Part B: Selected issues

11. Residential treatment programmes for drug users

11.1. History and framework of public policies

11.1.1. History of residential treatment programmes

Since the 19th century, the attraction of residential treatment programmes for people addicted to psychoactive substances has been growing. There are several reasons for this: firstly, drug addicts need a protective environment during withdrawal and not all addicts have one; secondly, for the immediate post-withdrawal period, physicians recommend, where possible, that addicts rest in a pleasant environment that is sufficiently removed in time and space from the environment in which they previously consumed substances.

It is appropriate to state in later years, programmes specifically designed to treat either alcohol or drug addiction developed separately. The first of these programmes arose within the healthcare setting (sick alcoholics are in hospitals). Given the communal, countercultural spirit of the 1970s, subsequent programmes were characterized - until the 1980s - by their suspicion of the medical domain.

Drug addictions

The increase in numbers of residential drug treatment programmes appeared following the increasingly widespread use of illegal drugs amongst young people towards the end of the 1960s. The 31 December 1970 law was intended as a response to this upward trend in drug use. Various establishments became available to "drug addicts" in this period. For the most part, these “rehabilitation” programmes gradually became links in an increasingly large and varied therapeutic chain, in response to the growing nature and diversity of problems, including solutions such as therapeutic apartments and foster families. At that time, numerous establishments opened. As was appropriate at the time, these sites were often located in the countryside and founded upon an ideal of “getting back to healthy living” and encouraging the restoration of satisfactory human relationships. The goal was abstinence from illegal drug use, but these structures also occasionally helped with professional placement within a society that was close to full employment. The opening of such establishments was made even easier since budgets at the time were approved on a departmental level, and the government reimbursed 80% of these departmental budgets. The residential treatment structures were run by associations since the authorities considered associations to be more responsive than governmental services. In the absence of evidence on the effectiveness of treatments, it was decided to heavily fund experimentations, which disappeared for the most part due to an inability to maintain long-term relationships with their public or due to ideological or financial deviations.

After the euphoria of creating such programmes wore off, the 1980s can be characterized by the professionalization and organization of this sector. For example, there was the creation of the *Association nationale des intervenants en toxicomane* (ANIT, or the French national association of drug addiction professionals), the implementation of annual conferences throughout France and the first “*journées de Reims*” seminars with a strong psychoanalytical focus. This is also the

period during which AIDS appeared in the United States (1981) and shortly thereafter in France. This disease heavily affected injecting heroin users, who became the majority "clientele" of treatment programmes. As a result, the authorities began to question the system that was in place.

In 1987, a report by the *Conseil économique et social* (Economic and Social Council) described residential institutions (Sullerot 1989). Out of 30 aftercare establishments, 16 focused on “relational techniques” and 14 on “occupational techniques”, and three offered “semi-autonomous lifestyles” (therapeutic apartments). In addition to aftercare establishments, there were four major and 19 smaller foster-family networks in relation with treatment centres.

This report deplored the lack of sufficient numbers of residential programmes and also emphasised certain weaknesses by criticising the undermedicalisation of the centres, the underutilisation of certain measures, the inappropriateness of client personal development programmes and client selection, the distancing of families and the lack of communication between the residential centres and their local environment. Above all, the report challenged what formerly had been presented as a strong point of the French system, namely the diversity of available treatment methods. According to the report, such diversity is not effective for patients looking for treatment in centres: patients are referred based on affinities with caregiver ideologies, or in more simple terms, based on availability, which explains the short stays in such centres. “Variety is hardly a virtue if it does not provide choice” (Sullerot 1989).

In 1992, a decree[216] was issued on the missions of outpatient and residential treatment centres. To become a certified CSST (*Centre de soins specialisé aux toxicomanes*, or Specialised Care Centre for Drug Users), an establishment must be able to provide “at least 1) medical and psychological treatment for drug addicts, 2) drug addiction social support and education, which includes social integration and rehabilitation services.” If an establishment only fulfils one of these two missions, it must add the following services: “admitting, orienting and informing drug addicts and their families, and supporting them during withdrawal (…), providing family support”. This is accompanied by certain obligations: therapeutic, social and education treatment plans, like those that exist in the healthcare and medico-social sectors, along with activity reports. The plans must cover a period of no more than five years and prefects must be able to review these plans to assess the progress of the actions.

