ECOX9800170L).
[93] 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 (NOR SANX0609703D).

beverage (groups 2 to 5). The person providing the beverages can require proof of age by the client (art. 93 of the Loi HPST, amending art. L.3342-1 of the French Public Health Code).

The *Loi* HPST establishes the ban on the unlimited sale or free supply of alcoholic beverages for commercial purposes (except during traditional fairs and festivals where tastings[94] are kept authorised). Although this ban does not target young people exclusively, it does target open bars (bars with an entry fee that entitles the consumer to unlimited drinks) (art. 94 amending article L. 3322-9 of the French Public Health Code). During "happy hours", it also became mandatory to offer lower-priced non-alcoholic beverages (art. 96, L. 3323-1 of the French Public Health Code).

The sale of alcohol is restricted in petrol stations: formerly authorised between 6 a.m. and 10 p.m., it 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).

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 further sanctions: a temporary prohibition to exercise rights under a liquor licence for a year or more and the requirement to undergo training in parental responsibility (art. 131-35-1 of the French Penal Code). In the event of recidivism, the offenders are subject to one year imprisonment and a €15,000 fine.

At present, French law prohibits the sale or free supplying of tobacco products (e.g., cigarettes, rolling tobacco, hookah tobacco, pipe tobacco, cigars, cigarillos) or their components – including papers and filters – to all minors, 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 tobacco retail outlets[95].

Violations are subject to fines for 2nd class offences (up to €150) unless the offender shows proof that he or she was duped with respect to the minor's true age.

Restrictions on use: while driving, during pregnancy, in the workplace

Driving a motor vehicle under the influence of alcohol is an offence that has been punishable by law in France since 1965[96]. Since the 29 August 1995 decree[97], 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* (French penal authority that handles contraventions) or the *tribunal correctionnel* (French penal authority handling delicts), depending on the recorded blood alcohol level. This offence is, among other things, subject to a fine (from €135 to €4,500), a loss of driver's licence points, driver's licence suspension or revocation, or even prison. 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.

[94] The law stipulates that the conditions for authorising new parties and festivals must be established by order of the departmental prefect.
[95] Arrêté du 27 janvier 2010 fixant les modèles et lieux d'apposition des affiches prévues par l'article L. 3342-4 du Code de la santé publique (NOR SASP1002542A).
[96] Loi n°65-373 du 18 mai 1965 modifiant l'article L. 1er du Code de la route.
[97] Décret n°95-962 du 29 août 1995 modifiant les articles R. 233-5, R. 256 et R. 266 du Code de la route (NOR EQUS9500428D).

The recommendation of totally abstaining from consuming alcohol during pregnancy must be on all alcoholic beverage packaging units (TAV[98]> 1.2°). It can take the form of a pictogram or text (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 decree[99].

The French Labour code prohibits the presence of inebriated persons in the workplace and aims to limit the presence of alcoholic beverages in the workplace. Such beverages are banned from automatic distributors and the employer uses policies and procedures to establish the general context of their consumption and circulation[100]. The policies and procedures must specify conditions for possible blood alcohol level controls. Breathalyzers are not required to be performed by a physician. By virtue of individual freedoms, an employee can only be required to use 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 transport[101]. Breathalyzers may not be used by an employer to record employee fault, which is why case law considers there is no reason to impose the presence of a third party during such screening or to foresee the possibility of a second Breathalyzer assessment (decision of the Council State of 12th November 1990).

Restrictions on advertising

The *Loi* Évin regulates advertising content and media for alcoholic products. The law prohibits any propaganda or advertisement to promote alcoholic beverages of over 1.2° using media that is imposed on everyone, and minors in particular (television, cinema). It stipulates that all advertising messages are required to mention, “The abuse of alcohol is harmful to your health", and to urge the public to "drink with moderation".

Since then, given the financial claims of producers and distributors, relaxations of several of the 1991 provisions have been adopted, such as the authorisation of increasingly liberal display ads and references to the olfactory and taste characteristics of products (23 February 2005 law on the development of rural territories)[102]. Most recently, the *Loi* HPST gave a ruling on the authorisation of on-line advertising for alcoholic beverages, except on "sites intended for young people" (for which the definition was not specified: see article 97 of the law).

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.

French television stations can re-broadcast motorsport competitions that take place in countries where tobacco advertising is authorised. However, the 2009-2011 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”.

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[98] TAV: Titre alcoométrique volumique, or Alcohol proof

[99] 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 (NOR SANX0602395A).

[100] Circulaire TE n°69-4 du 13 janvier 1969 relative à l'introduction et à la consommation de boissons alcoolisées sur les lieux de travail.

[101] 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.

[102] Loi n°2005-157 du 23 février 2005 relative au développement des territoires ruraux, JORF du 24 février 2005 (NOR AGRX0300111L).

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.

Other social or normative changes

The *Loi* HPST (art. 94) establishes the obligation to train people wishing to sell alcoholic beverages off-licence (art. L. 3331-4 of the French Public Health Code) and measures to reinforce the powers of inspection agents (art. L.3351-8). Failure to comply with the training obligation is subject to a €3,750 fine.

The *Loi* HPST (art. 95) reinforces the power of municipalities to ban off-licence alcohol sales at night (from 8 p.m. to 8 a.m.). Breaches of the ban established by municipal order lead to a 4th class offence. In recent years, given the risks of violence and drunk driving, several "night life charters" arose between local decision-makers (prefectures or municipalities) and drinking establishment operators to improve users' security and controlled alcohol consumption by clients.

In 2003, awareness-raising on the risks of tobacco use became mandatory in primary and secondary school curricula[103].

3.3. Universal prevention

In 2011, at the end of the 2008-2011 governmental "drugs" plan, there were no new developments in prevention. The sections here, dedicated to universal prevention, selective prevention and indicated prevention, summarise the highlights of governmental action, which were already described in detail in the previous national report.

The 2008-2011 governmental drug plan sets down the principle of preventive intervention in all everyday environments of the French population, and particularly in those where the younger members of the population are often found. For the latter population, this is demonstrated by the high expectations of the secondary education and higher education systems due mainly to the spread of binge drinking. Such a global response approach also implies specific efforts directed towards families and adult referents who should be encouraged and supported in their role in prevention drug use among young people. The school environment, the family milieu and the workplace are all major areas targeted by the governmental drug prevention policy for the 2008-2011 period.

3.3.1. School

Universal prevention is directed primarily towards secondary students although, since the publication of the school intervention guidelines in 2005 (under the auspices of the French Ministry of National Education and the MILDT), the last year of primary school ("CM2", which is the equivalent of "5th grade" or "Year 6") should be the first stage of a prevention process that continues until the end of secondary school.

[103] Loi n° 2003-715 du 31 juillet 2003 visant à restreindre la consommation de tabac chez les jeunes. (NOR SANX0306354L).

The updated guide was finally issued in December 2010 (DGESCO (Direction générale de l'enseignement scolaire) *et al.* 2010).

In April 2010, the website of the IUFM (*Instituts universitaires de formation des maîtres* or French University Institutes for Teacher Training) network for training in health education and the prevention of addictive behaviours was officially inaugurated[104]. Among other things, it offers symposium proceedings and tools intended for training teachers in health education. In October 2010, the IUFM network and the INPES published the *Profédus* training pack to help educate and provide support on launching a first or second degree health education project. The training pack, which is intended to provide theoretical as well as practical support, includes a DVD, a manual, photo training and technical specifications on launching projects.

The student population (in higher education) is expressly mentioned by the 2008-2011 governmental plan as a priority target group. The 2010 national report summarises the latest epidemiological data available on students. In 2000 and 2005, alcohol, tobacco and cannabis use were indeed revealed to be high in students aged 18 to 25, but overall, they were lower than what was observed in the rest of the population in this age group (i.e., working or unemployed 18-to-25-year-olds) (Legleye *et al.* 2008). However, the trend is reversed when we focus on alcohol or cannabis use by women, which is higher in students than in other women in the same age group.

According to the available data, the student environment is not the environment where the greatest need is observed; however the health and social protection systems in place in this milieu certainly make it more conducive to organising prevention actions than the occupational or unemployment environments. From 2008 to 2011, several tools dedicated to the student population were developed: The Addict'prev website, the "*Guide d'organisation de soirées étudiantes*" ("Guide to organising student parties") and the www.montetasoiree.com site are all the result of local initiatives that can be easily reproduced on a larger scale. The Addict'prev[105] website was inaugurated in February 2010 by the university health services of Clermont-Ferrand (Auvergne region). Based on the principle of brief intervention and a motivational approach, it not only distributes general information on addictive behaviours, prevention measures and support initiatives, but it also offers resources for self-assessing alcohol, tobacco and cannabis use. People demonstrating harmful use practices are referred to the university healthcare system. The "*Guide d'organisation de soirées étudiantes*" *(Organisation guidelines for student parties)* drafted by the *Union nationale des mutuelles étudiantes régionales* (USEM, or the French national union of regional student supplemental health insurance companies) and the www.montetasoiree.com site designed by the *Avenir santé* association with the support of the Paris Prefecture, received the approval of the *Commission nationale de validation des outils de prévention* in May 2010 and November 2010 respectively. They provide the student event organisers with useful advice for helping these gatherings take place safely for participants and comply with current legislation on alcohol use or public events. The www.montetasoiree.com site also indicates where to find appropriate methodological, human, material and financial resources.

3.3.2. Family

The current policy encourages adult referents, with parents first and foremost, to take an active role in prevention.

[104] http://plates-formes.iufm.fr/education-sante-prevention/spip.php?article39
[105] Addict'prev: http://www.addictprev.fr/

The role of REAPPs (*Réseaux d'écoute d'appui et d'accompagnement des parents* or Parental Counselling and Support Networks) was reaffirmed. However, the activity statistics for these community networks do not clearly indicate which interventions are related to problems of drug use or addiction. After a marked decrease in 2009 of the budgets allocated by the DDASSs (*Directions départementales des affaires sanitaires et sociales* or Local Health and Social Affairs State Authority) (ASDO 2009), 10 million Euros in additional credits were granted to the REAAPs in 2010. Upstream, the purpose of the "*Points info famille*" family information sites (of which there are approximately 500) is to inform families of the parental assistance and support services available and to guide them towards the most appropriate measures for their needs.

The MILDT brought the debate on parenting and prevention to the public stage. The parenting conferences organised in May 2010 enabled various areas of expertise (such as paediatric psychiatry, education, law, the legal protection of minors, and childhood protection) to come together to discuss parental authority, the legitimacy of parental intervention and parental support. The discussions helped direct the governmental campaign aimed at increasing the awareness of parents and other adult referents, which took place from 13 December 2010 to 3 January 2011 (see 3.6). In the spring of 2010, an opinion poll revealed that 21% of parents with a child under 26 years of age had never mentioned the dangers of illegal drug use to their children, and 22% had never reminded their children of the illegal nature of this use.

In May 2010, the French Ministry of Health announced the creation of a website dedicated to parenting and a telephone helpline for parents in difficulty. The project for a website for providing support, exchanging ideas and rapidly identifying resources may be inspired by the German "Quit the shit" experience[106], borrowing the concept of regular monitoring by a team of professional "listeners". These measures are currently being developed.

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 environments. Universal community prevention is defined with reference to two areas: the workplace and the realm of recreational activities, culture and sports.

The workplace is the main "capture" area for adult populations, but it is an environment in which it is difficult to organise collective prevention actions. Although 20% of absenteeism cases are related to alcohol, psychotropic or narcotic use, the barriers to preventive measures are as much psycho-sociological (e.g., taboo, denial, overlap between the public and private) as they are financial or legal. Following interregional preparatory forums in July and November 2009, the MILDT organised conferences on "Illegal drugs and occupational risks" for 25 June 2010. The aims were to adopt targeted measures and bring appropriate consensus changes to the French Labour Code. These events encouraged both discussions on the current legal, regulatory and accountability situation - particularly in the area of prevention – and the coordination needed between the specialists in relevant areas. They also involved promoting the collective drafting of proposals that would be acceptable by all those involved. They reflect the willingness of public authorities to place value on the current ideas surrounding these issues in order to incorporate them into the public debate and provide visibility and recognition for an issue that has been evaded in the workplace until now.

[106] "Quit the shit" is a support programme for stopping cannabis use that was launched in 2004 through a website dedicated to young users wishing to reduce or stop their cannabis consumption. The focal point of the programme is an interactive journal in which users regularly discuss their progress and hurdles. A team of counsellors supports each participant in reaching their personal goal by maintaining contact and providing regular advice (at least once a week) during the 50-day monitoring period.

A guide created under the supervision of the *Direction générale du travail* (General Labour Directorate) and the MILDT, and announced during conferences, was issued in January 2012. 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),* the purpose of the guide is to provide companies with useful tools and references for devising an appropriate legal/illegal drug use prevention policy for their context.

Nevertheless, the *Plan de santé au travail 2010-2014* (2010-2014 Occupational Health plan) drafted by the French Ministry of Labour, of Solidarity and Public Service does not discuss psychoactive substance use in the workplace or its consequences.

The 2008-2011 government plan mentions specific objectives for developing drug use prevention in recreational sports and cultural activities (in addition to the prevention of doping). The OFDT has not noticed any special measures in this area for 2011.

3.4. Selective prevention in at-risk groups and settings

3.4.1. At-risk groups

The selective prevention of drug use is closely tied to the prevention of drug trafficking and recidivism.

The government plan provides for multidisciplinary teams to perform global prevention actions against high-risk behaviour in the penal population, particularly minors (point 1-11). For populations in (underprivileged) neighbourhoods identified by urban policy, the government wants to model strategies in order to improve the coordination of decision-makers and other stakeholders and to combat the underlying causes of delinquency related to drug use and trafficking (point 1-12).

On 2 and 3 December 2010, the *Direction de la protection judiciaire de la jeunesse* (DPJJ, or the Judicial Youth Protection Directorate) and the MILDT opened expert hearings on the theme of "the impact of narcotics on the modes of socialisation among minors". Nearly 80 professionals and experts (psychiatrists, addiction specialists, educators, magistrates, police officers and sociologists) took part to exchange their knowledge on education good practices for preventing and fighting against drug trafficking and the black market. The announcement of specific guidelines on this subject concluded these two days of hearings.

3.4.2. At-risk families

The interministerial activities to combat drugs do not directly target families deemed "at-risk" because of drug use or addiction. Public actions with regard to these families are the shared responsibility of the French administrative *départements* and the legal authorities. This largely decentralised (*départementale*) policy is supervised by the coordinated efforts of the *directeur général de l'action sociale* (General Director for Social Action) and uses common law assistance systems. We note, however, that the law of 5 March 2007 reforming child welfare[107] amongst other things is notably intended to improve prevention with regard to children at risk of abuse or negligence, particularly when related to drug use or addiction problems.

[107] Loi n°2007-293 du 5 mars 2007 réformant la protection de l'enfance (NOR SANX0600056L).

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

The recreational environment groups together the alternative festive scene and the commercial festive scenes (bars and clubs). Since the so-called “Mariani et Vaillant” decree of 2002[108], the institutional approach to prevention in the festive or recreational settings has not seen any particular changes apart from the July 2009 introduction of the legal ban on offering or selling alcoholic beverages to minors (under the age of 18) in public places (article 93) and the legal ban on selling on an inclusive basis or providing on an unlimited basis alcoholic beverages (open bars) (article 94[109]). Finally, we observe that, given the increase in injection among participants of alternative festive events, there is now frequent syringe distribution, at least during the largest events.

Since 2002, however, specialists have noted the split of the festive scene into smaller, but more numerous and more clandestine events, thereby complicating the efforts of harm reduction workers. These workers have difficulties in increasing their activity at the different sites and in keeping informed of the events, which are increasingly advertised through social networks (e.g., Facebook).

3.5. Indicated prevention

Indicated prevention measures are largely tied into the legal responses applied to drug users.

Drug awareness training courses are offered to people aged thirteen at least, arrested for use as an alternative to prosecution, a “penal arrangement”[110] or as an additional sentence. This system is described in more detail in chapter 9, sections 9.1.1 and 9.4.1.

The CJCs are clinics for young users and their parents. The CJC scheme is described in more detail in chapter 9.4.

3.6. National and local media campaigns

The third communication section of the 2008-2011 governmental “drugs” plan (“Everyone can act against drugs”) was completed early in 2011. Three different advertisement spots emphasising the role of parents and those close to young people in preventing use in teens were launched jointly by the French Ministry of Health, the MILDT and the INPES. They were distributed from 13 December 2010 to 3 January 2011. This series of films followed the October 2009 "*Drogues*: *ne fermons pas les yeux*" (“Don’t ignore drugs”) and the November 2009 "*La drogue, si c'est interdit, ce n'est pas par hasard*" (“Drugs, there's a reason they are illegal”) campaigns.

During 2011, there were no totally new actions taken, but several earlier initiatives were resumed or completed.

[108] 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 (NOR INTD0200114D.

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

[110] A procedure allowing the Public Prosecutor to offer one or more measures to a person admitting to having committed an infraction or offence punishable by a period of imprisonment of five years or less.

Hence, the parenting campaign was once again conducted France-wide from 12 September to 2 October 2011 on digital terrestrial television channels and on overseas channels. In September and October, the French Antilles and French Guyana also prolonged this parenting campaign through the use of three, specifically-adapted visuals in the press and the use of display ads.

A few weeks prior, from 4 July to 14 August, still in the French Antilles and French Guyana, the 2008 "*Boire trop*" (excessive drinking) ad spot was rebroadcasted, and then a booklet on alcohol was distributed on the first day of school (in September).

For the October 2009 campaign, the viral "*si les dealers disaient la vérité*" (if drug dealers told the truth…) films originally included in the measure and intended for social networks were adapted to television. These 35-second-long films, which talked about cannabis, cocaine and ecstasy, were broadcast on different digital channels that target young audiences from 12 September to 2 October 2011.

Finally, it is appropriate to mention that, during this period, work undertaken during the November 2009 campaign on the legal ban on the "*Talents vs. drogues*"[111](Talent vs. Drugs) contest was completed. Warner Music France and the French NRJ radio station worked together to select projects to expose the dangers of drug use through musical creations. This initiative was launched on 3 October 2010 and finished on 24 January 2011 with the release of the winning single "*Ne joue pas les bad boys*" ("don't play the bad boys") by Jahriki & Blessinfire.

Furthermore, this campaign on the legal ban provided the opportunity for a final prolongation until early 2012. This time, the campaign "*l'envers du décor*"[112] (the flip side) was interactive, broadcast on Youtube from 13 February to 11 March 2012, and informed citizens, and especially 13-to-18-year-olds, about the dangers posed by drug use and trafficking to society as a whole. A budget of €600,000 was earmarked for purchasing Web space and referencing; 365,000 videos were watched by Internet users going directly to Youtube, but the total number of viewings may be in the region of 650,000.

[111] http://www.talentsvsdrogues.com/
[112] http://www.youtube.com/lenversdudecor

4. Problem drug use

4.1. Introduction

France has recorded national estimates of the number of problem drug users since the mid 1990s. The last estimate produced by the OFDT relates to 2011 data and follows on from earlier estimates in 1995, 1999 and 2006. The definition of problem drug use has, however, changed from one study to the next: in 1995, the inclusion criterion for this category was the use of opiates; in 1999, this criterion was extended 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 all drugs administered intravenously or regular users of opiates, cocaine or amphetamines. There is, however, a slight difference between the approach used in France and EMCDDA recommendations. In the studies conducted in 2006 and 2011, all patients who had consumed the aforementioned substances or administered drugs intravenously within 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 – 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 seen in treatment and harm reduction centres are long-term users.

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

The 2011 and 2006 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; 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 towns/cities: Lille, Lyon, Marseille, Metz, Rennes and Toulouse (Cadet-Taïrou *et al.* 2010b; Vaissade *et al.* 2009). The local prevalence of problem use will be broached in an initial section. The national results are presented in a second phase.

The French context is characterised by the fact that some drug users may slip through the net in administrative information systems due to respect for anonymity, therefore prevalence studies involve the recording of an actual census at local level by overworked shelter professionals. A census is 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 based on data relating to prevalence studies. The characteristics of these users presented in section 4.3 of this chapter are described on the basis of the results obtained in the ENa-CAARUD 2010 survey conducted amongst users attending harm reduction centres. This survey is described in Appendix IV.

4.2. Prevalence and incidence estimates of PDU

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 also highlight the number of users seen in one or more locations in each town/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 centres likely to come into contact with drug users in the six towns/cities were contacted and asked to participate in the user census produced within the framework of this study. These included specialised addiction treatment centres (outpatient clinics and remand centres), hospital services, harm reduction centres, rehabilitation centres in contact with vulnerable and homeless people, general practitioners, as well as police services in some areas. The information was collected over a 6-month period (from January to June 2011) in each city and then sent to the OFDT where it was subsequently analysed.

The number of problem drug users in each town/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 therefore to 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 (age, gender, accommodation, reported substances, etc.) 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 by 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 between 15 and 64 years of age in Rennes to 13.7 for 1,000 inhabitants in Metz. The related confidence intervals were particularly broad for both these cities. Comparison of the prevalence 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 per site in 2011, and prevalence (‰) amongst the 15-64 year-olds.

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, authors' calculations.*

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 to the other two cities where prevalence was more stable.

Table 4-2: Prevalence estimates for heroin and cocaine problem drug users per site and prevalence (‰) amongst 15-64 year-olds, 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 2011, authors' calculations.

National estimates

The number of problem drug users estimated at national level varies from 222,000 (multiplier applied to arrest data) to 340,000 (multivariate indicator method), corresponding to a prevalence of 5.5 per thousand and 8.4 per thousand, respectively, depending on the method employed. The multiplier method applied to treatment data gives an intermediate prevalence of 7.5 per thousand. Estimates based on arrest data are lower than the other two estimates, especially for those obtained with the multiplier method, with no cross-checking 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 confidence intervals calculated for each estimation method. Adoption of the same principle for the 2011 data led to disgard the multiplier method applied to arrests. The only estimates retained were based on treatment data and the multivariate indicator. 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 thousand and 9 per thousand. This result places France on an upper average ranking in terms of European Union statistics, with prevalences rounding similar levels to that observed in western European countries such as Italy, Spain and the UK, although markedly superior to Portugal and Germany.

Table 4-3: Estimation of the number of problem drug users in metropolitan France in 2011.

Estimation method	2011 Estimates	95 % CI	2006 Estimates	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 2011, authors' calculations.

Overall, the three estimation methods highlight a marked rise in the prevalence of problem drug use compared to 2006 estimates. However, given the broad confidence intervals, it is difficult to confirm any increase. It can simply be pointed out that an increase in the number of problem drug users seems plausible. In fact, other information sources indicate firstly, the "ageing of the population concerned", with reduced mortality rates given the increase in substitution treatments at the end of the 1990s, and secondly, a degree of "population renewal" because of the diffusion of stimulants, the emergence of new opiate users and changes in the party scene, etc.

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 for two opioid substitution products, thus allowing the number of drug users receiving these treatments to be estimated. In view of 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 according to geographical area. This lack of geographical homogeneity could lead to a slight over-estimation of the prevalence of problem use with this method.

The second method, "Multiplier method using arrest data" is based on the number of arrests for heroin or cocaine use, which can be considered as 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 region to the next without always reflecting differences in drug use. Another possible bias in the use of this indicator is the fact that people arrested by the police for using opiates or cocaine do not always correspond exactly to problem drug user inclusion criteria. 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 indicator method" based on indirect indicators of problem drug use has the advantage of linking different data sources for which known prevalence estimates for 6 *départements* are extrapolated to the other 90 *départements* in France. Nevertheless, like the two other methods, it is based on local prevalence estimates presented in the previous section. Given the complexity and cost involved in carrying out the survey in each town/city in order to obtain an estimate, the number of cities has been limited to 6, which is too small to work out a truly reliable national estimate. The precision of the estimates would have to be increased by carrying out estimates in a higher number of towns/cities. This appears to be impossible in the French context at the present time. The French administrative system is still characterised by a high level of data protection. In contrast to other countries, this prevents the confirmation of the presence or absence of a drug user in several administrative data sources and the multiplication of local prevalence estimates relating to problem drug use.

4.2.1. Indirect estimates of problem drug users

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 in order to describe those users most heavily involved in drug use is that obtained from the surveys carried out in the Support Centre for the Reduction of Drug-related Harms (CAARUDs). Although a certain percentage of the clients of these centres are also enrolled in treatment programmes, these users tend to be more focused on managing their drug addictions than on receiving healthcare. The CAARUDs also 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 all non-recreational drug users.

The probable under-representation of younger people, young wanderers or travellers emerging from this party scene, and often accompanied by dogs, who attend these centres less than other users, should thus be noted in these data. For their part, the most integrated drug users are even less likely to use the CAARUDs facilities (Cadet-Taïrou *et al.* 2010a).

The results of the 2010 ENa-CAARUD survey (see appendix IV-F) are marked by a drop of almost 10% in terms of response rate compared to the 2008 version (60 % vs. 70 % in 2008). The lack of time spent by CAARUD professionals on issuing this questionnaire appears to be the main reason for the decline in responses (42 %), followed by refusal on the part of the users (30.2 %). In 11.7 % of cases, this problem was due to the inability of the user to speak French. Similarly, a decrease in variable values was recorded between 2008 and 2010, regarding the precarious lifestyle of the users. However, the qualitative elements available appear to suggest the contrary, in an unstable population context. It is therefore appropriate to consider a possible link between the fall in the response rate and the less precarious lifestyle of the study responders. The hypothesis that the most difficult users to interview, probably the ones with the most precarious lifestyles, have been interviewed to less of an extent than the others, seems plausible. However, the possibility that CAARUDs have enrolled new users with better social integration or that the living conditions of unstable users have improved, cannot be ruled out.

Drug users were interviewed in a specific treatment centre as a matter of priority (84.8 %). 14.6 % were met by a mobile unit or street team.

The general precariousness of drug users

According to the 2010 ENa-CAARUD study, drug users visiting harm reduction centres in an urban environment are relatively older on average (35.5 years), i.e. 1.4 years older on average than in 2008. More than half of them (57.2 % vs. 48.8 % in 2008) were at least 35 years old with

the under-25s representing 13.9 % of the overall cohort (vs. 18.2 % in 2008) (Cadet-Taïrou 2012) (see also chapter 8).

This is still a predominantly male population group (80.0%). The percentage accounted for by women tends to be higher among the youngest users. Consequently, although only 10.8% of the men were aged under 25, this was the case with 26.4% of the women. They account for 38.0% of the under 25s.

More than half the people encountered live alone (54.3%) and 20.3% live as part of a couple, with the others living with friends, parents or alone with their children. Fewer women live alone than men, most of them living as part of a couple (38.4% vs. 13.0%) or alone with their children (7.4% *vs.* 1.4%). Almost half of the women are mothers (47.3%).

In 2010, drug users visiting the harm reduction facilities in urban environments displayed a high degree of social vulnerability (Cadet-Taïrou 2012).

- Amongst these, half (46.8%) live in unstable housing conditions, with 62% of them being homeless or living in a squat while the others have some form of temporary housing[113].

- A quarter receives a salary or unemployment benefits (25.6%). More than half (53.6%) receive a social income benefit: the minimum benefit income or a disability living allowance, but this is less common with income coming from family or a third party. Finally, one in five (20.8%) have no lawful income (begging, illegal resources, prostitution). The study also shows that the structure of the resources differs considerably depending on the age group in question. Indeed, we should note that more than half of the under 25s (53.7%) have no legal income.

- Most drug users who visit CAARUDs are affiliated to a Social Security scheme (88.8%). Almost two-thirds of these (63.2%) are covered by the CMU[114]. Only 11.2% of CAARUD users declared that they were not affiliated to Social Security. Less than half of the latter answered the question enquiring whether they were in receipt of AME (State Medical Assistance, generally reserved for foreigners in an irregular situation). One-third of those who responded did not receive this.

- In terms of education, only 23.2% of them had reached baccalaureate level (A-level/High School Diploma) with or without sitting the exam. The majority (65.2%) possesses a secondary education level vocational qualification (the CAP or BEP vocational training certificates) or did not progress beyond middle school.

- The vast majority are in possession of valid identity papers (whether French or foreign). However, 13.3% have no identity papers. Among these, half are living in France illegally, while the other half have lost their identity papers or had them stolen.

Furthermore, clients of the CAARUD facilities are frequently in contact with the law enforcement system. In 2010, 14.9% of them were incarcerated on at least one occasion during the year. One in six men (17.3%) and 5.6% of women had been incarcerated.

[113] Available for a period of less than six months
[114] It provides minimal sickness cover for those who do not belong to a Social Security scheme.

Heavy users of psychotropic drugs

The products most frequently consumed by those users who responded to the survey in 2010 were still cannabis and alcohol.

Approximately one-third of users encountered in 2010 had taken heroin in the previous month, but the most widely consumed opiate was still HDB (39.5%). Amongst the recent users of HDB, three quarters stated that they received it as a substitution treatment. HDB is also the product most regularly consumed by its users, three quarters of whom use it on a daily basis.

The use of cocaine in its hydrochloride (powder) form or in the form of freebase concerns almost half of all drug users seen by the CAARUDs (45.7%). 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 43.4% and 4.9%.

The consumption of MDMA, amphetamines and hallucinogenic drugs among drug users visiting the frontline structures is chiefly accounted for by those users who also frequent the techno/party scene (with the exception of certain natural hallucinogenic products).

Table 4-4: Drug consumption prevalence during the last month among drug users visiting the CAARUDs, N=3132, 2010

	Recent users (used during previous month)	% of recent users who are daily users
Cannabis	71.7%	52.8%
Alcohol	63.0%	50.7%
HDB	39.5%	78.2%
Heroin	31.3%	22.3%
Methadone	28.1%	75.0%
Morphine sulphate	14.1%	41.2%
Powder cocaine/Freebase	32.8%	9.0%
Crack	15.3%	24.7%
Amphetamines	12.9%	4.4%
Ecstasy	8.7%	2.1%
Benzodiazepines	28.6%	56.1%
Plants and hallucinogenic mushrooms	5.6%	2.4%
LSD	7.7%	4.1%
Ketamine	6.5%	0.7%

Sources: ENa-CAARUD 2010, OFDT, DGS

Interviewed in 2010 on the subject of which drug posed the most problems for them, in the first place drug users mentioned opioids (43.0 %), the main one being HDB (18.1%). Heroin was only mentioned by 14.9% of them. Fewer differences between HDB (21.6% in 2008) and heroin (12.6% in 2008) may be linked to greater heroin use.

Alcohol was mentioned by almost one user in five (21.5%)

Cocaine (6.0 %) and crack (7.8 %) were the stimulants mainly referred to as most problematic by 15.7 % of users interviewed.

In 2010, 65.1% of users of harm reduction centres in urban locations (CAARUDs) had injected at least once during their lives. This fact stems the decreasing trend witnessed since 2003. The

average age of the first injection was 20.9 years (median of 20 years). This has not varied since 2006.

Considering recent injection (45.2%), the concordance of the available quantitative data suggests a reduction in the prevalence of this practice despite the fact that the situation was somewhat less clear around 2006 and that the qualitative data seem to indicate a rather more complex situation.

Indeed, an increase in the practice of injection is reported (in the qualitative data) around the mid-2000s, although this practice appears to be concentrated, not only on certain sites but also among certain non-integrated population groups referred to as "travellers"/"wanderers".

The use of injection appears to be a frequent practice in order to consume opioids, with the exception of methadone, cocaine (which is injected by more than half of CAARUD clients) but also ketamine and amphetamines. An increase in the number of heroin users who snort (47.1% vs. 42.0% in 2008) and who smoke (28.9% vs. 24.2% in 2008) was also observed. It was also noted that cocaine (purchased in powder form) is smoked as freebase (after base transformation) by a third of its users encountered in the CAARUD programs. This figure is also increasing, as highlighted in the qualitative data collected (30.9% vs. 23.3%). If we also take crack users into account (who have purchased freebase cocaine), more than half (55.6%) of recent cocaine and/or crack users also smoke cocaine.

Table 4-5: Routes of administration of drugs used during the month preceding the interview by CAARUD clients, 2008

	N	injection	Oral route	Snorting	Inhalation/ smoking
Morphine sulphate	359	85.2	14.5	7.8	0.3
Heroin	803	60	1.4	47.1	28.9
Cocaine	790	53.3	0.8	50.6	30.9
HDB	902	50.9	47.2	23.5	5.8
Ketamine	191	34	9.9	72.8	2.6
Amphetamines	323	33.1	35	56	3.7
Ecstasy	222	17.1	83.8	23.4	5
Codeine	147	6.1	93.2	4.1	2
Benzodiazepines	655	6	96.8	2	0.8
LSD	218	4.1	98.6	0.5	0
Crack	371	4	0.3	1.9	97.3
Methadone	609	2	98.5	0.3	0.2
Hallucinogenic plants	160	1.9	94.4	0.6	10.6
Alcohol	1301	1	98.8	0.3	1.1
Cannabis	1634	0.1	3.1	0.7	98

Notes: 1/ Several routes of administration may be used by a consumer for the same drug. Consequently, the total percentages per drug may exceed 100%.

2/ Products listed according to the injection use frequency

The TREND data: Key changes in 2010-2011 concerning uses and modalities of use (Cadet-Taïrou et al. 2012)

Information on the main trends (particularly related to the market) can be found in chapter 10 (mainly drug trafficking via the Internet and emerging drugs).

Heroin: continued growth and increase in chasing the dragon (smoked)

Continuing on from previous years, all observations focus on the increased use of heroin by new users. Away from groups of "traditional" drug users who turn more frequently to heroin (OST users or young people with a precarious lifestyle), typical usage is currently developing in an entirely different context: used discretely and by fringe groups on the underground techno scene since the early 2000s to regulate the effects of stimulants, it has subsequently spread more extensively to the party scene under the name of rabla. Nowadays, heroin tends to be no longer used as a by-product (secondary to the use of stimulants), but for its own specific effects, just like any other substance in the context of polydrug use. It is used in a recreational setting by young, socially integrated adults from a variety of backgrounds – both rural and urban, and socially integrated (see the results of a general public survey in chapter 2). Access to the substitution and use of snorted (as opposed to injected) substances involving young users has freed heroin from the characteristic image of death and social decline as far as this age category is concerned.

In 2010, the increase in the practice of chasing the dragon (smoking, inhaled warm without combustion) was reported by 6 of the 7 TREND network sites. It primarily concerns new users of heroin, namely those who used to snort the drug: socially integrated users, younger users and party goers. This route allows former injectors with damaged veins and users in search of more intense effects, especially if they have become dependent or are familiar with the tolerance phenomenon, to experience effects similar to those obtained with an injection but without the image and, in their opinion, without the risks.

Synthesis drugs available on the Internet – use that is developing more slowly than the rapidly growing range of products available.

In France, these new synthetic substances, stimulants or cannabinoids are not that well known outside restricted environments. The media coverage of these products and the ensuing confusion between information and promotion has certainly worked "in favour" of these new drugs, encouraging some users to get hold of them and experiment. Although the level of use of such products still cannot be estimated, it seems that they are "definitely" used in France by essentially polydrug users. Several profiles exist side by side: firstly, these drugs may be used by a group of experienced users who share the product whilst partying. They are also used by those on the gay party scene, who are traditionally fans of new psychoactive substances used in a sexual context. The products can also be used on the party scene where they are not routinely presented as new synthetic drugs. What's more, the places where these substances are used by polydrug users with a precarious lifestyle seem to cover a wide radius, supplies being obtained from a dealer except in the case of those users who have the necessary means (credit card, Internet connection) to carry out an Internet transaction.

Increased first time use with freebase cocaine

The growth in the practice of freebasing cocaine is still underway among user groups well removed from the alternative techno underground scene to which it was largely confined in the early 2000s: drug users operating in the alternative party setting, some of them very young (18-20 years old) but also young people (aged 20-25) from comfortable backgrounds, socially well-integrated or from disadvantaged suburban areas.

The growing availability and use of Ketamine

Over the last three years, ketamine – a human and veterinary anaesthetic, misused for its hallucinogenic and dissociative effects – has become more prominent. The use of this drug has expanded outside the original circle of historical consumers, namely those firmly anchored in the counter-culture environment attached to the alternative techno movement. The growth of this drug was initially witnessed amongst party-goers. This involved experienced users who took ketamine along with other drugs and younger people who were experimenting in particular. In some towns/cities, its use also extends to precarious populations in an urban environment via young travellers. It is also used on the gay scene where it has not kindled any specific interest. The image of the product seems to improve from one year to the next amongst familiar drug users who have learned how to control it. It has come a long way from its controversial label of "equine (horse) anaesthetic" to become a more amusing, party product.

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 PDU definition (in vulnerable groups)

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

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

5.1. Introduction

Definitions

A system for recording demands for treatment conforming to the European Protocol (Common Data Collection on Addictions and Treatments or “RECAP”) was introduced in France in 2005 in the various specialised centres dealing with drug users (see Appendix IV-Q). These centres, previously known as CSSTs (Specialised Care Centres for Drug Users) took on their new name of National Treatment and Prevention Centres for Substance Abuse (CSAPAs) in 2010. From then on, this term also covered institutions providing support for people with illegal drug and people with alcohol problems. In accordance with the European protocol, only those persons for whom illegal drugs or psychotropic agents pose the main problem will be taken into account.

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. An incoming 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 patient 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 1980s and the late 1990s involving drug users seen by the various types of establishments during the month of November. The move from this survey to the RECAP survey was made necessary by the need to adopt the European protocol for the recording of treatment demands, required for all countries of the European Union.

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

Virtually all of the centres today manage their patient files using specialised software. A feature included within the software makes it possible to obtain the RECAP data for patients seen during the year in an anonymous file based on 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

The treatment policy concerning users of illegal drugs can be characterised by several major distinctive periods in France. Before the 1970s, illegal drug users were mostly treated in psychiatric hospitals.

The first major turning point dates back to the adoption of the French Drug Law of 1970. This law provided the possibility for any drug user to obtain anonymous, free treatment to wean themselves off drugs. The adoption of this law prompted the development of specialist outpatient centres or residential centres, the latter being provided for drug users after withdrawal. Psychiatric institutions proved reticent to accommodate increasing numbers of drug users. In contrast, teams working for related associations volunteered to manage these patients. The latter were therefore accommodated in these two different settings (psychiatric hospitals and related institutions), with the second 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 harm reduction opioid substitution treatments and measures in the early 1990s, which was rather late compared to other countries.

In France, it was decided to quickly make HDB substitution treatments widely available. Any practicing physician was authorised to prescribe them[115]. Subsequently, general practitioners played an increasingly important role in the treatment of opioid drug users. At the same time, the rapid spread of AIDS and the adoption of a harm reduction policy (as a direct result) raised the question of treating drug users in general as opposed to only in psychiatric establishments for their somatic 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 management 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 policy for treating drug use in France is based both on specialised treatment and harm reduction centres, as well as on general physicians 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 care policy issued by the French public authorities was defined in two plans adopted in 2006 and 2008. The first, the 2007-2011 Plan for the care and prevention of addictions, only focuses on care 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, mentioned in the previous report, was produced on the initiative of the president of MILDT (see chapter 1). It focuses on care, prevention and repression. The health aspect incorporates the strategies outlined in the French Ministry of Health plan whilst outlining new, specific objectives.

[115] The introduction of methadone treatments was initially authorised only for doctors practising in specialist drug addiction treatment centres. Primary care physicians were only authorized to prescribe this treatment in a second phase. The number of persons receiving methadone substitution treatment has therefore increased far more slowly than HDB treatments.

The 2007-2011 Plan for addiction treatment and prevention (Ministère de la Santé et des Solidarités 2006) re-affirms the need to implement a policy on all addictive behaviours: illegal drug, alcohol and tobacco use as well as non-substance addictions such as gambling. This plan primarily concerns increasing the resources for addictions care in the hospital system. It envisages the creation of addiction consultation services or addiction liaison teams in all hospitals with an emergency department. These consultation services or liaison teams must be able to group together all existing consultations in smoking cessation, alcohol, and drug addiction in a single place and within a single department. Addiction services offering simple or complex withdrawal regimes are to be created during the period covered by this plan (2007-2011) for patients requiring more specific care or hospitalisation. The plan also stipulates that each university hospital (i.e. 26 establishments) will have an addictions unit which will be both an addictions service for patients and a regional reference training and research centre.

This plan incorporates objectives already outlined in earlier plans: bringing the specialist drug and alcohol addiction services into the framework of CSAPA, extending the facilities for therapeutic residential care for illegal drug users through the creation of several therapeutic communities and the involvement of primary care medicine by strengthening health networks dealing with addictions. The plan states the need for precise reference texts to be produced for patient management strategy before, during and after their care.

All of these objectives are restated in the 2008-2011 (MILDT (Mission interministérielle de lutte contre la drogue et la toxicomanie) 2008) Government action plan against drugs and drug addiction, which, however, stresses some of these more specifically and proposes new objectives:

- improving professionals' skills in targeted individual prevention and care through different training programmes;
- improving the health and social care of young users of psychoactive substances by increasing the number of consultations for young users and, in particular, by the availability of forms of advanced consultations in generalist centres open to young people;
- creating new therapeutic communities, centres in which the aim of abstinence must be clearly stated;
- developing new care measures for cocaine users;
- improving the care and continuity of care for drug and alcohol users in prison;
- preserving the health of the unborn child and mother and taking account of the particular features of drugs and alcohol women users;
- reducing the drug use health risks;
- reducing the morbidity and mortality from hepatitis C in drug users;
- improving the social integration and reintegration of people with addictions.

5.2.2. Treatment systems

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

Organisation and quality assurance

The specialised scheme

These centres have been created in accordance with the 1970 law. The law provides free, anonymous treatment for all illegal drug users who wish to benefit from it. Almost all of the French départements now have at least one of these centres called CSAPA.

Originally financed by the state and since 1st January 2003 by the social insurance bodies as socio-medical establishments, these centres provide medical, social and educational services, as well as social rehabilitation amongst other things.

There are three types of CSAPA:

- Outpatient treatment centres. In 2011, there were around 440 of these centres but only 200 or so were mainly used to treat illegal drug users. The rest were mostly frequented by people primarily affected by alcohol problems. In nearly all cases, these centres follow patients receiving treatment on an outpatient basis. However, some of them can also manage the residential treatment apartments used to provide housing for patients for a few months. The number of residential patients in these centres represents only a very small percentage of all patients treated in the CSAPAs (1 to 2%).

- Residential treatment centres including therapeutic communities. These amounted to 48 in 2011 and were once known as "aftercare" centres treating patients after withdrawal or those receiving substitution treatments. Residential withdrawal most frequently takes place in general hospitals.

- Treatment centres in penal establishments. Totalling 16 in 2011, they are similar to outpatient centres located within prisons. They only treat patients who are in jail. Drug-free quarters in prison do not exist in France.

A circular of 28 February 2008[116] describes the missions of the CSAPA. The CSAPA are responsible for receiving, informing and ensuring the psychological, medical and social assessment and onward referral of all people with an addiction problem to any substance or a non-substance addiction coming to their premises. CSAPAs also ensure medical, psychological and socio-educational treatment, as well as harm reduction care. CSAPA can specialize in treating addictions to illegal drugs or alcohol.

The outpatient CSAPAs are designed to meet the outpatient withdrawal requirements of patients. They can also organise and support patients wishing to undergo drug withdrawal in a hospital setting.

[116] 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. (NOR: SJSP0830130C).

The doctors practising at the CSAPAs are entitled to initiate methadone substitution treatments. Like all practising doctors, they can also prescribe HDB treatment for patients. In France, the concept of “drug-free centre” is not really used. It is difficult to compare this to an existing device. However, some "therapeutic communities", which only deal with abstinent cases, have recently been set up. There were 10 such centres in 2011. They are currently under evaluation. The results of this assessment are not yet available.

Clinics for Young Users also exist in France[117]. The public authorities have encouraged the creation of such services from 2004 onwards by financing projects to open this type of centre. They are intended to deal with young illegal drug users (usually cannabis) on an outpatient basis. Several hundred such centres are now available. Their opening times can vary (sometimes half a day each week, sometimes every working day). These clinics are mostly managed by a CSAPA. These clinics were created in line with the desire to set up a specific care and management framework for young users for whom the addiction problem is mostly inextricably linked with that of adolescence and related psychological problems. The creation of these clinics has probably led to an increase in the number of cannabis users treated in the CSAPAs. With regard to the figures quoted in the activity reports generated by these centres since the late 1990s, it seems that the proportion of cannabis users amongst those attending this facility was already increasing prior to the creation of these clinics. In 2008, an estimated 23,000 young people attended the Clinics for Young Users organised by the CSAPA.

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 1990s, there has been a focus on improving how patients suffering from addiction problems are received by the general healthcare system (hospitals and general practitioners).

A - Hospitals

As mentioned earlier, (see "Background"), the Plan for addiction treatment and prevention envisaged the establishment of a new organisation of addiction care within hospitals. The administrative circulars of 16 May 2007[118] and 26 September 2008[119] gave precise instructions on the organisation to be established within the hospital system. Hospital addictions care is organised into an addictions unit bringing together different components, with the aim of allowing each person with addictive behaviour to have access to a nearby, global and graduated care system and, if necessary, a specialist technical platform. This sector involves three distinct levels.

Level 1 structures are responsible for simple, residential withdrawal courses and liaison and consultation activities. Created by the circular dated April 3, 1996[120], the liaison and addictions treatment teams, which usually comprise three people including one hospital doctor, have the task of training and assisting teams of care staff in hospitals. More specifically, this involves creating treatment protocols and working with hospital and emergency patients. These teams

[117] 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 (NOR : SANP0430495C).
[118] 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 (NOR SANP00730376C).
[119] Circulaire DHOS/O2 n°2008-299 du 26 septembre 2008 relative à la filière hospitalière de soins en addictologie, (NOR SJSH0830983C).
[120] Circulaire DGS/DH n°96-239 du 3 avril 1996 relative aux orientations dans le domaine de la prise en charge des toxicomanes en 1996 (NOR TASP9630145C).

are responsible for prevention, providing information and boosting awareness within the care setting. Patients can also be seen in outpatient addictions clinics.

Level 2 structures offer the same services as level 1 structures with the additional possibility of providing complex residential care through full or day-hospitalisation.

Level 3 structures provide education, training, research and regional coordination activities in addition to the activities of level 2 structures.

The circular of 26 September 2008 also states that the hospital addictions care units must act in coordination with the CSAPA and CAARUD specialised schemes, primary care doctors and health networks.

B - General practitioners

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

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

Availability and diversification of treatment

Withdrawal

Withdrawal can take place in an outpatient setting, with the patient being followed up in a CSAPA, in hospital addictions clinics or in a residential setting, mostly in a hospital with a withdrawal ward. The withdrawal of illegal drugs involving hospital admission is less common in France nowadays. Opiate users previously admitted to hospital for withdrawal programmes are now mostly prescribed opioid substitution treatment.

Opioid substitution treatments

After first being marketed in 1996, HDB very quickly became the leading treatment for opiate dependency in France. Since 2006, Subutex® is no longer the only product available. Generic preparations appeared on the market (particularly HDB Arrow® in 2006, and then HDB Merck® in 2007[121]). The generic form was accepted above all by a number of users who were at an earlier stage in their drug addiction trajectory than the average user, better integrated into a care protocol, and more stable. The 2008 version of the OPPIDUM survey (Afssaps *et al.* 2008) showed that the average age of the 31% of patients receiving generic HDB in specialist care centres was two years younger than the others, and that their average daily doses were approximately 1 mg less than doses taken by other patients.

[121] HDB Merck became HDB Mylan® in 2008

Recent data from the Caisse nationale de l'assurance maladie (French National Public Health Insurance Centre) show that almost 145,000 people received reimbursements for opioid substitution treatments (primary care) in the first half of 2010, with the particular French feature of a clear predominance of HDB which made up almost 75% of the total. Generics still represent approximately one-third of all HDB reimbursements.

The role of methadone nevertheless continues to increase whereas ease of access to this medication was part of the consensus Conference recommendations on substitution treatments in June 2004[122]. Health Insurance data also show that, between between 2004 and 2010, trends in HDB reimbursements were + 29.3% versus + 276% for methadone[123].

