SECTION B: SELECTED ISSUES.

11. Drug use among young adolescents

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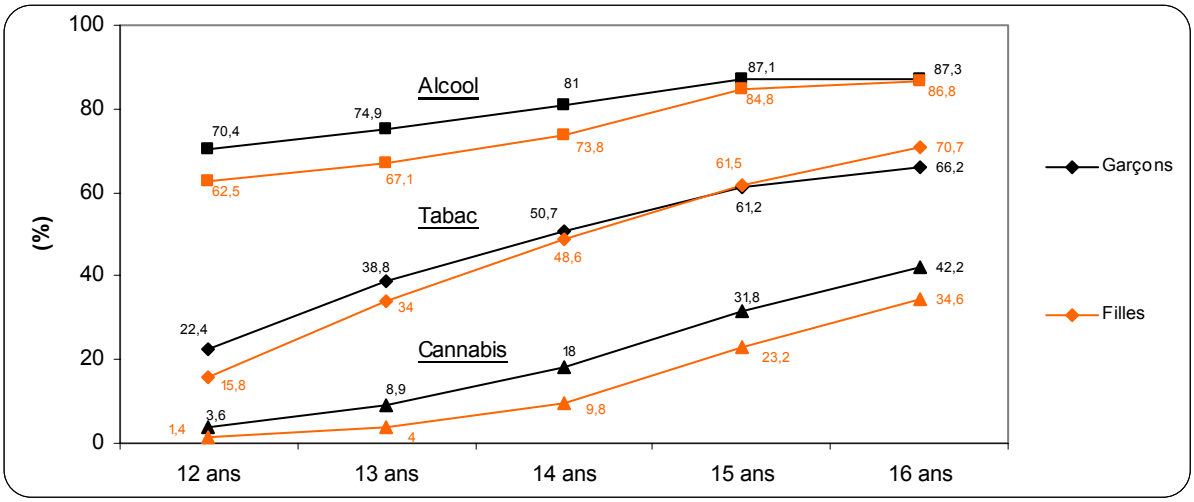
Adolescence is the age at which experimentation with psychoactive substances takes place and, in some circumstances, can be the age at which more regular use begins. This article aims to evaluate the situation surrounding the consumption of illicit drugs among very young people (adolescents under the age of 15) and the consequences of entering into drug use at such a young age. Legal products such as alcohol and tobacco will be mentioned comparatively. Surveys of the general population provide an opportunity for the exploration of these questions and the observation of the distinctive features of very young people in comparison with behaviours observed at the end of adolescence. They have certain limitations, which should be mentioned here. In addition, they may equally effectively be carried out by other sources, illustrating the manners of usage and the discussions, preventative measures and suggested treatments offered to very young adolescents in France, and especially those facing drug use problems.

1. Use among very young people

In terms of general population outline data, three surveys dealing with adolescents can be called upon. All three are carried out via an automatically administered questionnaire and are strictly anonymous. The *European School Survey Project on Alcohol and Other Drugs* (ESPAD), carried out in 2003, offers the opportunity to observe use among young people in school (Choquet *et al.*, 2004), particularly those aged between 12 and 16 who are obliged to attend school. The Survey on Health and Drug uses During Call-up and Preparation for Defence Day (ESCAPAD) allows for the annual evaluation of the levels of psychoactive substance consumption of young people aged 17-18 and demonstrates recent trends in these practices at the end of adolescence (Beck *et al.*, 2004). These two surveys therefore allow the distribution of drug uses throughout adolescence – between 12 and 18 years old – to be observed, particularly the regular use of tobacco, alcohol and cannabis. In the *Health Behaviour in School-aged Children* (HBSC) survey carried out in 2002, pupils aged 11, 13 and 15 were questioned (Godeau *et al.*, 2005). Adolescents aged 11 and 13 were not asked questions relating to the consumption of illicit drugs, the questionnaire dealing only with the use of alcohol and tobacco for these age groups.

Figure 7. Experimentations with tobacco, cannabis and alcohol: prevalence over the course of a lifetime, according to age and gender



Source: ESPAD 03 – INSERM –OFDT – MENRT

Whilst experimentation increases with age for the three products, the progression appears rather different when they are compared to each other. For cannabis, whilst prevalence remains low at ages 12 and 13, especially among girls, it increases significantly from the age of 14. For tobacco, the proportion of people experimenting increases rapidly from 12 to 13 years old, after which the rate of increase becomes less and less marked, whilst the gap between the genders decreases. The increase in experimentation is nevertheless more significant among girls than among boys. Finally, in contrast with the other products, experimentation with alcohol is already widespread at 12 years old: the rate of increase is therefore slower, particularly after the age of 14, with girls catching up with boys.

