# Treatment workbook

# 2019

## *France*

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**2019 National report (2018 data) to the EMCDDA by the French Reitox National Focal Point**

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## Table of Contents

# T0. Summary

Please provide an abstract of this workbook (target: 500 words) under the following headings:

- National profile
- Trends
- New developments

Please include here a brief description of:

- The main treatment-related objectives of the national drug strategy, and the co-ordination bodies responsible for their funding and provision.
- An overview of the main providers of outpatient and inpatient treatment.
- The main treatment modalities available in your country.
- Provide a short description of key data on clients profile and patterns of drug use


National profil

Two schemes make it possible to provide treatment to illicit drug users: the specialised service for addiction treatment (available either in medical-social establishments - National treatment and prevention centres for addiction - or CSAPA, either in hospitals or towns) and the conventional scheme mainly represented by general practitioners and pharmacists. According to CSAPA activity reports, approximately 138,000 individuals were received in outpatient CSAPA (specialised addiction treatment centres) in 2016 for problems with illegal drugs or diverted psychotropic medications. In 2018, about 57,000 users starting a course of treatment in a CSAPA were actually included in TDI data. However, these figures account for only a proportion of users corresponding to exhaustive data collection.

OST is mainly prescribed in a primary care setting by general practitioners, and is usually dispensed in community pharmacies. In 2017, 162,300 persons received opioid substitution treatment dispensed in community pharmacies and 23,330 patients received treatment dispensed in a CSAPA in 2016.

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

Trends

After increasing between 2014 and 2016, the number of people receiving care for the first time as part of the specialised service for addiction treatment, declined in 2017. It remained stable between 2017 and 2018. The increase in these treatment demands between 2014 and 2016 mainly came from cannabis users, who represented an overwhelming majority (74% in 2018). The number of treatment demands related to opiates has been declining since 2016. The number of demands related to cocaine, which were very low in 2014, more than doubled between 2014 and 2018 and may soon exceed the number of demands related to opioids. Over the 2007-2018 period, the number of cannabis related demands increased between 2007 and 2014 and then stabilised. The proportion of opioid related demands decreased between 2007 and 2014 at the same rate. Since then, the figure has continued to decline but at a fairly slow rate. The proportion of opioid related demands slightly increased between 2016 and 2018.

Developments in the number of treatment entrants are similar to those for first treatment demands, even though there are less when it comes to cannabis (lower increase and decrease rate). The distribution according to substances seems fairly stable up to 2010, with a slight downward trend in the percentage of cannabis users. The percentage of these users then increases significantly, peaking at 62% in 2016 to then decrease in 2017 for the first time since 2010 and stabilising in 2018 at around 60%. The evolution of the share of opiate users is roughly symmetrical to that of cannabis users. As for first-time treatment demands, the most significant trend is the continued increase in the number and share of treatment demands related to cocaine.

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

New developments

As in 2017, 2018 was marked by the number and percentage of treatment demands related to cocaine continuously progressing. The number and percentage of treatment demands related to cannabis seem to stabilise after the sharp increase from 2010-2016.

In 2017, 162,300 people received opioid substitution treatment dispensed in community pharmacies: 99,900 were prescribed buprenorphine (Subutex® or generics), 61,700 methadone and 7,600 buprenorphine in combination with naloxone (Suboxone®).

Furthermore, 23,330 patients were dispensed opioid substitution medications in CSAPA (19,800 methadone and 3,530 buprenorphine) in 2016.

# T1. National profile

## T1.1. Policies and coordination

The purpose of this section is to

- describe the main treatment priorities as outlined in your national drug strategy or similar key policy documents
- provide an overview of the co-ordinating/governance structure of drug treatment within your country

T1.1.1. What are the main treatment-related objectives of the national drug strategy? (suggested title: Main treatment priorities in the national drug strategy)

**Main treatment priorities in the national drug strategy**

As regards the management of addiction, the 2018-2022 National Action Plan on Addictions (MILDECA 2018) defines six objectives:

1) Allow for the routine and stepped up detection of addictive behaviours
2) Increase the role of front-line professionals in supporting patients suffering from addictions
3) Develop and promote the adoption of best practice guidelines in addiction medicine
4) Change professional practices, including systematically integrating harm reduction objectives, developing outreach services and integrating peer helpers into addiction care teams
5) Structure the addiction medicine healthcare pathway
6) Open up healthcare pathways to the disabled

T1.1.2. Who is coordinating drug treatment and implementing these objectives? (suggested title: Governance and coordination of drug treatment implementation)

**Governance and coordination of drug treatment implementation**

See T1.1 in the "Drug policy" workbook

*T1.1.3.* ***Optional****. Please provide any additional information you feel is important to understand the governance of treatment within your country (suggested title: Further aspects of drug treatment governance)*

## T1.2. Organisation and provision of drug treatment

The purpose of this section is to

- describe the organisational structures and bodies that actually provide treatment within your country
- describe the provision of treatment on the basis of Outpatient and Inpatient, using the categories and data listed in the following tables. Drug treatment that does not fit within this structure may be included in the optional section
- provide a commentary on the numerical data submitted through ST24
- provide contextual information on the level of integration between the different treatment providers (e.g. umbrella organizations providing multiple services, for instance both outpatient and low threshold services);

### Outpatient network

T1.2.1. Using the structure and data provided in table I please provide an overview and a commentary of the main bodies/organisations providing Outpatient treatment within your country and on their respective total number of clients receiving drug treatment (suggested title: Outpatient drug treatment system – Main providers and client utilisation)

**Outpatient drug treatment system – Main providers**

There are two schemes available for dispensing treatments to people using illicit drugs: the specialised addiction treatment system (in socio-medical establishments) and the general healthcare system (hospitals and general practitioners). Only those individuals overseen by the professionals mentioned in Table I will be described herein.

*The specialised socio-medical scheme*

Until 2004, illegal drug users were only overseen at specialised care centres for drug users (CSST). Outpatient alcoholism treatment centres (CCAA) only received individuals with alcohol problems. After this date, both categories of centres adopted the same name, national treatment and prevention centres for addiction (CSAPAs or specialised drug treatment centres), and in 2008 were assigned the joint task of treating all individuals with an addiction problem, irrespective of the substance, nonetheless with the possibility of retaining their previous specialisation. Until 2010-2011, the latter maintained a strong presence and the number of illegal drug users admitted in the former CCAA has remained negligible. CSAPA which had previously been outpatient alcoholism treatment centres were not therefore taken into account in the treatment demand data sent to the EMCDDA. However, the gradual increase in the number of drug users receiving treatment in former CCAA now means that it is no longer appropriate to make a distinction between CSAPA based on their history. All CSAPA have been included in TDI data since 2013, even though some centres only oversee a minority of drug users, and sometimes none. This change explains the sudden increase in the number of CSAPA registered since.

The CSAPA are predominantly managed by not-for-profit non-governmental organisations. A minority of centres (approximately a third) are dependent upon a public health establishment. All are funded by the National Health Insurance Fund budget.

CSAPA in a prison setting, few in number (11), focus their activities on incarcerated drug users (including alcohol and tobacco). Therapists at the CSAPA offer counselling for inmates that request it in the context of addiction medicine appointments. These are not drug-free zones like in certain countries. However, their activity only represents part of addiction health care delivery in a prison setting. On the one hand, addiction health care is delivered by general hospital or mental health establishments which provide health care in a prison setting. However, no information system exists able to measure this activity. On the other hand, the public authorities wished to set in place, as from 2011, a reference CSAPA for each of the prisons in France (See Prison workbook). These CSAPA are responsible for intervening in custody mainly to ensure continuity of care upon release. A financial budget has been planned to allow each reference

CSAPA to dedicate an additional part-time social worker (or a full time equivalent in large prisons) to intervention alongside incarcerated drug users or those having recently left prison.

In France, the activity of the CAARUD (low-threshold structures) is not perceived as falling within the scope of treatment in the same way as the CSAPA: the information relating to this type of facility are detailed in the "Harms and harm reduction" workbook.

*The general scheme*

The activity of office-based general practitioners with regard to treatment of drug use is described via the *Santé Publique France* Health Barometer general practitioner survey, conducted on a sample of practitioners. However, this survey has not been conducted since 2009. In 2009, two thirds of general practitioners (about 40,000) saw at least one opioid-addicted drug user in the last year (Gautier 2011). The proportion of those receiving at least one user per month substantially increased to almost 50% (compared to one-third in 2003) and 12% (about 7,000) received at least 5 user per month. This substantial level of activity alongside opioid-dependent drug users is mainly related to the prescription of opioid substitution treatment (OST). Appointments related to cannabis concern considerably fewer physicians: nearly 3,000 claim to have seen at least 5 patients per month related to cannabis use. Lastly, approximately one in five physicians (13,000) saw at least one patient in the course of the year for problem stimulant use. Since this survey among general practitioners is quite old, the numbers may have changed since then. In 2017, independent prescribers of opioid substitution medications predominantly correspond to general practitioners (96.2%) and, more rarely, psychiatrists (3.2%) (Brisacier 2019).

In 2017, 51 medical micro-structures were established in seven regions and followed up nearly 1,700 clients: mainly in Grand-Est (where they were first created in Strasbourg back in 1999), Hauts-de-France, PACA, Bourgogne-Franche-Comté, and more recently Occitanie, Ile-de-France and Auvergne-Rhône-Alpes. A micro-structure is a multidisciplinary healthcare team working within a general practitioner's clinic, consisting of the GP, and at least a psychologist and social worker. It represents a primary care unit and is part of the nationwide first-line care network. Its target population consists of patients in complex situations in terms of addictive behaviours, unstable situations or with comorbidities related to drug use.

A national micro-structure network coordination scheme was created in 2006 (Coordination nationale des réseaux des microstructures 2018). It is currently being trialled in 4 regions to evaluate the structural and economic model so it can be implemented across the country.

Illegal drug users may also be treated in an outpatient setting at numerous addiction medicine clinics created in general hospitals and psychiatric clinics. In 2010, approximately 480 hospital addiction medicine clinics were registered (Palle *et al.* 2012). This figure refers both to clinics open for a few hours a week and those which operate every working day. Patients are mainly seen for alcohol problems; however all clinics may treat illegal drug users. Some hospital-based addiction medicine clinics are specialised on tobacco.

### Outpatient drug treatment system – Client utilisation

According to the data provided in the CSAPA activity reports, the approximate number of individuals admitted in outpatient CSAPA is 138,000[1] in 2016 for problem use of illegal drugs or misappropriated psychoactive medicines. This figure includes clients already receiving treatment the previous year. It is much higher than the number of people registered as starting a new course of treatment according to the definition in the TDI protocol (56 845 in 2018). This discrepancy is related both to the difference in the definition, and also to the exhaustiveness of the data originating from progress reports, whereas numerous CSAPAs do not take part in TDI data collection or, even if they do take part, do not provide data which can be used to determine whether a patient is starting or continuing treatment.

[1] This figure takes into account a 5% proportion of double entries of declared data, a percentage evaluated based on the last capture-recapture study conducted in a few French towns.

The number of drug users seen by general practitioners is estimated at 132,000 based on the reimbursements for prescription of OST.

In 2016, the 11 CSAPA in a prison setting having contributed data on the number of patients claimed to have treated approximately 4,500 individuals in the past year for use of illegal drugs or psychoactive medicines. Extrapolating these figures, the total number of patients treated in these CSAPA can be estimated at approximately 6,000. However, the treatment of incarcerated drug users is also provided by CSAPA, carrying out activities not limited to prison-based interventions. In 2016, 202 CSAPAs claimed to operate in the prison setting. Overall, the number of prison inmates treated for misuse of psychoactive medicine or illicit drug use can be estimated at approximately 15,000. These figures are, however, partly included in the 138,000 drug-treatment clients in outpatient CSAPA.

