

# Treatment workbook

## 2021

*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 2020, just over 45 700 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 (69%), the total number of people starting treatment at the CSAPA could be in the range of 66 000.

The total number of people cared for in a CSAPA during the year because of their use of illicit drugs or psychotropic medicines diverted from their therapeutic use, which also includes people already receiving treatment last year, is 137 000 according to the latest available data going back to 2019<sup>1</sup>.

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 pharmacies <sup>2</sup>. Almost 22 000 received treatment dispensed in a CSAPA in 2017.

Data 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.

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<sup>1</sup> 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.

<sup>2</sup> 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.

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, the number of people receiving care (in-person or remotely) for the first time in their lives in the specialised addiction treatment service, which had changed little between 2015 and 2019, fell by almost 30% in 2020. The numbers recorded have decreased for all substances involved, but the decrease is more pronounced for cannabis (-32%) than for opioids (-22%) and cocaine (-27%). The health crisis thus had a particularly strong impact on the first treatment requests. Part of this decrease could be linked to a lower registration of persons in care due to the more difficult reception conditions during the health crisis. However, this lack of registration would explain only a small part of the decrease in numbers.

The number of all users entering treatment (in constant terms) is also falling, but less sharply: the drop is almost 22% overall, and 26% where cannabis is concerned, 16% for opioids and 20% for cocaine.

The differentiated developments in the number of people involved according to the product result in an increase in the share of treatment for opioids of almost 2 points between 2019 and 2020 and an almost equal decrease in the share of treatment for cannabis. The share of cocaine remained stable.

Furthermore, the number of persons receiving opioid substitution treatment (OST) has remained stable between 2013 and 2018, 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.

## 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). 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.

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 demand<sup>3</sup>: the information relating to this type of facility are detailed in the "Harms and harm reduction" workbook.

#### *The general scheme*

In 2017, independent prescribers of opioid substitution medications predominantly correspond to general practitioners (96.2%) and, more rarely, psychiatrists (3.2%) (Brisacier 2019). In the absence of a recent survey on the activity of general practitioners in the field of addiction, the number of people treated for an illicit drug use problem is based solely on prescriptions for opioid substitution treatments. Opioid users in need of such treatment represent the bulk of the patients monitored by general practitioners for illicit drug addiction problems. The total number of people seen for these reasons is however higher. The number of drug users seen by general practitioners, estimated on the basis of reimbursements for OST prescriptions, was 132 000 in 2017. Within the context of primary care, an original system of care for drug users, known as a microstructure, has been developed in France for over 15 years. At the end of 2020, 70 addiction treatment medical microstructures had been set up in seven regions and monitored nearly 2 200 people, mobilising the activities of 159 general practitioners, 44 psychologists and 41 social workers. Microstructures have been set up in the following regions: Grand-Est with 29 microstructures, Hauts-de-France (12 microstructures), Provence-Alpes-Côte d'Azur (4 microstructures), Bourgogne-Franche-Comté (8 microstructures), and more recently Occitanie (12 microstructures), Ile-de-France (4 microstructures), and Nouvelle Aquitaine (1 microstructure) (CNRMS 2021). A national micro-structure network coordination scheme was created in 2006.

The 2018 Budget Act provided for the encouragement of innovative health projects (Article 51). In this context, projects to strengthen and extend microstructures (Equip'Addict) have been set up in six of the seven regions where microstructures are located (excluding Nouvelle-Aquitaine). In addition, still in the same framework, a project starting in 2021 (Post COVID medical

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<sup>3</sup> 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](https://www.emcdda.europa.eu/publications/manuals/tdi-protocol-3.0_en).

microstructures), aims to strengthen microstructures in the same six regions to enable them to provide care for vulnerable patients involving psychiatrists and mental health stakeholders (Ministère des Solidarités et de la Santé 2021).

Illegal drug users may also be treated in an outpatient setting at numerous addiction medicine clinics created in general hospitals and psychiatric clinics (see T.1.2.1 of the 2020 ‘Treatment’ workbook).

### 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 45 717 patients being recorded in 2020, almost all in outpatient CSAPAs. However, only 69 % of the CSAPA participated in collecting this data in 2020. 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 in 2020 in outpatient CSAPAs would then be about 66 000.

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 longer delay than for the TDI data and only data from 2019 is available for this report. During that year, according to this comprehensive source, 137 000<sup>4</sup> people have been monitored for a problem of illicit drug use in the CSAPA.

In 2019, the 11 CSAPA in a prison setting having contributed data on the number of patients claimed to have treated approximately 5 000 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 2019, 187 outpatient 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 16 500. These figures are, however, partly included in the 137 000 drug-treatment clients in outpatient CSAPA.

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

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

	<b>Total number of units</b>	<b>National Definition</b> (Characteristics/Types of centre)	<b>Total number of clients</b>
<b>Specialised drug treatment centres (CSAPA)</b>	374	Drug users having been seen at least once in the year as part of a meeting (face to face or online) 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).	137 000

<sup>4</sup> 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.

	<b>Total number of units</b>	<b>National Definition</b> (Characteristics/Types of centre)	<b>Total number of clients</b>
<b>Low-threshold agencies focused on harm reduction approaches (CAARUD)</b>	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
<b>Système de soins général (ex. médecins généralistes)</b>	30 000	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.	132 000
<b>General mental health care</b>			
<b>Prisons: CSAPA in prison settings</b>	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.	5 000
<b>Other outpatient units</b>			

**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 (45 700 individuals in 2020), 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)*

In 2019, 39 % of CSAPA are managed by public hospitals or public medical centres and 61% 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	39%	61%			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 for users of illicit drugs or psychotropic medicines diverted from their therapeutic use can take place in 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 in French) (see 2020 ‘Treatment’ workbook). There were 36 CTR in 2019. In addition to these institutions, 10 therapeutic communities (TC) also exist. CSAPA with housing, as well as those in an outpatient setting, may offer housing services in residential therapeutic apartments (ATR in French), for stays of not more than two years. In 2019, at least 63 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 2019, there were 7 CSAPA offering this kind of service.

