12. Cocaine and Crack Use: prevalence, risks and responses

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Apart from a short period of time around the First World War, the consumption of cocaine in France has remained moderate and has never been considered as a major public health issue. Its use has always been insignificant compared to opiates. The increase in the use of cocaine since 1995 has represented a break in the history of this product. The 1990s saw not only an increase in the dissemination of the chlorhydrate form of cocaine (powder), but also the emergence and relative increase of the base form (free base or crack) (see Bello and Toufik 2004, Bello and Toufik 2005).

Looking more specifically at the dissemination of the base form of cocaine, its use was introduced almost simultaneously by two distinct groups, aiming at two distinct types of user:

- People who travelled to or stayed in the United States during the 1980s introduced it to cocaine powder sniffers in relatively affluent city environments of under the name *free-base*, usually making the base form of cocaine themselves[34];
- People of West Indian origin preferred distributing it on the streets of Paris, exclusively under the name crack, which they acquired already in base form in rocks.

This double origin has probably contributed to the confusion surrounding the name of the base form, which some people call *crack* and others *free-base*, believing they are talking about two different products.

The market for crack thus first appeared in the three French overseas territories (Guyana, Guadeloupe, Martinique) in the middle of the 1980s. Their proximity to cocaine-producing regions (South America) and to Spanish- and English-speaking islands, which became one of the main transit zones for cocaine and crack destined for Europe and the United States, contributed to the development of the local crack market in these territories, to the point where it became the second most widespread illegal local product after cannabis.

Of all French cities, it was Paris where crack first appeared. The existence of an open scene in the north of the capital acted as a platform for its dissemination. When crack first appeared in Paris around 1990, the consumers, like the petty traffickers, were of Caribbean origin. The spread of consumption to other French and North African ethnic groups, and of trafficking to Africans, as well as the spread of the drug to other French cities, only came about several years later (Bello and Toufik 2005). In comparison with fears of an epidemic in the French Antilles and Guyana, where crack users can be found in affluent circles, use of the drug under this name seems numerically and geographically limited to cities. Use of the free-base form, however, has spread to new groups of consumers: young people involved in the dance scene or from the inner city.

1. Observation of cocaine and crack use. Consumption: a strong increase but still a moderate level

The extension of consumption across the general population

In 2005, 2.6% of 15-65 year-olds in France had experimented with cocaine. Although this prevalence remains low in comparison with the consumption of other psychotropic drugs

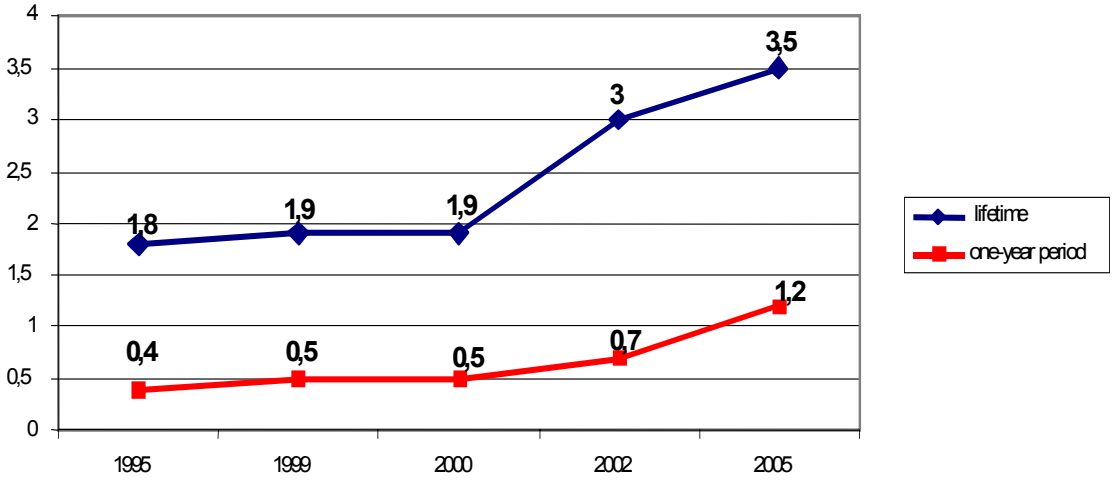
[34] Etienne Matter (A.S.U.D). *Rapport national sur le 'Freebase' et le 'Crack'*, January 2003 (unpublished report carried out within the framework of the TREND system)

such as cannabis, the product nevertheless seems easily accessible, as 8% of 15-65 year-olds had been offered it(Beck and Cytrynowicz 2006). The most significant proportion of people who had tried cocaine was in the 25-34 year-old category, with a figure of 4%, compared with 3.4% of 18-25 year-olds and 1.3% of 45-64 year-olds (Beck, Legleye et al. 2006). The average age at which cocaine was first taken among 15-65 year-olds is 22.6 years (Beck, Legleye et al. 2006).