AIDS not only revealed the problem issues of access to treatment, equality of access to treatments and risk reduction but also France’s underequipped situation in terms of responding to drug use. However, it also called into question the very nature of the responses provided to these issues, and especially professional practices based solely on abstinence.

This led to a 1993 decree that aimed to double residential capacity specifically by developing "therapeutic apartment” programmes and by creating the first therapeutic communities. However, the decree also emphasised developing outpatient structures throughout France and the importance of city hospital networks.

Simultaneously, the authorities, motivated by numerous stakeholders, including those involved in the fight against AIDS, worked to redefine public policy by using several reports: the 1989 Trautmann report (Trautmann 1990), the Henrion report (Henrion 1995), the Parquet-Reynaud report (Parquet 1997) and the Roques report (Roques 1998). These reports provided the

[216] Décret n°92-590 du 29 juin 1992 relatif aux centres spécialisés de soins aux toxicomanes (NOR SANP9201106D).

foundation for addiction treatment on the one hand and supported the development of a harm reduction policy and the use of opioid substitution treatments, on the other hand.

The territorial coverage of outpatient centres authorised to prescribe methadone, then in 1995 the launch of Subutex®, resulted in repositioning the role of residential treatment centres. These measures, which were crucial to drug addiction treatment, became an option along the treatment path. Moreover, such centres were forced to become medicalised, to accept users receiving substitution therapies, and to work in networks, an aspect reiterated in a memorandum from the *Direction générale de la santé* (National Health Directorate) in 1998[217]. These changes led to the closure of several establishments, especially those functioning collectively, since such structures could not become medicalised and received little support from the authorities, who were busy establishing access to substitution therapies and harm reduction measures. Moreover, some people believed that substitution therapies would render these specialised programmes useless. Nevertheless, professionals regularly question the authorities about the need not only to maintain, but also to develop, the capacity for residential treatment programmes. It was quickly observed however, that although substitution therapies considerably improved the situation for drug users, medication alone does not resolve the complex and intricate medical, psychological and social problems inherent in many addictions. At the same time, drug use or practices had changed, and the use of cocaine (crack included) had risen. The polydrug use, including alcohol, had become the norm. For these more complex addiction forms, the services available in outpatient centres or in primary care settings seemed insufficient.

In order to improve the stability of these programmes, for which funding was instable, they were integrated into the medico-social sector in 2002[218]. This sector is not funded by the government, but rather, by the French national health insurance system. These centres then became known as CSAPAs and their missions were clarified in 2008[219].

It was not until 2006[220] that public policy relaunched the creation of residential treatment centres through the establishment of therapeutic communities. Changes in drug use habits, the need to offer longer stays (up to two years) for very socially isolated users coupled with the desire to rebalance therapeutic options, resulted in the drawing up of specifications or working guidelines for therapeutic communities. In particular, support for abstinence and socio-professional rehabilitation was proposed. Seven therapeutic communities with 35 beds opened their doors between 2006 and 2011, bringing the total number of community establishments to 10.

During this time, the ‘housing group’ of the addiction commission[221] of the French Ministry of Health examined housing needs and pointed out the difficulties encountered by certain populations in gaining access to therapeutic housing: women with or without children, convicts released from prison, young drug users, elderly drug users, people suffering from psychiatric comorbidities, people suffering from cognitive disorders related to neurological deterioration and “active” users, who were typically refused by the majority of medico-social and social programmes.

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[217] Note de service DGS/SP3 n°98-659 du 5 novembre 1998 relative à la révision des projets thérapeutiques des centres spécialisés de soins aux toxicomanes (NOR MESP9830471N).

[218] Loi n°2002-2 du 2 janvier 2002 rénovant l'action sociale et médico-sociale (NOR MESX0000158L).

[219] Circulaire DGS/MC2 n°2008-79 du 28 février 2008 relative à la mise en place des centres de soins, d'accompagnement et de prévention en addictologie et à la mise en place des schémas régionaux médico-sociaux d'addictologie (NOR SJSP0830130C).

[220] Circulaire DGS/MILDT/SD6B n°2006-462 du 24 octobre 2006 relative à la mise en place des communautés thérapeutiques (NOR SANP0630464C).

[221] http://www.sante.gouv.fr/commission-addictions.html

To take these unmet needs into consideration, the authorities launched calls for projects for certain of these groups, particularly women and convicts released from prison. Furthermore, residential programmes for active users began on an experimental basis.

