

Treatment workbook

2020

France

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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

Treatment for illicit drug users may be provided in health and social care centres specialising in addiction medicine, the CSAPA (specialised drug treatment centres), in primary care settings (mainly by general practitioners), or in hospitals, including some psychiatric hospitals. The place of addiction medicine in hospitals varies. Some have addiction medicine departments with several hospital practitioners who take care of patients on an outpatient basis, but mostly on a full inpatient or day admission basis. Others have one or two withdrawal beds and an addiction medicine outpatient clinic. ELSA (addiction liaison and treatment teams) exist in many of the hospitals with emergency care services.

However, only persons received at the CSAPA are subject to data collection in accordance with the European protocol for recording data processing requests. In 2019, about 54 000 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. Given the participation rate of the CSAPA in collecting TDI data (64%), the total number of people starting treatment at the CSAPA could be in the range of 84 000.

The total number of people cared for in a CSAPA during the year, which also includes people already receiving treatment last year, is 136 000 according to the latest available data going back to 2017¹.

The activity of community doctors in the field of addiction treatment mainly involves prescribing opioid substitution treatments (OST). These doctors are not the only ones who prescribe these treatments, but they provide the highest proportion of them. These treatments are most often dispensed in pharmacies.

In 2017, 162 300 persons received opioid substitution treatment dispensed in community pharmacies². Almost 22 000 received treatment dispensed in a CSAPA in 2017.

Sources on hospital-based addiction treatment are incomplete and difficult to interpret. Data is only available for inpatients, as outpatient care is not reported. In 2017, 11 500 people were hospitalised in general hospitals with a primary diagnosis of addiction to illicit drugs or psychoactive medicine (hypnotics or anxiolytics). Some of these hospitalisations may, however, be related to the management of acute intoxication in people who are not enrolled in a treatment process for their addiction problem.

¹ This data is from a different source, the CSAPA activity reports, which have so far taken longer to process for national data than for TDI data. For more details, see T5 Sources and Methodology.

¹ According to the latest data for 2018, 161 000 people received opioid substitution treatment at community pharmacies. For more details, see T5 Sources and Methodology.

² According to the latest data from 2018, 161 000 people received opioid substitution treatment dispensed in community pharmacies. For more details, see T5 Sources and Methodology.

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

In constant terms, 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 and remained fairly stable since. The increase in these treatment demands between 2014 and 2016 mainly came from cannabis users, who represented an overwhelming majority (73% in 2019). 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 2019.

Over the 2007-2019 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.

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 and 2019 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 and 2018, the amount and proportion of cocaine-related treatment demand continued to increase in 2019. However, the rate of increase was significantly lower than in the previous two years. The number and percentage of treatment demands related to cannabis seem to stabilise after the sharp increase from 2010-2016.

In 2018, 161 400 people received opioid substitution treatment dispensed in community pharmacies: 96 300 were prescribed buprenorphine (Subutex® or generics, Orobupré®), 63 400 methadone and 7 300 buprenorphine in combination with naloxone (Suboxone® or generics). Furthermore, 21 960 patients were dispensed opioid substitution medications in CSAPA (18 520 methadone and 3 440 buprenorphine) in 2017.

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 Plan for Mobilisation against 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

Outpatient treatment for illicit drug users may be provided at health and social care centres specialising in addiction medicine, the CSAPA (specialised drug treatment centres), in primary care settings (mainly by general practitioners), or in hospitals, including some psychiatric hospitals, as part of outpatient addiction treatment clinics.

Only those individuals overseen by the professionals mentioned in Table I will be described herein.

The specialised socio-medical scheme

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 has 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 harm reduction facilities known as CAARUD (support centres for the reduction of drug-related harms) is not considered to fall within the scope of treatment as defined by the European protocol for recording treatment demand³: 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) reported to have seen 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).

³ One of the criteria for inclusion is that interventions with drug users must be part of planned programmes. This protocol can be consulted on the EMCDDA website: https://www.emcdda.europa.eu/publications/manuals/tdi-protocol-3.0_en.

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 addiction 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 5 regions to evaluate the structural and economic model so it can be implemented across the country (Equip'addict project).

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 or tobacco problems; however all clinics may treat illegal drug users.

Outpatient drug treatment system – Client utilisation

The number of people treated can be calculated in several ways. The European protocol for recording treatment demand provides for the inclusion only of persons who start treatment during the year. Data collection in accordance with the European protocol resulted in 53 900 patients being recorded in 2019. However, only just under two-thirds of the CSAPA participated in collecting this data in 2019. To give some idea of the magnitude of the problem, it is possible to extrapolate this number to all the CSAPA. The total number of people starting treatment would then be about 84 000.

However, it is useful to know the total number of people treated at the CSAPA, also taking into account those who are monitored from one year to the next. Another data source, the CSAPA activity reports (see T5 Sources and Methods), provides this number. This figure is currently only known after a long delay and only data from 2017 is available for this report. During that year, according to this comprehensive source, 136 000⁴ people would have been monitored for a problem of illicit drug use in the CSAPA.

In 2017, the 11 CSAPA in a prison setting having contributed data on the number of patients claimed to have treated approximately 4 100 individuals in the past year for use of illegal drugs or psychoactive medicines. However, the treatment of incarcerated drug users is also provided by CSAPA, carrying out activities not limited to prison-based interventions. In 2017, 201 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 14 500. These figures are, however, partly included in the 136 000 drug-treatment clients in outpatient CSAPA.

The number of drug users seen by general practitioners is estimated at 132 000 in 2017 based on the reimbursements for prescription of OST.

⁴ This figure takes into account a 5% proportion for double counting the reported data, a percentage estimated from the latest capture-recapture study conducted in a few French cities.

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)

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Table 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)	375	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. 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).	136 000
Low-threshold agencies focused on harm reduction approaches	141	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.	89 600
General primary health care (e.g. GPs)	60 000	Individuals having benefited from reimbursement further to prescription of an opioid substitution treatment by a general practitioner (GP). Estimated number of general practitioners having claimed to have seen at least one opioid client in the past month.	132000
General mental health care			
Prisons: 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.	4 100
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 (53 900 individuals in 2019), 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*)

41% of CSAPA are managed by public hospitals or public medical centres and 59% by associations. All these centres 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	41%	59%			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 2017. In addition to these institutions, 9 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 2017, 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 2017, 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 (mainly alcohol), hence it is difficult to identify those which are actually open to drug users. A census of these hospital facilities has not been carried out since. A very large number of hospitals are equipped with ELSAs, whose mission is not to treat patients but to identify addiction problems among hospitalised patients and refer them to addiction treatment facilities.

