European Monitoring Centre for Drugs and Drug Addiction

OBSERVATOIRE FRANÇAIS DES DROGUES ET DES TOXICOMANIES
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France

Country Drug Report 2017

THE DRUG PROBLEM IN FRANCE AT A GLANCE

Drug use

in young adults (15-34 years) in the last year

Cannabis

22.1 %

16.3 % 27.9 %

Other drugs

Cocaine	2.4 %
MDMA	2.3 %
Amphetamines	0.7 %

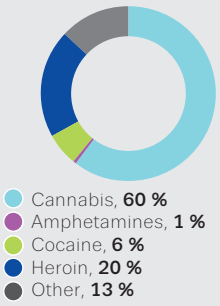
High-risk opioid users

211 000

(180 000 - 300 000)

Treatment entrants

by primary drug



Opioid substitution treatment clients

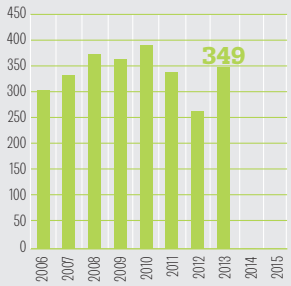
168 840

Syringes distributed

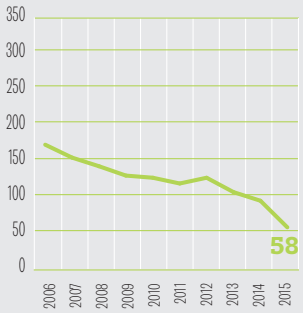
through specialised programmes

12 314 781

Overdose deaths



HIV diagnoses attributed to injecting



Source: ECDC

Drug law offenders

199 667

Top 5 drugs seized

ranked according to quantities measured in kilograms

1. Cannabis resin
2. Herbal cannabis
3. Cocaine
4. Heroin
5. Amphetamine

Population

(15-64 years)

41 896 237

Source: EUROSTAT
Extracted on: 26/03/2017

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or reported numbers through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnosis, drug law offences and seizures). Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin.

About this report

This report presents the overview of the drug phenomenon in France, covering drug supply, use and public health problems, as well as drug policy and responses. The statistical data reported relate to 2015 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

An interactive version of this publication, containing links to online content, is available in PDF, EPUB and HTML format: www.emcdda.europa.eu/countries

National drug strategy and coordination

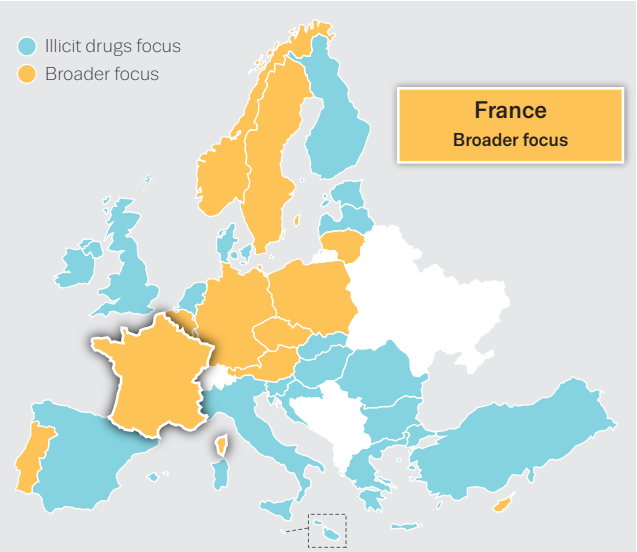
National drug strategy

In France, the Government Plan for Combating Drugs and Addictive Behaviours 2013-17 is the responsibility of the Inter-ministerial Mission for Combating Drugs and Addictive Behaviours (MILDECA). The Government Plan addresses the use of illicit and licit substances (narcotics, alcohol, tobacco, psychotropic medicines and new synthetic products) and non-substance-related addictive behaviours (gambling, gaming, doping) (Figure 1). It has three main priorities, which are addressed across five areas of action that structure the Government Plan: (i) promoting prevention, care and risk reduction; (ii) stepping up the fight against trafficking; (iii) improving the application of the law; (iv) basing policies for combating drugs and addictive behaviours on research and evaluation studies; and (v) reinforcing coordination at the national and international levels. The Government Plan is supported by two consecutive action plans, covering the years 2013-15 and 2016-17. Both action plans detail specific objectives and actions for these periods, identify key stakeholders and detail the planned timelines and expected outcomes for delivering the strategy.

An intervention-based external evaluation of four priority areas (two per action plan) of the Government Plan was commissioned to examine the relevance of new experimental approaches (e.g. peer-led prevention, community action against drug trafficking). This external evaluation is complemented by an internal indicator-driven evaluation examining the effectiveness of the Government Plan in achieving the stated objectives.

FIGURE 1

Focus of national drug strategy documents: illicit drugs or broader



NB: Year of data 2015. Strategies with broader focus may include, for example, licit drugs and other addictions.

National coordination mechanisms

France's drug policy is coordinated at the national level by MILDECA, which is the responsibility of the prime minister and prepares all government decisions on drug issues. MILDECA reports to the prime minister and is tasked with the organisation and coordination of France's policies against drugs and addictive behaviours. Its mandate covers the use of illicit and licit substances and non-substance-related addictive behaviours. Throughout France and its territories, MILDECA territorial representatives (chefs de projet) are responsible for implementing drug policy.

The Government Plan for Combating Drugs and Addictive Behaviours 2013-17 addresses the use of illicit and licit substances and non-substance-related addictive behaviours

Public expenditure

Understanding the costs of drug-related actions is an important aspect of drug policy. Some of the funds allocated by governments to expenditure on tasks related to drugs are identified as such in the budget ('labelled'). Often, however, the majority of drug-related expenditure is not identified ('unlabelled') and must be estimated by modelling approaches.

The total drug-related public social costs for France have been estimated for 1996 and 2003. A new estimate of the social cost of drugs, alcohol and tobacco was published in 2015.

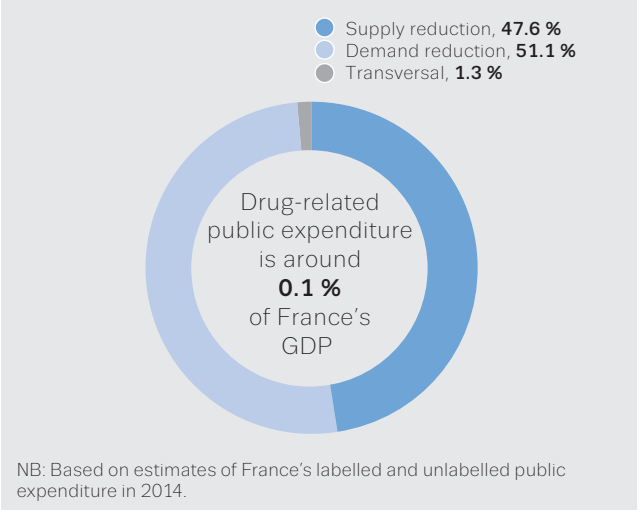
Since 2008, the total expenditure of central government and the social security system has been presented annually in a general document submitted to the French Parliament.

In 2014, total drug-related expenditure represented 0.1 % of the gross domestic product (approximately EUR 1.8 billion), with 51.1 % of the total being spent on health activities and social protection, 47.6 % on public order and safety and 1.3 % on general public services related to drug-related initiatives (Figure 2).

The available data suggest total drug-related expenditure increased at a slow pace between 2008 and 2010, following the national fiscal consolidation trend registered in France. Between 2011 and 2013, drug-related expenditure increased at a faster rate before stabilising in 2014.

FIGURE 2

Public expenditure related to illicit drugs in France



NB: Based on estimates of France's labelled and unlabelled public expenditure in 2014.

Drug laws and drug law offences

National drug laws

The use and possession of illicit drugs are criminal offences in France. The law itself does not distinguish between possession for personal use or for trafficking, or by type of substance. However, the prosecutor will opt for a charge relating to use or trafficking based on the quantity of the drug found and the context of the case. Based on the principle of the appropriateness of proceedings, the prosecutor may decide to take legal action against the offender, simply close the case or propose other measures as an alternative to prosecution. An offender charged with personal use faces a maximum prison sentence of one year and a fine of up to EUR 3 750 (Figure 3), although prosecution may be waived or a simplified procedure of a fine of up to EUR 1 875 can be ordered in minor cases. The maximum sentence increases to five years and the fine increases to EUR 75 000 if endangering users of transport or if the offence has been committed by a public servant while on duty. A directive of 9 May 2008 defined a new 'rapid and graduated' policy. In simple cases, drug users may receive a caution, but this should usually be accompanied by a request to attend a compulsory drug awareness course, introduced in March 2007, for which a non-drug-dependent offender may have to pay up to EUR 450. Drug-dependent individuals would continue to receive the therapeutic injunction directing them to treatment. If there are aggravating circumstances, such as in the case of recurring offenders, a term of imprisonment may be imposed. In 2012, a directive establishing a criminal policy strategy for drug-related crimes reiterated that, when sentencing, courts should take account of factors that suggest a simple drug use or drug dependence. The principle of proportionality calls for systematic penal responses and increasingly effective judicial measures in the case of more severe offences. The application of educational and health measures is prioritised for simple drug law crimes and for minors, in line with a general trend in the EU to reduce the severity of punishments for such offences.