Alcohol rehabilitation

“Modern” residential alcoholism treatment programmes developed shortly after the end of the Second World War: The first French alcoholism rehabilitation centre was founded in Alsace in 1932 at Château Walk. It was based on the therapeutic farm model. Inspired by this model, the 1950s saw the launch of several establishments. Some of these sites operated from within the healthcare sector and others from within associations in the social sector (rehabilitation homes), and opened gradually as projects and opportunities arose.

These two programme types, i.e., health and social, developed for alcoholics primarily during the 1960s and 1970s. Their treatment approaches were very similar, despite their different funding methods, since public policy was not well established in the area at that time.

The hospital reform act[222], and then the SSR (*soins de suite et de réadaption*, or rehabilitation) decree of 17 April 2008[223] modified these establishments, which were formerly medium-stay hospitals, transforming them into *Soins de suite et de réadaption en addictologie* (SSRAs, or addiction follow-up and rehabilitation centres).

This journey back in time highlights the current issues: SSRAs are still tethered to the healthcare system, residential CSAPAs remain embedded within the medico-social sector and addiction CHRS centres (*Centres d’hébergement et de réinsertion sociale*, or social housing centres) appear to be the passing fancies of history.

11.1.2. Residential treatment strategies and regulatory frameworks

Since initial legislation, public policies have remained focused on residential treatment measures for drug users. However, the missions of such measures have evolved over time to take into account changes in needs and the development of knowledge on the one hand and developments in available treatments and the subsequent diversity of residential treatment modalities, on the other hand.

Hence, the 1992 decree stipulated that outpatient and residential centres were required to offer at least: 1) medical and psychological treatment for drug addicts, and 2) drug addiction social support and education, which comprises social integration and rehabilitation services. This created a significant challenge for project sponsors.

The 14 May 2007 decree[224] regarding the missions of CSAPAs required these centres to be more specific regarding their missions:

1) “Admit, inform, provide the medical, psychological and social assessment of the person and guide the person and the person’s family or circle

[222] Loi n°91-748 du 31 juillet 1991 portant réforme hospitalière (NOR SPSX9000155L).
[223] Décret n°2008-377 du 17 avril 2008 relatif aux conditions d'implantation applicables à l'activité de soins de suite et de réadaptation (NOR SJSH0803309D).
[224] Décret n°2007-877 du 14 mai 2007 relatif aux missions des centres de soins, d'accompagnement et de prévention en addictologie (NOR SANP0721630D).

2) Reduce the risks associated with the use of psychoactive substances

3) Provide medical, psychological, social and educational elements in the patient's treatment programme. The mission includes diagnosing, providing healthcare services, ensuring access to entitlements and offering assistance in social integration or rehabilitation. The centres provide withdrawal facilities and support. They also prescribe and monitor medical treatments, including opioid substitution treatments."

The decree also stipulates that the team must be multidisciplinary and placed under the supervision of a director. A physician must be responsible for the medical activities performed.

Therapeutic communities, whose missions are stipulated in the 24 October 2006 circular regarding the implementation of therapeutic communities more oriented to abstinence, are exempt from the need to obtain prescriptions for the substitution therapies they provide.

Appendix 5 of the circular of 28 February 2008 regarding the implementation of the CSAPAs and the implementation of regional medico-social addiction programmes defines the various authorised residential programmes which are grouped according to duration of stay:

- Short-stay (under 3 months), pertains mainly to emergency and transition structures

- Medium- and long-term stays, pertain to therapeutic apartments (stays of no longer than 12 months, stays can be renewed once), residential therapeutic centres (stays of no longer than 12 months), foster families ("from several days to several months") and therapeutic communities (12 to 24 months at most).

The recommended staff-to-patient ratios are only indicated for therapeutic communities. They must not exceed 0.5 to 1.

11.2. Availability and characteristics

11.2.1. Establishment types and characteristics

As CSAPAs, the following establishments are forced to undertake certain missions set forth by the 28 February 2008 circular. These missions include:

- Admitting: this mission entails opening the doors to any person who comes to or contacts the CSAPA, whether that person is the care seeker or a member of the care seeker's family circle. It involves listening, establishing initial contact to create the foundations for a relationship and providing initial responses to the demands and needs of people. Simply making an appointment does not constitute "admission".

- Informing: written or oral, information must be supported by leaflets or brochures and explained, whether this information concerns the user's rights or the treatment modalities.