The graph below shows the estimated numbers of patients treated with HDB and methadone in France. These data are based on sales figures for the two substitution treatments provided by GERS (Groupement pour l'élaboration et la réalisation de statistiques) and assuming an average daily dose of 8 mg for Subutex® and 60 mg for methadone, over a 12-month period. The amounts of Subutex® sold therefore are equivalent to 77,000 theoretical patients receiving a daily dose of 8 mg throughout 2010. A similar calculation for methadone produces a theoretical 37,711 patients (based on primary care and hospital reimbursement data on the liquid and capsule forms) in 2009 (last available data).

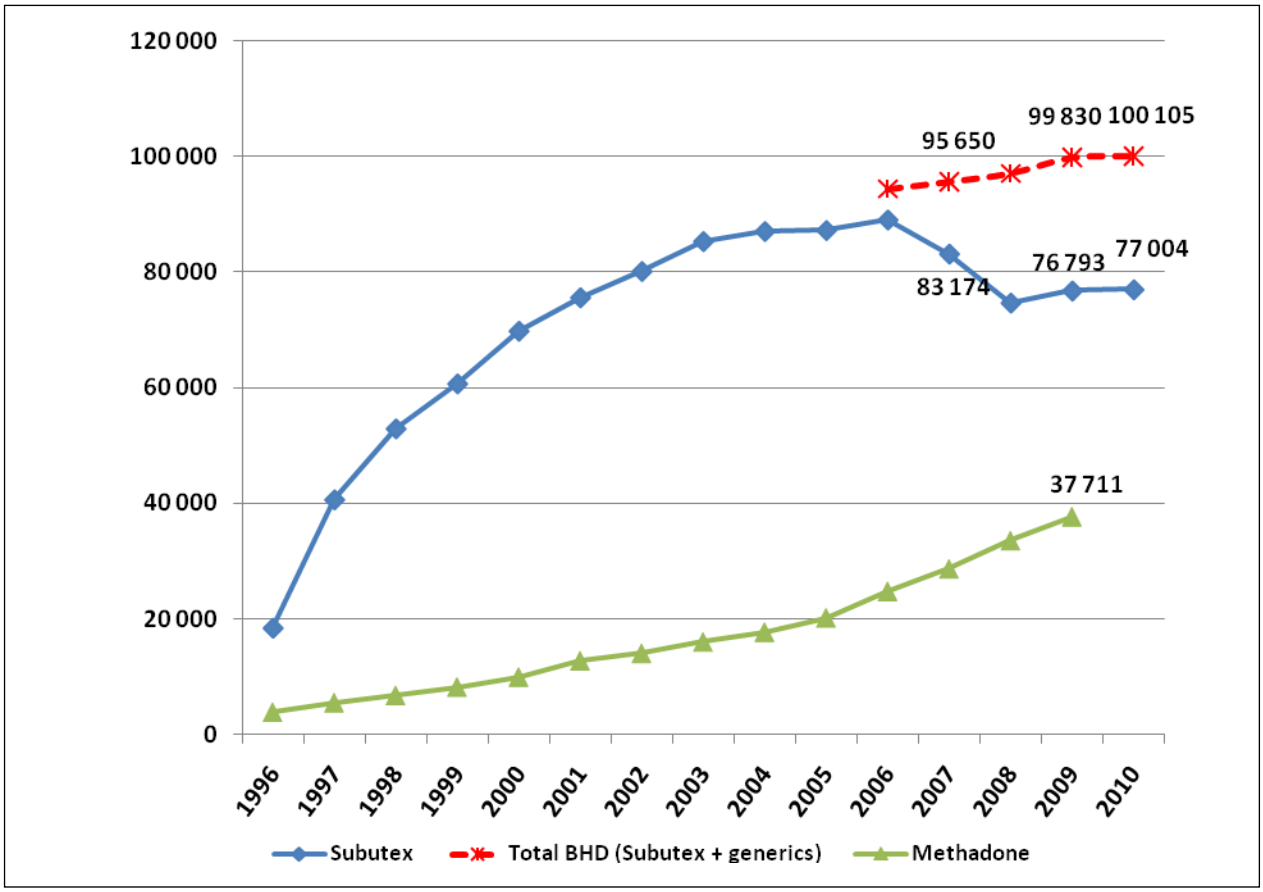
HDB generics introduced in France since 2006 offset, to an extent, the actual reduction observed in the number of patients receiving Subutex® since that year. An extrapolation helps estimate the number of patients receiving generic forms, for which there has been a progressive increase, up to one-third of all HDB patients in 2010 (graph 5.1). Slightly over 100,000 theoretical patients might have received HDB, either in its proprietary or its generic form.

These are theoretical patients as not all actual patients are as compliant and do not all take treatment from 1st January to 31st December. In a given year, some may stop their treatment and others may start it. The number of people with at least one prescription for one substitution treatment is therefore logically slightly higher than this theoretical patient number. Moreover, the number of theoretical patients calculated does not include HDB misuse or diversion. Fewer patients are actually receiving opioid substitution treatment although it is still difficult to give a precise figure as the borderline between patients following treatment and those receiving HDB prescriptions but who cannot be considered as following treatment, is unclear.

[122] Consensus Conference "treatment strategies for opiate-dependent subjects: the role of substitution treatments", 23-24 June 2004, National Authority for Health.

[123] The 2008 marketing authorisation of methadone capsules contributed to this increase. In fact, capsules represent 28% of all dispensed methadone.

Graph 5-1: Opiate substitution treatments: estimation of the number of persons receiving opioid substitution treatment (Subutex® 8 mg, Methadone® 60 mg) between 1996 and 2010 (based on primary care and hospital reimbursements)



Source: GERS/SIAMOIS/InVS

Interrupting opioid substitution treatment

To date, there is no reliable, regularly updated source to provide 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 stop substitution treatment altogether given the potential risk of relapse and overdoses that may ensue.

Misuse and dealing of HDB

Some of the HDB prescribed is misused and is not taken as part of a treatment programme. This proportion has diminished since the implementation of the French National Health Insurance Fund's plan to control opioid substitution treatments[124]: One of the main indicators for HDB misuse (average daily dose higher than 32 mg/d[125]) fell by two-thirds between 2002 and 2007.

[124] The French national insurance organisation controls introduced since 2004 primarily aim to identify dealers ("patients" as well as a few doctors and pharmacists) through reimbursement data, focusing on users who have at least five prescribers or who are being given an average dose of more than 32 mg.

[125] The maintenance dose of HDB is 8 mg/D with a maximum dose of 16 mg/D. An average daily dose of more than 32 mg/D is an indicator of very suspicious HDB use (dealing and/or resale).

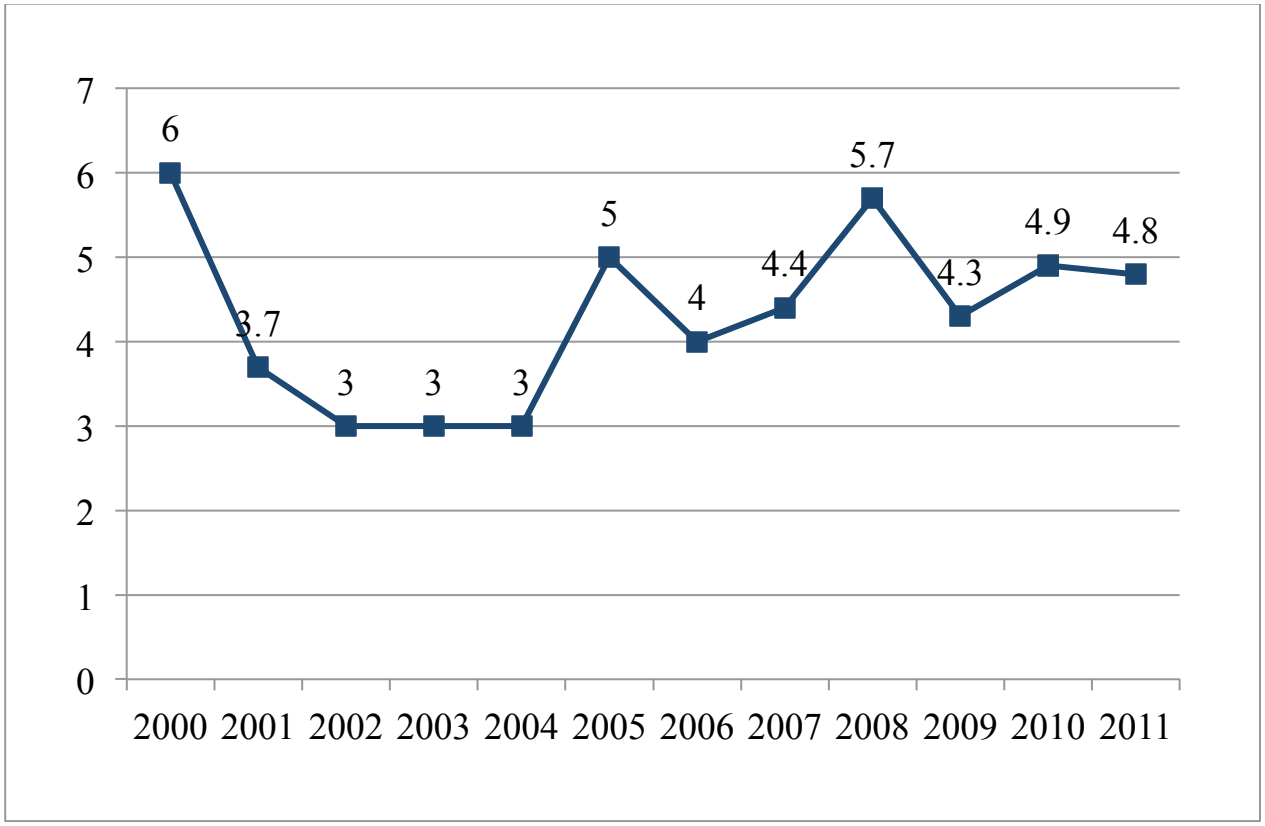
At the time, six per cent of people had been receiving more than 32 mg/d of HDB versus 2% in 2006 and 1.6% the following year according to a recent study (Canarelli *et al.* 2009). Similarly to the previous 2002 study, this study also found that two-thirds of people who had received reimbursements for opioid substitution treatments in 2006 and 2007 were taking regular treatment and therefore, in principle, were included in a treatment process. All of the other people taking these treatments are not, however, necessarily beyond any care strategy in the same way as users taking this medication as part of a care plan, are not exempt from certain forms of misuse (INSERM 2012).

It seems that, in the long term, the measures taken have only had a minor impact upon the availability of HDB on the black market. More organised dealing has developed in some regions, particularly the Paris and Marseilles regions and, to a lesser extent, the East of France, since 2007. Fewer users re-sold their excess supplies, but there was better organised health insurance fraud carried out by a collective organisation of "doctor shopping" (e.g., theft of the "carte vitale" national insurance cards that grant health treatment rights in France, recruitment of "false users", consultations in several departments, etc.). In 2010, four of the seven TREND network sites (see description of information systems) reported an increase in the number of pseudo-heroin addicts obtaining Subutex® prescriptions for resale (Cadet-Taïrou *et al.* 2012).

Field observations in the techno party arena have revealed that this substance is only used marginally and that its availability is also marginal except in very large events.

In 2010 and 2011, HDB was therefore once again described as being very easily available and accessible on the black market with an average national price levelling off just below €5 per 8 mg Subutex® tablet but subject to variations depending on the town and market fluctuations. (Graph 5-2) (Cadet-Taïrou *et al.* 2010b). Continued widespread perceived availability could be linked to the reduced demand for HDB as a drug. It is, in fact, subject to competition from heroin and, to a lesser extent, methadone, the availability of which is increasing although it remains the basic opiate of the less affluent. Only the proprietary drug, (Subutex®), is available on the black market, HDB generics being reputed to be more difficult to inject or snort because of their excipients (Cadet-Taïrou 2012)).

Graph 5-2: Annual change in price of an 8 mg HDB tablet on the black market between 2000 and 2011 (price in euros)



Source: TREND / OFDT

Misuse involves three types of administration: injecting, snorting and less often, smoking. 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 2009 OPPIDUM survey (Afssaps *et al.* 2009), HDB was injected during the previous week by 7% of users following a substitution protocol and viewed within a therapeutic framework. 8% snorted and a tiny proportion of users inhaled. Amongst those people also seen for treatment purposes, but who reported that they used HDB outside of a treatment protocol, 16% injected, 46% snorted and 49% took the drug orally. The prevalence of HDB injection has continued to fall annually in this second group (34% in 2005) and this fall has accelerated markedly since 2006. Snorting, however, has seen the reverse change (34% in 2007). In 2010, among the persons viewed in the CAARUD category (harm-reduction or "low threshold" centres), 50.9% of HDB users reported having injected in the last month, i.e. more than the oral route (47.2%). 23.5% declared having snorted it and 5.8% declared having smoked it. For 5.7% of them, HDB is the first drug to be injected (Cadet-Taïrou 2012). Two groups of the population in particular use HDB as a drug: on the one hand, drug users in the most vulnerable of situations, i.e. homeless males in 90% of cases, some of whom are illegally staying on French territory and who take mostly medication and alcohol, and itinerant young people, most of whom are polydrug users, on the other hand (INSERM 2012).

Methadone misuse

Despite the emergence of more visible methadone misuse in parallel to its wider distribution, methadone misuse remains limited compared to HDB. Nevertheless, trafficking is increasing year on year with the appearance of street markets on several TREND sites. The average cost of a 60 mg bottle varies considerably depending on the site, ranging from €4 in Paris to €20 in Toulouse. This always involves patients who are actually taking substitution treatment and who save some of it for bartering, for emergency situations or for sale. The capsule form, which has been available since 2008, appeared on the black market in 2011 but seems generally unscathed to date (Cadet-Taïrou 2012). Already reported since 2006, the use of methadone in an auto substitution setting (use of non-prescribed methadone for substitution purposes) tends to be a generalised practice on all TREND sites (Cadet-Taïrou 2012; Cadet-Taïrou *et al.* 2010b).

Substitution treatment in the hospital setting

A survey conducted in 2007 by the OFDT (Obradovic *et al.* 2008a) to assess the impact of the circular dated 30 January 2002[126] on initial methadone prescribing by doctors practicing in health institutions (hospitals and prisons) demonstrated that access to methadone had increased in these two areas six years after this circular was introduced.

The hospital component of this survey showed that general practitioners played an important role in access to specialist care by opiate-dependent users. This holds true both early on, when they referred their patients to hospitals to start treatment and later, when they took over care from hospital treatment. This survey also demonstrated the importance of the link between the different partners in the care system to avoid substitution treatment being stopped when the patient left hospital.

Substitution treatment in prison

Whereas half of the hospital services surveyed reported that more than 50% of patients were receiving methadone, this is reported by only a third of the prison medical services (excluding CSSTs). Average initial prescribed amounts in prison are similar to those seen out of prison, which would appear to indicate some consistency in following the therapeutic indications. Further progress is required in order to effectively generalise methadone access in all health care establishments managing incarcerated patients and to facilitate a smoother treatment transition (especially on leaving prison).

Furthermore, a national survey on the prevalence of HIV, HCV and opioid substitution medications (OSMs) in prison was conducted in 2010 in mainland France and in the overseas French departments ("DOMs")[127]. The initial results indicated a prevalence of OSMs in prisons of 7.9% [6.49-9.79], which corresponds to fewer than 5,000 prisoners, one-third (31%) of whom had treatment initiated during their incarceration. On the other hand, the predominance of HDB is less marked than outside prison: 68.5% of subjects take HDB and 31.5 % methadone (data pending publication) compared to 75% and 25%, respectively, in primary care.

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[126] 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 (NOR MESP0230029C).

[127] This is the PREVACAR survey. It is based on disseminating one "treatment availability" questionnaire to 168 UCSA (outpatient treatment and consultation units) (excluding institutions for minors) and one "patient" questionnaire sent to 27 randomly selected establishments. One thousand, eight hundred and sixty-one (1861) individual questionnaires were able to be used.

5.3. Access to treatment

Total number of patients receiving treatment

Data compatible with the EMCDDA's TDI protocol are only recorded from people seen in the CSAPAs in France. This data collection is not exhaustive, since approximately one-third of CSAPAs did not provide data in 2011. Furthermore, TDI data only concern new patients, persons 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 problems with illegal drug use.

We currently have relatively accurate information about the number of people receiving care in the specialist centres. The CSAPAs are required to provide the administrative authorities with an annual activity report containing certain information about people received during the previous year (see Appendix IV-P). The response rate for these reports is close to 90% annually and almost 100% over a two-year period. Based on these reports, it is possible to estimate at approximately 96,000 the number of people who were seen in the outpatient CSAPA in 2008[128] for their problem with illegal drugs. This includes overlapping, although these should not make up more than 5% of the total. Compared to the outpatient CSAPA, very few people, slightly fewer than 2,000, appear to be accommodated in a residential treatment centre, some of whom are already included in the figures for the outpatient CSAPA. In fact, these centres send a large number of patients to the residential centres where they are then housed. The number of people seen for a problem with illegal drugs in 2008 in prison CSAPAs can be estimated at 5,000.

The only national data available for primary care is for people receiving substitution treatment. In 2010, as was previously mentioned, approximately 145,000 people were refunded by social security for their substitution treatment. Some of these may also have been monitored jointly or in succession by a CSAPA during the year.

As regards hospitals, national data obtained from the PMSI medicalised information system programme are available[129] specifying the number of hospital admissions in the departments of medicine, surgery and obstetrics with a 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 7,500 hospital admissions in 2011, 1,900 of which concerned opiate users, almost 2,200 sedatives and hypnotics, around 1,000 cannabis users and 1,600 polydrug users. It should be noted that this data does not include attendance at emergency departments or those monitored on an outpatient basis for hospital addictions clinics. Overlapping also exists between hospitalised patients and those seen in specialist centres or primary care.

5.3.1. Characteristics of treated clients (TDI data included)

Patients seen in outpatient centres

In 2011, 161 outpatient CSAPAs took part in the RECAP study, i.e. just over two-thirds of CSAPAs mainly involved with illegal drug users. **The data shown below concerns more than**

[128] Last available figures at the time of drafting this report
[129] http://stats.atih.sante.fr/mco/diagone.php

45,000 patients (referred to as “new patients”) who started a new episode of treatment in one of these centres during the year.

Those patients receiving treatment for the first time in their life (referred to as "first-time patients") accounted for 30%[130] of all new patients seen, and this percentage was even lower in women (26% vs. 31% in men). The other patients (remaining 70%) had previously been monitored for an addiction problem but were about to start a new treatment episode in a CSAPA. Caution must be exercised when considering the percentage of patients receiving treatment for the first time, 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 2011, nearly four out of every five (80%) new patients were men. The mean age of these new patients was 30.9 years. The women were slightly older than the men on average (31.4 vs. 30.8). This mean age is actually the result from the mix of two subpopulations, cannabis users on the one hand, with a mean age between 25 and 26 years, and opiate and cocaine users on the other hand with a mean age of around 34 years. 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 32% of the total. A little more than 20% of the patients were over 40.

Men are slightly more represented among patients seeking treatment for the first time in their lives than among all new patients (82% vs. 80%). Above all, first-time patients were much younger. Their mean age was 26.4. Just over half of these patients were under 25, and 10% were 40 and above.

Table 5-1: Breakdown of patients by age (as a %), in 2011.

Age	All treatments	First treatments
- 20 years old	11,5	22,2
20-24 years old	19,6	27,7
25-29 years old	20,5	20,9
30-34 years old	15,9	12,6
35-39 years old	13,0	7,9
40-44 years old.	9,7	4,7
45-49 years old.	5,4	2,2
50 and over	4,3	1,9
Total	100,0	100,0

Source: RECAP / OFDT – 2011.

New patients mostly come into contact with the treatment centres on their own initiative (35%) or following referral by a legal department or the police (29%). The latter method of contact has much lower representation among women (12% vs. 34% in men). Of first-time patients, nearly half (47%) were referred in this way. Most of the persons referred to a treatment centre by a court of law or the police are cannabis users.

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

Table 5-2: Breakdown of patients by treatment origin (as a %), in 2011.

Origin of the treatment	All treatments	First treatment
Patient's own initiative	34,5	23,4
Family or friends	9,5	9,8
Other specialised centres for drug users	6,1	2,0
General practitioners	7,1	4,3
Hospital or other medical establishment	5,2	3,4
Social services	3,8	4,2
Police, courts or drug treatment order	29,4	46,8
Others	4,4	6,1
Total	100,0	100,0

Source: RECAP / OFDT – 2011.

New patients most frequently live with their parents or alone (35% and 29% respectively) and most often live in stable housing (79%). Nevertheless, 20% of them stated that they were living in unstable housing conditions. The situation for women differed from that of men: they lived 10 times more often than men alone with their child (11% vs. 1%), and more often with a partner (19% vs. 11%). In contrast, they much less frequently lived with their parents (26% vs. 37%). Due to the higher proportion of younger people among them, first-time patients were less likely to live alone and lived more frequently (45%) with their parents.

Table 5-3: Breakdown of patients by living status (with whom) (as %), in 2011.

Living status (with whom)	All treatments	First treatments
Alone	28,6	22,7
With parents	34,8	45,4
Alone with child	3,1	2,6
With partner but without children	12,5	11,3
With partner and child(ren)	11,6	10,2
With friends	3,2	2,4
Others	6,2	5,4
Total	100	100

Source: RECAP / OFDT – 2011

Table 5-4: Breakdown of patients by type of dwelling (as %), in 2011.

Type of dwelling	All treatments	First treatments
Stable housing	78,9	86,1
Unstable housing	18,1	11,3
Institutional housing	3,0	2,7
Total	100,0	100,0

Source: RECAP / OFDT – 2011

The total of all economically inactive people (retired, at home, disabled) and unemployed (Table 5-5) account for 45% of new patients. Slightly more than a quarter (26%) has regular employment and 15% are still high school or post-high school students. The percentage of economically inactive patients was clearly higher among women than men (26% vs. 21%). First - treatment patients differed from patients as a whole in that there was a higher percentage of high school pupils and post-high school students and a lower percentage of economically inactive people.

Table 5-5: Breakdown of patients by professional situation (as %), in 2011.

Professional situation	All treatments	First treatments
Regular employment	26,2	27,1
Post-high school student, high school student	15,3	24,7
Economically inactive	21,8	15,3
Unemployed	23,4	18,6
Others	13,4	14,3
Total	100,0	100,0

Source: RECAP / OFDT – 2011.

Nearly two-thirds (62%) of new patients stated having reached secondary school level, 4% had not got past primary school level and 34% indicated that they had an educational level above the baccalauréat (A-level/High School Diploma). The women were characterised by a much higher percentage of post-secondary level education (46% vs. 31%). The breakdown of educational level remained unchanged among first-treatment patients.

Drug use

In 2011, almost half of new patients (48%) were treated in specialised treatment centres for problems associated with cannabis use. A majority (57%) of them stated using cannabis every day. The percentage of people treated for their cannabis use was much lower among women (35% vs. 51%). The proportion of people using it daily was slightly lower among men, but this difference was not very marked (57% vs. 61%).

The proportion of first-time treatment patients stating that cannabis posed the biggest problem was higher than that recorded in all new patients (71% vs. 48%). The breakdown of the frequency of use was similar in the two groups. The large number of cannabis users among patients in treatment in France is partly the consequence of the large and still increasing number of arrests for cannabis use. In fact, some of the users who have been arrested were sent to treatment centres by the courts.

After cannabis, opiates are the second product most often cited as causing the majority of problems: 41% of new patients fall into this category. Of these patients, 77% stated heroin, 5% methadone and 18% other opiates (primarily HDB)[131]. Of these patients, heroin was most frequently used nasally (65%), but one in every five heroin users still injects. The monthly percentage of injectors is much higher (37%) amongst other opiate users. Among the opiate users, almost 80% consumed these substances on a daily basis and 11% took them regularly (i.e., several times a week).

Women are treated less often than men for cannabis use. However, they are treated far more than men for their opiate use (50% vs. 38%), regardless of the type of opiate in question. They used the injection route slightly less often than men to consume heroin (22% vs. 24%), but as often for the other opiates.

The percentage of first-time treatment patients listing opiates as the substance posing the most problems is far lower than that recorded for all new patients (20% vs. 41%). Distribution of frequency of use is similar in the two groups although there is a slightly higher proportion of daily use among first-treatment patients. This group administers fewer injections during the month (15% versus 21%).

Table 5-6: Distribution (as %) according to the product posing the majority of problems, 2011.

Main drug	New patients	First treatment patients
1. Opiates (total)	40,8	20,2
1.1. heroin	31,4	15,9
1.2. methadone	2,1	0,9
1.3. other opiates	7,3	3,5
2. Cocaine (total)	6,5	5,0
2.1. cocaine	5,0	4,3
2.2. crack	1,5	0,7
3. Stimulants (total)	0,8	1,1
3.1. amphetamines	0,3	0,3
3.2. MDMA and other derivatives	0,3	0,2
3.3. other stimulants	0,2	0,6
4. Hypnotics and sedatives (total)	2,2	1,2
4.1. barbiturates	0,1	0,1
4.2. benzodiazepines	1,6	0,7
4.3. others	0,5	0,4
5. Hallucinogens (total)	0,3	0,2
5.1. LSD	0,2	0,1
5.2. others	0,1	0,1
6. Volatile inhalants	0,2	0,3
7. Cannabis (total)	48,1	71,1
9. Other substances (total)	1,1	0,9
Total	100,0	100,0

Source: RECAP / OFDT – 2011.

After cannabis and opiates, cocaine is way behind; the third product mostly implicated in treatments; it is listed as the product posing the most problems by just over 5% of patients. Amongst these, the frequency of use for a product posing the most problems is far lower than in

[131] For methadone and HDB, this means use other than therapeutic use.

the case of opiates: 37% of cocaine users (in terms of the product posing the most problems) use it every day and 24% admit to frequent use. Cocaine is mostly snorted (71%) and rarely smoked (16%). 17% of cocaine users will have injected in the previous month. This proportion is virtually identical to that recorded for opiate users. Cocaine was slightly less frequently mentioned among first-treatment patients, but the difference was not very significant. Cocaine is also mentioned more frequently as a secondary product than as a product posing the most problems. Of the new patients for whom product information was available, 18% mentioned the use of cocaine as a secondary product. As a secondary product, cocaine is the product posing the most problems for opiate users 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 is negligible. In 2011, 25 residential centres provided RECAP data on nearly 780 patients.

Nearly all of the patients housed in these residential centres had already been helped by a healthcare professional for their addiction. It is rare for the patients themselves to request treatment directly from these centres. In the majority of cases, they are referred, at least the first time, by other treatment centres. The data on patient referrals indicates that 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. Nevertheless, it can be surmised that, for the majority of these patients, it was not their first stay in such a centre.

The patients seen in residential centres were on average older than those seen as outpatients (33.4 years of age vs. 30.9 years of age). In general, these centres tend to treat patients with the most serious addiction problems. These people are 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 from an addiction and social rehabilitation standpoint than for older patients. The lack of sufficient residential treatment for the youngest users is often pointed out by addiction scientists. 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 there are very few of the youngest users represented, just over 40% of new patients treated in these centres are under the age of 30.

The most significant evidence of social exclusion characterising this population was the still-high percentage of patients, in relation to those seen on an outpatient basis, who were living alone (47%), who had unstable housing conditions (42%) or who were unemployed or economically inactive (40% and 34% respectively).

In the older age bracket, the seriousness of problems of addiction and exclusion were more often related to opiate and cocaine use, which was seen much more frequently in this population (54% and 21% respectively) than in the population being followed on an outpatient basis. The percentage of people being followed in these centres for their cannabis use was in contrast much lower (17%). Due to the seriousness of the addiction problems, the proportion of people who had injected in the last 30 days was much higher in this population: it reached almost 35% in persons who experienced most problems with opiates and 33% for cocaine.

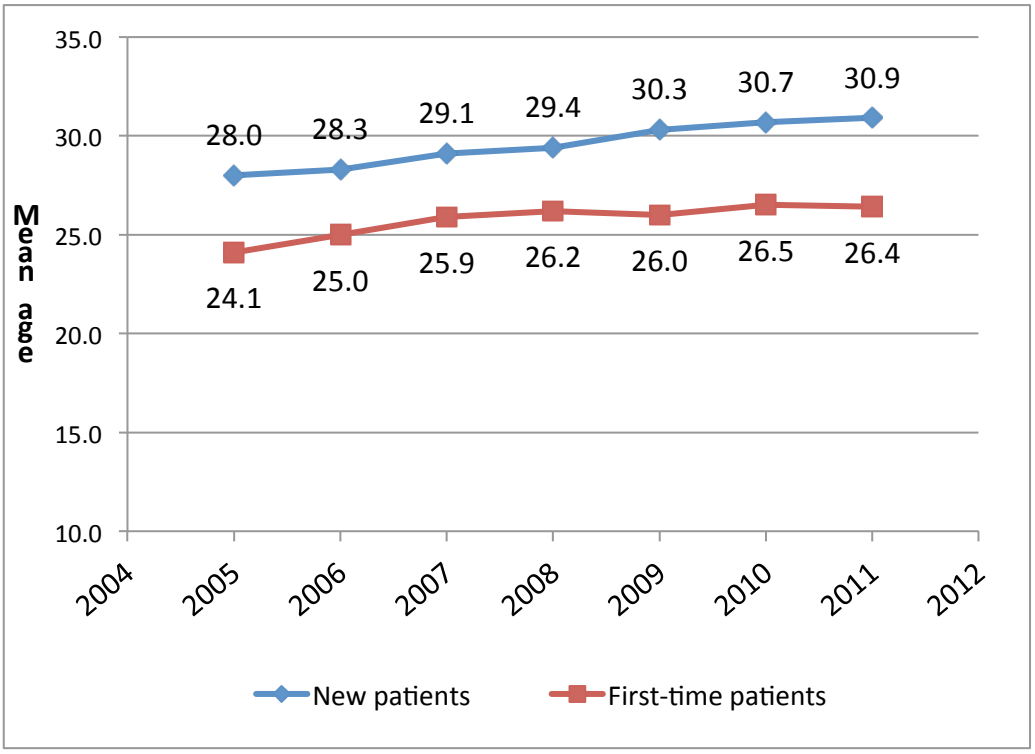
5.3.2. Changes in the characteristics of new patients and first-treatment patients managed in CSAPAs

Patient data that are TDI-compatible have only been available in France since 2005. Consequently, changes in these data can only be genuinely monitored over a relatively short period of time. As regards housing centres, major variations in numbers associated with levels of response, make it difficult to interpret the changes. Consequently, only trends relating to patients viewed on an outpatient basis will be considered in this section.

Data for the 2005-2011 period are now available. The first two years (2005 and 2006), however, correspond to a data collection implementation phase with a rather low participation level 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 five years, the level of centre participation in the survey averaged two-thirds but the centres who responded were not always the same. This situation can cause fluctuations in the data, which do not necessarily reflect changes in the patients' situation. Attention should therefore only be paid to major trends remaining constant over several years.

As shown in the graph data opposite, the mean age of the patients is constantly increasing, rising from 28 to almost 31 years of age between 2005 and 2011.

Graph 5-3: Changes in the mean age of new and first-treatment patients managed in CSAPAs, 2005-2011



Source: RECAP/OFDT

An observation of changes in terms of breakdown of age (Table 5-7) shows that ageing is essentially due to a decrease of approximately 10 points in the 15-24 year-olds in favour of the over 40 year-olds, with values increasing almost two-fold, ranging from almost 11% in 2005 to over 21% in 2011. This decrease was mostly apparent in 20-24 year-olds between 2007 and 2011. It is important to bear in mind when interpreting these changes that, according to the activity reports provided by the CSAPA, the number of people received has tended to increase annually. A decrease in the proportion of younger people does not necessarily indicate a lower number in absolute terms. The tendency towards an increase in the mean age was also apparent for initial treatment requests. Between 2008 and 2011, the mean age of these people nevertheless seemed to remain relatively stable. This stabilisation can perhaps be explained in part by the decrease in the number of first-treatment patients mainly experiencing difficulty with opiates in favour of cannabis users, who tend on average to be much younger than the former.

Table 5-7: Distribution of patients by age (as a %), changes between 2005-2011.

Age bracket	2005	2006	2007	2008	2009	2010	2011
<15	0,6	0,8	0,7	1,4	1,2	1,1	1,4
15-19	16,0	14,8	11,9	11,3	11,4	10,4	12,1
20-24	24,8	25,2	24,7	23,3	20,4	19,6	18,6
25-29	19,0	19,4	21,2	21,4	20,2	20,5	19,1
30-34	16,6	15,4	14,9	14,6	14,8	15,9	15,7
35-39	12,3	12,3	12,5	12,7	13,4	13,0	11,8
40-44	6,8	7,1	8,4	8,4	9,3	9,7	10,0
45-49	2,5	3,2	3,5	4,2	5,4	5,4	6,1
50-54	0,8	1,2	1,4	1,7	2,3	2,5	3,0
55-59	0,3	0,5	0,6	0,7	1,0	1,1	1,2
60-64	0,2	0,2	0,2	0,3	0,4	0,5	0,6
>=65	0,1	0,1	0,1	0,2	0,3	0,3	0,4
Total	100,0	100,0	100,0	100,0	100,0	100,0	100,0

Source: RECAP / OFDT – 2005 - 2011.

The aging of people treated in the centres has repercussions on certain patient characteristics. Thus, in keeping 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 35%. In contrast, the number of people living alone has increased from 25% to 29%. For reasons also associated with changes in age distribution, the numbers of high school and post-high school students are also decreasing, falling from 17% in 2005 to 15% in 2011.

It is also useful to note that the proportion of people with stable housing conditions has been increasing since 2007. It is difficult to establish whether this change is also due to the increase in the mean age or whether other factors are implicated.

As regards the distribution of patients using products causing the most problems, data recorded between 2007-2011 have shown considerable stability. The percentage of drug users seen mainly for a heroin problem increased slightly between 2007 and 2010, ranging from 31.1% to 34.4%, only to fall again in 2011 to reach 2007 levels. These changes are accompanied by a symmetrical movement in terms of patients seeking advice for a cannabis problem (decrease from 49.4% in 2007 to 45.9% in 2010, rising to 48.1% in 2011). Conversely, changes are more marked in first-treatment patients: a marked, constant fall in heroin cases has been observed over the last 4 years (24.0% in 2007 versus 15.9% in 2011, with a particularly marked decrease between 2010 and 2011) whereas figures for cannabis users increased over the same period (from 65.8% to 71.1%). As regards route of administration, the data recorded between 2007 and 2011 highlight stability in the percentage of people treated for opiate use and who injected in the month prior to inclusion.

Table 5-8: Percentage of patients who injected over the last 30 days, depending on the product posing the most problems - changes observed between 2005 and 2011

	2005	2006	2007	2008	2009	2010	2011
1. Opiates (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 opiates	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 – 2005 - 2011.
Sample table reading: in 2011, 17.6% of new patients treated for heroin use injected at least once over the last 30 days. This does not necessarily mean that all of these patients use heroin intravenously. Although it seldom happens, a user may not have injected heroin but another product over the last 30 days

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 diseases 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 diseases[132]) or the psychiatric 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 amongst drug users are based on data gathered within the scope of various surveys:

- The reported prevalence of HIV, hepatitis B and hepatitis C: starting in 2005 (Palle *et al.* 2007), these prevalence levels are supplied by the RECAP survey (of patients seen in CSAPAs) and by surveys of patients seen in so-called, "low-threshold" structures (CAARUDs[133]), particularly the PRELUD (see appendix IV-G) and ENa-CAARUD surveys.

- The biological prevalence of HIV and HCV, based on blood samples and calculated using the Coquelicot survey (see appendix IV-C) (Jauffret-Roustide *et al.* 2006): this was conducted in 2004 by the Institut de veille sanitaire (InVS, or the French National Institute for Public Health Surveillance) in five French cities amongst drug users frequenting specialised treatment centres (CSAPAs, CAARUDs, residential structures and general practitioners). A two-phase survey was carried out: firstly, amongst structures according to a "time location sampling method", and secondly, amongst users. Those who agreed to take part in the study took their own sample through a blood stick; the blood sample was tested for HIV and HCV. Users were questioned about their use of psychotropic substances and their at-risk practices. There was a new edition in 2011.

- The biological prevalence of HIV and HCV based on saliva samples taken from people frequenting CAARUDs: these data were gathered during the BioPRELUD[134] survey conducted by the OFDT in 2006 in five cities amongst user volunteers. The data helped summarise the current use of and practices regarding psychoactive substances in a population with a high prevalence of drug use. The analysis of saliva samples, which were 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 population was different (on the one hand there were

[132] In addition to IV drug use, at-risk sexual behaviours among IV drug users increase the risk of sexually transmitted diseases.
[133] Centres d'accueil et d'accompagnement à la réduction des risques pour usagers de drogues, or Reception and harm reduction support centres for drug users
[134] The BioPRELUD survey (five cities) represents the biological portion of the larger PRELUD study, which was conducted among CAARUDs in nine cities (including the five BioPRELUD cities) in 2006. The HIV and HCV prevalence data gathered within the scope of the PRELUD study were reported data.

"inhalers" encountered in numerous structures, and on the other hand, users encountered at exclusively low-threshold structures; such users were five years younger on average), the methodologies were different (blood samples vs. saliva samples), the users surveyed during the BioPRELUD study were much younger, and the surveys were conducted in different cities.

- Estimates of the incidence of AIDS, HIV infection and acute hepatitis B were also performed. AIDS case reporting (via the InVS – the French National institute for public health surveillance), which has existed since the early 1980s, has been mandatory since 1986. A new anonymous reporting method implemented in 2003 following a circular[135] issued by the Direction générale de la santé (National Health Directorate) made HIV-infection reporting obligatory as well. This system is combined with the virological monitoring of HIV.

- Cases of acute hepatitis B reported since 2004 (reporting has been made mandatory since this date).

Sexually transmitted diseases and tuberculosis

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

Other infectious diseases

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

Behavioural data

In France, quantitative information (ENa-CAARUD study conducted by the OFDT and Coquelicot conducted by the InVS) as well as qualitative information (TREND and the qualitative section of the Coquelicot survey) is available on the perceived health status of drug users and their at-risk behaviour (Cadet-Taïrou *et al.* 2010a; Cadet-Taïrou *et al.* 2008; Jauffret-Roustide *et al.* 2006). The surveys conducted within TREND amongst users frequenting low-threshold structures also previously provided indications of certain diseases and their appearance (Bello, P. Y. *et al.* 2005; Bello, P.Y. *et al.* 2004).

Psychiatric comorbidities

The few studies available in France do not make it possible to draw any consistent conclusions concerning the prevalence of miscellaneous psychiatric pathologies amongst drug users.

Drug-related deaths

In France, there are currently two sources that list deaths by overdose:

- The national statistics on the causes of deaths (CepiDc-INSERM): this is a registry that gathers information from death certificates of all deaths in the past year. Deaths

[135] 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 (NOR SANP0330122C).

by overdose 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 B[136]) established by the EMCDDA. Without going into further detail here, this is a group of codes in which consumption of an illegal substance or certain medication is involved. Some deaths by overdose are nevertheless coded under deaths with poorly defined causes and therefore are not registered. Furthermore, the substances responsible for death are poorly recorded in this source, since the most frequently seen wording is that of polydrug use without any further specifications. These data only become available after two years.

- The system known as DRAMES (Décès en relation avec l'abus de médicaments et de substances, or Drug and Substance Abuse-related Deaths – issued by France's ANSM National Agency of Medicine and Health Product Safety, formerly known as the AFSSAPS, see appendix IV-D). This information system records deaths that involved legal proceedings and a request for a toxicology analysis and/or autopsy. Toxicological analysts report these cases on a voluntary basis throughout the French territory. Thirty-one experts who performed toxicological analyses within a forensic scope participated in the 2010 edition of the survey. The 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 judicial system requested a toxicological analysis, and such requests are not systematic. Therefore DRAMES data are especially useful in determining a breakdown of overdose deaths according to the product that caused them.

Deaths by overdose recorded by the police and *gendarmerie* and centralised by the OCRTIS (*Office central pour la répression du trafic illicite de stupéfiants* or Central Office for the Repression of Illicit Narcotics Trafficking) formerly constituted another source whose data were mentioned in preceding reports. However, since 2008 this body has no longer provided these data due to the lack of reliability of the information system of these institutions with respect to deaths by overdose. As a result, it was decided to discontinue mentioning this source.

The number of AIDS deaths related to intravenous drug use can be estimated using the national HIV/AIDS surveillance database coordinated by the InVS.

6.2. Drug related Infectious diseases

6.2.1. HIV/AIDS and viral hepatitis

Surveillance system for HIV infection and new AIDS cases

The estimate of the number of new HIV patients since HIV reporting became mandatory in 2003 was 55,168 on 31 December 2010[137]. Given reporting delays and under-reporting, in 2010 the

[136] The definition for fatal overdose is the same throughout all European countries: http://www.emcdda.europa.eu/publications/methods/drd-overview

[137] Data corrected due to delays in reporting and under-reporting.

number of positive notifications was estimated at 6,265, which is slightly lower than the two preceding years (6,341 in 2009 and 6,340 in 2008).

In 2010, people infected through intravenous drug use represented no more than 1.13% (71/6,265) of these new cases of infection. The most frequent contamination route is heterosexual intercourse (57% of cases) followed by homosexual intercourse between men (40%) (Cazein *et al.* 2011). It is still too early to assess the impact of the recommendations (generalised screening and repeated screening amongst exposed populations) of the 2010-2014 French national HIV-AIDS and Sexually Transmitted Infection plan on HIV surveillance data. In 2008, the incidence of HIV amongst IDUs was estimated at 86 per 100,000 person-years [95% CI, 0-192] (Le Vu *et al.* 2010). (Table 6-1).

Table 6-1: Number of new HIV-1 infections and incidence amongst IDUs in France in 2008

	New HIV-1 infections [95% CI]	Estimated population	Incidence per 100,000 person-years [95% CI]
IDUs (all nationalities combined, both genders)	70 [0-190]	81,000	86 [0-192]

Source, InVS, BEH, n°45-46, 2010

The number of new AIDS cases amongst IDUs has fallen continuously since the mid-1990s. Whereas IDUs represented a quarter of the people diagnosed at the AIDS stage at that time, they represented only slightly fewer than 8% in 2008 and approximately 5% in 2010 (provisional data).

Table 6-2: Number of new AIDS cases amongst IDUs and total number of new cases 2000-2010.

	<2003	2004	2005	2006	2007	2008	2009*	2010*
IDUs	12,919	170	127	102	87	82	54	53
Total new AIDS cases	58,929	1405	1361	1169	1000	1033	919	888
IDU proportion (%)	21.9	12.1	9.3	8.7	8.7	7.9	5.9	6.0

**: provisional data not yet adjusted for delays in reporting*
Source: InVS, "Base de données sida" (AIDS database), (http://www.invs.sante.fr/surveillance/vih-sida/default.htm), consulted on 19 July 2012.

Hepatitis B surveillance system

The number of acute hepatitis B cases reported between 2004 and 2009 was 894; of these 23 cases (2.6%) were related to drug use.

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

The prevalance 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 to

chapter 6). Until now, the evolution of prevalence rates could only be compared using declarative data.

Data based on biological samples

The biological (blood) presence of HIV in users who have injected at least once in their lives as measured in the 2004 Coquelicot survey was 11.3%. Two percent of users wrongly believed that they were HIV negative. The prevalence was the same whether or not the user injected. It is higher in older generations: only 0.3% of drug users under the age of 30 were infected. This prevalence varied widely from city to city: from 1% in Lille (in the North of France) to 31.5% in Marseille (South of France). Nearly all HIV-positive drug users were also HCV-positive (Jauffret-Roustide *et al.* 2009).

The biological (blood) presence of HCV in the same population was 73.8%. A significant proportion of drug users (27%) wrongly believed that they were seronegative.

Table 6-3: Estimate of the prevalence of HIV and HCV in blood samples from drug users by city taking part in the Coquelicot study, 2004

	HIV		HCV	
	% positive	Population	% positive	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: InVS (Jauffret-Roustide et al. 2009)

According to the BioPRELUD study, the prevalence of HIV infection amongst people encountered in CAARUDs was 8.5% in 2006. The proportion of people who tested positive amongst those who said they were negative was 5.0%.

Table 6-4: Estimated prevalence of HIV infection from saliva samples of CAARUD users who took part in the BioPRELUD survey (by injection status and age group) 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	N = 134	6.0%	-	5.6%	6.2%
25 to 34 yrs	N = 211	7.1%	-	5.5%	7.4%
> 34 yrs	N = 139	13%	-	13%	13%

Source: PRELUD 2006, Trend / OFDT

Regarding hepatitis C, the BioPRELUD survey in 2006 indicated a prevalence of 32% of all users who accepted to be tested. Amongst IDUs, the estimated prevalence was 42%. The proportion of people who tested positive of 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 users frequenting low threshold structures surveyed in the BioPRELUD survey (by injection status and age group)

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

Source: PRELUD 2006, Trend / OFDT

As mentioned in the introduction, the prevalence figures obtained from these two surveys were difficult to compare. The data based on the saliva samples probably tended to underestimate prevalence values. Furthermore, users surveyed within the BioPRELUD study were five years younger on average than those surveyed as part of the Coquelicot study. 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 of Paris and Marseilles in BioPRELUD - cities known for their high prevalence of infectious diseases among drug users – contributes to minimizing prevalence figures in this survey; the heavy weight of users in both of these cities in the Coquelicot study had the reverse effect.

Declarative data

PRELUD data (2003-2006)

The data obtained in the nine PRELUD cities revealed a decline in HIV infection from 2003[138] (10.2%) to 2006 (6.2%). The reported prevalence of hepatitis C declined from 2003 (43.4%) to 2006 (34%). The decrease is especially marked in people under the age of 25 (from 17.6% in 2003 to 8.4% in 2006).

[138] The latest edition of the "Première Ligne" (low threshold) survey in 2003 replaced in 2006 by the PRELUD survey.

For the hepatitis B virus, more than a third of users from urban harm reduction support centres did not know their hepatitis B viral 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 than under reported being infected (17% compared with 4% of 25- to 34-year-olds and 2.1% of those under 25 years of age). 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 2010, questioned 2,505 users seen over the span of one week in 112 CAARUDs[139]. In 2010, the majority of drug users underwent one of these screening tests at least once (87.0% underwent HIV screening 83.9% underwent HCV screening).

Of people who had used drugs intravenously at least once in their life and underwent screening, 7,2% reported being HIV positive in 2010. This percentage was 8.7% in 2006 and 7.7% in 2008. The data obtained from CAARUD users indicate a decrease in reported HIV seropositivity since the screening rate was stable and the proportion of screening performed less than six months ago increased (44.7% in 2010 vs. 41.8% in 2008 for the entire CAARUD population).

Although the data on hepatitis C was declarative, they also suggest a decline in hepatitis C prevalence amongst drug users (see graph 6.1). This decrease in reported seropositivity is especially marked amongst people under the age of 25 who had injected at least once in their life: declared HCV seropositivity was 22.5% in 2006, 14.3% in 2008 and 8.5% in 2010 for respective populations of 222, 237 and 201 people (Cadet-Taïrou 2012).

However, it should be noted that amongst people who had already injected at least once in their life, 11.9% had never been tested for HIV infection and 11.9% had never been tested for HCV infection.

The vast majority of HIV-positive people (91.8%) consulted at least one physician during the previous 12 months for the disorder in 2010 and 74.6% received treatment over the same period (compared with 68.5% in 2006). Of HCV seropositive subjects, 77.2% consulted a physician during the same period and 36.3% received treatment for this illness (vs. 28% in 2008 and 22.5% in 2006).