It is estimated that 200,000 people consumed it in the year 2005, accounting for 0.6% of 15-65 year-olds. This rate rises to 1.5% among 18-25 year-olds. Men consume cocaine three times as often as women (0.9% vs. 0.3%).

Cocaine use is most often found among young adults and children. In 2005, among young people aged 17, it was estimated that 2.0% of girls and 3.0% of boys had already experimented with cocaine (Beck, Legleye and Spilka 2006). This data, collected during the compulsory citizenship day for all young French people aged 17-18, is in line with data from the ESPAD survey, which shows that 2.6% of boys and 2.0% of girls aged 16-17 had experimented with cocaine by 2003 (Coquet, Beck et al. 2004).

Figure 10. Trends in the frequency of cocaine consumption among French people aged 15-34 (1995-2005)



Source: Health Barometer, OFDT/ INPES

All available indicators show a spread in cocaine consumption. In fact experimentation across the general population (15-65 year-olds) as more than doubled in 10 years (1.1% in 1995, 1.6% in 2000 and 2.6% in 2005). Use in a one-year period among 15-64 year-olds has tripled between 2000 and 2005 (0.2% in 2000, 0.6% in 2005) (Beck, Legleye et al. 2006).

Among very young people, the acceleration is even more marked. In 2000, 0.6% of girls had experimented with cocaine by the age of 17. In 2003, this figure was 1.1%, and 2.0% in 2005. Among boys, experimentation by the age of 17 rose from 1.3% in 2000 at 2.0% in 2003, finally reaching 3.0% in 2005 (Beck, Legleye and Spilka 2006).

The social environments affected by cocaine have become rather heterogeneous, and it is therefore difficult to draw up of profile of types of user. Cocaine is no longer used only in upper social classes or by marginalised drug users, but also affects the economic middle classes and users found in the dance scene (Bello and Toufik 2005). However, it is possible to identify a core group of users, comprising mainly people who frequent night clubs and parties, former drug abusers who have moved onto methadone and Subutex®, and finally more or less marginalised drug users who are able to frequent so Low Threshold" structures.

A substance which is firmly embedded in the dance scene

In the "electronic music" dance scene of the five towns which participated in a study in 2004-2005 (Nice, Toulouse, Rennes, Bordeaux, Metz), 34.6% (n=1,496) of people surveyed said they had consumed cocaine during the previous month and more than two thirds had taken it at least once in their life. Of those questioned, 6.1% said they had consumed crack/free-base in the previous month. It should be noted that there is a low prevalence of daily consumption of cocaine and crack within this mainly festive population, with figures of 2.7% (14/518) and 3.2% (3/91) respectively (Reynaud-Maurupt 2006).

The frequency of cocaine consumption varies according the different "scene groups" identified within this dance scene population. These "scene groups" correspond to a typology of populations frequenting the recreational dance music scene. Based on an ethnographic study, these groups are formed according to the style of music and type of establishment visited.

Table 26. Prevalence of cocaine consumption in the population frequenting the "electronic music" dance scene, 2004-2005

	Consumption	**Monthly**		**More than once per week**
Scene groups		Non-base form	Base form	
"Alternative"	(free party, rave), n=276	50.0 %	13.4 %	16.0 %
"Urban"	Pubs, n=398	27.1 %	4.5 %	8.0 %
"Clubbing"	Night clubs, electronic clubs n=430	27.9 %	1.4 %	11.2 %
"Select "	privileged admission clubs, "selective" pubs n=192	27.1 %	1.6 %	10.4 %

Source: Reynaut-Maurupt [8]

The Alternative scene group comprises the population frequenting *rave parties* and *free parties.*

The Urban scene group comprises people who visit pubs or occasional parties in specially hired premises with a capacity of less than 1,000 people, and very occasionally "Electronic" festivals.

The Clubbing scene group comprises those who attend night clubs specifically dedicated to electronic music, called "Electronic clubs".