*T1.2.2.* ***Optional****. Please provide any additional information you feel is important to understand the availability and provision of Outpatient treatment within your country (suggested title: Further aspects of outpatient drug treatment provision)*

**Tableau I.** Network of outpatient treatment facilities (total number of units and clients)

| | **Total number of units** | **National Definition** (Characteristics/Types of centre) | **Total number of clients** |
|---|---|---|---|
| **Specialised drug treatment centres (CSAPA)** | 374 | Drug users having been seen at least once in the year as part of a meeting in person with a healthcare professional employed at a CSAPA in the context of structured treatment.<br>Facilities of a medical-social nature authorised and funded by the Social Security scheme, the activity of which completely focuses on the treatment of individuals addicted to illegal drugs, alcohol and tobacco or with a behavioural addiction (gambling, cyberaddiction). These facilities are known as national treatment and prevention centres for addiction (CSAPA). | 138 000 |
| **Low-threshold agencies focused on harm reduction approaches** | 160 | Drug users seen at least once at a CAARUD or seen externally by a team from the CAARUD. In France, drug users seen at a CAARUD are not considered as receiving treatment. | 60 000 |
| **General primary health care (e.g. GPs)** | 34 000 | Individuals having benefited from reimbursement further to prescription of an opioid substitution treatment by a general practitioner (GP).<br>Estimated number of general practitioners having claimed to have seen at least one opioid client in the past month. | 140 000 |
| **General mental health care** | | | |
| **Prisons:**<br>**CSAPA in prison settings** | 11 | Facilities authorised and funded by the Social Security scheme, the activity of which completely focuses on the treatment of incarcerated individuals addicted to illegal drugs, alcohol and tobacco or with a behavioural addiction (gambling, cyberaddiction). These facilities are known as national treatment and prevention centres for addiction (CSAPA) in a prison setting. | 4 500 |
| **Other outpatient units** | | | |

**Source**: Standard table 24.

Note: These data are an estimation of all individuals treated over the past year in CSAPAs, whether for a new course of treatment or not. These figures are comparable to those obtained for other types of facilities. If these data are limited to TDI figures (56 845 individuals in 2018), it would not then be possible to provide figures for other types of facilities.

*T1.2.3.* ***Optional****. Please provide any additional information on treatment providers and clients not covered above (suggested title: Further aspects of outpatient drug treatment provision and utilisation)*

*T1.2.4. Using the structure and data provided in table II please provide an overview and a commentary of the main bodies/organisations owning outpatient treatment facilities in your country*
(Suggested title: Ownership of outpatient drug treatment facilities)

37% of specialised drug treatment centres are public hospital-owned facilities and 67% are non-government (not for profit) owned facilities. All these centres (CSAPA and CAARUD) are funded by the social security scheme. However, it is not necessary to contribute to social security to be able to access these centres, as treatment can be accessed anonymously and for free.

Primary care general practitioners mainly work in private practices.

Table II. Ownership of outpatient facilities providing drug treatment in your country (percentage). Please insert % in the table below. Example: about 80% of all outpatient specialised drug treatment centres are public/government-owned facilities and about 20% are non-government (not for profit) owned facilities.

| | Public / Government | Non-government (not for profit) | Non- government (for profit - Private) | Other | Total |
|---|---|---|---|---|---|
| Specialised drug treatment centres | 37% | 63% | | | 100% |
| Low-threshold agencies | | 100% | | | 100% |
| General primary health care (e.g. GPs) | | | 100% | | 100% |
| General mental health care | 100% | | | | 100% |
| Other outpatient units (1) | | | | | 100% |
| Other outpatient units (2) | | | | | 100% |

### Inpatient network

T1.2.5. Using the structure and data provided in table III please provide an overview and a commentary of the main bodies/organisations providing Inpatient treatment within your country and on their respective total number of clients receiving drug treatment (suggested title: Inpatient drug treatment system – Main providers and client utilisation)

### Inpatient drug treatment system – Main providers

As for an outpatient setting, residential treatment may have a role in the context of a CSAPA or public, general or specialised psychiatric hospital or in follow-up and rehabilitation care (SSR).

*Residential care in CSAPAs*

CSAPA with housing offer different types of services. The most important in terms of the number of patients concerned, corresponds to collective housing in the context of residential treatment centres (CTR). These centres were historically created to receive drug users after withdrawal for stays over a few months, allowing them to readjust to life without drugs. Since OST became more widespread in the 1990s, these institutions are also open to individuals receiving this type of

treatment. There were 35 CTR in 2016. In addition to these institutions, 10 therapeutic communities (TC), created in the 2000s, also exist. All the CTR and TC are managed by non-governmental organisations and funded by the National Health Insurance Fund with no residual costs for the people receiving treatment. It can also be observed that TC have a considerably higher number of spaces compared to CTR (30 vs. 10 on average). CSAPA with housing, as well as those in an outpatient setting, may offer housing services in residential therapeutic apartments (ATR), for stays of not more than two years. In 2016, 61 CSAPA offered stays in ATR. Lastly, there is also another type of service: short stays which meet the requirements of emergency housing for homeless drug users or transitional housing (notably for newly released inmates). In 2016, there were 7 CSAPA offering this kind of service.

*Residential care in hospitals*

Further to the 2007-2011 Plan for addiction treatment and prevention (Ministère de la santé et des solidarités 2006), the resources available for residential treatment of addiction were considerably increased. In 2010, there were 391 hospitals in France, practically all public, equipped with hospital beds for withdrawal and 113 offering aftercare activities (follow-up and rehabilitation care or SSR in French) including addiction medicine (Palle *et al.* 2012). These services cover all types of addiction (notably alcohol), hence it is difficult to identify those which are actually open to drug users.

### Inpatient drug treatment system – Client utilisation

Based on the CSAPA activity reports, the number of individuals housed by CTR (residential treatment centres) and TC (therapeutic communities) may be estimated at 1,800 in 2016. Around 1,000 individuals were housed in ATR (residential therapeutic apartments) and about 600 were housed in an emergency or transitional facility run by a CSAPA. The parallels with drug users seen in outpatient CSAPA are undoubted fairly broad: a large proportion of the individuals received are, in fact, referred by an outpatient CSAPA.

*T1.2.6.* ***Optional****. Please provide any additional information you feel is important to understand the availability and provision of Inpatient treatment within your country (suggested title: Further aspects of inpatient drug treatment provision)*

**Tableau III.** Network of inpatient treatment facilities (total number of units and clients)

| | **Total number of units** | **National Definition** (Characteristics/Types of centre) | **Total number of clients** |
|---|---|---|---|
| Hospital-based residential drug treatment | na | | na |
| Residential drug treatment (non-hospital based) | 35 | Individuals housed in residential treatment centres<br>Residential treatment centres are facilities which combined collective housing and treatment. It carries out the same missions and services as in an outpatient setting. It offers support for customised treatment.<br>It is aimed at individuals, including those on OST, who need a structured framework together with temporary distancing, a break from their usual environment. It offers a variety of approaches: medical and psychological treatment, support, socialisation (activities and community life, but with a different approach to the therapeutic community), and socioprofessional reintegration. | 1 500 |

| | Total number of units | National Definition (Characteristics/Types of centre) | Total number of clients |
|---|---|---|---|
| Therapeutic communities | 10 | Individuals housed in experimental therapeutic communities. Therapeutic communities are housing facilities which target users dependent on one or more psychoactive substances, aiming for a goal of abstinence, with the specific feature of placing the group at the heart of the therapeutic and social integration project. | 300 |
| Prisons | na | | na |
| Other inpatient units | 61 | Individuals housed in residential therapeutic apartments<br>Housing in therapeutic apartments allows individuals followed up in the context of medical, psychosocial and educational care (outpatient follow-up) to regain their autonomy and re-establish their social relationships (e.g., by sharing daily tasks in the apartment) and professional relationships (searching for training, employment, etc.). This type of housing aims to prolong and reinforce the therapeutic action undertaken. It particularly aims at individuals receiving major treatment (OST, HCV, HIV). | 900 |
| Other inpatient units | 7 | Individuals housed in emergency or transitional facilities<br>Short stays, in emergency or transitional facilities, are intended for counselling over short periods (less than three months), during which the user's health and social situation is assessed and medical, psychosocial and educational care proposed.<br>This should enable a break and/or transition period (initiation of OST, awaiting withdrawal, newly released inmates, etc.) which is conducive to initiating a treatment process.<br>Short-stay housing may be collective (such as in a residence) or individual (hotel stays). | 600 |

na: not available
**Source:** Standard table 24

*T1.2.7. Using the structure and data provided in table IV please provide an overview and a commentary of the main bodies/organisations owning and operating inpatient treatment facilities in your country (Suggested title: Ownership of inpatient drug treatment facilities)*

In France, nearly all facilities that offer therapeutic shelter are either managed by public hospitals or CSPA which are managed voluntarily but funded by the social security scheme. However, there are a very small number of private clinics that may offer clients withdrawal services or a stay of abstinence following withdrawal services. Nearly all residential withdrawal services take place in public hospitals. Therapeutic shelter without withdrawal services is most often offered by CSAPA through voluntary management. All therapeutic communities are managed by CSAPA on a voluntary basis.

Table IV. Ownership of inpatient facilities providing drug treatment in your country (percentage). Please insert % in the table below. Example: about 80% of all Therapeutic communities are public/government-owned facilities and about 20% are non-government (not for profit) owned facilities.

| | Public / Government | Non-government (not for profit) | Non- government (for profit - Private) | Other | Total |
|---|---|---|---|---|---|
| Hospital-based residential drug treatment | 97% | | 3% | | 100% |
| Residential drug treatment | 5% | 90% | 5% | | 100% |
| (non-hospital based) | | | | | 100% |
| Therapeutic communities | | 100% | | | 100% |
| Prisons | | | | | 100% |
| Other inpatient units (1 - please specify here) | | | | | 100% |
| Other inpatient units (2- please specify here) | | | | | 100% |

*T1.2.8.* ***Optional****. Please provide any additional information on types of treatment providers and its utilisation not covered above (suggested title: Further aspects of inpatient drug treatment provision and utilisation)*

## T1.3. Key data

The purpose of this section is to provide a commentary on the key estimates related to the topic. Please focus your commentary on interpretation and possible reasons for the reported data (e.g. contextual, systemic, historical or other factors but also data coverage and biases). Please note that for some questions we expect that only some key TDI data to be reported here as other TDI data are reported and commented in other workbooks (drugs, prison, harm and harm reduction, etc.). However, please make cross-references to these workbooks when it supports the understanding of the data reported here.

T1.3.1. Please comment and provide any available contextual information necessary to interpret the pie chart (figure I) of primary drug of entrants into treatment and main national drug-related treatment figures (table V). In particular, is the distribution of primary drug representative of all treatment entrants?

Summary table of key treatment related data and proportion of treatment demands by primary drug)

In 2018, about 57,000 drug-treatment clients in a CSAPA setting were included in TDI data, compared to approximately 58,000 in 2017. This slight decrease is related to the variations in specialised centres that have reported TDI. In constant terms over the 2014-2018 period (44,000 people included in 2018, 52% of the number of outpatients CSAPA), this number increased very slightly (+ 1.6%) between 2017 and 2018. Given the inaccuracies in this data collection, the number of new clients in facilities that have provided data since 2014 appeared stable between 2015 and 2018.

Nearly 69% of outpatient CSAPAs took part in the RECAP survey from which the TDI data are extracted. However, data may be missing for numerous patients for each CSAPA (missing data on substances or type of treatment). The rate of coverage[2] probably therefore ranges from 60% to 65%. Centres which did not provide data do not seem to display common characteristics which would distinguish them from those having submitted data. Drug users at

[2] This coverage rate is calculated using the estimated number of people entering treatment within the year in all CSAPA as the denominator.

centres contributing to the TDI may therefore be considered as representative of all patients seen at CSAPA in an outpatient setting.

In 2018, the proportion of new patients treated for cannabis problems in CSAPAS was stable at 60% after a slight decrease in 2017 (Figure I). In constant terms, the number of people treated with cannabis as the primary substance used increased by a little more than 4% (Figure III). Opioid users represent the second largest group in France. Their share which has fallen sharply over the last four years (from nearly 35% in 2013 to 26% in 2016) continued to decline in 2018 to just under 25%. In constant terms, the number of people with a treatment demand for this substance decreased by 4% between 2017 and 2018. The most significant phenomenon in 2018 is once again the increase in cocaine-related treatment demands. The percentage of these people making requests increased proportionately from 8.4% to 10.8%. In constant terms, the number of the people making these demands increased by 26% i.e. around the same increase as there was in 2017 (+24%). However, the people for whom a stimulant was cited as the primary drug only represent a very small proportion of new clients.

The total number of individuals on treatment is only known for CSAPA. It is not currently possible to determine the number of individuals admitted in hospitals or in prison settings, or the proportion of patients seen by a primary care practitioner having also been treated at a CSAPA in the last year.