For the other psychoactive products dealt with in the ESPAD survey, experimentation levels turn out to be low. Indeed, they are all below 5%, except for inhalants (glues, solvents) and hallucinogenic mushrooms. Whatever the age or the product, experimentation appears more frequent among boys than among girls. Whilst this experimentation increases with age for hallucinogenic mushrooms, it remains stable among boys, and even falls slightly among girls, for inhalants. Inhalants appear to be a one-off case, with experimentation beginning at a very young age (three quarters of those experimenting with inhalants did so for the first time before the age of 15), but their use is almost never continued into adulthood. In the following table, too much importance should not be accorded to the precise values and to the gaps between the different ages, since the majority of these figures are not significant (and are often small in size, especially among very young people) and because the validity of the declaratory survey for very young people, and for these substances, is questionable. It is possible to conclude that, from the age of 14, 2% of adolescents have experimented with most illicit drugs other than cannabis. Nevertheless, the majority of those who have tried one of these products do not repeat the experience. The percentage of amphetamine experimenters among young people is clearly linked to medical treatments for hyperactivity.

Table 23. Experimentation with other psychoactive products: prevalence over the course of a lifetime, according to gender and age (in %)

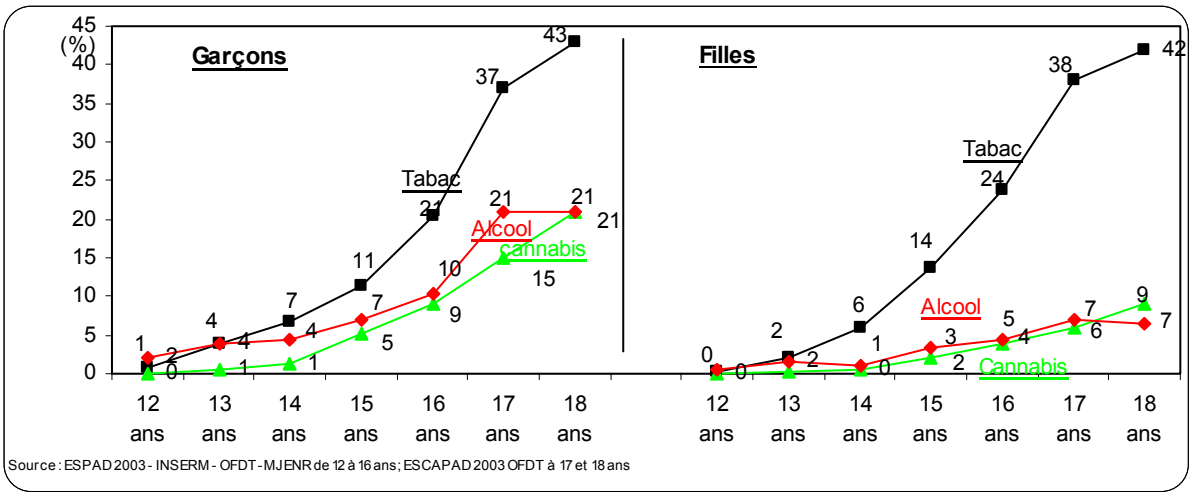
boys	12 yrs*	13 yrs *	14 yrs	15 yrs	16 yrs	17 yrs	18 yrs
inhalants	7.5	9.7	11.3	11.6	11.6	12.4	17.3
amphetamines	0.9	2.1	2	3.4	2.8	3	3.2
ecstasy	0.5	2	1.7	3.9	3.5	5.2	7.2
hallucinogenic mushrooms	-	-	2.1	5.2	6.9	6.7	11.3
LSD	-	-	0.3	1.4	1.3	1.8	2.3
heroin	-	-	1.3	2.7	2.3	2.1	1.8
cocaine	-	-	2.5	4	2.7	2.6	3.1
girls	12 yrs*	13 yrs*	14 yrs	15 yrs	16 yrs	17 yrs	18 yrs
inhalants	6.5	6.8	8.4	12,0	9.7	9.6	9.8
amphetamines	0.1	0.9	1.4	1.9	2	1.8	1.5
ecstasy	0.4	0.8	1.4	2.9	3	2.6	3.1
hallucinogenic mushrooms	-	-	0.4	1.8	2.8	2.8	2.6
LSD	-	-	0.1	0.8	0.8	0.5	0.9
cocaine	-	-	2.2	2.6	2.5	1.6	1.9
heroin	-	-	0.5	1,0	1.4	1.5	0.8

Source: ESPAD 03 – INSERM – OFDT – MENRT

(*) For pupils aged 12 and 13, the questionnaire was simplified and some products removed.