Drug supply is punishable with imprisonment of up to 10 years, or up to life in prison if offences are particularly serious, and a fine of up to EUR 7.5 million.

In France, new psychoactive substances (NPS) are controlled by decisions of the Ministry of Social Affairs and Health, which applies a generic classification of chemical substances. As of 2015, placement of cathinones, synthetic cannabinoids and 25x-NBOMe (phenethylamine) derivatives into the market has been prohibited.

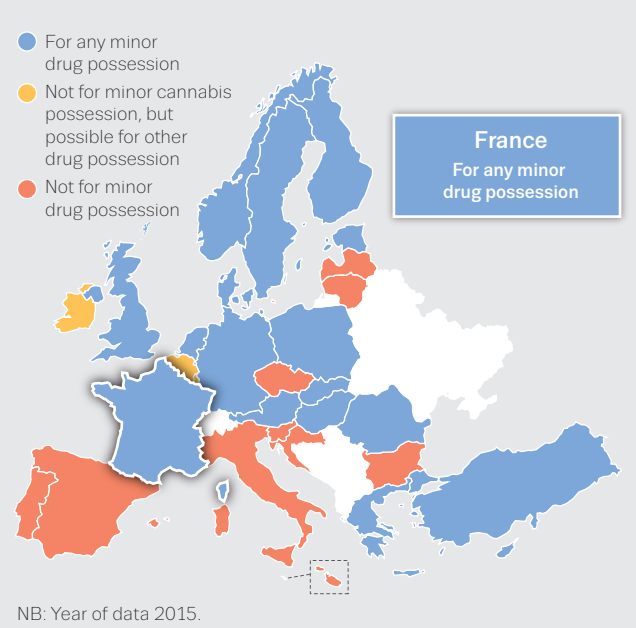
Drug law offences

Drug law offence (DLO) data are the foundation for monitoring drug-related crime and are also a measure of law enforcement activity and drug market dynamics; they may be used to inform policies on the implementation of drug laws and to improve strategies.

In France, the most recent data on drug law offenders are obtained from the database of the Ministry of the Interior (ETAT 4001). In 2015, approximately 199 700 drug law offenders were reported in France. However, this database does not provide details on the substances involved. Since 2004, the reported numbers of drug law offenders charged have almost doubled, with drug use/possession offences being more common than supply offences.

FIGURE 3

Legal penalties: the possibility of incarceration for possession of drugs for personal use (minor offence)



NB: Year of data 2015.

In 2015, France reported approximately 199 700 drug law offenders

Drug use

Prevalence and trends

According to a recent general population survey, cannabis remains the most widely used illicit substance in France, followed by cocaine, although at much lower levels.

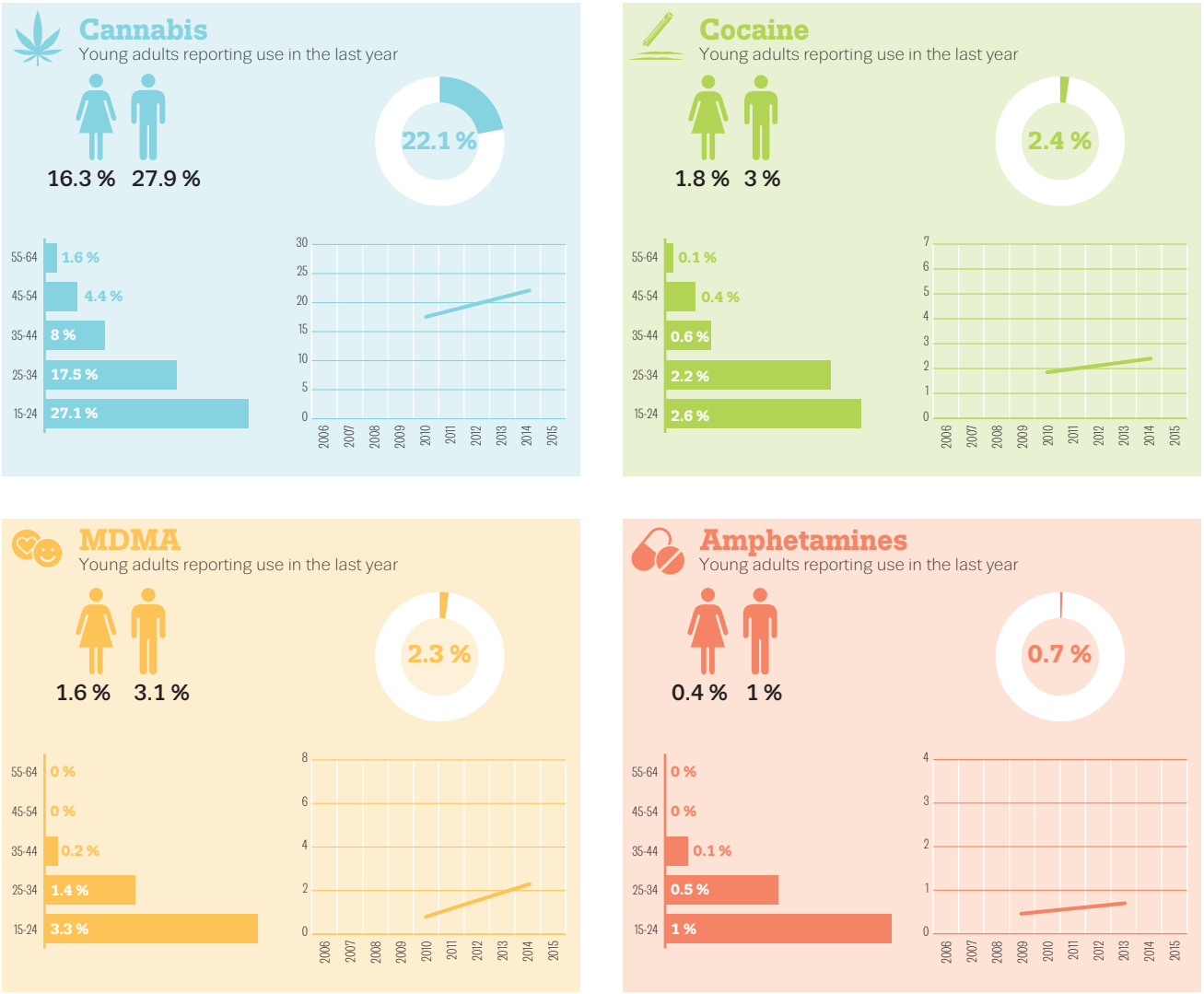
Cannabis and cocaine use has increased in the last two decades. Although the prevalence of synthetic stimulant use was lower than that of cocaine, the last-year prevalence of MDMA/ecstasy use, for instance, reached its highest recorded level in 2014. Young people aged 15-34 years reported the highest prevalence of cannabis, cocaine and MDMA use in the last year (Figure 4).

The latest general population survey indicated that the lifetime prevalence of synthetic cannabinoid use is 1.7 % among 18- to 64-year-olds.

Paris participates in the Europe-wide annual wastewater campaigns undertaken by the Sewage Analysis Core Group Europe (SCORE). This study provides data on drug use at a community level, based on the levels of illicit drugs and their metabolites in sources of wastewater. The results from Paris suggest a decreasing trend in MDMA levels between 2012 and 2016. The levels of cocaine, however, remained relatively stable, while the residues of amphetamine and methamphetamine detected were very low, indicating limited use of these substances in Paris.

FIGURE 4

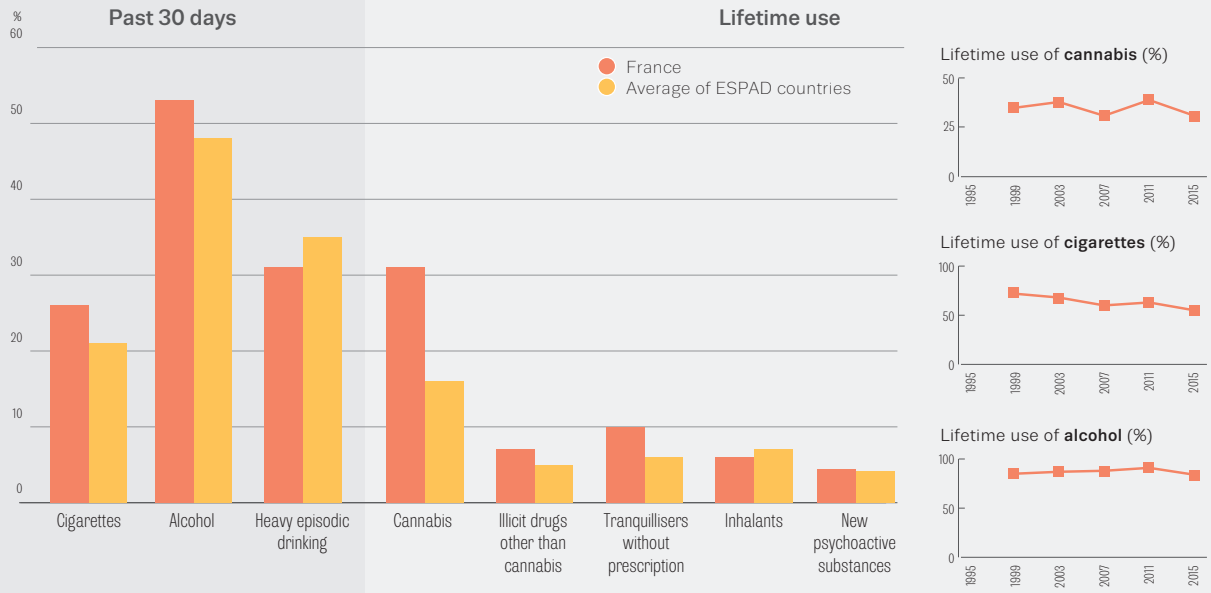
Estimates of last-year drug use among young adults (15-34 years) in France



NB: Estimated last-year prevalence of drug use in 2014.