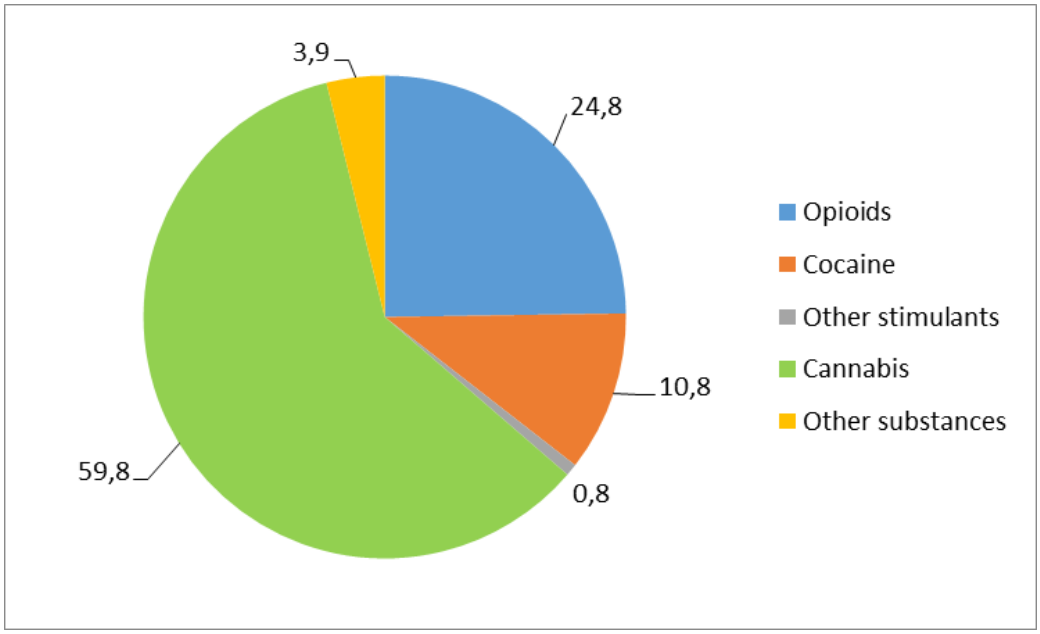
The extent of treatment related to cannabis in France is partly explained by the declining proportion (which nonetheless remains fairly high) of clients referred to a CSAPA by the judicial authorities further to arrest for use of this substance (approximately 39% in 2018, based on TDI figures), but also by the measures taken by the public authorities faced with levels of substance use causing France to rank as the country with the highest substance use among 16 year-olds (The ESPAD Group 2016) and, more generally, as one of the countries with the highest substance use for the overall population. In response to incentives from public authorities (creation of youth addiction outpatient clinics, see T.1.4.5 below), CSAPA have therefore put considerable effort into providing counselling for this population, as shown by a substantial increase in the number of cannabis uses treated in a CSAPA setting, particularly since 2010 (+ 21,000 clients initiating treatment or already followed up between 2010 and 2016) (Palle and Rattanatray 2018). As this usually involves short-term treatment, in contrast to opioid users, the number of clients able to receive counselling is limited more slowly by the available counselling facilities. Conversely, the number of opioid users treated in a CSAPA setting tends to decrease, which may partly stem from the fact that, due to readily accessible OST in France, referral via a CSAPA is required to a lesser extent.

**Table V.** Summary table - Clients in treatment

| | **Number of clients** |
|---|---|
| Total number of clients in treatment | na |
| Total number of OST clients | 178 700 |
| Estimated total number of all clients entering treatment in a CSAPA | 89 300* |

na : not available
*: based on a coverage rate of 65%
**Source:** Standard Table 24 and TDI

**Figure I.** Distribution of the number of individuals having started treatment in a CSAPA in 2018, according to the primary drug (%)




**Source**: TDI

*T1.3.2.* ***Optional****. If possible, please provide any available information on the distribution of primary drug in the total population in treatment (suggested title: distribution of primary drug in the total population in treatment)*

*T1.3.3.* ***Optional****. Please comment on the availability, validity and completeness of the estimates in Table V below (suggested title: Further methodological comments on the Key Treatment-related data)*

**Further methodological comments on the key treatment-related data**

The total number of clients in treatment is not known. Firstly, no statistical sources are available on drug users receiving counselling in an outpatient setting or in prison settings as part of non-CSAPA hospital addiction medicine appointments. As regards general practitioners, the number of patients in treatment may be estimated based on the number of patients reimbursed for OST. However, an unquantified proportion of these patients may have already been included among clients treated in a CSAPA setting. The total number of clients in treatment more than likely lies between 200,000 and 300,000 individuals.

*T1.3.4.* ***Optional****. Describe the characteristics of clients in treatment, such as patterns of use, problems, demographics, and social profile and comment on any important changes in these characteristics. If possible, describe these characteristics of all clients in treatment. If not, comment on available information such as treatment entrants (TDI ST34) (suggested title: Characteristics of clients in treatment)*

*T1.3.5.* ***Optional****. Please provide any additional top level statistics relevant to the understanding of treatment in your country (suggested title: Further top level treatment-related statistics)*

## T1.4. Treatment modalities

The purpose of this section is to

- Comment on the treatment services that are provided within Outpatient and Inpatient settings in your country. Provide an overview of Opioid Substitution Treatment (OST) in your country

### Outpatient and Inpatient services

T1.4.1. Please comment on the types of outpatient drug treatment services available in your country and the scale of provision, as reported in table VI below.

**Outpatient drug treatment services**

The kind of therapy and services offered by the facilities welcoming outpatient drug users has not been subject to a detailed study until now. The information provided below is mainly based on expert opinions. OFDT are undertaking work to improve knowledge of professional practices in CSAPA.

CSAPA

In France all CSAPA must provide medical, psychological, social and educational treatment (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 [Directive regarding the establishment of National treatment and prevention centres for addiction and the establishment of regional medico-social plan schemes in addiction care]) for people struggling with addictive behaviour. All CSAPA employ trained psychologists and specialist teachers who can offer therapy based on different approaches but who address the psychological and social aspect of addiction. Prescription to opioid substitution treatments is also one of CSAPA's main objectives (see below). This kind of treatment is therefore available in all CSAPA in principle. Some CSAPA that used to be specialised in addiction care do not prescribe these treatments, but this is becoming increasingly less frequent.

Screening for mental illnesses is not protocol and not all people that go to a CSAPA are seen by a psychiatrist, as there are not many among CSAPA employees (2% to 3% of ETP in 2016). However, there are large numbers of psychologists in the CSAPA and they are often able to detect the mental disorders of the people they are working with. The possibility of treating mental illness within the CSAPA is, however, rare except of course in the few CSAPA that are part of a psychiatric institution or in CSAPA that have (a) psychiatrist(s).

No information is available on « individual case management » in CSAPA.

CAARUD

In France, CAARUD are not considered as facilities that offer addiction treatment, like CSAPA. It is not within the mission of CAARUD to prescribe opioid substitution treatments.

General practitioners

General practitioners (GP) are all likely to prescribe opioid substitution treatment (buprenorphine or methadone). Buprenorphine treatments can be initiated by these practitioners, but those on methadone can only be prescribed after starting this treatment in a CSAPA or in a hospital. However, GPs rarely provide psychological and social care. The logic of fee-for-service remuneration that prevails in primary care in France does not favour this kind of activity.

Mental health

Screening for and treating mental illnesses naturally form part of the mental health care system's objectives. It can be assumed that when faced with an addiction problem, these facilities offer psychological and social care. No precise information is available on opioid substitution treatment prescriptions in this type of facility.

Table VI. Availability of core interventions in outpatient drug treatment facilities.
Please select from the drop-down list the availability of these core interventions (e.g. this intervention is available, if requested, in >75% of low-threshold agencies).

| | Specialised drug treatment centres | Low-threshold agencies | General primary health care (e.g. GPs) | General mental health care |
|---|---|---|---|---|
| Psychosocial treatment/ counselling services | >75% | not known | not known | not known |
| Screening and treatment of mental illnesses | <25% | <25% | >25%-75% | >75% |
| Individual case management | not known | not known | not known | not known |
| Opioid substitution treatment | >75% | <25% | >25%-75% | not known |
| Other core outpatient treatment interventions (please specify in T1.4.1.) | Please select | Please select | Please select | Please select |

*T1.4.2.* ***Optional****. Please provide any additional information on services available in Outpatient settings that are important within your country (suggested title: Further aspect of available outpatient treatment services)*

Low threshold services do not provide treatment in France.

T1.4.3. Please comment on the types of inpatient drug treatment services available in your country and the scale of provision, as reported in table VII below. (Suggested title: Availability of core interventions in inpatient drug treatment services)

**Inpatient drug treatment services**

As a general rule, OST and appointments with psychologists or psychiatrists are fairly widely available in France in hospital addiction medicine departments, residential treatment centres, therapeutic communities and residential therapeutic apartments. The availability of the other types of services mentioned in the SQ27P1 is not known.

Table VII. Availability of core interventions in inpatient drug treatment facilities.
Please select from the drop-down list the availability of these core interventions (e.g. this intervention is available, if requested, in >75% of therapeutic communities).

| | Hospital-based residential drug treatment | Residential drug treatment (non-hospital based) | Therapeutic communities | Prisons |
|---|---|---|---|---|
| Psychosocial treatment/ counselling services | >75% | >75% | >75% | >25%-75% |
| Screening and treatment of mental illnesses | Please select | Please select | Please select | Please select |
| Individual case management | Please select | Please select | Please select | Please select |
| Opioid substitution treatment | >75% | >75% | >75% | >25%-75% |
| Other core inpatient treatment interventions (please specify in T1.4.3.) | Please select | Please select | Please select | Please select |

*T1.4.4.* ***Optional****. Please provide any additional information on services available in Inpatient settings that are important within your country (suggested title: Further aspect of available inpatient treatment services)*

T1.4.5. Please provide any additional information on available services, targeted treatment interventions or specific programmes for specific groups: senior drug users, recent migrants (documented or undocumented), NPS users, gender-specific, under-aged children, other target groups (Suggested title: Targeted interventions for specific drug-using groups)

In terms of outpatient treatment provision, other than measures relating to OST (widely available), the public authorities have primarily attempted to develop counselling and treatment specific to young users (for whom addiction problems are even more often intertwined with adolescent problems and their associated psychological difficulties), by particularly targeting adolescents and young adults who use cannabis. Created in 2004 [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], 90% of youth addiction outpatient clinics (CJC) are managed by a CSAPA (association or hospital-based management) and the remainder by hospitals and other types of facilities (youth reception and counselling centres (PAEJ), health counselling facilities for adolescents and their parents). Approximately 540 clinics are currently in operation (Obradovic 2015; Protais *et al.* 2016). Their opening hours can vary (sometimes half a day each week, sometimes every working day). Numerous CJC have opened advanced clinics in schools or different youth facilities (such as PAEJ, youth reception and counselling centres, which are counselling structures on health issues for adolescents and their parents). This resource is available throughout France, and may be perceived to have a high level of accessibility. A best practices guide intended for professionals operating in the context of CJC, issued by the professional body for those working in the field of addiction medicine (Fédération addiction 2012) was published in 2012.

In the context of early referral into treatment ordered by the public prosecutor's office or courts (see "Legal framework" workbook) further to a drug-related offence, health care delivery is available for this type of population. However, it is undoubtedly not always adapted to the needs of the population concerned, particularly newly released inmates, for whom housing is an acute problem. To prevent breaks in care and “cold releases”[1], as part of the 2008-2011 governmental plan on drugs, the public authorities implemented experimental, rapid access, short-stay admission programmes in social and medical-social structures (with housing) for newly released inmates. In two years (2009-2010), seven programmes targeting newly released inmates were thus funded (4 projects of rapid access, short-stay units and 3 projects of early CSAPA consultations in social housing and rehabilitation centres) and then assessed by the OFDT (Obradovic 2014). The public authorities recently promoted the implementation of an experimental programme for the prevention of subsequent offences and an alternative to imprisonment among drug users having committed criminal acts related to their addiction, within the jurisdiction of a Paris court[3]. This experimental programme (the “Bobigny city project”) was initiated in March 2015. The objective is to invite approximately fifty multiple offenders to follow an intensive treatment programme (five hours of activities and treatment per day, five days a week, for a year) rather than returning to prison.

Senior drug users (>40years old):

[3] The project run by the Bobigny courts is inspired by those existing in Canada (Montreal, Vancouver) which are based on an all-round approach to the individual and reinforced collaboration between the different protagonists of the programme, particularly in the health and judicial fields. Individuals with a complex psychiatric profile cannot be included in this programme.

NPS users:

Recent undocumented migrants (asylum seekers and refugees):

**Women (gender-specific):** The issue of specific care for women, which is not targeted solely at pregnant women or women who have just given birth, has also long been a concern of the public authorities as well as healthcare professionals working in the field of addiction medicine. The 2008-2011 Government action plan against drugs and drug addiction (MILDT 2008) aimed to encourage projects along these lines. Further to a call for tenders, approximately forty projects have been funded, all contributed by CSAPA (Mutatayi 2014). Two residential treatment centres, located in two different regions (Aquitaine and Île-de-France), are entirely or highly specialised in the treatment of this population. In a hospital setting, addiction liaison and treatment teams (ELSA) also regularly work with maternity units, either directly with patients or to train and support obstetrical staff.