Regular tobacco or alcohol use appears relatively infrequent under the age of 14 and cannabis use is very rare under the age of 15. Regular use of these products then increases with age, with daily tobacco use taking a clear lead over the regular consumption of alcohol and cannabis. Between the ages of 12 and 15, the proportion of daily tobacco smokers increases from 1% to 11% of boys and 0% to 14% of girls. There is also an upward trend with age for alcohol and cannabis, especially among boys, and to a lesser extent among young girls.

Figure 8. Regular* tobacco, alcohol and cannabis use, according to age and gender among 12-18 year-olds in 2003



** at least ten uses during the last 30 days for alcohol and cannabis; daily use for tobacco*

According to the answers given in the HBSC survey of 2002, at the age of 11, 14.4% of boys and 9.7% of girls ($p<0.0001$) stated that they had already tried smoking tobacco. The levels of current smokers appear vastly inferior: whilst 1.6% of 11-year-old pupils stated that they smoke once per month, only 0.6% said they do so daily. No gender difference was observed in current tobacco use among 11-year-old pupils.

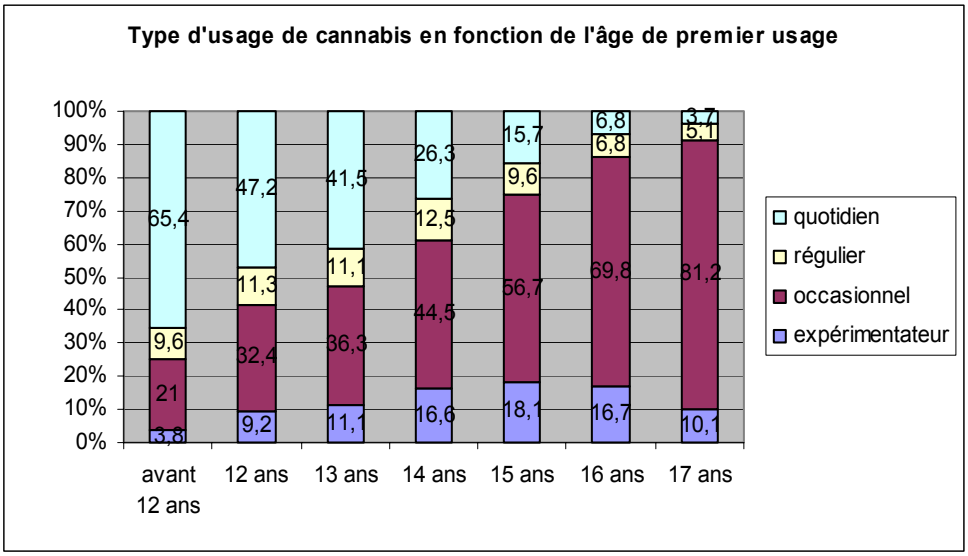
In terms of alcohol use among 11-year-olds, 81.6% of boys and 92.2% of girls stated that they did not drink at the time of the survey. If we now look at consumption, occasional use is the most frequent type of use at this age, with daily consumption remaining quite rare (2.5% of boys and 0.8% of girls), and at this age should be interpreted with a note of caution. As with older individuals, this type of alcohol consumption is more frequent among boys than among girls (Godeau *et al.*, 2005).

2. Use at a young age: a retrospective approach

From the answers to the question about the age of first use of the different products, the timeline of consumption appears relatively weak compared with the most recent North American studies (Johnson and Mott, 2001). The effect of the first drug use being at a very young age on the probability of persistent use (Robins, 1984, Windle, 1996), even problematic consumption or the movement to other products such as cocaine or heroin in adulthood (Yamaguchi and Kandel, 1984), has been widely dealt with by epidemiologists, across all psychoactive substances (Kraus, 2003) and alcohol in particular (Hawkins *et al.*, 1999; Kraus *et al.*, 2000; DeWilt *et al.*, 2003; Hingson *et al.*, 2003). In terms of cannabis, this influence has been judged fundamental and can compromise cognitive development (Pope *et al.*, 2003), as well as being linked to psychiatric comorbidity (Armstrong and Costello, 2002) or to social problems such as unemployment, academic failure or delinquency (Fergusson and Horwood, 1997). As a result of the American SAMSHA study, Gfroerer *et al.* (2002) demonstrated that 62% of adults over the age of 25, who had been introduced to cannabis before the age of 15, declared having consumed cocaine at some point in their lifetime, as well as 9% for heroin and 54% using psychotropic medicines regularly. These figures are significantly higher than those observed across the general population, which were 0.6%, 0.1% and 5.1% respectively.