#### *Residential care in hospitals*

In almost all cases, public hospitals have inpatient beds for withdrawal, sometimes offering aftercare activities (follow-up and rehabilitation care or SSR in French) including addiction medicine (see T.1.2.6 of the 2020 ‘Treatment’ workbook). A very large number of hospitals are equipped with ELSAs (addiction liaison and treatment teams), 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 almost 2 000 in 2019. Around 900 individuals were housed in ATR (residential therapeutic apartments) and about 400 were housed in an emergency or transitional facility run by a CSAPA. The overlap with drug users seen in outpatient CSAPA is undoubtedly quite large: a large proportion of the individuals received are, in fact, referred by an outpatient CSAPA and have already been registered in these structures.

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)

	<b>Total number of units</b>	<b>National Definition</b> (Characteristics/Types of centre)	<b>Total number of clients</b>
Hospital-based residential drug treatment	na		na
Residential drug treatment (non-hospital based)	36	Individuals housed in residential treatment centres Residential treatment centres are facilities which combined collective housing and treatment. It carries out the same missions and services as in an outpatient setting. It offers support for customised treatment. 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.	1 400
Therapeutic communities	10	Individuals housed in experimental therapeutic communities. Therapeutic communities are housing facilities which target users dependent on one or more psychoactive substances, aiming for a goal of abstinence, with the specific feature of placing the group at the heart of the therapeutic and social integration project.	550
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).	900
Autres structures résidentielles	7	Individuals in emergency or transitional accommodation. 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).	400

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)

No change – see the 2020 ‘Treatment’ workbook.

**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?

#### **Summary of data on patients in treatment and proportion of treatment demands by primary drugs**

In 2020, 45 700 drug users treated for a new treatment episode in a CSAPA were included in the TDI data, compared to approximately 54 000 in 2019. The number of CSAPAs reporting TDI data was 266 in 2020 vs 249 in 2019. The drop in the number of people included is therefore not linked to the drop in participation by the CSAPAs in the survey, but to the drop in the number of drug users treated in the CSAPAs and to a lower registration of people treated, both of which are attributable to the health crisis. The drop in the number of people starting treatment among the 239 CSAPAs that submitted data in 2019 and 2020 (in constant terms) is just over 21%.

Nearly 69% 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 66 000 people began an outpatient treatment in 2020. This figure should only be considered as an order of magnitude.

The majority of people start treatment at CSAPA due to their cannabis use (57% in 2020). This share fell by 2 percentage points compared to 2019, as the total number of users starting treatment declined (-26 %) more than the average (in constant terms over the 2015-2020 period). Opioid users make up the second largest group, accounting for just over a quarter of those starting treatment (26% in 2020). Their share is up by 2 points due to a smaller than average decrease (- 16%). The proportion of cocaine users among those starting treatment was 11.8% in 2020, 7.6% of which were powder cocaine users and 4.2% were free base cocaine users. This share has risen slightly (11.5% in 2019), but the number of these users, which had risen sharply in previous years, has fallen by 20% in constant terms, slightly more sharply for powder cocaine (- 21%) than for crack/cocaine-based drugs (-18%). Among users of other products were hypnotics and sedatives (2.5%), other stimulants (1.8%) and non-detailed substances (1.2%).

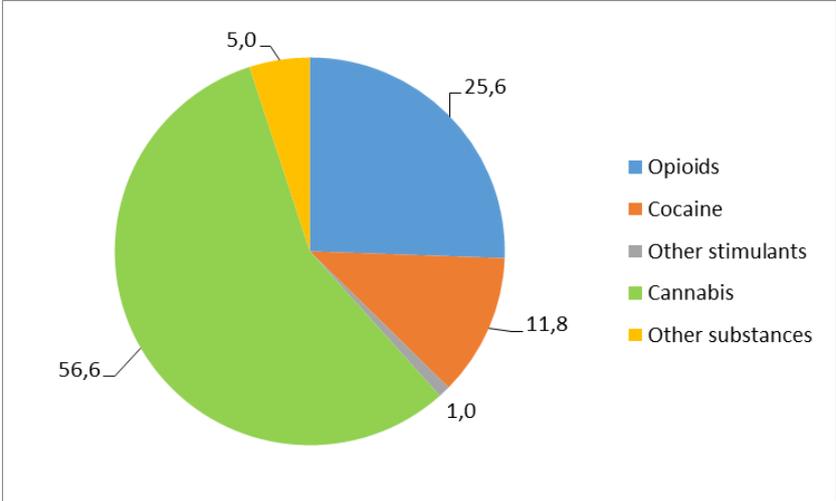
Breakdown by products for individuals starting treatment with a community doctor is likely different from that observed for the CSAPA. Given the role of community doctors in prescribing opioid substitution treatment, it is likely that the share of opiate users is overwhelmingly higher and the share of 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.

**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 an outpatient CSAPA	66 000*

na: not available  
 \*: based on a coverage rate of 69 %  
**Source:** Standard Table 24 and TDI

**Figure I.** Distribution of the number of individuals having started treatment in a CSAPA in 2020, according to the primary drug (variable field), in %



*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 2020 as 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 one of the country with the highest substance use among 16 year-olds (Spilka *et al.* 2021) 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), 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**

(see T1.3.3. of the 2020 'Treatment' workbook)

Registration of treatment requests in the context of the health crisis

As mentioned above, the drop in the number of people included in the TDI statistics in 2020 could be partly linked to a lower registration of people received due to the difficulties in operating the CSAPA during the health crisis. In an attempt to assess the extent of this failure to register, the CSAPAs were asked to indicate in an online questionnaire whether they had been able to register the same proportion of people treated as in the previous year. Of the 126 CSAPAs that completed the questionnaire, 22% responded negatively, i.e. slightly more than one in five. These CSAPAs were then asked to indicate the proportion of people they were unable to register. Of the 25 CSAPAs that answered negatively to the previous question, only 14 CSAPAs provided a figure. On average, of these, the percentage of people who have not been registered is 15%. Assuming that the number of people in care is roughly proportional to the number of CSAPAs (the 22% of CSAPAs provide care to about 22% of the population), the proportion of people in care who are not registered can be estimated at 3 to 4%. The use of remote consultations could be a major reason for the lack of registration. Almost all the CSAPA respondents indicated that they had conducted remote consultations, with the number of people affected varying from 1% to 25% for 41% of the CSAPAs, from 26% to 45% for 32%, from 46% to 65% for 13% and over 65% for 12%. Among the CSAPAs in which remote consultations took place, a large majority (71%) felt that recordings were no less frequent for people treated remotely than for people seen on the CSAPA premises. A quarter of the CSAPAs, most often those which indicated that they had had difficulties in registering all the

people they treated, consider, however, that the lack of registration is more frequent with remote consultations than in face-to-face consultations.