Under-aged children and adolescents:

**Other target groups:** Numerous CSAPA also face the situation of counselling homeless drug users. Although some have specialised in counselling this population, their number is not sufficient. A programme called "*Un chez soi d'abord*" (inspired by the north-American *Housing first* program) has been trialled in four French towns (Paris, Lille, Marseille and Toulouse). It is not specifically aimed at drug users but homeless individuals suffering from major psychiatric disorders, a population which partly covers drug users without fixed abode. Recruited individuals are offered access to ordinary housing in return for intensive health and social support. This support is provided by teams bringing together both health professionals (psychiatrists, addiction specialists, general practitioners, nurses) and social workers, housing specialists or even individuals having experienced life on the streets or mental illness. This programme is accompanied by an evaluation study based on data collection from participants and qualitative interviews. The evaluation study programme and protocol have been described in a publication (Tinland et al. 2013). At the end of the experimental phase, the programme was made permanent and made widespread by the decree of 26 November (Décret n° 2016-1940 relatif aux dispositifs d'appartements de coordination thérapeutique « Un chez-soi d'abord »). 2,000 accommodations are scheduled to open at 20 sites by 2023 (DIHAL 2017).

*T1.4.6. Please provide any available information on the availability of E-health interventions, such as web-based treatment, counselling, mobile applications, e-learning for drug professionals, etc. for people seeking drug treatment and support online in your country* ***(Suggested title: E-health interventions for people seeking drug treatment and support online)***

Following a request from the MILDECA, a report on "e-Health and Addiction" (Thierry and Reynaud 2019) was produced in May 2019. This report identifies some e-health initiatives. Firstly, it refers to the non-nominative, regional national platforms where information, assessment tools and interactive community spaces can be found. We can classify the Drugs and Alcohol Addiction Information Service (ADALIS) in this category, managed by the French Public Health Agency (SpF), which groups counselling services and websites (http://www.drogues-info-service.fr/ ; http://www.alcool-info-service.fr/ ; https://www.tabac-info-service.fr/).

The second site worth mentioning is Addict'Aide which includes a forum managed by expert clients. But there is also a telemedicine scheme for clients with psychiatric or addiction disorders: Doctoconsult.

The PulsioSanté website specialises in managing addictive behaviour. This website provides early detection tools, brief interventions and an onward referral to an addiction specialist, which can be done remotely (telemedicine) or as part of a traditional consultation.

*T1.4.7.* ***Optional****. Please provide any available information or data on treatment outcomes and recovery from problem drug use (suggested title: treatment outcomes and recovery from problem drug use)*

*T1.4.8.* ***Optional****. Please provide any available information on the availability of social reintegration services (employment/housing/education) for people in drug treatment and other relevant drug using populations (suggested title: Social reintegration services (employment/housing/education) for people in drug treatment and other relevant populations)*

### Opioid substitution treatment (OST)

T1.4.9. Please provide an overview of the main providers/organisations providing OST within your country and comment on their relative importance (suggested title: Main providers/organisations providing Opioid substitution treatment)

**Main providers/organisations providing opioid substitution treatment**

There are two schemes available for dispensing treatments to people using illicit drugs: the specialised addiction treatment system (CSAPA) and the general healthcare system (hospitals, prison-based hospital healthcare unit and general practitioners).

OST is mainly prescribed in a primary care setting by general practitioners, and is usually dispensed in community pharmacies.

The organisation of access to OST is based on two different prescription frameworks, one for methadone, and the other for buprenorphine. Methadone, classed as a narcotic, has a more stringent prescription framework than buprenorphine (with or without naloxone). The latter is a list I[4] drug, but is regulated by narcotics prescription and dispensing rules. This difference is related to the lesser danger involved with buprenorphine (a partial opioid receptor agonist) compared with methadone (a pure agonist), since buprenorphine's ceiling effect limits the depressant, and particularly cardiopulmonary depressant effects.

Methadone treatment must be initiated by physicians working in a CSAPA or a hospital (or in a prison health unit). Primary care physicians may provide follow-up care once patients have been stabilised. However, this restriction has been the subject of debate and the public authorities have questioned the advantages and disadvantages of allowing treatment with methadone to be initiated by primary care practitioners. The results of the Méthaville study published in November 2014 (Carrieri *et al.* 2014) support those in favour of extending initiation of methadone treatment to a primary care setting : similar results (whether initiation took place in primary care or at a CSAPA) regarding opioid abstinence and adherence to treatment, and better satisfaction among patients treated in a primary care setting. However, the study authors emphasise the fact that this result is determined by the willingness of primary care practitioners, through access to specific training on methadone prescribing and collaboration with a CSAPA and a reference pharmacist. Trialling of the initial methadone prescription in a primary care setting, envisaged in the previous 2013-2017 plan (MILDT 2013), is not mentioned in the 2018-2022 National Action Plan on Addictions (MILDECA 2018).

The methadone capsule form, which is more discreet than the large-volume syrup bottles and does not contain sugar or ethanol, is not intended for treatment initiation. It can be prescribed to

[4] Medications dispensed only on medical prescription are included on list I (for those presenting high risks), list II (for those perceived as less hazardous) or on the narcotics list. Narcotics carry the risk of addiction with their use and are subject to controlled prescriptions.

patients taking the syrup form once they have been stabilised. Initial methadone capsule prescriptions can only be written by CSAPA or hospital physicians specialised in treating drug users. The maximum prescribing duration for the capsule form is now 28 days as opposed to 14 in the past [Arrêté du 13 octobre 2014 modifiant l'arrêté du 20 septembre 1999 modifié fixant la liste des médicaments classés comme stupéfiants dont la durée maximale de prescription est réduite à quatorze jours ou à sept jours]. However, the syrup form maintains a maximum prescribing duration of 14 days.

Any physician can initiate buprenorphine treatment. The maximum duration of prescription is 28 days. Both methadone and buprenorphine are subject to controlled prescriptions.

Although the percentage of physicians prescribing OST has not significantly changed since 2003 (9 out of 10), the prescription structure has. More than one-third of these general practitioners prescribing an OST prescribed methadone in 2009, while the percentage prescribing buprenorphine is diminishing (from 84.5% in 2003 to 77% in 2009) (Gautier 2011).

T1.4.10. Please comment on the number of clients receiving OST within your country and the main medications used (suggested title: Number of clients in OST)

**Number of clients in OST**

After first being marketed in 1995, buprenorphine very quickly became the leading treatment for opioid dependency in France. A number of generics have arrived on the market, seven in 2018, marketed by Arrow, Biogaran, Cristers, EG, Mylan, Sandoz and Teva. Since 2008, the capsule form of methadone is available. In January 2012, Suboxone® (a combination of buprenorphine and an opioid antagonist, naloxone) was launched in a sublingual tablet administration form. The purpose of this combination is to prevent buprenorphine misuse, by provoking withdrawal symptoms when used by the injection route. In 2018, the generic drugs buprenorphine/naloxone and a new formulation of buprenorphine in oral lyophilisate (Orobupré®) were launched. Orobupré® dissolves on the tongue in a few seconds, unlike the 5 to 10 minutes required for sublingual forms, thereby making it easier to take and making it a good option for monitored use (HAS 2018).

According to data from the national public health insurance centre (CNAM) collected from the EGBS database (simplified General sample of beneficiaries, sample of French persons with social security coverage), 162,300 individuals were reimbursed for opioid substitution medications dispensed in community pharmacies in 2017 (revised estimation taking into account the EGBS extrapolation coefficient and the representativeness of the EGBS evaluated at 95.6% of the population covered by the Social Security scheme). The number of people receiving opioid substitution treatment (OST), having risen constantly since it was first introduced in 1995, has remained stable since 2013. More than three-quarters of individuals reimbursed for opioid substitution medications are male. More specifically, in 2017, 99,900 individuals were dispensed buprenorphine in community pharmacies (Subutex® or generics), 61,700 methadone and 7,600 buprenorphine in combination with naloxone (Suboxone®).

Furthermore, 23,330 patients were dispensed opioid substitution medications in a CSAPA setting (19,800 methadone and 3,530 buprenorphine) in 2016, among the 56,200 patients followed up in a CSAPA setting and receiving OST (37,700 with methadone and 18,500 with buprenorphine) according to the data provided in the CSAPA activity reports (DGS/OFDT). In total, approximately 180,000 clients receive treatment with opioid substitution medications in France, taking into account possible duplicates between those treated by general practitioners, CSAPA, hospitals and in prison. The predominance of buprenorphine in opioid substitution medication sales, representing 63% overall, still clearly predominates, despite the growing proportion of methadone (Figure IX).

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

*Initiation and maintenance of OST*

Approximately 14,800 individuals were dispensed OST in a primary care setting for the first time in 2017, i.e. 9% of patients reimbursed for OST over the year. Retention in treatment falls in the first two years, then decreases more slowly after. The proportion of clients still in treatment the year after first reimbursement is 62%, 51% two years later and 41% six years later. Retention in treatment is higher for clients receiving methadone than for those receiving buprenorphine (Brisacier 2019).

*Interrupting an opioid substitution treatment*

Among those patients dispensed OST in a primary care setting, nearly 13,500 patients stopped their OST in 2014 (without resuming treatment in the next three years), i.e. 11% of all clients reimbursed for OST over the year (Brisacier 2019). Many French addiction specialists and specialised psychiatrists are reluctant to fully withdraw substitution treatment too suddenly given the potential risk of relapse and overdose that may ensue. Unlike retention in treatment, discontinuing substitution treatment did not appear as a key objective in the 2004 consensus conference (FFA and ANAES 2005). However, many patients request discontinuation of their substitution treatment, leading health professionals to rethink their practices to determine strategies, indications and procedures that are favourable to this kind of discontinuation(Dugarin *et al.* 2013; Hautefeuille 2013).

*Buprenorphine misuse and trafficking*

Some of the buprenorphine 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 2004 strategy to control opioid substitution treatments[5]. One of the main indicators for buprenorphine misuse (average daily dose higher than 32 mg/d[6]) fell by two-thirds between 2002 and 2007 (Canarelli and Coquelin 2009). Since then, this indicator has remained stable (2.0% in 2017) (Brisacier 2019). Moreover, 73% of patients receiving buprenorphine are receiving regular treatment [7] and therefore are integrated into a therapeutic process. People who are not regularly receiving these treatments are not necessarily cut off from any treatment strategy, just as users taking this medication as part of a treatment plan are not necessarily exempt from certain forms of misuse (INSERM 2012). Another indicator of misuse, the presence of multiple prescribers (5 and over) for the same beneficiary and several dispensing pharmacies (5 and over), included 4.2% and 2.8% of patients, respectively, taking buprenorphine in 2017 (Brisacier 2019). Factors associated with patients seeking multiple prescriptions (defined as prescriptions which overlap by one day or more and/or issued by at least 2 different prescribing physicians and/or dispensed in at least 3 different pharmacies) were male gender, low income, psychiatric disorders, concomitant use of hypnotic drugs, weak opioids and morphine (Delorme *et al.* 2016).

Among CAARUD clients (2015 ENa-CAARUD survey), oral use (51%) was the most common route of administration for buprenorphine in 2015, ahead of injection (46%) which was the most widespread consumption pattern up to 2012. Oral use is on the increase, in contrast to injection

[5] The French national insurance organisation (CNAMTS) controls introduced since 2004 primarily aim to identify dealers ("patients" as well as a few doctors and pharmacists) through reimbursement data. These controls red flag users who have at least five different prescribers or dispensing pharmacies, or who are being given a mean dose of more than 32 mg.

[6] The buprenorphine maintenance dose is 8 mg per day with a maximal daily dose of 24 mg. A mean daily dose of greater than 32 mg is a very suspicious indicator of buprenorphine trafficking or dealing.

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

which declined between 2012 and 2015. Snorting, less common (21%), after a marked increase between 2008 and 2012, showed a downward trend in 2015. Inhalation or smoking consumption patterns, although in the minority (7%), have been increasing since 2008 (Brisacier 2017).
Improper buprenorphine use patterns, observed for several years, persisted in 2017, particularly among highly vulnerable users. This trend appears to be stable or even on the decline, particularly owing to "competition" arising from morphine sulphate in some regions (Milhet *et al.* 2017).

*Methadone misuse and risks*
National methadone dependence monitoring, placed under the responsibility of the CEIP-A (Centre for evaluation and information on pharmacodependence) in Marseille, was set in place when methadone capsules were placed on the market in 2008. The overview at 9 years reveals the increase in the number of patients treated with methadone, but also in the illegal procurement of methadone (5.9% in 2008 *versus* 9.7% in 2016) and in cases requiring hospital management. Furthermore, in year 9, there was an increase in methadone use among new or occasional users, and in the number of patients falling into a deep coma or attempting suicide. The mortality rate due to methadone is estimated at 2 deaths per 1,000 treated patients, this rate being 6 times higher than buprenorphine and 4.5 times higher than heroin. The Commission on narcotics and psychotropic substances wished to draw up an action plan with a view to bringing down the constant increase in the cases of overdose and deaths involving methadone (ANSM 2018).