The Select scene group comprises people who visit clubs where entry is by invitation only or pubs with free access, but where a specific dress code is in force (Reynaud-Maurupt 2006).

Frequent consumption among drug users who are in contact with risk reduction and socio-sanitary structures

The most recent data available (2003) shows that 35% of drug users encountered in low threshold structures[35] who responded to the survey carried out in these structures had consumed cocaine in the course of the previous month (Bello and Toufik 2004).

For the powder form of cocaine, the proportion of daily consumers varies from 25% in 2001 to 8% in 2003. It remains at around 40-50% for the base form of cocaine and, according to

[35] Corresponds to the urban space as defined in the OFDT's TREND information system: all areas of a town/city where active drug users can be observed. It essentially comprises people who may be encountered in low threshold structures (reception centres and syringe exchange programmes), in certain specialised care centres and in "open" locations such as streets and squats.

the year observed, represents two to four times more than the proportion of daily cocaine consumers. This difference can be explained, at least partly, by the socio-demographic characteristics of the users: cocaine users are more socially integrated and consume occasionally and "recreationally", whereas crack users are rather marginalised and consume more compulsively (Bello and Toufik 2005).

Table 27. Proportion of cocaine and crack/free-base consumers in the previous 30 days among low threshold structure users

	Cocaine		Crack/free base	
	In last 30 days	*of whom daily*	In last 30 days	*of whom daily*
2001* (n=799)	39 %	*25 %***	20 %***	*50 %****
2002* (n=964)	42 %	*19 %*	26 %	*39 %*
2003* (n=1082)	35 %	*8 %*	18 %	*40 %*

*** The question asked did not mention free base

*Sources: Data and interpretation: * TREND/OFDT; [1-3] ;*

The average age of recent cocaine chlorhydrate consumers among users of low threshold structures is 28.4 years, compared with 31.7 years for those not using these structures. Three quarters of users are less than 32 years old, and 4 out of every 5 users are male. Almost 60% of consumers experimented with cocaine for the first time between the ages of 17 and 22 (Bello and Toufik 2005). Users of the base form of cocaine within this framework are older. The average age is 32.5 years and 41% of them are aged 35 or over. Men outnumber women by four to one (Bello and Toufik 2005).

While the proportion of drug users in risk reduction structures consuming cocaine remains stable, it has seen a steady increase in socio-sanitary centres specialising in drug use since 2001: 8% in 2001, 9% in 2002, 10% in 2003 and 11% in 2004 [9]. Amongst these users, 20% consume it daily.

In French cities, the consumption of the base form of cocaine known as crack remains relatively concentrated in the north-east of Paris (18th *arrondissement* and the neighbouring *arrondissements*), tending to extend into the Seine Saint Denis region. These areas contain a population of between 2,000 and 3,000 drug addicts (Lebeau 2006).

This particular group of crack users in the north-east of Paris has formed the focus of a specific study, not yet publishedable, demonstrating the extreme social difficulties of this population (absence of stable housing, lack of access to rights and due to a lack of identity papers, absence of social security and work) and cites the poor access to healthcare. These users take many more risks and may undergo extended periods of consumption (3 consecutive days for example) without eating or sleeping. The lack of housing removes access to any basic hygiene facilities (EGO 2004). This population is 80% male, with ages ranging from 18 to 57, and an average age of 36 (EGO 2004).

Crack, the most frequently-consumed drug in the Caribbean

In the three French overseas territories, Martinique, Guadeloupe and Guyana, the situation differs significantly, in that crack is the most widespread illicit product among drug users. In Martinique, 66% of people attending low threshold structures had consumed crack and cocaine chlorhydrate within the previous month. In Guyana, 58% had consumed crack, but only 2% had taken cocaine chlorhydrate recently. There is a marked difference between the daily life of a cocaine consumer and a crack consumer. Given the differences in price and supply methods, the two products do not concern the same audience, with cocaine use remaining the privilege of relatively affluent communities (who do not attend low threshold

structures). In contrast, crack affects a much more socially marginalised population. In Guyana in particular, the homeless and/or marginalised population comprises most crack users. They are becoming more and more visible and numerous. The "recruitment" of these individuals is carried out by dealers among the most fragile population groups: the mentally ill, unemployed, those on welfare benefits and illegal immigrants. Nevertheless, crack consumers are not all social outcasts from disadvantaged social environments. In Martinique, it has been noted that many people manage to consume crack, usually occasionally (in the form of black joints), whilst maintaining a job and a family. Among these users are several former heroin addicts or polydrug consumers returning to the country to discover a drug to which they had not formerly had access. Moreover, it is among these users that unusual usage methods can sometimes be found, such as injection after acidification. In Guyana, it is becoming more and more common to find crack consumption in affluent environments (Bello and Toufik, 2005).