- Providing medical, psychological and social assessments: this mission comprises assessing the needs of the patient and the patient's family circle. For patients, this involves determining their level of use, their social situation and any related difficulties in order to offer patients the treatment that is most appropriate for their needs. For the family circle, this means mainly assessing the psychological and social effects of the addictive practices of the person on the family circle, as well as the family circle's needs in terms of support and assistance.

The circular also outlines the content of certain, mandatory missions:

- Medical treatment, which comprises:
    - assessing the medico-psychological dimension of addiction
    - looking for somatic and psychiatric comorbidities
    - proposing different treatment protocols, including treatment for the withdrawal states inherent to addiction and for comorbidities
    - proposing therapeutic withdrawal, and if not directly provided by the centre, the CSAPA must accompany the patients.
    - considering the patient's health in a broader sense and not just from an absence of illness point of view
    - as part of their medical treatment offer, CSAPAs must provide prescriptions for all opioid substitution treatments (OST) and issue initial methadone prescriptions, as well as all other medications necessary for treatment.
- Psychological treatment: this is based on assessing the psychological dimension of use and addiction, and complements the medical assessment. It comprises psychological monitoring and support appropriate to the situation and the user's needs. It must provide for the possibility of referring users to psychiatric services in the event that psychiatric comorbidities are revealed.
- Social and educational management: it consists of socio-educational support to help the patient gain or regain independence so that therapeutic treatment can ensue. More precisely, it encompasses support to recover social entitlements and actions or referrals aimed at social rehabilitation.
- Harm reduction: its purpose is not only to limit the health and social risks related to psychoactive substance use, but also to contribute to the treatment process and to the maintenance and restoration of social ties. Any person treated by a CSAPA should be able to benefit from group information sessions and/or customised health education counselling (e.g., in hygiene, infection and overdose prevention). They are accompanied throughout their treatment and aided in the design and implementation of a customised harm reduction strategy.

These different missions are distributed among the establishments that shall be described below, in more or less detail, depending on the establishment's nature and project.

Transition and emergency housing structures:

Sleep-ins

Individual or collective (134 beds funded in 2001, source DGS – the National Health Directorate)

This "Sleep-in" programme offers housing at night for users awaiting treatment or requiring temporary shelter. They mainly target people with significant social difficulties, one of their aims being to help users rebuild social ties. The nighttime accommodation is followed up by consultations during the day with a social worker, a physician, a nurse, a legal counsellor and a host in order to advise, monitor, refer and support people in terms of medical, paramedical, social and legal needs.

Quick treatment and short stay centres

There are four of these centres, which accept drug or alcohol users and multi-relapsers as soon as they are released from custody. The recent opening of these establishments, which resulted from the transformation of CSAPAs with an existing residential capacity, illustrates the willingness of the authorities to orient a portion of the residential programmes towards the most excluded populations. Stays, which are limited to three months, offer intensive treatment to support ex-convicts in devising a care or rehabilitation plan. These centres focus on rehabilitating former detainees to help them reintegrate into a non-prison environment, to prevent relapse and to involve them with treatment and rehabilitation networks.

Individual housing:

Therapeutic/follow-up apartments:

This is a type of therapeutic housing in individual or shared apartments. Residents receive intense support from a multidisciplinary team. The therapeutic apartments available to users represent rehabilitative or maintenance support for a care plan based on outpatient assistance. They prepare residents for access to a social integration programme or, whenever possible, for direct access to a self-financed individual apartment.

Regular, mandatory meetings with team members are organized either at the reception centre or in the apartment. Some services accept couples and even people with children. For people with children, the parents must not have had parental custody removed. Participation in housing costs is often requested. This participation is comprised of a fraction of the income of the resident. If necessary, the implementation of the social assistance that helps fund this participation helps prepare the resident for paying real rental fees.

The maximal duration of stay has been extended to two years to take into consideration the difficulty residents have in gaining access to independent housing when leaving these programmes.

These programmes are accessible either directly or upon discharge from a group residential treatment programme. For people discharged from a group programme, therapeutic apartments enable people receiving treatment to try out living conditions that are closer to independent conditions while maintaining significant professional support. Users can enter directly into a therapeutic apartment if group housing is contraindicated (for people accompanied by children or couples, for example). This support, which implies regular visits to the apartment by professionals and appointments in the reception centre, targets social aspects to facilitate apartment upkeep, budget management, time management and craving management, and to

prevent re-use so that it does not turn into a fully-fledged relapse. Medico-psychological support is systematically provided within the scope of this residential model.