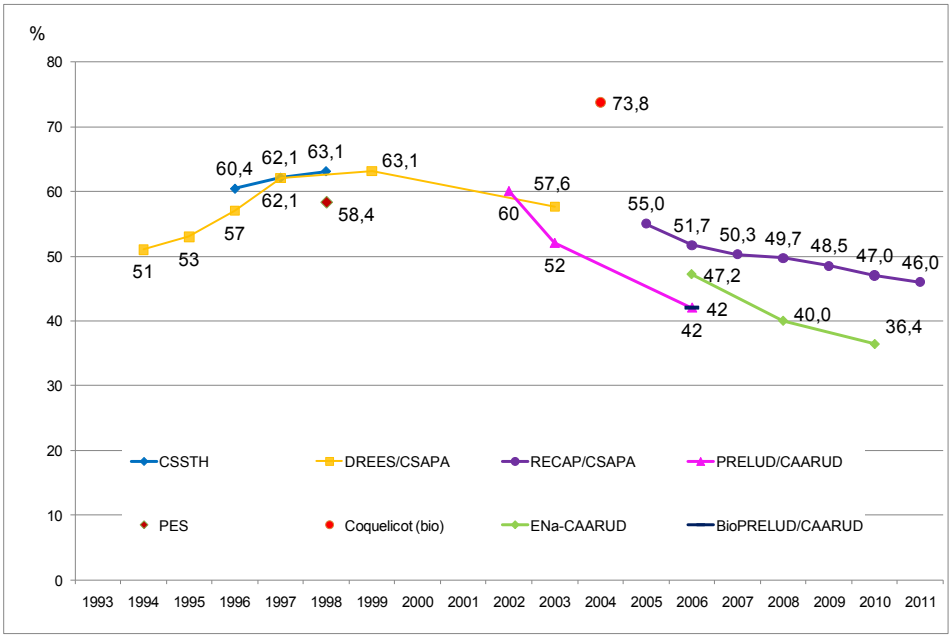
Questions on hepatitis B status were introduced into the ENa-CAARUD 2010 study. They demonstrated that users were ignorant of their status. Half (50%) of users stated that they had been vaccinated, but of these, one third were fully vaccinated (three injections, 32.5%), one third had begun the vaccination process (one to two injections, 34.5%) and one third (33%) did not know how many injections they had received. Moreover, 5.3% stated having been infected (whether cured or not) and 23.3% thought they had neither been infected nor been vaccinated. Finally, 21.4% had no idea what their hepatitis B status was (Cadet-Taïrou 2012).

For HIV as for HCV, since the early 2000s there has been a decline in the reported prevalence of these infections in IDUs (Graph 6-1). This evolution can be explained by different factors: the impact of the different public health measures taken in France, greater accessibility to treatment, greater access to screening and changes in practices by most drug users. Nevertheless, HIV

[139] The 2006 survey was on 3,349 users recruited in 114 CAARUDs.

prevalence amongst IDUs in 2010 was definitely below 10%, and that of HCV was at even higher levels, since the reported prevalence seemed to remain clearly below the actual prevalence.

Graph 6-1: Change in the prevalence of hepatitis C virus infection amongst IDUs in France



Sources:
CSSTH: Housed IDUs, reported prevalence
RECAP/CSAPA: IDUs treated in specialised treatment centres, reported prevalence
PRELUD/CAARUD: IDUs seen in low-threshold structures (CAARUDs), reported prevalence
ENa-CAARUD: IDUs seen in low-threshold structures (CAARUDs), reported prevalence
PES: IDUs using an SEP (syringe exchange programme), reported prevalence
Coquelicot: IDUs, biological data
BioPRELUD/CAARUD: IDUs seen in low-threshold structures (CAARUDs), biological data
DREES/CSAPA: IDUs treated in specialised treatment centres
Note: Injecting drug user (IDU) means a person who has injected at least once in their life.

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 increases with age (with 38% of those under 25 years of age reporting this compared to 46% of 25-to 34-year-olds and 49% of those over 35 years of age). Users describe symptoms of depression or anxiety, suicidal impulses and even delusional episodes. More than one out of every five hospitalisations in the last 12 months mentioned by CAARUD users was related to psychiatric problems in 2010 (except for withdrawal, which also represented one out of every five hospitalisations)[140]. In women, the percentage of self-reported hospitalisations for psychiatric problems (excluding withdrawal) was 25% (Cadet-Taïrou 2012).

[140] Out of the 34.9%, or 854 users who reported having been hospitalised in the last year.

6.2.2. STIs and tuberculosis

There is no specific information system in France providing information on the reported or laboratory prevalence of tuberculosis or of sexually transmissible diseases amongst drug users.

6.2.3. Other infectious morbidity

Different diseases, particularly infectious ones, may occur with the injection of HDB or other substances. The different, particularly infectious, states found amongst CAARUD clients interviewed in 2006 are shown in the table below (PRELUD survey)

Table 6-6: Consequences of injection reported by low threshold centre users 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 %*
Blocked veins, thrombosis, phlebitis	46 %	29 %	38 %*
Swollen hands and forearms	43 %	30 %	37 %*
Swollen feet or legs	16 %	12 %	14 %
"Poussières" [141]	31 %	24 %	27 %

**statistically significant difference with an error risk of <1%*

6.2.4. Behavioural data

Information about injection can be found in chapter 4 (CAARUD data).

Whilst most drug users have adopted the concept of not sharing syringes, this does not apply to other 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 already been used. Slightly fewer than one intravenous user out of every 10 (9.1%) seen in CAARUDs in 2010 stated having shared his or her syringe in the last month, but one out of every five had shared at least one other piece of equipment. These values are all down compared with the 2008 data, but these decreases are not always statistically significant. Moreover, in the 2010 edition there was an overall decrease in risk indicators with a concomitant 10% drop in user response rate. This may indicate a bias (fewer of the more unstable users were surveyed); consequently these results should be considered with caution. The 2012 edition of this study should confirm or refute the trend.

[141] "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".

Table 6-7: Prevalence of equipment sharing among CAARUD users, 2010

	Male	Female	All
	N = 872	N = 230	N = 1102
Syringes	7.9 %	13.6 %	9.1 %
Water for preparation	15.0 %	26.4 %	17.4 %
Water for rinsing	6.3 %	14.8 %	8.1 %
Spoons	13.5 %	24.2 %	15.7 %
Cotton/Filters	11.5 %	20.0 %	13.3 %
Equipment	20.3 %	33.2 %	23.0 %
At least one item of equipment	21.0 %	35.5 %	24.0 %

Source ENa-CAARUD, 2010, OFDT

Amongst those CAARUD users who had been incarcerated in 2010 (N=363), 7.7% had injected, 38.4% had snorted and 2.9% had shared a “syringe”.

It would appear that the younger the users, the more prevalent these sharing practices. Depending on the piece of equipment in question, in 2008 recent injectors under 25 years of age were two to three times more likely to share than those under 35 years of age ($p<0.01$).

In addition, the ENa-CAARUD survey findings show that for a given age and level of instability, women are approximately twice as likely as men to share their injection equipment ($p<0.01$). Several studies recently identified higher risk practices in women (Cadet-Taïrou *et al.* 2010b; Jauffret-Roustide *et al.* 2006), particularly amongst the younger women.

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 use of multiple drugs, injection), live in extremely unstable conditions and make little use of treatment systems. This new generation of unstable users (under 25 years of age) is therefore one with cumulative health risks from more widespread sharing of injection equipment and a higher prevalence of prostitution (Rahis *et al.* 2010).

6.3. Other drug-related health correlates and consequences

In 2008, more than a third of CAARUD users (35% in 2006) felt that they were in poor or very poor physical health, and this proportion remained stable from 2001 to 2008. Whilst the most commonly reported morbidity was infection (bronchitis, colds, abscesses), trauma was also reported (fractures, violence, accidents) together with skin and teeth problems (fungal infections, wounds, ulcers), gastrointestinal (constipation, diarrhoea) and cardiac problems (Bello, P.Y. *et al.* 2010). Of CAARUD users in 2008, 38% had been hospitalised at least once during the previous year; 44% of women and 37% of men had been hospitalised.

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 2010, 6.5% (N=144) of CAARUD users reported having experienced a non-fatal overdose in the last 12 months. Heroin was the main cause (23.6% of cases), followed by cocaine (18.8%) and alcohol (13.9%). Benzodiazepines were mentioned as the second or third product responsible in nearly half of non-fatal overdoses and alcohol in 34.3% of cases.

6.3.2. Other topics of interest

6.4. Drug-related deaths and mortality of drug users

6.4.1. Drug-induced deaths (overdose/poisonings)

Data from the death registry reveal a constant increase in the number of drug-induced deaths from 2003 to 2008, and even until 2009 if we limit the age range to 15-49-year-olds, amongst whom the large majority of cases were due to overdose.

Table 6-8: Deaths by overdose in France according to the death registry

Year	Death registry (EMCDDA, selection B definition)		
	All	15-64 yrs	15-49 yrs
2000	248	225	219
2001	274	243	232
2002	244	225	208
2003	233	212	204
2004	268	239	226
2005	303	264	241
2006	305	275	260
2007	333	287	260
2008	374	322	298
2009	365	321	305

Source: CépiDc

DRAMES provides information on the substances that are the main cause of deaths by overdose. In 2009, illegal drugs were the main cause, as the main product, of death in slightly more than half of the cases (53%), followed by substitution treatments in approximately 34% of cases and opioid medications (excluding substitution treatments) in almost 13% of cases. Overall, opioids were chiefly involved in 87% of cases and cocaine (alone or combined with other substances) in approximately 12%. The rise in the number of overdoses between 2006 and 2009 is explained by an increase in the number of deaths from heroin overdose (+ 44 cases) and methadone overdose (+ 27 cases).

Table 6-9: Substances mainly responsible for fatal overdoses from 2006-2009, DRAMES data

	2006		2007		2008		2009	
	Number	%	Number	%	Number	%	Number	%
Heroin, alone or in combination	59	35,1	69	35,9	79	36,4	103	39,6
Cocaine, alone or in combination	31	18,5	39	20,3	30	13,8	32	12,3
Other illegal substances, alone or in combination	5	3,0	2	1,0	4	1,8	2	0,8
Methadone, alone or in combination	31	18,5	61	31,8	63	29,0	58	22,3
Buprenorphine, alone or in combination	20	11,9	11	5,7	21	9,7	31	11,9
Other opioids, alone or in combination	18	10,7	10	5,2	19	8,8	34	13,1
Others	4	2,4	0	0,0	1	0,5	0	0,0
Total	168	100,0	192	100,0	217	100,0	260	100,0
Number of participating departments	16		18		19		19	

Source: AFSSAPS. Only deaths directly caused by drug use are mentioned.

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 authorities wished to assess the number of deaths caused by driving under the influence of an illegal drug, and cannabis in particular. Since the number of fatal accidents in which the driver responsible was under the influence of opiates or cocaine was too low, it was not possible to determine the number of deaths by road accident caused by these substances. Cannabis use can be deemed responsible for 170 to 190 deaths each year by the end of the 2000s (Van Elslande *et al.* 2011).

7. Responses to health correlates and consequences

7.1. Introduction

The response to drug users' health problems over the last two decades have largely been focused on injecting-related infectious diseases (HIV and hepatitis) (Bello, P.Y. *et al.* 2010). For this reason, the oldest and best structured programs concern the fight against these diseases. Three levels of prevention are described[142]: primary prevention with harm reduction, secondary prevention with an encouragement to undertake screening and early treatment and, finally, tertiary prevention, which aims at improving the access to treatments and their follow-up for users. Other pathologies related to drug use, psychiatric comorbidity, or arising as a result of serious incidents for example, have not been the subject of specific responses from the public authorities up until now.

With the exception of substitution treatments[143], changes in the supply and availability of treatment and 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 addiction centres provided for drug users. Two surveys among a sample cohort of pharmacists and doctors, carried out by the INPES make it possible to measure the density of the health professionals contributing to the harm reduction measures or treatments (the INPES Health Barometer survey for pharmacists and the Health Barometer survey for doctors).

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

Up until 2008-2009, no national policy or specific measures existed in France concerning the reduction of acute serious pathologies and drug use-related death. Access to substitution treatments and the harm reduction policy (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" services) offer a number of indirect means of preventing deaths caused by opioid usage. The increasingly widespread use of HDB, even when misused, which results in relatively few overdoses compared to 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 products, and organised as of 2006, is now operational and is gradually coming on stream.

Nationally, this includes the DGS (the addictions office and the alert warning unit), the InVS, the ANSM, the OFDT, the MILDT, the local networks of each of these institutions (hospitals, GPs, addiction centres, regional monitoring units, low threshold services, pharmacists, etc.) and their international networks (the Early Warning System, and the European Centre for Infectious Disease Control, etc.).

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

[142] We are currently witnessing a change in the way the prevention field is perceived with the dissemination of concepts focusing on universal, selective or indicated prevention. However, the classification used here is still relevant for pinpointing actions in relation to the various stages in the pathological process (see chapter 3).
[143] The legal framework for substitution treatments: see chapter 1

- case-related signals: 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;

- substance-related signals: circulating, seized or already used psychoactive substances or a combination of substances, of an unusual or dangerous nature likely to pose a lethal risk or entail serious health consequences (the presence of specific additives, the level of purity, the extent to which the substance is new or use patterns, etc.).

Following an analysis of the signals in question, the response can range from a simple monitoring of the phenomenon to a health warning 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 death 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. A group of harm reduction and self-support associations has produced information resources pertaining to the prevention of overdose specifically aimed at drug users (DUs).

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 years 1999-2002, when the first national plan against hepatitis C was adopted[144]. The prevention measures it contained chiefly concerned drug users, who account for the vast majority of new cases in France. This plan contained measures concerning prevention, screening, access to treatment and improvements to treatment. With the decline of 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 "the national hepatitis B and C plan" also includes the fight against hepatitis B. In December 2008, while awaiting the publication of a new plan, measures were taken aimed in particular at building awareness among health professionals of the need to vaccinate "at risk" individuals, including drug users[145]. The new plan (2009-2012) (DGS (Direction générale de la santé) 2009) is based on the same issues, but more extensively identifies the "at risk" groups to better reach them. The prevention aspect is also aimed at the most vulnerable and precarious

[144] See chapter 3.

[145] 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 level of vaccinations tended to drop. In 2004, the vaccination levels were 29% for children under the age of 24 months and 42.4% for teenagers aged 15 (BEH 2009 20/21 panel 1).

groups in society, and particularly migrant populations. The plan further stipulates working **on preventing the first injection**. Furthermore, it also covers possible contamination by drug snorting or smoking, whereas up until now the French preventive system had scarcely considered this aspect. Preventive measures in France cover 3 main areas:

1) **The harm reduction policy**[146]

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

- The distribution and recovery of sterile injection, single-use equipment. Syringes and injection kits are sold without restriction in pharmacies (no prescription required since 1987). Injection kits are also distributed or exchanged by low threshold structures (CAARUDs) or dispensing machines. For several years now, the availability of preventive equipment has gradually been extended to administration routes other than injection, with the distribution of sniff kits and base kits for crack smokers and the distribution of special leaflets intended to "chase the dragon"[147]. Finally, distributing condoms (and encouraging their use) also contributes to reducing HIV virus contamination.

- The circulation of information on drug-related risks and the promotion of health education.

- The distribution of opioid substitution treatments from 1995 onwards (see chapter 5) which initially seeks to reduce injecting drug use (preventing the first injection and/or encouraging users to give up the intravenous route) by reducing heroin use, but also to encourage access to treatment by providing a joint objective for both doctors and drug users, making it possible to develop a strong therapeutic relationship between them.

The harm reduction system is chiefly based on local pharmacies (for the sale of equipment and participation in syringe exchange programmes), the specialised medical/social system comprised of CAARUDs and the non-medical/social services offered by the associations. The latter is mainly involved in the party scene and in the municipal schemes in charge of syringe distribution machines (one-third of schemes in France). Treatment access points also contribute to reducing risks, either directly (through the provision of information or equipment, etc.) or indirectly (substitution treatments). General practitioners and pharmacists also contribute to the harm reduction policy by prescribing and dispensing HDB. In order to provide substitution treatment access to the most vulnerable drug-using populations (e.g., pregnant women, prisoners), health care professionals can initiate methadone substitution treatment in a hospital or prison setting[148]. This possibility has been limited to physicians working in CSAPAs until now.

2) **Encouragement to undergo screening for HIV, hepatitis C or hepatitis B infection and ease of access to this screening**.

The plan stipulates 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

[146] The legal harm reduction framework: See chapter 1.
[147] i.e. to smoke or inhale the vapours of a substance previously deposited on an "aluminium" type surface and heated.
[148] Circulaire n°2002-57 du 30 janvier 2002 relative à la prescription de la 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.

treatments available to drug users in areas that generally attract unstable and migrant populations. It also includes an information campaign aimed at the general population and health professionals. The aim is to reduce the percentage of cases in which the disease is already highly advanced by the time it is detected by screening.

The circular dated 9 November 2009[149] implements the provisions stipulated in the plan.

The screening programme is chiefly carried out in CDAGs (Anonymous Free Screening Centre). 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 addiction centre initiatives which organise the collection of samples directly on site in the concerned centres. The CSAPAs also provide screening free of charge. Finally, access to screening is also possible via traditional treatment channels. However, whereas the cost of screening for HIV and hepatitis C infection is 100% covered by the French national insurance scheme, the search for chronic hepatitis B markers is only 65% covered.

3) **Encouragement to undergo vaccination against hepatitis B.**

In addition to continuing to encourage "at risk" people to get vaccinated (in particular in treatment centres and harm reduction structures), the new plan also seeks to encourage vaccination among the general population, for infants and teenagers. The hepatitis B vaccine is provided free of charge by the CDAGs and CSAPAs. 65% is refunded by the French national health insurance scheme as part of the general treatment programme.

Monitoring

Data allowing the quantities of injection equipment delivered to DUs to be monitored was collected by the OFDT in 2008. The OFDT gathers these data from:

- the sale of syringes by the *Becton Dickinson* company to pharmacies;
- Stéribox® sales to pharmacies (System of Information on the Accessibility of Injection Equipment and Substitution Products, SIAMOIS, data transmitted to InVS by GERS (Groupement pour l'élaboration et la réalisation de Statistiques – Group for the Production and Elaboration of Statistics);
- the information system based on standardised annual reports produced by the CAARUDs (ASA-CAARUD, see Appendix IV-V);
- evaluations produced by various associations distributing syringes.

The information system based on these CAARUD activity reports also makes it possible to monitor undertaken activities aimed at preventing infectious diseases through the number of condoms distributed, and the average annual number of acts per CAARUD client concerning access to screening for viral disease and vaccination against hepatitis B.

[149] Circulaire DGS/MC2 n°2009-349 du 9 novembre 2009 relative à la mise en oeuvre 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 drogue de bénéficier d'un service de proximité assurant gratuitement le dépistage de ces hépatites et, le cas échéant, une vaccination contre l'hépatite B (NOR SASP0927192C).

The monitoring of the policy aimed at encouraging access to screening is chiefly based on the ENa-CAARUD survey carried out every two years by the OFDT among CAARUD clients. The percentage of users having already undergone screening for HIV or hepatitis C is now very high (above 85%). What is important is that this screening needs to be repeated. The OFDT monitors this, also measuring the percentage of users for whom the most recent “all clear” result dates back less than six months.

Finally, although measurements are being carried out, a number of indicators are not available on a sufficiently regular basis, such as the percentage of infected drug users for hepatitis C (or HIV) unaware of their infection. The Coquelicot survey carried out by the InVS in 2004 found that a large part of hepatitis C infected drug users were unaware of their infection status (27 %) (Jauffret-Roustide *et al.* 2006). Similarly, the measurement of drug users’ knowledge of their hepatitis B status (vaccinated, contaminated, cured or otherwise) was carried out in 2006 with the PRELUD study (OFDT) without being subsequently repeated (Cadet-Taïrou *et al.* 2008).

Treatment of drug-related infectious diseases

Finally, facilitating access to treatment for infected persons is the main point of the "treatment" aspect, but also a harm reduction measure for those users who are not yet infected.

Ministerial measures introduced in December 2005 created "a co-ordinated treatment procedure for hepatitis C" organised around hospital contact points in order to improve liaison between GPs and the specialised medical services, in addition to the quality of treatment offered to patients and their overall quality of life. A “doctor’s” guide to hepatitis C was produced by the French National Authority for Health (HAS) in 2006.

Infectious disease prevention is also planned for drug users in prison. The new hepatitis plan sees prevention in prison as one of the five strategic areas for attention. Access to HIV and hepatitis screening is also a main strategy of the 2010-2014 "health/prison” plan (see chapters 9 and 1).

Responses to other health-related consequences of drug use

Other health-related consequences of drug use have not been the subject of any specific responses in France. Addiction services and harm-reduction structures have to facilitate access to treatment, with certain treatments provided on-site (skin treatments, etc.). The activities carried out by the CAARUDs in this particular field can be measured. Furthermore, drug users also make use of the general treatment system (emergency care, hospitals, independent doctors, etc.).

For economically disadvantaged population groups, access to treatment is possible thanks to the Universal Medical Coverage (CMU). 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 (4.8% in 2008) have no social cover whatsoever (Toufik, A. *et al.* 2008).

Concerning drug users’ psychiatric comorbidities, their treatment in France remains an unresolved problem. In fact, although there are psychiatrists in the addictions field and although some psychiatric hospitals have developed treatments for drug addicts over recent years, these

initiatives are few and far between and remain insufficient when compared to needs. Doctors treating drug addicts experience major difficulties in finding suitable treatment establishments for those requiring residential and often particularly complex treatments.

No national monitoring indicators exist concerning the treatment of psychiatric comorbidities.

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

In 2010, the organisation of health warning measures for psychoactive substance use improved by promoting and inciting coordination among players likely to receive, process and respond to signals[150] on a regional level: Regional Health Agencies (ARS) and Centre for Evaluation and Information on Pharmacodependence (CEIP) of the AFSSAPS network and TREND/SINTES sites of the OFDT if need be. This measure also ensures that these players are able to inform potential targets (e.g. harm reduction structures, specialised treatment centres for drug users, networks of physicians specialised in drug addiction, user associations, and hospital emergency departments). In 2011, the programme advanced at regional level but is still not fully operational in all areas.

Several files have been coordinated by the warning system over the year but no risk was identified at national level in 2011. The various players have been able to carry out some investigations on a regional scale, which led to communications where applicable, targeting only professionals working in the drug field and local user associations. This partly explains why the alerting system did not produce any press releases in 2011.

The OFDT SINTES programme published 5 information notes[151]:

- SINTES note on “Methoxetamine”, **7 November 2011;**
- Rumours of the circulation of Desomorphine or “Krokodil”, 28 October 2011 (updated on **4 November 2011**);
- Heroin: contents and adulterants. Recent changes, **25 May 2011;**
- List of new synthetic drugs identified in France since 2008, 9 May 2011 (updated on **6 March 2012**);
- Mephedrone and other synthetic stimulants in circulation, 31 march 2010 (updated **7 February 2011).**

The experience gained with this system clearly shows the merits of active surveillance systems such as TREND and SINTES, which allow the significance of the signal to be interpreted very quickly thanks to relatively accurate knowledge of users, practices, contexts and markets.

[150] A signal is likely to be linked to a phenomenon warranting management. It must be evaluated and possibly investigated.
[151] http://www.ofdt.fr/BDD/sintes/ir_methoxetamine_111105.pdf
http://www.ofdt.fr/BDD/sintes/ir_desomorphine_111028.pdf
http://www.ofdt.fr/BDD/sintes/ir_110525_coupe.pdf
http://www.ofdt.fr/BDD/sintes/ir_110509_nds.pdf
http://www.ofdt.fr/BDD/sintes/ir_100331_mephedrone.pdf

7.3. Prevention and treatment of drug-related infectious diseases

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

Accessibility of harm reduction structures: systems, structures and professionals involved

In order to guarantee wide access for drug users to harm reduction, the health authorities have promoted local access based primarily on pharmacies, GPs 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 scope of the systems in place.

Level of involvement and location of professionals from the pharmacy-based device

INPES has not repeated its Barometer from dispensing pharmacists. The last data available therefore date back to 2003 (Gautier *et al.* 2005). They can be inspected in the recent French national reports to the EMCDDA.

Another national survey involving community pharmacies was carried out in 2010. According to the initial results released by AFSSAPS, 48% of the retail pharmacies surveyed stated providing information on preventing infectious diseases, and 41.5% confirmed having syringe retrieval services (report to be published).

Level of professional involvement in community medicine

A new edition of the *Baromètre santé médecins généralistes*[152] survey on general practitioners took place in 2009, six years after the prior version (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 has substantially increased to reach almost 50% (compared to one-third in 2003) (Gautier 2011).

- Although the percentage of these physicians prescribing substitution treatment did not significantly change, 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 diminished (Gautier 2011). The latter differ from their colleagues in certain ways. Their profile type is as follows: a man in group practice who carries out over 20 procedures a day and for whom at least 10% of his patients have CMU[153]. The physicians who prescribe OST feel that they can easily broach the subject of drug use more frequently than other GPs. Finally, doctors participating in a network for the treatment of drug addiction, hepatitis or HIV are far more inclined than others to treat drug users (74.8% vs. 47.2%, $p<0.001$[154]). However, unlike the 2003 situation, the age of the physician seems to be unrelated to his propensity to treat

[152] Telephone survey of general practitioners. In 2009, n=2083

[153] Universal Medical Coverage: health coverage available to French people not paying into the system or to foreign nationals who do not have authorisation to be in France.

[154] Inclusion in the logistical model of participation in a drug user, HIV or hepatitis network does not change the results (OR=2.9, p<.001).

drug users. Moreover, there are now more physicians treating opioid-addicted people in municipalities of fewer than 20,000 inhabitants than in more populated municipalities.

Table 7-1: Change in involvement of general practitioners in harm reduction between 1999 and 2009

	1998/1999	2003	2009
Proportion of general practitioners seeing at least one DU (opioids) per month	35 %	34 %	49 %*
Of which:			
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 %*
Others	13.5 %	7.4 %*	14.9 %

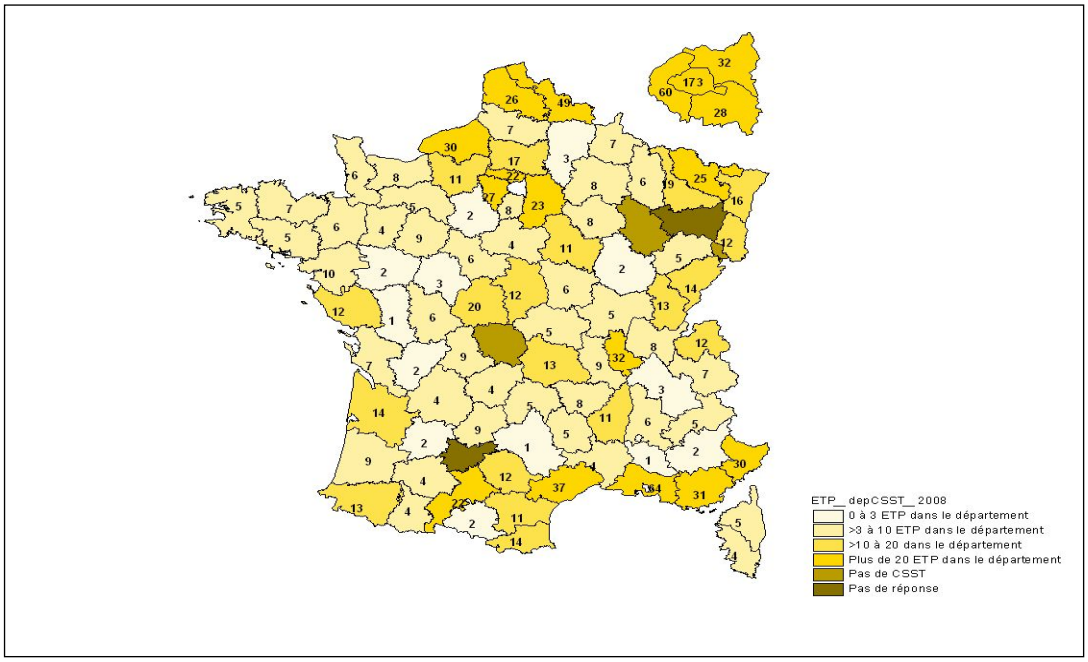
Source: INPES, Health Barometer – Physicians
(: Significant dif. P < 0.001 compared to the previous edition)*

In 2009, physicians saw an average of 1.8 [1.7-1.9] opioid-addicted drug users per month, which was not significantly different from the number they saw in 2003 (1.6). However, the physicians who saw at least one opioid-addicted patient per month saw 3.6 [3.4-3.8] per month, which was significantly lower than in 2003 (4.6).

National coverage of the harm reduction medical-social system

In 2008, the medico-social harm reduction system (CAARUD) together with the CSAPA covered most of France, although 27 (out of 100) departments did not have a CAARUD, and two of them had neither a CAARUD nor a CSAPA.

Map 7-1: Breakdown of human resources in outpatient CSAPAs in the various French regions in 2008 (former Outpatient Alcoholism Treatment Centres (CCAA) not included)



Source: Evaluation of the Government's Plan to fight drugs and drug addiction, 2008-2011

CAARUD harm reduction activities

In 2010, 135 CAARUDs existed throughout France. These are medico-social centres funded by the French social security system. They operate in various places with diverse methods. Of these, 95% offer a stationary reception service, 66% have street teams, 47% operate in squats, 40% have mobile teams, 39% work with teams on the party scene and 28% have developed prison activities. They largely contribute to distributing clean injection equipment (3.8 million syringes in 2008) and other prevention equipment (e.g., ancillary injection equipment, condoms).

The major activities undertaken by these units are: providing assistance with hygiene and first aid care, offering health education promotion activities, helping people get access to social services, following-up on administrative and legal procedures and seeking out urgent accommodation.

More specifically, the 2008 CAARUD activities pertaining to distributing prevention equipment were:

- syringes: 2.3 M single syringes and 530,000 kits (2 syringes per kit, i.e. approximately 1 M syringes) handed over personally and 200,000 kits (2 syringes, i.e. 400,00 syringes) via distribution machines managed by CAARUD (see below);
- small injection equipment: 1.1 M filters and the same number of "cookers", 1.7 M water vials, 2 M alcohol wipes

- condoms: 782,000, 91% of which were male condoms
- gel: approximately 292,000 units.

Providing assistance in gaining access to OST and general care is one of the CAARUD's primary missions:

- 83% of the CAARUDs reported that they had set up access to OST (referral or monitoring)
- of all of their activities involving access to hygiene and first aid, the most common procedures (35%) were body care, followed by nursing care (26%);
- 84.7% of CAARUDs developed health education promotion activities, 75% of which were individual interviews and group sessions focussing on the risks related to substances and to modes of contamination.

The CAARUDs saw 48,000 people in 2008. The new patient intakes per structure stands at an average of approximately 200 subjects, although in reality the figures varied greatly: 41 centres saw fewer than 200 people whereas 11 CAARUDs saw more than 1,000 [155] (Chalumeau 2010).

The role of the CSAPAs in reducing risks, which is one of their missions, cannot be quantified in the absence of data.

Actual scope of dispensing machines and operational status

The CAARUDs are not the only centres to circulate injection equipment via distribution machines. Other operators, essentially non-CAARUD-related associations and municipalities also provide drug users with prevention kits such as the Stéribox2® or Kit+[156] 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 distribute just under 10% of all syringes sold or distributed in France, i.e. approximately 1 M out of around 13 M in 2008) but also in terms of the service they provide (anonymity and around-the-clock access). Furthermore, this allows them to reach a different population from that of other programmes. There were 255 prevention kit distribution outlets and 224 syringe collection points in 2007 throughout 56 French administrative departments. Slightly over 40% of French *départements*, therefore, did not have either of these services. These outlets/collection points distributed more than a million syringes and collected more than 600,000 used syringes. In 2007/2008, individual operator share amounted to between one quarter and one third of the quantities distributed. Nevertheless, the system is vulnerable, since more than a quarter of the machines are old or in poor condition (Duplessy-Garson 2007).

[155] See chapter 4 for a description of the clients seen at least once within the reference period ("file active" in French).
[156] The kits or prevention kits are intended to limit the risks of transmitting infectious diseases amongst IDUs. These kits comprise 2 syringes, 2 alcohol buffers, 2 bottles of sterile water, 2 sterile aluminium containers (to replace the spoon), a cotton filter, a dry buffer (to dab the injection point after administration), 1 condom, instructions for use and general prevention messages.

Table 7-2: Role of the various operators in the distribution of syringes via distribution machines, 2007 - 2008

CAARUD (2008)	38 %
Non-CAARUD associations (2007)	33 %
Communities (2007)	27 %
Others (2007)	1 %
All	100 %

Source: SAFE survey, 2007 and ASA-CAARUD/OFDT, 2008

Availability of injection, smoking and snorting equipment

From the different 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 IV drug users (81,000 recent IV 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, may indicate rather high accessibility to syringes in France for IV drug users. The pharmacies play a key role and are involved in over two-thirds of the sale or distribution of syringes. However, a reliable evaluation of requirements together with an analysis of geographical disparities (accessibility of syringes in rural areas in particular) has yet to be carried out.

No estimate has been completed since 2008 when 13.8 M syringes were estimated to be distributed or sold. Some data are, however, available for 2010. Almost 2.4 M Stéribox2® kits (kits containing sterile injection equipment) were distributed in pharmacies in 2010, which corresponds to 4.7 M syringes (2 syringes per kit) based on InVS SIAMOIS data. The distribution of Stéribox2® in pharmacies has thus been stable since the early 2000s. Dispensing machines outside CAARUD distributed 1.1 M syringes in 2010 based on the data provided by the Safe Association – a figure that has increased compared to 2007.

Table 7-3: Number of syringes dispensed by pharmacies or distributed by CAARUDs and distribution machines according to the latest available data

	Number of syringes sold or distributed (millions)
Pharmacy: single syringes (2008)	4,3
Pharmacy: Stéribox® (2010)	4,7
CAARUD: single syringes handed over personally (2008)	2,3
CAARUD: Stéribox® (handed over personally) (2008)	1,0
CAARUD distribution machines (2008)	0,4
All distribution machines excluding CAARUD (2010)	1,1
Total	13,8

Source: OFDT data, InVS data, GERS, Becton Dickinson, ASA-CAARUD, SAFE

Following a significant increase up to the late 1990s, syringe sales to drug users in pharmacies have fallen markedly since (last full estimate in 2008). This significant drop is only partially offset by the increase in the distribution of injection equipment by the CAARUDs. The CAARUD centres currently only represent less than a quarter of all syringes sold or distributed to drug users.

Two hypotheses may be put forth to explain the fall in the number of syringes distributed to drug users during 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 forms of drug use instead (snorting and smoking). These alternative routes of administration are largely predominant in drug users who began taking drugs on the party scene and have also been adopted by some vulnerable users.

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

One pessimistic hypothesis would be a return to syringe sharing and reuse, observed among some drug users, particularly the most precarious ones.

In 2008, moreover, 28,500 crack pipes were also distributed by the CAARUDs. Eighty percent of these were from centres in the Paris region and in Guiana.

Finally, 197,000 sniffing equipment items (rolling papers or snort kits) were also distributed, mostly by the CAARUDs working on the party scene (Chalumeau 2010).

Harm reduction on the party scene

Nearly 4 out of every 10 CAARUDs have a team that works on the party scene. Other associations carrying out harm reduction activities are not included in the medical-social system. These are mainly certain humanitarian, community health or specialised associations which are not CAARUD-certified. Many of these non-certified associations, whose activities are not counted, work mostly in harm reduction on the party scene.

There is no information available to compare the care offered and the needs of users on the party scene. Qualitatively, since the publication of the decree of 2002[157], which describes the means by which parties are organised, the TREND system has observed the fragmenting of the non-commercial party scene into many small, undeclared free parties which take place without advertising in premises announced at the last moment to circles of people “in the know”. These parties are becoming increasingly inaccessible to harm reduction associations which cannot be present everywhere.

The intervention methods on the party scene depend primarily on the type of event organised and on the ability of the social workers to attend them and organise their intervention (Table 7-4) (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. This essentially comprises the promotion and distribution of information material (leaflets on the risks associated with drug use and their prevention) and/or harm reduction tools such as syringes and straws, etc. For public parties, apart from information and preventive equipment, food and drink are also supplied. In addition, areas are set aside where social workers can hold consultations, give

[157] 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 (NOR INTD0200114D).

counselling, provide reassurance and carry out first aid procedures. When used, on-site substance testing is one way for workers to make contact with drug users.

Table 7-4: 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 (without prefect permission)	Downloadable flyers for participants and organisers and the possibility of ordering HR materials If there is knowledge of such a party: information leaflets and materials ("flyers")	Tekno music regulars, socially integrated people
"Legal" free party: "multi-sound" party event with more than 500 people (2 days)	Stand or "chill out"	Large proportion of Techno scene newcomers (most at risk).
Teknival: party event with more than 50,000 people (several days)	Creation of one or more "HR" 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 and equipment leaflets) or stand for prevention activities	Generally mixed audience, poor hygiene conditions
Town parades, festivals, etc.	"Flyers" (information and equipment leaflets), mobile "stand" or " chill out" area	Many very young people

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

Harm reduction awareness

TREND reveals that groups of users who make little or no use of urban CAARUD services have little awareness of HR measures. This particularly involves errant young people as well as "socially integrated" users who are beginning to inject, young people from working class neighbourhoods and younger users on the party scene (Cadet-Taïrou *et al.* 2010b).

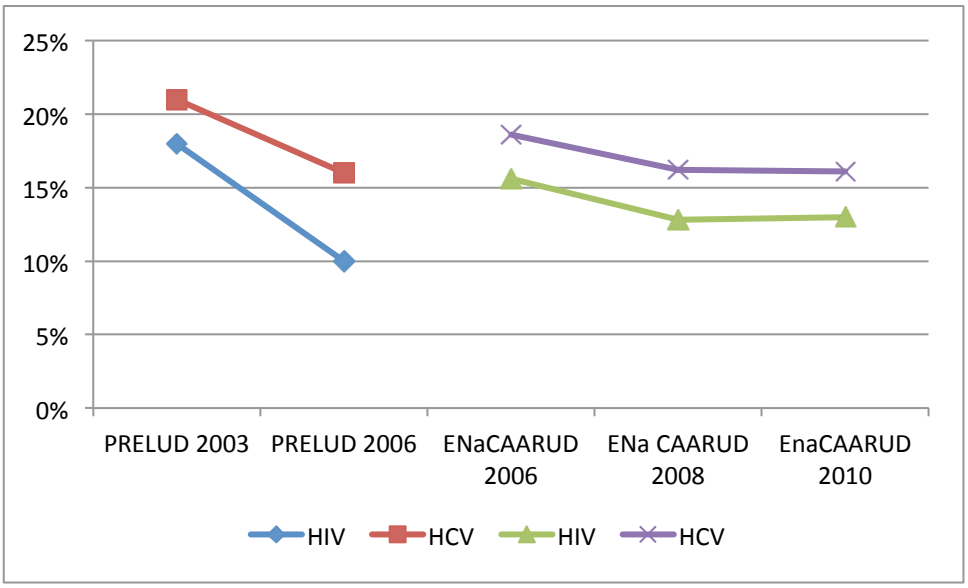
Activity and screening rates for drug users in France

In 2008, of the approximately 55,600 drug users seen at least once, the CAARUDs organised almost 32,000 hepatitis B or C and HIV infection screening tests (HCV: 12,200, HIV: 11,000, HBV 8,800). There were 1,300 interventions to provide access to hepatitis B vaccination in this framework.

Screening rates for drug users in France

The ENa-CAARUD study showed that the vast majority of drug users frequenting low threshold centres in 2010 had already been screened for HIV and HCV infection (see chapter 6.2). Only 8.9% of those who had already injected at least once during their life had never had a hepatitis C screening test, compared to 7.7% for HIV (Cadet-Taïrou *et al.* 2010b).

Graph 7-1: Proportion of CAARUD users who have never had a screening test for HIV and HCV



Sources: Frontline 2003, PRELUD 2006 / TREND OFDT, ENa-CAARUD 2006, 2008 and 2010 /OFDT, DGS

The proportion of CAARUD users who have never had a screening test has regressed and currently appears to be stagnating.

As high risk behaviour continues, however, the screening tests rapidly become obsolete: in more than half of the people who had a negative result, the result was at least 6 months old (Table 7-5). This proportion has regressed slightly compared to 2008 but the difference is only statistically significant for HIV (59.0% to 55.3%).

Table 7-5: HIV and HCV infection screening practices in users attending CAARUDs, ENa-CAARUD 2010

	HIV		HCV	
	Numbers treated	%	Numbers treated	%
Had had the test	2 156	87.0%	2 059	83.9%
Had not had the test	322	13.0%	295	16.1%
Of those with a negative response*, date of last test				
Less than 6 months ago	815	44.7%	598	44.8%
6 months to one year ago	434	23.8%	340	25.5%
More than one year ago	575	31.5%	397	29.7%

** Stated results*
Source: ENa-CAARUD 2010, OFDT, DGS

The proportion of positive users aware of their serological status appeared to be the best indicator of the screening outcome, although this requires measurement of laboratory serological status, which France struggles to do regularly.

In 2004, the Coquelicot study conducted in 5 French towns estimated that 2% of the HIV positive users were not aware of their current serological status. The bio-PRELUD study conducted in 2006 on 5 sites estimated this figure to be 5% (Cadet-Taïrou *et al.* 2008; Jauffret-Roustide *et al.* 2006). For the Hepatitis C virus, these levels increased to 27% in the Coquelicot study (2004) and to 8.5% in the BioPRELUD study (2006), respectively. The difference can be explained, firstly, by the significant difference between the sites. Next, Coquelicot measured blood serology and BioPRELUD saliva serology. Furthermore, in the second case, only patients whose viremia was detectable were positive; cured patients were therefore no longer positive. Third and finally, two years passed between these two studies (see also chapter 6.2). In 2006 (PRELUD), 36% of CAARUD users 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 treats a portion of patients carrying the hepatitis C virus, made it possible to monitor the proportion of late screening tests in newly treated patients (Brouard *et al.* 2009). In this case, a late 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% ($p< 0.01$) in the total patient group (regardless of the source of the infection). The proportion of intravenous DUs in these late-tested patients did not change significantly (39.6% in 2001 compared to 35.5% in 2007 in men and 15.9% compared to 12.7% in women) and it can be concluded that late testing is falling in DUs in the same way as the group average. The same applies to late testing in DUs who exclusively snort.

The number of users who personally reported hepatitis B was assessed in 2010 in the ENa-CAARUD study. Only 16.3% of users confirmed having received the 3 vaccinations needed to be fully vaccinated; 17.2% said they had only received one or two. Furthermore, 16.5% of users believed they had been vaccinated but could not state the number of injections received. 5.3% declared that they were or had previously been infected. Almost one quarter (23.3%) of users think that they have never been infected or vaccinated. The remaining 31.4 % of persons do not know their situation regarding hepatitis B. Overall, only just over one in five CAARUD users has already been immunised (Cadet-Taïrou 2012).

Access to treatment

Data obtained in 2010 from CAARUD users show that the majority of users aware of being infected by HIV [158] are followed up medically, since 91.8% had at least one medical consultation for their infection during the year. Only 74.6 % were prescribed treatment for the infection. No statistically significant changes can be seen given the low cohort involved.

In 2008[159], the same survey showed that two-thirds (70.5%) of people interviewed who said that they had tested positive for hepatitis C had had at least one consultation for their infection in the 12 months before the survey. Slightly over one quarter (28%) were or had been prescribed treatment for this infection. This result appears to have increased from the previous 2006 survey, since only 22.5% of CAARUD users who were HCV positive reported that they had received treatment (*p=0.02*).

[158] N = 122

[159] The level of response to this question was very low for 2010 (around 20% for seropositive users). Therefore, the result cannot be used.

7.4. Responses to other health correlates among drug users

In the absence of a specific response to other health problems, access to care is the only factor that can be observed.

Among the drug users seen at the CAARUD centres in 2008, only 4.6% had no medical cover. More than half (54.8%) were covered by social funding (Universal Medical Coverage, State Medical Assistance) and 6.3% had all their costs paid because of a “long-term” illness (Cadet-Taïrou *et al.* 2010b).

Provision of care and access to care both represented the second leading activity of the CAARUDs in 2008 after social-integration activities.

8. Social correlates and social reintegration

8.1. Introduction

The lives of drug users are often characterised by difficulties in terms of social integration both professionally and personally. All these problems (unemployment, housing problems, social isolation, etc.) can be grouped together under the term “social harm”. They are often analysed as being the consequence of taking psychoactive substances. The relationship between these two terms is, however, far from one-sided with social difficulties creating a situation conducive for the development and continuation of drug use. It is also important to restrain a caricatural vision, linking any drug use to social exclusion.

Social integration problems for drug users will be described on the basis of the results of surveys carried out amongst drug users visiting National Treatment and Prevention Centres for Substance Abuse (CSAPA) and harm reduction centres (CAARUD).

In order to deal with problems of poverty and social exclusion, the French public authorities are introducing a large number of social policies focusing primarily on health issues, employment, training and housing, which cannot be discussed in detail in this report. Drug users can benefit from these policies in the same way as non-drug-users in France.

Some aspects of the social policies mainly concern drug users in that a large proportion of the latter face social exclusion. Reference should be made here to the introduction of the *Revenu minimum d’insertion* (RMI, Minimum Benefit Income paid to those with no other source of income) in 1988, which entitles anyone to receive a minimum level of resources in addition to protection in the event of illness. The RMI has been replaced by the RSA since 1 June 2009[160]. In 2011, 2.02 million people were receiving RSA. Overall, 4.30 million people are covered by this benefit, which integrates the families of recipients[161].

In 2000, France also introduced basic CMU, which applies to numerous drug users. The CMU provides access to medical insurance for all persons living in a stable and legal manner in France for more than three months, who are not entitled to medical insurance by other means (through their professional activity, etc.). The beneficiaries of the CMU are exempt from the patient's contribution towards costs and are not required to pay any fees in advance. As an additional supplement, the CMUC (supplementary medical insurance) has also been introduced, which guarantees an entitlement to supplementary health cover free of charge (mutual fund, private insurance or welfare fund). Beneficiaries therefore have the option to consult a doctor (hospital or general practitioner) free of charge and without having to pay in advance. Finally, the AME (State Medical Assistance), introduced at the same time, seeks to provide access to treatment for foreigners living in France on a continuous basis for more than three months but whose papers are not in order (lacking a residence permit or a receipt to prove that a permit has been requested).

160 The *Revenu de solidarité active* (Active Solidarity Benefit) guarantees an increase in revenue and tops up the existing resources of those whose earnings are limited. The payment of the RSA is not subject to any time limit: the person may continue to receive the same sum as long as his or her situation does not change. Loi n° 2008-1249 du 1er décembre 2008 généralisant le revenu de solidarité active et réformant les politiques d'insertion (NOR PRMX0818589L).

161 http://www.rsa-revenu-de-solidarite-active.com/actualite-rsa/126-beneficiaires-rsa-juin-2011.html

Thus, in theory, drug users can benefit from numerous programmes introduced for all French people. In practice, the most serious exclusion situations in which some drug users find themselves are often accompanied by an inability to assert their rights, with procedures becoming too complex for non-integrated persons. Thus, one of the main activities of the CSAPAs and CAARUDs is to help these people regain their rights. More generally, they issue information and handle social assessments, providing guidance to the persons concerned or their families in addition to social and educational assistance which includes access to social entitlements and help with integration and reintegration. Although special intervention programmes are developed by these professionals, access to the general system remains a central theme and the main means for improving people's social situations.

In terms of public policies specifically implemented for drug users, as part of the 2008 – 2011 government plan, the MILDT listed the improvements to the social integration and reintegration for persons with an addiction amongst its priority areas for action. This strategy has been organised around the following 6 themes:

- drafting social reintegration indicators;
- introducing a "best practices guide" to improve cooperation between professionals in the addiction field and those working with other vulnerable sectors of the population;
- extending the "medical micro-structure" model;
- experimenting with new social assistance solutions for drug users treated via private practice physicians;
- encouraging the supervision of drug users after they leave prison within the scope of the residential reintegration schemes (AHIs);
- developing partnerships between medical/social centres specialising in addictions and the residential reintegration and reception schemes.
- No evaluation can be carried out as yet.