A contrasting situation in prostitution environments

The situation regarding cocaine seems significantly different in male and female prostitution environments.

Whilst the proportion of male prostitutes who had experimented with cocaine at least once in their life appeared quite high in 2002 (50%, n=258) (42% of "boys"[36] and 58% of "transgender individuals"[37]), consumption in the previous month appeared rather low (13%; 4% of boys and 12% of transgender individuals). Among boys, cocaine was seen as a drug of "high-class" customers, which was consumed occasionally when offered by the client. Among transgender individuals the use of cocaine seems more widespread and more frequent, especially recreationally. Although such use turned out to be controlled, the testimonies of some transgender individuals pointed to periods of dependency [12]. Six percent of boys and ten percent of transgender individuals (eight percent in total) had consumed crack at some point in their lifetime. Of these, 0.8% had consumed it in the month preceding the survey. In this population, cocaine is most often taken by sniffing, rarely smoked, but never injected.

A study carried out in female prostitution environments in 2002 found a lower level of experimentation with cocaine or crack among prostitutes (30 out of 165, or 20%). In contrast, all current consumers of cocaine or crack were dependent on opiates (13 out of 165). Whether or not prostitution had preceded drug addiction, dependence on opiates had always preceded crack or cocaine use, having been used to "replace" the pleasure lost through the dependence on opiates (Cagliero and Lagrange 2004). All those who had consumed within the previous month had either smoked or injected the base form of cocaine.

2. Consumption methods: the sniffing majority

Different methods according to user groups…

Among those frequenting the "electronic music" dance scene, cocaine is mainly taken by sniffing (98%) and smoking "base" (19%), but very rarely injected (0.6%). In comparison, among users attending low threshold structures[38], who are usually active users, sniffing is the majority method (62%), but injection is widespread, concerning more than four users out of ten (43%) (Bello and Toufik 2005, Reynaud-Maurupt 2006). In specialised centres for drug

[36] Boys practising prostitution regularly or occasionally display their masculinity. In this case, they practice prostitution only with men.

[37] The term transgender refers to a person whose gender identity does not correspond to his/her sex at birth. Here, the term refers to people of male sex who dress as women to practise prostitution, whether or not they have undergone an operation or hormonal treatment, to fulfil the sexual desires of the market or for their personal pleasure.

[38] Risk reduction and drug addict support structures

addicts, the proportion of users who smoke cocaine is around one third of all consumers (CEIP Marseille 2005).

Table 28. Cocaine chlorhydrate administration methods* in the previous month among the 2003 "low threshold" survey and in the electronic dance music scene 2004/5

Method of use*	Low threshold** (n = 303)	Music scene*** (n = 506)	Socio-sanitary structures**** (n=374)
Injection	43%	0.6%	29 %
Sniffing	62%	98%	55 %
Inhaling, smoking	15%	19%	28 %

** one person may employ several administration methods*

*Data and interpretation: **TREND/OFDT; *** GRVS/TREND/OFDT **; * OPPIDUM/CEIP/AFFSAPS*

Most users employ only one administration method: just under half (46%) of users attending low threshold structures stated that they do not use sniffing, a third (33%) only inject, 9% smoke and sniff, and 5% sniff and inject (Bello and Toufik 2005).

The administration methods varied dramatically according to age: for low threshold structures, injection is more common among older users (69% of those aged 39 or over), whereas sniffing and smoking are more frequent among younger users (80% of 15-24 year-olds) (Bello and Toufik 2005).

In the three overseas territories of the Antilles and Guyana, crack is almost exclusively inhaled, whereas in Paris it may also be injected. The practice of injecting[39] crack remains limited almost exclusively to the Paris region and particularly inner city Paris. Elsewhere, this practice is rare.

To control and manage the anxiety associated with taking cocaine chlorhydrate or its base form, users turn to four families of psychoactive substances, according to their location: alcohol (rum) and cannabis in the Antilles and Guyana; opiates (heroin, Subutex® ; morphine sulphate), benzodiazepines and alcohol in cities (Bello and Toufik 2005).