FIGURE 5

Substance use among 15- to 16- year-old school students in France



Source: ESPAD study 2015.

Data on drug use among students are reported in the 2015 European School Survey Project on Alcohol and Other Drugs (ESPAD). This survey has been conducted every four years since 1999 in France and collects data on substance use among 15- to 16-year-old students. Lifetime use of cannabis reported by French students was about twice as high as the average (of 35 countries), while the lifetime use of NPS was more or less average, as was heavy episodic drinking in the past 30 days (Figure 5).

High-risk drug use and trends

Studies reporting estimates of high-risk drug use can help to identify the extent of the more entrenched drug use problems, while data on the first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform understanding on the nature and trends in high-risk drug use (Figure 7).

France is one of the EU countries where the estimated high-risk opioid use rate is above 5 per 1 000 of the adult population (Figure 6). Heroin and other opioids, such as medications used for opioid substitution treatment (OST), are injected, although smoking and inhaling practices are becoming increasingly common. The data from the 2014 Health Barometer suggest that 2.2 % of adults (18- to 64-year-olds) exhibit high-risk cannabis use behaviour. The level of high-risk cannabis use has remained rather stable over the years despite the reported increase in the prevalence of cannabis use in recent years.

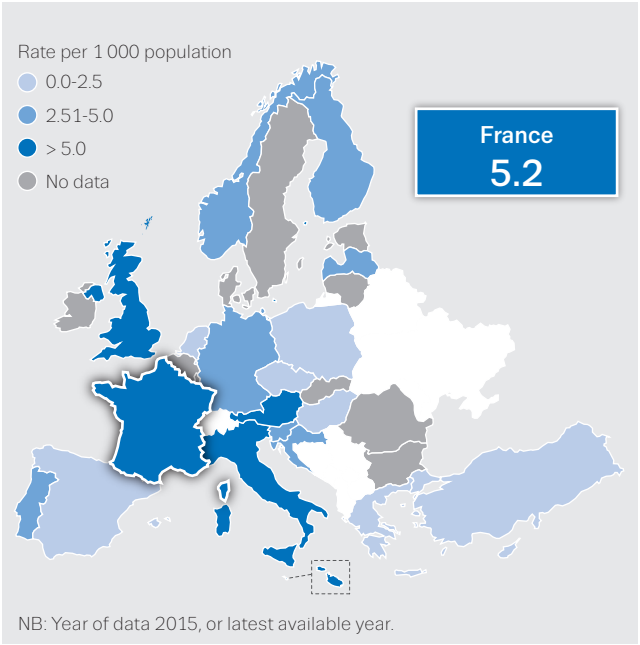
France is one of the EU countries where the estimated high-risk opioid use rate is above 5 per 1 000 of the adult population

Data from addiction treatment and prevention centres (Centres de soins, d'accompagnement et de prévention en addictologie or CSAPAs) indicate that cannabis was the most commonly reported primary substance for new clients entering treatment in 2015, followed by opioids (mainly heroin) and cocaine (Figure 7).

Cocaine is frequently mentioned as being a secondary drug of use. Approximately one out of five treatment clients are female; however, the proportion of females receiving treatment varies by type of primary drug and programme.

FIGURE 6

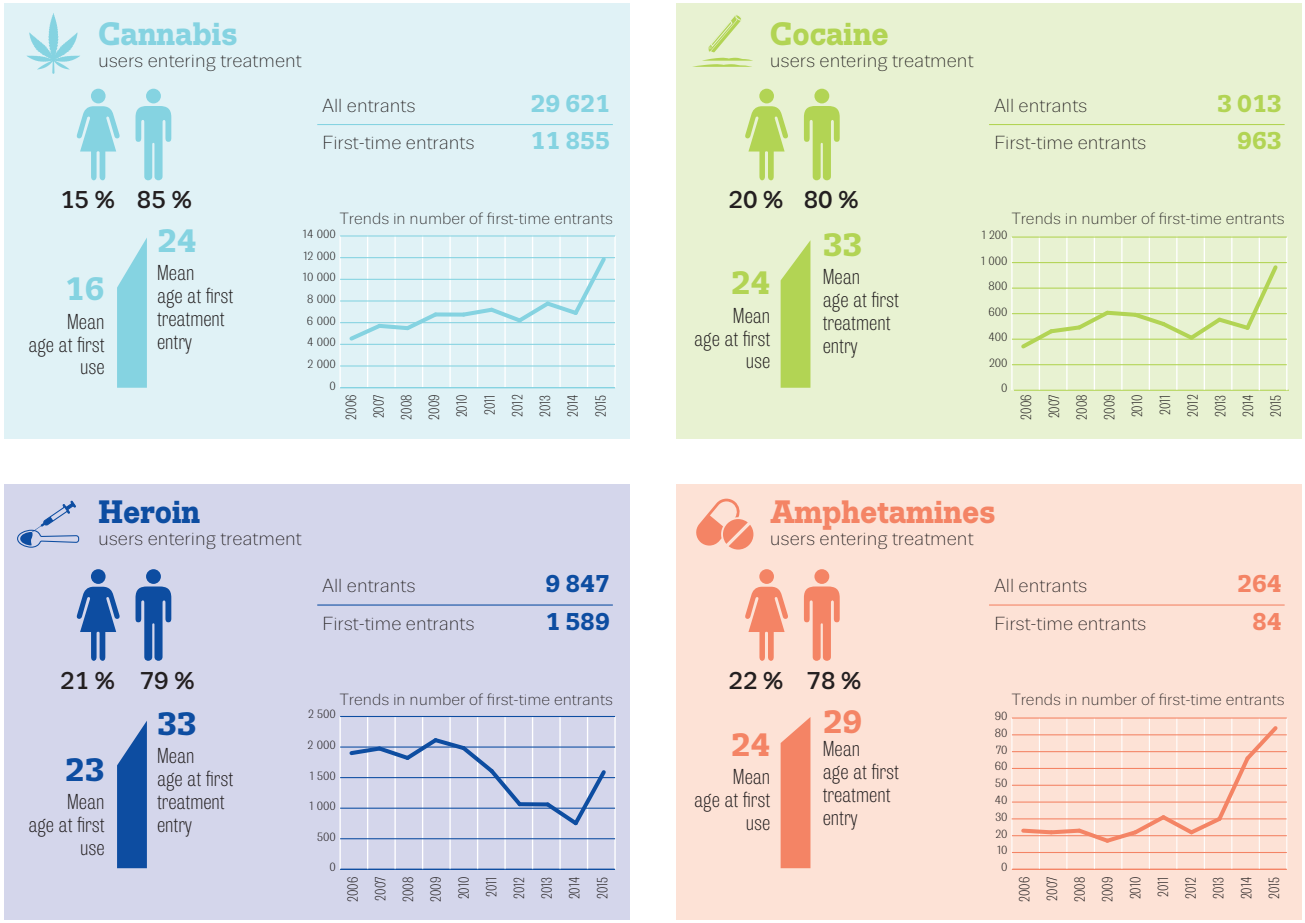
National estimates of last year prevalence of high-risk opioid use



NB: Year of data 2015, or latest available year.

FIGURE 7

Characteristics and trends of drug users entering specialised drug treatment in France



NB: Year of data 2015. Data is for first-time entrants, except for gender which is for all treatment entrants.
Variation in the number of clients may result from changes in the methodology, changing number of participant centres, percentage of patients with known substances and changes in the information of the treatment status of the client. Caution is required in interpreting recent trends.

Drug harms

Drug-related infectious diseases

In France, data on drug-related infectious diseases are collected from the national human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) monitoring database coordinated by the French Public Health Agency (Santé Publique France), and from self-reported or biological testing data from clients attending CSAPAs or low-threshold centres (Centre d'accueil et d'accompagnement à la réduction des risques des usagers de drogues or CAARUDs). Studies on HIV and hepatitis C virus (HCV) prevalence among people who inject drugs (PWID) were carried out in 2004 and 2011 (the Coquelicot study). The 2011 study indicated that HIV prevalence was 13 % among PWID, while nearly 64 % of PWID tested positive for HCV.

Despite the introduction of compulsory reporting for hepatitis B virus (HBV) infection in 2003, it is estimated that only a small proportion of HBV-positive individuals are reported. There is no compulsory notification system for HCV infection.

Since 2003, when the national HIV/AIDS monitoring database was set up, between 6 000 and 7 000 people a year have been diagnosed as HIV positive. However, a steady decline in the number of individuals for which injecting drug use was registered as the likely route of transmission has been observed during this period. In 2015, 58 cases of newly diagnosed HIV infections were related to injecting drug use (Figure 8).

Additional and more recent data on the prevalence of drug-related infectious diseases are based on self-reporting by PWID. Because many drug users are unaware of being infected, the reported prevalence is much lower than that derived from laboratory tests.