According to the most recent data available, in 2008, 58 CSAPAs managed[225] therapeutic apartments that overall represented 488 beds.

Foster families:

These are families that agree to host, for several days, weeks or months, a person referred to them by a specialised centre (one must be referred). They offer a lifestyle punctuated by family life in a friendly environment that fosters contact.

All families are selected by the specialised centres and are reimbursed for the expenses generated by the extra person in the household. Foster family networks are often located away from cities (in big cities, people rarely have a spare room to host someone).

They are particularly beneficial for people who need structure (and who know how to respect it), but who do not want to live in a group or an environment that is too institutional. The person being hosted is still followed by the treatment centre and the family is supported by a social worker with whom the family can discuss any problems encountered.

The development of these networks is limited by the difficulties encountered in recruiting motivated families and, beyond expense reimbursement, by the issue of remunerating families.

In 2008, six CSAPAs managed a foster-family network offering 47 beds.

Group housing

Centres thérapeutiques résidentiels (CTRs, or Residential treatment centres)

Residential treatment centres offer all the same services as CSAPAs, but within a group or fragmented residential framework. They aim to promote a dynamic of change in users, and to support this change through a therapeutic programme that may vary from one establishment to another. They are suggested when outpatient or individual programmes appear to be insufficient due to a deteriorated environment, somatic or psychiatric comorbidities or heavy social problems that prevent the person from fully benefitting from treatment, or when the person needs a secure, protective environment without needing hospitalisation.

Located in either an urban or a rural setting, residential treatment solutions provide a safe, drug-free environment. The activities offered aim to restore a rhythm to daily life and the ability to form satisfactory relationships for the person. They also promote the development of personal skills to prevent relapse. These establishments help implement life plans that include treatment.

These residential programmes offer a constant professional presence and generally provide psychological support (individual and/or group), psycho-educational support, medical support and rehabilitative social support. They must also be in contact with medical and psychiatric services and rehabilitative services as well as have access to housing to cater to the needs of patients.

[225] In France, therapeutic apartments are not independent units from a legal and budgetary point of view; they are generally supervised by an outpatient CSAPA and represent one of the services provided by the CSAPA.

Daily life entails therapeutic activities (individual and group meetings) and rehabilitative group activities. These activities may take place inside or outside of the establishment. After a while, it is often possible for patients to once again begin a professional activity while maintaining their housing and support. The family environment can be taken into consideration in order to prepare for a return to the family setting or enlist parenting support.

The duration of residential treatment, statutorily set at one year maximum, must take into consideration the time required for the patient to acquire sufficient autonomy in order to integrate into a more open treatment setting (such as therapeutic apartments and outpatient treatment centres) or towards social and/or professional rehabilitation. Receiving therapy in a residential treatment centre can be anonymous[226], if the user so desires, and is free of charge to the user (funded by French national health insurance).

Certain residential treatment centres cater to specific populations: two establishments in France are especially designed to treat minors, and some have sections for women with children. Only one establishment employs the Minnesota model, working cooperatively with Alcoholics Anonymous and Narcotics Anonymous networks.

In 2008, 35 residential therapeutic centres offered a total of 440 housing spots. Approximately 1,500 patients were housed in these centres in 2008.

Therapeutic communities:

Therapeutic communities are defined as long-term residential centres open to people who are addicted to opiates, stimulants, alcohol or multiple drugs. These communities provide a safe, drug-free environment of community living with drug addicts who are more advanced in their rehabilitation process. These peers can provide support by acting as positive role models and by using positive peer pressure to help addicts rebuild their lives. This approach aims to help residents develop their ability to manage their stress and distress without using drugs, to regain self-confidence and to gradually move forward towards independence and resocialisation by taking on greater responsibilities.

These programmes currently cater to patients who are too difficult to be able to reap the long-term benefits of outpatient or "short-stay" residential treatment programmes: these difficult patients may have experienced numerous failed treatment attempts and/or be suffering from psychiatric disturbances or significant social isolation.

French therapeutic communities take the environment into consideration and represent a treatment method that complements existing measures. Less rigid than their Anglo-Saxon counterparts, therapeutic communities offer support to those drug users wishing to achieve abstinence, when medically possible. Given the frequent psychiatric comorbidities, psychiatric treatments can be pursued.

Therapeutic communities function based on four main principles:

- Organization of time: the stay is organized into phases of varying duration depending on the progress a person makes in managing the tasks entrusted to them, their relationship with peers and the supervising personnel and their ability to manage any “cravings”. Days are also structured into different therapeutic and/or organizational activities.