… which correspond to distinctive motivations

Often unaware of the fact that crack and base cocaine are identical, users differentiate between homemade base cocaine and crack. Since the two names are considered to be different products, the motivations behind the choice of usage method are different. When consumed nasally (sniffed), it is the image of "control" over consumption which attracts many users to this method of administration. Cocaine, in comparison with crack, seems like a less risky alternative in terms of the personal health and social image of the user (Bello and Toufik 2005).

Several main motivations can be identified for consuming the drug in its smokable form (Bello and Toufik 2005):

- Inhalation allows the effects of the cocaine to be felt more quickly and intensely (flash effect) than sniffing, and less intensely that injecting.
- In addition, "basing" cocaine is seen as a purification process by those who consume free base, allowing the removal of any products with which the cocaine may have been cut, rather like a chemical process which is necessary for transforming cocaine into its smokable form.

[39] To turn crack into an injectable form, users employ the same chemical agent as for the base form of heroin – lemon juice.

- The base form of cocaine may also be smoked in a joint, mixed with cannabis, or in a cigarette joint with tobacco, and passed inconspicuously, unlike sniffing or injection, in locations such as nightclubs. Perceived as "normal", the act of smoking provokes little or no social disapproval.
- Finally, smoking is seen as a less risky practice than injection in terms of HIV and hepatitis contamination, and is also much less stigmatised.
- In Martinique and Guadeloupe, a small minority of cocaine users, for price or availability reasons, may resort to taking crack.

Users employ the following methods for smoking crack:

- By heating it directly with a lighter and inhaling it through a glass or home-made pipe (a plumbing pipe, covered with a layer of pierced aluminium foil). This equipment allows the "oil" to be collected, namely the residue at the bottom of the pipe once several rocks of crack have been smoked. Some people believe that this "oil" is much stronger than the rock itself;
- A beer or Coca-Cola can, with several holes pierced in it. The crack is placed on top, heated with a flame, then inhaled via the orifice used for absorbing the liquid;
- The method inspired by the "hookah" principle: a glass, partially filled with water, covered with aluminium foil, with several holes and pierced with a straw. Cigarette ash is placed on the foil, along with a lump of crack, which is heated directly and then inhaled. In Martinique, the water is sometimes replaced with alcohol, which is then consumed after the crack.
- By "*chasing the dragon*", which involves placing a small amount of cocaine chlorhydrate mixed with bicarbonate on a piece of aluminium foil, then heating it until the chemical reaction takes place and then drying off the water and smoking the resulting substance.
- In a "*bong*" (a type of water pipe for inhaling the product without air, resulting in more rapid effects)
- And finally via the black joint or "*blaka jango*" method, used in the Antilles and Guyana, which involves smoking a cigarette containing crack mixed either with tobacco or cannabis.

3. Representations: the three images of cocaine

Cocaine is subject to radically different opinions and images according to the name and form in which it appears. Cocaine in its chlorhydrate form is seen as a luxury product, the privilege of "trendy" environments. This is one of the reasons why this substance enjoys a "positive" image, associated with social success and the belief that it is relatively easy to manage in terms of moderate consumption. The fact that the principal method of administration is sniffing reinforces this perception. In the dance scene, group-consuming cocaine and the ritual of sharing the product are often associated with "conviviality", similar in some ways to that associated with cannabis. Cocaine is also seen in a positive light by young, occasional consumers, who either sniff or smoke the drug, and who are socially well integrated.

This positive image is tempered, however, especially among regular and chronic users. These individuals are in fact aware of the problems linked to its use, such as psychological dependence and the cost of the product. Regular use is seen as synonymous with the loss of control. Injectors of this substance also suffer from the repercussions of an administration method which is seen as degrading (Bello and Toufik 2005).

The representation of crack is quite the opposite to the prevailing image of cocaine "chlorhydrate". Its image is, without exception, negative, no matter what the location, context or length of time. From its first appearance on the French scene, crack has been labelled as a devastating, violent, criminal substance by the American media, and one which "hooks" an individual from the very first time it is taken. In the overseas territories, the stigmatisation of crack has reached its peak. The product is seen as the "rock of the devil"; the "product of the darkness" and dealers are presented as "devil's disciples", whilst consumers are considered to be "possessed".