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 2017. Around 1 000 individuals were housed in ATR (residential therapeutic apartments) and about 650 were housed in an emergency or transitional facility run by a CSAPA. The parallels with drug users seen in outpatient CSAPA are undoubtedly 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)

Table 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 Residential treatment centres are facilities which combine collective housing and treatment. It carries out the same missions and services as in an outpatient setting. It offers support for customised treatment. 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	9	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	63	Individuals housed in residential therapeutic apartments 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).	1 000
Other inpatient units	7	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. 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. Short-stay housing may be collective (such as in a residence) or individual (hotel stays).	650

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 to drug users are either managed by public hospitals or CSPA which are managed voluntarily but funded by the social security scheme. However, there are a 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 (non-hospital based)	5%	90%	5%		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?

In 2019, nearly 54 000 drug users treated for a new treatment episode in a CSAPA were included in the TDI data, compared to approximately 57 000 in 2018. This drop is related to the decrease in the number of specialised centres that transmitted TDI data (249 in 2019 compared to 271 in 2018). This lower participation appears to be largely related to the COVID19 epidemic. Due to the lockdown during the months of March and April, this year the Ministry of Health granted the CSAPA an extension to submit their annual activity report, which undoubtedly explains why a number of CSAPA did not submit their RECAP data within the usual timeframe. Calculated on a constant field⁵, the number of drug users increased very slightly (+2.7%) between 2018 and 2019.

⁵ The constant field analysis was conducted on a sample of CSAPA that reported TDI data each year between 2014 and 2019. This sample includes 168 outpatient CSAPA (45% of the total number of outpatient CSAPA) with 44 000 people in 2019.

The number of new clients in facilities that have provided data since 2014 appeared stable between 2015 and 2019.

Nearly 64% of outpatient CSAPAs took part in the RECAP survey from which the TDI data are extracted. A simple extrapolation from this participation rate and the number of people included by the CSAPA that submitted data makes it possible to estimate that 84 000 people began treatment in 2019. The imprecision of this figure does not, however, make it possible to analyse changes in the number of people treated.

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

The overwhelming majority of people starting treatment at CSAPA are cannabis users (59% in 2019). On a constant field, the number of these people remained more or less stable compared to 2018 (+1%). Opiate users make up the second largest group, accounting for just under a quarter of those starting treatment (24% in 2019). Their number also appears to have remained stable relative to 2018 (+0.1%). The proportion of cocaine users among those starting treatment was 11.5% in 2019, 7.4% of which were powder cocaine users and 4.1% were free base cocaine users. The number of these users, which had grown strongly in previous years, increased by a further 11% in 2019. Since 2015, the growth rate (on a constant field) of the number of free base cocaine users has been growing faster than that of powder cocaine users. In 2019, this increase was 16% for the former vs 8% for the latter. Among users of other products were hypnotics and sedatives (2.2%), other stimulants (1.5%) and non-detailed substances (1.3%). The numbers for these different categories of substances are very small.

Breakdown by products for individuals starting treatment with a community doctor is likely different from that observed for the CSAPA. Given the role of community doctors in prescribing opioid substitution treatment, it is likely that the share of opiate users is overwhelmingly higher and the share of cannabis users much lower than in the CSAPA. In hospitals, specialisation in substitution treatment is probably less strong than in urban medicine, but as the hospitalisation figures show (see below T1.3.3), the distribution of users according to substances appears more balanced than in the CSAPA.

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

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	84 000*

Table V. Summary table - Clients in treatment

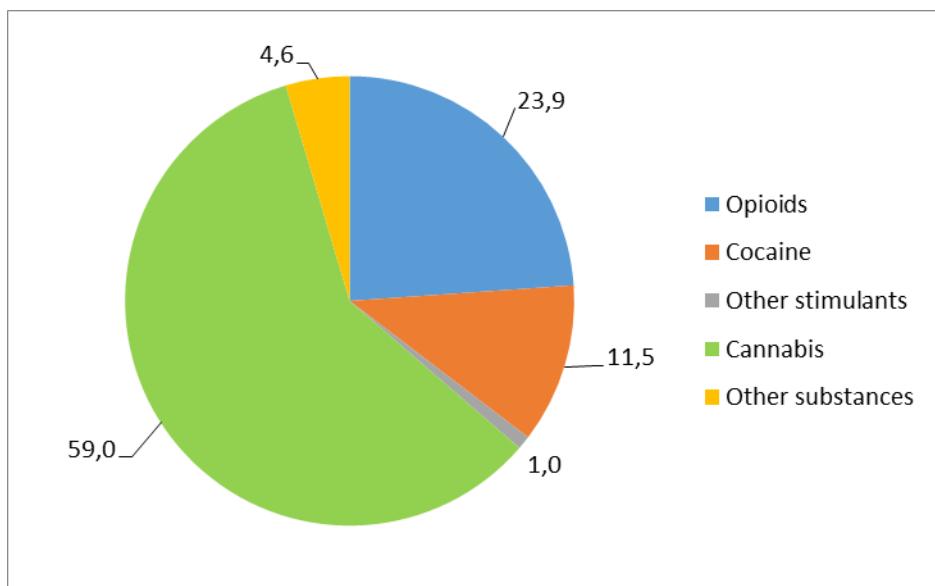
	Number of clients
Total number of clients in treatment	na
Total number of OST clients	178 700
Estimated total number of all clients entering treatment in a CSAPA	84 000*

na: not available

*: based on a coverage rate of 64%

Source: Standard Table 24 and TDI

Figure I. Distribution of the number of individuals having started treatment in a CSAPA in 2019, according to the primary drug (%)



Source: TDI

Note: the proportions are calculated taking into account the first mentioned product, which is considered to be the most problematic product for the consumer

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)

Distribution of primary drug in the total population in treatment

The extent of treatment related to cannabis in France is partly explained by the fairly high proportion of clients referred to a CSAPA by the judicial authorities further to arrest for use of this substance (approximately 40% in 2019, 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 users 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. The widespread use of community medicine for prescribing OSTs also explains to a large extent the high proportion of cannabis users in terms of treatment demand.

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. As indicated in the section describing the health care system in France, people who use drugs can also be treated in the general health care system, in hospitals or by community doctors. People can also be treated for an addiction problem in a mental health facility.