*Substitution treatment in prison settings*
Among the inmates, the percentage of OST beneficiaries remained stable between 2013 and 2017. It was estimated at 7.7%, or around 13,700 people, 57% of whom were treated with buprenorphine (42% with only buprenorphine, 12% with BHD/naloxone) and 43% with methadone (Brisacier 2019) (see Prison workbook). The proportion was significantly higher in the female prison population in 2011 (16 .5% among women *vs* 7.7% among men) according to the Prévacar study (Barbier *et al.* 2016).

*Impact of the change in codeine regulations*
Drugs containing codeine, ethylmorphine, dextromethorphan and noscapine were removed from the list of non-prescription drugs by legislative order with immediate effect as of 12 July 2017 (Arrêté portant modification des exonérations à la réglementation des substances vénéneuses [Legislative order amending exemptions to the regulation of poisonous substances]) (see T3.1 of the 2018 Legal Framework workbook), causing users in difficulty to consult primary care doctors or CSAPA or to remain drug free by themselves. This withdrawal was recommended by the ANSM following the reporting of several cases of abuse of these substances, including one fatal case at the beginning of 2017, among adolescents or young adults who had consumed purple drank (a mixture of soda and cough syrup made of codeine, promethazine or dextromethorphan (ANSM 2018; Cadet-Taïrou and Milhet 2017).

A study was conducted by the CEIP-A in Paris on the impact of this new regulation on health professionals (pain physicians, addiction specialists, general practitioners and pharmacists). These professionals (except general practitioners) have been led to identify more paracetamol-codeine dependent clients since the change in legislation. The care offered differs depending on the professional. The majority of general practitioners offer comprehensive withdrawal services and pain physicians offer a dosage that complies with the marketing authorisation. These two categories of physicians make little use of onward referrals to addiction specialists. The treatment offered can then also include prescription of an opioid substitution medication (most commonly buprenorphine) (CEIP-A de Paris 2018).

*T1.4.11* ***Optional****. Describe the characteristics of clients inopioid substitution treatment, such as demographics (in particular age breakdowns), social profile and comment on any important changes in these characteristics (suggested title: Characteristics of clients in OST)*

See figure X for the distribution of opioid substitution medication beneficiaries by age groups.

*T1.4.12.**Optional**. Please provide any additional information on the organisation, access, and availability of OST (suggested title: Further aspect on organisation, access and availability of OST)*

## T1.5. Quality assurance of drug treatment services

The purpose of this section is to provide information on quality system and any national treatment standards and guidelines. Note: cross-reference with the Best Practice Workbook.

*T1.5.1. **Optional**. Please provide an overview of the main treatment quality assurance standards, guidelines and targets within your country (suggested title: Quality assurance in drug treatment)*

**Quality assurance in drug treatment**

In 2017, in their concern for controlled treatment in compliance with current regulations for patients suffering from addictive behaviours and receiving OST, the national medical and pharmaceutical associations revised their joint professional guidelines for prescribing and dispensing opioid substitution medications, to facilitate access to care and improve patient management, compliance and follow-up (Conseil national de l'ordre des médecins and Conseil national de l'ordre des pharmaciens 2017). These guidelines point out that physicians and pharmacists have a duty to contribute to the management of addictive behaviours, notably by taking part in prevention, treatment and harm reduction measures related to the use of psychoactive substances, but also because they could always be held liable from a disciplinary, civil and criminal perspective.

In 2014, the medico-social system for the treatment of addictive behaviours was evaluated by the Interministerial Audit and Evaluation Office for Social and Health, Employment and Labour Policies (IGAS). In its conclusions, the IGAS confirmed the missions of the CAARUD and CSAPA and stated that *"the organisation and operation of these establishments meet the needs of the highly specific populations who turn to them"*. However, it recommends more stringent evaluation of *"the efficacy of the system, of its correct positioning and interaction with other protagonists in the prevention, health care, social and medico-social fields"* (Hesse and Duhamel 2014).

The latest national recommendations on therapeutic strategies for opioid-dependent individuals date back to the 2004 consensus conference (FFA and ANAES 2005).

In 2017, European experts published a consensus on best practices for methadone and buprenorphine use, by conducting an analysis of all guidelines published between 2014 and 2017 on this subject, supplemented by expert opinion based on clinical practice (Dematteis *et al.* 2017).

A guide on OST in a prison setting, published in 2013 (Ministère des affaires sociales et de la santé and MILDT 2013) describes in detail the legal and regulatory framework for OST (in France in general and in a prison setting) and gives recommendations for best practices in terms of treatment.

As regards youth addiction outpatient clinics, the publishing and distribution of the PAACT (Support and Alliance for Therapeutic Change) manual should be mentioned (Lascaux *et al.* 2014). This manual can be perceived as a best practice guide destined for CJC professionals and, more broadly, for all health professionals, who are the first point of contact and who aim to support young psychoactive substance users. Publication of this document on the initiative of professionals working in the Youth Addiction Outpatient Clinics (CJC), but with the support of MILDECA and the Ministry of Health is clearly in line with the improvement in quality of care. Among the treatment options presented in this manual, multidimensional family therapies (MDFTs) are provided for specific groups (minors under the age of 15, related psychiatric disorders, cannabis addiction, behavioural disorders). Following the publication of the manual, this kind of treatment is now widely available in CJCs. The National Action Plan on Addictions provides for "continuing support for the MDFT method in regions that do not have an addiction care team that are trained in this approach" (MILDECA 2018).

# T2. Trends

The purpose of this section is to provide a commentary on the context and possible explanations of trends in treatment data.

T2.1. Please comment on the possible explanations of long term trends (10 years - or earliest data available) in the following treatment data:
- New treatment entrants (Illustrative figure II),
- All treatment entrants (Illustrative figure III),
- OST clients (Illustrative figure IV)

For example, patterns of drug use, referral practices, policy changes and methodological changes.

**Long term trends in numbers of clients entering treatment and in OST**

*New treatment entrants*

Commenting on the changes in the absolute number of first-time treatment entrant is somewhat difficult owing to the particularly low coverage of this client category in terms of data collection. As stated above, a third of CSAPAs do not provide TDI data. And a large number of respondents do not state whether this is a client's first treatment in their lifetime or not. Furthermore, the scope of the respondents varies considerably from year to year (some CSAPAs having never taken part in a survey decide to do so, whereas others decide to no longer take part).

In order to eliminate variations related to changes in the scope of respondents, the data was analysed in constant terms, i.e. on a subset of CSAPAs that reported each year between 2014 and 2018. The institutional changes that occurred between 2007 and 2013, combined with the problems related to the change in the TDI protocol, would have led to the inclusion of too few CSAPAs for the 2007-2018 period. Even in constant terms, it is difficult to distinguish for one CSAPA what a real variation of the new outpatient admissions is from what could be the consequence of changes in data recording practices.

For the first treatment demands, the constant field analysis between 2014 and 2018 covered just under 100 outpatient CSAPAs (out of 375) that received just over 10,000 people starting treatment for the first time in their lives in 2018. The figures in Figure II only represent a proportion of the total number of applicants for this type of treatment seen by all CSAPAs in France, probably less than a third.

This data in constant terms is interesting because it allows changes to be monitored, assuming that the sample of CSAPAs selected is representative of all CSAPAs. The curves in Figure II first show a trend of an increase in people making cannabis-related treatment demands for the first time between 2014 and 2016. This development which affects all substances, may be partly due to a better recording of people making treatment demands for the first time. But it can also be compared to the influx of people observed between these two years in the Youth Addiction Outpatient Clinics, facilities that receive a great majority of first-time outpatients. The communication campaign led by the public authorities to promote CJCs in 2015 has therefore had an impact on the number of people visiting these facilities. This increase in treatment demands was followed by a decrease in 2017 that cannot be linked directly to a particular event that caused it but that could illustrate the often short-term effects of communication campaigns.

Opiates and cocaine account for a much smaller percentage of first treatment demands. Those related to opiates have tended to decline since 2016, while those related to cocaine have increased since 2014. If trends continue, the number of first treatment demands related to cocaine could soon exceed those related to opioids. The percentage of other substances is residual and does not require any particular comments.

Percentage data (in variable terms) (Figure III) shows that in the longer term, the trend is towards an increase in the number of first treatment demands related to cannabis and a decrease in the number of those related to opiates, as well as an increase in the number of those related to cocaine since2015.

*All treatment entrants*

The development of the number of people starting treatment was also analysed "in constant terms" for the 2014-2018 period. The number of outpatient CSAPAs that provided data each year between 2014 and 2018 represents just over half of the total number of outpatient CSAPAs. The number of people included in the data collection in constant terms reached approximately 44,000 people in 2018. The number of people included increased significantly (by 13%) between 2014 and 2015 and then decreased slightly between 2015 and 2018. An increase in numbers between 2014 and 2015 can be observed for all substances, although it is higher for cannabis than for opiates (+19% compared to +11%), and could also be linked to registering clients more exhaustively from 2015 onwards. The number of clients registered without specified substances decreased from 22% in 2014 to 15% in 2018, a significant decrease even if this number was still far too high in 2018.

Developments in constant terms show a relatively stable period in cannabis-related treatment between 2015 and 2018, after the sharp increase between 2014 and 2015, a slow decrease in opiate-related treatment (mainly heroin and buprenorphine), and a stable period in other stimulants (very low numbers) and other products (Fig VII). The most significant phenomenon during this period was the increase in the number of treatment demands related to cocaine (powder and crack). In 2014, this increase was roughly the same as the overall increase in the number of all substances combined and it was therefore only as of 2015 that this cocaine-specific trend really appeared, which is still present now, with a slight increase in 2018. This development appears to be consistent with the increase in annual use in France between 2014 and 2017 among the adult population as a whole (see the Stimulants section of the "Drugs" workbook).

As for the first treatment demands, the data analysed in constant terms is completed by an analysis of the proportion of the different substance categories in treatment demands for the 2007-2018 period. This data shows an increase in the number of cannabis-related treatment demands between 2010 and 2016, with this figure then stabilising in 2017 and 2018, with a symmetrical decline in the number of opiates and an increase in the number of cocaine-related demands from 2015 onwards.

The increase in the percentage of cannabis users since 2007 is both due to the increase in cannabis use in France among adolescents and adults at the start of the 2010s and to the mobilisation of public authorities to increase treatment provision for young cannabis users (see the Cannabis section of the "Drugs" workbook).

*OST clients*

Since 2010, the number of OST beneficiaries has been estimated based on National Health Insurance Fund reimbursement data (Figure VIII). This had previously been estimated based on sales data for opioid substitution medications (OSM). In order to maintain the long-term developments, Figure IX shows the available data on OSM use since 1995.

Since 2013, the number of persons receiving OST has remained stable, after increasing constantly since this type of treatment was first introduced (Figure VIII). The number of persons treated with buprenorphine has been decreasing slightly since 2014, in favour of patients treated with methadone whose numbers are increasing, in keeping with sales data for opioid substitution medications (Brisacier 2019).

The proportion of methadone continues to increase in compliance with the consensus conference recommendations on substitution treatments (FFA and ANAES 2005). The 2008 granting of the marketing authorisation for methadone capsules contributed to this increase. Since 2014, the syrup form no longer predominates. It is still exclusively prescribed to 31% of individuals having received reimbursement for methadone, compared to 57% for the capsule form. Furthermore, 12% of beneficiaries were reimbursed for both forms (EGBS data, CNAM, processed by OFDT). According to sales data, in 2017, the syrup form represented 36% (versus 40% in 2016, 44% in 2015 and 55% in 2013) of the methadone sold (by weight) and the capsule form 64% (versus

60% in 2016, 56% in 2015 and 45% in 2013). Moreover, 80% of the quantities were dispensed in retail pharmacies, while 20% were in CSAPAs or hospitals (Bouchara data).

