Trends
Review of the latest research

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[French monitoring centre for drugs and drug addiction]

Drug maintenance treatments in France: recent results 2004

This issue of Tendances *includes four articles. After dealing in the first part with the question of the number of users who have substituted HDB for opiates and an assessment of the treatments, the second part concentrates on misuse and non-substitutive uses of HDB.*

How many opiate users are there on HDB?

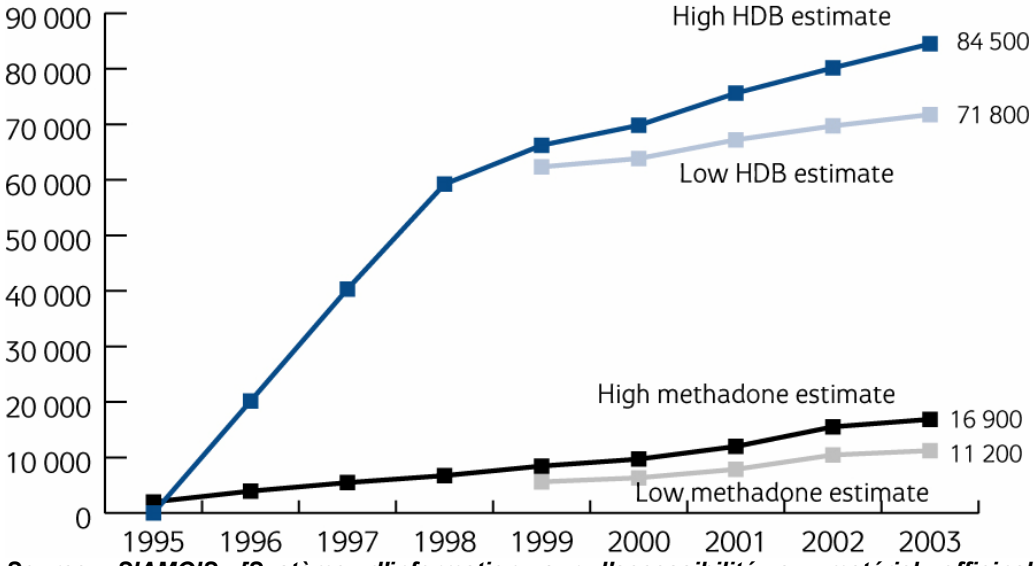
In France, the most recent assessments [1] report the existence of 150 000 to 180 000 problematic users of opiate drugs and/or cocaine. Substitution treatments are one of the therapeutic and support options offered to individuals who are dependent on opiates. These consist of prescribing medicines based on morphine derivatives to compensate for the withdrawal effects when stopping the use of illicit products, and are aimed at achieving and maintaining heroin abstinence.

The prescription framework, set up in 1995, is established around two medicines, methadone and high dosage buprenorphine (HDB), which is marketed under the name of Subutex®. Whereas methadone treatment can only be initiated in a specialist centre (CSST [*Centre spécialisé de soins pour toxicomanes* – Specialist centre for drug addicts]) or in a care establishment, HDB can be prescribed by any doctor.

Its main prescribers are GPs (between 91% and 99% depending on the city) [2].

Having come onto the market in 1996, HDB is rapidly becoming, in quantitative terms, the leading treatment for opiate dependency in France.

Figure 1 – Estimates of the number of people receiving substitution treatment



Source: SIAMOIS [Système d'information sur l'accessibilité au matériel officinal d'injection et à la substitution* – Information system on accessibility of medical equipment for injection and substitution] *and InVS [Institut national de veille sanitaire* – National health watch institute*] data and OFDT estimates

The theoretical number

The development of Subutex® distribution among individuals who are dependent on opiates is usually monitored using a theoretical number of patients treated (or patient-equivalents using 8 mg per day for a year), calculated by dividing the quantity sold in a year (Q) by 365 (days), then by 8 mg, this figure representing the daily theoretical dose recommended in the AMM *(Autorisation de mise sur le marché* – [Permit to market a product]). Using this indicator, it has been possible to observe a rapid growth in the number of HDB users since 1996 [Figure 1].