In a 2012 study conducted among CAARUD clients (the ENa-CAARUD survey), 6.2 % of 1 587 PWID reported being HIV positive, which indicated a slight decline in reported seropositivity since 2006, when a similar study was implemented for the first time. Self-reported data from the population followed in the CAARUD survey indicate that the prevalence of HCV among drug users is declining, while the same survey indicated that a large proportion of the respondents were unaware of their HBV infection status. Nevertheless, the self-reported data may underestimate the prevalence of drug-related infectious diseases (Figure 9).

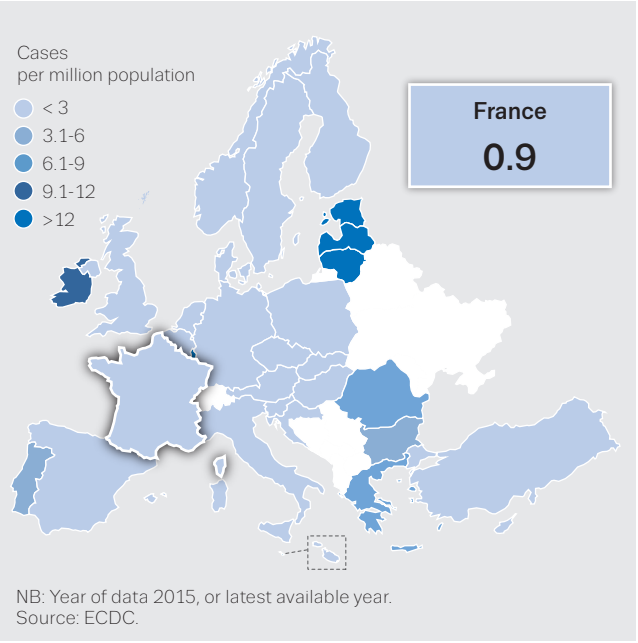
Drug-related emergencies

No national information on drug-related acute emergencies is available for France. However, the data from the 2012 survey of CAARUD clients indicated that almost 1 in 10 clients had experienced a non-fatal overdose in the last year, with alcohol being the most frequently involved psychoactive substance, followed by benzodiazepines, cocaine and heroin.

An emergency department from a Paris hospital participates in the European Drug Emergencies Network (Euro-DEN) project, which was established in 2013 to monitor acute drug toxicity in sentinel centres across Europe.

FIGURE 8

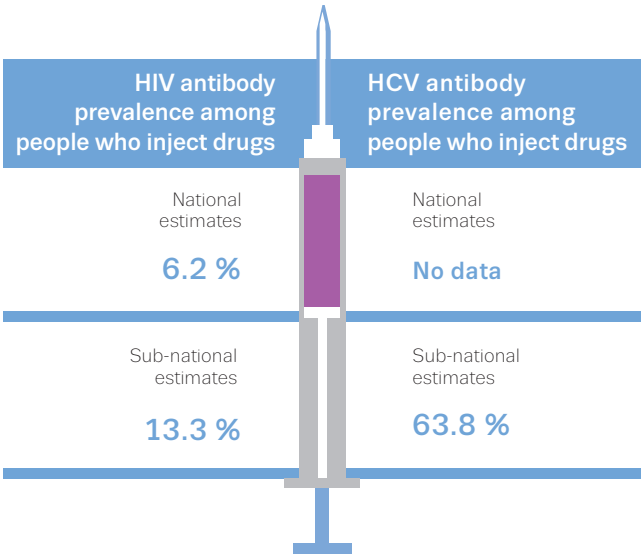
Newly diagnosed HIV cases attributed to injecting drug use



NB: Year of data 2015, or latest available year.
Source: ECDC.

FIGURE 9

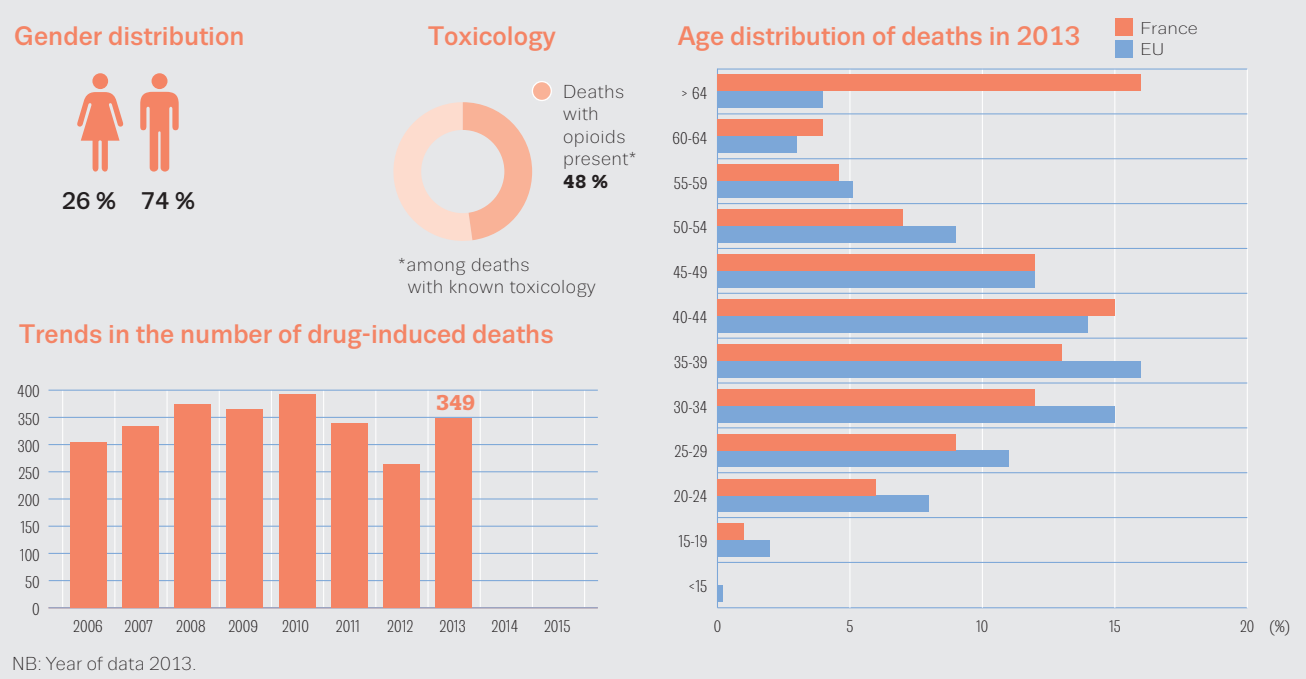
Prevalence of HIV and HCV antibodies among people who inject drugs in France



NB: Year of data HIV 2011/2012, HCV 2011.

FIGURE 10

Characteristics of and trends in drug-induced deaths in France



NB: Year of data 2013.

Drug-induced deaths and mortality

Drug-induced deaths refer to deaths directly attributed to the use of illicit drugs (i.e. poisonings and overdoses).

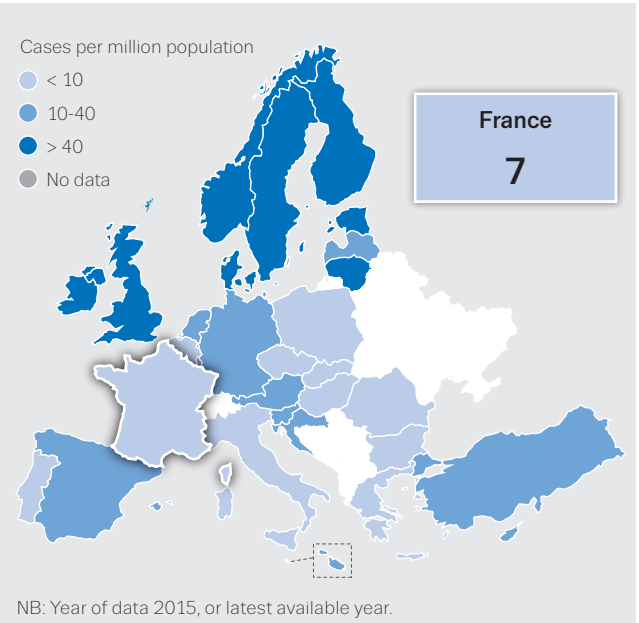
Data on drug-induced deaths in France are collected from the General Mortality Registry (INSERM CépiDc) and the forensic Special Mortality Register (DRAMES). Data from the General Mortality Register indicate that more overdoses were reported in 2013 than in 2012 and 2011. Toxicological data available from the Special Mortality Register indicate that OST medications were involved in about 55 % of deaths recorded in 2014 (Figure 10).

The estimated drug-induced mortality rate among adults (aged 15-64 years) was seven deaths per million in 2013 (according to the most recent data available from INSERM CépiDc), which is less than the most recent European average of 20.3 deaths per million. However, the data for France are likely to underestimate the mortality rate (Figure 11).

Data from a 2009-15 mortality study among a cohort of 1 134 drug users treated at CSAPAs and CAARUDs indicate that there are significantly higher mortality rates among drug users than among the general population. Moreover, the standardised mortality ratio is markedly higher among females than males.

FIGURE 11

Drug-induced mortality rates among adults (15-64 years)



NB: Year of data 2015, or latest available year.

Prevention

Drug use prevention policy in France is coordinated at the central level by MILDECA. The Ministry of National Education, the Ministry of Agriculture, the Ministry of Health, the Ministry of the Interior and the Ministry of Justice are other central stakeholders in the field of prevention. The French prevention policy embraces all psychoactive substances, both illicit and licit and other forms of addictive behaviours. It aims to prevent experimentation or delay it, or prevent and limit the use of these substances and activities.