Apart from Paris and the overseas territories, where the smokable form of cocaine is known as crack, other locations call the same form free base. Although they are chemically identical, "crack" and "free base" are not synonymous. The two nomenclatures denote different senses and meanings, with diametrically opposed representations. While crack is seen as a substance consumed by socially marginalised users, "base" appears more frequently in the dance scene and is consumed by users who are more socially integrated, many of whom believe that basing the cocaine is a form of purification (Bello and Toufik 2005).

4. Poorly-assessed health consequences

Cocaine and crack consumption are only rarely the cause of admittance to specialised centres for drug addicts (CSSTs). The proportion of patients admitted mainly due to cocaine use has remained stable for several years (6.1% in 2004, including crack[40]). The proportion of treatment requests for crack use varies from a quarter to a third of this total, depending on the year [14, 15]. One theory is that requests for care from non-excluded populations are not well expressed in this framework.

In contrast with opiates and benzodiazepines, cocaine does not cause physical dependence, but a strong psychological dependence. Therefore, among individuals who attended socio-sanitary structures in 2004, 4% said that cocaine was the product to which they were most addicted (CEIP Marseille 2005).

Cocaine consumption is one possible cause for death by overdose. The number of deaths recorded by the police is showing a progressively increasing trend. In 2004, 10 recorded deaths were uniquely attributable to taking cocaine, and 5 deaths to a mixture of cocaine and another product (OCRTIS 2005).

Table 29. Trends in overdoses linked to cocaine recorded by the police services, and percentage in relation to all overdoses

	1999	2000	2001	2002	2003	2004
Number	7	11	10	12	10	15
Percentage	5.9 %	9.2%	9.3 %	12.4 %	11.2 %	21.7 %

Source: OCRTIS 2005.

According to reports from health care activists in the TREND network, there are numerous health problems linked with regular consumption, consistent with data from literature on this subject. Quantified data is not available at this time. In terms of crack users, it can be said that such individuals are in extremely poor states of health, suffering both from pathologies linked with crack use and health problems associated with violence and difficult living conditions.

[40] Alcohol is included in the total. If alcohol-related treatment requests are removed, the percentage of requests mainly for cocaine use rises to 6.9%.

5. The marketing and trafficking of cocaine and crack

An increasing number of individuals questioned by the police – evidence of an expanding market

Police questioning for cocaine use has been on the increase since 2001 (+65%), reaching 2458 cases for trafficking in 2004, and 2484 cases for users dealing in the product in 2004, according to the police system. Police questioning for those simply using the product, however, represents only 2.4% of the total for illicit drugs, with questioning for dealing and trafficking occupying 12% of the total.

The average age of cocaine users questioned has been falling steadily for several years, reflecting the extension of questioning to younger age groups. The average age was 28.4 years in 2004, compared with 29.4 years in 1999. The number of minors questioned in 2004 (30 minors) represented a rise of 17% against the 2003 figure.

The volume of cocaine seized in 2004 was 4,484 kg. This represents an increase of 7.5% compared with 2003, which itself was a record year for the forces of prevention. This data shows that trafficking involves increasingly larger amounts of cocaine, imported directly by air from Latin America, or indirectly via Spain and the Netherlands. France remains a transit country: the proportion of cocaine destined for the French market was no more than 24% in 2004. Large quantities seized were destined for Italy and the Netherlands. Finally, the French Antilles are still used as transit or storage locations for products destined for the North American and European drug markets (OCRTIS 2005).

In terms of crack, the Interior Ministry statistics demonstrate a double dissemination phenomenon, both social and geographical: 22 individuals questioned in 1990 in five counties for the use or re-sale of crack and 16 for trafficking, compared with 744 for use and 462 for trafficking and re-sale in 40 counties in 2004 (OCRTIS 2004, OCRTIS 2005). Trafficking activity, however, remains marginal. Seizure amounts were around 18 kg in 2004, and almost 70% of the total related to trafficking in the three French Caribbean territories (OCRTIS 2005).

The organisation of cocaine chlorhydrate trafficking

Three main types of cocaine chlorhydrate trafficking networks can be identified in France (Gandilhon 2006).