[226] This anonymity is possible as the result of the criminalization of use.

- The group: it is hypothesised that the group can resolve problems that arise while working and living together. The group is called upon to use mutual aid to provide support for each member. Most of the therapeutic activities are based on group situations (group therapy sessions of varying types).

- The emotional approach: this approach helps group members to express emotions they feel "here and now", thereby facilitating emotional control and conflict resolution.

- Assuming responsibility: as users progress along their treatment path, they take on more responsibilities, whether this means helping users who are less advanced in their treatment or taking part in community decision-making.

Communities can also make use of workshops (such as occupational therapy) or rehabilitation services (government "*chantiers d'insertion*", or government certified occupational rehabilitation programmes that provide remuneration for participants). Therapeutic communities have both a cognitive-behavioural and a psychodynamic approach. They can work to develop specific programmes (e.g., relapse prevention, femininity) that are appropriate to their population. They undergo a special assessment process. There is a new therapeutic community being opened, and it is specifically intended for women with children.

In 2008, there were six therapeutic communities, which together had a 200-bed capacity. Since 2008, four new therapeutic communities have been launched. The total housing capacity of these therapeutic communities in 2012 is 350 beds.

Duration of stay and reasons for patients leaving residential treatment centres and therapeutic communities

In 2008, the patients living in residential therapeutic centres or therapeutic communities were mainly managed by specialised educators or activity leaders (56% of procedures) and by nursing personnel (33% of procedures). General practitioners, psychiatrics and psychologists carried out 22% of the procedures.

The average duration of stay in these centres in 2008 was approximately 100 days. For a little more than half of those patients who completed a stay in 2008, the duration was one to three months long, and for slightly over one quarter, the stay was three to six months long. Nearly one out of every five patients stayed for over six months. Approximately one out of every four patients completed their stay on the date that had been scheduled with the treatment personnel. Nearly one out of every 10 patients was referred to a structure considered more appropriate to their situation. Approximately two out of every 10 patients were expelled by the treatment centre and nearly three out of every 10 patients left the centre early of their own accord.

These data mainly depict the situation in residential therapeutic centres since there are many more such centres than there are therapeutic communities. Therefore, the figures do not illustrate the specificities of the latter type of residential programme, especially since such structures were only recently created and still under development at the moment the data was gathered.

CHRS Addiction centres (Centres d'hébergement et de réinsertion sociale)

As was previously mentioned, CHRS centres arose during an era when the authorities had just begun to consider treatment for people suffering from addictions. These CHRS centres (social housing centres) mainly receive people having trouble with alcohol, and most such centres aim

to become SSRs (*Soins de suite et de réadaption*, or follow-up and rehabilitation centres) or CSAPAs. With a view to implementing addiction treatment for alcohol and illegal drugs, some of these centres are gradually opening up to illegal drug users.

The missions of the addiction-oriented *Centres d'hébergement et de réinsertion sociale* (CHRS) are:

- to admit any person presenting with an addiction to single or multiple substances and seeking to abstain from use
- to admit mothers with children and pregnant women within the scope of preventing foetal alcohol syndrome
- to provide these people with support for quality social integration with consideration for the somatic, psychological and social aspects
- to continue providing such support within the framework of follow-up care.

There are 11 CHRS centres originally geared towards alcoholics, representing some 448 beds (source: FNESAA-COPAAH). The way they function is very similar to CSAPAs with housing.

Some CHRS centres plan to eventually become CSAPAs with housing, residential treatment centres or therapeutic apartments.

Health

Follow-up rehabilitation treatment programmes

Originally alcohol treatment centres, these centres are gradually opening up to other addictions. *Services de soins de suite et de réadaptation en addictologie* (SSRAs or Addiction follow-up care and rehabilitation) aim to prevent or limit the functional, physical, cognitive, psychological and social effects of people with addictions to psychoactive substances and to promote their rehabilitation.

The treatment targets achieving abstinence, preventing relapses and avoiding the risks related to substance use. In addition to providing medical care, such programmes ensure individual and group psychotherapy and a socio-educational programme intended to promote social rehabilitation.

Based on the complications and deficiencies caused by addictions, these measures can specifically target managing somatic complications, psychological or psychiatric disturbances and neurological or cognitive deficits as well as promoting social rehabilitation.