8.2. Social exclusion and drug use

The social situation of problem drug users in France is mainly reported through the specialised addiction care systems: the outpatient and residential specialised treatments centres (CSAPA) and the “low threshold” centres (CAARUD).

Every year, the OFDT TREND system provides information on changes in substance use, the type of substances in circulation, the method of use, the populations concerned and the contexts. The social situations of users can be broached within this framework, which also sheds light on specific populations (street youths, migrants and women, etc.).

8.2.1. Social exclusion among drug users

The users of treatment centres

Table 8-1 summarises the social situation of persons seen at specialised treatment centres in 2010 and 2011. It illustrates the significant number of people receiving treatment who find themselves in precarious situations in terms of housing, professional and financial status or level of training. A distinction was made when describing persons treated for cannabis on the one hand, and those using "opiates, cocaine and other drugs" on the other hand, given the marked difference in the characteristics of these two subgroups (especially in terms of age and substances used).

Table 8-1: Social instability of people treated in specialised centres in 2010 and 2011

	2010		2011	
	Users of "opiates, cocaine and other drugs"	Cannabis users	Users of "opiates, cocaine and other drugs"	Cannabis users
Gender				
M	77.8 %	88.1 %	77.3 %	87.3 %
F	22.2 %	11.9 %	22.7 %	12.2 %
Mean age	35.9 years	25.9 years	37.1 years	25.7 years
Unstable housing [162]	19.6 %	13.3 %	19.0 %	12.9 %
No fixed abode	6.3 %	2.1 %	5.9 %	1.5 %
Unstable occupational status [163]	64.6 %	50.2 %	62.8 %	48.6 %
Unstable financial resources [164]	41.8 %	24.9 %	40.7 %	24.9 %
Educational level below senior high school/upper secondary schooling [165]	22.7 %	23 %	22.7 %	23 %

Source: RECAP/OFDT, 2009, RECAP/OFDT, 2010
Interpretation: The average age of users of "other drugs" was 35.9 in 2010 compared with 25.9 years for cannabis users.

The group of people using "opiates, cocaine and other drugs" has become less precarious since 2005. 25.0% had unstable housing, 7.5 % were homeless, 69.0% had an unstable occupational status and 43.7 % had an unstable financial status. This decrease could be only apparent as, over the same period, the average age of users has increased along with the number of users monitored for alcohol problems. Both these factors are linked to less unstable situations. Cannabis users are witnessing a more or less stable situation.

162 Temporary or institutional residence and prisoners
163 Intermittent, paid activities, unemployed persons and other non-workers
164 Unemployment benefits and social welfare payments (RMI, AHH, etc.) and other funds (including without income). The 2009 data also included funds from third parties. They have been excluded because, as regards younger people, these are mostly persons who are not yet financially independent and who rely on their parents. The 2009 data is 24.1% based on the definition used in this context.
165 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 qualification status for workers, although it does not take account of improvements in said qualification status through continuing education and occupational experience During the first four years after leaving initial education, a worker without a diploma or with only a BEP (roughly equivalent to the British GCSE) was more than two times more likely to be unemployed in 2008 than a worker with an upper secondary schooling diploma.

CAARUD's clients

Drug users seen by the low threshold centres (CAARUD) are even more vulnerable. These people are usually not involved in an active care process or have withdrawn from the care system. Being seen without condition is the keystone of the work of these centres: guaranteeing anonymity and free provision of care. In addition, beyond their mission of receiving patients (almost always as outpatients; only 4 CAARUDs in France offer lodging), the CAARUDs are developing a number of "services", to reach out to the most marginalised drug user populations and those furthest away from the health and social services: street work, work in squats, mobile units, interventions on the party scene, etc.

A socio-economic vulnerability variable has been calculated to measure the level of precariousness of those concerned[166]. This model has been used to categorise individuals according to their degree of instability: minimal, moderate or high. This classification has been adapted in line with the description of the population visiting CAARUDs, who are in extremely precarious situations compared to the general population.

Almost three-quarters of CAARUD users lived in a situation of moderate to high precariousness (74.3%) in 2010. Although this figure remains high, it nevertheless seems lower than that recorded in 2008 when 8 out of 10 users found themselves in the same situation (79.9%) (Table 8.2). In fact, the reduction in the instability of the users interviewed – when qualitative data indicate the opposite – pose a problem and cast doubt over all the changes observed. The 10-point drop in the response rate could provide one explanation. CAARUD staff could have been biased in their choice of users to be interviewed due to a lack of time. The lack of time spent by staff is, in fact, the main reason for non-response (42 %) before the user's refusal to take part. The indicators highlighting user instability generally follow this trend even if all the deviations are far from being statistically significant (Cadet-Taïrou 2012).

Table 8-2: Unstable situation of CAARUD users in 2008 and 2010

	2008	2010
Minimally unstable	20.0%	25.7%
Moderately unstable	47.3%	46.5%
Highly unstable	32.6%	27.8%

Source: ENa-CAARUD 2008/OFDT, DGS, ENa-CAARUD 2010/OFDT, DGS
Interpretation: 32.6% of users presented with high instability in 2008 versus 27.8% in 2010.

The under 25 year-olds have a greater "higher instability" rate than their elders: 42.8% versus 29.5% among the 25-34 year-olds and 23.1% among the over 35 year-olds. In mainland France, the Paris region (Île de France) also stands out with its greater level of higher instability compared to the rest of France (37.3% compared to 23.9%) despite having a low proportion of young users.

166 This classification is based on calculating a score obtained from responses to the following three variables recoded in three categories as follows: a) Health cover: 1- affiliated to a social security scheme with supplementary cover, 2- affiliated to the social security scheme with or without CMU (Universal Medical Coverage), 3- no affiliation with or without AME (State Medical Assistance) ; b) Housing: 1- long-term (independent or long-term with relatives), 2- in an institution or lodging temporarily with relatives, 3- NFA (No Fixed Abode) or squatting; c) Origin of funding: 1- employment income and Assedic, 2- social welfare payments or funds from third parties, 3- other funds (illegal or unofficial) and with no income.

The vast majority of users treated in the CAARUD centres in 2010 had social security cover (85.3%). This situation confirms the fact that the French healthcare system has a strong foothold even in the most vulnerable strata of society. More than half of CAARUD users are affiliated to a general social security scheme via the CMU (53.9% in 2010). Almost one in six benefit from a cover for a long duration disease (ALD) (14.0%) and just over a quarter of users have supplementary cover (25.9%, i.e. in both cases, a two-fold increase since 2008). (Table 8-3)

Table 8-3: Social protection of CAARUD users

	2008	2010
	N=3 115	N=2480
Affiliated to Social security	87.8 %	85.3 %
With supplementary cover	14.4 %	25.9 %
With CMU	50.2 %	53.9 %
With ALD	6.3 %	14.0 %
Non-affiliated	7.5 %	10.8 %
Without AME (State Medical Assistance)	4.6 %	n.av.
With AME	2.9 %	n.av.
Other or does not know	4.8 %	3.9 %
All	100 %	100 %

Source: ENa-CAARUD 2008 and 2010/OFDT, DGS
Interpretation: Among the users seen in the CAARUDs in 2008, 87.8% were affiliated to a social security scheme and 50.2% of all CAARUD users had CMU.

There were fewer users with no official income or social income benefits compared to 2008 figures (22.0% versus 25.6%). The older users received more social welfare payments than the young users: 17.5% for the under 25 year-olds compared to 57.5% between 25 and 34 years old, and 65.2% over 35 years old. In fact, the under 25 year-olds are far more likely to be without any official income (58.3% versus 19.5% for the 25-34 year-olds and 14.3% for the over 35 year-olds).

Table 8-4: Origin of income for CAARUD users in 2008 and 2010

	2008 N=3 082	2010 N=2461
Work-related income	17.8%	22.0%
Employment income (including retirement/disability pensions)	13.4%	13.6%
Unemployment benefit	8.4%	9.5%
Welfare / From a third party	52.8%	56.1%
RMI (minimum income) / RSA (active solidarity benefit)	35.2%	40.7%
Adult disability allowance	13.9%	16.6%
Other social welfare payments	2.6%	1.5%
Funds from a third party	1.1%	1.7%
Other funds (illegal or not official)	25.4%	22.0%
Other funds (including illegal or not official*)	5.4%	8.2%
No income (including begging)	20.0%	17.5%
All	100 %	109.3 %/ 100 %

** Prostitution, dealing, theft and undeclared work, etc. are included in this category.*
Source: ENa-CAARUD 2008/OFDT, DGS, ENa-CAARUD 2010/OFDT, DGS
Note: In 2010, the total number of methods within each category was greater than the weight of this category because two methods were accepted. This was not the case in 2008. Conversely, the total percentage of the three main categories was equal to 100 %; individuals belonging to two categories were selectively classed in the less fragile category.

8.2.2. Drug use among socially excluded groups

New user "groups" living in extremely vulnerable conditions have emerged in recent years. These are "young wanderers" and young men from Eastern Block countries that started to use drugs before immigrating to France. In addition, the presence of under 25 year-old women at the low threshold centres has led drug workers to intervene even more massively because of their extreme practices and persistent high risk drug use (Rahis *et al.* 2010).

The "young wanderers" (younger individuals marginalised by extreme social and health difficulties) are polydrug users who not only use opiates but also inject. Nevertheless, in an attempt to move away from the typical image of problem drug users, their use of the "low threshold" system appears to be more occasional and directed more towards meeting their immediate needs than requests for care. Their precarious lifestyle and "resourcefulness" gives them an illusion of paradoxical, alternative integration.

The "**new migrants**" are mainly from Central and Eastern Europe, Asia, mostly China, and the African Continent (North Africa and Sub-Saharan Africa) (Rahis *et al.* 2010). Whilst Paris brings together a very wide range of origins, other parts of France see mostly immigrants from former Soviet block countries (Russia, Bulgaria, Georgia, Ukraine, Belarus, Romania, Moldavia and countries making up the 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 injectors who also have high levels of medical drug use (particularly HDB). CAARUD workers are striving to make these populations aware of the risk of viral transmission (HIV and hepatitis) as a result of their living conditions and the disapproval of injection within the groups to which they belong. Major tensions are reported between these groups and the other more "historical" beneficiaries of the low threshold facilities.

8.3. Social reintegration

Social support for drug users on treatment is provided, to a very large extent, by the specialist CSAPA and CAARUD services in France, through specific projects and programmes developed by these medical-social structures, acting as relays to the systems provided under common law.

Through its 2008-2011 national plan, the MILDT has included the improvement of social integration and reintegration for persons with an addiction amongst its top priorities (MILDT (Mission interministérielle de lutte contre la drogue et la toxicomanie) 2008). This strategy is structured around 2 main objectives:

Objective 1: Give priority to the accommodation of persons in difficulty with their consumption of alcohol or illegal drugs within the integration accommodation reception system on their release from prison:

- by setting up CSAPA advanced consultations in these structures and cross-discipline training;
- by writing a multi-disciplinary reference document in preparation for reintegration of prisoners with addictions;
- by creating short and quickly accessed reception programs offering care, social integration activities and accommodation.

Objective 2: To forge partnerships between medical-social structures (CAARUD and CSAPA) and the integration accommodation reception system; to test the implementation of consultations provided by medical-social professionals in twenty or so accommodation and cross-discipline training structures between the centres in the two areas concerned.

In terms of inter-institutional national partnerships, a working framework agreement was signed between the MILDT and the DGCS (General Directorate for Social Cohesion) in order to improve the link between the government action plan and social integration.

Through their annual activity reports, the specialist CAARUD structures report the actions implemented (number and nature). Reintegration measures (access to rights, housing and training-employment) are described, although they only represent a small part of their total activity, which is primarily centred on first line reception (“refuge” services, food, basic hygiene, etc.), harm reduction and care (Chalumeau 2010).

Apart from the CAARUD activity reports, there are no tools available to precisely trace the programs followed in the different pathways of social integration for people on treatment. The centre activity reports give very little or no details about either the needs or actions-programmes undertaken. Work is currently ongoing to define and apply relevant indicators.

Hence, the information given in the following three paragraphs (on accommodation, education and employment) only provides a limited view of the national situation (RECAP, 2010). This information is essentially the result of observations made by a group of experts (see structured questionnaire 28 – year 2009).

8.3.1. Housing

In 2010, almost 20% of users received in CSAPAs did not have any independent, long-term housing, with family or in an institution. Among these, users of “other opiates, cocaine and other drugs” were more numerous than cannabis users (24.4% versus 14%).

The question of housing remains one of the social integration priorities, particularly in large towns, and desperately so in the Paris region.

The main options available are: **social housing, emergency social housing and residential treatment**.

Social housing in France essentially comprises HLM housing (Low-rent Social Housing): 10 million people currently live in the 4.2 million homes managed by HLM administration centres, whose mission is to provide accommodation under optimal conditions for all those who cannot afford the rents proposed on the market. However, for several years now, the housing offer has been far short of demand. Whilst addicts on treatment are not subject to any demonstrable discrimination in terms of allocation procedures, they too suffer the effects of this shortage, unless they fulfil certain conditions giving them priority status. In mainland France in 2006, 1.2 million requests for HLM housing were not satisfied, 550,000 of which were from households which were already HLM tenants.

Some centres (particularly the CSAPA) are developing services facilitating access to individual accommodation, for example:

- "Sliding" tenancies ("baux glissants" in French): initially, the centre takes on the rental of the housing which belongs to private or public owners in order to sub-tenant legally. It signs the inventory of fixtures and lease and pays the rent to the owner. The housing allocation is directly paid to the centre and the remaining rent (rent minus housing allocation) is paid for by the sub-tenant. After a “probationary period” which may range from six months to a year, the tenancy “slides” and the sub-tenant then becomes the official tenant of the premises.

- “Educational” tenancy support: helping the tenant to optimise budget management and complete administrative tasks such as paying his bills, purchasing furniture, etc.

There are no data on the frequency or volume of these programmes.

Emergency social housing is a solution used by the specialist structures. This involves unconditional reception, i.e. with no selection of clientele. Accommodation is short term. The main structures and facilities which provide emergency social housing are:

- The CHRS (Social Housing Centre): 360 CHRS in France report handling an emergency department;

- hostel overnight stays;

- night accommodation centres, sometimes in dormitories, and sometimes more individual;

- centres which operate throughout the day and offer accommodation for sometimes very short periods of time (a few nights), sometimes similar to the CHRS (usually in the region of 6 months, renewable);

- emergency accommodation centres (known as "Sleep-in" and now CAARUD) intended solely for drug users. Three towns/cities in mainland France have this type of structure (Paris, Lille and Marseilles) as well as Cayenne.

Apart from these latter centres, the emergency accommodation centres favour reception of "stabilised" people who do not present any behavioural disorders. This may exclude a number of people on treatment. Residents in all these centres are asked to comply with the various in-house rules (no alcohol or drugs, no physical or verbal abuse, etc.).

Temporary housing or integration housing selects its residents and develops an integration project, while providing longer-term reception. A team of professionals is present continuously. The main structures which exist are:

- The social housing centres, CHRS (there are 827 of these): the aim of the CHRS is to enable the people it receives to become personally and socially independent. They provide accommodation, reception services, particularly in emergency situations, help and social support and aid in adaptation to working life and social and occupational reintegration. The population which may be accommodated in the CHRS is wide, and includes people or families in serious financial, family, health or integration difficulties, particularly because of a lack of housing or poor housing conditions. The "categories of people admitted" may differ from one centre to the next.

- Half-way houses: these are small social residences, each with ten to twenty-five lodgings, intended to receive extremely marginalised people. They offer them independent housing without length-of-stay conditions, common areas and increased assistance with everyday life (health, hygiene, food). Their aim is to fully integrate these structures into the local environment.

- Social residences: these offer a temporary furnished housing solution to households with limited income or those with difficulties in accessing ordinary housing for financial or social reasons, and who may require social support.

Despite the major efforts made by the specialist structures and these social "generalist" housing centres to offer solutions to people on treatment, the various players in the field have reported significant access difficulties. In an attempt to remedy the situation, the 2008-2011 Government Drug Action Plan promoted partnerships and joint working between the specialist addiction sector and the social housing sector: a call for projects was launched to promote these exchanges and 30 projects were selected and will be funded.

Finally, several specialist **"residential treatment"** centres, dedicated specifically to people on treatment, are available in France. All these residential centres are administered by specialist medical-social structures (CSAPA):

- The post-treatment alcohol addiction centre or centre for care, follow-on support and rehabilitation in alcohol addiction receive people dependent on alcohol after detoxification, who show a need to consolidate their abstinence in a protected

environment. Length of stay varies from 1 to 3 months and exits and visits are controlled.

- The Community Treatment Centre (CTC), also called the therapeutic community, is a care centre with community accommodation. The treatment community is similar to a structured, hierarchical, organised family unit. Each resident belongs to a group, with a group leader. Each group is responsible for different tasks such as cleaning, cooking, gardening and household maintenance. The community treatment centres can accommodate up to 50 people.

- The residential treatment centre (CTR), also called the post-treatment centre, is a care centre with community housing which accepts all drug addicts undergoing a voluntary care process. The CTR can accept up to 20 people. Initial length of stay is approximately 6 months, renewable. Some have long waiting times.

- Follow-on treatment apartments (ATR): individual or community apartments made available to former drug users who have begun a treatment process. The absence of permanent staff limits 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 the dependent or formerly dependent person who is between two periods of care or in a "transition period": before withdrawal, during stabilisation of withdrawal or substitution treatment, waiting for post-treatment admission or stable housing. This period can be adjusted according to the 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.

- The foster family network is a group of families trained and organised by professionals, who volunteer to take in a person on treatment for a period of time. The foster families offer the drug addict a personalised relationship in a family environment, and are paid depending on the actual time a person spends with them.

Despite this range of residential treatment schemes, the overall service offer is still inadequate.

8.3.2. Education and training

In 2010, almost 23% of people on treatment had not successfully completed secondary level education, i.e. they had no general education or occupational training[167].

People undergoing treatment do not have any specific programmes or schemes for training or refresher courses. Like the general population, and particularly those looking for work, they can however rely on the public and private occupational training organisations.

An identical situation exists for vocational skills training. The relevant measures are incorporated in the employment policy: the main operator is the National Agency for Employment (Pôle emploi), whose mandate includes training advice, guidance and funding. There is no dedicated, specific training for vulnerable people, although three priority public targets have been identified:

167 OFDT RECAP information system, 2010.

people who have been unemployed for a long time, young people and immigrants (particularly women). The VAE (Validation of acquired experience) and classical vocational skills training are the two main measures used.

8.3.3. Employment

Almost 23% of people on treatment in 2010 were unemployed, i.e. twice as many as in the active French population. The proportion of "opiate, cocaine and other drug" users is considerably greater than that of cannabis users (26.3% versus 19.8%)[168].

There are no particular administrative barriers in France to access to employment on the "open job market" for people on treatment (such as screening or discriminatory medical situations), although it may be assumed that employers are reluctant to employ such people. The high unemployment rates seen are undoubtedly due to lower levels of training, often chaotic careers and a very tight job market.

In France, there is also an "intermediary job market" which is very well structured and recognised by Labour Regulations (art. L 5121-1); it is covered by the term "integration through economic activity (IAE)". Since 1977, "assisted contracts" also exist (reducing the wage bill for the employer), intended for the most vulnerable people.

With effect from January 2010, these various assisted contracts are grouped together within a single integration contract (CUI) for the commercial sector and a professionalization contract for the non-commercial sector.

The IAE system consists of various organisations dedicated to integration through economic activity (SIAE). These organisations are employers which must be accredited by the State. They sign agreements which define the conditions under which their activities take place, the assistance given to them and result objectives. The four main SIAE are:

- intermediary associations (AI);
- temporary integration work companies (ETTI);
- integration workshops and ateliers (ACI);
- integration companies (EI).

253,000 people were estimated to be employed by the various SIAE in 2006 (61,000 full time equivalents), but such job offers remain well below demand and "selection" occurs naturally top down; those encountering the greatest difficulties are, in fact, generally excluded from the schemes because of this.

Nevertheless, some specialist structures have developed their own occupational integration scheme or promote reorientation pathways and co-operation, in light of the difficulties encountered in assisting their beneficiaries with finding a job (Maguet *et al.* 2009).

Occupational activities should be considered as separate from integration/back-to-work activities, although they do offer a "foretaste" of the work environment. The "Espace association"

[168] OFDT RECAP information system, 2010.

(CAARUD) has set up a low-requirement-threshold workshop in which the persons received recover books, register them in a computerised database, package them, and distribute them to partner associations which run educational or humanitarian projects. This organisation has also created an in-house post entitled "social integration manager", whose role consists in establishing a network of companies across his/her area of intervention, and facilitating contacts between candidates and potential employers, reassuring both parties with regard to their mutual concerns. This person's extensive knowledge of both the companies and people received in the centre enables him to adapt employment offers to the expectations and skills of the latter.

The "Drogues et société" (Drugs and Society) CSAPA invites patients from the care centre to take part in creative arts workshops in order to increase their sense of social utility: their creations can subsequently be used to illustrate information and prevention documents produced by the centre. This organisation also offers "reinvigoration" workshops ("ateliers de redynamisation").

The Fleuve (Gironde) treatment community has an integration workshop and atelier (ACI). Residents are supported by a social-occupational worker and can join the integration workshop as part of a personal integration project for a period of six months.

The ALIA CSAPA (City of Angers) has set up integration assistance workshops in which work is described as a "treatment tool". The work environment includes elements specific to working life: commuting, biological and work cycle times, compliance with instructions, income management, etc. These workshops (with multidisciplinary workers) offer a chance of immersion in the working life and specific support for adults with an addiction problem.

Partnerships have been established between care centres and *régies de quartier* (integration companies). An essential pre-requisite for these partnerships to operate successfully is dialogue between the professionals from these two types of organisations, in order to better understand each other and discuss the specific features of drug addicts. These integration companies are not, in fact, trained or prepared to receive this type of population.

National organisations, such as the Aurore association, are developing in-house partnerships to promote access by people undergoing treatment (care centre) to the "integration through economic activity" services (integration ateliers and companies).

This list of low threshold structures can be extended by adding other associations that promote the professional reintegration of drug users:

- The Association Parcours helps drug users to start their socio-professional integration project. The aim is to prevent the risk of relapse amongst users by directing them towards organisations/centres that can provide them with more appropriate solutions. For example, short-term assignments or part-time work noting that major organisations such as the Pôle Emploi (the French employment agency) stipulate requirements that may lead users to drop out.

- The FIRST Association, which manages a CAARUD at Aulnay-sous-Bois. Its aim is to link drug users with an activity that will allow them to benefit from additional funds. These are activities that do not require any qualification (cleaning Stéribox tokens, preparation of harm reduction kits, enveloping letters / newspapers, etc.). The users are remunerated in two ways: on the basis of the number of hours worked (minimum wage) or per item (number of kits packed). The aim is to familiarise the user, who is

often extremely vulnerable, with an activity in order to bridge the gap between total inactivity and a return to work.

- The Association Ligne de vie (Life Line Association) created in 2004 whose members are former drug addicts or drug users whose habit has been stabilised by substitution treatment. The aim is to offer the user a job combined with medical-social monitoring. Ligne de Vie passed the 400 reintegrated persons mark in July 2011.

- The recommendations put forward in the document, “Social integration and jobs for drug users” explore several avenues to promote the link between health management and occupational integration of users (Calderon *et al.* 2011). The recommendation is to opt for flexible partnerships between low threshold structures and integration associations based on the principle of permanent availability of integration managers.

- The involvement of other areas outside the medical and social domains is encouraged.

- A collective approach has been adapted in harm reduction centres so that users can discuss their problems and expectations with each other and with administrative staff.

- A further recommendation focuses on helping users to formalise their expectations within a framework of mutual aid and self-support, thus ensuring that they are involved in their treatment and integration strategy.

- The recommendations advocate analysing professional practices in order to manage relations between the user and social or medical staff more effectively.

- The aspect of training welcoming teams in the low threshold structures and in the integration fields is a new avenue to be explored. To promote better collaboration between these two areas, which are often separated, workers must be trained in the problems of integrating drug users with both medical-social and integration issues.

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

9.1. Introduction

Definitions

According to current legislation relating to the use of narcotics in France, any person consuming and/or possessing these substances is liable to a punishment ranging up to prison penalties. Ever since the law relating to the prevention of delinquency dated 5 March 2007, persons arrested for possessing and using narcotics may be sentenced to a drug awareness training course. Inspired by road safety awareness compulsory courses, this monetary punishment (to be paid for by the offender), with an educational goal, is aimed at occasional, not addicted users of narcotics in an attempt to dissuade them from reverting to drug use by making them aware of the consequences of their habit. Simple drug users may therefore face arrest and sentencing, with the possibility of imprisonment, particularly in the case of a related offence (see the description of the legal framework in chapter 1).

For offences judged to be less serious, the Public Prosecution may decide to impose alternatives to prosecution instead of criminal proceedings before a court. This alternative approach to criminal proceedings may take several forms such as a warning, a drug treatment referral order, conditional discharge with a social or treatment referral, a settlement, a compensation measure or penal mediation. Unless an alternative approach is selected, court proceedings are reinstated.

The range of penal responses to drug use also includes alternatives to imprisonment: community service (CS), court-ordered supervision in the community (possibly including a drug treatment order), home detention with electronic monitoring and probation.

In January 2011, France had 189 penal establishments with a total capacity of 56,358 prison places (i.e., useable operational capacity) divided between:

- 101 remand centres and 39 remand wings (situated in penal institutions) holding pre-trial detainees (remand prisoners), prisoners with less than 1 year of their sentence left to run and newly sentenced prisoners awaiting transfer to another prison setting (detention centre or high security prison);
- 82 prisons for sentenced detainees (with several wings), i.e.:
- 40 penitentiaries (‘centres pénitentiaires’) including at least 2 wings for prisoners of a different detention status (remand centre, detention centre and/or high security);
- 25 detention centres and 37 detention centre wings, holding sentenced adults with the supposedly best prospects of social reinsertion. Their detention programme is chiefly aimed at "re-socialising" prisoners;
- 6 high security prisons and 5 high security wings;

- 11 open prisons and 4 open prison wings housing convicted offenders who have been admitted there by the judge responsible for the execution of sentences with an outside placement without monitoring or open prison regime, and 4 resettlement prison wings which are located in penitentiaries;

- 6 penal establishments for minors, introduced by the French law of September 2002[169] and opened in mid-2008.

- 49 outsourced centres out of 189.

Data collection tools

The data from the police or criminal justice system concerning drug-related offences have the advantage of being regular, sufficiently historical and easily accessible. On the other hand, these data do not provide a complete overview of the manner in which offences are dealt with from arrest through to sentencing and possibly concerning the enforcement of the sentence. There are several reasons for this.

Arrests for drug-related offences are divided into two major categories: simple use and trafficking (broken down into usage-dealing, local trafficking and international trafficking). This police standard classification of drug offences dates back to 1971. Further on in the criminal justice process, penal statistics include the sentences recorded by the National Criminal Record (NCR, see Appendices IV-B) and computerised since 1984. They contain details of the judgements issued against persons brought before the courts for drug-related offences. This data base provides access to a homogeneous statistical processing system, which makes it possible to monitor changes in the volume and structure of sentences from 1984 to 2010. As changes in drug law during this period were limited, this offers a satisfactory degree of comparability for an analysis of the variations of court responses to drug-related offences during this period.

A sentence can cover several offences but sentences are usually listed based on the main offence. The statistical categories used are as follows: illegal use of narcotics, assisting another person to use them, possession/acquisition, manufacturing/use/transportation, proposal and dealing, importing/exporting and other drug-related offences.

- Until 2003, it was the statistical processing of the data contained in the National Prisoners' Register (NPR, see Appendix IV-N) which made it possible to analyse prison population flows and to track the persons incarcerated (whether for drug-related or other offences) during the detention period in question.

- Since 2003, the year in which the new version of the "National database of prisoners" application came on stream, all offences resulting in a sentence are recorded (previously, only the main sentence had been recorded). Yet, the current state of the new version of this database does not tell us the ranking of the offence concerned (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 (the number of people incarcerated for narcotics use alone is currently unknown).

[169] Loi n°2002-1138 du 9 septembre 2002 d'orientation et de programmation pour la justice (NOR JUSX0200117L).

Over and above the regular activity indicators, the French framework for the production of knowledge concerning drug-related crimes also includes data collected specifically in the prison setting:

- **Institutional surveys**. Initiated, designed and deployed by the government authorities (Ministry of Health, Ministry of Justice, etc.), their results are published by these authorities. They often comprise retrospective analyses of existing data (data based on health forms completed by every offender entering prison required by the Inmate Health Survey; prescription activity data, such as the number of substitution treatments prescribed in prison; data derived from the activity reports for the specialised treatment centres operating in penal environments, etc.). The samples involved are large and seek to be as representative as possible of the prison population. The frequency of these surveys is irregular, just like the Inmate Health Survey. Among the surveys carried out by the various ministries' research departments, we should mention those from the DREES (the Ministry of Employment, Labour and Social Cohesion /Ministry for Welfare, Health and the Family), carried out in 1997 and 2003, offering data analyses based on the health profiles of prisoners remanded in custody or entering prison after conviction (use of psychoactive substances, opioid substitution treatment, risk factors and pathologies), based on the information collected during the medical examination of prisoners on reception (see the list of detailed sources, Appendices IV-C). Similarly, the data supplied by the DGS-DHOS survey between 1999 and 2004 on substitution treatment in penal environments make it possible to track changes in the level of implementation of opioid substitution treatment (continuation or initiation during the period of detention) and the drug maintenance treatment provision involved (methadone, Subutex®).

- The surveys carried out "on a specific day" by the DHOS among inmates infected by HIV or hepatitis C identified by the medical teams operating in penal establishments (from 23-27 June 2003, for example) describe the profiles of tested HIV-positive and HCV-infected patients admitted in the outpatient treatment/consultation units operating in penal establishments. These "substitution" and "HIV-HCV" surveys, previously conducted by the Ministry of Health departments, have now been grouped together within the PREVACAR (*PREVAlences en milieu CARcéral* – prevalence in a penal setting) survey, designed and implemented by the General Directorate of Health (DGS) (sponsor) and the National Institute for Public Health Surveillance (InVS) (scientific co-ordination), working together as part of a national steering committee (comprising representatives from the General Directorate of Health, the Hospital Directorate, the National Institute for Public Health Surveillance, the prison administration and from prison-based hospital healthcare units, regional health agencies and patients' associations).

- The PREVACAR survey focuses on two particular areas:

- "treatment availability" (screening for HIV, HCV and HBV, vaccination against hepatitis B, support for people infected with HIV and viral hepatitis and opioid substitution treatments).

- "prevalence" (prevalence of HIV infection, prevalence of HCV, number of inmates receiving substitution treatment, sociodemographic characteristics of prisoners infected with HIV and/or HCV and/or receiving opioid substitution treatment). Following a pilot phase in 2008 aimed at testing questionnaires and validating the

sampling method, the survey was carried out in June 2010 in 27 penitentiaries randomly selected to investigate prevalence and 145 prison-based hospital healthcare units, out of the 168 selected, in order to assess treatment availability.

- **Epidemiological surveys**. Often backed by research institutes (for example, INSERM (Lukasiewicz *et al*. 2007; Vernay-Vaisse *et al*. 1997; Rotily *et al*. 1997) or InVS (Jauffret-Roustide *et al*. 2006)), these are local or national surveys based on pre-existing data.

- **Quantitative sociological studies and research**. Based on qualitative interviews with small samples of respondents, these surveys seek to describe user profiles and to document their trajectories through the incarceration and drug addiction process. These data are collected outside the period of incarceration.

- **Studies carried out by health care professionals.** Descriptive quantitative or qualitative studies, they are initiated by professionals working in a prison setting, e.g. the PRI^{2}DE survey (Michel *et al*. 2011b) (research and intervention programme for the prevention of infection amongst detainees). Although some of them may suffer from a lack of methodological discipline, they provide an opportunity to benefit from the views and experiences of the professionals involved in provision of drug-related health services in prison.

- **Official reports.** Commissioned in the perspective of drug law reforms, regulation, supported by political issues or cost-effectiveness concerns, their purpose is to put forward recommendations based on existing observations and assessments.

- **Publications from the NGOs**. In terms of content, they are similar to official reports (facts and recommendations) but they have a more flexible format. They may be based on a selection of data (OIP (Observatoire International des Prisons) 2005).

In addition, a number of more general documents concerning prisons, generally sociological or demographical works can be useful to ensure a better understanding of the general context of the prison environment. Finally, the use of various published articles and documents should be mentioned, which are often summaries of other works.

Background

Delinquency and drug use

The numerous surveys carried out on this topic have shown that drug users are more frequently responsible for serious and less serious offences. The number of acts of delinquency tends to increase in line with the frequency of use of psychotropic products.

The link observed between drug use among young people and problematic behaviour (acquisitive delinquency, absenteeism and exclusion from school, involvement in fights or vandalism, etc.) has also been established (Barré *et al*. 2001).

In France, the survey carried out since 1998 at the request of the Ministry of Justice involving youngsters aged 14 to 21 years processed by the Judicial Youth Protection Service teams (Protection judiciaire de la jeunesse, PJJ) has revealed high prevalence levels: 60% of the

minors and young adults under youth legal protection services had already used cannabis in their lifetime (Ministry of Justice, 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 psychotropic substances and all other lifestyle factors common to these types of deviant behaviour characterised by substance abuse and delinquency.

- The first of these three categories and the easiest to understand includes all crimes and offences immediately related to drugs: use, possession, trafficking or manufacturing of illegal substances, all of which represent drug-related offences. This should also include driving under the influence of narcotics.

- The second group of offences which are indirectly attributable to the use of psychoactive products includes acts of delinquency when these are associated in one form or another with the use of these substances without this however constituting an aspect of their definition (so-called "acquisitive" delinquency 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, considered as two joint aspects of a deviant form of socialisation and lifestyles (Joubert *et al.* 1995). From this virtually ethnological viewpoint, the use of psychoactive substances should be regarded as one occurrence among others, integrated in a set of risk-taking behaviours. Most of the epidemiological and sociological works in France tend to favour this approach.

Drug use in prison

Drug-related offences accounted for almost 14% of sentences in 2010. The grounds for incarceration do not necessarily indicate that the French offenders were drug users. Furthermore, some of the people imprisoned for non-drug-related offences may be drug users. According to the report issued by the French Senate survey committee and published in 2000, almost 40,000 regular or occasional drug users are imprisoned each year (of the 68,765 new detainees in 2000, i.e. 58%), either as a result of direct involvement in the trafficking of narcotics or because of an offence related to drug use or acquisition (robbery, etc.) (Hyest *et al*. 2000).

In 2011, in France, epidemiological data relating to drug use were relatively historical with the last survey on “new offenders” carried out by the DREES dating back to 2003. Moreover, the proportion of injecting drug users (IDU) with a history of imprisonment was estimated at 61%, according to the “Coquelicot survey” conducted in 2004 by the InVS with the support of the ANRS in a sample population of 1,462 drug users in 5 French towns. The tendency for polydrug use is also evident, since in 2003, a quarter of “offenders” reported use of two psychotropic substances at least (Mouquet 2005).

The existing studies show that all products smoked, sniffed, injected or swallowed before incarceration continue to be used (albeit in reduced proportions) during incarceration (Rotily 2000a). Furthermore, the use of more easily accessible products (such as medicines) tends to develop in penal environments. Generally speaking, evidence shows a transfer of use from rare and illegal drugs to medicines (Stankoff *et al*. 2000).

This use of narcotics, whether initiated or continued in prison, can seriously affect health conditions: serious abscesses, risk of accident subsequent to the simultaneous use of multiple drugs, whether on prescription or not, severe and longer cravings, psychological or psychiatric disorders. Moreover, detainees constitute a population group combining numerous risk factors considering the health and social consequences of drug use. The low levels of access to treatment experienced by this population group and more fundamentally the situations of precariousness and social exclusion they have often faced before incarceration (including a lack of stable accommodation or social security cover) all contribute to explaining the prevalence of "at risk" use behaviour among new detainees.

The prevalence of injection appears to be higher among this precarious population group, although the number of users administering drugs intravenously seems to be declining: 6.2% of the newly sentenced prisoners 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 detainees stop injecting during their incarceration. The 20% to 40% who carry on injecting tend to reduce the frequency of their injections, although increasing 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. Finally, detainees appear to be more affected by infectious diseases than the general population. The most recent data show that the prevalence of HIV in penal establishments is 3 to 4 times higher than outside and the prevalence of HCV is 4 to 5 times higher than in general population. Inside and outside of prison, the prevalence of HIV has notably declined, while the prevalence of HCV has sharply increased.

According to the existing surveys, between 7% and 9% of detainees receive opioid substitution treatment (OST). Based on more recent surveys, PREVACAR (Chemlal *et al*. 2012) and PRI^{2}DE (Michel *et al*. 2011b), between 8% and 9% of detainees receive an OST (see section 9.6.1). According to the older DREES study, on prison reception, approximately 7% of the newly sentenced inmates report receiving substitution treatment, e.g. HDB (Subutex®) in 8 out of 10 cases (approximately 85%) (Mouquet 2005). During incarceration, this figure tends to decrease, as in a certain number of establishments, treatment is not continued, despite the stipulations of the 18 January 1994 Act[170] (which introduces an obligation to treat incarcerated patients in the same way as outpatients). The level of interrupted treatment fell sharply between 1998 and 2004 but nevertheless concerned more than 1 treatment in 10 (data from the Directorate for Hospitalization and Organization of Care and the General Directorate of Health). A survey conducted by the OFDT showed that access to methadone rose in penal institutions: among opioid-dependent detainees, 35% were treated with methadone-based opioid substitution therapy in 2006 (Obradovic *et al*. 2008a; Obradovic *et al*. 2008b), vs. 22% in a previous survey carried out in 2004 (DGS/DHOS, Ministry for Health). As a result, one third of penal establishments reported at least 50% of their patients undergoing substitution treatment using methadone (despite major disparities). The average initial prescription levels in detention establishments seem similar to the levels recorded for opioid-dependent outpatients (i.e. in hospitals), standing at between 23 (minimum) and 76 (maximum) mg per day. The OFDT survey also established that the first prescription of methadone maintenance treatment (MMT) by medical teams operating in prisons was also growing steadily since the legal authorization of MMT initiation in prison in 2002 (28%) (Obradovic *et al.* 2008a).

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

[170] Loi n°94-43 du 18 janvier 1994 relative à la santé publique et à la protection sociale (NOR SPSX9300136L).

Healthcare Units, labelled as 'UCSAs' ('Unités de consultation et de soins ambulatoires', reporting to the local hospitals and operating in all penal establishments), the treatment of addiction in detention centres is now based on a threefold system: the UCSAs, which are present in all penal establishments, have responsibility for the physical health of detainees; the Regional Medico-psychological Hospital Service ('SMPRs'), based in each of the 26 French regions, handle the mental health aspects of drug addicts in those establishments in which no local branch exists; and finally the "local addiction units" (CSST, renamed CSAPA in 2008) have been involved since 1987 in the 16 largest establishments in France (covering approximately a quarter of the penal population). This general scheme is completed by experimental units dedicated to inmates before release: the Care Units for Prison Leavers ('Unités pour sortants'), implemented in seven establishments.

At the same time, the legal risk and harm reduction scheme operating in penal environments also offers various possibilities for drug addicted detainees to have access to treatment (the circular of 5 December 1996[171]):

- Screening for HIV and hepatitis, theoretically proposed upon prison entry (CDAG - Anonymous Free Screening Centre – voluntary) although this is not systematic for HCV (source: POPHEC, Premier observatoire en prison de l'hépatite C / First monitoring group for hepatitis C in prisons);
- Prophylactic measures (hygiene measures and the provision of post-exposure treatments for both staff and detainees);
- The availability of condoms with lubricant (theoretically accessible via the UCSA);
- Access to opioid substitution treatments and the availability of bleach to disinfect any equipment in contact with blood (injection, tattooing and body piercing equipment).

No syringe exchange programme is available in French prisons. Such an initiative was considered "premature" by the Health and Justice Mission in 2000, although the 2010 INSERM collective expert evaluation recommended to experiment this kind of setting (INSERM 2010).

9.2. Drug-related crime

9.3. Drug law offences

Arrests for drug-related offences

The number of drug-related offences has risen sharply over the last 30 years. Almost 90% of all reported drug-related offences in France are related to drug use or possession. The numbers of arrests for drug offences have increased consistently since the 80s. There is no evidence showing whether this evolution is due to an intensification of police activity, an increase in drug use and trafficking or a better performance of the data gathering systems (or other factors) (OCRTIS (Office central pour la répression du trafic illicite des stupéfiants) A paraître).

[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 (NOR TASP9630649C).

Reasons for arrest

The use of narcotics is the main reason for arrest, accounting for 143,640 arrests in 2011, i.e. 89% of arrests for drug-related offences in 2011. This percentage has increased since 1998. In 2011, 18,111 arrests were recorded for usage-dealing and trafficking, i.e. 11% of arrests for drug-related offences. Contrary to arrests for drug use, arrests for usage-dealing and trafficking have decreased compared to the previous year (- 20% for usage-dealing; - 17% for international trafficking; - 16% for local trafficking).

Substances involved in drug-related offences

Cannabis remains the main substance involved in arrests for drug-related offences, regardless of the grounds for arrest, accounting for 90% of arrests for use and 70% of use-dealing and trafficking cases in 2011.

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).

We should point out the relative importance in France of the number of arrests related to the misuse of medicines (particularly HBD, aka Subutex®, but also unspecified substances, used in spite of the absence of any proof of a prescription), and those for hallucinogenic mushrooms.

Information from the Ministry of Justice: sentencing

Sentencing statistics are published within a two-year interval. The information below therefore relates to 2010 and is not officially considered as definitive (Ministère de la Justice 2010). Moreover, there is no distinction between products, in accordance with the terms of the Penal code, which bans indistinguishably use, possession and trafficking of all drugs, with no distinction between the substances.

The number of convictions for drug-related offences more than doubled between 1990 and 2010 (rising from 20,428 to 50,100). Among the persons sentenced for drug-related offences in 2010, 36% had already been arrested for the same offence (compared to 33% in 2005) and 9% were in legal recidivism (figure calculated on the basis of the main offences only and including attempted repeat offences). Sentences for the use of narcotics have increased the most: a four-fold increase has been recorded since 1990 but the rise is particularly marked from 2004 onwards (when such sentences were three times less prevalent than today). Sentences for the use of narcotics (28,146 in 2010) account for 56% of drug-related sentences but never exceeded 30% up to 2005. All the other drug-related sentences for possession, proposal, dealing and illegal trafficking have increased since the early 2000s, stabilising from 2004 onwards (Timbart 2011).

Convictions for road traffic offences have also sharply increased over the last two decades (+ approximately 60%). This trend has been continuous although it accelerated between 2000 and 2010. It reflects the stepping-up of the campaign against drinking and driving and the introduction of driving under the influence of a narcotic as an offence (since the law dated 3 February 2003[172]).

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

In 2010, 29,390 sentences were issued for drug use alone (an increase of 17% compared to the previous year). Accounting for more than 50% of convictions, simple use has become by far the leading category of conviction for drug-related offences.

Information from the Ministry of Justice: incarceration

Of the 82,725 new prisoners incarcerated in 2010, approximately 14% were imprisoned for a drug-related offence. The proportion of people incarcerated for narcotics use is approximately 5% (compared to 2.5% in 2006).

Among the convicted persons entered on the prison register as of 1 January 2011, 14% had been sentenced for the trafficking of narcotics.

9.4. Other drug-related crimes

Driving under the influence of narcotics ("Drug Driving"): screening and sentencing in 2005-2006 (Ministère de l'Intérieur 2006)

A recap of the applicable legislation

Since the law of 18 June 1999[173] (and its application decree dated 27 August 2001[174]), all drivers involved in road traffic accidents resulting in an immediate death are automatically screened for narcotics. If narcotics are detected in the blood, drivers can be imprisoned for a maximum of 2 years and are given a fine of up to 4,500 €, based on the terms of the law dated 3 February 2003. These sentences can be increased to 3 years' imprisonment and a fine of 9,000 € if alcohol is consumed in conjunction with the use of illegal substances. The French LOPPSI 2 law (on the homeland security performance planning) adopted on 14 March 2011[175] has added to these sanctions an additional sentence of vehicular 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 creates an additional sentence in the form of a prohibition after driving under the influence of alcohol or narcotics, for five years or more, to drive any vehicle that is not fitted with an accredited anti-start system based on an electronic ethanol test.

For a number of years, a special drug screening procedure has been performed on the road. 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 2008[176]. Until then, the screening procedure was performed with roadside urine tests, in the presence of a physician. This procedure was considered to be too complicated and not sufficiently cost-effective. The first operational deployment phase for the use of saliva screening kits by law enforcement agencies is therefore recent (October 2008): an initial evaluation carried out in mid-March 2009 registered 52,000 saliva kits deployed in virtually all the *départements* and 7,588 tests implemented. 37.4%

[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 (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 règlementaire du Code de la route (Décrets en Conseil d'État) et modifiant le Code de la route (NOR EQUS0100214D).
[175] Loi n° 2011-267 du 14 mars 2011 d'orientation et de programmation pour la performance de la sécurité intérieure (NOR IOCX0903274L).
[176] The decree dated 30 July 2008 amends several articles in the Highway Code in order to allow the law enforcement agencies to screen drivers for the use of narcotics using saliva tests performed at the roadside. Décret n°2008-754 du 30 juillet 2008 portant diverses dispositions de sécurité routière (NOR DEVS0810101D).

of these proved positive in the geographical areas covered by the police and 29.6% in the areas covered by the gendarmerie. However, two types of equipment-related difficulties came to light:

- Difficulties relating to the accuracy of screening tests, particularly regarding the detection of cannabis and benzodiazepines (the screening and detection cut-off concentrations for THC, amphetamine-type stimulant drugs, cocaine and opiates in oral fluid are 15 ng/ml, 50 ng/ml, 10 ng/ml and 10 ng/ml of saliva[177], respectively);

- Difficulties associated with the high number of "false positive" tests (approximately 11%): this problem of "false positives" is supposed to be resolved by a "confirmatory" blood test performed in a medical setting whenever the saliva test (carried out at the roadside) proves positive. This two-phase approach (saliva screening followed by a blood test) is, however, considered complex to implement (hospital waiting times, small number of laboratories granted the specific approval required).

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 (compared to 10,000 in 2003). However, the results of this policy have not been accurately evaluated to date. According to the road safety evaluation undertaken in 2010 by the Observatoire national interministériel de sécurité routière (French Interministerial Road Safety Monitoring Group), the "drugs" heading on the accident form could not be used in 2010 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 829 cases of physical injury were recorded in 2010, 192 of which were fatal accidents (i.e. 3%) where at least one driver had tested positive (regardless of whether or not he/she was deemed to be responsible for the accident). These accidents confirmed that cannabis use had triggered 209 deaths (i.e. 5% of road traffic deaths) but not all were attributable to cannabis (directly or indirectly). The results of the single epidemiological study conducted to date to assess the role of cannabis-related road deaths, the SAM enquiry ("Narcotics and fatal road traffic accidents") carried out in 2002-2003 by OFDT and IFSTTAR[178], nevertheless highlight the extremely important effect of cannabis when combined with alcohol. Driving under the influence of cannabis increases the risk of causing a fatal accident by 1.8. This risk increases almost 15-fold when cannabis use is combined with alcohol use (Laumon *et al.* 2005).