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

No change - see T1.4.1 of the 2020 'Treatment' workbook.

**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 - No change - see T1.4.3 of the 2020 'Treatment' workbook.**

**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)

No change - see T1.4.5 of the 2020 'Treatment' workbook.

Senior drug users (>40years old):

NPS users:

Recent undocumented migrants (asylum seekers and refugees):

Women:

Other target groups:

*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**  
No change - see T1.4.6 of the 2020 'Treatment' workbook.

*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)

**OST delivery systems** - No change - see T1.4.9 of the 2020 'Treatment' workbook

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.

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

In March 2021, the HAS issued a favourable opinion for the reimbursement of the speciality BUVIDAL<sup>®</sup> from MEDIPHA SANTE laboratories to treat opiate dependence in adults and adolescents aged 16 and over. BUVIDAL<sup>®</sup> is a subcutaneous sustained-release buprenorphine injection with weekly or monthly injections. The product has 7 different strengths (128 mg, 96 mg, 64 mg, 32 mg, 24 mg, 16 mg, 8 mg). Its prescription is reserved for hospital doctors and doctors working in CSAPAs. BUVIDAL<sup>®</sup> must be administered by a healthcare professional.

According to data from the national public health insurance centre (CNAM) collected from the EGBS database (simplified General sample of beneficiaries, sample of French persons with social security coverage), 161 400 individuals were reimbursed for opioid substitution medications dispensed in community pharmacies in 2018 (revised estimation taking into account the EGBS extrapolation coefficient and the representativeness of the EGBS evaluated at 95.6% of the population covered by the Social Security scheme). The number of people receiving opioid substitution treatment (OST), having risen constantly since it was first introduced in 1995, has remained stable since 2013. More than three-quarters of individuals reimbursed for opioid substitution medications are male. More specifically, in 2018, 96 300 individuals were dispensed buprenorphine (Subutex<sup>®</sup>, generics or Orobupré<sup>®</sup>), 63 400 methadone and 7 300 buprenorphine in combination with naloxone (Suboxone<sup>®</sup> or generics).

Furthermore, 22 900 patients were dispensed opioid substitution medications in a CSAPA setting (19 100 methadone and 3 800 buprenorphine) in 2019, among the 51 900 patients followed up in a CSAPA setting and receiving OST 36 900 with methadone and 15 000 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).

### *Buprenorphine misuse and trafficking*

Some of the buprenorphine prescribed is misused and is not taken as part of a treatment programme (see T.4.10 of the 2020 'Treatment' workbook). Among CAARUD clients (2019 ENA-CAARUD survey), oral use (57%) was the most common route of administration for buprenorphine in 2019, ahead of injection (38%) which was the most widespread consumption pattern up to 2012. Oral use is on the increase, in contrast to injection which declined strongly between 2015 and 2019. Snorting, less common (18%), after a marked increase between 2008 and 2012, showed a downward trend since 2015. Inhalation or smoking consumption patterns, although in the minority (10%), 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* – see the 2020 'Treatment' workbook

### *Substitution treatment in prison settings*

Among prisoners, the share of OST recipients in 2018 is 7%, or about 12 900 people; it is decreasing after a period of stability between 2013 and 2017. The share of methadone is increasing (47.4% in 2018 vs 42.8% in 2017 and 15.2% in 1998) while that of buprenorphine alone is decreasing (36.3% of cases in 2018 vs 42.1% in 2017). The share of persons treated with the combination of buprenorphine/naloxone is 16.3% (Brisacier 2020) (see the 'Prison' workbook).

*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)*

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## 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)*

For some developments on quality assurance in drug treatment, see T.1.5.1 of the 2020 'Treatment' workbook.

## 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*

Figures on the numbers of people being treated for an addiction problem for the first time in their lives should be treated with caution 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 transmitted, 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 changes have been calculated in constant terms, i.e. on a subset of CSAPAs that reported each year between 2015 and 2020. 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 2007-2020 period. Even among the CSAPAs in the constant field sample, very significant variations in staff numbers from one year to the next can sometimes be observed, which seem to be more related to changes in registration practices than to actual variations in staff numbers.

For the first treatment demands, the constant field analysis between 2015 and 2020 covered 102 outpatient CSAPAs (only 27% of the number of outpatient CSAPAs) that received 7 150 people starting treatment for the first time in their lives in 2020. 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. Overall, the number of first-time applicants for treatment fell by just over 29% between 2019 and 2020, a greater decrease than for all people starting treatment. The curves in Figure II show that this change is mainly linked to the sharp drop (-32%) in the number of people taken into care because of their cannabis

use in 2020, following a period of stability in numbers between 2017 and 2019. It is logical that the health crisis has had a greater impact on treatment demand for cannabis, as problems related to cannabis use are on average less acute than those related to the use of substances such as opioids or cocaine.

Opioids and cocaine account for a much smaller percentage of first treatment demands (9% and 8% respectively in 2020). The downward trend in the number of opioid-related claims observed since 2015 increased in 2020 (-22%), but this decrease was less pronounced than for cannabis. The upward trend in cocaine-related treatment since the mid-2010s was interrupted in 2020, with numbers falling by around 27%, more sharply than for opioids. The continuation of the trend of the years 2015-2019 could suggest that the numbers for cocaine would exceed those for opioids in 2020. It turns out that this is not the case, although it is not possible to say whether the health crisis has played a role or whether the increase in cocaine-related treatment, which was already lower in 2019, has reached a ceiling.

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 2015.

#### *All treatment entrants*

The development of the number of people starting treatment (whether it is the first request for treatment or not) was also analysed "in constant terms" for the 2015-2020 period. The number of outpatient CSAPAs that provided data each year between 2015 and 2020 represents 52% of the total number of outpatient CSAPAs in 2020. The number of people included in this sample of CSAPAs reaches 32 400. This number changed little between 2015 and 2018, increased by 4% in 2019 and then decreased by 21% in 2020.

The changes in constant terms for users entering treatment according to substance (Fig. VII) are fairly similar to those observed for first-time treatment requests, although less pronounced. The number of people admitted for cannabis use changed relatively little between 2015 and 2019, falling by 26% in 2020. The downward trend in numbers also increased in 2020 for opioids, but more slowly (-16%) than for cannabis. Cocaine numbers fall by about 20% after doubling between 2015 and 2019.