SSRAs are just one of the components of hospital-based addiction structures. They host patients who severely abuse and who are often dependent after withdrawal, or patients who have undergone complex residential treatment.

The areas of expertise of SSRAs include addiction to psychoactive substances, which may or may not be associated with other behavioural addictions.

There are currently 70 addiction follow-up and rehabilitation services, with a total capacity of 2,305 beds. Until 2010, these services almost exclusively treated patients with alcohol problems.

11.2.2. Methods of intervention

Operating in a network

Establishments are encouraged to enter into agreements with partners who are crucial to their activities. Subsequently, there are agreements with outpatient CSAPAs to ensure subsequent treatment, with hospital addiction services to provide the support needed for simple and complex withdrawal, with medical and psychiatric services to provide better management for people with dual diagnoses, with child welfare services when residents are minors, with CAARUDS to provide support for any relapses and harm reduction or to take part in a CSAPA harm reduction mission, or with prison administrative staff for residential programmes open to convicts.

In all cases, stays in residential establishments are designed to be a step in the treatment process, allowing patients to become aware of the totality of treatment options available to them.

Since the causes of addictions are multifactorial, the related treatments usually involve several approaches: pharmacotherapies, psychotherapies, physical therapies and rehabilitative assistance. It is the combination of these approaches, which are all of interest, as well as the concurrent observations by different professionals, that seems relevant.

11.3. Quality management

All CSAPAs and therapeutic communities are medico-social establishments and are therefore regulated by French law no. 2002-2, which stipulates the assessment modalities for establishments and imposes a certain number of standards and tools, especially with respect to user representation.

In particular, each establishment must:

- have a brochure that presents the establishment
- have policies and procedures
- establish a residential contract or individual treatment document with each user
- inform users of their rights and their possibilities for recourse
- display the charter for residents in the establishment
- organize a “Council for social life”. This acts as a body through which users of the establishment can express themselves; the Council should also have members from outside of the establishment.

Furthermore, each establishment must have an establishment plan validated by the inspection authority and be part of a quality improvement process, which implies the establishment of regular internal and external assessments. Such assessments must occur before the renewal of the authorisation to operate.

11.3.1. Availability of the framework and standards

The *Agence nationale de l'évaluation et de la qualité des établissements et services médico-sociaux* (ANESM, National agency for the assessment and quality of social and medico-social establishments and services) produces frameworks[227] with which establishments must comply as well as good practice guidelines.

Some guidelines apply to all of the medico-social establishments, such as "*bientraitance*" (Welfare: definition and references for implementation)[228], or those related to the internal and external assessment of establishments[229]. Others are more specific, such as "*la participation des usagers dans les établissements médico-sociaux relevant de l'addictologie*" (The participation of users in addiction-based medico-social establishments) (ANESM 2010).

La Fédération addiction, an NGO that groups the majority of addiction medico-social establishments, prepares good practice guidelines for CSAPAs with housing using the support of the authorities and an approach that incorporates the participation of all relevant establishments[230].

National and local frameworks

La Fédération addiction has also developed a framework for its members[231], to support them in performing self-assessments. It helps analyse the different operational areas in establishments:

- Appropriateness of the response to the needs of the population
- Partnerships and the place in the environment
- Compliance with the rights and duties of the users and their participation
- Management of human resources
- Administrative and financial management
- First contact
- Information
- Medical, psychological and social assessment, orientation

[227] The complete list of ANESM frameworks is available on the Internet: http://www.anesm.sante.gouv.fr/spip.php?page=rubrique&id_rubrique=10

[228] Agence nationale de l'évaluation et de la qualité des établissements et services médico-sociaux. La bientraitance : définition et repères pour la mise en œuvre (Welfare: definition and targets for action), Saint Denis, ANESM, 2008, 47 p.: http://www.anesm.sante.gouv.fr/spip.php?page=article&id_article=128

[229] *Fédération nationale des associations d'accueil et de réinsertion sociale*. *Évaluations internes et externes* (French federation of treatment and social rehabilitation, Internal and External Assessments). Summary sheets written from experience with the FNARS network, Paris, FNARS, 2010, 95 p :http://www.fnars.org/index.php/ressources-documentaires-evaluation/125-ressources-documentaires/2371-un-outil-pour-le-reseau-fnars

[230] *Fédération addiction*. *Guide méthodologique* "*Mener l'évaluation interne* : *pas de panique*!" (Methodology guide, "Conducting internal assessments: don't panic!"), 2008: http://www.federationaddiction.fr/guide-methodologique-mener-levaluation-interne-pas-de-panique/

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- Support
- Harm reduction
- Housing and methods.