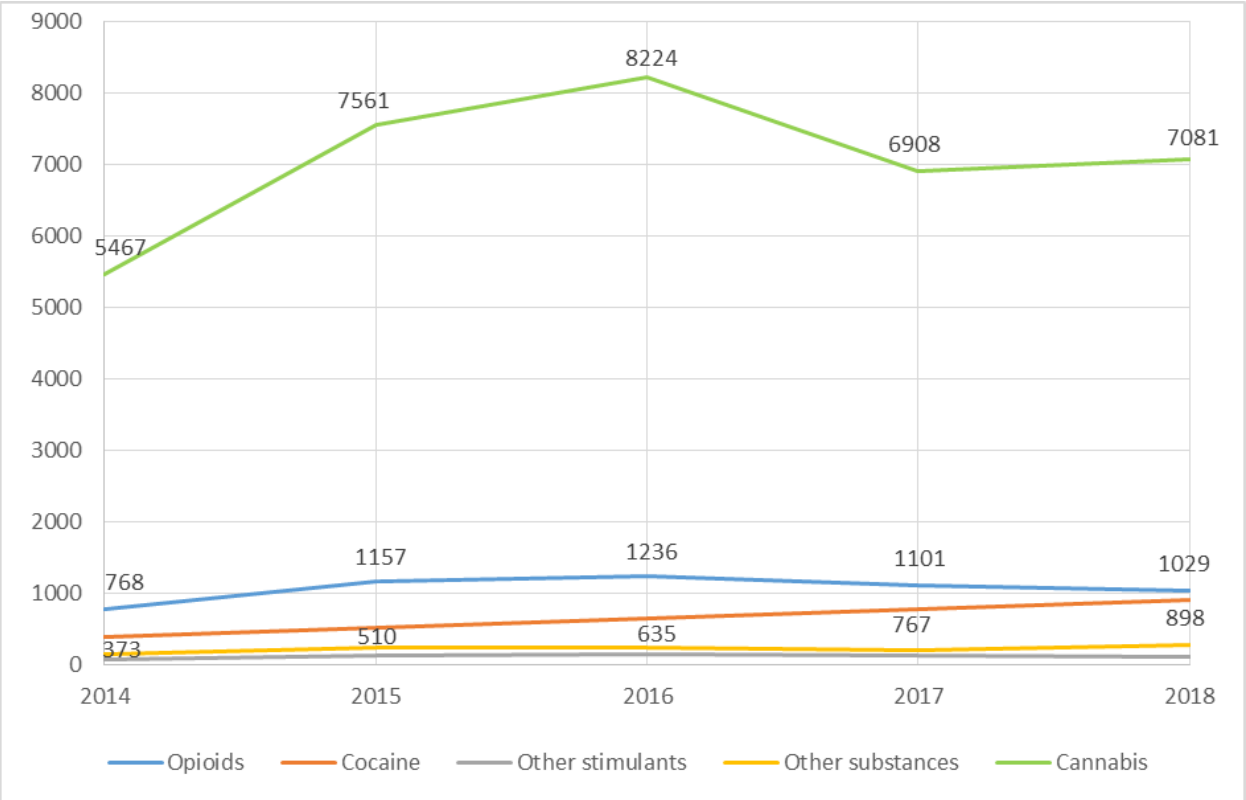
In 2017, the average age of patients dispensed opioid substitution medications in community pharmacies was 40.5 years (*vs.* 37.5 years in 2013). Men were older than the women on average (41.0 years *vs.* 39.2 years). Patients prescribed buprenorphine were older on average than those receiving methadone (41.8 years *vs.* 38.3 years). The most common five-year age groups are thirty-year-olds for clients receiving methadone (accounting for 45%), whereas those receiving buprenorphine are mainly in the age groups ranging from 35 to 49 (see figure X). The change in the age of patients receiving opioid substitution medications reflects the ageing of this population.

Figure IX presents the use of buprenorphine (including Suboxone®) and methadone in France since 1995. These data are based on sales and reimbursement figures, according to an assumed prescribed mean daily dose of 8 mg for buprenorphine (including Suboxone®) and 60 mg for methadone. Buprenorphine generics (introduced in France in 2006), and then Suboxone® (introduced in 2012) offset the decrease in Subutex® use observed since 2006. In 2017, the quantities of buprenorphine sold (by weight) were as follows: Subutex® 74%, generics 21% and Suboxone® 5% (versus 1% in 2012) (Gers-Siamois, processed by OFDT).

The market penetration rate for buprenorphine generics (number of packs of generics reimbursed relative to the total number of packs of buprenorphine reimbursed) remained stable at 32% in 2017 (Assurance Maladie 2018)

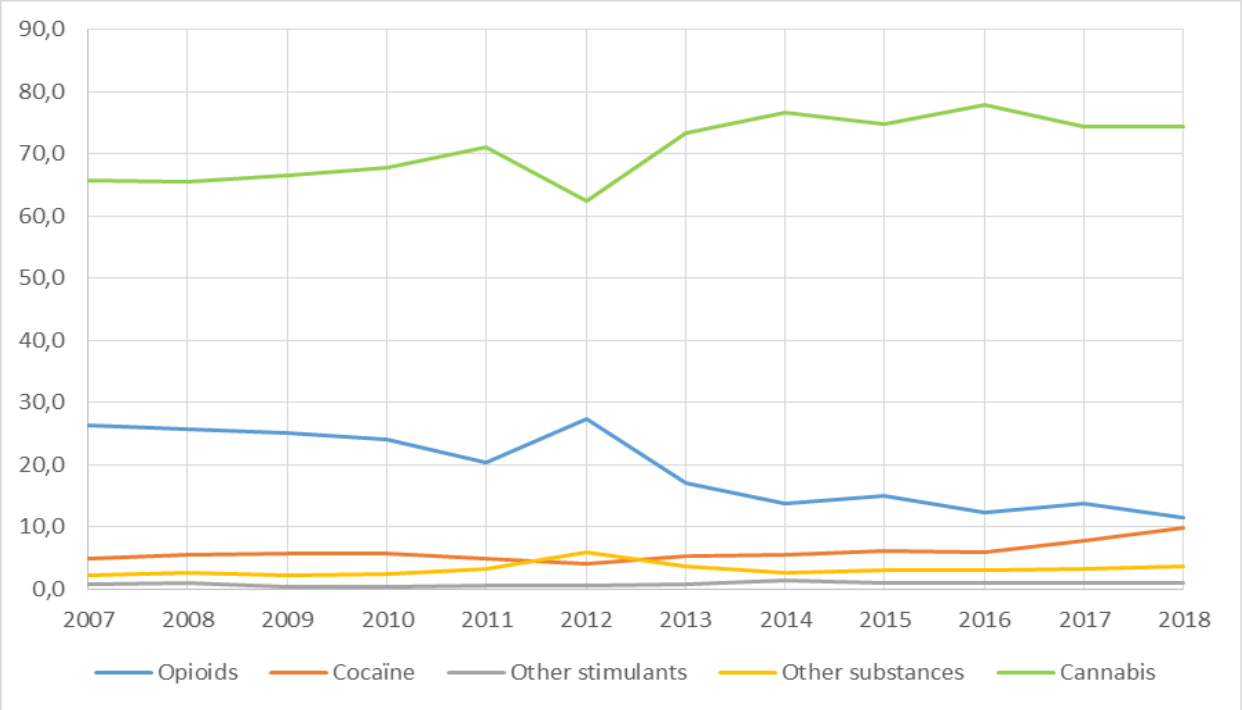
*T2.2.* ***Optional****. Please comment on the possible explanations of long term trends and short term trends in any other treatment data that you consider important. In particular when there is a strong change in trend, please specify whether this change is validated by data and what are the reasons for those trends (suggested title: Additional trends in drug treatment)*

**Figure II.** Evolution of the number of people starting treatment for the first time in their lives according to the most problematic substance between 2014 and 2018, data analysed in constant terms



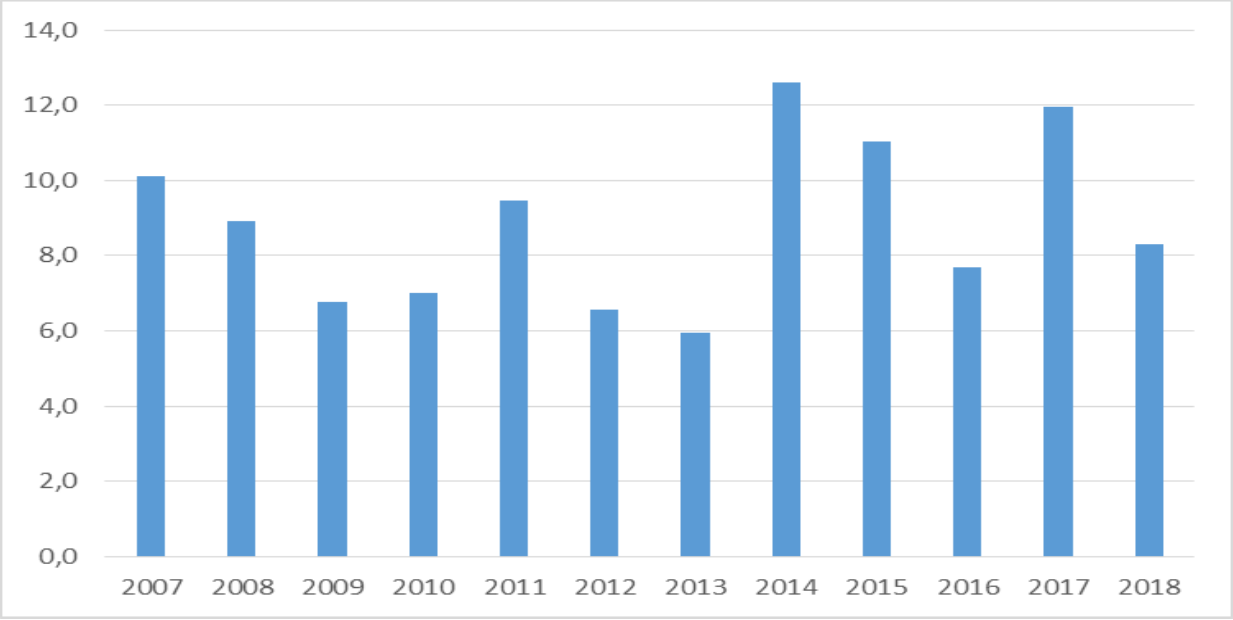

**Source: TDI**

**Figure III.** Trends in proportion numbers of first-time clients entering treatment, by primary drug, 2007-2018 (in %)



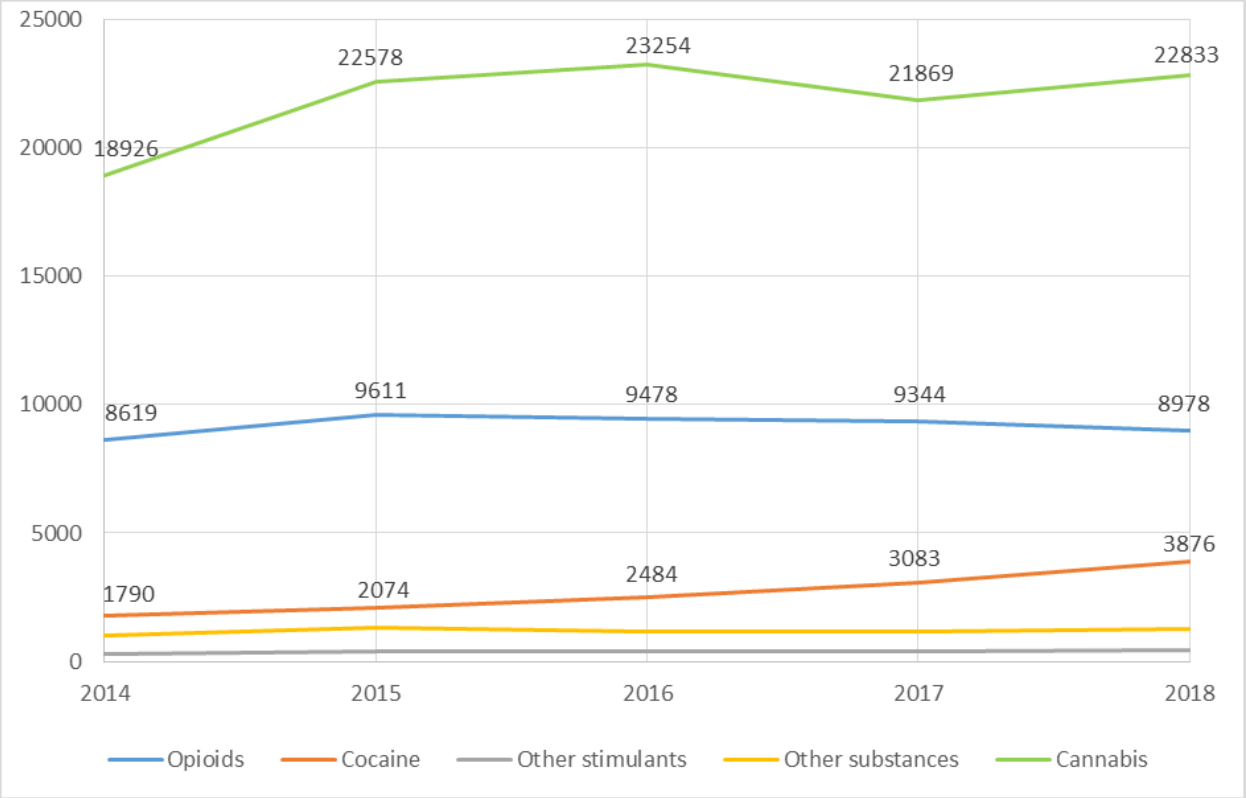

**Source** TDI

**Figure IV.** Changes in the proportion of patients starting treatment for the first time ever (substances unknown), 2007-2018 (in %)



