Treatment workbook

France

2015 National report (2014 data) to the EMCDDA by the French Reitox National Focal Point

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The EMCDDA is investigating how the submission of the workbooks could be made easier through the use of technology. In the first instance, a pilot using templates in Word with defined fields to distinguish the answers to questions is being tried. The outcome of the pilot will be to evaluate the usefulness of this tool and establish the parameters of any future IT project.

Templates have been constructed for the workbooks being completed this year. The templates for the pre-filled workbooks were piloted in the EMCDDA.

1. The principle is that a template is produced for each workbook, and one version of this is provided to each country, in some instances pre-filled.
2. Answers to the questions should be entered into the "fields" in the template. The fields have been named with the question number (e.g. T.2.1). It will be possible to extract the contents of the fields using the field names.
3. Fields are usually displayed within a border, and indicated by "Click here to enter text" Fields have been set up so that they cannot be deleted (their contents can be deleted). They grow in size automatically.
4. The completed template/workbook represents the working document between the NFP and the EMCDDA. Comments can be used to enhance the dialogue between the EMCDDA and the NFP. Track changes are implemented to develop a commonly understood text and to avoid duplication of work.

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T0. Summary

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

- National profile

There are two schemes available for dispensing treatments to illegal drug users: the specialised addiction treatment system (in socio-medical establishments) and the general healthcare system (hospitals and general practitioners). Approximately 104,000 individuals were received in outpatient CSAPA (specialised addiction treatment centres) in 2010 for problems with illegal drugs or diverted psychotropic medications.
A large proportion of new patients are treated for cannabis problems (58%). This was already the case in previous years; however, the inclusion of all illegal drug users treated in former alcoholism treatment centres in TDI (treatment demand indicator) data as from 2013 further reinforced the weight of cannabis.

OST is mainly prescribed in a primary care setting by general practitioners, and is usually dispensed in community pharmacies. In 2014, 147,000 people received opioid substitution treatment: 99,000 were prescribed buprenorphine (Subutex® or generics), 49,000 methadone and 6,500 buprenorphine in combination with naloxone (Suboxone®). Moreover, 20,000 patients received methadone dispensed at a CSAPA in 2010.

In terms of outpatient treatment provision, the public authorities developed specific healthcare for young users by creating youth addiction outpatients 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

Among those overseen for the first time in the specialised addiction treatment structure, the proportion of cannabis users is tending to increase whereas the proportion of opioid users is on the decline. In 2014, this population, with an average age of 26 since 2007, comprises nearly 70% cannabis users and slightly over 10% opioid users.
As regards all treatment entrants, the distribution according to substances seems fairly stable up to 2012, with a slight downward trend in the percentage of cannabis users up to 2010. In 2013, the proportion of cannabis users increased considerably, whereas the proportion of opioid users showed a symmetrical decline.

- New developments

The maximum prescribing duration for methadone capsules is now 28 days as opposed to 14 in the past. However, the syrup form maintains a maximum prescribing duration of 14 days.
Despite the debate on initial prescribing of methadone in a primary care setting, the results of the Méthaville study showed that this prescribing method was no less effective than the current method (exclusively by physicians at a CSAPA or hospital), paving the way to trialling this method.

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

Please structure your answers around the following questions.

T1.1.1 What are the main treatment-related objectives of the national drug strategy?

Main treatment priorities in the national drug strategy

As regards treatment, the 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours (MILDT 2013) comprises two main themes, split into objectives:

I) Adapt frontline and specialised health care delivery:

- Reinforce the skills of professionals in contact with young people (particularly Youth Addiction Outpatient Clinics (CJC), by developing early intervention).
- Reinforce the skills of healthcare professionals and the position of general practitioners (training in brief intervention and motivational interviewing).
- Extend interventions of specialised healthcare schemes (expand the missions of national treatment and prevention centres for addiction (CSAPA) and support centres for the reduction of drug-related harms (CAARUD) to prevention, professional integration, and family support; develop addiction liaison and treatment teams (ELSA) in healthcare establishments).
- Increase geographical and social accessibility.

II) Adapt therapeutic strategies

- Support and offer multidimensional family therapy (training of several CJC spread over the territory).
- Deploy an integrated approach to psychiatric and somatic comorbidities
- Support research on new treatments for addictive behaviours and addiction
- Improve the quality of care for patients receiving opioid substitution treatment (OST) and make it more accessible (new treatment procedures, such as initial prescription of methadone in a primary care setting; prison setting).
- Propose distance support services

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 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

Please structure your answers around the following questions.

Outpatient network

T1.2.1 Using the structure and data provided in table I please provide an overview of the main bodies/organisations providing Outpatient treatment within your country and comment on their relative importance.

Outpatient drug treatment system – Main providers

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

The specialised scheme

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

CSAPA mainly have association status, and a minority of centres are administered by hospitals.

CSAPA in a prison setting, few in number, focus their activities on incarcerated drug users. However, their activity only represents part of addiction health care delivery in a prison setting. On the one hand, addiction health care is delivered by general hospital or mental health establishments which provide health care in a prison setting. However, no information system exists able to measure this activity. On the other hand, the public authorities wished to set in place, as from 2011, a reference CSAPA for each of the 187 prisons in France. These CSAPA are responsible for intervening in custody to ensure continuity of care. A financial budget has been planned to allow each reference CSAPA to dedicate an additional part-time social worker to intervention alongside incarcerated drug users or those having recently left prison.

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

The general scheme

The activity of office-based general practitioners with regard to treatment of drug use is described via the INPES Health Barometer general practitioner survey, conducted on a sample of practitioners. In 2009, two thirds of general practitioners (about 40 000) saw at least one opioid-addicted drug user in the last year (Gautier 2011).The proportion of those receiving at least one user per month substantially increased to almost 50% (compared to one-third in 2003) and 12% (about 7 000) received at least 5 user per month. This substantial level of activity alongside opioid-dependent drug users is mainly related to the prescription of opioid substitution treatment (OST). Appointments related to cannabis concern considerably fewer physicians: nearly 3,000 claim to have seen at least 5 patients per month related to cannabis use. Lastly, approximately one in five physicians (13,000) saw at least one patient in the course of the year for problem stimulant use. No information is available on the treatment of drug users by office-based psychiatrists.

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

T1.2.2 ***Optional****. Please provide any additional information you feel is important to understand the availability 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)

	Total number of units	National Definition (Characteristics/Types of centre included within your country
Specialised drug treatment centres	410	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).
Low-threshold agencies	160	Facilities of a medical-social nature authorised and funded by the Social Security scheme, whose role is to contribute to harm reduction among drug users: unconditional counselling, personalised information and guidance, support for access to care and social rights, provision of equipment for prevention of infectious diseases, external interventions to meet drug users and social mediation actions. These facilities are known as support centres for the reduction of drug-related harms (CAARUD) and do not fall within the scope of treatment data in France.
General/ Mental health care	30,000	Estimated number of general practitioners having claimed to have seen at least one opioid client in the past month.