- Networks linked to organised crime, found in the major cities (Paris, Marseille). This type of network imports huge quantities of cocaine into France via wholesale dealers, generally located in Spain, Holland and Belgium. These networks normally buy the product uncut and sell it on after it has been cut by smaller wholesale organisations, which provide the link to the networks of small dealers.
- Networks of smaller wholesalers and/or professional dealers. These networks obtain their supplies either from wholesale dealers in France linked to organised crime, or from abroad: Spain, Holland or even the French Antilles. These networks retail the product via a relatively structured organisation (touts, sellers), who normally operate in the highly-populated suburbs of large cities or at large dance scene gatherings such as electronic music festivals. Most of these networks formerly specialise in the sale of cannabis.
- Micro-trafficking networks. This is probably the most common type of network in France. They are generally loosely structured, managed by one, two or sometimes three people, and only serve about a dozen clients. These micro-networks can be sub-divided into three main categories:

- "Start-up" networks: Networks managed by people who are not drug consumers and who enter into cocaine trafficking for purely financial reasons. Their nature is similar to networks found in suburbs.
- User-dealer networks: These are the most common networks according to studies. These micro-networks are managed by individuals who enter trafficking to finance their consumption and to make a small amount of money. They may or may not be highly dependent on the drug. In general, the network is small, with no more than about ten clients, recruited from family and friends and by word of mouth.
- Non-profit networks. These networks comprise people who wish to finance their consumption directly and as cheaply as possible, as well as providing for groups of friends. Financial considerations do not figure in these networks, nor does the wish to make profit. Cocaine is sold on at cost price (Gandilhon).

Table 30. Price of a gram of cocaine and heroin from medium-sized wholesale dealers in Belgium and Holland in 2004/2005

Country and city	Number of transactions	Cocaine	Heroin
Belgium	28		
Anvers	15	35	10
Gand	10	30	10
Mons	2	40	07
Bruges	1	25	15
Netherlands	30		
Amsterdam	15	30	15
Rotterdam	14	35	10
Maastricht	01	40	15

Sources: OCRTIS data, interpretation by OFDT [18]

The supply methods of cocaine trafficking networks are mainly via medium-sized wholesalers in France or via such wholesalers in the countries neighbouring France. The advantage of cross-border purchasing lies in the low price of cocaine from these wholesalers. A study of 150 transactions via police questioning for cocaine use and dealing shows that the price of cocaine from medium-sized wholesalers in Belgium and Holland is an average of 30 euros. This is then sold on in France for around 60 euros, resulting in a net profit of 30 euros per gram of cocaine sold. This data is consistent with the figures collected within the TRENDnetwork, which confirmed the average price of a gram of cocaine at around 60 euros in 2004. It is interesting to note that almost all the small cocaine dealership networks studied through the OCTRIS process sell multiple products, especially those such as heroin (Gandilhon 2006).

Whilst the average price of a gram of cocaine has fluctuated in recent years at user level, the average price in cities in 2004 was the lowest recorded in the last four years.

Table 31. Estimated average price of cocaine chlorhydrate in the locations observed by the TREND system

Location	2001	2002	2003	2004
Bordeaux	53	80	65	45
Dijon	72	55	55	60
Lille	62	52	55	50
Lyon	61	65	65	60
Marseille	61	73	50	65
Metz	65	75	70	60
Paris	76	60	77	55
Rennes	83	56	60	67.5
Toulouse	53	67	60	65
All cities (average)	*62*	*65*	*63*	*60*
Guyana	24	25	30	17.5
Martinique	122	60	55	52.5

Data and interpretation: TREND/OFDT (Bello and Toufik 2005).

6. Risk and care reduction – few specific answers

Harm-reduction in France: crack is the main focus

The spread of cocaine consumption observed among young people and/or the middle classes has lead to the belief, among decision-makers in the field, that its use is becoming trivialised. Action on the question of cocaine (in its chlorhydrate form) is a recent phenomenon and has not yet produced a risk reduction strategy for cocaine on a national level.

In contrast, the concentration of open dealing and consumption in the north east of Paris since the 1990s, and the failure of the traditional care structures to adapt, have lead harm-reduction structures to develop specific approaches for crack users. The EGO association, which has a drop-in centre and syringe exchange programme in the affected area, has taken measures such as the distribution of a risk reduction tool called "Kit base", introduced at the end of 2003. This tool allowed the association to initiate contact with 2,000 crack users during 2004, with an active membership of 2,500 users in 2006. In addition, the concentrated presence of crack users in the area has caused numerous problems with residents. An association called "*Coordination Toxicomanie*" (CT-18), which brings together harm-reduction structures and residents' associations in the 18th *arrondissement*, was created to implement social mediation and action in the field of drugs, with the aim of maintaining the approach of risk reduction, whilst relying on a minimum level of consensus, involving all interested parties in the area (Lebeau 2006). The 2004-2008 five-year Inter-ministerial Mission for the Fight Against Drugs and Drug Addiction (MILDT) plan incorporates and formalises this activity in a crack programme which will also be carried out in the Antilles and in Guyana (MILDT 2004).