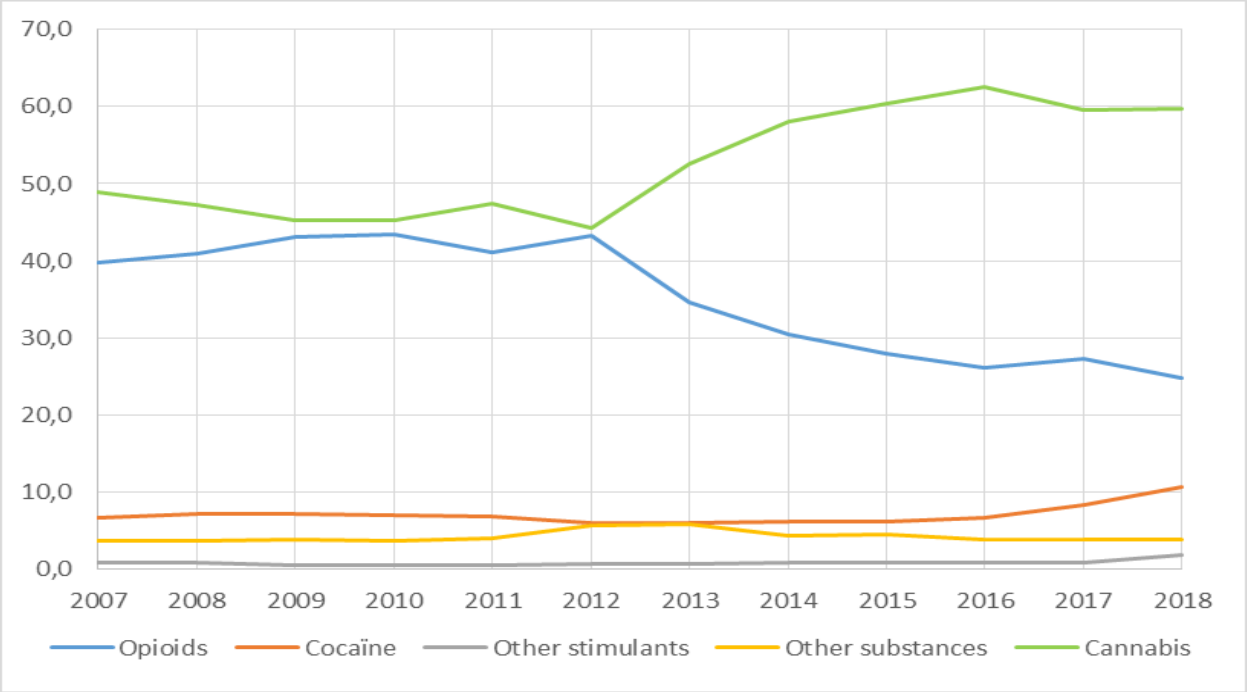

**Source**: TDI

**Figure V**. Evolution of the number of people starting treatment according to the most problematic substance between 2014 and 2018, data analysed in constant terms



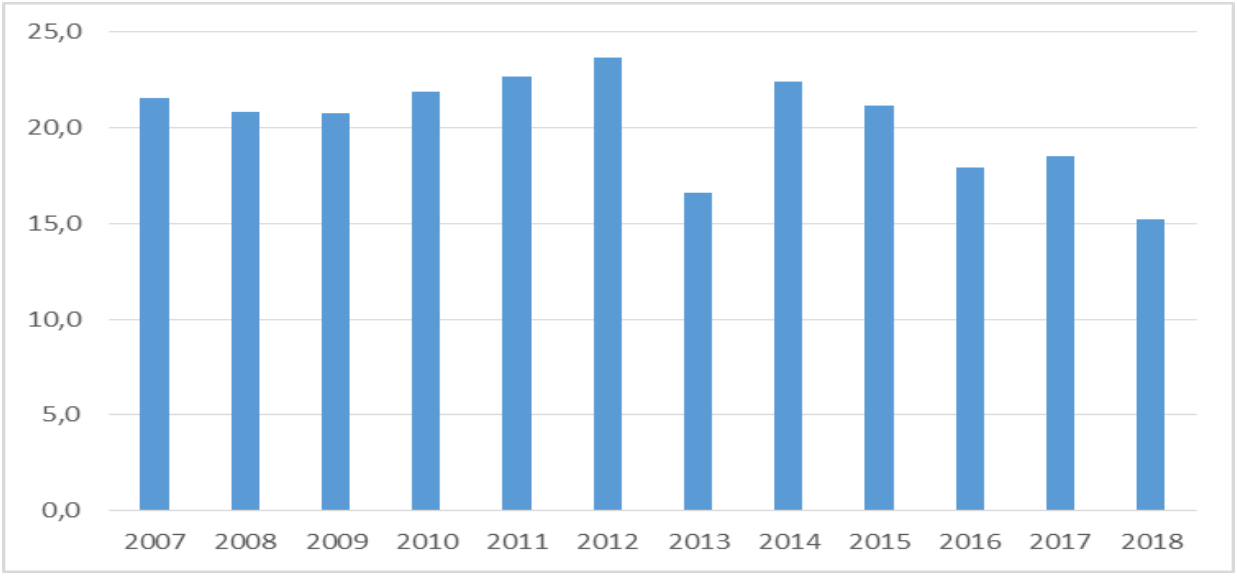

**Source: TDI**

**Figure VI.** Trends in proportion numbers of all clients entering treatment, by primary drug, 2007-2018 (in %)



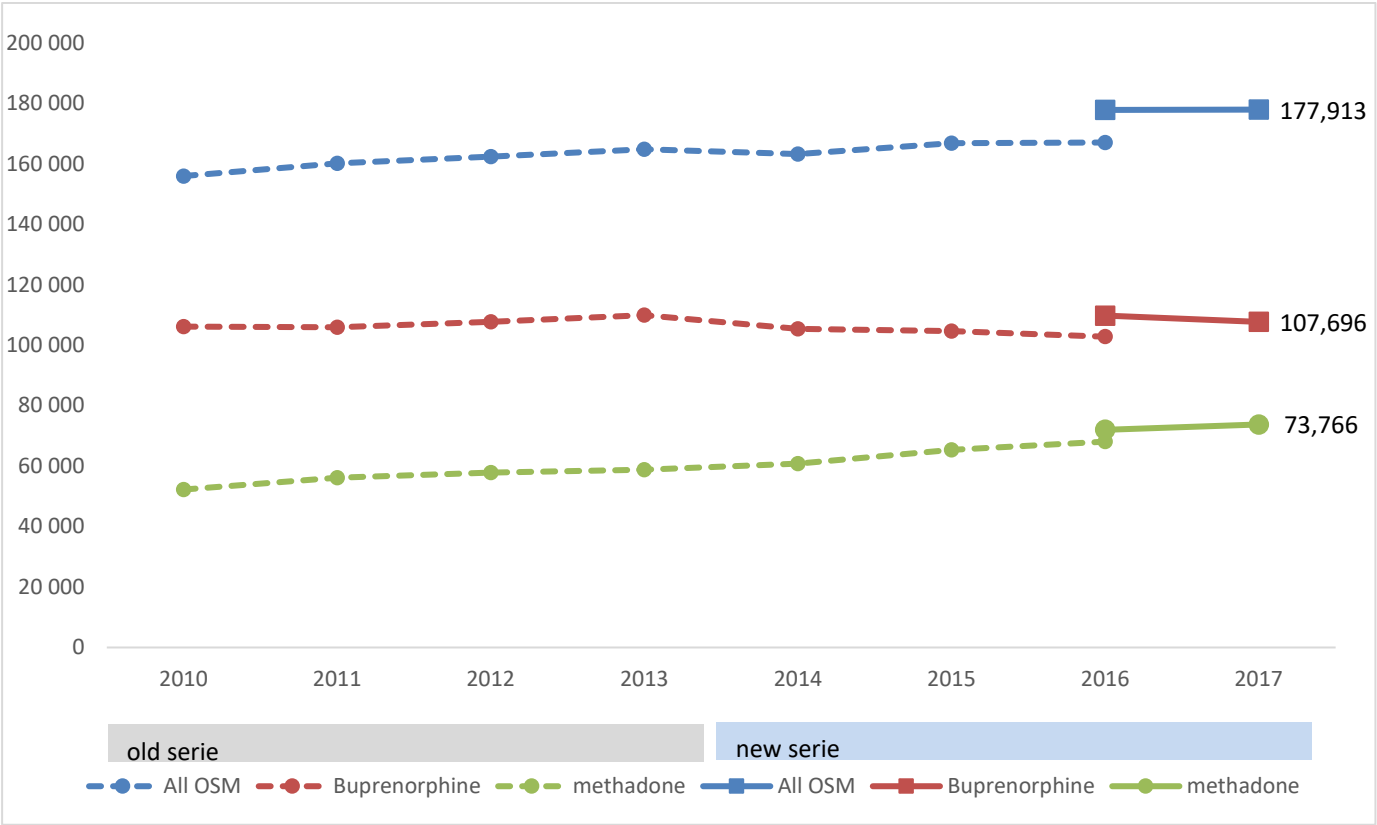

**Source**: TDI

**Figure VII.** Changes in the proportion of patients starting treatment (substances unknown), 2007-2018 (in %)




**Source**: TDI

**Figure VIII.** Trends in numbers of clients in opioid substitution treatment between 2010 and 2017



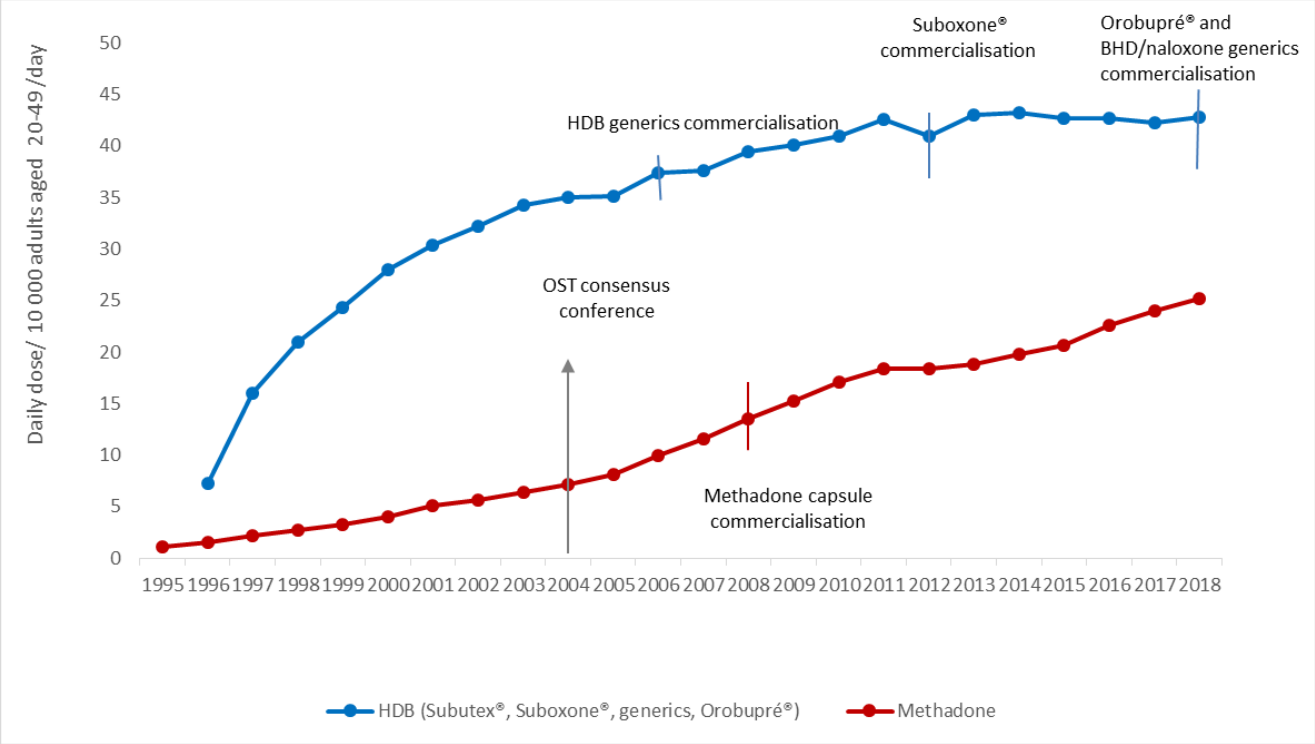

Note: The previous series ends in 2016, and took into account opioid substitution medications reimbursements for 86% of the population covered by the Social Security scheme. The new series starts in 2016, and includes reimbursement data for the whole population covered in France, estimated and readjusted based on EGBS data representing 96% of the covered population.

These two series also include individuals with treatment dispensed in CSAPAs and in prison, which do not appear in National Health Insurance Fund reimbursement data.