Narcotics checks in 2010

In 2010, 63,500 narcotics screening procedures (preventive and obligatory) were carried out by the law enforcement services (police and gendarmerie), i.e. 6% up on the previous year. Of these, 4,204 narcotics controls were carried out following a fatal road traffic accident (- 1.5% compared to the previous year). Since 2005, when the number of screening procedures following a fatal accident was at its highest (5,248), this figure has fallen almost continuously. 13% of these tested positive, i.e. registering a two-fold increase compared to 2004, which

[177] Arrêté du 24 juillet 2008 modifiant l'arrêté du 5 septembre 2001 fixant les modalités du dépistage des stupéfiants et des analyses et examens prévus par le 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 (NOR SJSP0817087A).

[178] Institut français des sciences et technologies des transports, de l'aménagement et des réseaux (French Institute of Science and Technology relating to Transport, Urban Planning and Networks) created by the merger between INRETS (Institut national de recherche sur les transports et leur sécurité – National Institute for Research into Transport and Transport Safety) and the LCPC.

confirms the relevance of narcotics in fatal accidents. However, this positive figure seems to have fallen for the first time since 2004.

Sentencing in 2010

According to the most recent figures, the number of convictions for driving under the influence of narcotics has risen rapidly in recent years: it has increased 4-fold, rising from 2,976 in 2005 to 14,919 in 2010, including settlements (according to the statistics provided by the National Criminal Record). In 2010, the number of sentences increased by 33% compared to the previous year.

Among the 12,428 convictions for driving under the influence of narcotics (excluding settlements), 77% committed just this one offence, whereas 23% were associated with one or more other offences. More than one-third of sentences led to imprisonment (34%, including less than 1 in 5 comprising time in a closed prison); half were fined (49%) and approximately 17% were given an alternative sentence (most often a driving licence confiscation).

Punishments tend to be less severe for driving under the influence of narcotics alone or for refusing to cooperate. However, they are more severe in the case of physical injury (8 sentences out of 10 lead to imprisonment) and particularly in the case of homicide where most punishments include total imprisonment without remission (Obradovic 2010).

9.5. Prevention of drug-related crime

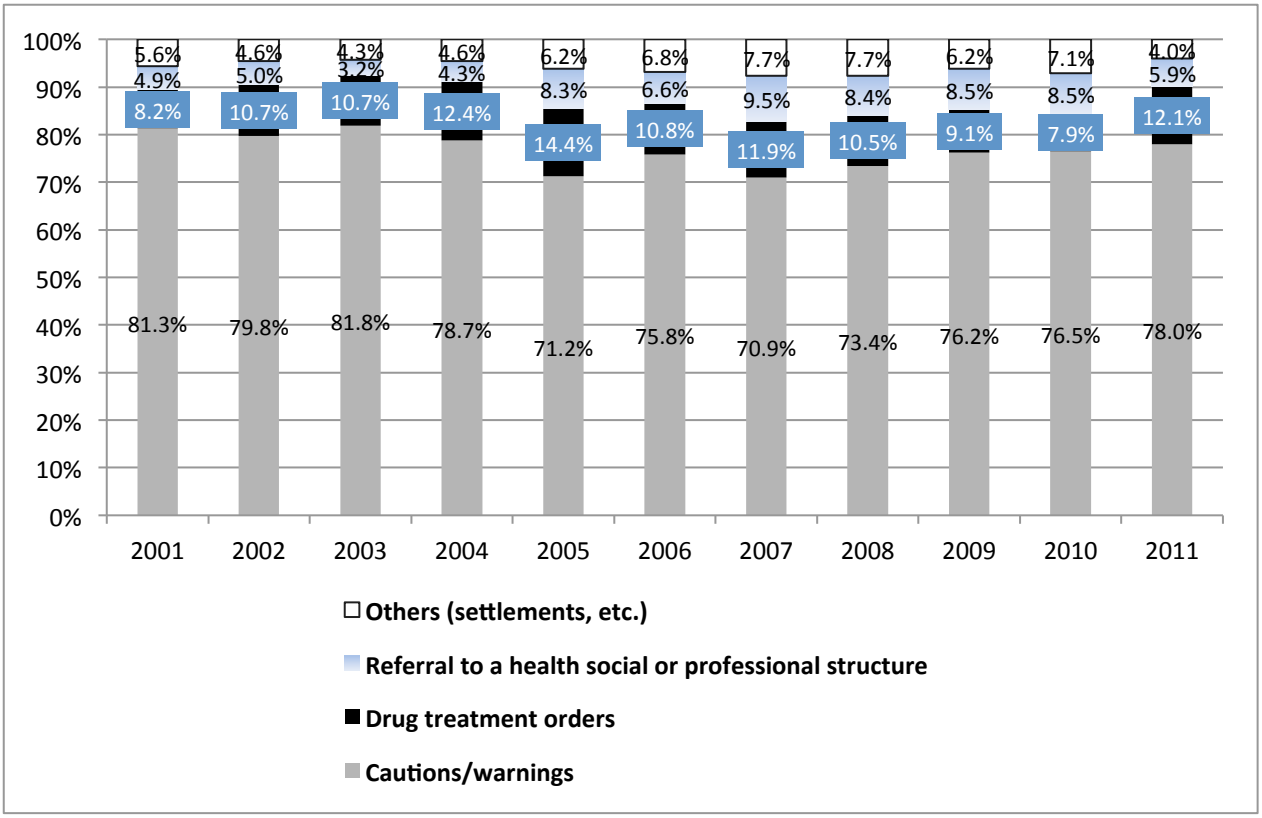
According to the terms of the law dated 31 December 1970[179], the French criminal justice system presents an array of court-ordered treatment options for drug users. These treatment referrals can be ordered by the Public Prosecutor (discontinue proceedings provided that there is contact with the care system, drug treatment order) or by the courts, some of them being obligatory (conditional discharge with a drug treatment order, mandatory withdrawal, legal reminder possibly associated with a health care referral). Since the law dated 5 March 2007[180], the scope for a drug treatment order has, in fact, been extended (see chapter 1), such that this penal approach can[181], from now on, be adopted at all stages in the criminal proceedings, as an alternative to prosecution, settlement or for enforcing the sentence (especially in the case of probation with court-ordered supervision), for all narcotics users aged 13 years and above. Compulsory treatment in itself can be used as an alternative measure to either prosecution (deferred prosecution, mandatory screening and treatment ["injonction thérapeutique"]) or imprisonment (as an alternative or supplement to existing criminal justice sanctions and procedures: drug treatment order for drug offenders within a deferred sentence, a pre-trial intervention, a community sentence, diversion, probation).

Examination of penal statistics for the Paris area, including the suburbs (which represents 25% of national prosecutions for 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 has almost doubled, increasing from 10,261 in 2001 to 22,663 in 2011. At the same time, amongst all the decisions, the proportion of case closures fell and the proportions of alternatives to legal action conversely increased. Whilst rare until the end of the 1990s, alternatives to legal

[179] 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.
[180] Loi n°2007-297 du 5 mars 2007 relative à la prévention de la délinquance (NOR INTX0600091L).
[181] Articles L3413-1 à L. 3413-4 et L3423-1 et suivants du Code de la santé publique (CSP).

proceedings now make up 70% of the decisions issued with regard to drug users whereas the range of alternative sanctions applied has diversified (Obradovic 2010).

Graph 9-1: Distribution of the alternatives to prosecution prescribed to drug users, 2001-2011



Source: Data collected from the Cassiopée Infocentre, Ministry of Justice (Paris area only)

The most recent examples of treatment referral options can be found in the Clinics for Young Users ("Consultations jeunes consommateurs") which have been in operation since 2004. It has been shown that 50% of the outpatients admitted in these clinics (screening, counselling and brief intervention) were referred by the criminal justice system, especially among males and young adults (Obradovic 2009).

In addition to these various treatment options, the range of alternatives to prosecution offered to drug offenders has been extended since the law of 5 March 2007 and the 16 April 2008 decree[182] (see chapter 1). Adults and minors arrested for the use or possession of cannabis may be ordered to pay for and attend a compulsory course to heighten their awareness of the risks associated with the use of narcotics. The aim of these mandatory drug awareness training courses is educational: users are informed of the risks relating to drug use, drug-related policies and legislation currently in force and the health and social consequences of drug use.

Based on an initial evaluation of the system implemented by the OFDT at the request of the Ministry of Justice, 1,800 to 1,900 collective Drug Awareness Training Courses have been introduced in mainland France and the overseas French departments since the 2007 law, by 101

[182] Décret n°2008-364 du 16 avril 2008 relatif au suivi des mesures d'injonction thérapeutique et aux médecins relais (NOR SJSP0769782D).

approved associations distributed between 35 courts of appeal. At least one training course provider comes under the jurisdiction of each court of appeal (CA). With ten trainees on average, the training courses have been attended by 18,000 to 19,000 people since 2008 (96% of whom were cannabis users), i.e. averaging approximately 4,500 trainees per year, but this figure is constantly rising.

The drug awareness training sessions providers range from medical-social establishments (31%) of associative CSAPAs[183], 30% departmental committees of ANPAA[184] and social-judicial associations (31%). Less than 10% present another profile: CIRDD[185], CODES[186], social, housing or humanitarian associations. The average cost of these training programmes is €190, which is considerably lower than the maximum amount stipulated in the legislation (€450). However, the cost of the training programmes varies from one area of jurisdiction to the next: one-third of organisations invoice between €240 and €300 for training periods.

Nine drug awareness training courses out of ten are introduced as an alternative to proceedings (50% as alternatives to "traditional" proceedings and 39% as settlements). The average age of the mostly male trainees (93%) is 25 years. This population is characterised by a preponderance of young adults (64%), way in front of minors who account for only 3% of the training programme cohort. Nine trainees out of ten have been arrested for the use or possession of cannabis. More specifically, almost 7 in 10 trainees have been arrested for cannabis use with no related offence (68%). This is the first arrest for two-thirds of them. Furthermore, 11% of the persons attending these training courses have been arrested for a road traffic offence (driving under the influence of narcotics or in a state of drunkenness, breaking the speed limit, etc.).

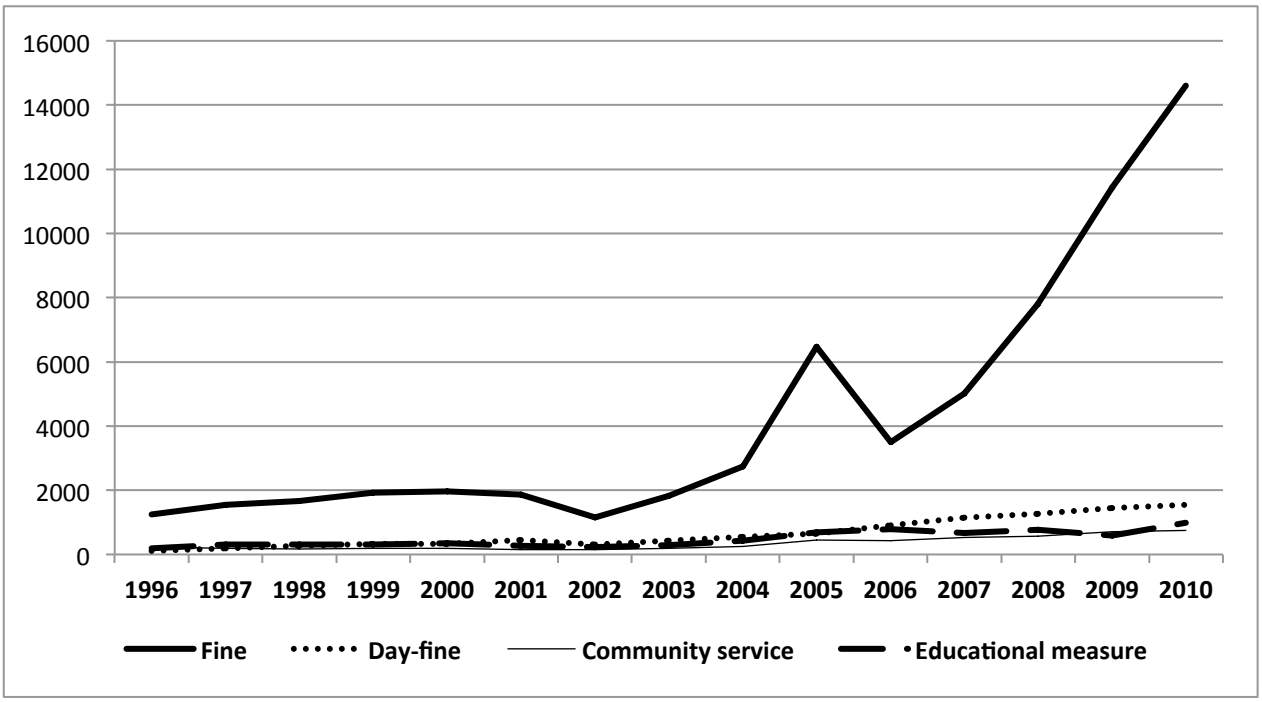
Most trainees take cannabis occasionally, i.e. less than 10 times a month (41%). 30% use it regularly (but not every day) and 29% smoke cannabis on a daily basis. More than 6 out of 10 trainees usually smoke in the festive or recreational setting (62%) and 8 out of 10 at home or at friends' houses.

9.6. Interventions in the criminal justice system

People found guilty of a drug-related offence by correctional courts may receive alternative sentencing, i.e. avoid imprisonment. These alternatives to imprisonment may take various forms: community service, 'jours-amendes' penalties (day-fines, literally, corresponding to days in prison paid off by fines), or other types of penalty. Although the national data on this topic are fragmentary, they show a rise in the numbers and proportions of these measures applied to single drug users.

[183] National Treatment and Prevention Centre for Substance Abuse
[184] French National Association for the Prevention of Alcoholism and Addiction
[185] Regional Information Centre on Drugs and Drug Addiction.
[186] Departmental Health Education Committee.

Graph 9-2: Distribution of alternatives to imprisonment for narcotics users, 1996-2010



Provisional 2010 data
Source: Ministry of Justice

9.7. Drug use and problem drug use in prison

With 61,771 inmates reported in February 2011, for 56,454 operational places, there are 109 inmates for every 100 places in France. Overcrowding is one of the distinctive characteristics of French prisons, as well as poor detention conditions, regularly denounced by various international bodies[187]. This helps account for some of the difficulties encountered in accessing treatment. Prison overcrowding varies considerably between mainland France and the overseas departments and territories, and especially between the various types of establishments. Of the surplus inmates, 96% are in remand centres, since the assignment of convicted offenders to penal establishments is managed by the Prison Service according to the numerus clausus principle. Overcrowding particularly affects remand centres and remand wings in penitentiaries, i.e. the most widely found establishments in the prison system, and which are supposed to house a majority of pre-trial detainees and convicted offenders with short sentences (with less than one year remaining of their sentence).

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 within the preceding six months were addicted to illegal substances and 30% were alcohol-dependent. A combination of mental disorders and addiction is commonplace amongst

[187] 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.

the prison population, mainly manifesting in the form of anxiety and dependence on illegal substances or alcohol. Each of these combinations affects approximately 1 in 5 inmates.

A 2003 inquiry into the health of new arrivals conducted by the DREES confirms the overrepresentation of addictions in the prison setting (Mouquet 2005). One-third of new inmates reported long-term, regular use of illegal drugs during the year preceding their incarceration: cannabis (29.8 %), cocaine and crack (7.7%), opioids (6.5%), abused prescription drugs (5.4%) and other products (LSD, ecstasy, glues, solvents, 4.0%). Nearly 11% of inmates stated that they used illegal drugs on a regular basis before their incarceration. This high prevalence of psychotropic drug consumption should be linked to the frequency of imprisonment due to drug-related offences[188] because, with the exception of cannabis, the reported use of such drugs is marginal in the general population.

Prison inmates are also affected by infectious diseases to greater extent than the general population. People who have already been incarcerated at least once have a prevalence of HCV, i.e. nearly 10 times higher than in the general population (7.1% versus 0.8%), as shown by the biological data of the 'Coquelicot survey' (INVS, CNAMTS, CTAFCES, 2005). Depending on the source, the prevalence of HIV in prison varies from 1.1% to 1.6%, and that of HCV from 3.1% to 7.1%. The most representative, up to date survey was carried out by the DREES in all remand centres and remand wings in penitentiaries in 2003. Il showed that the prevalence of HIV in the prison setting was 1.1%, or three to four times higher than outside prison, and the prevalence of HCV was 3.1%, four to five times higher than outside prison (Mouquet 2005). Moreover, 0.2% of new inmates stated that they were infected with both HIV and HCV, and 0.1% stated that they were seropositive for all three viruses (HIV, HCV, HBV).

According to the unpublished, preliminary results of the PREVACAR survey (Michel *et al*. 2011b) (DGS/InVS), 2% of inmates are HIV-positive, i.e. fewer than 1,220 inmates, three-quarters of them being immunocompromised (with a CD4 count of under 350). The prevalence of HIV infection is comparable in men and women (2.5% vs. 2.0%). HIV+ inmates are characterised by longstanding infection (diagnosed 9 years before on average). The infection was discovered in prison in 25% of HIV+ inmates and one-third of them are suffering from full-blown AIDS. In addition, 72% of HIV+ detainees 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% vs. 4.5% male inmates; drug abuse is the most common mode of transmission (70%). Older figures showed that the risk of viral transmission in prison is higher since injectors tend to share equipment (Ben Diane *et al*. 2001). Hence, among the 43% of intravenous drug users who were active users before being incarcerated and who continue to inject drugs in prison, 21% state that they share their equipment (Rotily 1999). While prison is a place where the prevalence of HIV and viral hepatitis infections is elevated, due mainly to the high percentage of intravenous drug users, it is also an environment that is conducive to risky behaviour: of incarcerated intravenous drug users, 13% to 23% started injecting in prison (Rotily 1999). Moreover, not all of those infected with HIV or HCV are aware of this when entering prison: only 40% have already had an HIV screening test, 27% an HCV screening test and 31% an HBV screening test (Mouquet 2005).

The use of narcotics, whether initiated or continued in prison, has a major influence on the state of health of the individuals concerned, including serious abscesses and the risk of accidents when medicines are combined with other substances, severe and longer withdrawal symptoms,

[188] In fact, thanks to the French Prison Service's statistics approximately 15% of convictions are known to be primarily linked to drug-related offences.

in addition to the occurrence of psychological or psychiatric disorders (see last year's Selected Issue). Furthermore, detainees constitute a population group more likely to combine risk factors where the health and social consequences of drug use are concerned. The low level of access to treatment experienced by this population group, and more fundamentally, the situations of precariousness and exclusion which they often face prior to incarceration (including the lack of a stable home or Social Security cover, etc.) help explain the prevalence of "high risk" consumption among new detainees.

9.7.1. Illegal drug market in prison

Although it is known that illegal drugs are available in prison in France, it is difficult to define the magnitude of the problem. In France, the sparse official information available on the subject goes back to 1996 and is found in a report submitted to the Justice Ministry, "*Rapport sur l'amélioration de la prise en charge des toxicomanes incarcérés et sur la lutte contre l'introduction de drogues en prison*", by Jean-Paul Jean (Jean *et al*. 1996), who was then Inspector of Prisons (Report on improvements in the treatment of incarcerated drug users and the fight against the introduction of drugs in prison). This document revealed the dimensions of the phenomenon of drug trafficking in prison, showing that 75% of French penal establishments were concerned. In 80% of cases, the illegal substance seized was cannabis, a medicinal product was confiscated in 6% of cases, and heroin or another drug in the rest (Senon *et al*. 2004).

Fifteen years later, the evidence suggests that little has changed and that cannabis remains the most trafficked substance during detention. This is probably truer than ever since it is reasonable to assume that the demand for heroin has substantially fallen following the introduction of opioid substitution treatments into prisons in 1996. Moreover, as is the case outside prison, in some centres, the distribution of HDB has triggered the trafficking of tablets, highly sought after for their sedative properties.

Although cannabis is the most widely trafficked illegal drug 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 the supply. In any case, there is currently a considerable demand for cocaine in prison. The DREES inquiry on the consumption of psychotropic substances by new inmates showed that between 1995 and 2003, the proportion of users consuming cocaine in the hydrochloride or freebase form (crack cocaine) had substantially risen (Mouquet 2005). In addition, epidemiological surveys conducted in low threshold structures - the CAARUDs - show that use has significantly expanded among the most marginalised addicts (a significant proportion of whom, it should be remembered, enter prison at one point or another) because cocaine replaced heroin as the most widely consumed product in the month before the study (Toufik, A. *et al.* 2008).

In terms of supply, the fact that on its way to the major European market cocaine is passing increasingly often via West and North Africa, i.e. the traditional routes for cannabis resin (Gandilhon *et al.* 2010) means that this substance is increasingly becoming part of the contraband sold by city dealers, who are highly present in prisons. The large numbers of inmates involved in narcotics trafficking – notably cannabis resin imported from Morocco - who continue to bring cannabis and, to a lesser extent, cocaine into prisons from their contacts outside, contributes to the expansion of the use of these two substances. These networks are generally run by North African crime bosses who reproduce inside prisons their gangs from the

suburban housing projects on the outskirts of the main French urban centres. Although it is difficult to measure this phenomenon because of the lack of evidence, it nevertheless seems to be a major problem, notably in the French penal establishments close to the main French urban centres in which the percentage of patients jailed for drug-related offences can reach 40% to 50% of all prisoners.

The observations of a prison governor on this subject, questioned by the sociologist Farhad Khosrokhavar in his survey on "Islam in prisons" (Khosrokhavar 2004), are very informative in this respect:

'There is a highly significant phenomenon in this prison: drug addiction. This has repercussions at the psychological level and it requires specific attitudes on the part of prison staff. Here, many prisoners are youths [from the suburban districts], delinquency is compact. The drug networks found outside the prison setting tend to re-form inside the prisons, but this is not something that is tolerated. Prison authorities react with repression, or by informing the Public Prosecutor, etc. It is not something that is allowed [...]. On 10 August, two detainees escaped which led to reinforced surveillance inside the prison. That stopped much of the trafficking and the atmosphere deteriorated. Drugs go round—we know and try to stop it. When there is tension with the inmates, you feel it. It is important to strike a balance between repression and a hands-off approach. But I do not have the resources to do a better job combating these behaviour patterns. And too much repression turns prisons into time-bombs'.

In the light of these observations, which seem to represent the illegal drug trafficking phenomenon prevailing in penitentiaries close to the main urban centres, it can be seen that prison mimics greater society: trafficking exists, the traffickers and places are known, and public policy steers a course between repression and tolerance in order to prevent excessive social outbursts. Drug trafficking and consumption seem to play a social regulation role and guarantee civil peace.

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. Usually not drug-users themselves, these individuals rule a band of addicts who have been imprisoned for the use/dealing of drugs or related offences.

The development of new information technology tools, notably in the form of mobile telephones (the trafficking of which is a very intense business activity in prisons), makes it possible to direct networks outside from a prison cell, and supply the prison on a just-in-time basis depending on prisoners' needs.

9.8. Responses to drug-related health issues in prisons

Regularly, data emerge showing how difficult it is to provide inmates with personalised care against a background of overcrowded prisons.

All inmates must have a medical examination upon prison entry. This visit is performed by the UCSAs with a possibility to screen for infectious diseases. In order to guarantee the application of harm reduction measures, which are now legal[189], two main tools have been implemented in

[189] Loi n° 2004-806 du 9 août 2004 relative à la santé publique (NOR SANX0300055L). This law offers a new official definition of the harm reduction policy ('Harm reduction policy for drug users aims at preventing infections transmission, intravenous drug

penitentiaries since 1996[190] in an attempt to prevent infectious diseases. The circular of 5 December 1996 initially advocates access to OST in prison: inmates receiving substitution treatment 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, OST can also be initiated in prison for methadone[191].

In addition to substitution, penal 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[192]. Furthermore, since the memorandum dated 9 August 2001[193], the Prison Service has been encouraging health personnel to inform prisoners on how to use bleach as a product to disinfect injection equipment. The legal measures implemented by the 5 December 1996 circular tackling the spread of HIV also recommend to make free condoms available (NF-compliant condoms) with lubricants (theoretically obtainable through UCSAs). Prisoners 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 personnel as well as for inmates. Subsequently, for intravenous drug users, the only current way to protect against contracting AIDS, other than 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 proved acceptable in eliminating HIV: however, it has been established that these measures are not sufficiently effective in combating the HCV 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 prison, support for drug users is limited in the prison setting (counselling, peer education, primary health care) and access to sterile injection equipment (alcohol wipes, vials of sterile water, sterile cups, sterile syringes), which has been authorised in the general population since 1989, is absent from all penal establishments. There is no medicalised heroin programme in prison.

Despite the World Health Organisation’s (WHO) repeated recommendations since 1993, incarcerated intravenous drug users in France subsequently do not benefit from access to sterile injection equipment. The principle of equivalence of treatment for both incarcerated patients and outpatients, embodied in the Law of 18 January 1994, is therefore not applied to the letter in

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injection mortality and social as well as psychological harm related to narcotics addiction’, art. L. 3121-4) and assigns to the State the responsibility for defining this policy (art. L. 3121-3).

[190] Priority objective of public authorities since 1994 (Bergeron 1999; Coppel 2002), harm reduction is required in 1996 through a circular concerning prison settings: circulaire DGS/DH n° 96-239 du 3 avril 1996 relative aux orientations dans le domaine de la prise en charge des toxicomanes en 1996 (NOR TASP9630145C) ; 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 (NOR TASP9630649C).

[191] Circulaire DGS/DHOS n° 2002-57 du 30 janvier 2002 relative à la prescription de la 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 (NOR MESP0230029C).

[192] 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 (NOR TASP9630649C).

[193] 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.

France. However, various action plans are designed to improve access to health care. The 2010-2014 Strategic Action Plan on health policy for inmates makes provision to act on inmates' health determinants (practices exposing them to a risk for infection) and making screening programmes available for detainees. It provides for the establishment of suitable harm reduction measures that can be applied in detention to remedy the shortcomings observed in France: distributing bleach with instructions for use, providing access to condoms, taking into consideration the infection risk of certain forms of behaviour (e.g., snorting, tattooing, injections, etc.), providing access to HR sterile equipment related to drug abuse, access to Fibroscan® 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 care and complement the objectives of the last national plan for the fight against hepatitis (2009-2012) (DGS (Direction générale de la santé) 2009) (National Health Directorate). The latter plan defines a general framework for intervening in the prison setting, limiting itself to restating the need for hepatitis screening for new inmates and assessing the Health/Justice memorandum of 9 August 2001. The 2007-2011 plan for addiction treatment and prevention (Ministère de la Santé et des Solidarités 2006) provides no specific actions for the prison setting.

9.8.1. Drug treatment (including number of prisoners receiving opioid substitution treatment)

Between 8% and 9% of inmates received opioid substitution treatment, i.e. about 5,000 people are taking OST in prison (Michel *et al*. 2011a). Upon prison entry, 7% of inmates reported being on substitution treatment, HDB being the declared drug used 8 times out of 10 (just like in the general population) (Mouquet 2005). Conversely, one-third of OSTs were introduced during incarceration (31%), as confirmed by the results of the 2010 PREVACAR survey. Amongst the inmates receiving opioid substitution therapy, the prevalence of HIV was estimated at 3.6% in this study, whilst the prevalence of HCV was much higher (26.3%). The survey showed that approximately 70% of cases of HCV contamination were related to drug use. Furthermore, the average age of OST patients was estimated to be 34.9 years. This population was characterised by a precarious employment situation at the time of imprisonment: 46% were unemployed and the situation was unknown for 31.7%. Only 16.5 % of the persons receiving OST at the time of the survey had a job before being imprisoned.

The predominance of HDB over methadone in OST seems to be less marked in prison than in the general population: 68.5% HDB vs. 80% outside. This figure tends to drop during incarceration because treatments are not routinely continued, despite the recommendations of the law of 18 January 1994. Interruptions of treatment - an indicator of the importance attached to the continuity of treatments in prison - concern about one inmate in 10, although this figure was reduced between 1998 and 2004 (see Selected issue 2011).

Although in nine out of ten cases, substitution treatment is continued upon entry in prison, the challenge of providing equivalent treatment to opioid addicts in prison and outside seems unguaranteed. Over recent years, the total number of inmates receiving substitution treatment increased and the number of medical services reluctant to OST prescription decreased[194]. Nevertheless, the availability of OST varies. In France, there is still a “pocket of resistance” from

[194] Between 1998 and 2004, the number of inmates receiving substitution treatment increased faster than the prison population. The prison population receiving substitution treatment subsequently increased from 2% in 1998 to 6.6% in 2004. Concurrently, the proportion of medical services (UCSAs, SMPRs or CSSTs) not providing substitution treatments diminished.

a bunch of establishments that do not initiate OST[195] (Morfini *et al.* 2001/2004), (Obradovic *et al.* 2008b), (INSERM 2010). There are also issues related to the provision conditions: in some prison settings, the health professionals in charge develop practices that are likely to compromise the efficacy of the treatment (crushing pills or making solutions) (Michel *et al*. 2003). In the 2010 PRI^{2}DE inventory (Michel *et al.* 2011b): 19% of establishments stated that they crushed or diluted high dose buprenorphine, mainly in order to limit its misuse. Moreover, methadone doses were limited in 17 % of establishments, while the full market approval does not contain any dosing limitations. Despite repeated ministerial circulars and clinical practice guidelines, access to substitution treatment for heroin-addicted inmates remains, despite real progress, more limited than outside of prison, even though it has been demonstrated that the number of incarcerations (or re-incarcerations) is lower in people who received substitution treatment prior to or during incarceration (Rotily *et al*. 2000); (Levasseur *et al*. 2002).

The PREVACAR survey helps update knowledge on available care, especially regarding OST in France. Conducted in June 2010 at 145 penal establishments (out of the 168 interviewed), the participation rate was 86% representing 56,011 inmates, i.e. 92% of the incarcerated population on 1 July 2010. With respect to the provision of OST, it shows that 100% of UCSAs were offering at least one of the two forms, either HDB or methadone. However, a few establishments only offer one treatment: HDB only 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 state that they do not have a formalised procedure.

Regarding harm reduction services, 18% of the UCSA teams were aware of 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. These data concur with those collected during the 'Coquelicot survey', which revealed that 12% of drug users had injected at least once in their lifetime (Jauffret-Roustide *et al.* 2006; Jauffret-Roustide *et al*. 2009).

Although there is no estimate of the number of inmates who began OST during their incarceration, it is now evidenced that the Subutex® proportion (70%) tends to decline among OST initiated in prison, which is explained in part by the risks associated with this treatment[196]. Moreover, since the governmental plan to combat illegal drugs, tobacco and alcohol (2004-2008), the authorities have been aiming at improving access to methadone OST by making it accessible in all penal establishments. This objective, which was confirmed in a circular issued by the French Ministry of Health on 30 January 2002[197], was assessed by the OFDT (Obradovic, Canarelli, 2008). The survey conducted among UCSAs and SMPRs (with a 65% response rate) revealed a remarkable progression in access to methadone. In 2006, 35% of opioid-addicted

[195] In 2004, nine prison establishments alone, representing 20% of the prison population, prescribed one-third of substitution treatments, and one of these nine establishments prescribed more than 10%. The successive editions of the survey demonstrated that there were still penal establishments where no substitution treatment was prescribed, even though this number is declining, and that certain establishments only prescribe methadone OST. Complementary qualitative studies confirmed these findings by revealing the application, in certain sites, of quotas for substitution treatment, criteria for receiving substitution treatment (estimated sentence duration, for example) or administration methods that do not correspond to the proper prescription rules: Subutex® that is crushed or diluted before administration, for example (Delfraissy 2002).

[196] Although high dose buprenorphine is the main treatment prescribed in community practice (Canarelli, 2009), in the prison setting, it is "relatively easy to misuse" (Pradier, 1999) in addition to the fact that it 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 conducive to this kind of abuse, the French Ministry of Health authorised in 2002 initial methadone prescriptions in all health establishments, including UCSAs and SMPRs.

[197] 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 (NOR MESP0230029C).

inmates were being treated within the scope of methadone, vs. 22% in 2004 (Obradovic *et al*. 2008a); (DGS/DHOS, Ministry of Health, 2004), representing 40% of the entire opioid-dependent penal population. In 2010, this percentage remained stable (2/3 of substitute-receiving inmates received HDB and 1/3 methadone) (Michel *et al*. 2011a). Changes in medical practices are evidenced in 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 PRI^{2}DE inventory stated that they never initiate substitution treatment (Michel *et al*. 2011a). The OFDT assessment also demonstrated that, although the rules for organising prescriptions were heterogeneous, the medical practices for dispensing and monitoring showed little variation from one establishment to another[198]. Furthermore, it appears that approximately 8% of establishments give priority to a withdrawal strategy and nearly 10% of professionals foresee the risk of overdose as a barrier to methadone maintenance prescription, since the lethal risk is set at approximately 1 mg/kg/d for a non-opioid-tolerant subject (Michel 2006). The structure of accessible OST in the prison setting has therefore evolved over the past ten years: although HDB (Subutex®) is still the predominant treatment used in prison, methadone treatment is on the rise, especially since the 30 January 2002 circular allowing physicians to prescribe methadone as first-line therapy: in 2004, 30% of the treatments initiated were methadone-based (versus 12% prior to the circular).

9.8.2. Prevention and reduction of drug-related harm

Harm minimisation strategies are dedicated to reducing harm related to drug use thanks to interventions modifying the risk behaviours associated with drug use and drug effects (acquisition, drug use, withdrawal). A number of strategic documents (2008-2011 governmental plan, 2010-2014 Strategic Action Plan on the health care policy for prisoners) address public problems encountered at three different levels of drug-related damage:

- Drug acquisition harm (acquisitive crime), which may be related to the risks of being exposed to high-risk situations, such as delinquency (either being exposed to or conducting criminal acts such as drug dealing, robbery, etc.).

- Drug use harm related to the drug used, the amount consumed, and the route of administration, generating pharmacological effects and consequences on the individual's health (for example, injection drug use 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).

[198] In nearly two-thirds of cases, methadone prescriptions are shared with or delegated to a service other than the UCSA, although the latter is designated as competent in the legislation (UCSAs only carry out their mission in one-third of cases). The modalities for dispensing methadone-based treatment are, however, very homogeneous: dispensing is mainly done on a daily basis at a treatment site (dispensing is performed in cells in less than 10 % of establishments) and, in general, under the supervision of a physician or nurse (except for rare cases when the treatment is handed over to the inmates themselves without monitoring of administration). The average levels of initial prescription in prisons are close to what is observed outside of prisons (in hospitals), i.e. between 23 mg/day and 76 mg/day (minimum/maximum), which translates into the proper application of the therapeutic indications, promoting caution: 60% of the treatment units state giving minimal initial doses lower than the daily initial doses indicated in the 2002 circular ("20 to 30 mg, depending on the level of physical addiction"). In contrast, one-quarter of services (generally UCSAs) state giving high initial maximal doses of at least 100 mg per day. This observation is reminiscent of the results recorded in the international literature, which reveal high, or even very high methadone doses (from over 100 mg to over 1000 mg per day), justified by a pharmacological necessity for certain patients. (Maremmani et al. 2000) ; (Leavitt et al. 2000)

- Drug withdrawal harm related to the effects of reducing or eliminating drug use that may impair the 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 illicit conditions of use, bleach is considered to be a poor HIV decontamination solution (WHO (World Health Organisation) *et al*. 2004), and a very poor HCV decontamination solution (Hagan *et al*. 2003). In fact, the prevalence of infectious diseases in penal establishments remains much higher than outside the prison setting, at over 1% for HIV, approximately 3% for HBV and 7 % for HCV (INSERM 2010). Moreover, injection practices are well-known in prisons (INSERM 2010), where one to three out of every five drug users share equipment (Rotily 2000b); (Jauffret-Roustide *et al.* 2006; Jauffret-Roustide *et al*. 2009), and these populations often carry the HIV and HCV viruses. Nevertheless, imprisoned drug users still do not benefit from the same harm reduction measures as outside prison. They do not have the chance, notably, to benefit from Syringe Exchange Programmes (SEP) (CNS (Conseil national du sida) 2009; CNS (Conseil national du sida) 2011).

9.8.3. Prevention, treatment and care of infectious diseases

- Infectious diseases are more prevalent among prisoners than in the general population. The prevalence of HIV in the prison population is 3-4 times higher than in the population as a whole, and that of HCV 4-5 times higher.

- New arrivals are screened for health problems related to substance use. Upon their arrival in prison, all detainees are offered a medical examination provided by a UCSA, with tuberculosis screening, a voluntary HIV test free of charge and, more recently, screening for Hepatitis C along with Hepatitis B vaccination. Regional medico-psychological hospital services (SMPR) are responsible for psychiatric care in 26 penitentiary institutions (larger prisons in general), while the UCSA deal with physical care. The 2008-2011 government action plan against drugs and drug addiction set an aim of improving 'care and continuity of care provided to drug and alcohol users in prison' in order to reduce the associated risks and prevent relapse, considering that 'the means offered within the existing system are insufficient to control these problems'. It thereby proposes to change the regulations such that prison hospital units, the UCSAs can control care for addictions, to define care objectives to be achieved for addicted persons and to increase the financial resources for these services. It also calls for the introduction of a 'genuine prison addiction plan', including in particular the setting-up of hepatology consultations, including the supply of Fibroscan®, addiction and hepatitis training for health professionals and information about hepatitis C for users.

In terms of information and prevention, the PREVACAR survey conducted in 2010 shows that three-quarters of UCSAs run health information and prevention campaigns for inmates but only one-third had done so in the preceding 6 months. The survey also showed that screening for infectious diseases has improved in the last decade: three viruses (HIV, HBV and HCV) are more or less systematically screened for in prison. 93% of UCSAs guarantee such screening but only one in two offers repeat screening. Furthermore, just over half of the UCSA (52%) offer a specialist HIV consultation, especially in the largest penitentiaries. A slightly greater proportion of UCSA offer a specialist hepatology consultation for inmates (57%). In terms of HCV care in prison, 50% of UCSAs perform a HCV RNA test + HCV control + ELISA.

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 receiving substitution treatment (Harding-Pink 1990); (Seaman *et al.* 1998); (Marzo *et al.* 2009). According to a study conducted in 2001 on prisoners released from the Fresnes Remand Centre, the risk of death by 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 particularly high excess mortality by overdose in released prisoners 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, the *Guide méthodologique relatif à la prise en charge sanitaire des personnes détenues* (methodological guide relating to the health care of prisoners) established by the Directorate for Hospitalisation and Organisation of Care (DHOS) to help professionals clearly summarises the specific conditions for providing health care to inmates at the various stages of their incarceration. It specifies that the modalities for release need to be planned sufficiently early, before the planned definitive release date. The preparation for release needs to engage the coordinated efforts of internal health and prison teams and external specialised structures. The necessary continuity of care must be in place to provide health and social support (housing, care, social protection) as well as social and professional rehabilitation support upon release. For pre-trial detainees with a bail order, information on outside health and social services for continued care must be provided upon their release. Therefore, theoretically, upon release, a prescription for methadone or Subutex® substitution treatment needs to be provided to the inmate in order to avoid any interruption in treatment while awaiting a consultation. This requires that the UCSA or the SMPR be informed beforehand of the release by the clerk of the establishment, which is not always the case. In order to receive treatment upon release, patients must know an identified, informed prescriber outside prison to which he or she can refer for follow-up medical and/or psychiatric treatment: this can be in a specialised structure (CSAPA), a hospital structure or with a general practitioner (preferably belonging to a network that has been contacted beforehand). To promote this continuity, meetings must be organised and contacts must be made during incarceration – which often proves to be complex in practice – since admission to a CSAPA or a post-cure centre is done upon medical prescription. Prisoners who wish to benefit from such follow-up care upon release must furthermore request such care from the UCSA or SMPR physicians. The SPIP (*Service pénitentiaire d'insertion et de probation*, Penitentiary Service for Reintegration and Probation) and UCSA or SMPR personnel are responsible for informing detainees about the treatment possibilities after release.

Given the complexity of these prerequisites to be ensured in a prison setting, in practice, the recommendations are not systematically followed and the health treatment of newly-released prisoners suffers from many deficiencies. The assessment of initial methadone prescriptions given by UCSAs revealed that in 2007, the UCSA professionals deemed that the continuity of care is 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.* 2008b). 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.

In accordance with the provisions of the 2008-2011 Government action plan against drugs and drug addiction, a professional guide to good practices (concerning opioid substitution treatments in particular) has been drafted under the auspices of MILDT.

9.9. Reintegration of drug users after release from prison

The 2008-2011 Government action plan against drugs and drug addiction also envisages the creation of ‘short and quickly accessed reception programmes for released prisoners, within existing structures, in relation with the hospital related to the prison’, highlighting ‘difficulties with accommodation on release from prison’. This programme is currently being evaluated by the OFDT.

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 (its level of purity and the products used to cut it) of the products 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 monitoring scheme known as *Tendances récentes et nouvelles drogues* (TREND, or *“*Emerging Trends and New Drugs”), which, since 1999, has been providing chiefly qualitative information (accessibility, availability and price) from users and the various key players in the fields of prevention, treatment and law enforcement. Today, the TREND survey is conducted in seven cities in metropolitan France (Bordeaux, Lille, Marseille, Metz, Paris, Rennes and Toulouse) and focuses on two areas of observation: the urban environment and the "festive" environment. The former is comprised of sites frequented by active drug users (squats, the street, low threshold structures, transit areas); the second includes festive events or establishments that are mainly part of the techno culture: alternative (such as teknivals and free-parties) and commercial sites (clubs).

The product analysis scheme referred to as the *Système national d'identification des toxiques et substances* (SINTES, or National Detection System of Drugs and Toxic Substances), an integral part of the TREND system, provides information on the circulation of rare and emerging products.

Surveys among the general population on the perceived accessibility, supply and availability of various illegal substances can also provide us with data on the most widely available products.

Seizures and the structure of trafficking activities

France is a transit country particularly for substances intended 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 products 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 drugs:

- Networks linked to major criminal organizations are often encountered at the "wholesale" or "semi-wholesale" sale stage.
- Networks of "retailers" which are based on a strict organizational structure (manager/dealer/tout/lookout).
- "Micro-networks" of user-dealers.

The main source of information is data from law enforcement forces (the police, customs and *gendarmes*). This data is produced and published on an annual basis in the form of a report under the responsibility of the OCRTIS. This report includes, amongst other things, the quantities of illegal drugs seized in France, the number of arrests (for use, use-resale and trafficking) related to drug related offences, the prices involved and any information on the structure of the trafficking networks.

Additionally, the TREND system provides qualitative information on methods for gaining access to products and on micro-trafficking.

Prices

Two resources make it possible to gather unit sales prices of illegal products:

- A periodic OCRTIS survey based on data collected at 69 sites throughout metropolitan France records the median semi-bulk and retail prices of certain illegal substances (heroin, cocaine, cannabis and ecstasy).
- The TREND network uses qualitative questionnaires that are completed by low-threshold structures and people working in the festive techno scenes near each TREND site. For each substance under consideration (whether illegal drugs or misused medicines), 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, the gathering of prices was reinforced by data collected from the seven TREND sites every six months. The illegal substances in question are cannabis (herbal, resin), heroin, MDMA (tablets, powder, crystal) and cocaine (for which the prices are collected in both urban and festive areas).

Drug 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 being sought in the product.

Products 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 products in circulation:

- Analyses are performed on products seized by the law enforcement agencies. These data are supplied by law enforcement laboratories and are grouped together in the report from the OCRTIS.

- Analyses are also performed on data collected among drug users as part of the OFDT's SINTES system.

Analyses of seizures

Analyses of seizures by law enforcement laboratories provide the main source of information on the composition of illegal products in France. The annual OCRTIS report provides a summary of all of the data on the composition of the illegal substances seized and analysed by all French law enforcement structures (customs, the police and the *gendarmerie*) during the year for the whole country. The data represents all 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 European alert system of the EMCDDA - and SINTES - the EWS's national correspondent - also helps identify new molecules.

Finally, SINTES is also in contact with the laboratories of law enforcement bodies (customs, *gendarmerie* and the police) through an agreement that officially establishes and authorises an exchange of information on drugs in circulation. Following a specific request from the OFDT, these entities provide information on the nature and composition of products 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 products directly from drug users. The drugs 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 product and its purchase price. This makes it possible to directly correlate the price and purity of a given product. SINTES employs two methods:

- The observation component provides an annual overview of the composition of a particular illegal product. (2006, cocaine; 2007-2008, heroin; 2009, synthetic substances; 2011, heroin). The SINTES-observation scheme is largely based on the French TREND network, which is itself organized into seven regional coordination units. "Collectors" are selected and trained according to their networks and skills by the regional coordinator under the responsibility of the OFDT, which then supplies collectors with their collector's card. Each year, about 350 to 450 samples of the

product 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 product on a national basis for a given year.

- The monitoring component comes under the health alert system. Any professional working with drug users may ask the OFDT for authorisation to collect an illegal product as long as this product has generated undesirable and unusual effects amongst users, or if it is new in some way. The annual number of samples collected is generally between 60 and 100. The contributions made by this approach are the identification of newly circulating molecules and occasional information on the composition of certain molecules at a given moment and in a given location.

- Since 2010, the SINTES system has benefitted from the addition of Internet monitoring for new psychoactive substances in order to help identify the emergence of new products and new circulation modalities.

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 in France. According to data from 2007, the estimated market value of resin and herbal cannabis combined is €832 M (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 in 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 is produced in France according to a study from 2005 (Ben Lakhdar 2009). This cannabis is mainly cultivated by an estimated 80,000 small-scale growers[199]. In the overwhelming majority of cases, these small-scale growers aim to supply their own personal use. However, several elements demonstrate that this fragmented image of herbal cannabis supply is changing. It seems that some criminal sectors are becoming more interested in intensive cannabis production.

A new form of cannabis resin called “olive” has progressively appeared at four of the seven TREND sites. These four sites are not geographically grouped. These are egg-shaped balls that weigh about 10 grams. They have a reputation of being fairly pure, which has been confirmed by several analyses performed on seized product (an average of 14% THC for 10 seizures vs. 11% for all seized resins).

[199] In 2010, 2 % of the people aged 18 to 64 years (80,000 people) who had used cannabis in the last year stated having used only cannabis that they had grown themselves. The 2005 data cannot be directly compared: 5 % of the people (200,000 individuals) had stated using cannabis they had grown themselves on occasion. *Baromètre santé 2005, 2010* (INPES), used by OFDT.

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 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 1990s, observers of drug markets as well as drug trafficking and drug-use law enforcement services noted that brown heroin has again 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 €40 compared to the early 2000s, when the price reached €60 or even €70. This increase in availability occurs in low-threshold structures amongst the most marginalised users, as well as in specialised treatment centres and certain alternative and underground festive milieus with close ties to the electronic music scene (Cadet-Taïrou *et al.* 2010b). The latter group tends to use heroin by snorting or even inhaling it (“chasing the dragon”), thereby minimising heroin’s dramatic image.

In 2011, this trend was confirmed by the majority of the TREND sites, and for OCRTIS, "The availability of heroin is increasing all over France.” (DCPJ (Direction centrale de la police judiciaire) *et al.* 2012). In French regions, the presence of heroin is determined by proximity to the developing Afghan heroin storage and distribution markets of the Netherlands, Belgium and Switzerland. Subsequently, it is in the northeastern and Rhône-Alpes regions of France that heroin is the most widely available. Furthermore, SINTES, conducted a survey in 2011 amongst users on the composition of heroin, and confirmed the high availability of the product at TREND sites, since 71% of the consumers met stated that they had no difficulty in procuring it.

Cocaine

In 2011, according to a study published by the OFDT, cocaine sales in France were approximately €900 M, representing a domestic consumption of about 15 tonnes (Ben Lakhdar 2012).

The availability of cocaine in France has been continuously expanding since the late 1990s. This development is steady and does not seem to be exhibiting any declines or stagnation. Indeed, the demand for cocaine hydrochloride is extremely dynamic in widely varying sectors of the French population, ranging from the very well off to the most marginalised clients of low threshold services (Cadet-Taïrou *et al.* 2010a).

In 2011, the availability measured by TREND remained just as high, both in urban and festive environments. According to the OCRTIS, cocaine is widely available in the main urban centres of Metropolitan Lille, Paris, Lyon and Marseille.