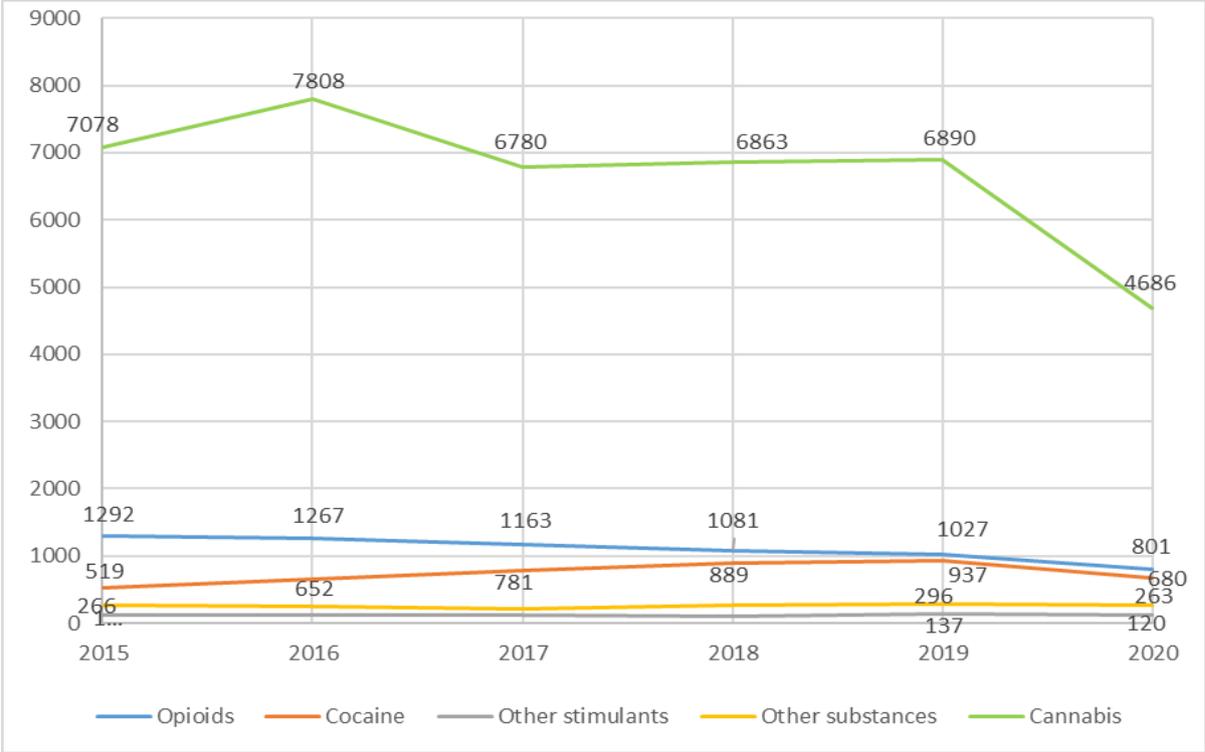
As for the first treatment demands, the data analysed in constant terms is completed by an analysis of the proportion of the different substance categories in treatment demands for the 2007-2020 period. As with initial treatment requests, the larger decrease in the number of people treated for cannabis use is reflected in a decrease in the share of cannabis and an increase in the share of opioids.

#### *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 (see the 2020 'Treatment' workbook).

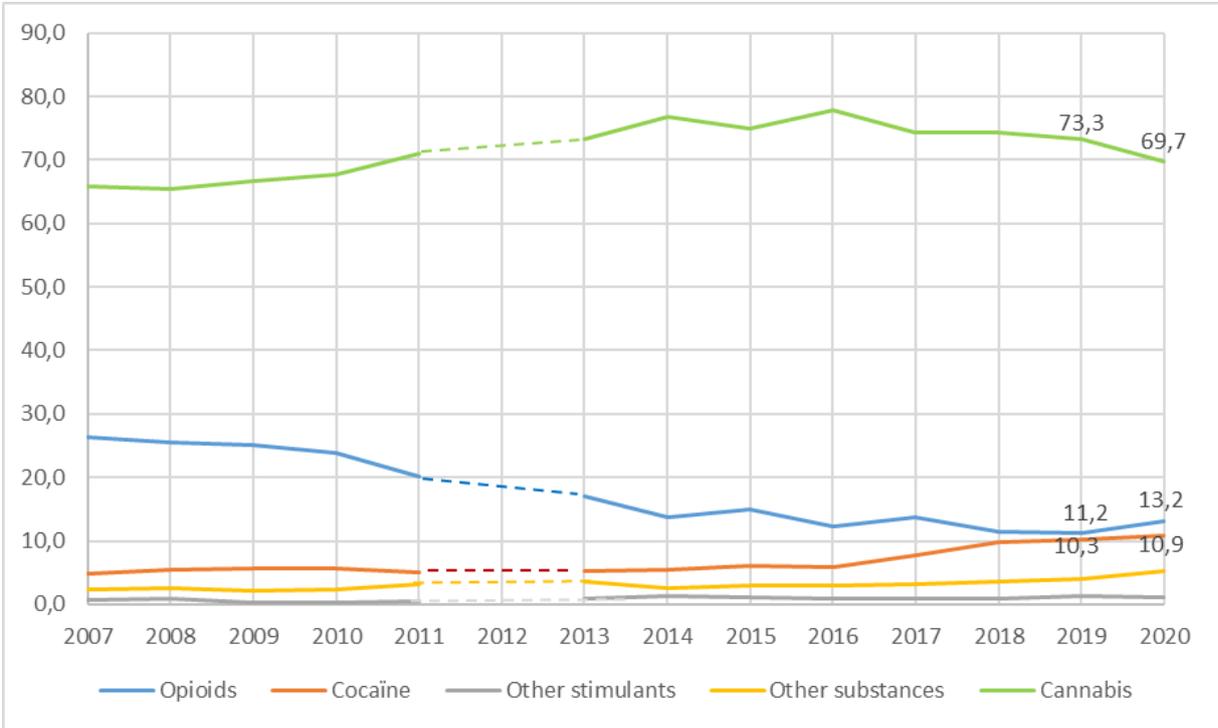
**T2.2. Optional.** *Please comment on the possible explanations of long-term trends and short term trends in any other treatment data that you consider important. In particular when there is a strong change in trend, please specify whether this change is validated by data and what are the reasons for 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 2015 and 2020, data analysed in constant terms