OSM: opioid substitution medications

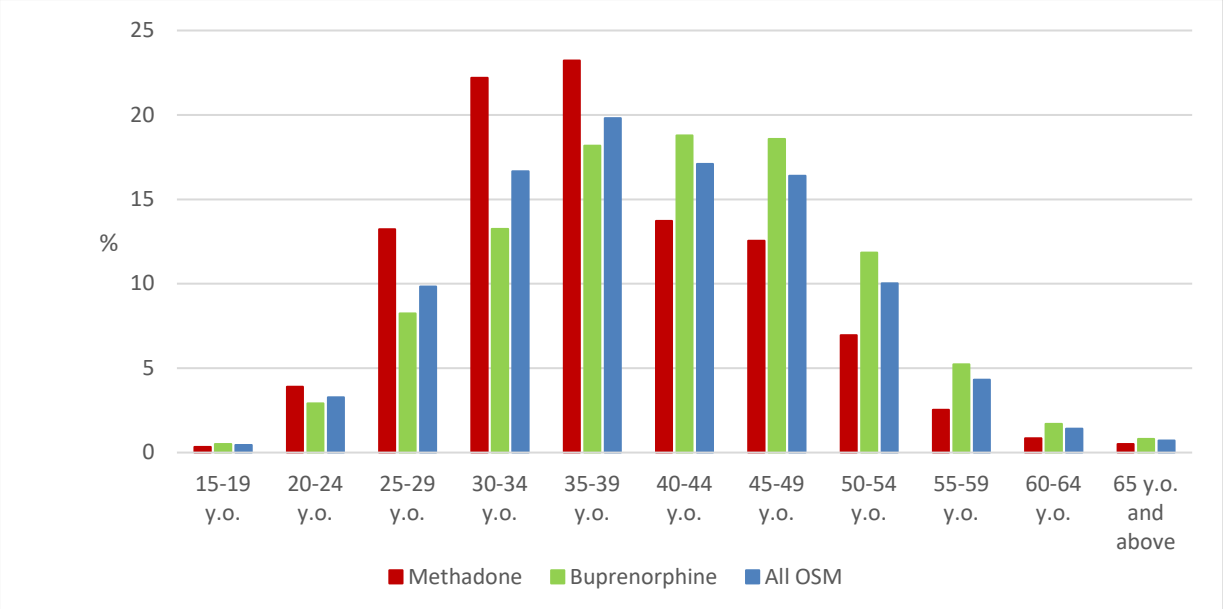
**Source** Standard Table 24

**Figure IX.** Opioid substitution treatments: use of buprenorphine and methadone from 1995 to 2018 in terms of daily dose / 1,000 inhabitants aged 20 to 49 years / day (Subutex® 8 mg/day, Suboxone® and generics 8 mg/day, Orobupré® 8 mg/j, methadone® 60 mg/day)




HDB: high-dose buprenorphine
**Sources**: SIAMOIS (GERS, processed by InVS then OFDT), Bouchara-Recordati, Medic'AM (CNAM)

**Figure X**. Distribution of opioid substitution medication beneficiaries reimbursed in a community setting in 2017, by five-year age groups




OSM: opioid substitution medications

**Source**: EGBS (CNAM, processed by OFDT)

## T3. New developments

The purpose of this section is to provide information on any notable or topical developments observed in drug treatment in your country **since your last report**.
T1 is used to establish the baseline of the topic in your country. Please focus on any new developments here.
If information on recent notable developments have been included as part of the baseline information for your country, please make reference to that section here. It is not necessary to repeat the information.

T3.1. Please report on any notable new or topical developments observed in drug treatment in your country since your last report (suggested title: New developments)

**New developments**

The main highlight is the increase in the percentage of new clients treated for cocaine as the most problematic substance (primary drug): from 6.1% in 2015 to almost 11% in 2018. The proportion of people receiving treatment for their cannabis problem seems to have stabilised at around 60% since 2015. For opioids, this proportion is continuing to decrease (from 30.5% in 2017 to 28.0% in 2018).

In 2017, 162,300 people received opioid substitution treatment dispensed in community pharmacies: 99,900 were prescribed buprenorphine (Subutex® or generics), 61,700 methadone and 7,600 buprenorphine in combination with naloxone (Suboxone®). Furthermore, 23,330 patients were dispensed opioid substitution medications in CSAPA (19,800 methadone and 3,530 buprenorphine) in 2016.

In March 2017, the Commission on narcotics and psychotropic substances approved the availability of a proprietary medicinal product containing buprenorphine for injection in the management of opioid-dependent patients. The target population consists of users who inject buprenorphine and/or other opioids and/or dependent on injection (ANSM 2017). The PrébupIV survey was conducted in France alongside a drug addict population injecting opioids, with a view to studying the factors associated with acceptability with respect to intravenous buprenorphine treatment. The vast majority (83%) claimed to be in favour of this type of treatment. Individuals mainly injecting buprenorphine, those reporting more complications related to injection and those never having overdosed were more favourable to receiving buprenorphine treatment for injection (Roux *et al.* 2017). The results of this study were, moreover, presented in a brochure destined for users, bringing together personal accounts and illustrations on buprenorphine treatment administered by injection (SESSTIM (UMR1252) and Aides 2018).

In December 2017, CNAM simultaneously launched national monitoring programmes for professionals and beneficiaries focusing on OST. Targeting and detection is based on reimbursements issued by the National Health Insurance Fund and examination of scanned prescriptions.

## T4. Additional information

The purpose of this section is to provide additional information important to drug treatment in your country that has not been provided elsewhere.

*T4.1.* ***Optional****. Please describe any additional important sources of information, specific studies or data on drug treatment. Where possible, please provide references and/or links (suggested title: Additional Sources of Information)*

T4.2. ***Optional**. Please describe any other important aspect of drug treatment that has not been covered in the specific questions above. This may be additional information or new areas of specific importance for your country (suggested title: Further Aspects of Drug Treatment)*

T4.3. ***Optional**. Please provide any available information or data on* psychiatric comorbidity, e.g. prevalence of dual diagnosis among the population in drug treatment, type of combinations of disorders and their prevalence, setting and population*. If available, please describe the type of services available to patients with dual diagnosis, including the availability of assessment tools and specific services or programmes dedicated to patients with dual diagnosis (suggested title: Psychiatric comorbidity)*

## T5. Sources and methodology

The purpose of this section is to collect sources and bibliography for the information provided above, including brief descriptions of studies and their methodology where appropriate.

T5.1. Please list notable sources for the information provided above (suggested title: Sources)

**Sources**

CSAPA activity reports (CSAPA are specialised drug treatment centres)
EGBS: General sample of French persons with social security coverage (*Échantillon généraliste des bénéficiaires simplifié*)
ENa-CAARUD survey: National survey of CAARUDs' clients (CAARUDs are low-threshold structures)
CJC survey: Survey in Youth Addiction Outpatient Clinics
RECAP: Common data collection on addictions and treatments
TREND: Emerging Trends and New Drugs
SIAMOIS: System of Information on the Accessibility of Injection Equipment and Substitution Products

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T5.2. Where studies or surveys have been used please list them and where appropriate describe the methodology? (suggested title: Methodology)

**Methodology**

**CSAPA activity reports: use of activity reports from the specialised drug treatment centres (CSAPA)**
*National Health Directorate (DGS) / French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

Since 1998, CSSTs (Specialised care centres for drug users), and then the CSAPAs that followed them, have been annually completing a standardised activity report and submitting it to their Regional Health Agency (ARS). These reports are then sent to the DGS, which processes them with the assistance of the OFDT. The aim of this data collection exercise is to monitor the activity of the centres and the number and characteristics of the patients received. Epidemiological data are not recorded patient by patient, but rather for all people received in the centre. For 2016, the reports from the 377 outpatient CSAPAs and 11 prison-based CSAPAs were analysed. The respective response rates were 100% and 69%.

**EGBS: Échantillon généraliste des bénéficiaires simplifié [General sample of French persons with social security coverage]**
*National public health insurance (CNAM), processed by the French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

The population being dispensed an opioid substitution medication in the primary care setting was studied using data from the simplified French National Health Insurance Fund's "EGBS" general population sample. The EGB is a permanent representative sample of the population protected by the general health insurance scheme (excluding students and civil servants), the agricultural worker health insurance scheme (MSA) and the health insurance scheme for self-employed people (RSI). It comprises 1/97$^{th}$ of the list of Social Security numbers, grouping more than 700,000 beneficiaries in 2017. The database resulting from this sample contains some sociodemographic data and all reimbursed health services and treatments (medical consultations, medications and laboratory work, etc.). There are also medical data on treatment under the French ALD (long-term illness) scheme as well as hospital data from the Programme of Medicalisation of Information Systems (PMSI) covering medicine, surgery and obstetrics. The CNAM has made the EGB available to several health agencies, including the ANSM and OFDT. The 2011 and 2012 data were extracted by the ANSM, and the 2013 to 2017 data by the OFDT.

**ENa-CAARUD: National survey of low-threshold structures (CAARUD)**
*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

Conducted every two or three years since 2006 in all CAARUDs (on mainland France and in French overseas departments), this survey determines the number of users seen in these structures, the characteristics of these users and their use patterns. Each user who enters into

contact with the structure during the survey undergoes a face-to-face interview with someone working at the structure. The questions asked are on use (frequency, administration route, equipment-sharing), screening (HIV, HBV and HCV) and social situation (social coverage, housing, level of education, support from friends and family, etc.).

The 2015 survey was conducted from 14 to 27 September: 3,129 individuals completed the questionnaire and were included in the analysis. Out of the 167 CAARUDs registered in France, 143 took part in the survey (i.e. 86%). The data collection rate (proportion of users for whom the questionnaire was completed relative to all users encountered during the survey in the CAARUDs having taken part in the survey) was 64% in 2015.

**CJC survey: Survey in Youth Addiction Outpatient Clinics**
*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

2015 is the fourth year (after 2005, 2007 and 2014) of the survey on clients of youth addiction outpatient clinics (CJC), a scheme created in 2005 to offer counselling for young psychoactive substance users. The 2015 survey is based on the responses by professionals having seen the patients or their families between 20 Avril and 20 June 2015. It covers mainland France and French overseas departments. Out of 260 facilities managing a CJC activity in mainland France and the DOM recorded in 2015, 199 responded to the survey, i.e., a response rate of 77%.

A year after a first survey in 2014, this second one reveals the evolution of the population attending the clinics following a communication campaign. In total, 3,747 questionnaires were collected during the 9-week inclusion period in 2015 (vs. 5,421 during the 14-week survey period in 2014), ensuring a stable base of facilities participating in both surveys: 86% of facilities responding in 2015 took part in both surveys.

The questionnaire comprises four parts: circumstances and reasons for consulting, user sociodemographic characteristics, substances used and evaluation of cannabis dependence by the Cannabis Abuse Screening Test, and decision made at the end of the appointment.

**RECAP: Common Data Collection on Addictions and Treatments**
*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

This system was set up in 2005 and continually collects information about clients seen in National Treatment and Prevention Centres for Addiction (CSAPAs). In the month of April, each centre sends its results from the prior year to the OFDT, which analyses these results. The data collected relate to patients, their current treatment and treatments taken elsewhere, their uses (substances used and substance for which they came in the first place) and their health. The common core questions help harmonise the data collection on a national level and fulfil the requirements of the European Treatment Demand Indicator (TDI) protocol.
In 2017, approximately 208,000 patients seen in 260 outpatient CSAPAs, 15 residential treatment centres and 3 prison based CSAPAs for an addiction-related issue (alcohol, illicit drugs, psychoactive medicines, behavioural addiction) were included in the survey.

**SIAMOIS: System of Information on the Accessibility of Injection Equipment and Substitution Products**
*Groupement pour la réalisation et l'élaboration d'études statistiques (GERS) / French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

The system of information on the accessibility of injection equipment and substitution products (SIAMOIS) was designed in 1996 to monitor trends in terms of access to sterile injection equipment available in pharmacies and opioid substitution medications on a departmental level. No data are available from 2012 to 2015, but only from 2016 onwards.

**TREND: Emerging Trends and New Drugs**
*French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

The aim of the TREND scheme, which was established in 1999, is to provide information about illegal drug use and users, and on emerging phenomena. Emerging phenomena refer either to new phenomena or to existing phenomena that have not yet been detected by other observation systems.

The system is based on data analysed by eight local coordinating sites (Bordeaux, Lille, Lyon, Marseille, Metz, Paris, Rennes and Toulouse) that produce site reports, which are then extrapolated to a national level using the following tools:

- continuous qualitative data collection in urban settings and in the party scene by the local coordination network, which has a common data collection and information strategy;
- the SINTES scheme, an observation system geared towards detecting and analysing the toxicological composition of illegal substances;
- recurring quantitative surveys, particularly among CAARUD clients (ENa-CAARUD);
- partner information system results;
- thematic quantitative and qualitative investigations that aim to gather more information about a particular subject.