Several recent studies temper these claims, however, citing possible biases in the measurement of cannabis dependency (Chen and Anthony, 2003). According to the Roques report (1998) on the level of danger posed by different drugs, whilst a childhood family and socio-cultural environment characterised by conflict is a particularly high risk factor for dependency on a psychoactive substance, it seems aggravated when the first experiment is at a very young age. It is possible to explore this question through the data of the 2003 Escapad survey (Beck *et al.*, 2004). This data also tends to point towards the primacy of the first use being at a very young age over other possible variables (school situation, proportion of consumers among friends and family, signs of anxiety and depression, consumption of medicines and professional status of parents).

Figure 9. Type of cannabis use according to age at first use



Source: ESCAPAD 2003, OFDT

Across all the adolescents questioned in the 2003 Escapad survey, we can observe a marked trend in the distribution of types of cannabis use as the age of the first use increases: a very young age is linked to future heavy consumption of cannabis. Two-thirds of 17-19 year-old adolescents who smoked their first joint before the age of 12 became daily cannabis smokers, and only 3.8% of them stopped consuming it altogether. In contrast, those who did not start smoking it until the age of 16 or 17 are almost always occasional smokers.

It is not possible here to give an outline of any reflections on the strength of the link between very young experimentation and regular use. Grass-roots drug addiction activists, particularly social workers, agree that very young engagement in consumption is one of the signs to be monitored carefully. Should the fact that young adolescents find themselves trapped by the addictive potency of the product not be considered? It would seem that very young people are often psychosocially vulnerable, which can lead to situations throughout adolescence where use becomes problematic. In addition, the question of age at first use of these products was only asked for the first time in France in 1999 in the ESPAD survey, a fact which does not allow for the high levels of dissemination of cannabis and any change in the age at which it is first consumed to be put into perspective. The trend observed between 1999 and 2003 is therefore not particularly informative, with the average age of introduction falling slightly among 17-year-olds (from 15.3 to 15.2 years old), although this fall is not significant. It must nevertheless be noted that the widespread dissemination of the product coincides with relatively disinterested individuals beginning to consume the drug and experimenting recreationally as and when the product is available.

3. The questioning of very young people through general population surveys: a question of methodology?

The questioning of very young people through general population surveys poses several limitations. In 1997, in the Health Barometer of Young People (Baudier *et al.*, 1998), adolescents aged from 12 to 14 years old were not asked the questions relating to the consumption of illicit drugs. This precautionary measure was taken following the pilot survey, carried out in October 1997, during which the researchers had noted that very young people were frequently uncomfortable with this theme, creating a high level of non-response. The

research team also decided that such questioning, taken out of the context of preventative action and without any possibility for in-depth discussion on the subject, was likely to worry the least informed respondents to the survey, often including very young people. It should be noted that this same concern in the HBSC survey meant that questions on illicit substances were only asked to 15-year-old pupils. What is more, with this survey having been carried in the classroom with the prior agreement of the educational establishment and parents, the posing of questions on these products to very young people would have risked the acceptability of the entire survey, given that this is a general survey normally acceptable even to very young people. This sensitivity is more marked in some countries than in others but, for the sake of standardisation, it was preferred across the board to remove these questions for the versions of the questionnaire intended for 11 and 13 year-olds, as well as questions dealing with sexual activity.

In the 2000 Health Barometer, however, this question was posed to very young people (12-14 year-olds), but only for cannabis. It was noted that, over the telephone, they declared very low usage levels (3.6% of boys and 3.7% of girls aged 12-14 years old stated that they had experimented with the drug), whilst the number who had been offered it was already quite significant: at this age, 9.9% of boys and 13.6% of girls said they had been offered cannabis (Beck, 2000). These usage levels can be compared retrospectively (by looking at the question of the age of first use) with the answers given by the 18 year-olds questioned in the 2001 Escapad survey:

Table 24. Use of cannabis over the course of a lifetime among 12-14 year-olds, according to the declarations of age of first use given in 2001

	Boys	Girls
12 yrs	1.7 %	0.6 %
13 yrs	5.0 %	2.3 %
14 yrs	13.8 %	7.3 %
12-14 yrs	**6.8 %**	**3.4 %**

Note: 13.8% of boys stated they had already smoked before the age of 15

Source: ESCAPAD 2001, OFDT

Whilst the levels among girls appear very similar in the two surveys, twice as many boys stated they had smoked cannabis when the question was asked retrospectively, despite a negative generational effect (those aged 18 in the 2001 Escapad survey were 12 years old in 1995, at a time when the levels of cannabis use were lower than in 2000).

