I would like to begin my intervention by giving figures on the epidemiological situation relating to drug use in France. Until the first half of this year, the known AIDS cases among drug users was 4387 cases, i.e. 27.4% of all cases in France in 1992. The number of cases, and therefore the percentage, have been on the increase since 1984. It is estimated that 40-50% of all users are seropositive. There are thus between 40,000 and 75,000 drug users who have AIDS.

Before beginning my discussion of methadone, I will give an outline of French policy on AIDS prevention among drug users. This can be summarised as follows:

1. There are only three needle exchange projects in the whole of France.
2. There is little outreach work and little education.
3. There is a policy based on the moralistic view: 'Abstention'- coming off or dying.
The consequences of this policy are:

Repressive policing that endangers AIDS prevention. In some 'hot' areas, policemen wait outside pharmacies in order to arrest users with needles and syringes. This discourages many from obtaining new needles.

In budget terms, France assigns US$50 million for the fight against drugs, and only US$500 000 in the fight against AIDS among drug users.

Most professionals follow the official drugs policy as they fear being accused of being an accomplice of the devil (the drugs).

Although many European countries facilitate access to synthetic substitutes, France has recently included Terngesic in class B of controlled substances.

My conclusion here is that although some countries follow the policy of harm minimisation, France follows that of 'harm maximisation'.

METHADONE

Two methadone programmes have been in existence in France since 1973. Three years earlier, the parliament passed a law on both drug trafficking and drug treatment - this makes the user an offender by the simple fact of using an illicit substance. The drug user also becomes a sick person who can benefit from specialised care. In addition there is a new law that forces care and treatment on those not sentenced to prison.

It is in this context, and in view of the first American results on methadone treatment, that the authorities are proposing methadone as a detoxification treatment or substitute.
Following a decision taken by the Ministry of Health and Social Security, a commission of experts (under INSERM) was formed to define the mode of administration of methadone in France. This commission defined the criteria of admission as the following. voluntary treatment of adults: a person must be clearly dependent on drugs (an addict); and the person must have a real wish or desire to give up.

The distribution of products has also been well defined. The daily dosage has to be taken under supervision by a member of the medical staff. Urine checks are also carried out regularly.

There are techniques available for methadone use:

1. Short term: rapid detox, with decreasing dosage of methadone over 15 days.

2. Medium term: substitution treatment over 6 or 8 weeks, whereby methadone doses are decreased.

3. Long term: real substitution cure (originally called substitution toxicomania) using small doses and extending them over a longer period. The first dose for long-term treatment is 20 mg/24 hours, leaving the adjusting to the judgement of the clinicians.

As a result of these criteria, four centres that have the technical and personnel infrastructure have put themselves forward to take part in the experiment. At that time, the debate was raging in the USA about the usefulness of methadone, its risks and the ethical problems -associated with a new type of intoxication/addiction. France faced this same debate and ethical questions. Many centres estimated that substitution treat. merit was incompatible with their methods of care.

Finally, only two centres accepted participation in this experiment, each offering 20 places.
From 1973 to 1990 (17 years), no other centre opened its doors, but in 1990 a third one was opened with 12 places.

It is important to note that these two programmes were developed as experimental programmes and that they remain as such. Two remarks must be made:

1. In these two programmes, it is the programme itself that is experimental and not the methadone.

2. By defining them as experimental the Government was denying that they were based on official policy, one in opposition to the War on Drugs.

Below some facts are presented about the dosage and the duration of the treatment in these two centres; these are based on a study carried out in 1989.

**Dosage**

The starting dose is established in terms of addiction, assessed through conversations with the patient, an assessment of his or her clinical state. Doses are smaller than those usually prescribed in the USA, the Netherlands and Switzerland. For most patients, taking into account all the years of use, the average starting dose is 40 mg; 50.64% of patients are given an average dose of 30-50 mg.
Duration of treatment

It is important to remember that methadone is not considered as a maintenance treatment. When the programme was established, three techniques were used: short term for less than 2 months, medium term, for less than 6 months, and so-called subsistence treatment with no precise time limit. However, it has always been said that there is a time limit to methadone treatment, even if the date was not previously defined. It has never been a question of life-long treatment.

In-patient treatment was abandoned early on, all treatment being as out-patients. Most treatment lasts less than 12 months and is true in 86.43% of patients:, 5 5.29% left before 2 months, 18.2 7% between 3 and 5 months, 9.62% for between 6 and 8 months and finally 3.37% for between 9 and 11 months. Of patients 5.76% benefited from the treatment for a period ranging between 1 and 2 years and 3.36% between 2 and 3 years. Longer-term prescriptions are very rare. The longest uninterrupted treatment lasted for 6 years. Methadone has not yet been used as a way to reduce HIV infection, for the following reasons:

1. Lack of awareness on the part of politicians, health and social professionals of the seriousness of HIV infection among injecting drug users.

2. So-called ethical reasons: legal medical prescribing of an opiate is not without problems. On the one hand, methadone is legitimately given to users by a doctor. On the other, the reluctance of health and social workers to use methadone is based on the following contradiction: they need to work towards the detoxification of patients to help them regain independence; in order to maintain users, but providing them with substances (methadone) and causing the users to be dependent.

3. French policy officially gives priority to abstinence and the 'War against Drugs' and not to risk reduction.

4 Methadone is seen - even by those working in AIDS prevention - as a partial Solution, which is true. However, no social problem has a single solution but a combination of partial solutions. Taken together, similar partial solutions can be a base for a coherent risk-reduction policy.