As far as hospitals are concerned, according to the data transmitted by ATIH (the French Technical Agency for Information on Hospital Care) for the year 2017, 11 500 people with a main diagnosis of mental disorders linked to an illicit drug (ICD10 codes F11 to F19 excluding F17) or "rehabilitation of drug addicts and after drug abuse" (ICD10 code Z503), including 1 800 specifically linked to the use of opioids, 930 to cocaine, 1 220 to sedatives or hypnotics, 1 800 to cannabis and 2 000 to other drugs or polydrug use. Some of these hospitalisations, which are short-term, are the result of a visit to the emergency room and do not necessarily lead to treatment of the addiction problem itself. There is no statistical source on the number of drug users treated on an outpatient basis within the framework of inpatient addiction treatment services and inpatient services in prisons done outside the CSAPA.

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

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.

The prevalence of psychiatric comorbidities among the people treated at the CSAPA has not been measured rigorously, but these pathologies are perceived by the health care teams of most CSAPA as being strongly present among the people monitored. (Fédération Addiction 2019). According to the data collected through RECAP, out of all individuals treated at the CSAPA for a problem with illicit drugs other than cannabis, just over 25% had ever been hospitalised in a psychiatric unit for a reason other than withdrawal. (OFDT 2019).

Initial assessments can be an opportunity to detect a possible psychiatric problem. However, the professionals at the CSAPA, as there are very few psychiatrists among them, point out the difficulties in diagnosing these pathologies, in addition to patients minimising or denying these problems as they prefer to blame their disorders on their use. (Fédération Addiction 2019). Treatment of psychiatric disorders at the CSAPA is infrequent, mainly limited to those CSAPA that are integrated into a psychiatric facility or those staffed by a psychiatrist(s). If it becomes apparent that a patient needs psychiatric treatment which cannot be provided at the CSAPA, the patient must be referred to a specialised psychiatric facility for treatment, in coordination with the addiction treatment team. However, the caregivers at the CSAPA point out the difficulties of implementing coordinated treatment due to multiple obstacles: the rigidity of the health care systems, lack of knowledge of how the other system works, lack of trust, etc. (Fédération Addiction 2019).

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

CAARUD

As mentioned above, the CAARUD are not considered in France to be facilities offering addiction treatment in the same way as the CSAPA, even though as part of their harm reduction mission they participate in the system of treatment for drug users.

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

Until the 1970s, people with addiction problems were treated in psychiatric hospitals. These facilities lost this central role with the creation of specialised outpatient centres in the 1970s and the adoption, later on, of a policy aimed at having people with addiction problems also treated in general hospitals. Nevertheless, some psychiatric hospitals have continued to develop specialised addiction treatment. In addition, all psychiatric hospitals encounter substance use problems among people with psychiatric disorders. As with the CSAPA, these institutions are confronted with the issue of addiction treatment either internally or in liaison with facilities specialising in addiction treatment. The same difficulties of coordination between the two sectors mentioned for the CSAPA also appear for psychiatric hospitals.

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)

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 are fairly widely available in France in hospital addiction medicine departments, residential treatment centres, therapeutic communities and residential therapeutic apartments. The difficulties encountered by outpatient CSAPA in the detection and treatment of psychiatric problems mentioned above appear in a similar way for CSAPA with accommodation. 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	not known	not known	not known	not known
Individual case management	not known	not known	not known	not known
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 releases without any therapeutic follow-up, 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 professionals in charge of these new measures, when questioned as part of a focus group, while considering these initiatives to be positive, pointed out difficulties due to the lack of preparation upstream and downstream (a lack of follow-ups at the end of the short-term reception centres) for prison leavers. Advanced clinics in accommodation centres are hampered by the slow implementation of the partnership and the lack of staff resources. 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 court⁶. The objective was 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. This trial, which began in March 2015, has now been completed, but the project is

⁶ 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.

continuing at the initiative of those working in the field. Other similar trials based on reinforced monitoring are taking place at the initiative of the courts in various cities such as Beauvais, Soissons (persistent offenders with an alcohol addiction problem), Lyon, Dieppe, Châlons-sur-Saône, Fontainebleau.

Senior drug users (>40years old):

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.

Adolescents and younger children are part of the target audiences for the youth addiction outpatient clinics (see above).

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 28 December 2016 ([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)

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. The health crisis has encouraged the use of telemedicine, although data is not yet available to measure the extent to which the proportion of telemedicine consultations has increased over time.

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

OST can be prescribed by general practitioners, doctors in a CSAPA, or a hospital facility, including psychiatric hospitals. Dispensing can be done in a CSAPA, in a hospital facility or in a community pharmacy.

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 I⁷ 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

⁷ 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.

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 Plan for Mobilisation against 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 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 28 days since 2010 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.

See also section T4.2. regarding government-imposed lockdown measures to limit the COVID-19 pandemic and their impact on dispensing opioid substitutes in community pharmacies, as well as sales and reimbursement data.

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 EGDS database (simplified General sample of beneficiaries, sample of French persons with social security coverage), 161 400 individuals were reimbursed for opioid substitution medications dispensed in community pharmacies in 2018 (revised estimation taking into account the EGDS extrapolation coefficient and the representativeness of the EGDS 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 2018, 96 300 individuals were dispensed buprenorphine (Subutex®, generics or Orobupré®), 63 400 methadone and 7 300 buprenorphine in combination with naloxone (Suboxone® or generics).

Furthermore, 21 900 patients were dispensed opioid substitution medications in a CSAPA setting (18 500 methadone and 3 400 buprenorphine) in 2017, among the 56 200 patients followed up in a CSAPA setting and receiving OST 36 400 with methadone and 16 200 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 62% overall in 2019, 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 treatments⁸. One of the main indicators for buprenorphine misuse (average daily dose higher than 32 mg/d⁹) 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 treatment¹⁰ 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

⁸ 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.

⁹ 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.

¹⁰ 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.

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 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 in opioid 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 VIII 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 CJC. The National Plan for Mobilisation against 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).

Published in 2016, the guide "Femmes et Addictions" (Women and Addictions) was designed to help professionals at the CSAPA and CAARUD to improve the counselling and support provided to women. It presents French and foreign experiences and formulates recommendations aimed at changing the professional practices of all those working with women with addictive behaviours. (Fédération Addiction 2016).

As a result of work supported by the public authorities, the Fédération Addiction published a guide in 2019 with the aim of improving collaboration between the two fields of addiction treatment and psychiatry in order to diagnose psychiatric comorbidities and provide appropriate treatment for the people affected. The development of this guide was based on the participation of addiction treatment and psychiatry stakeholders. This guide first of all presents an overview of the current situation and the difficulties encountered and, based on the favourable practices observed in a number of CSAPA, provides tools to promote comprehensive support for users. (Fédération Addiction 2019).