In contrast, the availability of crack cocaine (sold in its crack form and in very small quantities to a primarily very unstable clientele) remains characteristic of north-eastern 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 forms of cocaine hydrochloride that are converted to “freebase” form by dissolving the hydrochloride form in water and adding an alkaline 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 of use that determines the use of "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.

Crack, for which the only significant markets remain north-eastern Paris and the Antilles-Guyana French region, is mainly sold to an extremely unstable population, while freebase is primarily used (but used to a lesser extent) by the cocaine-using population. Therefore, freebase users often consider themselves in surveys to be cocaine users rather than crack users. However, this theory has been disproven recently on several levels: on the one hand the use of cocaine that is freebased after purchase and the use of crack, in Paris in particular, can overlap since some freebase users source on the crack market; on the other hand, there is no “official” definition of crack and freebase, and users employ these terms interchangeably. Subsequently, certain Parisian users talk about crack when they use a crack pipe and freebase when they use a homemade tool (aluminium foil on glass, for example) (Pousset 2012).

Ecstasy and amphetamines

To correctly understand the current ecstasy market and supply, a distinction needs to be made between the drug’s different forms, which include tablets, capsules and powder. Although the tablet is the most widespread form in France, it is true that the market is much less dynamic than it was when the techno movement began developing in the mid-1990s. After a 2009 characterised by a drop in the availability of tablets containing MDMA, it seems that this ecstasy form is once again present on the festive scene.

For several years now, the powdered MDMA form has become increasingly available in various festive 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 only attracts a specific festive scene clientele (those frequenting discotheques and nightclubs). This specificity contributes to maintaining the clandestine nature of distribution networks, of which we currently know relatively little.

However, 2011 was characterised by a sharp rise in the availability of the so-called “crystal” form. The “crystal” form, which is not to be confused with methamphetamine, is available as translucent rocks or crystals (red, white, grey or yellow) that need to be reduced into powder form to be snorted or ingested. It was in 2006 that this new MDMA form appeared within the TREND network. This product seems to be increasingly popular among users due to its effects, which are purportedly more powerful than those of the powder form. Over a three-year period, the price of crystal MDMA dropped from €80 to €55 (Cadet-Taïrou *et al.* 2012).

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 product is predominantly available in the alternative environments of the festive techno setting, but also appears to be gaining ground in nightclubs and discotheques as increasing numbers of consumers have become dissatisfied with ecstasy tablets.

In France, until now, toxicological analysis almost always showed that products considered to be "methamphetamines" were not. This situation changed in 2010 since, after years of rumours about the arrival of methamphetamine in France, two "cases" helped to verify its presence. The first was revealed by the French police force when it dismantled a clandestine Parisian consumption site being run by people in the Chinese community. The second became evident after collecting two samples from the Toulouse TREND site (one sample was in tablet form and the other in liquid form). The toxicological analysis of these samples confirmed the presence of methamphetamine (Sudérie 2010). However, the investigation conducted following the collection of these samples demonstrated that there was no real diffusion of this product in Toulouse or elsewhere in France. Its presence remained limited to very tight circles of experienced users who most often procured the substance abroad during touristic visits (for the "Yaba" tablet form found in Toulouse, the source was Thailand, while for the liquid form, the source was Israel). Methamphetamine use remains exceptional and characterised by sporadic supply. The meagre quantities of product seized on French soil are usually in transit on their way to other countries.

Other synthetic drugs: New psychoactive substances (NPS)

NPS represents a vast group of products that are collectively referred to as "new drugs". These are psychoactive products, whose effects are similar to those of known products, such as amphetamines, cocaine and ketamine, but whose molecular structure is different. This difference means that narcotics laws do not regulate these products. This is why the number of "new drugs" appearing is steadily rising. Each time a NPS is classified as a narcotic, a new, similar but distinct molecule is invented and launched. The one thing all these products have in common is that they are sold over the Internet.

Generally speaking, the term "new psychoactive substance" encompasses both synthetic products designed to circumvent narcotics legislation and entheogenic plants[200]. In addition to these two major categories, we also find some medications, non-essential amino acids (L-Tyrosine) and plant-based precursors (DMT) being considered as NPS. The majority of medications being considered as NPS are psycholeptics. They can be analogues of known medications, such as ethylphenidate[201] or etizolam[202]. Psycholeptics also include medications such as dextromethorphan. Commonly known as DXM, this molecule is present in several cough medications. The Internet reveals DXM's various methods of consumption and the different effects that can be achieved through DXM use.

Some of the terms employed when speaking of these molecules are "legal highs", "bath salts"[203], "party pills" and "legal ecstasy". The products may be known by a generic trademark (see Organization of the market). The best known of these trademarks is "Spice", which is a mixture of herbs used as a vehicle for synthetic cannabinoid consumption. These products are often presented as incense, bath salts or fertilisers and bear the phrase, "not for human consumption".

The circulation and consumption of NPS in France constitutes an emergent phenomenon. From the late 1990s to 2008, there were rumours that such substances were being distributed (OFDT 2001; Hautefeuille *et al.* 2002). These rumours were not substantiated until 2008, when online

[200] Plants are considered entheogens when they have psychoactive properties and are used in a religious or spiritual context. Currently, entheogenic plants have been rediscovered and are being increasingly abused to experience hallucinations or altered states of consciousness.
[201] An analogue of methylphenidate, the active substance in Ritalin®.
[202] Belongs to the family of benzodiazepines, of which Valium® is a member.
[203] Expression used only for cathinones (mephedrone, methylone, butylone, pentedrone…).

retail sites were pinpointed and toxicological analyses performed within the SINTES scheme confirmed the presence of some of the substances.

Despite a growing supply, use in France remains fairly secret. Consequently, the extent of the supply is still difficult to determine with precision. The characteristics of the supply, and particularly the supposedly scattered production and Web distribution, partially explain this difficulty. Indicators and observation protocols in this new area are being determined in France, as elsewhere.

For now, the indicators used to assess European and French supplies are the number of online retail sites and the toxicological identification of molecules. This identification is performed in France through the activities of the police and customs[204] or via the SINTES scheme, and is performed in the European Union through the Early Warning System (EWS).

From 2008 to 2011, 44 molecules were identified through toxicological analyses as having circulated at least once on French territory[205]. Most of these molecules had already been identified in other EU countries. During the second half of 2011, the *Service commun des laboratoires* (SCL, or Joint Laboratories Department) analysed 170 seizures containing already-known NPS products. Of these 170 seizures, 52 were NPS recently classified as narcotics and 120 were non-classified NPS products.

However, these indicators do little to reveal the extent of the actual distribution of the products. Although they attest to a different kind of supply, their contribution to demonstrating the true diffusion of these products is minimal. The identification of a molecule in France is not the same thing as tangible, identified distribution on the territory.

Hallucinogens

The market for hallucinogens is broken down into two segments: there are the synthetic products, like LSD, and natural products, like mushrooms or *Salvia divinorum* (Diviner'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 the law enforcement 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 within the market. Since 2006, the supply of LSD seems to have experienced no major interruptions and the drug has been mainly available in festive settings associated with free parties and teknivals, where the drug appears to be actively sought by a fringe group of consumers comprised of young thrill seekers.

It seems that, since 2008, there has been an increasing availability of ketamine. While it appeared occasionally on the alternative festive scene, where it was mainly used by a specific extreme group of the festive population (travellers), ketamine appears to be much more available there recently. In 2010 and 2011, the alternative festive scene remained the environment of choice for ketamine use, even though the substance exists – albeit very marginally – in clubs and discotheques as well as in the urban arena. The supply of these two

[204] The analysis of NPS within the scope of law enforcement appears to be only partially reflected in the figures when compared to narcotics seizures. NPS are not all legally classified as narcotics. Subsequently, in the statistics, they are classified in another category.

[205] The OFDT regularly updates a summary table of the identification of these substances. It is available on the Internet at: http://www.ofdt.fr/ofdtdev/live/donneesnat/notes.html

products does not appear to be driven by organized networks; instead, the drugs are produced by individuals on a small scale or acquired via the Internet. Although its availability is expanding, ketamine's presence at festive events remains random for the most part. Furthermore, it is very difficult to obtain information about the nature and source of the ketamine being distributed on such festive scenes.

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 1.2.2). Until 2007, its consumption was mainly limited to the gay festive 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 festive population 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 products 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.

10.2.2. Drug origins: national versus imported production

Herbal cannabis is the only illegal substance produced in France, primarily grown by individuals at home and on a very small scale.

This phenomenon is related to several factors. Firstly, there is the development of a trend in which people are opting for "organic" products, which are reputed to be of higher quality. Secondly, there is an increasing desire on the part of 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. An estimate indicates that approximately 30 tonnes of domestic cannabis are grown per year in France (Toufik, A. *et al.* 2007).

The various law enforcement 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 has expanded dramatically due to the involvement of organized crime in large-scale production (Weinberger 2011), and it seems that the lion's share of this production is intended for export. However, it appears that France, just like other European countries, has been experiencing the same phenomenon in recent 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, OCRIEST investigators (*Office central pour la répression de l'immigration irrégulière et de l'emploi des étrangers sans titre*, or the 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 sinsemilla[206] representing €400, 000 in annual sales (Weinberger 2011).

10.2.3. Trafficking patterns, national and international drug flows, 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-organized, transnational criminal networks. These networks tend to form in the so-called vulnerable housing estates that surround major French cities due to the cultural ties the communities therein have with the countries of production. The cannabis resin trafficking network in France comprises three major types of traffickers:

- 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 agencies, there are approximately sixty such networks comprising about one thousand people in total.

- 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 type of product, although they may also import other illegal products (cocaine, heroin). There are an estimated 689 to 1,504 semi-wholesalers (Ben Lakhdar 2007a).

- Finally, we observe local traffickers who oversee a network of dealers in charge of selling the product 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 traffickers to have multiple storage areas thereby fragmenting their deliveries. This seems to increase costs and produce a decline in profitability of trafficking.

Heroin

The trend towards increasing heroin availability in the French market is encouraged both by renewed dynamism of supply seen 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-Taïrou *et al.* 2012).

The rise in opium and heroin production has encouraged the development of criminal organizations (particularly Turkish and Albanian) that import heroin through the Balkans onto French soil[207] .

[206] 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 contents (upwards of 20%, and sometimes reaching 35%).

This importation occurs through one of two major circuits. One circuit receives the heroin directly on French soil (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. The latter are also generally involved in trafficking cannabis resin imported from Spain or Morocco and are based in housing estates surrounding major French cities.

Alongside these networks, which are controlled by organised crime, we also find what the police refer to as *secondary networks*, i.e. small-scale organizations 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 (Office central pour la répression du trafic illicite des stupéfiants) 2009) All of these factors contribute to the increasingly widespread presence of the product in France.

High-Dose Buprenorphine (HDB)

Ever since its 1996 launch, the HDB prescribed for heroin substitution treatment has been the subject of trafficking on the urban black market, often targeting extremely marginalised drug users (Toufik, A *et al.* 2010). This trafficking is organized by two types of groups.

- The first group, which displays a certain degree of organisation, obtains major quantities of tablets available for sale on the black market (or for export) by falsifying prescriptions and obtaining multiple prescriptions from people not dependent on opioids.

- The second group is chiefly comprised of users receiving the substitution treatments themselves who carry out small-scale dealing in the products.

In 2010, within the scope of reported cross-border trafficking from eastern France to Germany, a 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 appears that despite enhanced monitoring and control methods employed by French national health insurance on a regional level, French demand remains substantial although occasional shortages may occur in one city or another. The availability of the drug is therefore high, as is its level of accessibility, since, in stark contrast to the situation with illegal drugs such as heroin or cocaine, an open drug scene for the sale of substitution drugs exists in many big French cities.

Methadone

A street methadone market has been progressively emerging in the last few years. Essentially developing through stopgap demand, this street market is expanding as the number of methadone prescriptions in France rises. Despite the authorisation of the prescription of methadone in capsule form in France since 2008, vials of liquid methadone prevail on the market (Cadet-Taïrou 2012).

Cocaine

Today, there are three major types of cocaine distribution networks in France:

[207] According to the UNODC (UNODC (United Nations Office on Drugs and Crime) 2012) 80% of Afghan heroin intended for the European market transits through the Balkans.

- There are networks related to organized crime in France and elsewhere; these networks specialise in wholesale.

- There are so-called “housing estate” networks, which are established in neighbourhoods located on the edges of major cities; these networks deal either in wholesale or in retail sales.

- Finally, there are more or less professionalized user-dealers.

Although the organized crime networks represent a minority in terms of quantity, they play an important role in determining the availability of the product. These organized crime networks can be divided into two subgroups:

- There are “soilless” traffickers operating in the countries that receive the cocaine arriving into Europe, particularly in southern Spain. These traffickers 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 the product obtained mainly from the organizations mentioned in the first group and who sell it to more or less organized retail networks.

In contrast to French wholesalers, the first group is in direct contact with European crime organizations, 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), or more recently, West Africa.

Within the network of traffickers who source abroad, the “housing estate” organizations are well represented due to their decades-long experience in importing cannabis resin. They generally have close ties with organized crime networks due to business relationships and a certain exchange of movement between the two areas: the more dynamic members of these networks can join the upper echelons of organized 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. In the past ten years, the retail per-gram price dropped from €150 in the late 1990s to €60 or even €50, which has facilitated access to the product 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 1970s by the heroin epidemic, the taboos related to the use of illegal substances such as heroin and cocaine are dissolving. This promotes the emergence of demand inherent to the estates, which in turn is feeding an increasingly structured local supply.

The higher profitability of selling retail cocaine compared with retail cannabis resin also encourages traffickers to shift towards cocaine. Given the wholesale prices, every gram of cocaine sold retail provides a margin of €30 vs. barely €3 for cannabis resin.

The third major organizational structure is that of micro-traffickers, characterised mainly by user-dealers. 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, 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 organized crime networks and professionalised dealer groups. On their level, these networks make a strong contribution to the quantity of cocaine available in France. Furthermore, the 2004-2005 study on arrests for cocaine use-dealing revealed the relative ease with which these types of organizations can form (Gandilhon 2007).

These micro-networks are strengthened by the large numbers of well-established Belgian, Dutch and Spanish wholesalers and semi-wholesalers, who know how to attract “drug tourists”. Moreover, for the most organized 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 net revenue. This is particularly attractive considering than many user-dealers come from socially and professionally unstable environments. In any event, according to the increasing number of arrests and the TREND 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 product 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 France according to some estimates) of highly marginalised users (Janssen 2012). The users are chiefly found in Paris and in the overseas departments of French Guyana, Guadeloupe and Martinique (Merle *et al.* 2010), even though this product has been sporadically reported at other TREND 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 the resale of cannabis resin to the detriment of traditional dealers, who are usually from West Africa and particularly from Senegal.

Unlike crack, freebase is not marketed via a dealer system structured by organized networks. In most cases, users manufacture the product themselves. Furthermore, freebase involves a completely different clientele than that of the “crackheads”: freebase-users are mainly a population group comprised of members of the underground techno movement (travellers and nomads) generally found at “free party” dance events. TREND reported that in 2010 and 2011 in Paris and Toulouse, freebasers occasionally frequented local crack markets and switched back and forth between crack and freebase. This can be explained in part by the lack of resources of

certain freebase users, who buy crack because they cannot afford cocaine, and/or as partial "stopgap" use.

Ecstasy

It appears that the low level of demand for ecstasy in its "tablet" form has caused French criminal organizations to lose interest in this product (Girard *et al.* 2010). In 2011, most of the supply found in the French market came through micro-networks that sourced abroad (from Belgium, the Netherlands or Germany) and less commonly through Eastern Europe's organized crime networks.

NPS and their development via the Internet

Since 2009, the number of online retail sites for psychotropic products has increased. The SINTES system has determined a typology for the market. Four market segments have been identified. The first two – the "informed" 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"[208] and "classifieds" – are only accessible in specialised areas.

The informed segment

The first segment of the NPS market is relatively easy to understand and transparent, and seems to be the oldest of the segments. The sites that target this segment are usually understated and fewer in number than the more commercial sites. The chemical names of the molecules are displayed. The products are sold in plastic sachets without any specific marketing. The products are for a target clientele who is 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 sites targeting this segment are often more attractive than the sites that target the first segment. Product packaging is colourfully designed. The sites 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 product or on the packaging. In general, the products 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 dose has been prepared by the manufacturer. In contrast to the first market segment, whose products are presented directly in powder form, presentations for this segment imply that the consumer does not need to take product dosage into account. 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 sites raise doubts as to the psychoactive nature of the substances being sold. For example, synthetic cannabinoids are sometimes presented as plant-based or natural with the synthetic fragments invisible to the naked eye. This presentation or appearance may lead consumers to believe that they are consuming a plant rather than a synthetic product. For the

[208] This part of the Internet is called the "Deep Web". In general, it is comprised of directory pages or internal pages of websites. Nevertheless, these are sites launched by a server specifically designed not to be picked up by traditional Internet protocols.

first market segment, this presentation “effort” is not made, since cannabinoids can be sold directly in powder, tablet or paste form.

These sites can also offer “complementary” items similar to those sold in the “smart shops” of the Netherlands and some Eastern European countries. These complementary products 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 market segment. Subsequently, in 2011 the OFDT examined 32 retail sites[209]. Some of these sites only focused on one of the two aforementioned markets, while others targeted both. It appeared that there were three times more “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” or a “commercial” segment. As a result, seizures and SINTES data collection reveal that "commercial packaging" for NPS products contain more molecules than the bags sold on the "informed" sites. The analyses performed by the *Service commun des laboratoires* (SCL, or joint laboratories department) on several commercially packaged products with the same name revealed that as many as five different synthetic cannabinoids were mixed[210]. Conversely, analyses performed in 2011 by SINTES on 16 bags with the chemical name and one single molecule sold on sites for the informed 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 sites that are not referenced by search engines. Two such sites were closed down by the American DEA (Drug Enforcement Administration) between the summer of 2011 and March 2012.

This segment is specific due to 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 products through virtual money. On these sites, it is possible to find products categorised as narcotics, prescription-only drugs and NPS products.

Other, similar sites put buyers and sellers in a given geographic location into contact with each other. This trend seems to be marginal since users need to be part of a network with extensive IT know-how.

The classified advertisement 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”[211] of Web-based drug information in general. The work led to a classification of online NPS sites (Delprat 2011) referenced by search engines. Subsequently, the majority of today's leading products appeared to be available in

[209] The sites were selected using “snapshot” methodology, i.e. by using the relevant results of the first 100 pages found by a search engine, followed by a search using a combination of key words.
[210] Synthetic cannabinoids are molecules that are chemically similar to delta-9-tetracannabinol.
[211] The term as it is used here has a meaning specifically related to the field of publishing. It indicates the process by which a site becomes increasingly recognised, demonstrating the sites authority in the field in question.

classified advertisements listed under general categories. The majority of the ads refer people to addresses in Africa (Nigeria, Cameroon) or in China. User sites 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 method. Nevertheless, the persistent, overwhelming presence of classified ads listing sites warrants further investigation.

The communication strategy of vendors

Vendors put in place 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 product.

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, non-specialised forums on products or IRC platforms[212] 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 for all illicit drugs

In 2010, the number of narcotics, all substances combined, seized by French law enforcement[213] (police, customs and *gendarmerie*), was 129,529, representing an increase of nearly 20% compared with the previous year. These remain at historically high levels compared with the late 1990s and the early 2000s. Data are not yet available for 2011.

Cannabis

The downward trend recorded for cannabis resin seizures since 2004, the year when resin seizures reached an all-time high in France (about 100 tonnes), did not continue in 2011; quantities seized in 2011 increased by more than 5% compared with 2010. However, despite this slight increase, 2011 is part of a long-term trend characterised by an overall decline in cannabis resin seizures. This trend may be explained by a fragmenting of storage facilities and transport, which led to more deliveries, each of which contained less merchandise. Hence, in 2011, intercepted “go fast” road convoys transported an average of 400 kg versus the 2010 average of 600 kg. We cannot exclude the assumption that French and European users have a decreased appetite for Moroccan resin as a result of the heavier competition from European-grown herbal cannabis.

[212] Internet Relay Chat is an instant, text-exchange protocol that uses “rooms" or “channels” for themed discussions.
[213] This year we do not have data on the number of seizures performed for each of the illegal substances in question.

In contrast, the quantities of herbal cannabis seized continue their steady rise. From 2010 to 2011, they increased by nearly 20%, and since 2004 they have increased by over 130%. For 2011, there is no data available on seizures of cannabis seeds and plants. In 2010, such seizures were down versus 2009 (by 51.45% and 3.05% respectively).

Table 10-1: Quantities of drugs seized (in kilograms) in 2011, and changes from 2010-2011 (%)

Drugs seized	2006	2007	2008	2009	2010	2011	Change from 2010 to 2011
Cannabis resin	67,891 kg	34,182 kg	71,075 kg	56,073 kg	52,795 kg	55,641 kg	+ 5.3 %
Herbal cannabis	3,773 kg	3,047 kg	3,422 kg	3,495 kg	4,564 kg	5,450 kg	+ 19.4 %
Cannabis seeds	57 kg	51 kg	30 kg	45 kg	22 kg	Not available	
Heroin	1,051 kg	1,035 kg	1,117 kg	970 kg	1,087 kg	883 kg	-18,7 %
Cocaine	10,166 kg	6,578 kg	8,214 kg	5,211 kg	4,125 kg	10,834 kg	+162 %
Crack	8 kg	6 kg	12 kg	12 kg	14 kg	13 kg	-7.1 %
Amphetamines	77 kg	307 kg	109 kg	564 kg	176 kg	601 kg	+241 %
Ecstasy (tablets)	1,488,919	1,359,912	342,923	106,597	663,595	1,510,500	+127.6 %
LSD (units)	5,589	13,107	90,021	10,209	28,411	NA	
Ketamine	5 kg	2 kg	65 kg	3 kg	14 kg	NA	

Source: FNAILS, OCRTIS 2011

Heroin

The quantity of heroin seized decreased dramatically in 2011. Since 2006 seized quantities have been hovering around a tonne or so, but according to the latest figures, they are now approximately 900 kilos. However, the 2011 seizures remained high compared with those of the 2000s - the 2011 quantities were three times what they were in France in 1999 or 2001.

Cocaine

Cocaine seizures in 2011 broke the symbolic 10 tonne mark to reach an unprecedented level and exceed the 2006 historical record. Compared with 2010, the quantity seized rose sharply by 162%. These unusual results are explained mainly by the significant maritime seizures in the Antilles (Guadeloupe, Martinique) and by the increase in air seizures in French airports. In any event, these results are in line with those of the previous years: while in the 1990s, the average of French seizures was approximately one tonne, since the early 2000s, this average has regularly exceeded 5 tonnes (Gandilhon 2012).

Crack seizures have been variable since the early 2000s. Although they have been on the rise since 2007, it is difficult to discern a long-term trend.

Ecstasy

In 2011, ecstasy tablet seizures reached 1,500,000 units, an increase of 127% compared to 2010, which had also been characterised by a significant rise compared with 2009. The year 2009 was an exception due to short MDMA supplies following the massive destruction in Cambodia of a precursor needed for MDMA production. Nevertheless, given the downward trend of prior years, the quantities of ecstasy seized are extremely high, reaching levels comparable to those of the 2000s, when ecstasy use was making its ascent.

10.3.2. Quantities and numbers of precursor chemicals used in the manufacture of illicit drugs

There is no data concerning seizures of precursor chemicals because France is currently not (or is only marginally) an illicit drug-producing country (with the exception of herbal cannabis).

10.3.3. Number of illicit laboratories and other production sites dismantled and specific types of illicit drugs manufactured there

The last major case involving the dismantling of a clandestine production laboratory dates back to 2005. This was a cocaine production unit located at Le Perreux in the Val-de-Marne administrative department.

10.4. Prices /purity

10.4.1. Price of illicit drugs at retail level

Cannabis

According to OCRTIS[214] the median price for herbal cannabis in 2011 was approximately €7.50 per gram and ranged from €5.80 to €10 per gram. This price is up compared with previous years (€6.50 in 2009 and €7.00 in 2010). According to the TREND 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 consumers appear to display a marked preference for high-quality products.

The wholesale price, as measured by the police, stands at €3,000 per kilogram.

For the OCRTIS, the median price of cannabis resin has remained stable. In 2011, it was still €5 per gram. This observation was confirmed by the TREND system, since the median price per gram is approximately €5. The wholesale price of cannabis resin for the same year was €2,000 per kilogram.

Heroin

According to the OCRTIS in 2011, 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 2011, the TREND system reported a stabilisation of the price at around €40.

The wholesale price for brown heroin has also decreased to approximately €10,500 per kilogram.

[214] The retail and wholesale prices of cannabis, heroin, cocaine and ecstasy were obtained from the OCRTIS publication *Les prix des stupéfiants en France en 2011* (Narcotics prices in France in 2011).

Misuse of substitution products

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 to the late 1990s. In 2011, the median price according to the OCRTIS was approximately €60. However, TREND's observation was different, reporting an upward trend with prices closer to €65 in cities and over €70 on the festive scene. Nevertheless, it is still too early to draw any conclusions from this observation.

The wholesale price, which also remained stable, was €30,000 per kilogram.

Table 10-2: Median and mean prices per gram in Euros (TREND/OFDT)

Sites	Cannabis (n=27)		Cocaine (n=121)		Heroin (n=112)	MDMA (n=73)		
	Herbal cannabis	Cannabis resin (n=17)	Urban	Festive		Tabs	Powder	Crystal
Bordeaux	9	5.3	61.3	90	44	10.7	63.3	NR
Lille	12.4	6.8	57.5	67.5	26.8	3.2	NR	54.3
Marseille	5	3	64	71	41	NR	58.9	78.3
Metz	12	8.3	90	70	43.6	NR	NR	73.3
Paris	NR	13.3	63	74.2	42	5	NR	60
Rennes	12.7	6	67.7	NR	45.4	NR	NR	NR
Toulouse	8	6.8	59.4	73	50	10	63.3	65
Median*	10.5	6.8	63	72	43.6	7.5	63.3	65
Mean	9.9	7	66	74.3	41.8	7.2	62	66.2

** The mean and the median are calculated using the mean prices recorded at each site, and not using all of the reported transactions. This enables each site to always carry the same weight[215] and avoid variations in samples collected at each site.*
Source: TREND/second semester 2011

Ecstasy

It s necessary to distinguish the dosage forms in which the product is sold: tablet, powder or crystal.

According to the OCRTIS, the 2011 price of a tablet of ecstasy was €6, indicating relative stability 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 tabs at once to lower the unit price they pay. By doing so, consumers can lower the unit price of a tablet to €2.50.

[215] Although the same weight deliberately given to each site does not necessarily reflect the reality of the markets, this approach provides a consistently-calculated indicator, enabling comparisons in which only price variations are taken into consideration.

For the TREND system, the median price of a tablet was a bit higher at around €7, while the powder (MDMA) and crystal forms were approximately €60 and €65 respectively. For the latter two forms, the price is clearly trending downward.

10.4.2. Purity/potency of illicit drugs

Cannabis

The mean THC (tetrahydrocannabinol) potency observed since the 2000s were once again seen in 2011. The THC content of cannabis resins rose slightly from 11% in 2010 to 12% in 2011. For resins, (INPS (Institut national de police scientifique) 2011), this is due mainly to the increase in the circulation of high dose (>15%) resins and the concomitant decrease in the circulation of low dose (< 2%) resins. The maximum THC content observed in resin was 53% in 2011.

The THC content in herbal cannabis rose from 10% in 2010 to 11% in 2011. This can also be explained by the increase in circulating high dose (>15%) herbal cannabis. The maximal THC content found in herbal cannabis in 2011 was 34%.

Heroin

The year 2011 was characterised by the seizure of samples with lower content (mean content 8%, (INPS (Institut national de police scientifique) 2012) and the collection of samples with lower content (mean content 7.2%, SINTES 2012). In 2010, mean content was 13% (INPS (Institut national de police scientifique) 2011). In 2011, significant variations in purity were still observed from one sample to the next.

The national SINTES survey conducted in 2011 confirmed the geographic disparity in content. The highest contents (10.3%) were observed in regions that are close to the Belgian border (Lille, Metz and Paris) and the lowest contents (4.2%) were observed elsewhere in France (Bordeaux, Rennes, Marseille, Toulouse). In 2011, it should be noted that much higher contents were determined through analysis in samples collected from the Greater Paris area (median rate, 17%).

Cocaine

The content of cocaine samples seized from the street fell in 2011. The majority of these samples had a content ranging from 10% to 20% in 2011 versus 10% to 40% in 2010.

Ecstasy

The powder form, which was the most frequently seen form in 2011, had highly variable MDMA contents: the mean was approximately 55%, while the maximum was nearly 83%. The mean content in tablets was lower than for powders, but rose slightly (23% in 2011 vs. 15% in 2010).

10.4.3. Composition of illicit drugs and drug tablets

Heroin

Since the beginning of the 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%). Therefore, paracetamol remains the cutting product 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 several samples in 2011. In most cases their concentration was below 1%.

Cocaine

When cocaine arrives in France it has already been cut using psychoactive substances such as levamisole, hydroxyzine and diltiazem. It is then re-cut with other psychoactive substances such as phenacetin, lidocaine and sugars before being resold on the street.

Levamisole remains the most frequently found adulterant (present in 75% of samples, representing an increase since 2010) although its content is low (mean of 9% of the total volume of a sample, but as high as 34%). Phenacetin is still the second most frequently seen adulterant in cocaine samples (approximately 40%). On average, it represents 32% of the sample, or nearly as much as cocaine itself.

Ecstasy

In 2011, caffeine was the ingredient most often combined with MDMA. The presence of mCPP has dropped since 2009.

Part B: Selected issues

11. Residential treatment programmes for drug users

11.1. History and framework of public policies

11.1.1. History of residential treatment programmes

Since the 19th century, the attraction of residential treatment programmes for people addicted to psychoactive substances has been growing. There are several reasons for this: firstly, drug addicts need a protective environment during withdrawal and not all addicts have one; secondly, for the immediate post-withdrawal period, physicians recommend, where possible, that addicts rest in a pleasant environment that is sufficiently removed in time and space from the environment in which they previously consumed substances.

It is appropriate to state in later years, programmes specifically designed to treat either alcohol or drug addiction developed separately. The first of these programmes arose within the healthcare setting (sick alcoholics are in hospitals). Given the communal, countercultural spirit of the 1970s, subsequent programmes were characterized - until the 1980s - by their suspicion of the medical domain.

Drug addictions

The increase in numbers of residential drug treatment programmes appeared following the increasingly widespread use of illegal drugs amongst young people towards the end of the 1960s. The 31 December 1970 law was intended as a response to this upward trend in drug use. Various establishments became available to "drug addicts" in this period. For the most part, these “rehabilitation” programmes gradually became links in an increasingly large and varied therapeutic chain, in response to the growing nature and diversity of problems, including solutions such as therapeutic apartments and foster families. At that time, numerous establishments opened. As was appropriate at the time, these sites were often located in the countryside and founded upon an ideal of “getting back to healthy living” and encouraging the restoration of satisfactory human relationships. The goal was abstinence from illegal drug use, but these structures also occasionally helped with professional placement within a society that was close to full employment. The opening of such establishments was made even easier since budgets at the time were approved on a departmental level, and the government reimbursed 80% of these departmental budgets. The residential treatment structures were run by associations since the authorities considered associations to be more responsive than governmental services. In the absence of evidence on the effectiveness of treatments, it was decided to heavily fund experimentations, which disappeared for the most part due to an inability to maintain long-term relationships with their public or due to ideological or financial deviations.

After the euphoria of creating such programmes wore off, the 1980s can be characterized by the professionalization and organization of this sector. For example, there was the creation of the *Association nationale des intervenants en toxicomane* (ANIT, or the French national association of drug addiction professionals), the implementation of annual conferences throughout France and the first “*journées de Reims*” seminars with a strong psychoanalytical focus. This is also the

period during which AIDS appeared in the United States (1981) and shortly thereafter in France. This disease heavily affected injecting heroin users, who became the majority "clientele" of treatment programmes. As a result, the authorities began to question the system that was in place.

In 1987, a report by the *Conseil économique et social* (Economic and Social Council) described residential institutions (Sullerot 1989). Out of 30 aftercare establishments, 16 focused on "relational techniques" and 14 on "occupational techniques", and three offered "semi-autonomous lifestyles" (therapeutic apartments). In addition to aftercare establishments, there were four major and 19 smaller foster-family networks in relation with treatment centres.

This report deplored the lack of sufficient numbers of residential programmes and also emphasised certain weaknesses by criticising the undermedicalisation of the centres, the underutilisation of certain measures, the inappropriateness of client personal development programmes and client selection, the distancing of families and the lack of communication between the residential centres and their local environment. Above all, the report challenged what formerly had been presented as a strong point of the French system, namely the diversity of available treatment methods. According to the report, such diversity is not effective for patients looking for treatment in centres: patients are referred based on affinities with caregiver ideologies, or in more simple terms, based on availability, which explains the short stays in such centres. "Variety is hardly a virtue if it does not provide choice" (Sullerot 1989).

In 1992, a decree[216] was issued on the missions of outpatient and residential treatment centres. To become a certified CSST (*Centre de soins specialisé aux toxicomanes*, or Specialised Care Centre for Drug Users), an establishment must be able to provide "at least 1) medical and psychological treatment for drug addicts, 2) drug addiction social support and education, which includes social integration and rehabilitation services." If an establishment only fulfils one of these two missions, it must add the following services: "admitting, orienting and informing drug addicts and their families, and supporting them during withdrawal (…), providing family support". This is accompanied by certain obligations: therapeutic, social and education treatment plans, like those that exist in the healthcare and medico-social sectors, along with activity reports. The plans must cover a period of no more than five years and prefects must be able to review these plans to assess the progress of the actions.

AIDS not only revealed the problem issues of access to treatment, equality of access to treatments and risk reduction but also France's underequipped situation in terms of responding to drug use. However, it also called into question the very nature of the responses provided to these issues, and especially professional practices based solely on abstinence.

This led to a 1993 decree that aimed to double residential capacity specifically by developing "therapeutic apartment" programmes and by creating the first therapeutic communities. However, the decree also emphasised developing outpatient structures throughout France and the importance of city hospital networks.

Simultaneously, the authorities, motivated by numerous stakeholders, including those involved in the fight against AIDS, worked to redefine public policy by using several reports: the 1989 Trautmann report (Trautmann 1990), the Henrion report (Henrion 1995), the Parquet-Reynaud report (Parquet 1997) and the Roques report (Roques 1998). These reports provided the

[216] Décret n°92-590 du 29 juin 1992 relatif aux centres spécialisés de soins aux toxicomanes (NOR SANP9201106D).

foundation for addiction treatment on the one hand and supported the development of a harm reduction policy and the use of opioid substitution treatments, on the other hand.

The territorial coverage of outpatient centres authorised to prescribe methadone, then in 1995 the launch of Subutex®, resulted in repositioning the role of residential treatment centres. These measures, which were crucial to drug addiction treatment, became an option along the treatment path. Moreover, such centres were forced to become medicalised, to accept users receiving substitution therapies, and to work in networks, an aspect reiterated in a memorandum from the *Direction générale de la santé* (National Health Directorate) in 1998[217]. These changes led to the closure of several establishments, especially those functioning collectively, since such structures could not become medicalised and received little support from the authorities, who were busy establishing access to substitution therapies and harm reduction measures. Moreover, some people believed that substitution therapies would render these specialised programmes useless. Nevertheless, professionals regularly question the authorities about the need not only to maintain, but also to develop, the capacity for residential treatment programmes. It was quickly observed however, that although substitution therapies considerably improved the situation for drug users, medication alone does not resolve the complex and intricate medical, psychological and social problems inherent in many addictions. At the same time, drug use or practices had changed, and the use of cocaine (crack included) had risen. The polydrug use, including alcohol, had become the norm. For these more complex addiction forms, the services available in outpatient centres or in primary care settings seemed insufficient.

In order to improve the stability of these programmes, for which funding was instable, they were integrated into the medico-social sector in 2002[218]. This sector is not funded by the government, but rather, by the French national health insurance system. These centres then became known as CSAPAs and their missions were clarified in 2008[219].

It was not until 2006[220] that public policy relaunched the creation of residential treatment centres through the establishment of therapeutic communities. Changes in drug use habits, the need to offer longer stays (up to two years) for very socially isolated users coupled with the desire to rebalance therapeutic options, resulted in the drawing up of specifications or working guidelines for therapeutic communities. In particular, support for abstinence and socio-professional rehabilitation was proposed. Seven therapeutic communities with 35 beds opened their doors between 2006 and 2011, bringing the total number of community establishments to 10.

During this time, the 'housing group' of the addiction commission[221] of the French Ministry of Health examined housing needs and pointed out the difficulties encountered by certain populations in gaining access to therapeutic housing: women with or without children, convicts released from prison, young drug users, elderly drug users, people suffering from psychiatric comorbidities, people suffering from cognitive disorders related to neurological deterioration and "active" users, who were typically refused by the majority of medico-social and social programmes.

[217] Note de service DGS/SP3 n°98-659 du 5 novembre 1998 relative à la révision des projets thérapeutiques des centres spécialisés de soins aux toxicomanes (NOR MESP9830471N).
[218] Loi n°2002-2 du 2 janvier 2002 rénovant l'action sociale et médico-sociale (NOR MESX0000158L).
[219] 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 (NOR SJSP0830130C).
[220] Circulaire DGS/MILDT/SD6B n°2006-462 du 24 octobre 2006 relative à la mise en place des communautés thérapeutiques (NOR SANP0630464C).
[221] http://www.sante.gouv.fr/commission-addictions.html

To take these unmet needs into consideration, the authorities launched calls for projects for certain of these groups, particularly women and convicts released from prison. Furthermore, residential programmes for active users began on an experimental basis.

Alcohol rehabilitation

"Modern" residential alcoholism treatment programmes developed shortly after the end of the Second World War: The first French alcoholism rehabilitation centre was founded in Alsace in 1932 at Château Walk. It was based on the therapeutic farm model. Inspired by this model, the 1950s saw the launch of several establishments. Some of these sites operated from within the healthcare sector and others from within associations in the social sector (rehabilitation homes), and opened gradually as projects and opportunities arose.

These two programme types, i.e., health and social, developed for alcoholics primarily during the 1960s and 1970s. Their treatment approaches were very similar, despite their different funding methods, since public policy was not well established in the area at that time.

The hospital reform act[222], and then the SSR (*soins de suite et de réadaption*, or rehabilitation) decree of 17 April 2008[223] modified these establishments, which were formerly medium-stay hospitals, transforming them into *Soins de suite et de réadaption en addictologie* (SSRAs, or addiction follow-up and rehabilitation centres).

This journey back in time highlights the current issues: SSRAs are still tethered to the healthcare system, residential CSAPAs remain embedded within the medico-social sector and addiction CHRS centres (*Centres d'hébergement et de réinsertion sociale*, or social housing centres) appear to be the passing fancies of history.

11.1.2. Residential treatment strategies and regulatory frameworks

Since initial legislation, public policies have remained focused on residential treatment measures for drug users. However, the missions of such measures have evolved over time to take into account changes in needs and the development of knowledge on the one hand and developments in available treatments and the subsequent diversity of residential treatment modalities, on the other hand.

Hence, the 1992 decree stipulated that outpatient and residential centres were required to offer at least: 1) medical and psychological treatment for drug addicts, and 2) drug addiction social support and education, which comprises social integration and rehabilitation services. This created a significant challenge for project sponsors.

The 14 May 2007 decree[224] regarding the missions of CSAPAs required these centres to be more specific regarding their missions:

1) "Admit, inform, provide the medical, psychological and social assessment of the person and guide the person and the person's family or circle

[222] Loi n°91-748 du 31 juillet 1991 portant réforme hospitalière (NOR SPSX9000155L).
[223] Décret n°2008-377 du 17 avril 2008 relatif aux conditions d'implantation applicables à l'activité de soins de suite et de réadaptation (NOR SJSH0803309D).
[224] Décret n°2007-877 du 14 mai 2007 relatif aux missions des centres de soins, d'accompagnement et de prévention en addictologie (NOR SANP0721630D).

2) Reduce the risks associated with the use of psychoactive substances

3) Provide medical, psychological, social and educational elements in the patient's treatment programme. The mission includes diagnosing, providing healthcare services, ensuring access to entitlements and offering assistance in social integration or rehabilitation. The centres provide withdrawal facilities and support. They also prescribe and monitor medical treatments, including opioid substitution treatments."

The decree also stipulates that the team must be multidisciplinary and placed under the supervision of a director. A physician must be responsible for the medical activities performed.

Therapeutic communities, whose missions are stipulated in the 24 October 2006 circular regarding the implementation of therapeutic communities more oriented to abstinence, are exempt from the need to obtain prescriptions for the substitution therapies they provide.

Appendix 5 of the circular of 28 February 2008 regarding the implementation of the CSAPAs and the implementation of regional medico-social addiction programmes defines the various authorised residential programmes which are grouped according to duration of stay:

- Short-stay (under 3 months), pertains mainly to emergency and transition structures

- Medium- and long-term stays, pertain to therapeutic apartments (stays of no longer than 12 months, stays can be renewed once), residential therapeutic centres (stays of no longer than 12 months), foster families ("from several days to several months") and therapeutic communities (12 to 24 months at most).

The recommended staff-to-patient ratios are only indicated for therapeutic communities. They must not exceed 0.5 to 1.

11.2. Availability and characteristics

11.2.1. Establishment types and characteristics

As CSAPAs, the following establishments are forced to undertake certain missions set forth by the 28 February 2008 circular. These missions include:

- Admitting: this mission entails opening the doors to any person who comes to or contacts the CSAPA, whether that person is the care seeker or a member of the care seeker's family circle. It involves listening, establishing initial contact to create the foundations for a relationship and providing initial responses to the demands and needs of people. Simply making an appointment does not constitute "admission".

- Informing: written or oral, information must be supported by leaflets or brochures and explained, whether this information concerns the user's rights or the treatment modalities.

- Providing medical, psychological and social assessments: this mission comprises assessing the needs of the patient and the patient's family circle. For patients, this involves determining their level of use, their social situation and any related difficulties in order to offer patients the treatment that is most appropriate for their needs. For the family circle, this means mainly assessing the psychological and social effects of the addictive practices of the person on the family circle, as well as the family circle's needs in terms of support and assistance.

The circular also outlines the content of certain, mandatory missions:

- Medical treatment, which comprises:
    - assessing the medico-psychological dimension of addiction
    - looking for somatic and psychiatric comorbidities
    - proposing different treatment protocols, including treatment for the withdrawal states inherent to addiction and for comorbidities
    - proposing therapeutic withdrawal, and if not directly provided by the centre, the CSAPA must accompany the patients.
    - considering the patient's health in a broader sense and not just from an absence of illness point of view
    - as part of their medical treatment offer, CSAPAs must provide prescriptions for all opioid substitution treatments (OST) and issue initial methadone prescriptions, as well as all other medications necessary for treatment.
- Psychological treatment: this is based on assessing the psychological dimension of use and addiction, and complements the medical assessment. It comprises psychological monitoring and support appropriate to the situation and the user's needs. It must provide for the possibility of referring users to psychiatric services in the event that psychiatric comorbidities are revealed.
- Social and educational management: it consists of socio-educational support to help the patient gain or regain independence so that therapeutic treatment can ensue. More precisely, it encompasses support to recover social entitlements and actions or referrals aimed at social rehabilitation.
- Harm reduction: its purpose is not only to limit the health and social risks related to psychoactive substance use, but also to contribute to the treatment process and to the maintenance and restoration of social ties. Any person treated by a CSAPA should be able to benefit from group information sessions and/or customised health education counselling (e.g., in hygiene, infection and overdose prevention). They are accompanied throughout their treatment and aided in the design and implementation of a customised harm reduction strategy.

These different missions are distributed among the establishments that shall be described below, in more or less detail, depending on the establishment's nature and project.

Transition and emergency housing structures:

Sleep-ins

Individual or collective (134 beds funded in 2001, source DGS – the National Health Directorate)

This “Sleep-in” programme offers housing at night for users awaiting treatment or requiring temporary shelter. They mainly target people with significant social difficulties, one of their aims being to help users rebuild social ties. The nighttime accommodation is followed up by consultations during the day with a social worker, a physician, a nurse, a legal counsellor and a host in order to advise, monitor, refer and support people in terms of medical, paramedical, social and legal needs.

Quick treatment and short stay centres

There are four of these centres, which accept drug or alcohol users and multi-relapsers as soon as they are released from custody. The recent opening of these establishments, which resulted from the transformation of CSAPAs with an existing residential capacity, illustrates the willingness of the authorities to orient a portion of the residential programmes towards the most excluded populations. Stays, which are limited to three months, offer intensive treatment to support ex-convicts in devising a care or rehabilitation plan. These centres focus on rehabilitating former detainees to help them reintegrate into a non-prison environment, to prevent relapse and to involve them with treatment and rehabilitation networks.

Individual housing:

Therapeutic/follow-up apartments:

This is a type of therapeutic housing in individual or shared apartments. Residents receive intense support from a multidisciplinary team. The therapeutic apartments available to users represent rehabilitative or maintenance support for a care plan based on outpatient assistance. They prepare residents for access to a social integration programme or, whenever possible, for direct access to a self-financed individual apartment.

Regular, mandatory meetings with team members are organized either at the reception centre or in the apartment. Some services accept couples and even people with children. For people with children, the parents must not have had parental custody removed. Participation in housing costs is often requested. This participation is comprised of a fraction of the income of the resident. If necessary, the implementation of the social assistance that helps fund this participation helps prepare the resident for paying real rental fees.

The maximal duration of stay has been extended to two years to take into consideration the difficulty residents have in gaining access to independent housing when leaving these programmes.

These programmes are accessible either directly or upon discharge from a group residential treatment programme. For people discharged from a group programme, therapeutic apartments enable people receiving treatment to try out living conditions that are closer to independent conditions while maintaining significant professional support. Users can enter directly into a therapeutic apartment if group housing is contraindicated (for people accompanied by children or couples, for example). This support, which implies regular visits to the apartment by professionals and appointments in the reception centre, targets social aspects to facilitate apartment upkeep, budget management, time management and craving management, and to

prevent re-use so that it does not turn into a fully-fledged relapse. Medico-psychological support is systematically provided within the scope of this residential model.

According to the most recent data available, in 2008, 58 CSAPAs managed[225] therapeutic apartments that overall represented 488 beds.

Foster families:

These are families that agree to host, for several days, weeks or months, a person referred to them by a specialised centre (one must be referred). They offer a lifestyle punctuated by family life in a friendly environment that fosters contact.

All families are selected by the specialised centres and are reimbursed for the expenses generated by the extra person in the household. Foster family networks are often located away from cities (in big cities, people rarely have a spare room to host someone).

They are particularly beneficial for people who need structure (and who know how to respect it), but who do not want to live in a group or an environment that is too institutional. The person being hosted is still followed by the treatment centre and the family is supported by a social worker with whom the family can discuss any problems encountered.

The development of these networks is limited by the difficulties encountered in recruiting motivated families and, beyond expense reimbursement, by the issue of remunerating families.

In 2008, six CSAPAs managed a foster-family network offering 47 beds.

Group housing

Centres thérapeutiques résidentiels (CTRs, or Residential treatment centres)

Residential treatment centres offer all the same services as CSAPAs, but within a group or fragmented residential framework. They aim to promote a dynamic of change in users, and to support this change through a therapeutic programme that may vary from one establishment to another. They are suggested when outpatient or individual programmes appear to be insufficient due to a deteriorated environment, somatic or psychiatric comorbidities or heavy social problems that prevent the person from fully benefitting from treatment, or when the person needs a secure, protective environment without needing hospitalisation.

Located in either an urban or a rural setting, residential treatment solutions provide a safe, drug-free environment. The activities offered aim to restore a rhythm to daily life and the ability to form satisfactory relationships for the person. They also promote the development of personal skills to prevent relapse. These establishments help implement life plans that include treatment.