In 2003, according to this calculation, the average number of HBD users was 84,500.

However, based on data from the health insurance organisation *Assurance Maladie*, several recent studies suggest that the average daily dose really "used" per patient may be higher than 8 mg [2-4]. Several recent works [2-4] have tried, using different methods, to identify the average doses received within the context of a therapeutic process. The CNAMTS [*Caisse nationale d'assurance maladie des travailleurs salariés* - National state health insurance office for salaried workers]/OFDT 1999/2002 survey across 13 CPAMs [*Caisse primaire d'assurance maladie* – National health authority] spread throughout France estimates the average dose of the patients on a treatment programme, based on the median doses of the group of patients "in continuous treatment" (treatment period ≥150 days and interval between two drug issues ≤ 30 days). This method makes it possible to disregard isolated or irregular prescriptions and to limit the impact of the extremely high doses received by some patients. The dose estimated in this way is equal to 9.6 mg. This is the only estimate that has a general aspect, in the absence of being able to claim national representativeness.

Use of this data leads to a low estimate, based on the average number of patients treated daily, equal to 71,800 patients for 2003.

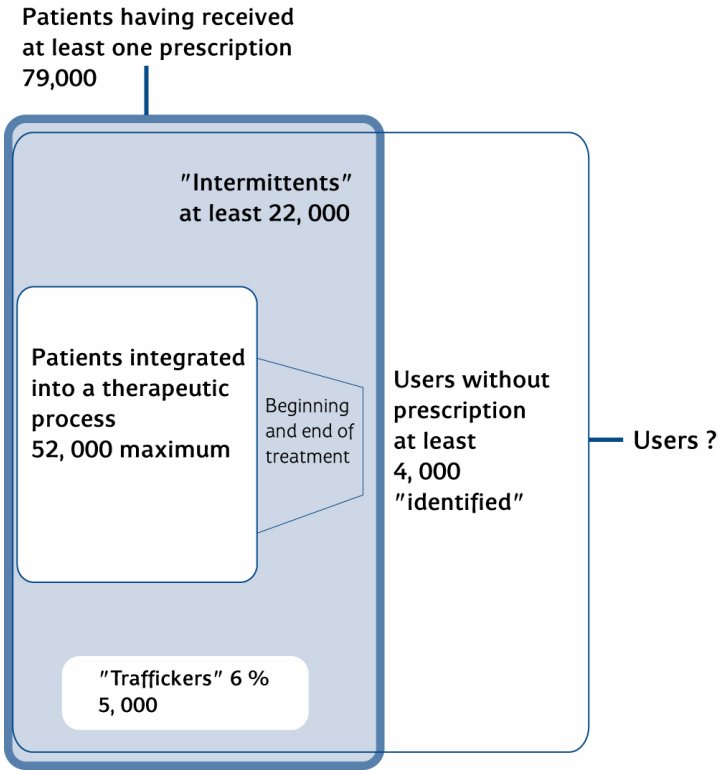
How to take better account of reality

Today, the latter indicator seems to be moving away from representing the true situation. In fact, some of the buprenorphine prescribed is diverted to the black market and is therefore not used within a treatment context. Moreover, the drug-issuing data from *Assurance Maladie* makes it

possible to distinguish individuals who receive prescriptions on a fairly occasional basis or who present multiple interruptions in treatment [2-4]. Several HDB populations can therefore be identified:

- patients enrolled on a treatment programme under medical observation;
- patients receiving prescriptions of substitution products on an irregular basis, the "substitution intermittents";
- finally, added to these two groups are the users "without prescription" who are difficult to count.

Figure 2 – The different populations receiving Subutex® on prescription



Source: CNAMTS data/OFDT estimates

Based on the results from the second half of 2002 in the CNAMTS/OFDT study across 13 CPAMs [2], it has been estimated that[1]:

1. between 21 and 25% of the quantities reimbursed may currently supply the black market;
2. the average daily dose used by patients on a treatment programme is equal to 9.6 mg, (the median dose of the patients in "continuous treatment");
3. 6% of the individuals receiving a prescription over a 6-month period carry on a significant trafficking activity: they receive more than 32 mg of HDB per day (51 mg on average).