MILDECA provides funding to implement the national prevention priorities at a local level (regions, local communities), which are coordinated by MILDECA territorial representatives. Decentralised credits for prevention activities are allocated by these MILDECA territorial representatives or by regional health authorities, while the French national health insurance system also provides funding for prevention. At a local level, prevention activities are implemented by a large number of professionals (school communities, non-governmental organisations, police/gendarmerie officers, etc.), while since 2016 prevention officially falls also under the remit of CSAPAs.

Prevention interventions

Prevention interventions encompass a wide range of approaches, which are complementary. Environmental and universal strategies target entire populations, selective prevention targets vulnerable groups that may be at greater risk of developing drug use problems and indicated prevention focuses on at-risk individuals.

The current French Government anti-drug plan gives priority to preventing drug use among young people, especially those in contact with a juvenile court system; pregnant women and female drug users; and people who are remote from the care system, whether geographically or socially.

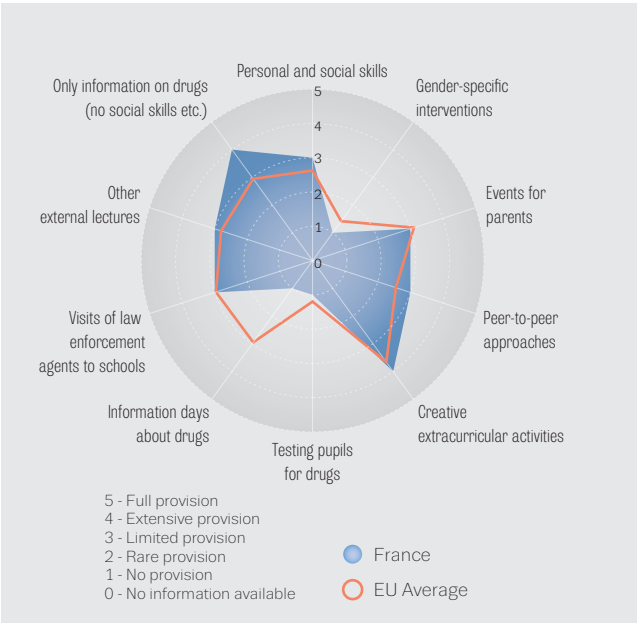
Environmental strategies on alcohol and tobacco are well developed and have substantial political support. Universal prevention is mostly carried out in secondary schools, with the school community involved in the coordination and implementation of prevention activities and external actors contributing as required (non-governmental organisations and police/gendarmerie officers). In 2008, the National Institute for Prevention and Health Education (INPES) issued best practice guidelines for addressing health and risky behaviours in school settings. As for any existing guidelines, their use is strongly encouraged, but is not compulsory. The main focus of the school-based prevention activities, within the area of health education, is to develop students' individual and social skills to enable them to resist drug use. Some examples include life skills prevention programmes in secondary schools, while experimental implementation of internationally validated programmes is also reported (Figure 12).

Drug prevention is also recommended for secondary and higher educational settings under the responsibility of the Ministry of Agriculture. The prevention of licit and illicit substance use in the workplace, incorporating, although uncommonly, the use of screening for substance use, has been in the remit of occupational physicians since 2012. Staff representative bodies are also engaged in workplace prevention as part of the legal obligation to ensure employee safety and to protect employee health. Implementation varies across companies and services. Community-based prevention is carried out in youth counselling centres. Educators at recreational centres for children and teenagers are trained to implement awareness-raising actions on addictive behaviours and risky sexual practices. Activities that aim to reduce risk related to psychoactive substance use in recreational settings are employed in some large cities or are provided at large music festivals or sporting events.

Selective prevention is mainly the responsibility of specialised non-governmental organisations, and is mainly delivered outside the school setting. Law enforcement services rarely deliver selective prevention activities. The actions are promoted within a neighbourhood, in recreational settings and towards at-risk families. As for indicated prevention, some 260 youth addiction outpatient clinics (CJCs) have been opened throughout France to carry out 'early screening and intervention' at approximately 550 consultation points. A requirement to reinforce the CJC system, in particular through training professionals, is specified in the current Government Plan for Combating Drugs and Addictive Behaviours.

FIGURE 12

Provision of interventions in schools in France (expert ratings)



NB: Year of data 2015.

Harm reduction

In France, one of the objectives of the Government Plan for Combating Drugs and Addictive Behaviours 2013-17 is to reduce risk among vulnerable populations that use drugs. In accordance with the provisions of the public health law of 2004 and the law on health system reform of 2016, harm reduction policies aim to protect drug users from acquiring injecting-related infections but also to prevent them from dying as a result of a drug overdose. Moreover, the law defines further public health priorities, such as providing referral to the care system, contributing to improving the health of drug users and facilitating their social reintegration.

Facilities designed to reduce risk and harm complement the work of specialised drug treatment centres (CSAPAs) and the network of CAARUDs, mainly funded directly by the social security system, and form an integral component of the response to drugs in France. All French regions are covered by at least one CAARUD.

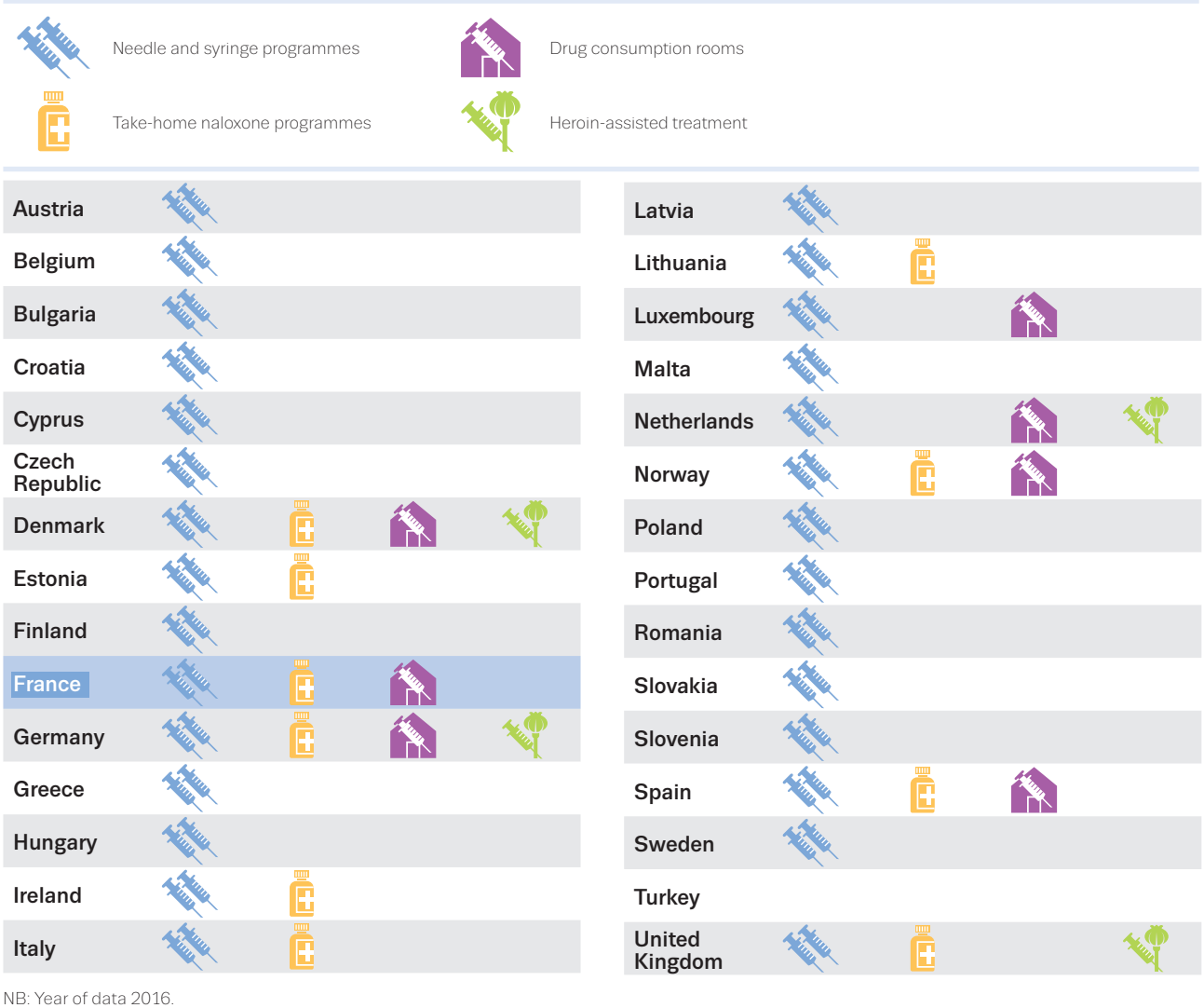
Harm reduction interventions

Harm reduction services provided in CAARUDs include needle and syringe programmes, advice on safer drug use and general health promotion activities, such as condom distribution. A state-subsidised kit containing sterile syringes and other paraphernalia is also available from pharmacies and dispensing machines for a small fee. A recent estimate indicated that annually approximately 12.3 million syringes are distributed or sold to drug users in France. Harm reduction measures have been expanded and diversified in recent years, following new drug use trends. Specific 'sniff and base kits' as well as foil are also being made available to drug users at harm reduction sites.