Source: TDI

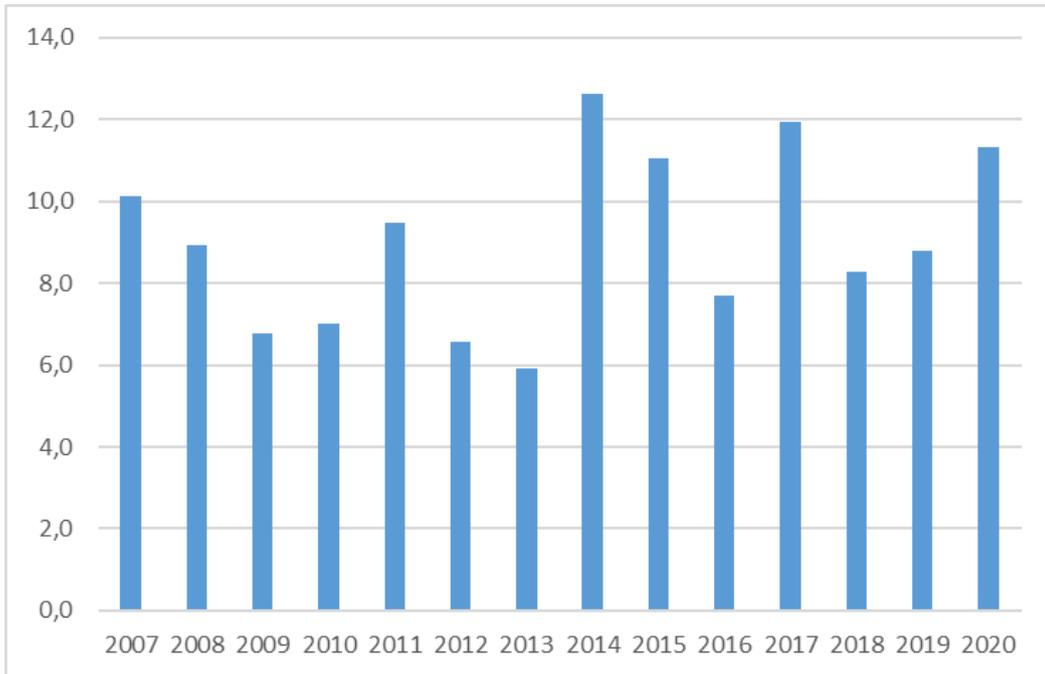
**Figure III.** Trends in proportion numbers of first-time clients entering treatment, by primary drug, 2007-2020 (in %), data analysed in variable terms



Source: TDI

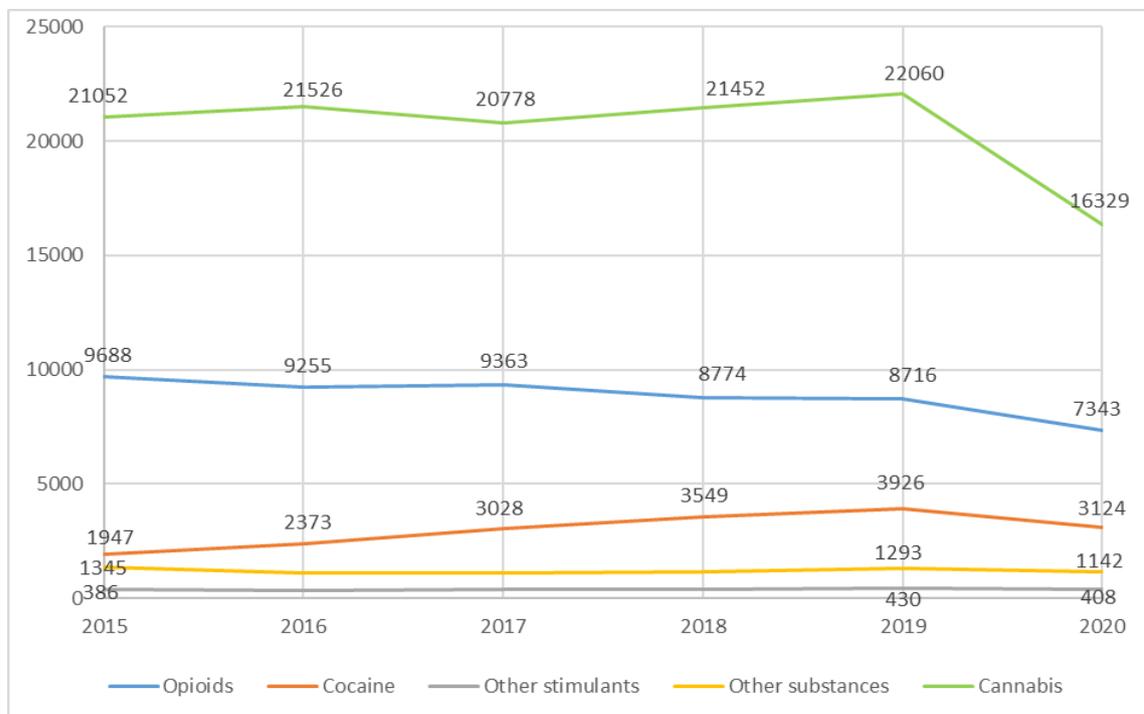
Note: due to the implementation of the new protocol for recording treatment demand in 2012, the data for that year is not valid; it can be considered with a high degree of certainty that the 2012 values were in line with the trends observed between the years 2010 and 2016

**Figure IV.** Changes in the proportion of patients starting treatment for the first time ever (substances unknown), 2007-2020 (in %)