Prisons	15	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.
Other outpatient units		

Source: Standard Table 24.

T.1.2.3 Using the structure and data provided in table II please provide an overview of the utilisation of the outpatient treatment system within your country and comment on the clients served.

Outpatient drug treatment system – Client utilisation

According to the data provided in the CSAPA activity reports, the approximate number of individuals admitted in outpatient CSAPA is 104,000[1] in 2010[2] for problem use of illegal drugs or misappropriated psychoactive medicines.
The number of DU seen by general practitioners (147,000) is estimated based on the reimbursements for prescription of OST.

CSAPA in a prison setting treat 5,000 to 6,000 patients over the year. These figures only represent undoubtedly a relatively small proportion of all incarcerated drug users receiving addiction medicine delivered by the CSAPA. Treatment is indeed often provided also by CSAPA whose activity is not only in prison settings (outpatient CSAPA) and by general or mental health hospitals intervening in prisons. A more in-depth evaluation of these figures should be available for the next report.

[1] These figures take into account a 3% proportion of double entries of declared data, a percentage evaluated based on the last capture-recapture study conducted in a few French towns.

[2] The number of individuals seen in the CSAPA has not been updated since 2010 due to the delays in submission of activity reports to the OFDT. This update is, however, currently in progress and should most likely lead to a markedly higher estimate for 2014.

T1.2.4 ***Optional****. Please provide any additional information you feel is important to understand the utilisation of Outpatient treatment within your country*
(Suggested title: Further aspects of outpatient drug treatment utilisation.)

T1.2.5 ***Optional****. Please provide any additional information on treatment providers and its utilisation not covered above.*
(Suggested title: Further aspects of outpatient drug treatment provision and utilisation.)

Table II. Total outpatient treatment provision (number of clients)

	Total number of clients	National Definition (Characteristics)
Specialised drug treatment centres	104,000	Drug users having been seen at least once in the year as part of a meeting in person with a healthcare professional employed at a CSAPA in the context of structured treatment.
Low-threshold agencies	60,000	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.
General/ Mental health care	147,000	Individuals having benefited from reimbursement further to prescription of opioid substitution treatment.
Prisons	5,700	Drug users having been seen at least once in the year as part of a meeting in person with a healthcare professional employed at a prison CSAPA in the context of structured treatment.
Other outpatient units		

Source: Standard Table 24

Inpatient network

T1.2.6 Using the structure and data provided in table III please provide an overview of the main bodies/organisations providing Inpatient treatment within your country and comment on their relative importance.

Inpatient drug treatment system – Main providers

As for an outpatient setting, residential treatment may have a role in the context of a CSAPA or public, general or specialised psychiatric hospital.

Residential care in CSAPA
CSAPA with housing offer different types of services. The most important in terms of the number of patients concerned, corresponds to collective housing in the context of residential treatment centres (CTR). These centres were historically create to receive drug users after withdrawal for stays over a few months, allowing them to readjust to life without drugs. Since OST became more widespread in the 1990s, these institutions are also open to individuals receiving this type of treatment. 37 CTR currently exist. In addition to these institutions, 8 experimental therapeutic communities (CTE), created in the 2000s, also exist. CTE should in principle be changed to CSAPA, but have not yet officially been awarded this status[1]. All CTR and CTE are administered as associations. It can also be observed that CTE have a considerably higher number of spaces compared to CTR (30 *vs.* 10 on average). CSAPA with housing, as well as those in an outpatient setting, may offer housing services in residential therapeutic apartments (ATR), for stays of not more than two years. In 2011, there were 64 CSAPA with spaces in ATR. Lastly, one more type of service exists: short stays which meet the requirements of emergency housing for homeless drug users or transitional housing (notably for newly released inmates). In 2011, there were 8 CSAPA offering this kind of service.

Residential care in hospitals
Further to the 2007-2011 Plan for addiction treatment and prevention (Ministère de la santé et des solidarités 2006), the resources available for residential treatment of addiction were

considerably increased. In 2010, there were 391 hospitals in France, practically all public, equipped with hospital beds for withdrawal and 113 offering aftercare activities including addiction medicine (Palle *et al.* 2012). These services cover all types of addiction (notably alcohol), hence it is difficult to identify those which are actually open to drug users.

[1] CTE are not therefore subject to the same obligations as CSAPA regarding activity reports and the RECAP scheme (which does not therefore include their data).

T1.2.7 ***Optional****. Please provide any additional information you feel is important to understand the availability 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)

	Total number of units	National Definition (Characteristics/Types of centre included within your country)
Hospital-based residential drug treatment	na	
Residential drug treatment (non-hospital based)	37	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.
Therapeutic communities	8	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.
Prisons		
Other inpatient units	68	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).

Other inpatient units	8	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).

na: not available
Source: Standard Table 24

T1.2.8 Using the structure and data provided in table IV please provide an overview of the utilisation of the inpatient treatment system within your country and comment on the clients served.

Inpatient drug treatment system – Client utilisation

Based on the CTR and ATR activity reports, the number of individuals housed by these two schemes may be estimated at 1,400 and 1,000 drug users respectively in 2010[1]. The number of individuals housed in CTE should also be taken into account. The precise figure is not currently known, but should lie between 300 and 400 individuals in 2014. The parallels with drug users seen in outpatient CSAPA are undoubted fairly broad: a large proportion of the individuals received are, in fact, referred by an outpatient CSAPA.

[1] The number of individuals seen in the CSAPA has not been updated since 2010 due to the delays in submission of activity reports to the OFDT.

*T1.2.9 **Optional**. Please provide any additional information you feel is important to understand the utilisation of Inpatient treatment within your country.*
(Suggested title: Further aspects of inpatient drug treatment utilisation.)

*T1.2.10 **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.)

Table IV. Total inpatient treatment provision (number of clients)

	Total number of clients	National Definition (Characteristics)
Hospital-based residential drug treatment	na	
Residential drug treatment (non-hospital based)	1,400	Individuals housed in residential treatment centres
Therapeutic communities	na	Individuals housed in experimental therapeutic communities

Prisons		
Other inpatient units	1,000	Individuals housed in residential therapeutic apartments
Other inpatient units	na	

na: not available

Source: Standard Table 24

T1.3 Key data

The purpose of this section is to provide a commentary on the key estimates related to the topic.