[1] The entire process will be published in a later article.

Given these various parameters, it can be estimated that the number of patients engaged in long-term treatment does not exceed 52,000 at the end of 2002, namely less than a third of problematic opiate users. The number of individuals carrying on a significant trafficking activity is estimated to be around 5,000.

From the data published by *Assurance Maladie* [5], it is possible to estimate that the number of individuals who received a HDB prescription in the last quarter of 2002 was around 79,000.

If one excludes from this figure the maximum numbers of patients treated and of individuals engaged in trafficking, the number of individuals receiving prescriptions on an irregular basis is at least 22,000.

Finally, the users who never receive a prescription (obtain supplies solely on the black market) cannot currently be counted, since the only information available is that at least 4,000 people who have used HDB without a prescription during the previous month visit low-threshold facilities annually.

The trend is now towards a stagnation in the number of patients receiving HDB and even a decrease across the areas where substitution practice has been extensive and in existence for a long time. [2].

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Impact of substitution treatments: assessment of the last ten years

Substitution treatments have developed very considerably in France from the second half of the 1990s onwards, and in particular from 1996 with the granting of the permit to market high dosage buprenorphine (HDB) which allows it to be prescribed by any doctor. Despite the deficient nature of the data available, it is still possible to issue a report of a generally positive impact, while drawing attention to some significant trends over the last ten years [6, 7].

A clearly positive impact

In terms of drug use, an overall reduction in problematic practices can be observed among individuals in the care system being treated with HDB. The use of heroin is falling, as are injection practices. Thus the frequency of the recent practice of injecting fell from 21 to 14% in the patients on a HDB protocol between 1998 and 2002 (Source: OPPIDIUM [*Observation des produits détournés de leur utilisation médicamenteuse* - Monitoring of illegal psychotropic substances or those that are used for purposes other than medicinal]/CEIP [*Centres d'évaluation et d'information sur la pharmacodépendance* - Drug Dependency Information/Evaluation Centres]). The sharing of equipment and syringes appears to be becoming less common.

In terms of health, the most striking impact is in the significant fall in deaths from overdose to which it is reasonable to think that substitution treatments have contributed. This fall is evidenced by the convergence of several sources (OCRTIS [*Office central pour la repression du trafic de stupéfiants* - Central office for the repression of drug-related offences], OFDT, INSERM [*Institut national de la*

santé et de la recherche médicale - National institute for health and medical research]): the number of deaths is now half, or even a fifth depending on the source, of the level it was at during the second half of the 1990s. Substitution treatment is also, for the patient, an opportunity for improved use of the care facilities, in particular better access to antiretroviral treatments. The lower frequency of injecting may have contributed to the slowdown in the HIV-related epidemic, which was particularly strong among injecting drug-users. Finally, there is absolutely no doubt as to the positive results of the substitution treatments prescribed during pregnancy on the condition of the mother and child.

The various follow-up studies on users on substitution treatment, or the qualitative studies carried out among users, testify to the assistance provided by a structured treatment, including substitution treatment, within the social readaptation process. Housing conditions tend to improve, as do work situations and access to social security insurance. The relational fabric shifts, moving away from the "network" linked to drug addiction. Finally, the patients' experience improves in terms of their quality of life.

Moreover, being on substitution treatment during a period of imprisonment appears to limit the number of subsequent periods of imprisonment.

The appearance of new difficulties

In parallel with the beneficial effects, the extensive development of substitution treatment at the end of the 1990s is accompanied by the observation of some undesirable consequences. These are almost exclusively reported in connection with HDB on account not of the characteristics specific to this product but of its particularly flexible prescription context. Even though theoretically it is not injectable, it is injected by 11% of individuals on a medical protocol (OPPIDIUM/CEIP, 2002) and by 54% of individuals who use it as a product for getting high (TREND/OFDT, 2003). On the one hand this practice limits the impact of substitution treatments on the reduction in injection practices, but it also leads to some worrying locoregional (abscesses, lymphoedemas, necroses, etc.) and systemic (viral contaminations, systemic candida infections, etc.) health consequences. Its misuse by some people when combined with other products (benzodiazepines, alcohol, etc.) is the cause of potentially lethal overdoses.