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.
(suggested title: Long term trends in numbers of clients entering treatment and in OST)

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, more than a third of CSAPAs do not provide TDI data. Out of those who responded, answers to the question of whether it is their first ever treatment or not was provided for only 38% of patients. 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 also analysed in constant terms, i.e. on a subset of CSAPAs that reported each year between 2014 and 2019. 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 2019 covered 92 outpatient CSAPAs (out of 375) that received almost 9 000 people starting treatment for the first time in their lives in 2019. The figures in Figure II thus only represent a small proportion of the total number of applicants for this type of treatment seen by all CSAPAs in France.

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 CJC 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. For the years 2017-2019, the level of cannabis-related treatment demand can be considered stable.

Opiates and cocaine account for a much smaller percentage of first treatment demands. Those related to opioids have tended to decline since 2016, while those related to cocaine have increased since 2014. In 2019, first treatment demands related to cocaine are almost as high as those related to opioids.

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 opioids, as well as an increase in the number of those related to cocaine since 2016.

All treatment entrants

The development of the number of people starting treatment was also analysed "in constant terms" for the 2014-2019 period. The number of outpatient CSAPAs that provided data each year between 2014 and 2019 represents 46% of the total number of outpatient CSAPAs. The number of people included in the data collection in constant terms reached approximately 39 400 people in 2019. In this sample of CSAPA, the number of people included increased significantly (+14%) between 2014 and 2015. It then changed little and in 2019, was at the same level as in 2015. An increase in numbers between 2014 and 2015 can be observed for all substances, although it is higher for cannabis than for opiates (+21% vs +13%), 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 13% in 2019, a significant decrease even if this number is still far too high.

Developments in constant terms show a relatively stable period in cannabis-related treatment between 2015 and 2019, 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 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) also in 2019. 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, however less marked in 2019 than 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 since. A decline in the number of opiates and an increase in the number of cocaine-related demands can be seen 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 VII 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 (Brisacier 2019). Data on OSM sales in relation to the population show a very slight decrease in buprenorphine consumption between 2014 and 2019, while methadone consumption increased by one third during this period (Gers-Siameois data, processed by the OFDT).

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 2019, the syrup form represented 29% (versus 55% in 2013) of the methadone sold (by weight) and the capsule form 71% (versus 45% in 2013). Moreover, 81% of the quantities were dispensed in retail pharmacies, while 19% were in CSAPAs or hospitals, stable figures compared to 2013 (Bouchara laboratory 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 reported to the population 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.

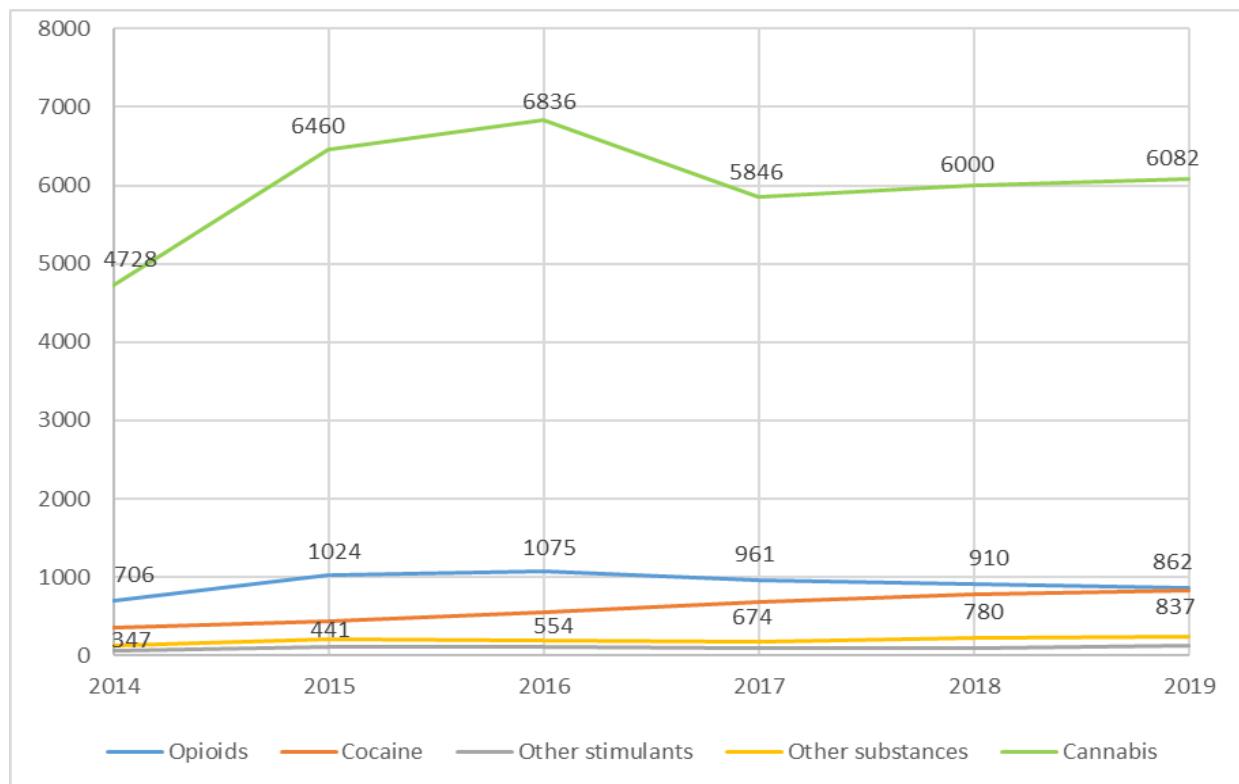
In 2019, the quantities of buprenorphine sold (by weight) were as follows: Subutex® 75%, buprenorphine generics 20%, Suboxone® and its generics 4% and Orobupré® 1% (Gers-Siameois, processed by OFDT).

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 31% in 2019 (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.