Please structure your answers around the following questions.

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

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

The TDI data coverage rate may be estimated at approximately 70% for CSAPA in an outpatient setting. The rate is lower for CSAPA with housing, but they have very little weight in terms of the number of users. Centres which did not provide data do not seem to display common characteristics which would distinguish them from those having submitted data. Drug users at centres contributing to the TDI may therefore be considered as representative of all patients seen at CSAPA in an outpatient setting.

The proportion of new patients treated for cannabis problems seems particularly high (58%) in 2014. This was already the case in previous years; however, the inclusion of all drug users treated in former CCAA in TDI data as from 2013 further reinforced the weight of cannabis (see T1.2.1).

Opioid users represent the second largest group in France. However, individuals for whom stimulants are described as the primary drug only represent a small proportion of new patients. Cocaine appears much more frequently as the secondary drug among individuals describing an opioid as the primary drug.

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

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

(Suggested title: distribution of primary drug in the total population in treatment.)

T1.3.3 ***Optional****. Please comment on the availability, validity and completeness of the estimates in Table V below.*

(Suggested title: Further methodological comments on the Key Treatment-related data.)

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.)

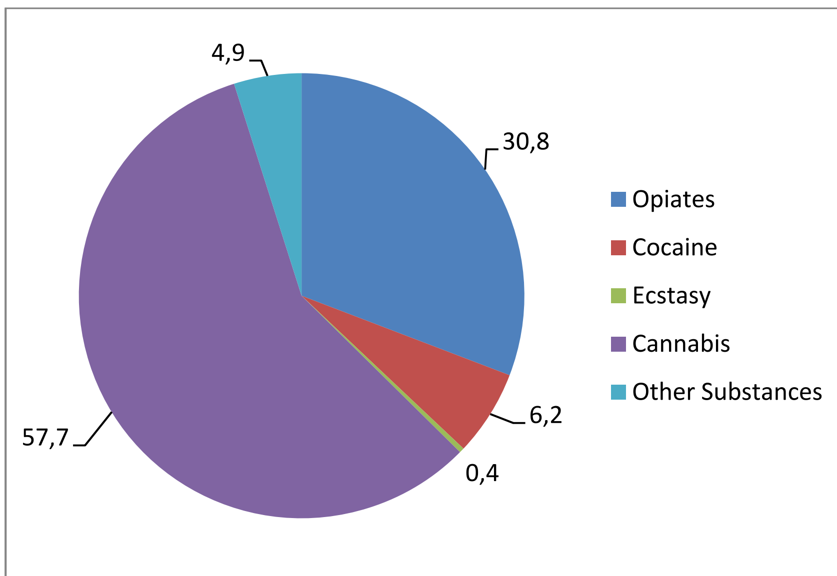
Table V: Summary table - Clients in treatment

	Number of clients
Total clients in treatment	na
Total OST clients	167,000
Total All clients entering treatment	70,000

na: not available

Source: ST24 and TDI

Figure I. Proportion of treatment demands by primary drug



Source: TDI

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, with reference to the categories and data reported in SQ27 part 1 where possible. provide an overview of Opioid Substitution Treatment (OST) in your country

Please structure your answers around the following questions.

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 to the EMCDDA in SQ27 part 1.
(Suggested title: Outpatient drug treatment services)

Outpatient drug treatment services

In terms of outpatient treatment provision, other than measures relating to OST (widely available), the public authorities have primarily attempted to develop counselling and treatment specific to young users (for whom addiction problems are even more often intertwined with adolescent problems and their associated psychological difficulties), by particularly targeting adolescents and young adults who use cannabis. Created in 2004 [Circulaire DGS/DHOS/DGAS n°2004-464 du 23 septembre 2004 relative à la mise en place de consultations destinées aux jeunes consommateurs de cannabis et autres substances psychoactives et leur famille], slightly more than half of youth addiction outpatient clinics (CJC) are administered by a CSAPA, and the remainder by hospitals. Approximately 540 clinics are currently in operation (Obradovic 2015). Their opening hours can vary (sometimes half a day each week, sometimes every working day). Numerous CJC have opened advanced clinics in schools or different youth facilities. This resource is available throughout France, and may be perceived to have a high level of accessibility. A best practices guide intended for professionals operating in the context of CJC, issued by the professional body for those working in the field of addiction medicine (Fédération addiction 2012), was published in 2012.

As regards other target groups mentioned in the SQ27P1 questionnaire, no national "programmes" comparable to the resources set in place for young users currently exist. However, some CSAPA are committed and specialise in the specific treatment of different populations, such as individuals presenting psychiatric comorbidities, for whom specific protocols have been set in place. Nonetheless, no specific information is available on this subject. The issue relating to the treatment of pregnant women or new mothers has also long been a concern of the public authorities as well as healthcare professionals working in the field of addiction medicine. The 2008-2011 Government action plan against drugs and drug addiction (MILDT 2008) aimed to encourage projects along these lines. Further to a call for tenders, approximately forty projects have been funded, all contributed by CSAPA (Mutatayi 2014). Two residential treatment centres, located in two different regions (Aquitaine and Île-de-France), are entirely or highly specialised in the treatment of this type of population. The 2013-2017 plan {MILDT, 2013 #2957} also provides for the creation of two residential schemes for women with children, and two teams for the early detection and treatment of parents/children.
In a hospital setting, addiction liaison and treatment teams (ELSA) also regularly work with maternity units, either directly with patients or to train personnel.

In the context of early referral into treatment ordered by the public prosecutor's office or courts (see "Legal framework" workbook) further to a drug-related offence, health care delivery is available for this type of population. However, it is undoubtedly not always adapted to the needs of the population concerned, particularly newly released inmates, for whom housing is an acute problem. To prevent breaks in care and "cold releases"[1], as part

of the 2008-2011 governmental plan on drugs, the public authorities implemented experimental, rapid access, short-stay admission programmes in social and medical-social structures (with housing) for newly released inmates. In two years (2009-2010), seven programmes targeting newly released inmates were thus funded (4 projects of rapid access, short-stay units and 3 projects of early CSAPA consultations in social housing and rehabilitation centres) and then assessed by the OFDT (Obradovic 2014). The public authorities recently promoted the implementation of an experimental programme for the prevention of subsequent offences and an alternative to imprisonment among drug users having committed criminal acts related to their addiction, within the jurisdiction of a Paris court[2]. This experimental programme (the "Bobigny city project") was initiated in March 2015. The objective is to invite approximately fifty multiple offenders to follow an intensive treatment programme (five hours of activities and treatment per day, five days a week, for a year) rather than returning to prison (see "Prevention" workbook).