HDB is the subject of a trafficking activity which may locally be on a considerable scale; it is estimated that between 20 and 25% of the quantities sold in France are diverted (OFDT-CNAM [*Caisse nationale d'assurance maladie* – National health insurance fund]). The spread of HDB is accompanied by the appearance of non-substitutive uses of it, like any other drug. Its wide availability on the black market means that it is sometimes a method of entry or re-entry into drug addiction or dependency. This is the case for a fifth of users visiting the front-line reception facilities and using HDB (Source: TREND/OFDT).

A few questions pending

Finally, there are some other elements which seem difficult to interpret in terms of positive or negative impact, given the knowledge available.

Illicit drug addiction…licit drug addiction?

The stopping of the use of illicit substances and injection practices, or the fall in these activities, is confirmed and accentuated with the length of treatment. But this improvement is accompanied by the development of new profiles of problematic use of other products: the increasingly frequent use of alcohol and benzodiazepines concerns patients on both methadone and buprenorphine. Is this the switch from an illicit drug addiction to a licit one? Although the benefit of substitution treatment for the patient is positive in the short or medium term (getting out of "trouble"), one may question the results of the assessment in the longer-term.

Self-substitution

The consequence of the accessibility desired for buprenorphine has been a use without medical supervision or even outside any medical prescription. This “unofficial” substitution involves opiate users who are still active, and is accompanied by problematic practices which are more often encountered in connection with patients on a treatment protocol: their injection practice, including injecting HDB, and their use of licit and illicit products is more extensive.

However, what information is available to us for evaluating the risk/benefit ratio of self-substitution in this population about which little is currently known? What role does HDB play in the addictive lifestyle of these users? Although HDB seems to be used initially as a drug by a significant portion of this population, does it not at a later stage provide a means of attaining a form of maintenance? Is self-substitution not a gateway to substitution treatment? Thus the use of buprenorphine outside a protocol is believed to precede entry into treatment in around a third of cases. Moreover, it is observed that individuals in highly precarious situations reach substitution in this way.

Therefore, having a better understanding of the role of street buprenorphine among active users would make us better able, in future, to answer these questions and to assess the impacts which might be expected from a possible change in the prescription context of substitution treatments aimed at reducing the principal misuses of HDB observed at present: injection, trafficking and the occurrence of first-time dependencies.

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HDB misuse

The regulatory framework for HDB makes this product very accessible. Some misuses – uses which are inconsistent with the planned therapeutic use – have developed.

The diagram opposite represents the different types of misuse encountered. There are two ways of tackling HDB misuse:

- from the medical angle, which focuses on what is happening “within the context of medical prescriptions”,
- from the “users” point of view, which concerns all forms of HDB use, both on and also outside a medical protocol.

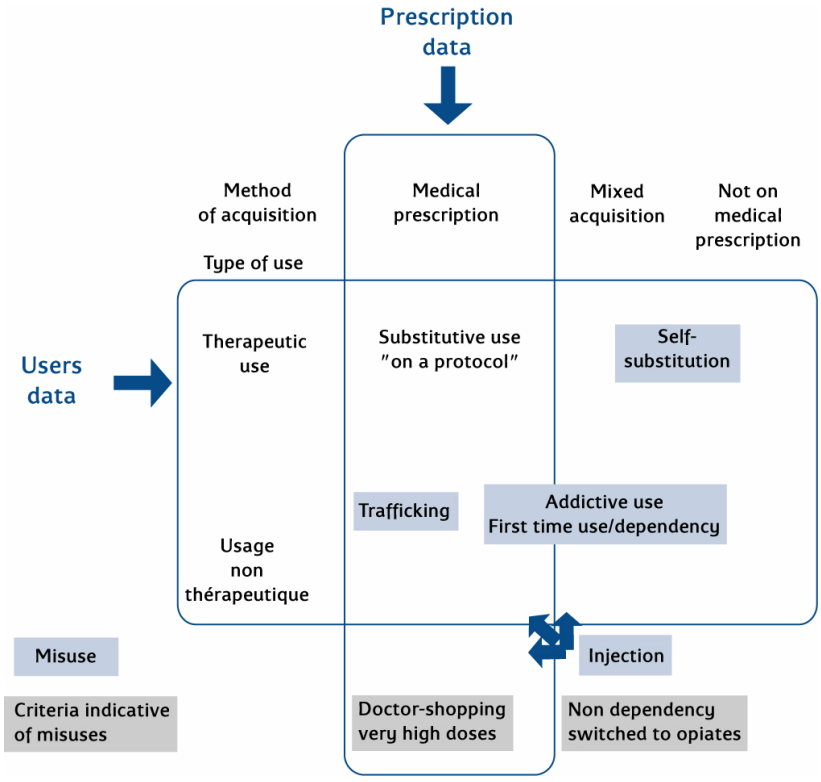
These two methods of tackling the subject correspond to the two major sources of information available for documenting the issue:

- the *Assurance Maladie* information system and the surveys among doctors,
- the surveys among drug users.

The debate surrounding misuse is often clouded by a lack of clarification of the concepts and imprecision concerning the populations observed. The best example in this regard is undoubtedly the issue of HDB injection whose frequency can vary from 8 to 65% depending on the observation perspective. It seems important therefore to state the types of misuse that it is possible to describe (Figure opposite):

- self-substitution: “therapeutic”-type use, where HDB is substituted for all or part of a previous heroin use with the aim of stopping or reducing the use of it, but outside a medical protocol;
- addictive use, where HDB is used as one drug among others in the absence of heroin;
  - either in people who were previously depending on an opiate,
  - or in people for whom HDB is the first opiate used or the first one to cause a dependency (non-substitutive uses of HDB);
- use of an administration method other than the sublingual method (injecting, sniffing, smoking) on or outside a medical protocol,
- taking inappropriate doses and the problematic use of other products;
- trafficking

Figure 3 – HDB misuse



Source: OFDT

It seems very difficult, or even impossible, to draw a clear boundary between self-substitutive (therapeutic) use and addictive (non-therapeutic) use, since both can be in play alternately. In the front-line facilities (2003) [8], which usually receive users who are still in their addictive lifestyle, 41% of people have used Subutex® during the previous month. Of these, 13% use it exclusively to get high, whereas 34% mix therapeutic use and addictive use.

Self-substitution

Several studies confirm the existence of self-managed substitution practices [9, 10]. Among the users of the front-line facilities, 18% of the people who say that they use HDB solely to treat themselves obtain their supplies solely on the black market, whereas 13% mix prescription and illegal supply. The reasons for this use of street substitution seem to be linked in particular to the existence of users who are homeless or in very precarious situations, young people and adolescents, and migrants who do not want to have to deal with the care system [11, 12]. It may be a question of the absence of social security insurance, the need for large doses or a need for anonymity (minors, young adults covered by their parents). This "unofficial substitution" is accompanied by more frequent at-risk behaviour than among patients on a treatment protocol [12, 13].

Addictive use

Among heroin-addict patients, HDB is used as an opiate, an alternative to using heroin when heroin is not available. Others use it to manage the use of other substances. Obtaining supplies in this context is for the most part illicit. In fact, only 22% of individuals who exclusively use HDB "to get high" acquire it all on prescription and 54% obtain their supplies solely on the black market. Addictive use usually leads to injection [Table 1], and to an increase in doses and polyuse of psychotropic products.

For several years, it appeared that HDB represented, for some people, a vehicle for entering or relapsing into drug addiction (non-substitutive use). In the context of the TREND network, this phenomenon was the subject of a specific study in 2002 and 2003 [9] (cf. *Usages non substitutifs de la buprénorphine haut dosage, en France* [Non-substitutive use of high dosage buprenorphine in France], p. 7).

The image of Subutex® among drug users is very negative [8]. In fact, HDB is regarded as a very addictogenic substance, making any detoxification painful and difficult. Its image appears increasingly to be linked to the injuries that occur when injecting. Finally, we are witnessing a growing discrediting and devaluing of its users as regards themselves and other users.