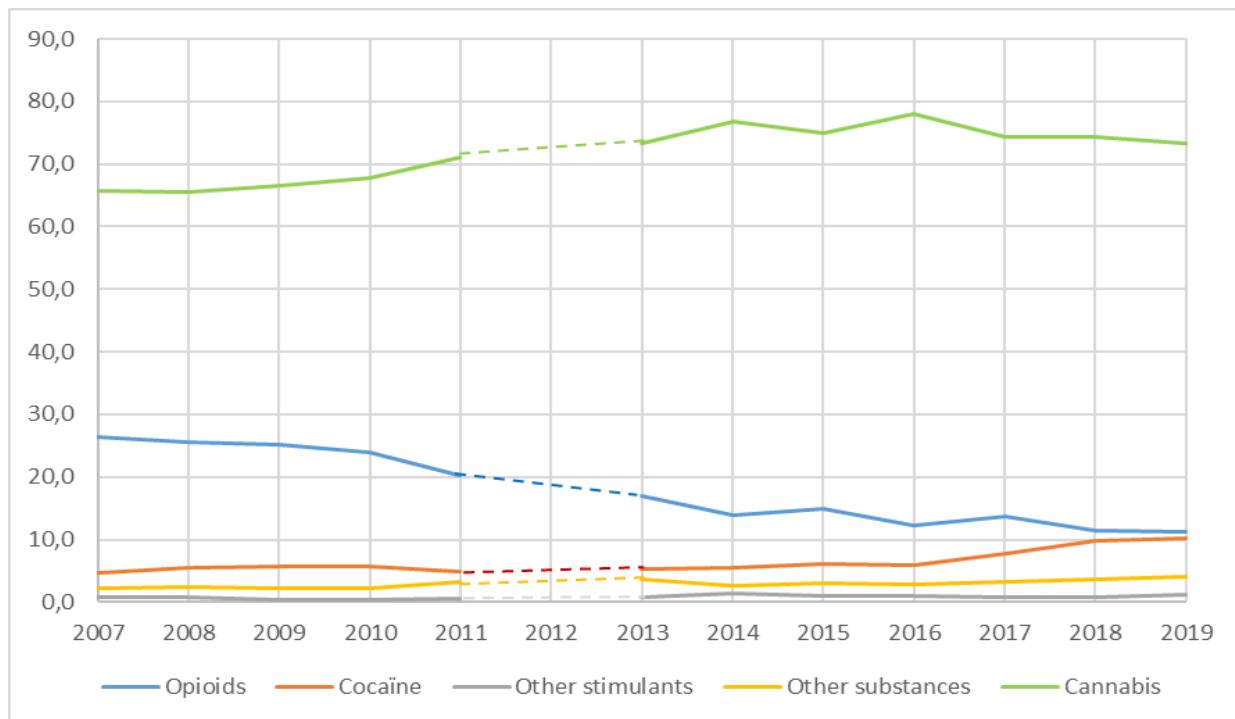
In particular when there is a strong change in trend, please specify whether this change is validated by data and what are the reasons for those trends (suggested title: Additional trends in drug treatment)

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 2019, data analysed in constant terms



Source: TDI

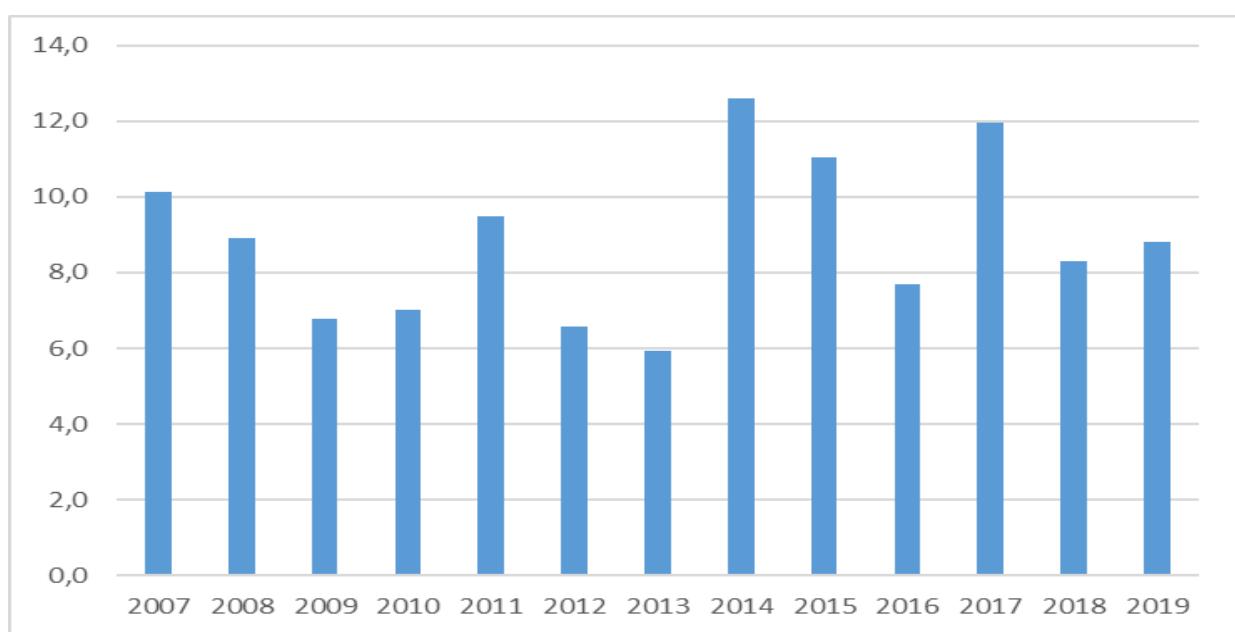
Figure III. Trends in proportion numbers of first-time clients entering treatment, by primary drug, 2007-2019 (in %), data analysed in variable terms