Numerous CSAPA also face the situation of counselling homeless drug users. Although some have specialised in counselling this population, their number is not sufficient. A programme called *"Un chez soi d'abord"* (inspired by the north-American *Housing first* program) is currently being trialled in four French towns (Paris, Lille, Marseille and Toulouse). It is not specifically aimed at drug users but homeless individuals suffering from major psychiatric disorders, a population which partly covers drug users without fixed abode. Recruited individuals are offered access to ordinary housing in return for intensive health and social support. This support is provided by teams bringing together both health professionals (psychiatrists, addiction specialists, general practitioners, nurses) and social workers, housing specialists or even individuals having experienced life on the streets or mental illness.

In the absence of a systematic survey on the development of specific counselling for the population listed in the SQ27P1 questionnaire, it was not possible to obtain information on counselling for seniors, sex workers or the LGBT community.

There is undoubtedly a need to develop specific programmes for these populations; however, the treatment of pregnant women or women with children, as well as individuals suffering from psychiatric problems or arrested for a drug-related offence, represents some of the situations which all CSAPA should be able to face. Training of CSAPA personnel and the development of specific "programmes" are most likely ways in which this goal can be achieved.

As a general rule, appointments with psychologists or psychiatrists are fairly widely available in CSAPA in an outpatient setting. The availability of the other types of services mentioned in the SQ27P1 is not known.

[1] Releases from prison without any therapeutic follow-up.

[2] The project run by the Bobigny courts is inspired by those existing in Canada (Montreal, Vancouver) which are based on an all-round approach to the individual and reinforced collaboration between the different protagonists of the programme, particularly in the health and judicial fields. Individuals with a complex psychiatric profile cannot be included in this programme. The trial planned for two years should enable 40 to 50 individuals to be included in this programme.

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 to the EMCDDA in SQ27part 1.

Inpatient drug treatment services

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

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 ***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)

T1.4.6 ***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)

T1.4.7 Please provide an overview of the main providers/organisations providing OST within your country and comment on their relative importance.
(Suggested title: Main providers/organisations providing Opioid substitution treatment)

Main providers/organisations providing opioid substitution treatment

There are two schemes available for dispensing treatments to illegal drug users: the specialised addiction treatment system (CSAPA) and the general healthcare system (hospitals and general practitioners).
OST is mainly prescribed in a primary care setting by general practitioners, and is usually dispensed in community pharmacies.

The organisation of access to OST is based on two different prescription frameworks, one for methadone, and the other for buprenorphine. Methadone, classed as a narcotic, has a more stringent prescription framework than buprenorphine (with or without naloxone). The latter is a list I[1] drug, but is regulated by narcotics prescription and dispensing rules. This difference is related to the lesser danger involved with buprenorphine (a partial opioid receptor agonist) compared with methadone (a pure agonist), since buprenorphine's ceiling effect limits the depressant, and particularly cardiopulmonary depressant, effects.
Methadone treatment must be initiated by physicians working in a CSAPA or a hospital (or in a prison health unit). Primary care physicians may provide follow-up care once patients have been stabilised. Trialling of initial methadone prescriptions in a primary care setting is part of the 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours.

The methadone capsule form, which is more discreet than the large-volume syrup bottles and does not contain sugar or ethanol, is not intended for treatment initiation. It can be prescribed to patients taking the syrup form once they have been stabilised. Initial methadone capsule prescriptions can only be written by CSAPA or hospital physicians specialised in treating drug users.
Any physician can initiate buprenorphine treatment. The maximum duration of prescription is 14 days for methadone, while it is 28 days for buprenorphine. Both of these treatments are subject to controlled prescriptions.

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

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

T1.4.8 Please comment on the number of clients receiving OST within your country and the main medications used.

Number of clients in OST

After first being marketed in 1995, buprenorphine very quickly became the leading treatment for opioid dependency in France. Since 2006, Subutex® is no longer the only product available. A number of generics have arrived on the market, six in 2015, marketed by Arrow, Biogaran, EG, Mylan, Sandoz and Teva. In January 2012, Suboxone® (a combination of buprenorphine and an opioid antagonist, naloxone) was launched in a sublingual tablet administration form. The purpose of this combination is to prevent buprenorphine misuse, by provoking withdrawal symptoms when used by the injection route.

According to data from the French national public health insurance centre (CNAM-TS) collected from the EGB database, 147,000 individuals were reimbursed for OST in a primary care setting in 2014. The number of OST beneficiaries, which had increased continuously since it was first introduced, has started to decline slightly since 2013 (150,000 beneficiaries *versus* 152,000 beneficiaries in 2012), related to a decline in the number of buprenorphine beneficiaries. More specifically, in 2014, 99,000 individuals were prescribed buprenorphine (Subutex® or generics), 49,000 methadone and 6,500 buprenorphine in combination with naloxone (Suboxone®). Buprenorphine, representing 69% overall, still clearly predominates. Moreover, 20,000 patients received methadone dispensed at a CSAPA in 2010 (Palle and Rattanatray 2013).

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.

Interrupting an opioid substitution treatment
To date, there is no reliable, regularly updated source of information on the number of persons who stop taking OST in the various systems (specialist or generalist). Many French addiction specialists and specialised psychiatrists are reluctant to fully withdraw substitution treatment too suddenly given the potential risk of relapse and overdose that may ensue. Unlike retention in treatment, discontinuing substitution treatment did not appear as a key objective in the 2004 consensus conference {FFA, 2005 #1052}. However, many patients request discontinuation of their substitution treatment, leading health professionals to

rethink their practices to determine strategies, indications and procedures that favourable to this kind of discontinuation (Dugarin *et al.* 2013; Hautefeuille 2013).

Buprenorphine misuse and trafficking

The line between patients following treatment and those receiving buprenorphine prescriptions, but who cannot be considered as following treatment, is unclear. Some of the buprenorphine prescribed is misused and is not taken as part of a treatment programme (see T1.1.1 in workbook Drugs). This proportion has diminished since the implementation of the French National Health Insurance Fund's 2004 strategy to control opioid substitution treatments[1]. One of the main indicators for buprenorphine misuse (average daily dose higher than 32 mg/d[2]) fell by two-thirds between 2002 and 2007 (Canarelli and Coquelin 2009). Since then, this indicator has remained stable (2.2% in 2012) (Brisacier and Collin 2014). Moreover, 73% of patients receiving buprenorphine are receiving regular treatment[3] and therefore are integrated into a therapeutic process. People who are not regularly receiving these treatments are not necessarily cut off from any treatment strategy, just as users taking this medication as part of a treatment plan are not necessarily exempt from certain forms of misuse (INSERM 2012).