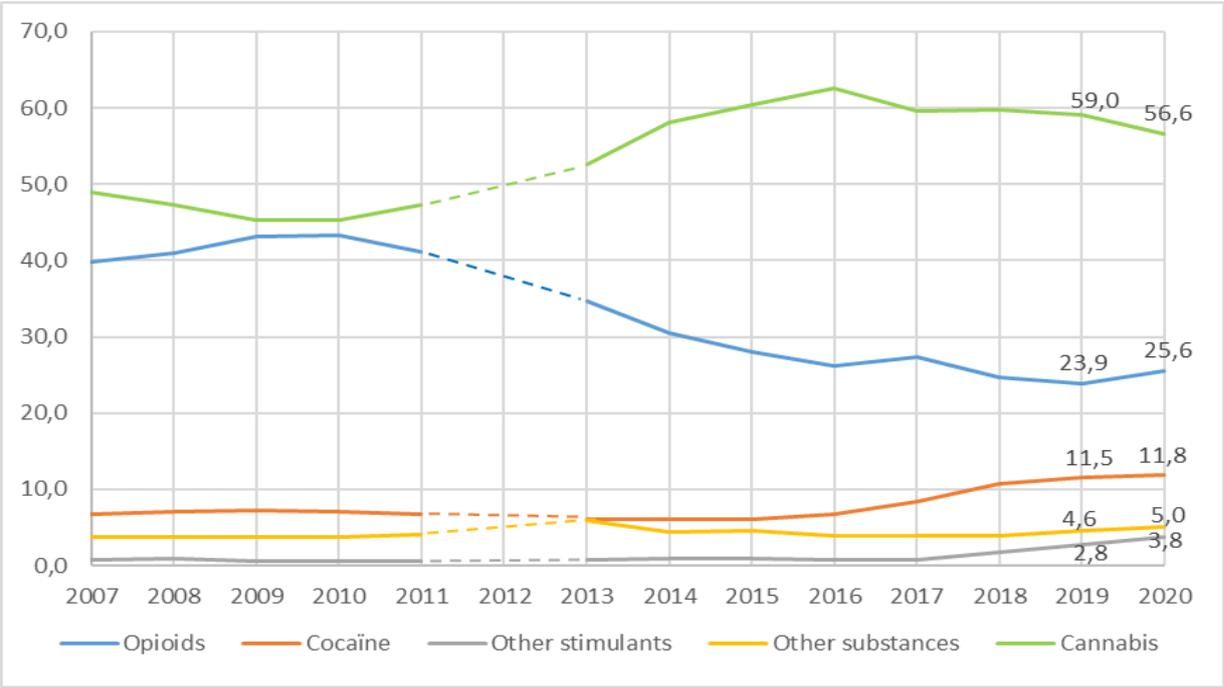
Source: TDI

**Figure V.** Evolution of the number of people starting treatment according to the most problematic substance between 2015 and 2020, data analysed in constant terms



Source: TDI

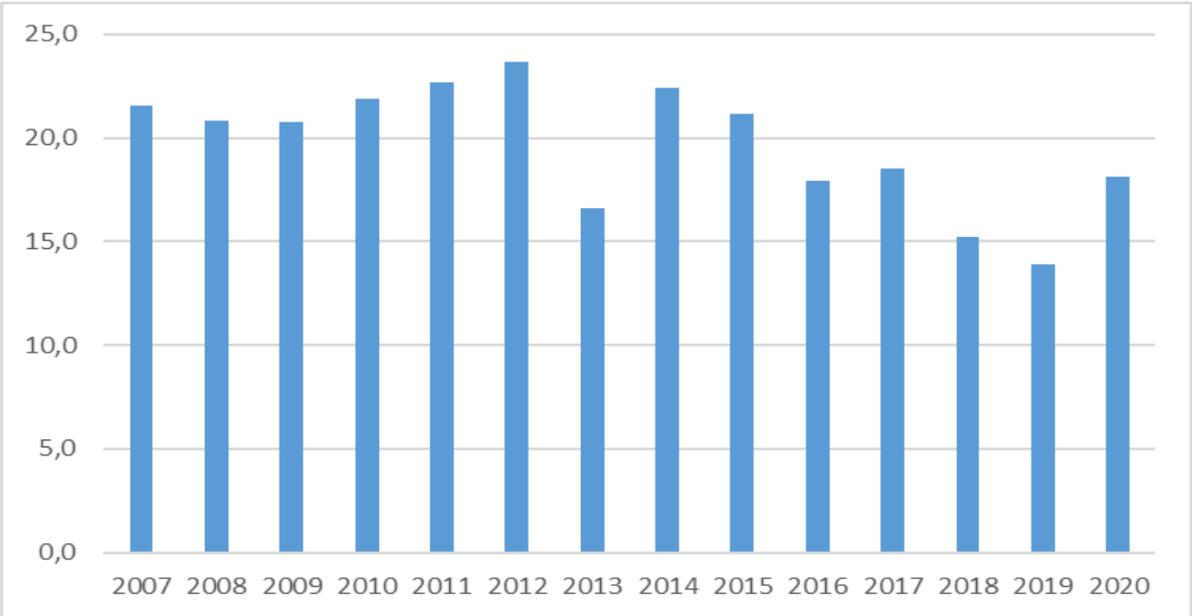
**Figure VI.** Trends in proportion numbers of all clients entering treatment, by primary drug, 2007-2020 (in %), data analysed in variable terms