Source: TDI

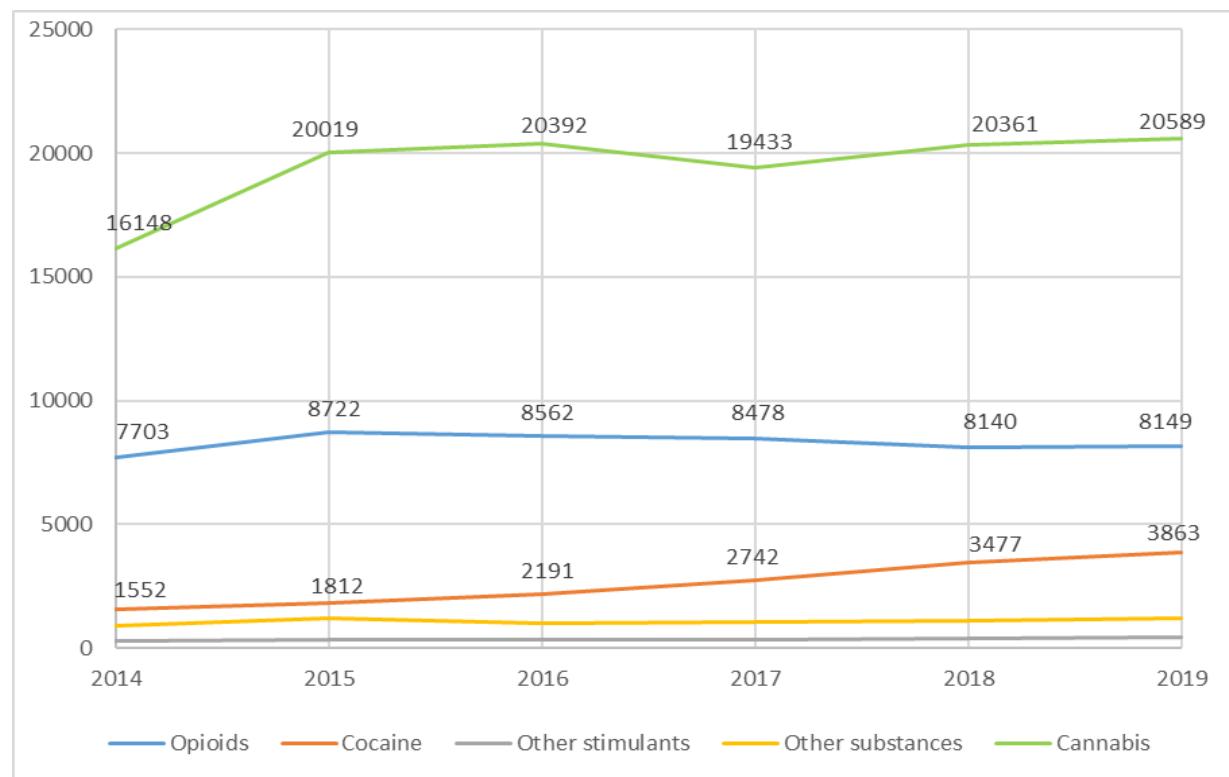
Note: due to the implementation of the new protocol for recording treatment demand in 2012, the data for that year is not valid; it can be considered with a high degree of certainty that the 2012 values were in line with the trends observed between the years 2010 and 2016.

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



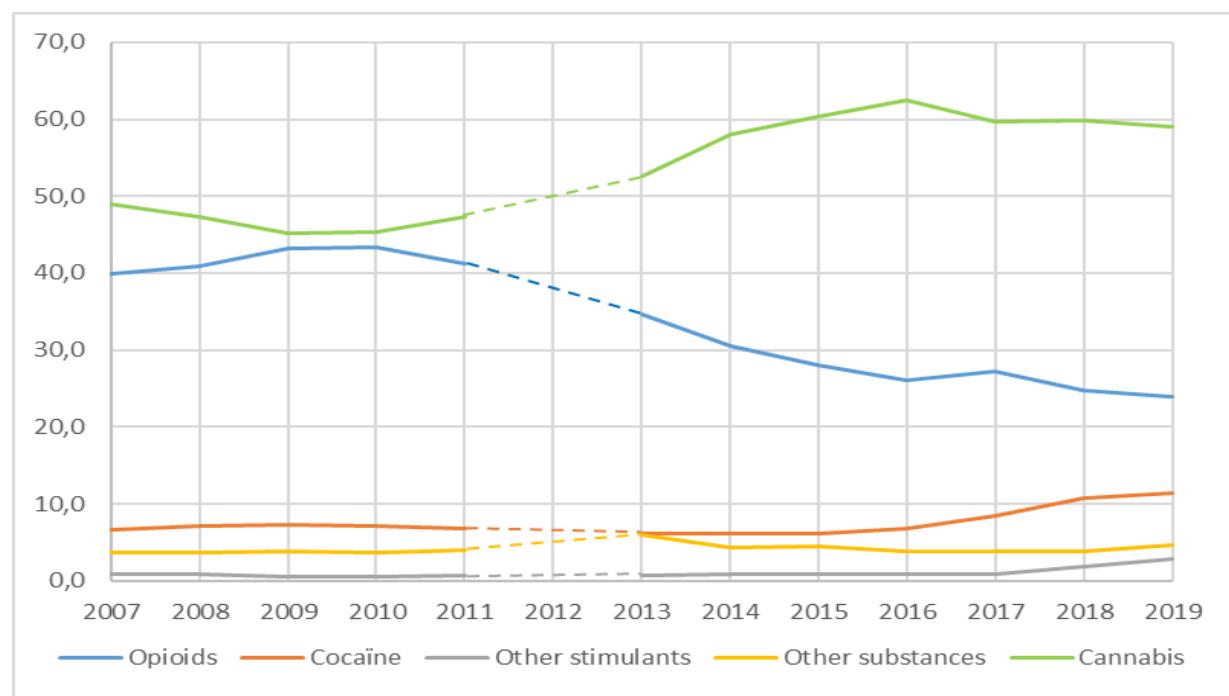
Source: TDI

Figure V. Evolution of the number of people starting treatment according to the most problematic substance between 2014 and 2019, data analysed in constant terms



Source: TDI

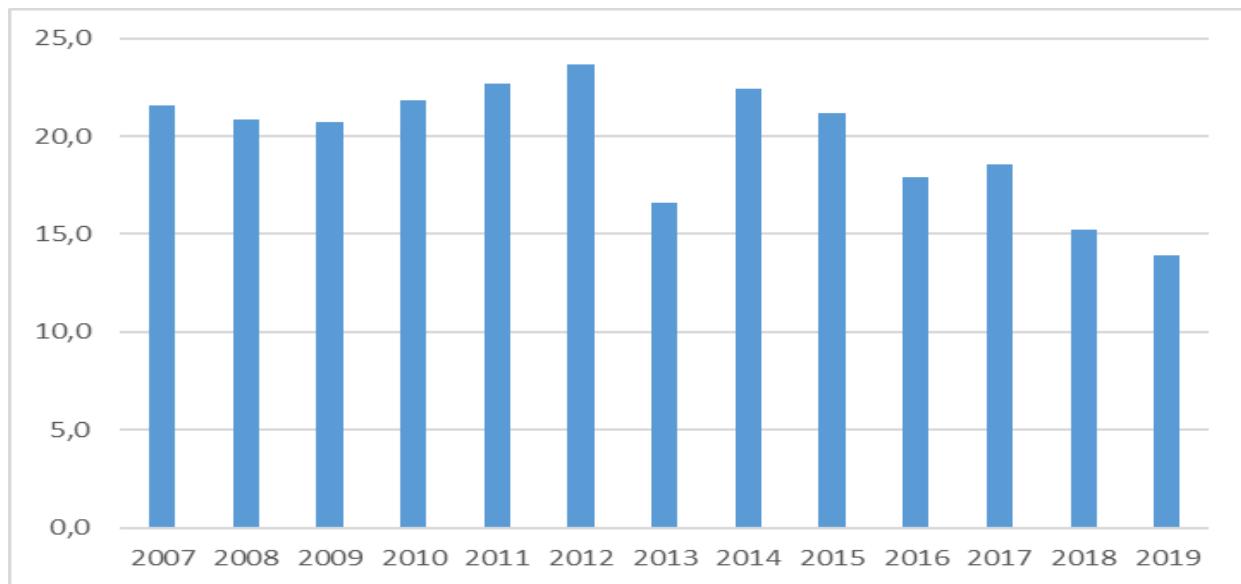
Figure VI. Trends in proportion numbers of all clients entering treatment, by primary drug, 2007-2019 (in %), data analysed in variable terms