According to the results of the OPPIDUM survey conducted in 2012 (CEIP and ANSM 2013), 10% of users undergoing substitution treatment and being seen in a therapeutic setting had injected buprenorphine. Of these users, 10% had snorted and a tiny proportion had inhaled. In 2012, of people seen in ENa-CAARUD survey, 54% of buprenorphine users reported having injected in the last month, i.e., more than the oral route (46%). Of these, 26% stated having snorted, and 5% having inhaled. Buprenorphine was the most frequently injected substance for 8% of CAARUD clients who had injected at least once in their lives (Cadet-Taïrou 2012).

Two population groups in particular tended to use buprenorphine as a drug: the first group is comprised of the most disadvantaged drug users, of whom 90% are homeless males and some are illegal aliens who tend to consume medications and alcohol; the second group is wandering young people, most of whom are polydrug users (INSERM 2012).

Methadone misuse and risks

The monitoring of methadone addictovigilance and toxicovigilance (ANSM 2014a), which is the responsibility of the CAPTV (Poison control and toxicovigilance centre) and the CEIP (Centre for evaluation and information on pharmacodependence) of Marseille, identified five risks: paediatric poisoning, death, attempting to snort or inject, occasional intake and intake by naive subjects (i.e., first time users). Over the six years of monitoring, there were 87 reports of paediatric poisoning (31 with the capsule dosage form, 56 with the syrup dosage form), causing 5 deaths, and 325 cases of misuse (illegal procurement, diversion of the route of administration by injecting or snorting, occasional use or overdose). The severity of the paediatric poisoning cases are often limited thanks to rapid parental response. An informational campaign targeting parents was launched.

Substitution treatment in prison settings

The proportion of inmates receiving OST was estimated in 2010 to be 7.9%, or approximately 5,000 people, of whom 68.5% were taking buprenorphine (see Prison workbook). The proportion is significantly higher in the female prison population (DGS 2011).

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

[2] The buprenorphine maintenance dose is 8 mg per day with a maximal daily dose of 16 mg. A mean daily dose of greater than 32 mg is a very suspicious indicator of buprenorphine trafficking or dealing.

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

T1.4.9 ***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)

T1.4.10 ***Optional****. Please provide any additional information on the organisation, access, and availability of OST.*
(Suggested title: Further aspect on organisation, access and availability of OST)

T1.5 Quality assurance of drug treatment services

The purpose of this section is to provide information on quality system and any national treatment standards and guidelines.

Note: cross-reference with the Best Practice Workbook.

Please structure your answers around the following question.

T1.5.1 ***Optional****. Please provide an overview of the main treatment quality assurance standards, guidelines and targets within your country.*

Quality assurance in drug treatment

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

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

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

T2. Trends

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

Please structure your answers around the following questions.

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 (figure II),
- All treatment entrants (figure III),
- OST clients (figure IV)

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

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

New treatment entrants

The proportion of cannabis users is increasing among individuals entering treatment for the first time in their lives (Figure II) whereas the proportion of opioid users is declining. In 2014, this population of individuals entering treatment for the first time, with an average age of 26 since 2007, comprises nearly 70% cannabis users and slightly over 10% opioid users. The downward trend in opioid users in 2014 could be related to the higher percentage of users without information on substances. In 2014, data on substances were deleted in order to avoid falsifying the results for ten or so CSAPA for which it was unclear as to whether their software had been updated further to changes in the European protocol. Furthermore, it should be borne in mind that the question relating to the existence of previous treatments is only completed for two-thirds of users included in TDI data.

The percentages for cocaine users and "other substance" users, at a fairly low level, remained relatively stable over the period. The proportions of amphetamine and ecstasy users are so low that changes do not require comment.
The developments observed in 2012 contrast with the trends over the entire period. Disruptions related to the changeover to the new European protocol for recording treatment demands may be apparent since 2012 and trends may not be an accurate reflection of reality.

All treatment entrants

As regards all treatment entrants (Figure III), the distribution according to substances seems fairly stable up to 2012, with a slight downward trend in the percentage of cannabis users up to 2010. The proportion of cannabis users increased considerably in 2013, whereas the proportion of opioid users showed a symmetrical decline. These developments are perhaps amplified due to all drug users (predominantly cannabis users) seen at the former CCAA being included as from 2013 (see T1.2.1). Inclusion of these centres resulted in an increase in numbers between 2012 and 2013 by 9,000 users, including 5,600 cannabis users. This therefore accounts for a large proportion of the overall increase (+ 9,000 cannabis users) but not the whole increase. Excluding these centres, the proportion of cannabis users has risen from 34% in 2012 to 40% in 2013.
The proportion of opioid users remained fairly stable between 2009 and 2012, and only declined from 2013, due to the large increase in the number of cannabis users. The decline observed in 2014 is the result of a drop in numbers which appears to be related to a slight reduction in the number of CSAPA responding in 2014 and the deliberate deletion of data on substances in ten or so CSAPA.

The proportion of non-respondents on substances was about 20% up to 2012, with, however, a slight trend towards an increase. The decline in 2013 is once again explained by the inclusion of the former CCAA in TDI data. The resulting increase in numbers (+ 9,000) was

only accompanied by a very small rise in non-respondents on substances. For all former CCAA, non-respondents on substances correspond, in the large majority of cases, to users for whom alcohol is the primary substance which should not be included in TDI data. All non-respondents on substances among individuals received at former CCAA were therefore excluded from the data analysis. The possible presence of these alcohol users among non-respondents at former CCAA was not detected during the 2013 data analysis. The numbers of non-respondents, hence the overall numbers, were partly overestimated (by approximately 10%) in the 2013 TDI data. Those used herein were recalculated after excluding the non-respondents on substances at former CCAA. The large increase in overall numbers without an increase in non-respondents on substances is mechanically expressed by a decrease in the percentage of non-respondents.