Table 1 – Frequency of methods of using HDB during the previous month, in 2003, among the participants in the "front line 2003" survey, according to the intentionality of the use

	To self-treat*	**To get high***	**Both***	**All**
Oral	66% (135)	33% (16)	64% (81)	61% (232)
Injected	41% (84)	50% (24)	55% (70)	47% (178)
Sniffed	17% (35)	33% (16)	33% (42)	25% (93)
Total	100% (205	100% (48)	100% (126)	100% (379)

Source: TREND/OFDT [8]

*wording of the questionnaire

Table 2 – Frequency of problems during the previous month among injectors in 2003

	Subutex® injectors	Injectors of other products	Ratios of marks and confidence interval at 95%	
Abscesses	31%	19%	1.9	[1.2-3.1]
Difficulties when injecting	68%	55%	1.7	[1.1-2.6]
Blocked vein, thrombosis, phlebitis	42%	30%	1.7	[1.1-2.5]
Swelling of hands or forearms	44%	26%	2.3	[1.5-3.5]
Dust	27%	22%	1.4	[0.9-2.1]
Haematoma	44%	36%	1.4	[0.9-2.1]

Source: TREND/OFDT [8]

Injection and its consequences

The use of HDB by injection involves all the groups of HDB users (medical or non-medical use, and substitutive or non-substitutive use) with different prevalences. It appears to diminish with the length of treatment and the degree of involvement in a treatment process [14]. In 2002, in the specialist care structures, 11% of the patients who were on a medical protocol which included HDB injected, as opposed to 27% of the HDB users who were not on a therapeutic protocol. This practice appears more common among the subjects monitored in general practice than among those treated in CSSTs (22% as opposed to 6% in the OPPIDIUM 2002 survey). Injection is frequent among the HDB users in the front-line facilities (47%), and even more so (54%) among those wanting to get high [Table 1].

In addition to the risk of viral contamination, injecting HDB increases the risk of respiratory depression and overdose, particularly when combined with the use of benzodiazepines or alcohol, and this all the more so when it is linked to the use of supratherapeutic doses.

The injecting of Subutex® tablets, which contain various excipients, is frequently the cause of locoregional injuries in the injection areas. Subutex® injectors present a higher risk for some of these injuries than injectors of other substances [Table 2]. Injection may also be the cause of systemic candida infections with prostatic, osseus, articular or cutaneous secondary locations [11] and other systemic symptoms.

Polydrug use among subjects on HDB

As in the subjects treated with methadone, use of other psychoactive products in parallel with the treatment is highlighted in the patients treated with HDB [8, 13]. This use is more extensive among users who are not on a medical protocol [Table 3]. It is all the more frequent when the use is addictive.

The *Assurance Maladie* data shows extensive prescribing of benzodiazepines: in the second half of 2002 [2], 47% of patients from thirteen cities who had acquired HDB received a prescription of benzodiazepines. Although some patients obtain these products from several doctors, joint prescriptions from a single doctor are frequent (56% of town practitioners in one study in the department of Les Bouches-du-Rhône [15]).

Some deaths associated with the presence of HDB have been reported. Combining it with other substances, particularly benzodiazepines [16], is almost continuous. The risk of death also seems to be particularly associated with intravenous injection, and may be more significant in cases of occasional combining of products [17].

Table 3 – Use of psychoactive substances by users of the CSSTs in 2002 according to whether or not they are on a treatment protocol

Products used	**HDB on a protocol**	**HDB "not on a protocol"**
Heroin	8%	27%
Cocaine	6%	19%
Alcohol dependency	17%	22%
Codeine	1%	0%
Benzodiazepines	21%	37%

Source: OPPIDIUM/CEIPs/AFFSSAPS [Agence française de sécurité sanitaire des produits de santé* - French Health Products Safety Agency*]

Table 4 – Distribution of the 13 sites according to three indicators demonstrating doctor-shopping and diversion activity in 2002

	Lille Rennes Metz and Dijon	Nice Bordeaux Lyon Grenoble Montpellier	Bobigny Toulouse Marseilles	Paris
Average % of patients having consulted at least 5 different prescribers	2%	4%	8%	11%
Average % of patients receiving more than 32 mg per day	1%	3%	8%	12%
Quantity potentially diverted	7%	12%	25%	40%

Source: CNAMTS data, ODFT processing [8]

Doctor-shopping and parallel market for HDB

HDB is the eleventh highest medicine, in terms of value, reimbursed in France (110 million euro in 2002) [18]. Yet, a sizeable portion of the reimbursements seems to correspond to prescriptions which will not end up in therapeutic use.