Following the adoption of the 2016 law on health system reform, the first two experimental drug consumption rooms were opened in Paris and Strasbourg in 2016 (Figure 13). These facilities are expected to operate for a six-year trial period, after which a thorough evaluation on their impact on public health will be carried out.

FIGURE 13

Availability of selected harm reduction responses



NB: Year of data 2016.

As regards the implementation of a naloxone distribution programme, a proprietary medicinal product containing naloxone for nasal use obtained a cohort temporary authorisation for use in November 2015. Take-home naloxone has been available since July 2016. Priority users are newly released inmates together with drug users after opioid withdrawal.

Screening for HIV, HBV and HCV infections and sexually transmitted diseases is provided on anonymous basis and free of charge at specialised information, screening and diagnosis centres. The costs for HIV and HCV antibody screening are fully covered by the French National Health Insurance Fund, while screening for chronic markers of HBV is reimbursed at a rate of 65 %. HBV vaccination is recommended for children and adolescents and is also mandatory in some specific health occupations if employees are at risk. Specialised drug treatment centres also provide free screening for HIV and HCV infection and free vaccination against HBV for any drug users attending such a centre. Moreover, the Minister for Health and Social Affairs has committed himself to providing universal access to innovative treatments for HCV infection. Since June 2016, the treatment of HCV infection with direct-acting antiviral medication is fully reimbursable by the National Health Insurance Fund for drug users who exchange their equipment (irrespective of their stage of fibrosis).

The first two experimental drug consumption rooms opened in Paris and Strasbourg in 2016

Treatment

The treatment system

In France, the provision of treatment for drug users is the responsibility of the regional and local authorities.

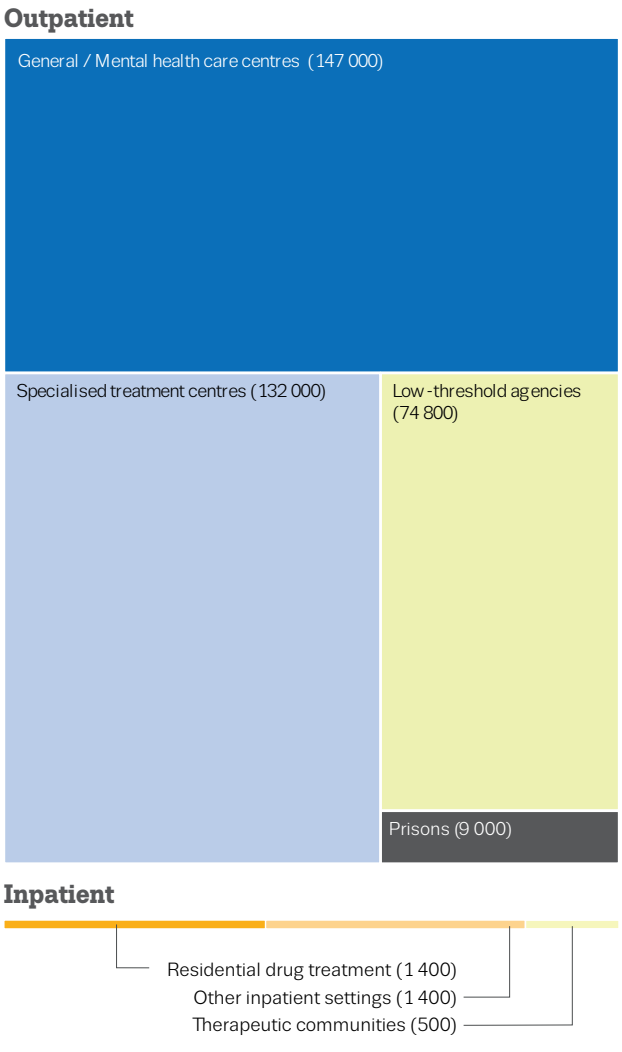
Since 2003, drug treatment has been financed by the social security system.

Two systems are involved in drug treatment: a specialised addiction treatment system and a general care system comprising hospitals and general practitioners (GPs) (Figure 14). Some care is also provided through the network CAARUDs.

Almost all of the 100 sub-regional administrative areas have at least one CSAPA. These centres, managed mainly by not-for-profit non-governmental organisations, provide both outpatient and inpatient care, and also provide care for prison inmates. Both pharmacologically assisted and psychosocial treatments are provided in the same centres. There are also eight 'drug-free' therapeutic communities,

FIGURE 14

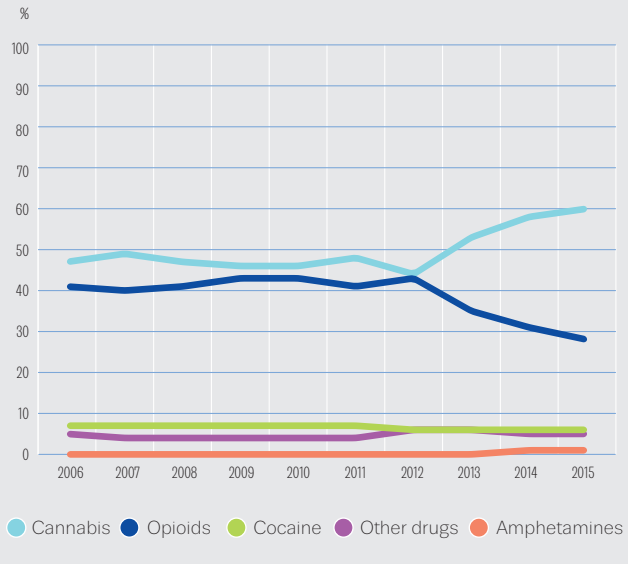
Drug treatment in France: settings and number treated



NB: Year of data 2015.

FIGURE 15

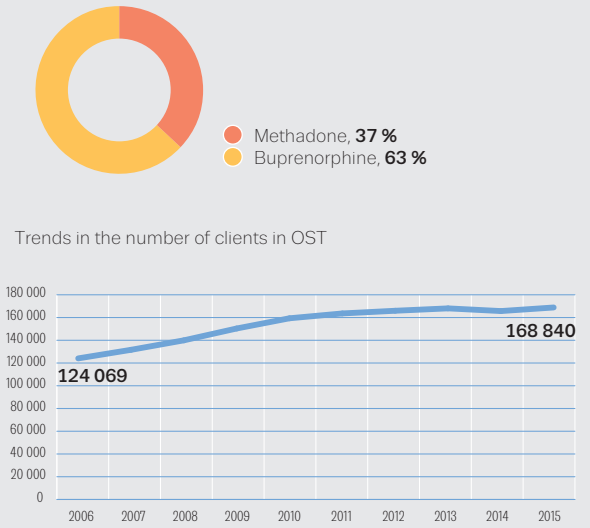
Trends in percentage of clients entering specialised drug treatment, by primary drug in France



NB: Year of data 2015. Variation in the number of clients may result from changes in the methodology, changing number of participant centres, percentage of patients with known substances and changes in the information of the treatment status of the client. Caution is required in interpreting recent trends.

FIGURE 16

Opioid substitution treatment in France: proportions of clients in OST by medication and trends of the total number of clients



NB: Year of data 2015.

which operate separately from CSAPAs, and more than 500 services for young drug users have been established since 2005, providing early intervention and psychological care on an outpatient basis.

The general addiction care system through hospitals is organised across three levels, with each new level building on services available in the previous level. First-level care manages withdrawal and organises consultations; the second level includes the provision of more complex residential care; and the third level expands the services to research, training and regional coordination.

Since 1995, OST has been the main form of treatment for opioid users, and has been integrated into a total therapeutic strategy for drug dependence, including for drug users in prison. Methadone and high-dose buprenorphine (HDB) are used for OST, although in rare cases morphine sulphate is used for substitution treatment. GPs are heavily involved in the initiation and continuation of HDB and methadone treatment, although methadone treatment can only be started in specialised centres or in hospitals. However, there is currently an ongoing debate about this restriction.

Treatment provision

In France, treatment demand data are mainly collected from CSAPAs. Between 2006 and 2013, the proportion of first-time clients requesting treatment for cannabis use increased, while the proportion of first-time opioid users beginning treatment declined. In recent years, however, some signs of stabilisation have been noted among first-time treatment clients. Among all treatment clients, the proportion of primary cannabis users entering treatment has increased between 2011 and 2015, while the proportion of primary opioid users has decreased (Figure 15). Three out of four first-time clients in 2015 entered treatment for cannabis use-related problems, while among all clients three out of five requested treatment due to cannabis use (Figure 15).

The high number and proportion of cannabis users among treatment clients in France may be attributed to several factors, including an increased number of people with problems related to cannabis use; the establishment some years ago of specialised consultation centres for young users, mainly cannabis users; and a high number of referrals to treatment by the criminal justice system.

Many drug users, particularly opioid users, are treated in the general healthcare system at hospitals and by GPs rather than in CSAPAs, and as such are not covered by the French system for data collection on addictions and treatments (RECAP).

Several directives regulate the dose, place of delivery and duration of OST. OST is mainly prescribed in a primary care setting by GPs, and is usually dispensed in community pharmacies. The number of clients steadily increased between 1995 and 2012, although since then it has remained rather stable. Buprenorphine, introduced in 1996, is still the most widely prescribed substance for OST, although the proportion of clients using methadone for OST is increasing (Figure 16).