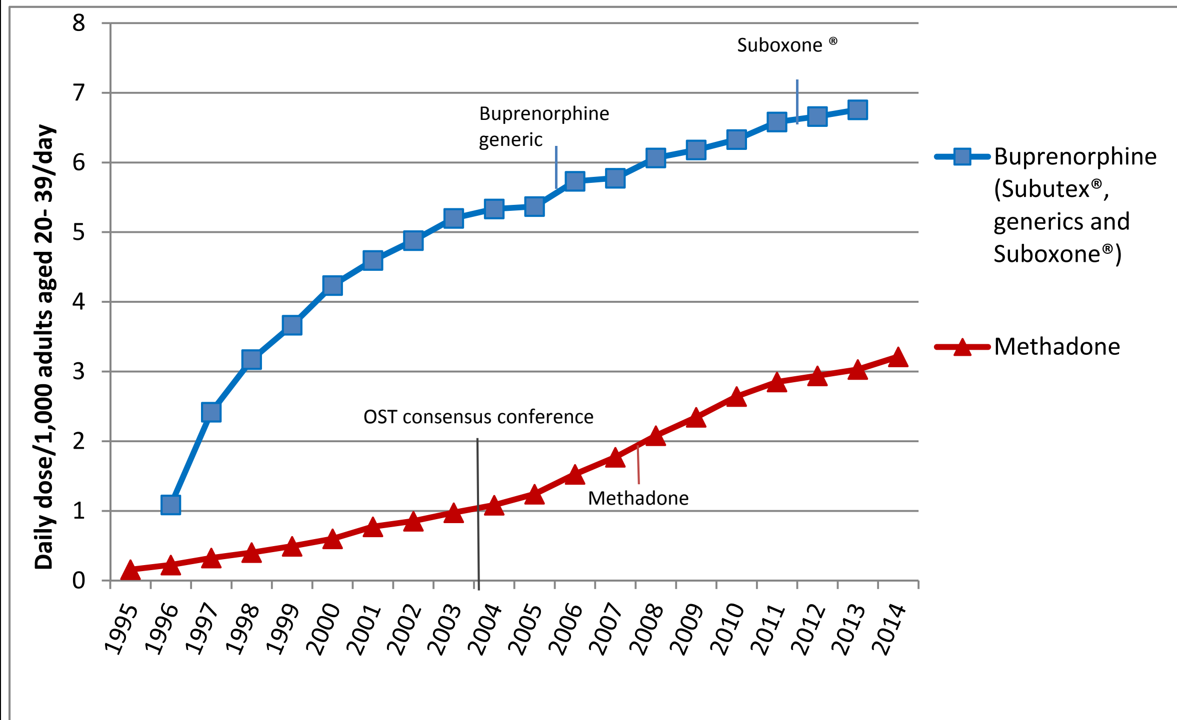
Despite the various disruptions in determining the TDI indicator, the rise in the proportion of cannabis users may be explained both by the increase in cannabis use in France among adolescents and young adults between 2010-2011 and 2014 and by the public authorities' investment to increase treatment provision for young cannabis users (see T1.2 in workbook Drugs).

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

In 2013 and 2014, the number of OST beneficiaries showed a slight decline, for the first time since OSMs were introduced (Figure IV). However, this trend is not significant. Sales data for OSM are conflicting to a certain extent, with growth continuing in 2013 (overall data for 2014 are not yet available).
The proportion of methadone continues to increase in compliance with the consensus conference recommendations on substitution treatments (FFA *et al.* 2005). The 2008 granting of the marketing authorisation for methadone capsules contributed to this increase. Among the 49,000 individuals having received reimbursement for methadone in 2014, for the first time, the syrup form no longer predominates, even though it is still widely prescribed (exclusively to 42% of beneficiaries of reimbursement for methadone *versus* 47% for the capsule form). Furthermore, 11% of beneficiaries were reimbursed for both forms (EGB data, CNAM-TS). According to sales data, in 2014, the syrup form represented 48% (*versus* 55% in 2013) of the methadone sold (by weight) and the capsule form 52% (*versus* 45% in 2013). Moreover, 78% of the quantities were dispensed in retail pharmacies, while 22% were in CSAPAs or hospitals (Bouchara data).

Figure V presents the use of buprenorphine (including Suboxone®) and methadone in France since 1995. These data are based on sales figures, according to an assumed prescribed mean daily dose of 8 mg for buprenorphine (including Suboxone®) and 60 mg for methadone. Buprenorphine generics (introduced in France in 2006), and then Suboxone® (introduced in 2012) offset the decrease in Subutex® use observed since 2006. In 2013, the quantities of buprenorphine sold (by weight) were as follows: Subutex® 73%, generics 24% and Suboxone® 3% (*versus* 1% in 2012). The penetration rate of generics, which has been steadily rising in the last five years, reached 35% in 2013 (Assurance Maladie). Within the scope of a substitution protocol, generics are prescribed at mean daily doses of approximately 2 mg less than the reference drugs, according to the results of the 2012 OPPIDUM survey (CEIP *et al.* 2013).

Figure V: Opioid substitution treatments: use of buprenorphine and methadone from 1995 to 2014 in terms of daily dose/1,000 inhabitants aged 20 to 39 years/day (Subutex® and generics 8 mg, Suboxone® 8 mg, methadone® 60 mg)



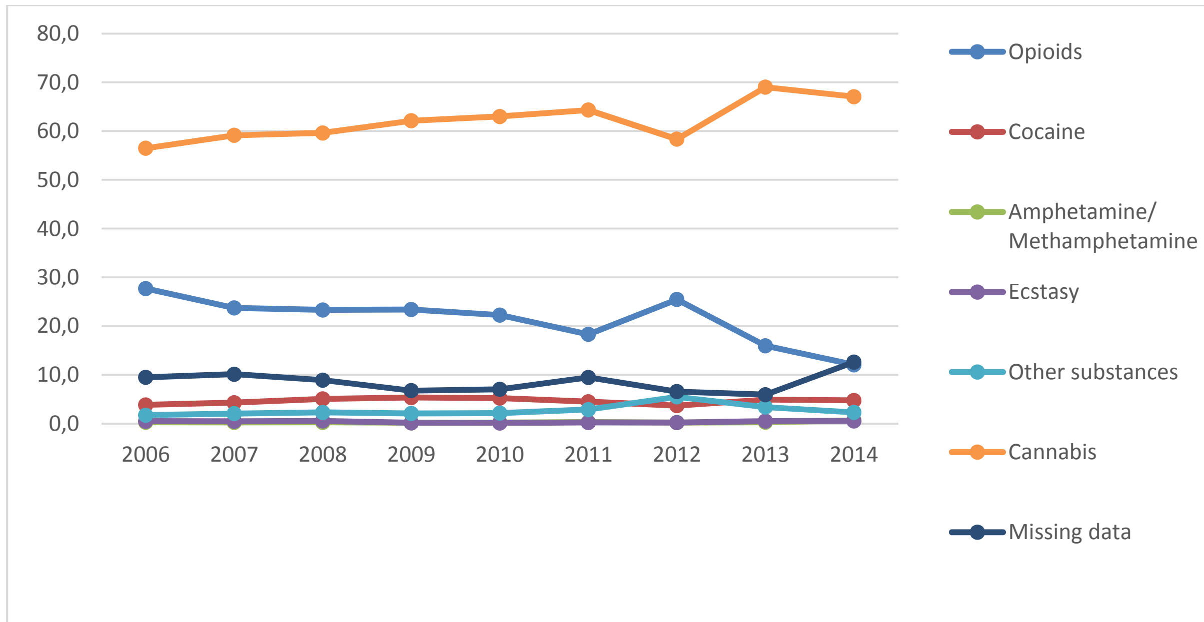
Source: SIAMOIS (InVS), Bouchara, Medic'AM (CNAM-TS)