These residential programmes offer a constant professional presence and generally provide psychological support (individual and/or group), psycho-educational support, medical support and rehabilitative social support. They must also be in contact with medical and psychiatric services and rehabilitative services as well as have access to housing to cater to the needs of patients.

[225] In France, therapeutic apartments are not independent units from a legal and budgetary point of view; they are generally supervised by an outpatient CSAPA and represent one of the services provided by the CSAPA.

Daily life entails therapeutic activities (individual and group meetings) and rehabilitative group activities. These activities may take place inside or outside of the establishment. After a while, it is often possible for patients to once again begin a professional activity while maintaining their housing and support. The family environment can be taken into consideration in order to prepare for a return to the family setting or enlist parenting support.

The duration of residential treatment, statutorily set at one year maximum, must take into consideration the time required for the patient to acquire sufficient autonomy in order to integrate into a more open treatment setting (such as therapeutic apartments and outpatient treatment centres) or towards social and/or professional rehabilitation. Receiving therapy in a residential treatment centre can be anonymous[226], if the user so desires, and is free of charge to the user (funded by French national health insurance).

Certain residential treatment centres cater to specific populations: two establishments in France are especially designed to treat minors, and some have sections for women with children. Only one establishment employs the Minnesota model, working cooperatively with Alcoholics Anonymous and Narcotics Anonymous networks.

In 2008, 35 residential therapeutic centres offered a total of 440 housing spots. Approximately 1,500 patients were housed in these centres in 2008.

Therapeutic communities:

Therapeutic communities are defined as long-term residential centres open to people who are addicted to opiates, stimulants, alcohol or multiple drugs. These communities provide a safe, drug-free environment of community living with drug addicts who are more advanced in their rehabilitation process. These peers can provide support by acting as positive role models and by using positive peer pressure to help addicts rebuild their lives. This approach aims to help residents develop their ability to manage their stress and distress without using drugs, to regain self-confidence and to gradually move forward towards independence and resocialisation by taking on greater responsibilities.

These programmes currently cater to patients who are too difficult to be able to reap the long-term benefits of outpatient or "short-stay" residential treatment programmes: these difficult patients may have experienced numerous failed treatment attempts and/or be suffering from psychiatric disturbances or significant social isolation.

French therapeutic communities take the environment into consideration and represent a treatment method that complements existing measures. Less rigid than their Anglo-Saxon counterparts, therapeutic communities offer support to those drug users wishing to achieve abstinence, when medically possible. Given the frequent psychiatric comorbidities, psychiatric treatments can be pursued.

Therapeutic communities function based on four main principles:

- Organization of time: the stay is organized into phases of varying duration depending on the progress a person makes in managing the tasks entrusted to them, their relationship with peers and the supervising personnel and their ability to manage any “cravings”. Days are also structured into different therapeutic and/or organizational activities.

[226] This anonymity is possible as the result of the criminalization of use.

- The group: it is hypothesised that the group can resolve problems that arise while working and living together. The group is called upon to use mutual aid to provide support for each member. Most of the therapeutic activities are based on group situations (group therapy sessions of varying types).

- The emotional approach: this approach helps group members to express emotions they feel “here and now”, thereby facilitating emotional control and conflict resolution.

- Assuming responsibility: as users progress along their treatment path, they take on more responsibilities, whether this means helping users who are less advanced in their treatment or taking part in community decision-making.

Communities can also make use of workshops (such as occupational therapy) or rehabilitation services (government "*chantiers d’insertion*”, or government certified occupational rehabilitation programmes that provide remuneration for participants). Therapeutic communities have both a cognitive-behavioural and a psychodynamic approach. They can work to develop specific programmes (e.g., relapse prevention, femininity) that are appropriate to their population. They undergo a special assessment process. There is a new therapeutic community being opened, and it is specifically intended for women with children.

In 2008, there were six therapeutic communities, which together had a 200-bed capacity. Since 2008, four new therapeutic communities have been launched. The total housing capacity of these therapeutic communities in 2012 is 350 beds.

Duration of stay and reasons for patients leaving residential treatment centres and therapeutic communities

In 2008, the patients living in residential therapeutic centres or therapeutic communities were mainly managed by specialised educators or activity leaders (56% of procedures) and by nursing personnel (33% of procedures). General practitioners, psychiatrics and psychologists carried out 22% of the procedures.

The average duration of stay in these centres in 2008 was approximately 100 days. For a little more than half of those patients who completed a stay in 2008, the duration was one to three months long, and for slightly over one quarter, the stay was three to six months long. Nearly one out of every five patients stayed for over six months. Approximately one out of every four patients completed their stay on the date that had been scheduled with the treatment personnel. Nearly one out of every 10 patients was referred to a structure considered more appropriate to their situation. Approximately two out of every 10 patients were expelled by the treatment centre and nearly three out of every 10 patients left the centre early of their own accord.

These data mainly depict the situation in residential therapeutic centres since there are many more such centres than there are therapeutic communities. Therefore, the figures do not illustrate the specificities of the latter type of residential programme, especially since such structures were only recently created and still under development at the moment the data was gathered.

CHRS Addiction centres (Centres d'hébergement et de réinsertion sociale)

As was previously mentioned, CHRS centres arose during an era when the authorities had just begun to consider treatment for people suffering from addictions. These CHRS centres (social housing centres) mainly receive people having trouble with alcohol, and most such centres aim

to become SSRs (*Soins de suite et de réadaption*, or follow-up and rehabilitation centres) or CSAPAs. With a view to implementing addiction treatment for alcohol and illegal drugs, some of these centres are gradually opening up to illegal drug users.

The missions of the addiction-oriented *Centres d'hébergement et de réinsertion sociale* (CHRS) are:

- to admit any person presenting with an addiction to single or multiple substances and seeking to abstain from use
- to admit mothers with children and pregnant women within the scope of preventing foetal alcohol syndrome
- to provide these people with support for quality social integration with consideration for the somatic, psychological and social aspects
- to continue providing such support within the framework of follow-up care.

There are 11 CHRS centres originally geared towards alcoholics, representing some 448 beds (source: FNESAA-COPAAH). The way they function is very similar to CSAPAs with housing.

Some CHRS centres plan to eventually become CSAPAs with housing, residential treatment centres or therapeutic apartments.

Health

Follow-up rehabilitation treatment programmes

Originally alcohol treatment centres, these centres are gradually opening up to other addictions. *Services de soins de suite et de réadaptation en addictologie* (SSRAs or Addiction follow-up care and rehabilitation) aim to prevent or limit the functional, physical, cognitive, psychological and social effects of people with addictions to psychoactive substances and to promote their rehabilitation.

The treatment targets achieving abstinence, preventing relapses and avoiding the risks related to substance use. In addition to providing medical care, such programmes ensure individual and group psychotherapy and a socio-educational programme intended to promote social rehabilitation.

Based on the complications and deficiencies caused by addictions, these measures can specifically target managing somatic complications, psychological or psychiatric disturbances and neurological or cognitive deficits as well as promoting social rehabilitation.

SSRAs are just one of the components of hospital-based addiction structures. They host patients who severely abuse and who are often dependent after withdrawal, or patients who have undergone complex residential treatment.

The areas of expertise of SSRAs include addiction to psychoactive substances, which may or may not be associated with other behavioural addictions.

There are currently 70 addiction follow-up and rehabilitation services, with a total capacity of 2,305 beds. Until 2010, these services almost exclusively treated patients with alcohol problems.

11.2.2. Methods of intervention

Operating in a network

Establishments are encouraged to enter into agreements with partners who are crucial to their activities. Subsequently, there are agreements with outpatient CSAPAs to ensure subsequent treatment, with hospital addiction services to provide the support needed for simple and complex withdrawal, with medical and psychiatric services to provide better management for people with dual diagnoses, with child welfare services when residents are minors, with CAARUDS to provide support for any relapses and harm reduction or to take part in a CSAPA harm reduction mission, or with prison administrative staff for residential programmes open to convicts.

In all cases, stays in residential establishments are designed to be a step in the treatment process, allowing patients to become aware of the totality of treatment options available to them.

Since the causes of addictions are multifactorial, the related treatments usually involve several approaches: pharmacotherapies, psychotherapies, physical therapies and rehabilitative assistance. It is the combination of these approaches, which are all of interest, as well as the concurrent observations by different professionals, that seems relevant.

11.3. Quality management

All CSAPAs and therapeutic communities are medico-social establishments and are therefore regulated by French law no. 2002-2, which stipulates the assessment modalities for establishments and imposes a certain number of standards and tools, especially with respect to user representation.

In particular, each establishment must:

- have a brochure that presents the establishment
- have policies and procedures
- establish a residential contract or individual treatment document with each user
- inform users of their rights and their possibilities for recourse
- display the charter for residents in the establishment
- organize a “Council for social life”. This acts as a body through which users of the establishment can express themselves; the Council should also have members from outside of the establishment.

Furthermore, each establishment must have an establishment plan validated by the inspection authority and be part of a quality improvement process, which implies the establishment of regular internal and external assessments. Such assessments must occur before the renewal of the authorisation to operate.

11.3.1. Availability of the framework and standards

The *Agence nationale de l'évaluation et de la qualité des établissements et services médico-sociaux* (ANESM, National agency for the assessment and quality of social and medico-social establishments and services) produces frameworks[227] with which establishments must comply as well as good practice guidelines.

Some guidelines apply to all of the medico-social establishments, such as "*bientraitance*" (Welfare: definition and references for implementation)[228], or those related to the internal and external assessment of establishments[229]. Others are more specific, such as "*la participation des usagers dans les établissements médico-sociaux relevant de l'addictologie*" (The participation of users in addiction-based medico-social establishments) (ANESM 2010).

La Fédération addiction, an NGO that groups the majority of addiction medico-social establishments, prepares good practice guidelines for CSAPAs with housing using the support of the authorities and an approach that incorporates the participation of all relevant establishments[230].

National and local frameworks

La Fédération addiction has also developed a framework for its members[231], to support them in performing self-assessments. It helps analyse the different operational areas in establishments:

- Appropriateness of the response to the needs of the population
- Partnerships and the place in the environment
- Compliance with the rights and duties of the users and their participation
- Management of human resources
- Administrative and financial management
- First contact
- Information
- Medical, psychological and social assessment, orientation

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[227] The complete list of ANESM frameworks is available on the Internet: http://www.anesm.sante.gouv.fr/spip.php?page=rubrique&id_rubrique=10

[228] Agence nationale de l'évaluation et de la qualité des établissements et services médico-sociaux. La bientraitance : définition et repères pour la mise en œuvre (Welfare: definition and targets for action), Saint Denis, ANESM, 2008, 47 p.: http://www.anesm.sante.gouv.fr/spip.php?page=article&id_article=128

[229] *Fédération nationale des associations d'accueil et de réinsertion sociale. Évaluations internes et externes* (French federation of treatment and social rehabilitation, Internal and External Assessments). Summary sheets written from experience with the FNARS network, Paris, FNARS, 2010, 95 p :http://www.fnars.org/index.php/ressources-documentaires-evaluation/125-ressources-documentaires/2371-un-outil-pour-le-reseau-fnars

[230] *Fédération addiction. Guide méthodologique* "*Mener l'évaluation interne : pas de panique*!" (Methodology guide, "Conducting internal assessments: don't panic!"), 2008: http://www.federationaddiction.fr/guide-methodologique-mener-levaluation-interne-pas-de-panique/

[231] *Fédération addiction. Un référentiel d'évaluation interne pour les CSAPA et CAARUD* (A framework for CSAPAs and CAARUDs on internal assessment), 2012: http://www.federationaddiction.fr/un-referentiel-dauto-evaluation-pour-les-csapa-et-caarud/

- Support
- Harm reduction
- Housing and methods.

Other frameworks that integrate the ANESM's directives were created, sometimes by the establishments themselves and sometimes by groups of establishments.

Results, documentation and assessment

Each establishment is required to submit an activity annual report to the territorial delegation of its regional health agency. However, the diversity of the populations seen and the modes of operation for the establishments (do they accept users with severe psychiatric comorbidities? unstable users? etc.) makes it difficult to globally assess their results, which do not take into consideration the baseline situation of users.

It is appropriate to point out that the most recent calls for projects (e.g., therapeutic communities, mother and child housing, persons just released from prison) incorporated the need to implement an assessment procedure into their specifications for these measures.

Relationships between funding and reporting

The report submitted each year to the territorial delegation of the regional health agency puts into perspective the use of the budget that was allocated and the activity of the establishment.

Moreover, a national system for information collection has been in place since 2005. This system is called "RECAP" (*Recueil commun sur les addictions et les prises en charge*, or Common Data Collection on Addictions and Treatments), and it provides an analysis of the major trends in populations and use. This knowledge helps guide the activity of establishments and authorities whenever necessary.

11.4. Discussion and perspectives

11.4.1. Trends in demand for access to treatments in the last decade

The last decade was characterised by several striking events. We will mention three here that had an impact on the development of residential treatment measures.

The first is the advent of the treatment of addictions, which groups problems with alcohol, tobacco, illegal drugs and non-substance related addictions all under the same heading. The distinct histories of these areas have left traces that are fading very slowly: the sector of alcohol addiction treatment, which was primarily managed in the hospital sector, is gradually opening up to illegal drugs, but the needs for alcohol addiction treatment remain tremendous. CSAPAs with housing still mainly accept illegal drug users, but are also open to alcohol users since alcohol is often the last substance used after the use of other substances has stopped. Nevertheless, the residential treatment of illegal drug users occupies a less central place than before since the possibilities for outpatient treatment have largely developed, particularly since the launch of effective substitution treatments. Outpatient CSAPAs have medico-social technical platforms that provide long-term support for drug users. Many physicians in private practice are also

involved, since they can treat many addictions through networks as long as the addictions do not present with significant complications.

The second significant event was the change in use habits, with the use of cocaine, and crack in particular, moving to centre stage. This led to a rethinking of treatment models, which up until then had essentially catered to heroin addicts. However, cocaine use also revealed “festive” use, particularly of psychostimulants, which sometimes got out of hand and required strong support. Users are also of different ages. There are still numerous young users, but there are also older users confronted with significant health problems for which professional rehabilitation no longer seems appropriate.

The third significant event to take into consideration is the economic crisis, which has made already-vulnerable populations even more susceptible: homeless young people and elderly people, ex-convicts, women, and especially women with children, sick people, particularly HIV- or HCV-infected people, and foreigners whose papers are not in order.

This difficult context has been evidenced through a major change in the place and operation of residential solutions: previously a solution of first resort, they are now part of a treatment course with a network of partners both upstream and downstream. They are becoming more technical, proposing complex treatment programmes including pharmacotherapies, psychotherapies and sociotherapies, and address populations requiring more resources, since residential solutions cater to heavier cases. Since the 2006 launch of therapeutic communities, some of these populations, which are often those furthest from integration, have been helped. However, there are still significant, and sometimes unmet, needs, as was shown in two surveys (Coquelin *et al.* 2009; Palle Non publié) conducted within the scope of a "housing" working group of the addiction commission of the French Ministry of Health. The surveys revealed the need to develop diverse responses to meet the therapeutic housing needs of drug users.

At the confluence of the health and social sectors, medico-social residential establishments must nevertheless take current trends into consideration: the development of health responses, and follow-up and rehabilitation services in particular, on the one hand and the “radical reform” of the social sector on the other hand, with experiments that aim to achieve unconditional housing access (“Housing first”).

This leads to a continuation of the effort in several directions: on the one hand, it is necessary to work to improve the acceptance of people suffering from addictions through “common law” measures to open up the field of housing and integration. On the other hand, it is necessary to continue developing residential measures for "over-excluded" populations, i.e., those who cannot directly access health, social and medico-social programmes, by including them in large partnership networks. Finally, it will be necessary to continue efforts to identify profiles of users who could benefit from the different residential structures so that these users can be better oriented.

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12. Recent trends in drug-related public expenditure and drug-related services in France

This special issue is intended to look into how the recent 2008 economic crisis is affecting drug policy public spending and drug-related services in France.

Firstly, we provide economic data on the factors that we believe to have started or explained the recent economic recession in France. Government expenditure series are also provided in order to assess the impact of the crisis on public finances.

Secondly, estimates for the recent trends in drug-policy public spending have been provided. We deal with the methods used and their short fallings and with estimation problems arising from the reliability of collected data.

The last part of the paper seeks to determine to what extent the crisis of 2008 has led to cuts or gradual reductions in drug policy public spending growth. We rely on available data on drug-related spending to determine austerity levels in French drug policy.

12.1. The 2007-2009 "Great Recession"

The aim of this section is to examine recent trends in public expenditure in France, and to assess the impact of the "Great Recession" on French public finances.

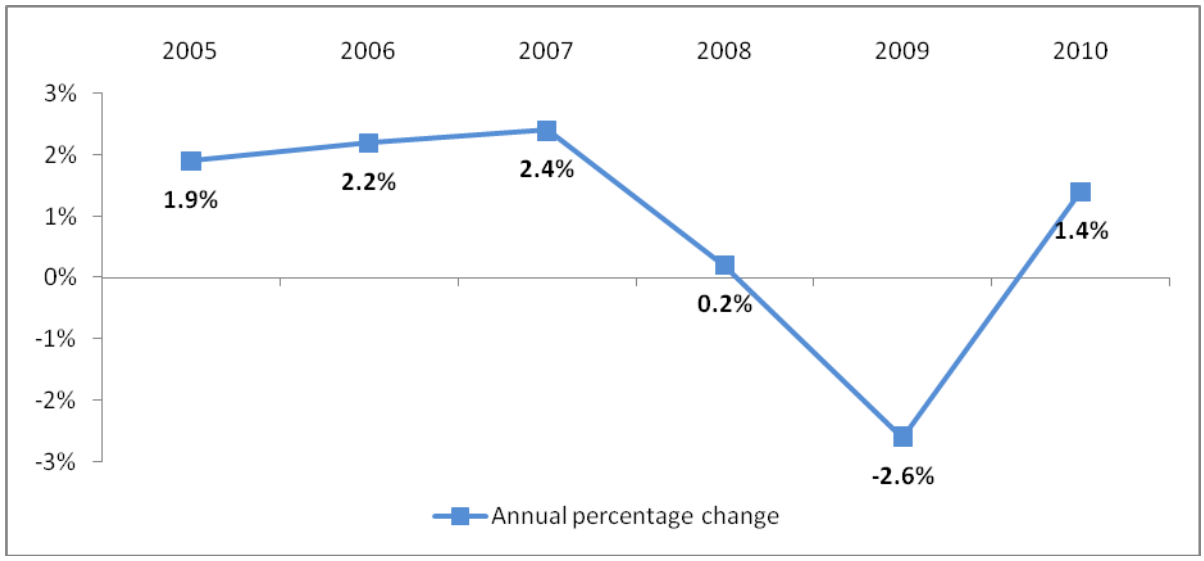
12.1.1. The global economic slowdown

In the late 2000s, advanced economies suffered the most severe world economic recession in five decades. According to the United States National Bureau of Economic Research, the "Great Recession" was caused by the U.S. housing market meltdown and the December 2007 financial bubble.

The financial crisis spread across Europe rapidly. In the second quarter of 2008, the euro zone economy was reported to have shrunk by 0.2 percent. The economy of the "euro-bloc" saw a new decline in the third quarter of 2008 which put the euro zone in a technical recession. This was the first time since the bloc's creation in 1999 that its economy contracted for two consecutive quarters.

France did not fall into recession then, but its economy also recorded a high rate of deceleration in the second quarter of 2008. In 2009, the French economy growth rate recorded a remarkable decrease. It dropped by -2.6 percent on average over 2009 after having recorded an annual growth rate of 0.2 percent in 2008.

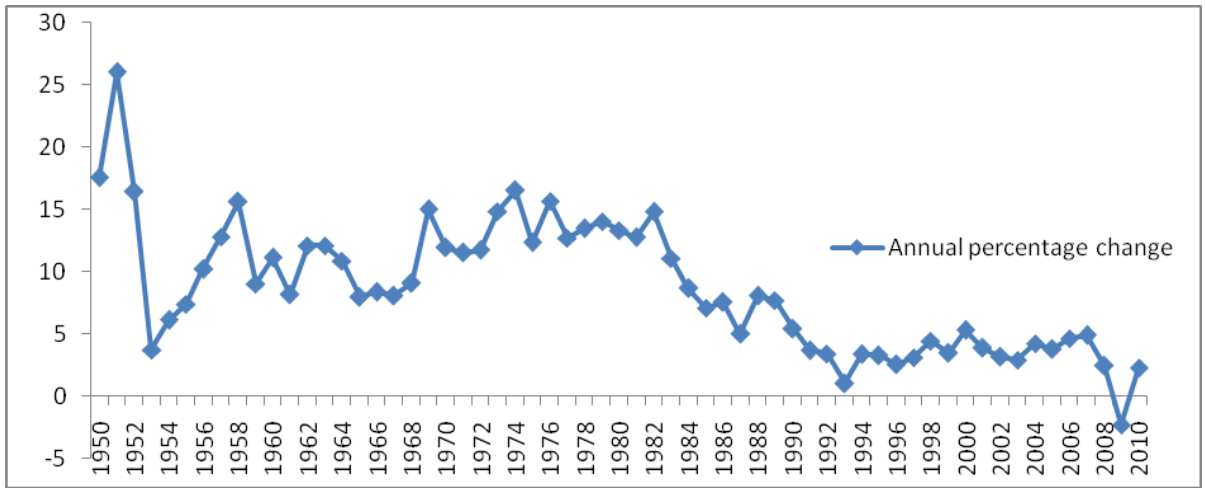
Graph 12-1: Recent trend in growth in France



Source: Statistical Annex of European Economy: Long-term macroeconomic series, EC (Spring 2011) from national sources.

Like every other industrial economy in the world, France experienced in 2008-2009 its most severe economic crisis since the end of World War II. The French economy has struggled in the past to overcome difficult situations (the first oil shock, the 1993 economic slump, the global deceleration of 1999, to name just a few), but the economic activity had never dropped so dramatically as it did during the recent crisis.

Graph 12-2: Growth of gross domestic product (GDP) in France since World War II

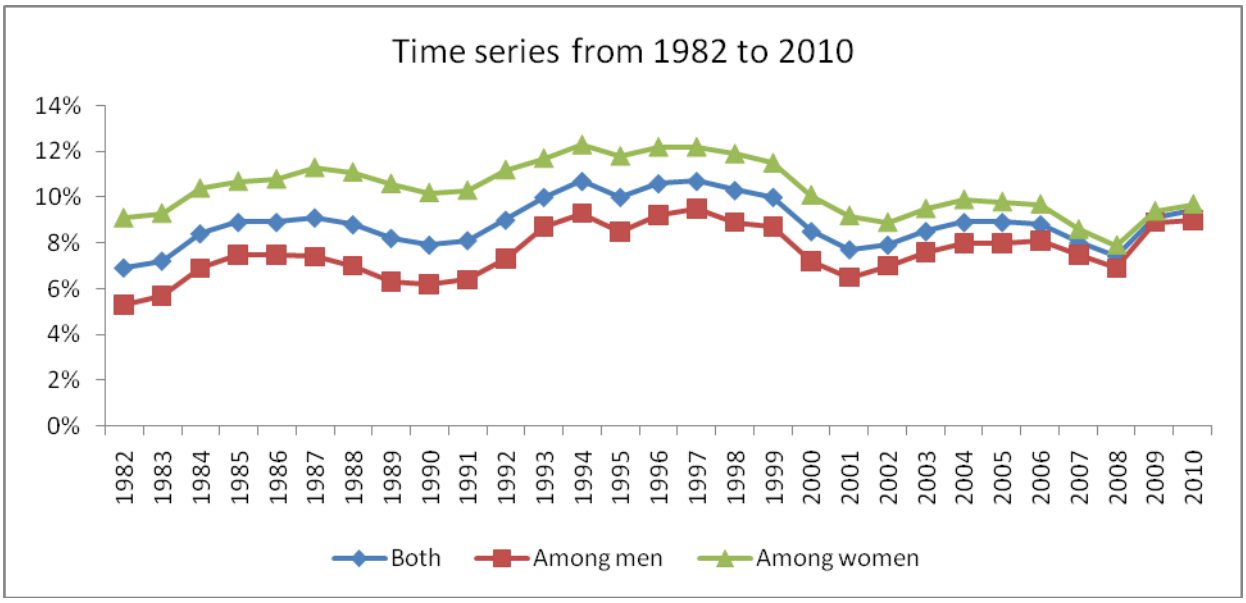


Source: Insee[232], National Accounts, base 2005.

Sluggish economic activity brought about a sharp rise in unemployment, especially affecting the non-agricultural market sectors.

[232] Institute National de statistique et études économiques (National Institute for Statistics and Economic Studies).

Graph 12-3: Rate of unemployment (in percentage) in France



Source: Insee, Employment survey.

12.1.2. French governmental economic measures to fight recession: an increase in public expenditures to support activity

In December 2008, the French government launched an economic stimulus package to fight recession. Run out in 2009, the 26 billion-euro rescue plan included 11 billion euros to help businesses increase their cash-flow, 11 billion euros of direct state investment and 4 billion euros to improve infrastructure (modernizing rail infrastructure in particular) and public services (energy and postal service). The stimulus package amounted to 1.4 percent of the GDP.

Although recession was not avoided, public sector investments supported considerably the global activity. In 2009, government consumption accelerated by 2.7 percent after 1.7 percent in 2008. Private consumption performed reasonably well (0.6 percent of annual change in 2009 from a 0.5 percent in 2008).

The decline in activity in 2009 was mainly prompted by a very sharp fall of exports. In 2009, exports fell by 12.4 percent, mainly due to sluggish world trade. The deceleration of exports began in 2007 to record 2.5 percent on average in 2007 from 4.8 percent in 2006.

After considering exports, the contraction in activity reported in 2009 can be explained by a great reduction in investment by companies, mainly because of unavailability of investment funds in 2008 and low expectations about future business activity. The gross fixed capital formation (GFCF) –which indicates what share of the new value added in the economy is invested rather than consumed– fell by 7.1 percent in 2009, from a 0.4 percent average over 2008. The downturn in the total demand led to a substantial drop in imports.

Table 12-1: Annual percentage change from previous period (Trading days, seasonally-adjusted data)

	2008	2009
Gross domestic product (GDP)	+0.2	-2.6
Imports	0.6	-10.7
Government expenditure	1.7	2.7
Private consumption	0.5	0.6
Exports	-0.5	-12.4
Gross fixed capital formation (GFCF)	0.4	-7.1

Source: Quarterly national accounts, INSEE

12.1.3. Threats posed by the sovereign debt crisis

Sluggish activity is causing government revenue to decrease. Revenue fell from 49.5 percent of GDP in 2008 to 48.7 percent of GDP in 2009. Notwithstanding this decrease, public expenditure has continued increasing (from 52.9 percent of GDP in 2008 to 56.2 percent in 2009) (INSEE official data). This revenue decrease is the result of a drop in personal as well as corporate tax collection and to a diminishing contribution by employers. The weakness of activity resulted in fewer available resources. The French government was left with no choice but to increase the sovereign debt. Prior to the crisis, the public debt[233] amounted to 60 percent of GDP. Since the recession took place, it has gone up vigorously. It amounted to 78.3 percent of GDP in the fourth quarter of 2009, 81.7 percent one year later to reach 85.8 percent in the fourth quarter 2011. In 2011, France recorded a deficit above 7 percent of GDP, according to the INSEE.

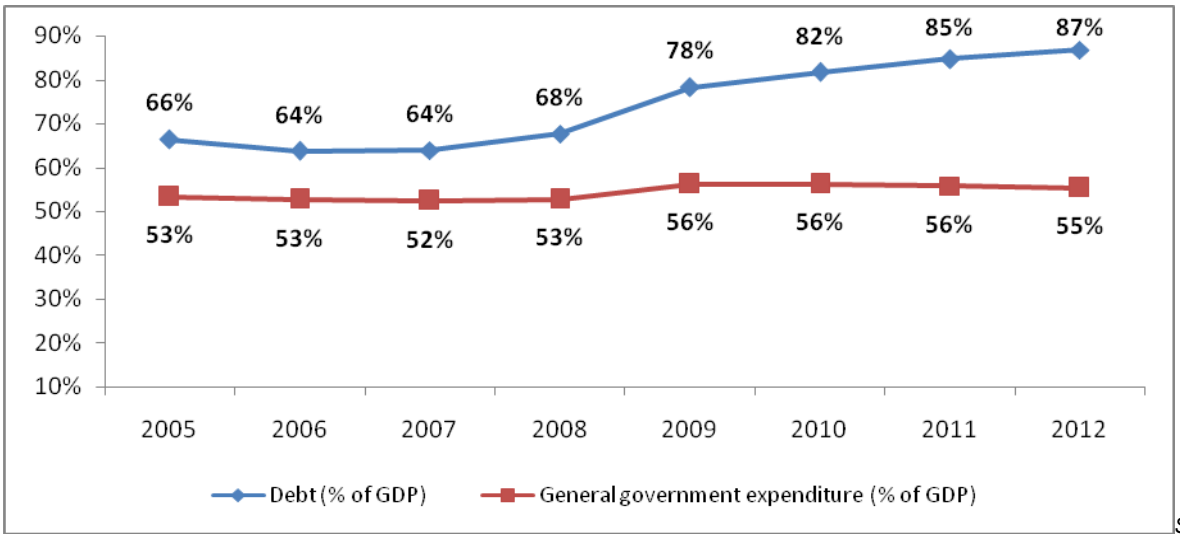
Table 12-2: Quarterly public debt, as defined by the Maastricht Treaty by sub-sector (€billions)

	Q4 2010	Q1 2011	Q2 2011	Q3 2011	Q4 2011
Public Debt	**1595,2**	**1650,0**	**1696,2**	**1692,5**	**1717,3**
% of GDP	82.3%	84.7%	86.3%	85.5%	85.8%
of which, by sub-sector :					
State	1245.0	1286.2	1338.7	1330.1	1335.2
Central administrations	14.1	11.0	9.8	9.9	10.4
Local administrations	161.1	157.2	154.3	153.4	166.3
Social Security Funds	175.0	195.7	193.4	199.1	205.4

Source: National Accounts - Insee, DGFiP, Banque de France

[233] Gross debt

Graph 12-4: The Sovereign debt and expenditure share of the GDP in France since 2005



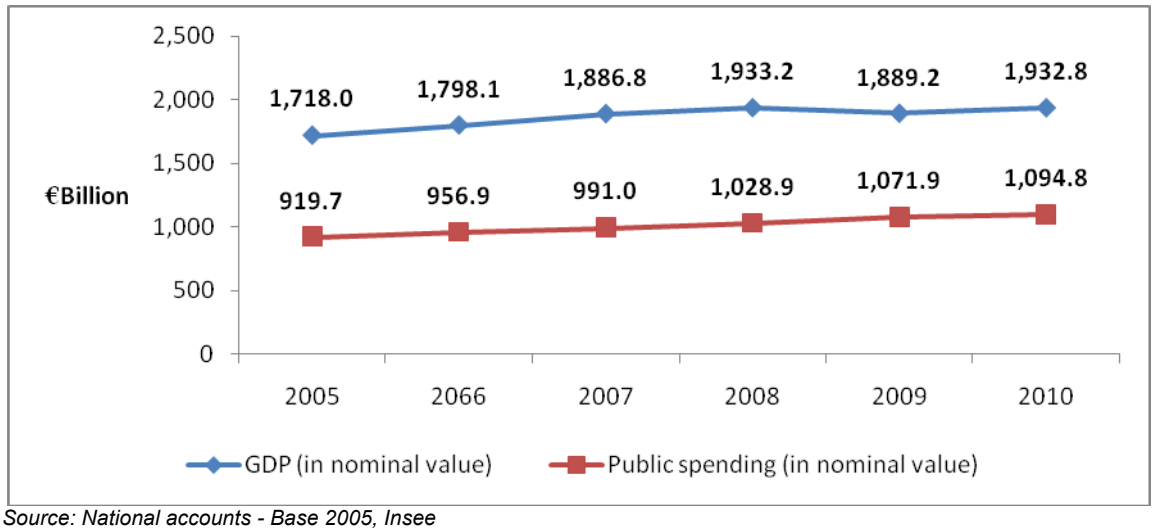
Source: Statistical Annex of European Economy: Long-term macroeconomic series, EC (Spring 2011). Figures for 2011 and 2012 are forecasts made by Commission staff using the definitions and latest figures available from national sources.

12.1.4. Public resources available to either consume or invest

After four negative quarters, France came out of the red. Since the beginning of the "Great Recession", activity has picked up moderately. According to the INSEE, GDP in physical terms increased by +1.4 percent in 2010. Nevertheless, there was still a long way to go before the pre-crisis levels of growth (+2.4 percent in 2007) can be regained. Nominal GDP reached €1932.8 billion in 2010, slightly below GDP for 2008.

As to recent trends in public expenditure, it appears that the 2007-2009 "Great Recession" has not led to a reduction in public spending over the reference period (public spending figures for 2010 refer to the latest available data). However, the increase in public expenditure has clearly slowed down in 2010 (see graph 12-5). Before the crisis, annual public spending was approximately increasing at a rate of 4 percent. In 2010, public spending growing slowed down to 2 percent. Forecasts for 2011 and 2012 indicate a progressive deceleration in public expenditure: 1.8 percent in 2011 and 0.5 percent in 2012.

Graph 12-5: Public spending compared to GDP



Source: National accounts - Base 2005, Insee

12.2. Public expenditure in the main areas covered by drug interventions

This paper seeks to shed light on the question of whether deceleration in global public expenditure has any impact on drug-related public spending. The following section explores this issue.

12.2.1. Evolution and breakdown of drug-related total expenditure

In France, public expenditure on fighting, preventing and treating drug addiction has already been dealt with in previous studies (Ben Lakhdar 2007b). Kopp and Fénoglio estimated the public spending by French authorities on illicit drug-related policy at €729.62 million in 1995. This study also estimated the expenditure on alcohol-related policy, which in 1997 amounted to €128.45. Note that the estimates for tobacco-related costs are not available for 1995 and 1997. In 2003, public expenditure on licit and illicit drugs (excluding drug-related costs for treatments) was estimated at €1,159.12 millions (Kopp *et al.* 2006). In 2005, Ben Lakhdar provided a new up-dated estimate for illicit drugs using a different method (Ben Lakhdar 2007b). The latest estimate was approximately €1,169 million (drug-related costs for treatments excluded).

The present work takes an alternative approach, providing estimates for the 2008-2010 period. Figures for 2011 or 2012 are provided only when forecasts are available. Estimates for 2008-2010 show direct costs, defined as the sum of labelled and unlabeled drug-related expenditure. A breakdown of tobacco, alcohol and illicit drug-related expenditure is not provided: data are all-inclusive.

Labelled expenditures are those which are identified as such in the budget. Calculation methods are not required for labelled drug-related budgets. Time series data for this category of expenditure are provided on a regular basis. However, variations in components in labelled drug-related expenditures make comparison between 1995 and 2008-2010 difficult. Differences are mostly explained by changes in the origin of the funding. For example, between 1995 and 2009, the Justice and Health National Programme was financed by the MILDT. Since 2010, this programme has been financed by the Social security system and credits have been matched

with those applied to the drug abuse & harm reduction centres. In most cases, data breakdowns are not available, making comparison of data between 1995 and 2008 impossible.

Labelled expenditures are not the only drug-related direct costs. There also exists a large amount of non-labelled expenditure which clearly belongs in the category of drug-related policy. Since 2008, drug-related non-labelled spending can be directly traced back by reviewing drug policy reporting documents. By focusing on actions implemented within broader programmes in the field of drugs (alcohol, tobacco and illicit drugs as well as doping), these financial reporting documents provide estimates on unlabelled drug related expenditures. Methods of calculation are not homogenous across programmes. Estimates are calculated by the authority responsible for carrying out the programme. For some programmes, estimates on drug-related direct costs are based on a bottom-up approach, and for others, the method of calculation is based on a top-down approach. A detailed explanation of the calculation method is provided in section on unlabelled expenditures. Obvious methodological reasons (different approaches in modelling methods in unlabelled drug-related expenditure and in the selection of components) explain why this report does not undertake the task of comparing new and previous estimates (Ben Lakhdar 2007b; Kopp *et al.* 2006) but to identify recent comparable trends.

Labelled expenditures are presented initially, together with an overview of the unlabeled expenditures and a further explanation on the calculation methods used. The last section presents the general drug-related expenditures for the 2008-2010 period, and a final discussion.

Labelled expenditures: main categories of payments and detailed purposes

Drug related labelled expenditures in France are divided into two main categories of payments: the payments made by the social security system and those made by the Interministerial Mission for the fight against drugs and drug addiction. For each main category of payment, detailed purposes of the drug-related labelled expenditure are indicated below.

Labelled payments made by the social security system

Providing drug abuse & harm reduction services has a direct cost borne in France by the social security system. The social security system pays out for the provision of services provided by the drug abuse & harm reduction centres (not only expenditures made for the provision of services related to illicit drug disorders, but also those related to alcohol abuse). It also contributes to funding a part of the direct costs of drug abuse services at hospitals. However, it is important to point out that it accounts for a very marginal part of the total drug related expenditures corresponding to health spending by hospitals (see section below dealing with unlabelled expenditures in health). Moreover, in France, the social security system also refunds part of the OST medicines.

Budget allocated by the social security system to providing drug abuse & harm reduction services in substance abuse centres

In France, the drug abuse & harm reduction centres are free for clients. Their budgets are therefore fully financed by the public system.

Total expenditures for the provision of drug abuse & harm reduction services are the sum of regular expenditures to finance staff costs and other spending due to the regular working of these centres, and additionally, complementary budgets which are allocated in accordance with priorities stated by national strategies dealing specifically with overall public policy in the field of drug addiction and health, in general.

Over the 2007-2014 period, extra budgets devoted to drugs health policy have been stated in the following three national strategies:

- the 2007-2011 "Addictions" plan which aimed at developing prevention and healthcare for drug users in health public establishments

- the 2008-2011 "Governmental Drugs" plan whose main purpose was to facilitate access to housing, healthcare and social services by vulnerable groups (young users, women, prisoners)

- the 2011-2014 "Health in prison" plan, which seeks to guarantee prisoners' access to healthcare under the same conditions as those affecting other vulnerable not-in-jail groups

Table 12-3: Labelled spending in substance abuse and harm reduction centres from the social security system (€ Million)

Social security funds (sector value[234]: s1314)	Cofog1 value[235]	Cofog2 value	2008	2009	2010
Cost of staff and spending due to regular working of substances abuse & harm reduction centres	Gf07 - Health	Gf0702 - Outpatient services	271.27	283.10	304.71
Expenditures devoted to drugs centres to implement national priorities stated in the 2008-2011 "Governmental Drugs" plan	Gf07 - Health	Gf0702 - Outpatient services	8.84	16.33	16.23
Expenditures devoted to drugs centres to carry out the Health/Justice programme (indicated prevention)	Gf07 - Health	Gf0702 - Outpatient services	(*)	(*)	5.25(*)
Total amounts of expenditure	**Gf07 - Health**	**Gf0702 - Outpatient services**	**280.11**	**299.43**	**326.18**

Source: ARS/DGS (credits allocated to the substance abuse & harm reduction centres by the Health Regional Authorities)
(*) Such a budget was supported by the Interministerial mission for the fight of drugs and addictions until 2009. Since 2010, such expenditure has been supported by the Social security funds. Since 2011, these credits have been integrated as a part of the cost of staff and regular functioning of the substances abuse & harm reduction centres.

Over the 2008-2010 period, the expenditures devoted to providing drug abuse and harm reduction services appear to show an upward trend. Therefore, there is no evidence of any budget reductions. In the short-term, the 2008-2009 crisis does not seem to have had any negative impact in budgets for the provision of substance abuse & harm reduction services. Furthermore, according to official sources (National Health Directorate - DGS), no cuts or reductions in budgets allocated to substance abuse services are expected, even when official data for 2011 and 2012 are not yet available.

[234] The "sector value" identifies the General Government Sector reporting the Expenditure (as defined by the European System of National and Regional Accounts).
[235] COFOG stands for "Classification of the functions of Government". It is 3-level classification with 10 "Divisions" at the first level (Cofog1) and 6 "groups" at the second level (Cofog2).

Budget allocated by the social security system to providing drug abuse & harm reduction services in hospitals

In France, health public establishments are also financed by the social security funds to provide drug abuse services to patients. The 2007-2011 “Addictions” plan allocated a special financial contribution over its span-period intended to create and strengthen substances abuse care in public health establishments. This expenditure accounted approximately for €30-40 million per year. Up to 2011, only the adoption of future plans in the field could guarantee unchanged funding in drug-related healthcare services. The plan recently adopted for promoting health in prison should contribute to improving responses intended to drug users in prison. However, amounts allocated do not seem to be as large as in previous efforts made by the security social system to tackle drugs and drug addictions in the health public establishments.

Table 12-4: Labelled expenditure in preventing and treating addictions in hospitals from the social security system (€ Million)

Social security funds: contribution to implement priorities stated in the 2007-2011 "Addictions" plan (sector value: s1314)	Cofog1 value	Cofog2 value	2008	2009	2010	2011	2012
Funds for creating or strengthening substance abuse care and liaison teams	Gf07 - Health	Gf0703 – Hospital services	2.31	4.62	4.62	3.33	1.53
Funds for carrying out hospital addiction consultations	Gf07 - Health	Gf0703 – Hospital services	7.08	10.16	10.16	5.94	2.97
Funds for developing hospital facilities for preventing and treating substance abuse	Gf07 - Health	Gf0703 – Hospital services	7.85	15.70	15.70	21.24	10.63
Hospitalisations for complex withdrawal	Gf07 - Health	Gf0703 – Hospital services	12.62	9.24	9.24	9.47	4.73
Funds for setting up weekly specialist consultations in the medical service for prison establishments	Gf07 - Health	Gf0703 – Hospital services	0	0.60	0	0	1.06
Sub-total expenditure in hospital for carrying out drug related activities planned in the 2007-2011 Addictions Plan	Gf07 - Health	Gf0703 – Hospital services	*29.86*	*40.32*	*39.72*	*40.03*	*20.92*
Social security funds: contribution to implement priorities stated in the 2011-2014 "Health in prison" plan"	**Cofog1 value**	**Cofog2 value**	**2008**	**2009**	**2010**	**2011**	**2012**
HIV and hepatitis detection in care units in prisons attached to hospitals units	Gf07 - Health	Gf0703 – Hospital services	-	-	-	1.57	11.37
Therapeutic groups in care units in prisons attached to hospitals units	Gf07 - Health	Gf0703 – Hospital services	-	-	-	1.26	3.74
Sub-total expenditure in hospital for carrying out drug related activities planned in "2011-2014 Health in prison plan"	Gf07 - Health	Gf0703 – Hospital services	-	-	-	*2.83*	*15.11*
Total amount of expenditure (both public plans)	**Gf07 - Health**	**Gf0703 – Hospital services**	**29.86**	**40.32**	**39.72**	**42.87**	**36.03**

Source: DGOS (credits allocated to the Public health establishments)

Budget allocated to financing expenditures in opioid substitution medicines from the social security system

In addition, the social security system contributes to drug-related expenditure by refunding the cost of part of the price of sale of opioid substitution medicines. It represents the second major part of labelled public payments in France.

The OST market in France is divided into HDB and methadone. Latest available data on both molecules is 2009 (HDB and methadone) (see table 5).

Table 12-5: Labelled expenditure to refunds OST (€ Million)

Social security funds (sector value: s1314)	Cofog1 value	Cofog2 value	2005	2006	2007	2008	2009	2010
HDB of which …			78.49	77.64	78.59	78.11	72.17	na
Subutex®			*78.49*	*74.63*	*70.86*	*61.55*	*56.96*	*na*
Generics			*0*	*9.82*	*11.71*	*16.55*	*15.21*	*na*
Methadone			8.41	9.82	11.71	14.41	16.70	na
Total OST	Gf07 - Health	Gf0701 – Medical products, appliances and equipment	**86.90**	**87.45**	**90.30**	**92.52**	**88.87**	**na**

Source: MEDICAM (ADELI)
Figures for 2010 are not yet available (data release is expected for the end of 2012).

Before 2006, the Subutex® was the only medicine registered and for sale in France for the HDB molecule. In 2006, the French health authorities allowed to prescribe generic medicines for the HDB. The fact that generics are less expensive than their brand-name counterparts explain why the number of generic boxes sold has been on the increase since 2006, while Subutex® sales dropped. Therefore, the social security system has been paying out growing amounts of generics refunds since their market entry in 2006.

Latest available data (2009) suggests a change in recent trends for the HDB refunds. While total HDB has experienced a remarkable drop of €6 million in reimbursement over the period, in the case of methadone, reimbursements are on the increase. This drop in HDB reimbursement could be explained by the large share corresponding to methadone, which has been on the increase all over the period. In 2009, it accounts for 19% of the total OST from 10% in 2005. It may also be explained by the drop in clients' demand, or the hypothetical larger availability of heroin, as reported in qualitative studies from 2007 to 2009 (Cadet-Taïrou *et al.* 2010b).

Labelled payments made by the Interministerial Mission for the fight against drugs and drug addiction

The other major category of expenditures clearly identified as "drug related" are those financed by the MILDT. The fact nevertheless remains that a major part of public expenditure is accounted for by the payments made by the social security system.

Compared to 2005, it should be highlighted that payments made by the MILDT have been reduced by about 15 percent in 2010. Ben Lakhdar (Ben Lakhdar 2007b) referred to €39.3 million while the MILDT's expenditure appears to account for €33.10 euro five years later (see table 6a). This budget reduction in MILDT's payments seems consistent with the transfer of €5.2 million paid out by the Social security system to finance Health and Justice's programmes allocated to substance abuse & harm reduction centres (see section above dealing with payments made by the social security system). Therefore, such a decrease in payments cannot be considered as a net reduction in the total budget devoted to drugs, because of the transfer of payments from the MILDT to the Social security system.

Table 12-6: Total annual payments made by the MILDT (€ million)

	2008	2009	2010
Total MILDT's spending … of which ….	30.87	35.39	33.10
MILDT's regular executed budget	*27.38*	*29.00*	*22.00*
MILDT's executed budget coming from the "Narcotics" fund (*)	*3.49*	*6.39*	*11.10*

Source: RAP (Performance-related Annual Report) and "Drug policy" DPT (Transversal Drugs Policy Document).
(*) These data have been calculated by the OFDT. "Narcotics" Fund figures has been calculated by comparing MILDT's expenditure reported in the "Drug policy" DPT and total MILDT's executed budget presented in the RAP. In fact, the credits reallocated effectively to ministries by the MILDT coming from the "Narcotics" fund can be solely retraced by data provided by the RAP.

Furthermore, fluctuations in the MILDT's executed budget over the period of reference (2008-2010) are difficult to interpret. Figures on expenditures for 2011 are not yet available. It is important however to point out that the contribution of the "Narcotics" support fund to the MILDT's budget is likely to continue increasing (see recent trends in table 6 above). This fund was created in 1995[236]. Since its creation, a growing share of the MILDT's credits came from this support fund. The MILDT is responsible for allocating this support fund to ministries carrying out activities in the field of drug addiction. The budgetary share allocated to each administration was set at the time the "Narcotics" support fund was created, in 1995. Practical difficulties encountered by the courts handling the cases of drug seizures and confiscations have made that before 2008 the effective contribution of the "Narcotics" fund did not account for a large share in MILDT's payments. The working of the fund has improved over the last few years. As a result, since 2008, the "Narcotics" fund has been steadily increasing its share in the MILDT's budget. This evolution might be matched to an equivalent reduction in the proportion of current regular credits. On the opposite, this trend might be matched to an unchanged proportion of current regular credits, increasing, at any rate, the total MILDT's credits.

Regarding the purposes of the MILDT's payments, the budgetary contribution of the MILDT has a twofold mission (see tables 7 and 8 below).