Drug use and responses in prison

The French prison directorate administers almost 200 prison establishments.

In studies conducted more than 10 years ago, one third of new inmates in France reported prolonged, regular use of illicit drugs, mainly cannabis, but also cocaine and crack cocaine, as well as opioids, in the year prior to entering prison. According to these studies, approximately 1 in 10 inmates were drug dependent, but the total number of high-risk drug users in prison settings was not quantified. Another study conducted in 2003 found that approximately 2.6 % of new inmates injected drugs in the year prior to entering prison. No studies have specifically investigated drug use in prisons.

Prison inmates in France had higher rates of drug-related infectious diseases than the general population, although a declining trend was noted in the last decade.

Since 1994, the Ministry of Health has been responsible for health in French prisons, and the treatment of drug dependency in prison settings is based on a three-tier system: prison-based hospital healthcare units, which are responsible for monitoring the physical health of inmates; Regional Medico-Psychological Hospital Services established in each French region, which handle the mental health aspects of drug users in prisons if no CSAPA exists in the prison; and CSAPAs for prisons, established in the 16 largest prisons in France and covering approximately one quarter of the incarcerated population and three quarters of existing establishments. Furthermore, a reference CSAPA is appointed for each prison so as to offer support to inmates with drug dependency problems, particularly after their release.

In France, strategies for the prevention of drug-related infectious diseases have been implemented in prison settings since 1996 through the provision of OST and the offering of bleach.

Studies conducted more than 10 years ago found approximately 1 in 10 inmates in France were drug dependent, but the total number of high-risk drug users in prison settings has not been quantified

Quality assurance

In France, quality assurance in drug demand reduction (prevention, risk reduction, treatment and rehabilitation) builds on specific advocacy, guidelines or training from professional organisations or public health institutions, but it is not institutionally structured or imposed. As for risk reduction and treatment, different guidelines exist on (i) OST; (ii) early intervention and risk/harm reduction for crack cocaine or free base users; (iii) clinics for young drug users; and (iv) the treatment of cocaine users. However, the implementation of these guidelines is not compulsory: there is no formal prerequisite to fulfil guidelines in order to obtain support or subsidies. CSAPAs are marginally affected by the existing accreditation and certification processes directed at health establishments.

The French Public Health Agency (Santé Publique France) distributes information on evidence-based prevention methods. However, there is no specific drug use prevention protocol for prevention providers, public servants or associative workers to follow.

A growing, though still limited, number of prevention organisations are involved in adopting and implementing international evidence-based programmes. Nevertheless, establishing good and evidence-based practices in prevention is among the government's drug policy priorities. The Inter-ministerial Commission for the Prevention of Addictive Behaviours (CIPCA), which aims to promote evidence-based prevention programmes, was launched in 2014. Currently, CIPCA is funding the impact evaluation of five prevention programmes selected on the basis of a call for tender.

Currently, five prevention programmes are undergoing impact evaluation

Drug-related research

In France, the Ministry of National Education, Higher Education and Research (MENESR) designs, coordinates and implements national policy on research and innovation through academic organisations such as the National Centre for Scientific Research (CNRS) and INSERM. The Ministry of Research, together with MILDECA, is responsible for building up the French drug-related research agenda included in the Government Plan for Combating Drugs and Addictive Behaviours 2013-17.

The French national focal point, the Observatoire français des drogues et des toxicomanies (OFDT), is the main body involved in drug-related data collection, studies and network development. It collaborates extensively with national and European drug-related research teams. The dissemination of data and research results is also part of its mandate, together with publishing these results in national and international scientific journals, and promoting the use of research results in practice and policymaking.

MILDECA funds prevention and evaluative drug-related research that responds to public policy needs. It promotes dissemination through national scientific events (including a scientific award, presented for the first time in 2016) and the creation of national scientific drug-related networks to share knowledge and expertise among practitioners and policymakers. As for citizens and young people, MILDECA promotes, together with academic organisations (INSERM), 'scientific mediation' through specific initiatives (MAAD Digital, Universcience TV) aimed at developing scientific drug-related knowledge among the public at large.

Currently, research on drugs and addictive behaviours is also among the strategic priorities of national thematic research alliances. Public authorities have identified the following key priorities:

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

A large number of research studies have been published recently, particularly studies in the field of basic research, population-based studies and epidemiological studies. Many studies have also focused on demand reduction.

The number of French scientific publications on drug-related research has increased significantly during the last six years (DPT 2017).

The Ministry of Research together with MILDECA are responsible for building up the French drug-related research agenda

Drug markets

As in other European countries, the cannabis market in France has undergone changes in the last five years. Seizure data indicate that the cannabis resin market remains larger than the herbal cannabis market, although the latter is becoming increasingly dynamic. In France, herbal cannabis, the only illicit substance produced locally, is cultivated mainly by individuals on a small scale, although in recent years the increasing involvement of some criminal groups has been noted. Cross-border trading of herbal cannabis, mainly from the Netherlands but also from Spain, has also been reported. Cannabis resin, the main drug trafficked in France, originates from Morocco and enters France through Spain, although some organised groups increasingly use Libya as a transit country or smuggle it directly via the Mediterranean route. The market for cannabis resin competes with that of herbal cannabis, and widespread law enforcement operations increase the costs and reduce the profitability of trafficking operations. There is also evidence that the potency of cannabis products has increased in recent years. In addition, some of the traditional cannabis resin trafficking organisations have been refocusing their work on more profitable operations, such as cocaine trafficking.

The cocaine market accounts for the second largest share of the French illicit drug market. Cocaine is mainly trafficked from South America, but French overseas departments and territories in the Americas are playing more of a role, as nearly one in five seizures originates from these regions.

Heroin, originating in Afghanistan, is mainly trafficked via the Balkan route. The heroin market, although in decline compared with the 1990s, has shown some signs of revival in the last few years in some parts of France, where user-dealer micro-networks play an important role in maintaining the availability of heroin. There is also a significant illicit market for opioid-containing medications diverted mainly from healthcare services.

Synthetic stimulants are chiefly smuggled from the Netherlands, though only in small amounts. France is also a transit country for dealers targeting the United Kingdom and Spain. Since 2009, the MDMA market has experienced renewed dynamism and there has been a diversification of marketed products, in addition to the appearance of high-potency products targeting mainly those in recreational settings and young people.

NPS are offered through various segments of an internet-based market, and those arriving to France are mainly produced in Asia, particularly China and India. Seizures of NPS indicate that cathinone-type substances dominate the market, followed by cannabinoids and tryptamines. In 2015, a total of 44 substances were identified for the first

FIGURE 17

Price and potency/purity ranges of illicit drugs reported in France

NB: Price and potency/purity ranges: EU and national mean values: minimum and maximum.
Year of data 2015.

time in France, eight of which were identified for the first time in the European Union.

Taking into account the nature of the illicit drug market in France, the priority of law enforcement remains interception of cannabis and cocaine trafficking routes in the Mediterranean and Caribbean Seas.

The retail price and purity of the main illicit substances seized are shown in Figure 17.

KEY DRUG STATISTICS FOR FRANCE

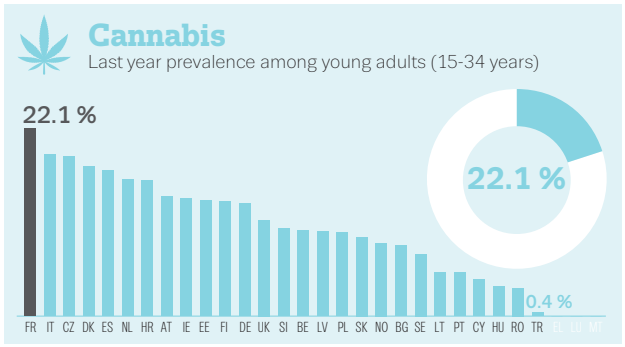
Most recent estimates and data reported

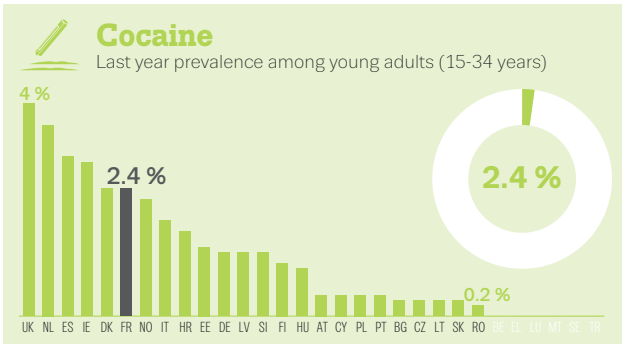
			EU range	
	Year	Country data	Minimum	Maximum
Cannabis				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	31.5	6.5	36.8
Last year prevalence of use — young adults (%)	2014	22.1	0.4	22.1
Last year prevalence of drug use — all adults (%)	2014	11.1	0.3	11.1
All treatment entrants (%)	2015	60	3	71
First-time treatment entrants (%)	2015	75	8	79
Quantity of herbal cannabis seized (kg)	2015	16 835	4	45 816
Number of herbal cannabis seizures	2015	32 446	106	156 984
Quantity of cannabis resin seized (kg)	2015	60 790	1	380 361
Number of cannabis resin seizures	2015	65 503	14	164 760
Potency — herbal (% THC) (minimum and maximum values registered)	2015	0-27	0	46
Potency — resin (% THC) (minimum and maximum values registered)	2015	0-48	0	87.4
Price per gram — herbal (EUR) (minimum and maximum values registered)	2015	7-10	0.6	31.1
Price per gram — resin (EUR) (minimum and maximum values registered)	2015	5-9	0.9	46.6
Cocaine				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	4	0.9	4.9
Last year prevalence of use — young adults (%)	2014	2.4	0.2	4
Last year prevalence of drug use — all adults (%)	2014	1.1	0.1	2.3
All treatment entrants (%)	2015	6	0	37
First-time treatment entrants (%)	2015	6	0	40
Quantity of cocaine seized (kg)	2015	10 869	2	21 621
Number of cocaine seizures	2015	9 483	16	38 273
Purity (%) (minimum and maximum values registered)	2015	0-88.3	0	100
Price per gram (EUR) (minimum and maximum values registered)	2015	60-75	10	248.5
Amphetamines				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2.4	0.8	6.5
Last year prevalence of use — young adults (%)	2014	0.7	0.1	3.1
Last year prevalence of drug use — all adults (%)	2014	0.3	0	1.6
All treatment entrants (%)	2015	1	0	70
First-time treatment entrants (%)	2015	1	0	75
Quantity of amphetamine seized (kg)	2015	385	0	3 796
Number of amphetamine seizures	2015	605	1	10 388
Purity — amphetamine (%) (minimum and maximum values registered)	2015	0-73.3	0	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	2015	10-20	1	139.8