The care of cocaine consumers: no consensus

The methods of care for cocaine users in France have not yet been studied, and no consensus or developed guideline exists. A conference organised by the MILDT in April 2006 on this subject demonstrated the disparity of practices in specialised centres, both in terms of the organisation of courses of treatment as well as the medical treatments chosen and the psycho-therapeutic methods offered. Although not formally documented, the fact remains that unprepared or untrained physicians feel inadequate in dealing with problematic

cocaine use, partly caused by the range of care methods resulting from the dissemination of opiate substitutes, with a therapeutic substitute available for each product consumed.

The therapeutic options discussed in French literature or among French practitioners are the same as those contained in international literature (Véléa and Caro 2006). Despite this, no data relating to successful therapeutic treatments carried out by professionals on cocaine and crack users in France is available.

In addition, one major question surrounding cocaine is that of access to healthcare or the adequacy of the care offered. It seems that the care system offered to drug users is still adapted to the "junky" model of opiate dependency which was fashionable in the 1980s, and has not been adapted to cocaine users who do not consider themselves to be "drug addicts".

In terms of crack users, there are reports of continuing difficulties with health and social care, associated in particular with the extreme marginalisation of these populations, and with the fact that medical teams are not always sufficiently sensitive to the specific pathologies caused by crack. In addition, many no-injecting crack users do not perceive themselves as drug addicts and, as such, attend CSSTs rarely or not at all. The lack of substitutive treatment for cocaine and/or crack hinders patient retention, as well as their willingness to follow the associated pathological treatments. In Paris in particular, there have been reports of difficulties in caring for users of West Indian origin, especially those who use rum to manage their "come downs". The care of these particular patients requires cultural factors to be taken into account (Bello and Toufik 2005, EGO 2005).

To address the significant healthcare needs of this population, which are difficult to integrate into traditional, and even specialised care methods, a risk reduction association, *Espoir Goutte d'Or* (EGO), is attempting to look again at the risk reduction care offered from a geographical and temporal perspective. It is doing so through proposals for a specialised healthcare centre project, aimed specifically at users of the base form of cocaine. The project looks specifically at the need to combine healthcare with social insertion strategies (EGO 2005).

7. Conclusion

The increasing use of cocaine in France, both problematic and non-problematic, has provoked wide questioning of the public powers in France, underlying which is the fear that its use is becoming trivialised among young people. The increase in the base form of cocaine, outside of populations of crack users, constitutes another point of concern about the current trends. For a clearer view of the situation in France, the French Focal Point has decided to undertake a series of studies in 2006 and 2007, to improve understanding of both use and users.

- The first, as part of the SINTES system, will provide an opportunity to analyse the composition of 519 samples of cocaine in is chlorhydrate form, taken directly from users (results mid-2007)
- The second aims to improve understanding of the hidden population of cocaine users not detected by healthcare, risk reduction or preventative service systems (results at the end of 2007).

As a prelude to a quantitative survey, a qualitative publication will have the following objectives:

- Update qualitative, descriptive knowledge relating to cocaine use in France and its consequences on the daily life of individuals who are unknown to the health and social care system;
- Produce a typological classification of different social profiles and consumption methods;
- Offer a user experience analysis;
- Produce the necessary elements for a questionnaire which will lead to the creation of a quantitative publication.

Another publication of observations relates to therapeutic treatments carried out by healthcare professionals in contact with cocaine and crack users. Two studies are under development to document this information. The first will look at professionals who provide treatment in specialist care centres (CSSTs). These centres are seeing a rise in the number of requests for treatment for cocaine use, as well as in cases of problematic cocaine or crack use among patients on methadone or buprenorphine substitution programmes. It will attempt to construct a typology of the treatment requests or needs of these patients, as well as of the treatment and monitoring programmes carried out by the professionals. A second study with the same objectives will be carried out in ER and cardiology services, which form another point of entry into the healthcare system for cocaine-related problems. After all the research is finished, these two studies will provide an opportunity to assess the correlation between the needs of a varied public and the intervention of the relevant professionals. They will constitute the first step towards the establishment of a more comprehensive set of practices for all professionals who encounter or are contacted by cocaine and crack users.