MILDT's expenditures to formulate and coordinate overall drug policy

The MILDT's budget is devoted to planning and coordinating the governmental priorities in the field of drug policy. It includes not only the missions of the MILDT itself concerning the formulation and coordination of the overall drug policy, but also the monitoring of the regular activities performed by the three following bodies: the French Monitoring Centre for Drugs and Drug Addictions (OFDT), the Inter-agency drug control training centre (CIFAD), and, finally, the Regional support devices on drugs and drug addiction (Dispositifs d'appui régionaux, DAR), responsible for providing assistance to the State government drugs national coordinators implementing the governmental priorities.

[236] 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 (NOR BUDB9560005D).
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 (NOR SANG9502738A).

Table 12-7: Labelled expenditure to formulate, coordinate, monitor and evaluate drug-related overall policies and support drug-related activities (€ Million)

Interministerial Mission for the fight against drugs and drug addiction	Sector value	Cofog1 value	Cofog2 value	2008	2009	2010
Formulation and coordination of overall drug-related policies (*)	S1311	Gf03 Gf07 Gf09 Gf10	Gf0306 – Public order and safety n.e.c Gf0706 – Health n.e.c Gf0908 - Education n.e.c Gf1007 – Social exclusion	6.82	8.82	2.58
OFDT	S1311	Gf03 Gf07 Gf09 Gf10	Gf0305 – R&D Public order and safety Gf0705 – R&D Health Gf0907 - R&D Education Gf1008 – R&D Social exclusion	3.15	3.19	3.44
CIFAD	S1311	Gf09	Gf0905 - Education not definable by level	0.49	0.49	0.49
CIRDD (**)/DAR	S1312	Gf03 Gf07 Gf09 Gf10	Gf0305 – R&D Public order and safety Gf0705 – R&D Health Gf0907 - R&D Education Gf1008 – R&D Social exclusion	2.80 (***)	2.80	2.44
Total MILDT's expenditures devoted to formulate, coordinate, monitor and evaluate overall policies related to drugs				**13.26**	**15.30**	**8.95**

Source: RAP and "Drugs Policy" DPT
(*) Data produced by the OFDT on the basis of data provided by the MILDT. Expenditures devoted to the MILDT's missions of policy planning and coordination have been estimated by taking away the transfers of credits made by the MILDT to various actors for implementing drugs interventions or carrying out monitoring, applied research or training. The beneficiaries of the MILDT's transfers of credits are the Regional Drugs Coordinators and the "Regional support devices" (DARs), the ministries and, finally, the OFDT and the CIFAD.
(**)The DARs have been created in 2010. This network replaces the previous Regional information centres on drugs and drug addiction (Centres d'information régionaux sur les drogues et les dépendances - CIRDDs).
(***) Amount for 2008 is not official.

Fluctuations in the budget allocated to the MILDT for carrying out drug policy design and coordination missions are quite large and, in particular, they show a large cut in the MILDT's credits for 2010 for implementing these tasks.

MILDT's expenditures to finance drug policy implementation

On the other hand, MILDT's payments allow ministries and decentralised services to carry out specific projects in drug-related programmes at central and local levels.

As we have already mentioned, the MILDT's funding allocated to the drug supply reduction policy has increased steadily from 2008 to 2010 to hit approximately the total amount of funds

allocated to undertake projects in the area of drug demand reduction (€12.85 million in 2010). The key role played by the "Narcotics" fund since 2008 explains to a great extent the above-mentioned trend: according to the budgetary rule set when the "Narcotics" support fund was created, about 90% of the total amount is redistributed to the ministries to fund the acquisition of equipment or services responsible for fighting drug trafficking and for law enforcement. No more than the remaining 10% can be used to fund preventive activities carried out by the relevant ministries.

Table 12-8: Labelled expenditure to support drug-related activities (€ Million)

Interministerial Mission for the fight against drugs and drug addiction	Sector value	Cofog1 value	2008	2009	2010
Transfer of credits to ministries to implement drug-related programmes in the area of order and safety *(Funds from the "Narcotics" Fund)*	S1311	Gf03 - Public order and safety	3.14	5.75	9.99
Transfer of credits to local governments for implementing drug-related programmes in the area of order and safety (*Funds allocated to National Drug Coordinators*)	S1312	Gf03 - Public order and safety	1.01	0.87	1.30
Total expenditure for financing drug supply reduction projects		Gf03 - Public order and safety	***4.15***	***6.62***	***11.29***

Source: Table elaborated by the OFDT using data from the RAP and DPT from 2010 to 2012.

Table 12-9: Labelled expenditure to fund drug-related activities (€ Million)

Interministerial Mission for the fight against drugs and drug addiction	Sector value	Cofog1 value	2008	2009	2010
Transfer of credits to ministries to implement drug-related programmes in the area of education, health and social exclusion (*Funds allocated to National Drug Coordinators*)	S1311	Gf07– Health	0.35	0.64	1.11
Transfer of credits towards State government at local level for implementing drug-related programmes in the area of education (*Funds allocated to National Drug Coordinators*)	S1312	Gf09 - Education	9.11	7.83	11.74
Transfer of credits to local governments for implementing drug-related activities in the area of health and social exclusion (*)	S1312	Gf07– Health Gf10 – Social Exclusion	4.00	5.00	Paid by the Social security system
Total expenditure for financing drug demand reduction projects			**13.46**	**13.47**	**12.85**

Source: Table elaborated by the OFDT using data from the RAP and DPT from 2010 to 2012.
(*): It concerns the "Health and Justice programmes". Such a budget has been financed by the Interministerial Mission for the fight against drugs and drug addiction from 1993 to 2009. Since 2010, such expenditure is made by the Social security system.

Unlabelled expenditures: source of information used and main components

Unlabelled expenditures presented in this work have been estimated by the ministerial services involved in combating drugs and preventing drug use. Since 2009, such estimates are listed in a financial reporting document: Transversal Drugs Policy Document "*Document de politique transversal: Politique de lutte contre les drogues et les toxicomanies*" ("drugs policy" DPT) which focuses on drug activities undertaken by authorities during the reporting year. Such document is issued by the MILDT in collaboration with the ministries involved.

The "drugs policy" DPT compiles the main interventions carried out by ministries in the field of drugs and publishes amounts disbursed for implementing such interventions. Estimates are broken down by programme and actions. Programmes are promoted by the ministries responsible for fighting drugs and preventing drug use. Thirty ministerial programmes are listed. They involve several ministries and related services:

- The Ministry of the Economy, Finance and Industry contributes to fighting the black economy related to narcotics and legal drugs through the Directorate for French Customs and Indirect Taxes (*Direction générale des douanes et droits indirects or "DGGDI"*), which is dependent from this ministry.

- The Ministry of National Defence, the Ministry of Domestic Affairs and the Ministry of Justice also participate in drug-fighting activities. They are responsible for the activities of the army and the police and for the working of the legal system (law courts activities) and of prison services.

- The Ministry of Foreign Affairs is also involved in fighting illegal drugs through international cooperation seeking to fight international drug trade.

- The Ministry of National Education participates in activities aimed at preventing addictive behaviour through interventions at schools.

- Finally, the Ministry of Health and Solidarity is also involved in the prevention of drug abuse.

Table 12-10 shows detailed expenditures attributable to drugs policy in the area of drug supply and drug demand reduction.

As table 12-10 shows, 2008-2010 expenditure trends by area of intervention show a remarkable difference. While unlabeled expenditure for carrying out action in the area of drug prevention has fallen sharply between 2009 and 2010, public spending attributable to security and public order has strongly increased.

Table 12-10: Un-labelled expenditure devoted to drug supply reduction policy (€ Million)

Drug Supply Reduction	Sector value	Cofog1 value	Cofog2 value	2008	2009	2010
Expenditure attributable to combat black economy related to narcotics and legal drugs (Customs Department)	S1311 S1312	Gf04-Economic Affairs	Gf0401 – General economic, commercial and labour affairs	193.50	191.00	240.00
Expenditure attributable to the Police related to narcotics and legal drugs offences	S1311 S1312	Gf03-Public order and safety	Gf0301-Police services	146.122	183.22	199.11
Expenditure attributable to the National Gendarmerie related to narcotics and legal drugs offences	S1311 S1312	Gf02-Defence	Gf0202-Civil defence	15.64	69.65	128.43
Expenditure attributable to combat international trafficking (Military defence)	S1311 S1312	Gf02-Defence	Gf0201-Military defence	32.16	22.35	14.55
Expenditure attributable to drug-related prosecution by law courts	S1311 S1312	Gf03-Public order and safety	Gf0303-Law courts	-	67.85	92.17
Expenditure attributable to foreign economic aid	S1311 S1312	Gf01-General public services	Gf0102-Foreign economic aid	2.88	0.17	0.43
Total of amounts devoted to drug supply reduction interventions	S1311 S1312			*390.30*	*534.24*	*674.69*

Drug Demand Reduction	Sector value	Cofog1 value	Cofog2 value	2008	2009	2010
Expenditure attributable to communication campaigns	S1311	Gf07-Health	Gf0704 Public health services-	4.19	6.75	5.64
Cost of staff and functioning of health ministerial services and health public services: ADALIS - Drugs and alcohol addiction information service in charge of the national telephone helpline and internet counseling service on licit and illicit substances INPES-National institute for prevention and health education	S1311	Gf07-Health	Gf0704 Public health services	21.01	39.72	30.75
Expenditure attributable to health services at school	S1311 S1312	Gf07-Health	Gf0704 Public health services	37.05	34.40	28.67
Expenditure attributable to selective prevention	S1311 S1312	Gf10-Social protection	Gf1004-Family and children	54.92	19.01	21.66
Expenditure attributable to universal prevention in school	S1311 S1312	Gf07-Health	Gf1004-Family and children	324.85	348.46	233.41
Total of amounts devoted to drug demand reduction interventions	*S1311 S1312*			*444.38*	*449.77*	*323.76*

Table 12-11 shows all categories of aggregated expenditures for unlabelled public spending.

Table 12-11: Unlabelled expenditure to fight drugs and prevent drug use (€ Million): evolution of main categories of expenditure (annual change)

	Sector value	Cofog1 value	2008	2009	2010
Unlabelled expenditure devoted to Defence, Public order & Safety and Customs' action against narcotics and black economy	S1311	Gf02 - Defence Gf03- Public order and safety Gf04 – Economic affairs	390.30	534.24	674.69
Unlabelled expenditure devoted to prevention (universal, selected and indicated)	S1311	Gf09 - Education Gf07 - Health	444.38	449.77	323.76
Unlabelled expenditure devoted to R&D (any area)	S1311	Gf07 - Health	12.07	14.84	11.47
Unlabelled expenditure devoted to Training (any area)	S1311	Gf09 - Education	10.75	10.59	11.02
Total			**857.51**	**1009.45**	**1020.92**
Annual change (%)			**na**	**+17.7%**	**+1.1%**

Source: Table elaborated by the OFDT using data from the RAP and DPT of 2010, 2011 and 2012
Note: Doping-related expenditures have been excluded. The annual budget amounts to approximately €9 million.

Globally, data make appeared an upward increase in unlabelled public spending attributable to combating and preventing legal and illegal drugs consumption from €857 million in 2008 to €1 billion in 2010. Nevertheless, figures describing the annual change in unlabelled drug related expenditures show a sharp slowdown in such increase (+17 percent to +1 percent of annual change over the period following the "Great Recession"). Note however that this remark does not concern GP's and hospital's trends over the period in health expenditure related to drugs for which up-dated estimates do not exist for the study period of reference (see further explanations in section below dealing with main shortfalls of unlabelled expenditures) This evolution appears to be consistent with the global public spending deceleration described in the first part of this work. It is essential, however, to aggregate both budgets (labelled and unlabelled) in order to interpret the global trend in drug-related expenditure (see section below).

Methods used to determine unlabelled expenditures and their main shortfalls

The financial reporting documents for the period 2008-2010 describe rarely in detail the methods used to produce estimates. More detailed methodological information has been requested by the MILDT to ministries for the year 2013.

Estimation of direct costs of specific services or interventions referred to as "drug-related"

It seems that the authorities responsible for the programmes have, at times, the possibility to identify clearly specific services and interventions. When ministerial services or activities which fall into broader programmes can be referred to as "drug-related", expenditures are identified as such and listed as "drug-related".

Some examples follow, by area of intervention:

- The implementation of a mass media campaign on drugs or the financing of ADALIS, the National Telephone helpline & Internet Counselling Service on licit and illicit drugs in the area of the drug demand reduction policy.

- The "police coordination units" for fighting drugs in the area of drug supply reduction policy.

Direct costs are easily determined. These items of expenditures include the costs of staff, regular functioning and equipments. This case may be assimilated to any other labelled expenditure (see the section above dealing with labelled expenditures). There is no specific calculation method required. The costs of activities or services compiled are just aggregated.

Methods of calculation relying on monitoring activity records

When monitoring records are available for the service concerned, estimates may be based on a "top down" or "bottom up" approach. The estimation method can vary from one activity to another depending on the availability of records. The total expenditure for drug-related activities is aggregated by programme. Some explanation about both methods follows:

The top down approach

In this case, the fraction of the overall activity which is devoted to drug use prevention or fighting drugs and drug addiction is known. The authorities can work out the expenditure attributable to the drugs policy even if they are not specifically "drug-related". In order to calculate an estimate, this fraction is applied to the total cost of staff and regular functioning of the service concerned. For the year 2010, for example, ten percent of police affairs stood for narcotics affairs which involved sixty police units accounting for several hundreds of thousands of hours/police officers. In this example, police expenditures attributable to drug-related activities have been calculated by multiplying the total expenditure of the police services by the fraction of 10 percent.

The bottom up approach

The work time spent by staff in charge of supporting drug-related activities or the equipments used have been recorded by the ministerial services. It is the case for example of the hours of prevention interventions in school or the alcohol tests conducted at the driving controls carried out by the Police corps or the National Gendarmerie.

The main methodological short falling worth discussing concerns the completeness of unlabelled expenditures compiled by the "drugs policy" DPT. It is important to note that several categories of drug-related expenditure cannot be identified in the above unlabelled figures:

- Major health expenditure

- Major prison services expenditure

- Expenditure by local administrations

Health expenditures

State expenditures in health

The Ministry of Health participates in the drug policy by formulating, coordinating and evaluating health policy. It finances not only health central services, but also public institutions involved in the field of drugs (such as the budget allocated to the INPES and NGOs' projects. These expenditures are included in the estimates presented in the table 10. The direct cost from the health regional services (decentralised health services) are not however taken into account in the estimation. This category of public expenditure does not seem to have been estimated in the past.

Expenditure attributable to the rest of decentralised ministerial services (Economy, Defence, Interior, Justice and Education) is contained in the financial reporting documents used for the present work.

General practitioners (GPs) and hospital expenditures for paying out the provision of drug abuse health services

Because refunded by the social security system, financial reporting documents used do not include major categories of expenditures in health as the costs of treatments provided by the French GPs or in hospitals (see labelled expenditure in table 12-10). These categories of expenditures have been estimated for 2003 by Kopp and Fénoglio (Kopp *et al.* 2006). It was estimated at somewhere between €573 and €632 million for the illicit drugs. Expenditures for alcohol-related treatments were estimated between €5,467 million and €6,156 million in the study of 2003. Treatment costs of tobacco-related health problems were estimated in the range of €15,537 and €18,254.

Taking into account inflation since 2003, such estimates on expenditures in health-related problems would have reached €689.50 million for illicit drugs, €6 646.50 million for alcohol and €19,322.50 million for tobacco, in 2010.

Prisons service expenditures

While estimates compiled in table 12-10 include the credits allocated by the prisons service to carry out selective prevention interventions which account for €2 million, the other items of expenditures have not been estimated, probably because of accounting difficulties. Kopp and Fénoglio (Kopp *et al.* 2006b) referred to €219.79 million in 2003, of which €200.49 accounts for illicit drug-related convictions, and €19.30 million for drink driving convictions.

After inflation since 2003, such estimates on incarceration spending would have reached €229 million and €22 million in 2010, respectively.

Drug-related expenditure by local administrations

The "drugs policy" DPT depends entirely on the State budget. Budgets applied to fighting, prevention and treating drug addiction by the local administrations are not included. This category of drug-related expenditure does not seem to have been estimated in the past.

12.2.2. Total drug-related expenditures and final discussion

Table 12-12 shows total labelled and unlabelled expenditures for implementing the drugs policy for the three-year period of reference.

Table 12-12: Total expenditure to fight drugs and prevent drug use (€ Million)

Total expenditures	Sector value	Cofog1 value	Cofog2 value	2008	2009	2010
Expenditure on Defence, Public order & Safety and Customs' actions against narcotics and black economy	S1311	Gf02 - Defence Gf03 – Public order and safety Gf04 – Economic affairs	Gf0202-Civil defence Gf0301- Police services Gf0401- General economic, commercial and labour affairs	394.46	540.86	685.98
Expenditure on universal and selected prevention	S1311	Gf09 - Education Gf07 - Health	Gf0704-Public health services Gf1004-Family and children	452.22	456.80	332.97
Expenditure on indicated prevention and health (*)	S1311	Gf07 - Health	Gf0704- Public health services	315.59	346.19	369.53
Expenditure on Research & Development (R&D)	S1311	Gf07 - Health	Gf0705-R&D Health	12.07	14.84	11.47
Expenditure on training	S1311	Gf09 - Education	Gf0905- Education non definable by level	11.24	11.08	11.51
Expenditure on overall coordination	S1311	Gf03 – Public order and safety Gf07 - Health Gf09 - Education Gf10 – Social exclusion	Gf0306-– Public order and safety n.e.c Gf0706- Health n.e.c Gf0908-Education n.e.c Gf1009-Social protection n.e.c	6.62	8.82	2.58
Expenditure on overall monitoring & evaluation (OFDT&DAR)	S1311	Gf03 – Public order and safety Gf07 - Health Gf09 - Education Gf10 – Social protection	Gf0306-– Public order and safety n.e.c Gf0706- Health n.e.c Gf0908-Education n.e.c Gf1009-Social protection n.e.c	6.15	5.99	5.88
Total				**1198.35**	**1384.58**	**1419.93**
Annual change (%)				**-**	**+16%**	**+3%**

(Total expenditure	Sector value	Cofog1 value	Cofog2 value	2008	2009	2010
Kopp and Fénoglio updated estimates on expenditure categories not included above (**)						
Updated costs for treatment attributable to drug-related health problems				26 237	26 264	26 657
Tobacco				19 018	19 038	19 323
Alcohol				6 541	6 548	6 646
Illicit drugs				678	678	688
Prison expenditure updated cost of drug-related convictions				246	246	251
Incarceration costs of illicit drug-related convictions				225	225	229
Incarceration costs for drink driving convictions				21	21	22

Source: Table elaborated by the OFDT using data from the RAP and DPT of 2010, 2011 and 2012
(*) In order to make year-on-year comparisons easier, OST refund figures for 2008-2010 have been taken away. This item accounts for €90 million approximately.
(**) The costs of treatment attributable to drug-related health problems were estimated at €21.58 billion in 2003 (Kopp and Fénoglio, 2006b). This study estimated prison expenditures at €219.79 million in 2003.

The figures presented above show the evolution of drug fighting and prevention government expenditure from 2008 to 2010. Collected data may seem to indicate a rapid deceleration in public spending on fighting drugs. Between 2008 and 2009, drug-related expenditure has gone up by 16 percent. After the crisis, however, the annual increase has not been so great, recording 3 percent in 2010. This trend is consistent with the global austerity policy led by the French government in the recent past, and, particularly so, after the “Great recession”. Accordingly to the INSEE, after the recent crisis, public spending increase slowed down to 2 percent. Forecasts for 2011 and 2012 announce a progressive deceleration in public expenditure: 1.8 percent in 2011 and 0.5 percent in 2012. The rescue measures set in place by the government at the beginning of the crisis have indeed led the French economy to come out the red in 2009. In order to stimulate the economy, the government increased sharply public expenditure at the beginning of the “Great Recession”. However, the economy recovery has proved modest. Sluggish global economic activity has made it impossible to remove the threat posed by the spiral of a deeper sovereign debt crisis. The French government was left with the only choice of carrying out austere public policies. As above figures indicate, the drugs policy carried out by the State has not been the exception.

In conclusion, drug-related spending is addressed by the government scheme in the same way as any other category in French public expenditure at large. By area of intervention, some facts must be highlighted. Expenditure on universal and selective prevention interventions has been drastically reduced between 2009 and 2010. The modest deceleration in public spending affects interventions in the area of health and indicated prevention. As a matter of fact, expenditure in this area has slowed down from 9 percent in 2009 to 6 percent in 2010. The largest expenditure increase corresponds to drug supply reduction policy. Nevertheless, such increase has slowed down sharply between 2009 and 2010, from 37 percent to 27 percent.

We must remark the fact that we cannot rely on complete data to conduct such analysis. As we mentioned above, estimates from 2008 to 2010 for unlabelled expenditures in the area of health and in prison are not available.

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Part C: Bibliography

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B - Alphabetic list of relevant databases available on Internet

BDSP. Banque de données en santé publique:
http://www.bdsp.ehesp.fr/Base/QbeA.asp.

Ireb (Institut de recherches scientifiques sur les boissons). Base de données bibliographiques:
http://www.ireb.com/html/form_fr.htm.

OFDT. Atlas régional des consommations de produits psychoactifs des jeunes Français - Exploitation régionale de l'enquête ESCAPAD 2005:
http://www.ofdt.fr/ofdtdev/live/donneesloc/atlas.html.

OFDT. ILIAD - Indicateurs locaux pour l'information sur les addictions:
http://www.ofdt.fr/ofdtdev/live/donneesloc/indic.html.

OFDT. Répertoire des sources statistiques:
http://www.ofdt.fr/ofdtdev/live/donneesnat/sources.html.

OFDT. Séries statistiques:
http://www.ofdt.fr/ofdtdev/live/donneesnat/series.html.

OFDT. SIMCCA. Système d'information mensuel sur les consultations cannabis:
http://www.ofdt.fr/ofdtdev/live/donneesnat/simcca.html.

C - Alphabetic list of relevant Internet adresses

AFR (Association française pour la réduction des risques):
http://a-f-r.org
AFSSAPS (Agence française de sécurité sanitaire des produits de santé):
http://www.afssaps.fr
ANITeA (Association nationale des intervenants en toxicomanie et addictologie):
http://www.anitea.fr
ANPAA (Association nationale de prévention en alcoologie et addictologie):
http://www.anpaa.asso.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
F3A (Fédération des acteurs de l'alcoologie et de l'addictologie):
http://www.alcoologie.org
FNORS (Les Observatoires régionaux de la santé et leur fédération):
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

Appendices

Appendix I - List of tables, graphs and maps

List of graphs

List of maps

Appendix II - List of full references of laws in original language

Appendix III - List of abbreviations

AAH	Disability Living Allowance
ACI	Integration Workshops and Ateliers
ADALIS	Drugs and Alcohol Addiction Information Service
AFSSAPS	French Agency for the Safety of Health Products
AGRASC	Agency for managing and recovering seized and confiscated assets
AHI	Reception, Housing, Social Integration
AI	Intermediary Association
AIDS	Acquired Immuned Deficiency Syndrome
ALD	Long Duration Disease
AME	State Medical Assistance
AMM	Marketing authorisation
ANAES	National Agency for Accreditation and Evaluation of Health Care
ANESM	(French) National agency for the assessment and quality of social and medico-social establishment and services
ANIT	National Association of Drug Addiction Professionals
ANITeA	National Association of Drug Abuse and Addictions Workers
ANPAA	National Association for the Prevention of Alcoholism and Addiction

ANRS	National AIDS and Viral Hepatitis Research Agency
ANSM	National Agency of Medicine and Health Product Safety (former AFSSAPS)
ARS	Regional Health Agency
ASIP Santé	Shared Healthcare Agency for Shared Health Information Systems
ASUD	Drug Users' Self-Help Association
ATR	Follow-on Treatment Apartment
BEP	Vocational Diploma
BHD	High-Dose Buprenorphine (HDB)
CAARUD	Support Centre for the Reduction of Drug-related Harms
CAMPS	Early Medico Social Services Centres
CAP	Vocational Training Certificate
CAST	Cannabis Abuse Screening Test
CCAA	Outpatient Alcoholism Treatment Centres
CCNE	National Ethics Advisory Committee
CDAG	Anonymous Free Screening Centre
CDO	Departmental Agreements on Objectives in Health and Justice
CEIP	Drug Dependency Information/Evaluation Centres
CEL	Local Educational Contract
CépiDC	Centre for Epidemiology of the Medical Causes of Death

CES	Economic and Social Council
CESC	Health and Citizenship Education Committee
CFES	French Committee for Health Education (now INPES)
CHRS	Social Housing Centre
CHSCT	Committees on Hygiene, Safety and Working Conditions
CIDDIST	Information, Screening and Diagnosis Centre on Sexually Transmitted Diseases
CIFAD	Interministerial Training Centre for the Fight Against Drugs
CIM	International Classification of Diseases (ICD)
CIRDD	Regional Information Centre on Drugs and Drug Addiction
CJC	Clinics for Young Users
CJN	National Criminal Record
CLS	Local Crime Prevention Plan
CMU	Universal Medical Coverage
CNAM	National Public Health Insurance Centre
CNAMTS	National Health Insurance Fund for Salaried Workers
CNRS	National Centre for Scientific Research
COFOG	Classification of the Functions of Government
COM	Pacific French overseas territories
CPAM	Primary Fund for Health Insurance

CPDD	Drug and dependencies project leaders
CPT	Committee for the Prevention of Torture
CRIPS	Regional Aids Information and Prevention Centre
CSAPA	National Treatment and Prevention Centre for Substance Abuse
CSST	Specialised Care Centre for Drug Users
CT	Therapeutic community
CTC	Community Treatment Centre
CTR	Residential Treatment Centre
CUI	Single Integration Contract
DAP	Directorate of Prison Administration
DAPSA	Support Facility for Parenthood and Addiction Care
DAR	Regional Centres on Drugs and Drug Addiction (Formely CIRDD)
DATIS	National “Drugs, Alcohol and Tobacco Information Service” telephone helpline
DCPJ	Central Directorate of the Judicial Police
DDASS	County (département) Health and Social Affairs State Authority
DESCO	School education Office (Ministry of youth, education and research)
DGAS	General Directorate for Social Action
DGCS	General Directorate for Social Cohesion

DGDDI	French Customs
DGS	General Health Authority of the Ministry of Health
DH	Hospitals directorate (Ministry for Health and Welfare)
DHOS	Directorate of Hospital Care and Treatment Organisation
DGOS	General Directorate for the Provision of Care
DLPAJ/CSR	Directorate of civil liberties and legal affairs, sub-department for traffic and road safety (Ministry of the Interior and Regional Planning)
DMT	Dimethyltryptamine
DOM	French Overseas Departments
DPJJ	Judicial Youth Protection Directorate
DPT	Transversal Policy Document
DRAMES	Drug and Substance Abuse Related Deaths (ANSM)
DRD	Drug Related Death (EMCDDA definition)
DRESS	Directorate for Research, Studies, Evaluation and Statistics
DSM	Diagnostic and Statistical Manual of Mental Disorders
DTTO	Drug Treatment and Testing Order
DU	Drug User
DXM	Dextromethorphan
EI	Integration Companies

ENVEFF	National Survey on Violence Against Women
EROPP	Survey on Representations, Opinions, and Perceptions Regarding Psychoactive Drugs (OFDT)
ESCAPAD	Survey on Health and Use on Call-Up and Preparation for Defence Day (OFDT)
ESPAD	European School Survey Project on Alcohol and other Drugs (INSERM- OFDT-MJENR)
ESSAD	Specialised Home Care Unit
ETTI	Temporary Integration Work Companies
EU	European Union
EWS	Early Warning System
F3A	Federation of Alcohol and Drug Addiction Stakeholders
FFA	French Federation of Addictology
FNAILS	National Drug-Related Offence's Record (OCRTIS, Ministry of Interior)
FND	National Register of Prisoners
FNES	National Federation of Health Education Committees
FNPEIS	French National Fund for Prevention, Education and Health Information
FRAD	Anti-drug trainer (Gendarmerie)
GBL	Gamma-Butyrolactone
GCSE	General Certificate of Secondary Education
GDP	Gross Domestic Product
GECA	Group of Studies on Pregnancy and Addictions

GERS	Group for the Production and Elaboration of Statistics
GFCF	Gross Fixed Capital Formation
GHB	Gamma-Hydroxybutyric Acid
GIP	Public Interest Group
GIR	Regional Intervention Group
GP	General Practitioner
HAS	French National Authority for Health
HBSC	Health Behaviour in School-aged Children
HBV	Hepatitis B Virus
HCSP	High Council for Public Health
HCV	Hepatitis C Virus
HDB	High-Dose Buprenorphine
HIV	Human Immune Deficiency Virus
HLM	Low-rent Social Housing
HPST	Hospital, Patients, Health and Territories (French) law of July 21, 2009
HR	Harm Reduction
IAE	Integration through Economic Activity
IC	Confidence Range
ICT	Information and Communication Technologies

IDU	Injecting Drug User
ILS	Drug-related offences
INPES	National Institute for Prevention and Health Education (former CFES)
INRETS	National Institute for Research on Transport and Safety
INSEE	National Institute for Statistics and Economic Studies
INSERM	National Institute for Health and Medical Research
INVS	National Institute for Public Health Surveillance
IRC	Internet Relay Chat
IST	Sexually Transmitted Infections
IT	Drug Treatment Order
IUFM	University Institutes for Teacher Training
IV	Intravenous
IVG	Termination of pregnancy
JAP	Judge responsible for the execution of sentences
JAPD	National Defence and Preparation Day
JDC	National Defence and Citizenship Day (formerly JAPD)
JO	Journal Officiel
LFI	Initial Budget Act
LFSS	Social Security Budget Act

LOLF	Constitutional Bylaw on Budget Acts
LOPPSI	Homeland Security Performance Planning Act
LSD	Lysergic Acid Diethylamide
LSQ	French Daily Security Act
M€	Million(s) of Euros
MDMA	3,4-methylene-dioxy-methamphetamine
MILAD	Mission for the Fight Against Drugs (Ministry of the Interior)
MILC	Interministerial Mission for the Fight Against Cancer
MILDT	Interministerial Mission for the Fight Against Drugs and Drug Addiction
MNCPC	(French) National Mission for the Control of Chemical Precursors
MST	Sexually transmissible diseases
NGO	Non Governmental Organisation
NPS	New Psychoactive Substances
OCRIEST	Central Office on Illegal Immigration and Employment
OCRTIS	Central Office for the Repression of Illicit Narcotics Trafficking
OEDT	European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)
OFDT	French Monitoring Centre for Drugs and Drug Addiction
OMS	World Health Organisation
ONDAM	National objective for health insurance expenditure

OPPIDUM	Monitoring of illegal psychoactive substances or those that are used for purposes other than medicinal (CEIP)
OR	Odd Ratio
OST	Opioid Substitution Treatment
PA	Person-year
PACA	Provence-Alpes-Côte d'Azur Region
PAEJ	Youth Reception and Counselling Centre
PAP	Annual Performance Project
PDU	Problem Drug User
PES	Syringe Exchange Programme
PFAD	Anti drug Police Trainer
PLFR	Amended Initial Budget Act
POPHEC	First hepatitis C prison's observatory
PRAPS	Programmes for access to preventive measures and health care for people in vulnerable situations
PRS	Regional Health Programmes
PRSP	Regional Public Health Programmes
RAP	Annual Performance Report
REAPP	Parental Counselling and Support Networks
RECAP	Common Data Collection on Addictions and Treatments
RDR	Risk and Harm Reduction (policy)

RELIONPREDIL	Survey for the Monitoring of Prevention Actions Related to Licit and Illicit Drugs
RESEDA	Health Education, Counselling and Adolescent Development Network
RMI	Minimum Benefit Income
RSA	Active Solidarity Benefit
RSM	Standardised Mortality Ratio
SAM	Road Safety epidemiological survey on narcotics and fatal road accidents
SCL	Joint Laboratories Department
SEP	Syringe Exchange Program
SFA	French Society of Alcohology
SIAE	Structures for Integration through Economic Activity
SIAMOIS	System of Information on the Accessibility of Injection Equipment and Substitution Products (InVs)
SINTES	National Detection System of Toxic Substances and Drugs (OFDT)
S[I]UMPPS	[Inter] University Preventive Medicine and Health Promotion Service
SMPR	Regional hospital medical/psychological services
SPIP	Penitentiary service for Reintegration and Probation
SSR	Follow-up and Rehabilitation Centres
SSRA	Addiction Follow-up and Rehabilitation Centres
TAV	Alcohol proof
TC	Therapeutic Community

TDI	Treatment Demand Indicator
THC	Tetrahydrocannabinol
TRACFIN	Money Laundering Service of the French Ministry of Finance
TREND	Emerging Trends and New Dugs (OFDT)
UCSA	Prison-based Hospital Healthcare Unit
UDC	Coordination Unit for Maternity and Risk Situations
UDVI	Intravenous Drug User
UK	United Kingdom
UNODC	United Nations Office on Drugs and Crime
UPS	Care unit for prison leavers
USEM	French National Union of Regional Student Supplemental Health Insurance Companies
VAE	Validation of Acquired Experience
VAT	Value Added Tax
WHO	World Health Organisation

Appendix IV – List of sources

A - Baromètre santé (Health Barometer)

National Institute for Prevention and Health Education (INPES)

This is a five-yearly telephone survey of a representative sample of the population li
France. The first edition was conducted in 1992. This survey examines smoking, a
medical drug and illegal drug use and much other behaviour which influence health (use c
depression, screening practices, vaccination habits, sports, violent behaviour, sexuality, et

The survey is conducted by the National Institute for Prevention and Health Education (I
in partnership with the "Caisse nationale de l'assurance maladie des travailleurs salarie
Ministry of Employment and Solidarity, the French Monitoring Centre for Drugs anc
Addiction (OFDT), the "Fédération nationale de la mutualité française", the "Haut comite
santé publique", the Interministerial Mission for the Fight against Drugs and Drug Ad
(MILDT) and the National Federation of Regional Health Monitoring Centres (FNORS).

B - CJN: National Crime Register

Sub-directorate for statistics, studies and documentation (SDSED) of the Ministry of Justic

Information on sentences has been obtained from 1984 through the study of the National
Register. This information describes the different offences for which sentences have
handed down by judges, the type of procedure, nature of the sentence, duration c
concerned and the specific characteristics of the people sentenced (age, sex and nationali

As sentences may be handed down for several offences, the concept of the main offence,
in principle is the most serious, is useful (the offences may also be listed in the order giver
report, although a consistency check is carried out depending on the magnitude
sentence). This is the most commonly used concept in Ministry of Justice statistics.
counting units can be used to refine the analysis. In the case of narcotics use, for ex
sentences for use as an associated offence (for example, the commonest associatior
corresponding sentences) or for use alone.

Sentenced persons and the sentences themselves must not be mixed up. A person sen
twice in a given year is counted twice in the sentencing statistics.

In accordance with the Penal Code, cannabis is not distinguished from other narcotics ir
data.

C – HIV and HCV prevalence survey in drug users (Coquelicot-2004)

Conducted by: The National Institute for Public Health Surveillance (InVS).

This study combines an epidemiological arm (combined with self-sampling of capillary
onto "dry spot") intended to measure the prevalence of HIV and HCV infection in drug use
a socio-anthropological arm to understand determining factors in risk-taking.

D – Deaths involving abuse of medicines and substances (DRAMES)

The French Health Products Safety Agency (AFASSAPS) and the Marseilles Drug Dependency Information/Evaluation Centres (CEIP).

This study uses a continuous collection method 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.

This enables:

- substances involved in psychoactive substance abuse deaths, regardless of whether they are medical drugs or otherwise, to be identified;
- quantitative data (blood measurements) to be collected about the substances responsible;
- a more detailed estimate of the number of drug-related deaths in France by reducing under-notification of some deaths due to toxic effects, particularly those occurring in a medico-legal situation and therefore not declared to the Health Authorities for legal confidentiality reasons.

E – Health behaviour in School-aged Children (HBSC) survey

University of Edinburgh for the HSBC network and for France by the medical department of the Toulouse regional education authority: a quantitative survey in 11-, 13- and 15-year-old school pupils being educated in mainland France.

This is intended to:

- Understand attitudes, behaviours and opinions of young people about their use of psychoactive substances (particularly alcohol and tobacco, but also illegal drugs), their health and lifestyles;
- measure changes in behaviour and these lifestyles over time;
- carry out international comparisons

F – National survey in centres for accommodation and assistance with the reduction of risks for drug users (CAARUD) (ENa-CAARUD)

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

Biennial quantitative survey of users received/seen by the CAARUD.

The aims of this survey are:

- to provide monitoring indicators for the number and characteristics of drug users;
- to adapt the responses of professionals and public authorities to the needs and expectations of this population of people in difficulty;

- to monitor trends in terms of use and help identify new trends

G – Survey among drug users attending low threshold services (Prelud)

French Monitoring Centre for Drugs and Drug Addiction.

This annual quantitative survey from 2000 to 2003, and then biennial or triennial thereafter, is designed to obtain knowledge about and monitor users of psychoactive substances and their practices.

The population studied consists of users attending low threshold facilities that provide support to drug users: harm reduction centres (shops, needle exchanges, etc.), so called “low-threshold” services, including “low threshold” methadone distribution centres. It should be pointed out that the people interviewed are not necessarily representative of users attending these centres as participation in the survey is voluntary.

H – Prison entrants health survey

Directorate for Research, Studies, Evaluation and Statistics (DREES) (Ministry of Health and Solidarity)

The prison entrants health survey was conducted for the first time in 1997 in all prisons and in the prison quarters of penal establishments. It collects information about risk factors for the health of entrants from the admission medical visit and diseases recorded on admission, identified in particular by treatments being taken. Declared use of psychoactive substances includes daily smoking, excessive alcohol consumption (>5 glasses per day) and “prolonged regular use during the 12 months before imprisonment” of illegal drugs, including cannabis.

I – Survey on the care of drug addicts in the medical-social system (in a given month)

Directorate for research, studies, evaluation and statistics (DREES, formerly CESI, Ministry for Health and Solidarity)

This survey was created at the beginning of the 1980s in order to monitor the number and characteristics of drug users seen in the addictology centres (mostly the Specialised Care Centres for Drug Users – CSST), health establishments (general public or specialist psychiatry public hospitals and some private psychiatric hospitals) and some social establishments handling prevention, referral or housing activities for drug users.

This survey was conducted, always in the month of November*, from 1989 to 1997, and then in November 1999 and 2003 (the date of the last edition).

All of the patients seen that month are interviewed: illegal drug users or people misusing psychotropic medical drugs. Overlapping (double counting) between the centres cannot be ruled out, but is likely to be limited given the relatively short observation period.

J - EROPP: Survey on Representations, Opinions, and Perceptions Regarding Psychoactive Drugs

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

This survey measures opinions and perceptions of the population about drugs and the related public actions. The people surveyed are also asked about their use.

The first survey was conducted in 1999 and was a telephone survey based on a quota sample (by sex, age, occupation of the household reference person, region and category of conurbation) in people between 15 and 75 years old representative of the population in mainland France.

K - ESCAPAD: Survey on Health and Use on Call-Up and Preparation for Defence Day

French Monitoring Centre for Drugs and Drug Addiction (OFDT) in collaboration with the National Service Directorate (DSN)

The ESCAPAD survey is conducted every tree years by OFDT in partnership with the National Service Directorate (DSN) and is carried out during the National Defence and Citizenship Day (JDC) which has replaced national service in France. Once a year, the young people participating in a Defence Preparation Day session fill out an anonymous self-completed questionnaire administered throughout the country about their use of legal or illegal psychoactive substances and their health and lifestyle.

The adolescents questioned are mostly 17 years old, French nationals and most are still in secondary education, although some have already entered the world of work, are apprenticed or in higher education.

L - ESPAD: European School Survey Project on Alcohol and Other Drugs

National institute for health and medical research-(INSERM, U472)/French Monitoring Centre for Drugs and Drug Addiction (OFDT)/Ministry for Youth, National Education and Research (MJENR)

This is a school survey on use, attitudes and opinions on drugs. ESPAD is conducted every four years at the same time and is used to monitor French and European trends in drug use. Pupils are selected randomly from classes after stratification.

M - FNAILS: National Drug-Related Offence's Record

Central Office for the Repression of Illicit Narcotics Trafficking (OCRTIS)

All procedures relating to narcotics legislation offences, conducted by the local police services and gendarmerie (including the overseas départements) are recorded in FNAILS, except for offences recorded by customs and not resulting in the writing of a statement.

FNAILS contains information about arrests (classified as simple use, use/dealing, local trafficking, international trafficking) and seizures. The substance listed is the "dominant drug", i.e. the substance mostly used by the user or which is held in the largest amount by the trafficker. When this rule cannot be used, the "hardest" substance is recorded.

Since 2006, FNAILS has been administered through an IT application called OSIRIS (Statistical information and research tool for drug-related offences) which automatically incorporates information from the customs and gendarmerie.

N - FND: National Prisoners' Register

Prison Service (DAP), Ministry of Justice

Since 1993, statistics on sentences served have been produced from the National Prisoners' Register (FND). This record identifies prison flows for the year, i.e. the number of people entering and leaving prison establishments between 1st January and 31st December in the year, for each offence. The difference between incoming and outgoing prisoners is used to determine the number of people in the prison establishments on a given date.

A new version of FND has been in preparation since 2003. Unlike the previous version, it takes account of all offences resulting in the sentence for each imprisonment, whereas only the main offence was used previously (see CJN). The offences are also described in more detail. Narcotics offences are now broken down into use, sale, possession, trafficking, aiding and abetting use, inciting use and unspecified narcotics offences compared to only four categories previously (use, sale, trafficking, other narcotics offence). A slippage of data from the former "trafficking" category to the "possession" category has been reported.

In accordance with the Penal Code, cannabis is not distinguished in these data from the other narcotics.

O – Monitoring of illegal psychoactive substances or those that are used for purposes other than medicinal (OPPIDUM)

Network of Drug Dependency Information/Evaluation Centres (CEIP) and French Health Products Safety Agency (AFSSAPS).

OPPIDUM is an annual, national pharmaco-epidemiological study conducted in October each year. It is coordinated by the CEIP network which is responsible for recruiting centres which manage patients with drug abuse or addiction problems or who are receiving opioid substitution treatment. It has been conducted since 1990 in the PACA region and since 1995 nationally. Its objectives are to:

- monitor the use of psychoactive substances by people with drug addiction;
- describe the specific characteristics of the people concerned;
- assess the potential of pharmaceutical products for abuse and addiction.

P – CSST Activity Reports: Use of activity reports from Specialised Care Centres for Drug Users

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

Since 1998, the Specialised Care Centres for Drug Users (CSST) have completed an annual standard activity report which is sent to the Departmental Directorate of Health and Social Affairs (DDASS). 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 for all people received in the centre.

A common activity report to the CSST and the Outpatient Alcoholism Treatment Centres (CCAA) was introduced from 2004.

Q - 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 patients in the outpatient specialist drug addiction and alcohol treatment centres. Annual results are sent in April of the following year to OFDT which analyses them.

The data collected relate to patients, their current management and treatments taken, uses (substances used and medicines taken as part of the care) and their health.

Cannabis users described through RECAP are those for whom cannabis is the substance used during the previous 30 days which, in the opinion of the care team, currently poses the greatest problem to the patient and led the person to seek care.

This system is replacing the DREES month spot survey

R - SINTES: National Detection System of Drugs and Toxic Substances

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

The SINTES system is intended to document the toxicological composition of illegal substances in circulation in France. The information incorporated in this system come from two sources:

- communication of toxicology test results performed on seizures by the law enforcement services' laboratories (Institut national de police scientifique, Institut de recherche criminelle de la gendarmerie nationale and customs laboratories) to OFDT;

- investigations conducted by OFDT based on samples of substances obtained directly from users. These collections are governed by a strict regulatory framework and obtained by specifically trained survey workers.

In its initial version of 1999, the system only examined synthetic substances. From 2006 onwards its scope has been extended to cover all illegal substances.

S – Road offences and testing statistics

Road safety sections (Bureau des usagers de la route et de la réglementation des véhicules - Sous-direction de la circulation et de la sécurité routières - Direction des libertés publiques et des affaires juridiques - Ministry for the Interior and National Works)

Since 2004, the Road Safety Section's publication combines statistics on tests performed by the local police services and gendarmerie and offence statistics (offences and infringements) of the Highway Code recorded by these services. These data are communicated monthly to the Ministry and are published nationally.

Information is given on speeding offences, driving without a licence, blood alcohol and, since 2004, the use of narcotics. For narcotics use, the number of screening tests and positive tests is described depending on the circumstances of testing (fatal accidents, body or material injury,

offences, suspected use of narcotics without accident or offence). Positivity rates should be interpreted with considerable caution as, in view of the particularly high positive test rates, it is likely that the screening and detailed result testing are not carried out at random but target the drivers who are most likely to test positive for narcotics.

The annual total of the different narcotics offences is also listed: driving a vehicle after using substances or plants classified as narcotics, driving a vehicle after using substances and under the influence of alcohol and refusal of the driver to have tests or investigations performed to determine whether he/she was driving after using narcotics.

In accordance with the Penal Code, cannabis is not distinguished in these data from the other narcotics.

T – AIDS surveillance system in France

This data collection system has been run continuously since 1982 by the InVS. It has the following objectives:

- to provide epidemiological surveillance on AIDS;
- to measure the incidence of the disease;
- to measure the impact of access of seropositive people to testing;
- to measure the impact of primary prophylaxis prevention actions;
- to measure the impact of therapeutic management before the AIDS stage;
- to measure AIDS-related mortality.

U - TREND: Emerging Trends and New Drugs

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

The aim of the TREND system, which has been established since 1999, is to provide information about illegal drug uses and users and on related emerging phenomena. These cover either new phenomena or existing ones which have not yet been detected by the other observation systems.

The observations are conducted in two social settings chosen by the high likelihood of finding new or not as yet observed phenomena, even if these do not alone affect the entire reality of drug use in France:

- the urban settings defined by TREND cover mostly low threshold services (“Drop ins” and Needle Exchange Programme) and open scenes (streets, squat, etc.). Most of the people met and observed in these settings are problem users of illegal drugs living in particularly precarious conditions;
- the techno party settings which describe places where events are organised around this music. These include the so-called “alternative” techno setting (free-party,

teknivals, etc.) and also clubs, discothèques and private parties for their "techno" events.

The system is based on a data set analysed by local coordinators who produce site reports which are then put into a national perspective:

- qualitative continuous collection instruments coordinated by OFDT and run by a network of local coordinating entities (Bordeaux, Lille, Lyon, Marseille, Metz, Paris, Rennes and Toulouse) with a joint information collection and analysis strategy;
- the SINTES system, an observation system geared towards detecting and analysing the toxicological composition of illegal substances;
- recurring quantitative surveys, particularly with low threshold services clients;
- use of results from partner information systems (particularly ESCAPAD, EROPP, FNAILS);
- and quantitative or qualitative subject-based investigations to provide more in-depth information on the subject.

V – National analysis of CAARUD activity reports. ASA-CAARUD

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

This annual study of standardised activity reports from the Support Centre for the Reduction of Drug-related Harms (CAARUD) is the second instrument of a set of epidemiological data collection mechanisms, the first of which was the national survey in Support Centres for the Reduction of Drug-related Harm (ENa-CAARUD), which concentrated more specifically on people seen in these centres.

ASA-CAARUD provides information about the type of activities developed and services available to clients.

W – Collection of local indicators for the national observation of prevention activities concerning legal and illegal drugs (ReLION)

French Monitoring Centre for Drugs and Drug Addiction (OFDT); Regional Information Centre on Drugs and Drug Addiction (CIRDD)

This is a qualitative, biennial survey intended to:

- document the main features of local prevention actions on legal and illegal drug use (alcohol, tobacco, psychotropic medical drugs, cannabis, ecstasy, doping substances, etc.);
- It identifies changes in prevention practices at different national levels though simple identifiers used in the field – for whom, from whom, when and how.