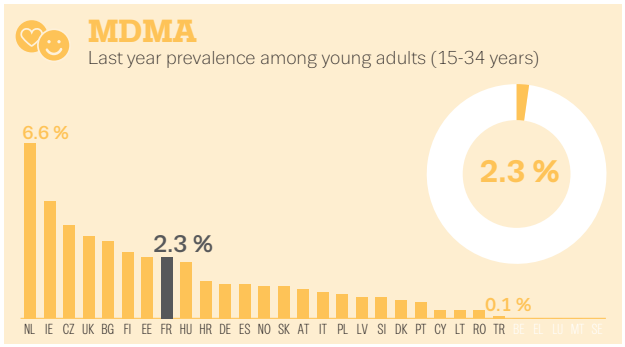
	Year	Country data	EU range Minimum	EU range Maximum
MDMA				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2.3	0.5	5.2
Last year prevalence of use — young adults (%)	2014	2.3	0.1	6.6
Last year prevalence of drug use — all adults (%)	2014	0.9	0.1	3.4
All treatment entrants (%)	2015	0	0	2
First-time treatment entrants (%)	2015	0	0	2
Quantity of MDMA seized (tablets)	2015	1 325 305	54	5 673 901
Number of MDMA seizures	2015	1 592	3	5 012
Purity (mg of MDMA base per unit) (minimum and maximum values registered)	2015	0-201.3	0	293
Price per tablet (EUR) (minimum and maximum values registered)	2015	6-10	0.5	60
Opioids				
High-risk opioid use (rate/1 000)	2013/2014	5.2	0.3	8.1
All treatment entrants (%)	2015	28	4	93
First-time treatment entrants (%)	2015	15	2	87
Quantity of heroin seized (kg)	2015	818	0	8 294
Number of heroin seizures	2015	4 692	2	12 271
Purity — heroin (%) (minimum and maximum values registered)	2015	0-77	0	96
Price per gram — heroin (EUR) (minimum and maximum values registered)	2015	25-45	3.1	214
Drug-related infectious diseases/injecting/deaths				
Newly diagnosed HIV cases related to injecting drug use (cases/million population, Source: ECDC)	2015	0.9	0	44
HIV prevalence among PWID* (%)	2011/2012	6.2	0	30.9
HCV prevalence among PWID* (%)	No data	No data	15.7	83.5
Injecting drug use (cases rate/1 000 population)	2014	2.6	0.2	9.2
Drug-induced deaths — all adults (cases/million population)	2013	7	1.6	102.7
Health and social responses				
Syringes distributed through specialised programmes	2014	12 314 781	164	12 314 781
Clients in substitution treatment	2015	168 840	252	168 840
Treatment demand				
All clients	2015	62 213	282	124 234
First-time clients	2015	17 789	24	40 390
Drug law offences				
Number of reports of offences	2015	199 667	472	411 157
Offences for use/possession	2015	166 390	359	390 843

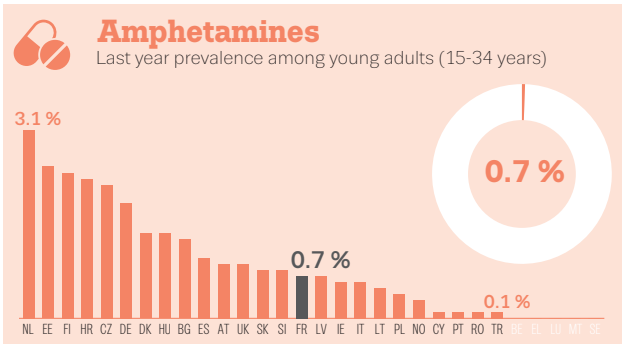
* PWID — People who inject drugs.

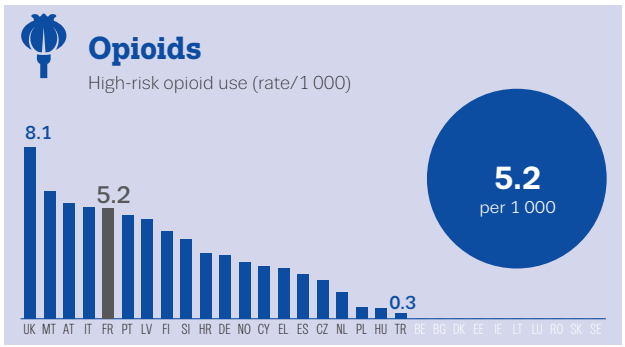
EU Dashboard

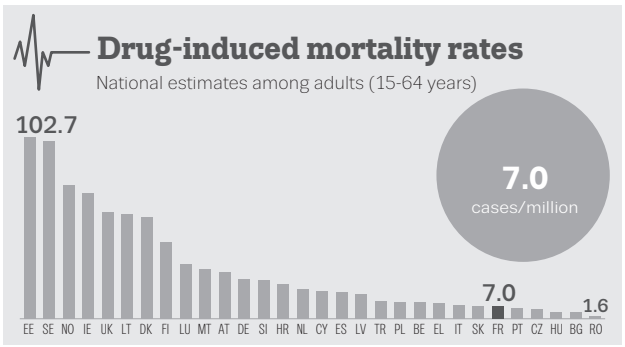


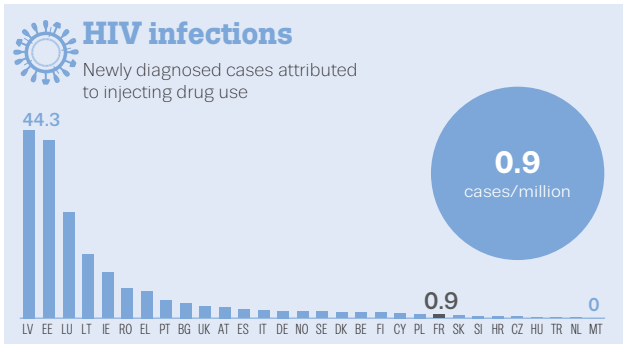


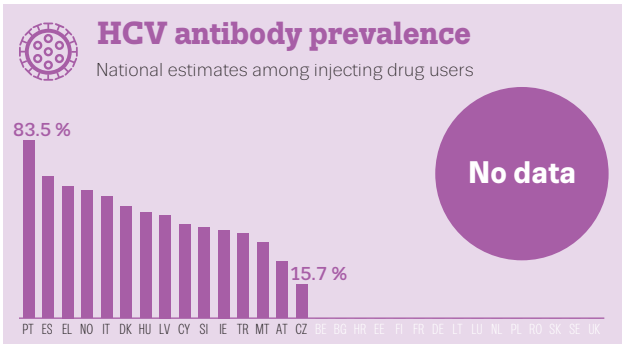












NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, differences may be due to reporting practices. Detailed information on methodology, qualifications on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Countries with no data available are marked in white.

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About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central source and confirmed authority on drug-related issues in Europe. For over 20 years, it has been collecting, analysing and disseminating scientifically sound information on drugs and drug addiction and their consequences, providing its audiences with an evidence-based picture of the drug phenomenon at European level.

The EMCDDA's publications are a prime source of information for a wide range of audiences including: policymakers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public. Based in Lisbon, the EMCDDA is one of the decentralised agencies of the European Union.

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About our partner in France

Since 1996, the French Monitoring Centre for Drugs and Drug Addiction (Observatoire français des drogues et des toxicomanies, OFDT) has been entrusted, as an independent body, with the coordination of all drug-monitoring activities in France, and has acted as the national focal point. The OFDT is also responsible for the evaluation of drug policies in France. Since 1999, its areas of activity have included licit substances (alcohol, tobacco and medicines) in addition to illicit drugs and addictive behaviours. The OFDT is mainly funded by the Inter-ministerial Mission for Combating Drugs and Addictive Behaviours (Mission interministérielle de lutte contre les drogues et les conduites addictives, MILDECA), an inter-departmental body composed of representatives of different ministries, which is responsible for the overall coordination of activities against drugs and drug dependency in France. For a comprehensive picture of the French drug situation, please refer to the national report 2016 to the EMCDDA.

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