**Source:** TDI

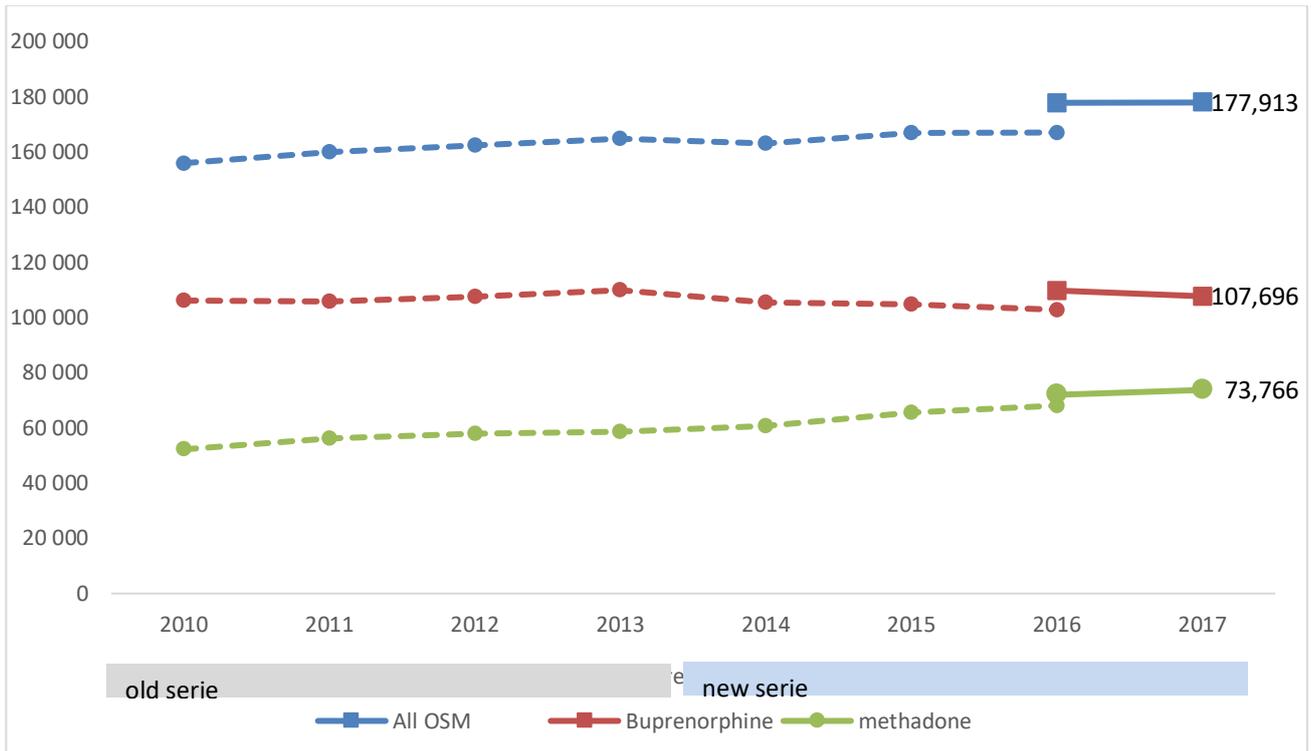
Note: due to the implementation of the new protocol for recording treatment demand in 2012, the data for that year is not valid; it can be considered with a high degree of certainty that the 2012 values were in line with the trends observed between the years 2010 and 2016

**Figure VII.** Changes in the proportion of patients starting treatment (substances unknown), 2007-2020 (in %)



**Source:** TDI

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

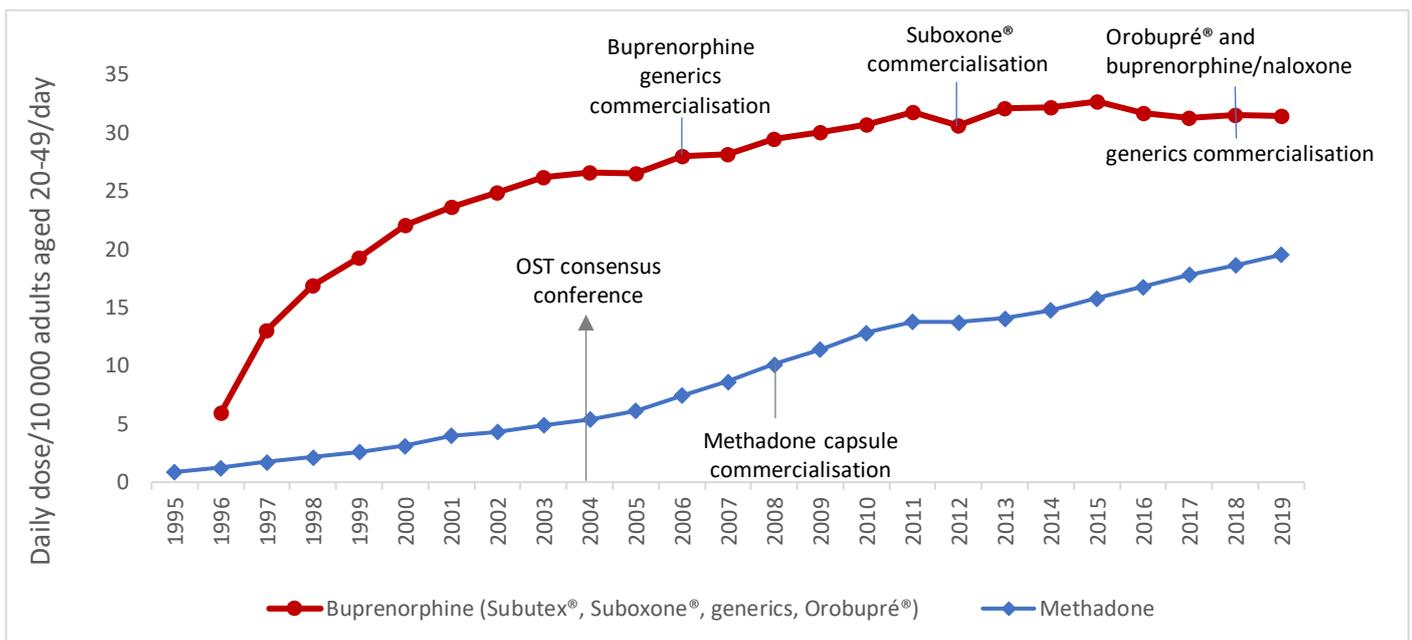


OSM: opioid substitution medications

**Source:** Standard Table 24

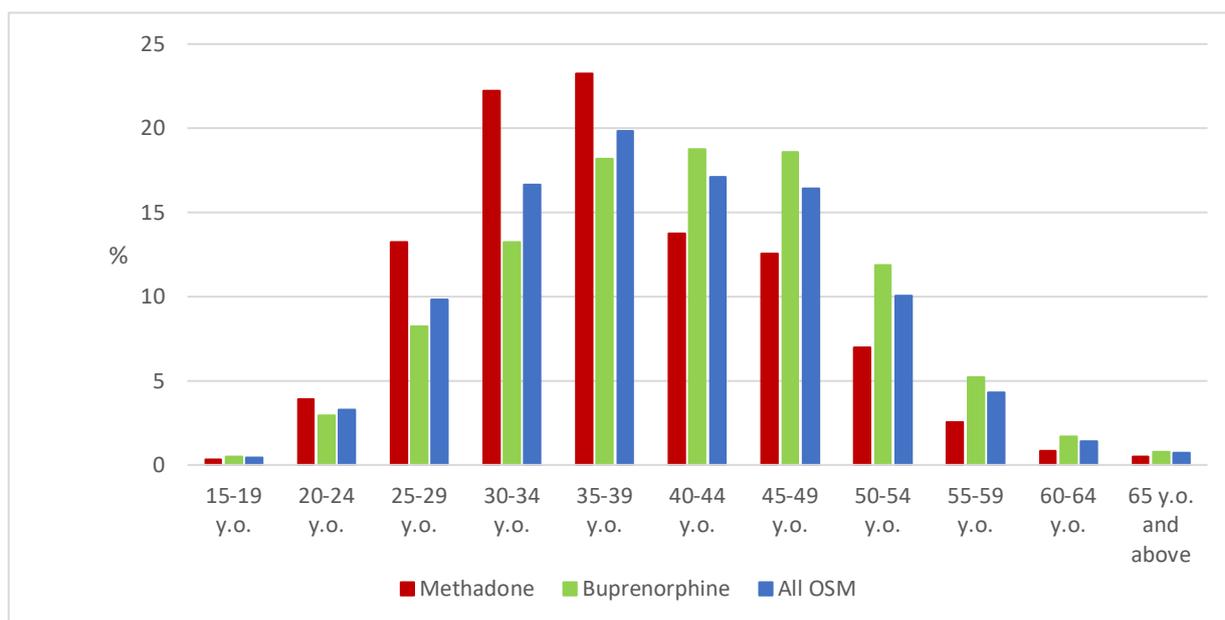
Note : The previous series ends in 2016, and took into account opioid substitution medications reimbursements for 86% of the population covered by the Social Security scheme. The new series starts in 2016, and includes reimbursement data for the whole population covered in France, estimated and readjusted based on EGBS data representing 96% of the covered population. These two series also include individuals with treatment dispensed in CSAPAs and in prison, which do not appear in National Health Insurance Fund reimbursement data.