The prescribing of HDB by different doctors for a single patient (doctor-shopping) has been highlighted for several years [2, 4, 5, 15, 19]. The use of doctor-shopping for trafficking purposes is believed to involve 6 to 10% of individuals who receive a HDB prescription (around 5 000 users, or supposed users).

One study on the 2002 data from 13 cities shows that Paris and its northern suburbs, Marseilles and Toulouse are places where trafficking is more frequent than in other sites which are practically untouched by it [Table 4]. The use of a diversion indicator representing the size of the portion diverted locally suggests that the quantities at stake are far from being insignificant across the sites concerned [2, 4]. Thus a minority of people are believed to divert 21 to 25% of the quantities of HDB sold in France.

The existence of a parallel market and the considerable accessibility of HDB is evidenced by numerous other indicators.

In the CSSTs in 2002, 10% of patients on buprenorphine obtained the treatment illegally [13]. In the front-line facilities, in 2003, 22% of users obtained supplies exclusively on the parallel market and 24% mixed licit (prescriptions) and illicit supplies. The price of an 8 mg tablet on the black market appears very modest (median price of 3 [?] in 2003 [8]). It varies depending on the site, from 1 [?] (Paris) to 4 [?] (Dijon, Bordeaux). Over the period 2000-2002, a significant increase in the diversion phenomenon can be observed [2]. In 2002, the observations by the TREND network note an increase in the presence of Subutex® on the parallel market in the majority of the cities [12]. Its median price fell by 50% between 2000 and 2003, testifying to the increasing availability of Subutex® on the black market in recent years [8].

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Non-substitutive uses of high dosage buprenorphine in France

This article summarises the main results of the report entitled "Usages non-substitutifs de la buprénorphine haut dosage – Investigation menée en France en 2002-2003 [Non-substitutive uses of high dosage buprenorphine – Investigation carried out in France in 2002-2003]*", available on the OFDT website (June 2004).*

For several years, various works have been reporting the increasing existence of the use of high dosage buprenorphine (HDB, Subutex®) by individuals who have never been dependent on opiates or who have never used them.

This observation led the OFDT's TREND device to promote a study [9] focusing on the non-substitutive uses of HDB in France in 2002-2003, aimed at describing these uses and providing information for understanding them. This article summarises the main results.

Methods

The investigation is based on qualitative and quantitative methods. It involves, firstly, an epidemiological survey carried out among 970 drug users visiting the front-line facilities and, secondly, 34 semi-directive interviews, gathered across 6 metropolitan sites. The data-gathering took place in 2002 and 2003. Several situations were identified:

- the first-time user: user using HDB without ever having used any other opiates previously;
- the first-time pharmacodependent: user for whom HDB is the cause of his first dependency on opiates;
- the non-consecutive dependent: former heroin addict who, after stopping his heroin dependency for at least 2 years, is beginning a HDB dependency.

The participants in the semi-directive interviews were either first-time users or first-time pharmacodependents. They were contacted via front-line facility, CSST, hospital or prison structure, GP, street or squat.

Table 5 – Frequency of non-substitutive uses of HDB among HDB users during their lifetime (more than 10 times) and during the previous month, encountered in low-threshold facilities in 2002

Type of HDB use	**Lifetime (n = 568)**		**Previous month (n = 407)**	
	%	n	%	n
First-time users	6%	35	7%	27
First-time pharmacodépendants	11%	65	12%	50
Non-consecutive dependents	10%	56	9%	38
Total non-substitutive users	25%	141	25%	102

Source: ODFT data, ORSMIP [l'Observatoire Régional de la Santé Midi-Pyrénées* – Midi-Pyrénées Regional health observatory*]/GRAPHITI exploitation

Since several replies per person were possible, the sum of the percentages is greater than 100.