Other frameworks that integrate the ANESM's directives were created, sometimes by the establishments themselves and sometimes by groups of establishments.

Results, documentation and assessment

Each establishment is required to submit an activity annual report to the territorial delegation of its regional health agency. However, the diversity of the populations seen and the modes of operation for the establishments (do they accept users with severe psychiatric comorbidities? unstable users? etc.) makes it difficult to globally assess their results, which do not take into consideration the baseline situation of users.

It is appropriate to point out that the most recent calls for projects (e.g., therapeutic communities, mother and child housing, persons just released from prison) incorporated the need to implement an assessment procedure into their specifications for these measures.

Relationships between funding and reporting

The report submitted each year to the territorial delegation of the regional health agency puts into perspective the use of the budget that was allocated and the activity of the establishment.

Moreover, a national system for information collection has been in place since 2005. This system is called "RECAP" (*Recueil commun sur les addictions et les prises en charge*, or Common Data Collection on Addictions and Treatments), and it provides an analysis of the major trends in populations and use. This knowledge helps guide the activity of establishments and authorities whenever necessary.

11.4. Discussion and perspectives

11.4.1. Trends in demand for access to treatments in the last decade

The last decade was characterised by several striking events. We will mention three here that had an impact on the development of residential treatment measures.

The first is the advent of the treatment of addictions, which groups problems with alcohol, tobacco, illegal drugs and non-substance related addictions all under the same heading. The distinct histories of these areas have left traces that are fading very slowly: the sector of alcohol addiction treatment, which was primarily managed in the hospital sector, is gradually opening up to illegal drugs, but the needs for alcohol addiction treatment remain tremendous. CSAPAs with housing still mainly accept illegal drug users, but are also open to alcohol users since alcohol is often the last substance used after the use of other substances has stopped. Nevertheless, the residential treatment of illegal drug users occupies a less central place than before since the possibilities for outpatient treatment have largely developed, particularly since the launch of effective substitution treatments. Outpatient CSAPAs have medico-social technical platforms that provide long-term support for drug users. Many physicians in private practice are also

involved, since they can treat many addictions through networks as long as the addictions do not present with significant complications.

The second significant event was the change in use habits, with the use of cocaine, and crack in particular, moving to centre stage. This led to a rethinking of treatment models, which up until then had essentially catered to heroin addicts. However, cocaine use also revealed “festive” use, particularly of psychostimulants, which sometimes got out of hand and required strong support. Users are also of different ages. There are still numerous young users, but there are also older users confronted with significant health problems for which professional rehabilitation no longer seems appropriate.

The third significant event to take into consideration is the economic crisis, which has made already-vulnerable populations even more susceptible: homeless young people and elderly people, ex-convicts, women, and especially women with children, sick people, particularly HIV- or HCV-infected people, and foreigners whose papers are not in order.

This difficult context has been evidenced through a major change in the place and operation of residential solutions: previously a solution of first resort, they are now part of a treatment course with a network of partners both upstream and downstream. They are becoming more technical, proposing complex treatment programmes including pharmacotherapies, psychotherapies and sociotherapies, and address populations requiring more resources, since residential solutions cater to heavier cases. Since the 2006 launch of therapeutic communities, some of these populations, which are often those furthest from integration, have been helped. However, there are still significant, and sometimes unmet, needs, as was shown in two surveys (Coquelin *et al.* 2009; Palle Non publié) conducted within the scope of a "housing" working group of the addiction commission of the French Ministry of Health. The surveys revealed the need to develop diverse responses to meet the therapeutic housing needs of drug users.

At the confluence of the health and social sectors, medico-social residential establishments must nevertheless take current trends into consideration: the development of health responses, and follow-up and rehabilitation services in particular, on the one hand and the “radical reform” of the social sector on the other hand, with experiments that aim to achieve unconditional housing access (“Housing first”).

This leads to a continuation of the effort in several directions: on the one hand, it is necessary to work to improve the acceptance of people suffering from addictions through “common law” measures to open up the field of housing and integration. On the other hand, it is necessary to continue developing residential measures for "over-excluded" populations, i.e., those who cannot directly access health, social and medico-social programmes, by including them in large partnership networks. Finally, it will be necessary to continue efforts to identify profiles of users who could benefit from the different residential structures so that these users can be better oriented.

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