Source: TDI

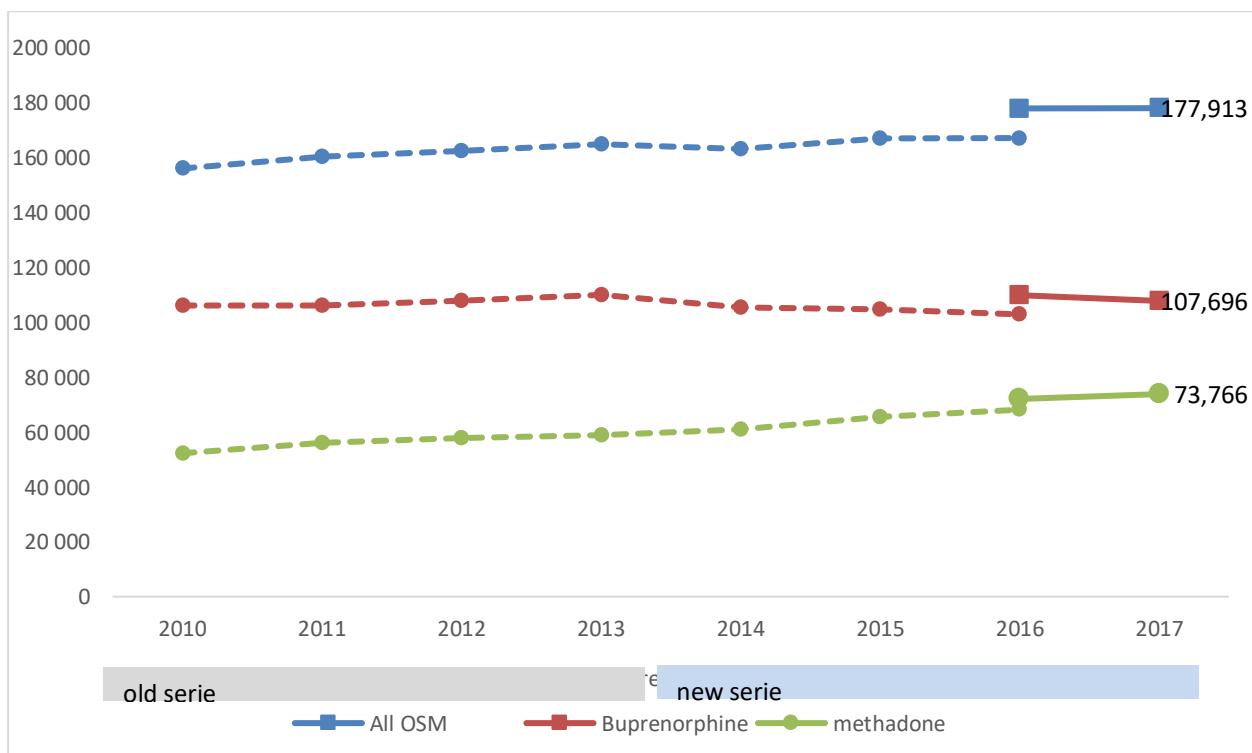
Note: due to the implementation of the new protocol for recording treatment demand in 2012, the data for that year is not valid; it can be considered with a high degree of certainty that the 2012 values were in line with the trends observed between the years 2010 and 2016.

Figure VII. Changes in the proportion of patients starting treatment (substances unknown), 2007-2019 (in %)



Source: TDI

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



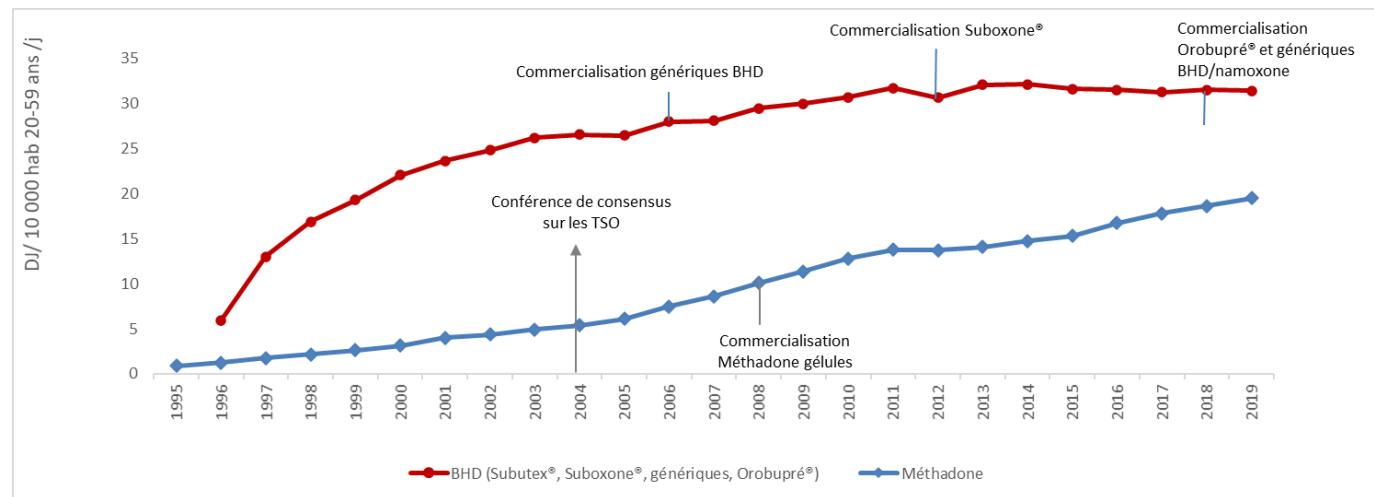
Note: The previous series ends in 2016, and took into account opioid substitution medications reimbursements for 86% of the population covered by the Social Security scheme. The new series starts in 2016, and includes reimbursement data for the whole population covered in France, estimated and readjusted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