N.B. Sales data on buprenorphine are not yet available for 2014

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.*

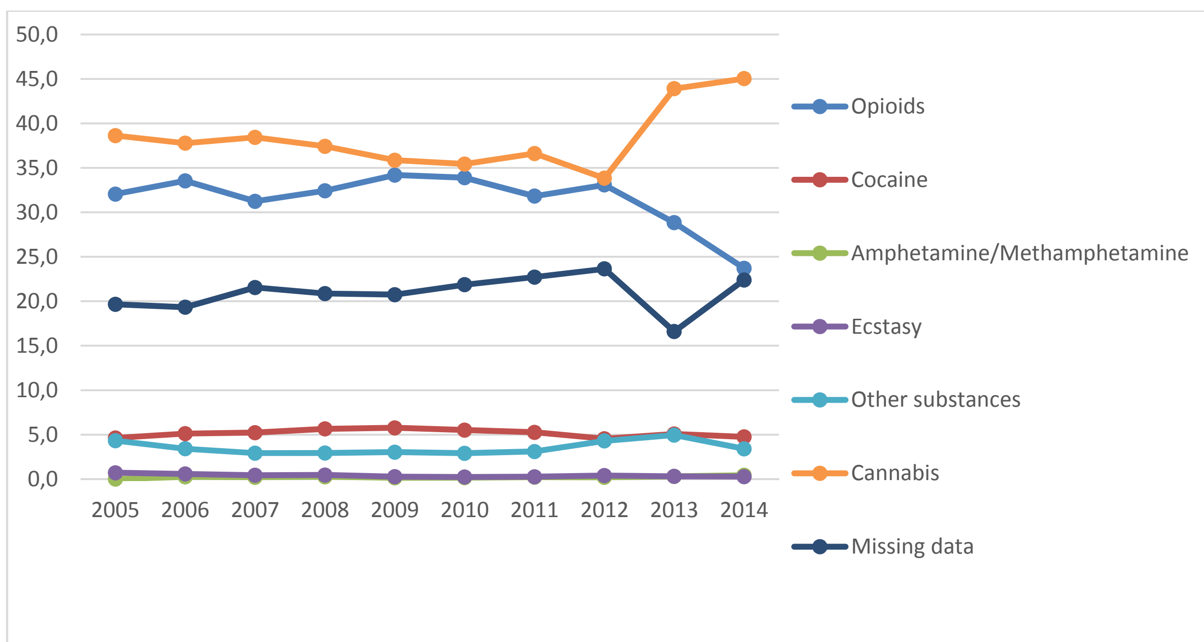
(Suggested title: Additional trends in drug treatment)

Figure II. Trends in numbers of first-time clients entering treatment, by primary drug, 2006-2014



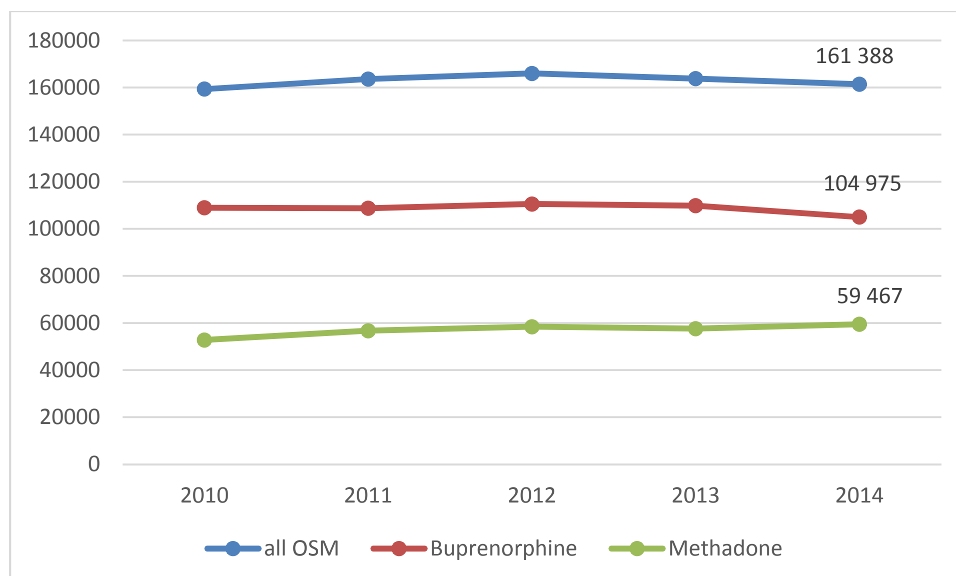
Source: TDI

Figure III. Trends in numbers of all clients entering treatment, by primary drug, 2005-2014



Source: TDI

Figure IV. Trends in numbers of clients in opioid substitution treatment, 2010-2014



Source: ST 24

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.

Please structure your answers around the following question.

T3.1 Please report on any notable new or topical developments observed in drug treatment in your country since your last report.

New developments

The prescribing conditions for methadone in capsule form were modified by decree in October 2014 [Arrêté du 13 octobre 2014 modifiant l'arrêté du 20 septembre 1999 modifié fixant la liste des médicaments classés comme stupéfiants dont la durée maximale de prescription est réduite à quatorze jours ou à sept jours]. The maximum prescribing duration for this form is now 28 days as opposed to 14 in the past. However, the syrup form maintains a maximum prescribing duration of 14 days.

Treatment with methadone can only be initiated in France by a physician practising at a CSAPA or in a hospital (see T1.4.7). However, this restriction has been the subject of debate and the public authorities have questioned the advantages and disadvantages of allowing treatment with methadone to be initiated by primary care practitioners. The results of the *Méthaville* study published in November 2014 in PLoS One (Carrieri *et al.* 2014) support those in favour of extending initiation of methadone treatment to a primary care setting. In this randomised study, opioid-dependent individuals wishing to receive methadone treatment were randomly divided into two groups: in the first group (155 individuals), treatment was initiated by a primary care practitioner and, in the second group (66 individuals), initiation took place at a CSAPA. Comparison between the two groups after a

year showed similar results for the two groups regarding opioid abstinence and adherence to treatment, and better satisfaction among patients treated in a primary care setting. However, the study authors emphasise the fact that this result is determined by the willingness of primary care practitioners, through access to specific training on methadone prescribing and collaboration with a CSAPA and a reference pharmacist. The 2013-2017 plan for combating drugs and addictive behaviours provides for the trialling of initial prescription of methadone in a primary care setting; however, this has not yet begun.