Results

Frequency of non-substitutive uses of HDB

Of the 970 individuals questioned in the front-line facilities, 568 (59%) say that they have used HDB more than 10 times during their lifetime and 407 (42%) during the previous month. Whichever of these two populations is involved, non-substitutive use is frequent (25%, see table). The respective portion of first-time users, first-time pharmacodependents and non-consecutive dependents is fairly similar (see table) in both populations. These results underline the importance of HDB-related dependencies in this type of population.

Contexts of using and of beginning non-substitutive use of HDB

The non-substitutive use of HDB does not appear to be a characteristic solely of individuals in social distress. It has been observed in a variety of social situations. The users encountered report varied methods of introduction to and development of a non-substitutive use:

- in the context of a relationship between a couple or between friends;
- in urban homelessness (squat, street) and situations of great precariousness;
- in prison environments
- in the techno music scene

Effects sought in non-substitutive use

When it is used in a non-substitutive logic, HDB meets three major effect-seeking categories: getting high, seeking performance and reducing anxiety. HDB is used as a means of getting high by some people on account of its “effectiveness” in a subject who is not dependent on opiates, the ease of obtaining it and its low cost (on prescription or on the black market). For some people, HDB allows them to carry out activities which are normally difficult or impossible for them: meeting other people, talking to them, begging, studying, working, having sexual relationships. Finally, for other people, this product brings a tranquillising effect, a means of easing tension, limiting aggressiveness and reducing anxiety. These three categories of effects sought overlap, intersect and sometimes succeed one another for a single subject.

Methods of administration and supply

A significant portion of non-substitutive users inject, sniff and smoke HDB. A third of first-time users and 42% of first-time pharmacodependents inject HDB. Injection as the principal method of administration seems frequent in the interviews. Obtaining supplies outside medical channels is standard practice for the initial uses, then most people turn to the doctor, since the absence of heroin dependency is not an obstacle to obtaining a prescription. Combining HDB with other products exists. This tends to involve users wanting to get high. In this case, cannabis, alcohol and benzodiazepines are the products mainly used. Subutex® may be combined with psychostimulants, particularly cocaine, when trying either to regulate stimulation or to get high.

First-time uses and possible harm

Some HDB users become dependent on this product without ever having developed an opiate dependency previously. Frequently, this involves people who have had problematic uses of non-opiate substances (benzodiazepines, alcohol). For these dependent individuals, HDB detoxification seems to be particularly painful and difficult. Although some of the first-time users had already used the intravenous method before using HDB, for a greater number the injection practices only began with the use of this product even if it is not possible to establish a causal relationship.

Health problems and non-substitutive uses of HDB

As in the case of substitutive users of HDB, non-substitutive users who inject present more health problems and in particular locoregional pathologies in the injection areas (abscesses, thrombophlebites, lymphoedemas, necroses). Detoxification is considered by the users to be very difficult and, although the majority have been confronted with it, few have been successful. Thus 85% of those surveyed and 23 of the 29 first-time pharmacodependent interviewees were still dependent at the time of the survey.

Conclusions

The use of HDB in a non-substitutive logic is, in France in 2003, an unquestionable reality among users in very precarious situations and also in larger groups. Several factors have been identified which may lead to fears of it spreading:

1. Considerable demand for psychoactive products exists within various suffering populations (precarious, homeless, people in prison) where HDB is already present and seems to be on the increase.

2. The pharmacological characteristics of HDB imply a range of effects sought by non-substitutive users and, simultaneously, imply powerful physical and psychic dependencies.

3. Some of the current practices for prescribing and dispensing HDB provide “excellent” availability and accessibility for users, whether they go to the doctor or not.

In the absence of a significant reduction in the accessibility and availability of HDB, there is no sign of any slowdown in the development of the non-substitutive use of HDB. Although this molecule, which is prescribed within a structured context, seems to be an effective therapeutic element for some people, it is currently functioning as a drug for others.

Serge Escots

Association Graphiti, coordinator of the Toulouse TREND website

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