**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)



Sources: SIAMOIS (GERS, processed by InVS then OFDT), Bouchara-Recordati, Medic'AM (CNAM)

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



OSM: opioid substitution medications

Source: EGBS (CNAM, exploitation 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)

The main highlight is the sharp decrease in the number of people in care in 2020 due to the health crisis (see T.3.1 of the 2020 'Treatment' workbook 2020) (G erome and Gandilhon 2020a, b).

Professionals at the CSAPAs adapted to the health crisis situation and the lockdown measures by facilitating the delivery of OSTs by means of prescriptions faxed to the pharmacy, the validity of which was automatically renewed. Access to OSTs for users in treatment was thus less restricted during the entire period of confinement for the majority of patients already being treated. Some CSAPAs also facilitated access to treatment for new users by relaxing the protocols for inclusion in methadone or even Sk enan<sup> </sup> (forms of low-threshold access). CSAPA caregivers have also responded to new requests for benzodiazepine treatment from dependent users who have difficulty accessing these drugs through GPs and pharmacists, as well as to adjustments for patients already receiving these treatments. Many facilities have implemented various actions to support users, such as the widespread use of remote consultations and the development of home visits, while maintaining (or re-establishing after a few weeks' suspension) the possibility of individual physical contact and access to healthcare staff in certain specific or urgent cases (inclusion of methadone OSTs, finalisation of care files or procedures for accessing rights, patients in great difficulty who express the need for physical contact, etc.).

The issue of fatal and non-fatal opioid overdoses during lockdown remains to be accurately documented.

In an online survey, the CSAPAs were asked to report changes related to the health crisis in terms of the characteristics of the people they were treating (use, socio-economic characteristics, health status). Of the 79 CSAPAs that provided a response to this question, 21% (14 CSAPAs) indicated that they had not perceived any change due to the health crisis. Among the 65 CSAPAs perceiving changes, the themes most often mentioned were the increase in use (from 26 CSAPAs: “general increase in use”, “relapse into use”, “increase in resuming use after abstinence”). But the most frequently mentioned product is alcohol. Increases in cocaine use are cited by 5 CSAPAs. The same number report an increase in recourse to non-substance addictions (games, screens). The other theme that appears most often is the increase in psychiatric and psychological problems (26 CSAPA: “Increase in severe anxiety and depression, anxiety attacks, isolation and psychotic decompensation”, “more frequent psychiatric comorbidities with pathologies that occur as a result of lockdown”, “increase in anxiety-depressive syndromes and the need for psychiatric hospitalisation”). An increase in social insecurity is mentioned by 7 CSAPAs. 3 CSAPAs report having seen more women, most of whom have problems with alcohol and psychotropic drugs, and who appear to be better socially integrated than the women they usually see.

## T4. Additional information

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

- T4.1. **Optional.** Please describe any additional important sources of information, specific studies or data on drug treatment. Where possible, please provide references and/or links (suggested title: *Additional Sources of Information*)
- T4.2. **Optional.** Please describe any other important aspect of drug treatment that has not been covered in the specific questions above. This may be additional information or new areas of specific importance for your country (suggested title: *Further Aspects of Drug Treatment*)
- T4.3. **Optional.** Please provide any available information or data on psychiatric comorbidity, e.g. prevalence of dual diagnosis among the population in drug treatment, type of combinations of disorders and their prevalence, setting and population. If available, please describe the type of services available to patients with dual diagnosis, including the availability of assessment tools and specific services or programmes dedicated to patients with dual diagnosis (suggested title: *Psychiatric comorbidity*)

## T5. Sources and methodology

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

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

### Sources

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

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

**CSAPA activity reports: use of activity reports from the specialised drug treatment centres (CSAPA)**

*National Health Directorate (DGS) / 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 the year 2019, the reports of 334 outpatient CSAPAs and 11 prison CSAPAs were able to be analysed, which corresponds to response rates of 89% for the former and 100% for the latter. In order to best estimate the number of people received and given the limited average variations, the missing values were replaced by those of the last year available, which in the vast majority of cases is year n-1.

**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.

**EGBS: Échantillon généraliste des bénéficiaires simplifié [General sample of French persons with social security coverage]**

*National public health insurance (CNAM), processed by the French Monitoring Centre for Drugs and Drug Addiction (OFDT)*

The population being dispensed an opioid substitution medication in the primary care setting was studied using data from the simplified French National Health Insurance Fund's "EGBS" general population sample. The EGB is a permanent representative sample of the population protected by the general health insurance scheme (excluding students and civil servants), the agricultural worker health insurance scheme (MSA) and the health insurance scheme for self-employed people (RSI). It comprises 1/97<sup>th</sup> 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 April 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 2020, approximately 206 000 patients treated for an addiction problem (alcohol, illicit drugs and psychotropic medicines, non-substance addictions) in 257 outpatient CSAPAs, 11 CSAPAs with accommodation and 1 CSAPA in prisons were included in the survey.

### **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.