Further to a survey conducted by the Nantes CEIP in 2013, which had shown that misuse by injecting buprenorphine (particularly generics) could cause necrotic skin lesions, the formulation of buprenorphine generics was modified at the end of 2014. The withdrawn excipients are colloidal silica, amide and magnesium stearate (ANSM 2014b).

As regards treatment, the experimental programme for the medico-judicial management of offenders suffering from alcohol or drug addiction, already described in part T1.4.1 and in the Prevention workbook, may also be mentioned.

T4. Additional information

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

Please structure your answers around the following questions.

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.)

T5. Notes and queries

The purpose of this section is to highlight areas of specific interest for possible future elaboration. Detailed answers are not required.

Please structure your answers around the following questions.

Yes/No answers required. If yes please provide brief additional information.

T5.1 Is there any monitoring in place and data available on the misuse of opioid substitution medications?

YES	• Monitoring of indicators for diversion (targeting individuals dispensed more than 32 mg buprenorphine per day, together with users having at least 5 prescribers or 5 pharmacies dispensing treatment) in the OSM reimbursement databases of the National Health Insurance Fund.

	• Qualitative monitoring via the TREND scheme (OFDT) in 7 cities which track the availability and prices of OSM on the black market together with patterns of use. • ENa-CAARUD surveys (OFDT): route of administration of buprenorphine by CAARUD clients. • Oppidum survey (ANSM): route of administration of buprenorphine by CSAPA or CAARUD clients.

T5.2 Is internet-based treatment available in your country?

NO	

T5.3 Has your country developed any specific treatments for NPS users?

NO	

T6. Sources and methodology.

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

Please structure your answers around the following questions.

T6.1 Please list notable sources for the information provided above.

Sources

CSAPA activity reports
EGB: General sample of French persons with social security coverage (*Échantillon généraliste des bénéficiaires*)
ENa-CAARUD: National survey of CAARUDs' clients
CJC 2014 survey: Survey in Youth Addiction Outpatient Clinics
OPPIDUM: Observation of illegal drugs and misuse of psychotropic medications
RECAP: Common data collection on addictions and treatments
TREND: Emerging Trends and New Drugs

T6.2 Where studies or surveys have been used please list them and where appropriate describe the methodology?

Methodology

CSAPA Activity Reports: use of activity reports from National Treatment and Prevention Centres for Addiction (CSAPAs)

National Health Directorate (DGS) / French Monitoring Centre for Drugs and Drug Addiction (OFDT)

Since 1998, CSSTs (Specialised care centres for drug users), and then the CSAPAs that followed them, have been annually completing a standardised activity report and submitting it to their Regional Health Agency (ARS). These reports are then sent to the DGS, which processes them with the assistance of the OFDT. The aim of this data collection exercise is to monitor the activity of the centres and the number and characteristics of the patients received. Epidemiological data are not recorded patient by patient, but rather for all people received in the centre. For 2010, the reports from the 348 outpatient CSAPAs and 10 prison-based CSAPAs were analysed. The respective response rates were 83% and 67%.

EGB: *Échantillon généraliste des bénéficiaires* [General sample of French persons with social security coverage]
National public health insurance centre-Employed workers (CNAM-TS)

The population being dispensed an OSM in the primary care setting was studied using data from the French National Health Insurance Fund's "EGB" general population sample from 2012. The EGB is a permanent representative sample of the population protected by the general health insurance scheme (excluding students and civil servants), the agricultural worker health insurance scheme (MSA) and the health insurance scheme for self-employed people (RSI). It comprises 1/97th of the list of Social Security numbers, grouping more than 600,000 beneficiaries in 2012. 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-TS 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 and 2014 data by the OFDT.

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

Conducted every two 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, age of experimentation, administration route, equipment-sharing), screening (HIV, HBV and HCV) and social situation (social coverage, housing, level of education, support from friends and family).
The 2012 survey was conducted from 26 November to 7 December: 4,241 completed or "non-responder" questionnaires were conducted in 142 CAARUDs. After eliminating duplicates (299) and "non-responders" (1,037), 2,905 individuals (in 139 CAARUDs) were included in the analysis.

CJC 2014 survey: Survey in Youth Addiction Outpatient Clinics
French Monitoring Centre for Drugs and Drug Addiction (OFDT)

2014 is the third year (after 2005 and 2007) 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 2014 survey is based on the responses by professionals having seen the patients or their families between 24 March and 30 June 2014. It covers metropolitan France and French overseas departments. Out of 260 facilities administering a CJC activity in metropolitan France and the DOM recorded in 2014, 212 responded to the survey, i.e., a response rate of 82%.
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.
Out of the 5,421 questionnaires collected, corresponding to the number of appointments held during the survey period, 5,407 were considered fit to describe consulting activity. After eliminating questionnaires not stating gender or age, the final user base included 4,958 individuals.

OPPIDUM: Observation of illegal drugs and misuse of psychotropic medications
Centre for Evaluation and Information on Pharmacodependence (CEIP)

This epidemiological system for monitoring narcotic and psychotropic drug use (illegal or misused substances), through an annual multi-centre study of structures that admit and treat drug users, has existed at national level in France since 1995. Any patient addicted to or abusing psychoactive substances or taking substitution treatment presenting to these structures in the month of October of any given year is included in this study.
The information collected includes the characteristics of individuals and each of the substances used in the last week (description, how it was procured, use, sought effect and signs of addiction). In 2012, 140 centres (or 4,765 patients) took part in the survey. The majority of patients had been seen in outpatient CSAPAs, but some had been seen in prison-based hospital healthcare units (UCSA) and CAARUDs).

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 2013, approximately 175,000 patients seen in 180 outpatient CSAPAs, 18 residential treatment centres and 10 prison based CSAPAs 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 observations are conducted in two social settings chosen due to the high likelihood of finding new or not as yet observed phenomena, even though these do not necessarily reflect the entire reality of the drug use in France:

- urban areas, as defined by TREND, mainly cover low-threshold structures (CAARUDs) and open sites (street, squats). Most of the people met and observed in these settings are problem users of illegal drugs living in particularly precarious conditions.
- Techno party settings refer to places where events are organised around techno music. These include so-called “alternative” techno settings (free-party, teknivals) and techno events in clubs, discothèques and private parties.

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

- continuous qualitative data collection 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.

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