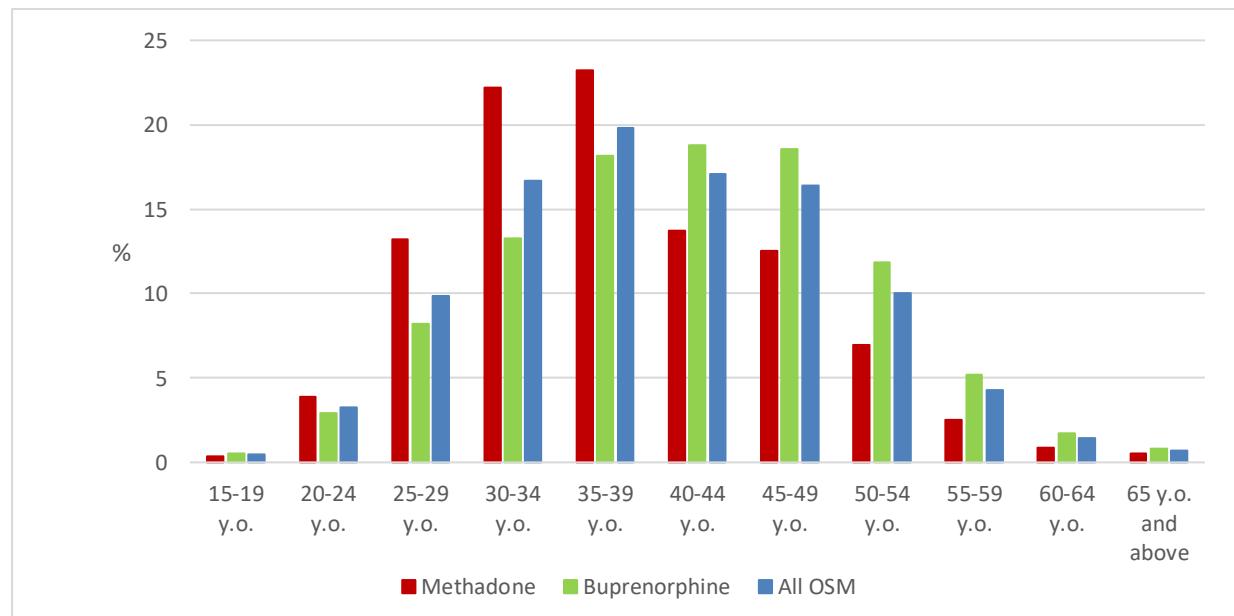
Figure IX. Opioid substitution treatments: use of buprenorphine and methadone from 1995 to 2019 in terms of daily dose / 1 000 inhabitants aged 20 to 59 years / day (Subutex® and generics 8 mg/day, Suboxone® and generics 8 mg/day, Orobupré® 8 mg/j, methadone® 60 mg/day)



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: EGGS (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 11.5% in 2019. 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 27% in 2017 to 25,0% in 2018 and 24% in 2019).

In 2018, 161 400 people received opioid substitution treatment dispensed in community pharmacies: 96 300 were prescribed buprenorphine (Subutex®, generics or Orobupré®), 63 400 methadone and 7 300 buprenorphine in combination with naloxone (Suboxone® or generics). Furthermore, 21 960 patients were dispensed opioid substitution medications in CSAPA (18 520 methadone and 3 440 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)

The lockdown measures imposed by the government to limit the COVID-19 pandemic resulted in increased risks of withdrawal and overdose among opioid-dependent users. Faced with the closure or reduction in activity of general practices and the CSAPA, access to opioid substitution medication prescriptions may have been more difficult. The very strict rules for prescribing and dispensing opioid substitution medication (OSM) have been relaxed somewhat to take into account the difficulties in renewing prescriptions for opioid substitution treatments (buprenorphine and methadone) during lockdown. A [legislative order of 19 March 2020](#) allows pharmacists to renew prescriptions when the validity of the last prescription has expired, provided that the treatment has been taken for at least 3 months. On the other hand, the method for dividing up remain those indicated on the prescription and the overlap between dispensings (unless indicated by the prescriber on the prescription) is not possible. A campaign to mobilise professionals (CSAPA-CAARUD specialised facilities, primary care physicians, private and hospital pharmacies) was also conducted during lockdown to encourage the delivery of naloxone kits to users and their families (see WB Harms and Harm reduction).

The OFDT has mobilised existing data sources to try to assess the impact of lockdown on the dispensing of opioid substitution medication in community pharmacies.

Sales of opioid substitution medication from wholesalers to community pharmacies are on a clear upward trend (+5.5%) in March 2020 compared to March 2019 (Figure 1). This increase is mainly concentrated in methadone sales, which increased 14.7% in March 2020 compared to March 2019, a much higher increase than in the last 12 months (7.5%) (Figure 2). On the other hand, in terms of buprenorphine sales, the increase in March 2020 compared to March 2019 is very slight (0.9%) and comparable to the increase in sales over the last 12 months (0.7%) (data from Siamois, Gers, processed by the OFDT).

Consistently, the number of people reimbursed for an OST increased by 4.3% (+1 490 users) in week 12 (week of 16-22 March 2020) and by 12.2% (+2 397 users) in week 13 (week of 23-29 March 2020) compared to the expected number. However, this increase is much lower than that observed for drugs for chronic diseases, for which the increase in the number of patients dispensed is between +20% and +40% depending on the therapeutic class. (Weill *et al.* 2020).

The TREND scheme has observed during this period an increase in requests to start opioid substitution treatment (OST) from users who usually obtain heroin and opioid drugs illicitly, due to fears of shortages. In addition, the CSAPA have received users treated with buprenorphine who felt insufficiently balanced during lockdown and who have requested a referral for methadone. (Gérome and Gandilhon 2020a, b).

Sales and reimbursement data for OSM shows that lockdown has not diminished access to OSM dispensing. Sales of buprenorphine are stable, while sales of methadone are increasing sharply in community pharmacies. This increase in methadone sales can be explained by an increase in the number of people who had it dispensed to them in community pharmacies. This may involve the transfer of patients being provided with treatment by the CSAPA to community pharmacies, prison leavers continuing their OST, but also new patients starting OST in primary care on methadone. Some of the increase in methadone sales may also be related to an increase in dosage. However, the hypothesis of stock build-up appears less plausible, given the strict rules for dispensing OSM and the fact that the increase does not relate to buprenorphine sales.

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 1/97th 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.