4. The legal framework

In France, the protection of minors under the age of 16 against tobacco smoking is based on two recent legal acts (the law of July 31st 2003, which aims to restrict the consumption of tobacco among young people and, more significantly, decree no. 949 of September 6th 2004, which sets the courses of action for preventing the sale of tobacco to minors under the age of 16, under which the vendor has the right to demand a form of identity). In general, tobacconists follow these two laws strictly for very young people (under the age of 12) but this obediance tends to weaken from aged 15 and beyond. The law of 2003 also forbids the sale of cigarettes in packs of less than 20, as smaller sizes were mainly aimed at young children.

In terms of alcoholic beverages, the legislation relating to minors under the age of 16 is much older: it is based on the order of January 7th 1959 and the law of July 5th 1974, which forbid their sale to minors under 16 years of age. More recent legislation has been brought in to protect very young people from products specifically designed for them: premixed alcoholic

beverages. Heavy tax penalties were levied against these products when they appeared on the market in 1996, causing the originally high sales figures to collapse in 1997. These products reappeared in 2002 due to alcohol producers bypassing the legislation. The law also prohibits the presence of a quantity of beverages in a "protected zone" (including the area around stadiums, educational establishments, swimming pools…) in order to protect very young people.

5. Very young people subjected to questioning

Using data from the *Office Central de Répression du Traffic Illicite de Stupéfiants* (OCRTIS), which records infringements of drug laws dealt with by the police, the proportion of individuals aged 15 and under subjected questioned by police about drug use can be observed. This has varied from 1.6% in 1996, to 3.3% in 1999 (OCRTIS, 2005). In 2004, the figure was 2.4% of the total number of people questioned, equating to 2,415 individuals nationally. More than 99% of them were for cannabis use, with the number of individuals questioned about other products never climbing above ten (8 for ecstasy, 6 for heroin).

The proportion of individuals aged 15 and under questioned about cannabis use represents 2.6% of the total number of people questioned about this drug, whilst the number questioned about selling or trafficking cannabis represents 1.9%. In 2004, the youngest person questioned was 7 years old (one case), but observations show that the number of individuals questioned for cannabis use becomes significant from the age of 13 (185 cases in 2004), and is rises at 14 (596 cases) and 15 (1567 cases). This figure mainly concerns boys (85.3% of these cases), but young girls are becoming more and more involved. The sex ratio is 97% for 16-20 year-olds and 92% for 21-25 year-olds, subsequently diminishing with age.

This trend among the population of 10-15 year-olds is dealt with by the law via cannabis clinics (see *infra*): out of 160 consumers in this age group admitted in one particular month, 36 had been ordered to go there by the courts, and 94% of them were boys.

6. Requests for help, consultation, offers of treatment and prevention

The survey of people attending cannabis clinics was introduced in 2005, and offers a complementary view of very young people. This survey was carried out by means of a questionnaire aimed at the professionals who dealt with patients (and/or their family and friends) between March 15th and April 15th 2005, and followed them until June 30th 2005. It deals with a sample of 229 cannabis treatment clinics, which received 4202 people in the course of one particular month, 72% of whom were consumers and 28% being the consumer's family or friends. Young people aged between 10 and 15 account for 6% of the total number of people attending cannabis clinics (which numbers 3000 consumers in an average month). Two thirds of these 160 young people are aged 15, 21% are aged 14 (33 individuals) and 10% are aged 13 or under (17 individuals). For comparison, the number of active consumers attending these specialist clinics comprises 41% adolescents aged 16-19, 40% young people aged 20-25 and 13% older consumers (26 or over).

The sex ratio is weighted towards boys at all ages, although less so among 10-15 year olds: girls represent 30% of this age group; this falls to 21% of 16-19 year olds, 18% of 2-25 year olds and only 17% of those over 25.

Requests made by a third party (from a family or school environment) are the main reason for attendance among 10-15 year olds: 61% of those attending do so on the advice of their family or friends – often accompanied, usually by one or more parent(s) – whilst 23% are required to attend by court, and 16% attend of their own free will. The proportion of court referrals is significantly smaller at this age than among older age groups (33% of 16-19 year olds, 48% of 20-25 year olds): at all ages, it is mainly boys who attend for this reason.

The reasons for attending cannabis clinics do in fact show significant differences according to gender: whilst the main reason for attendance is the advice of a third party for both sexes (71% of girls and 57% of boys), girls are much more likely to attend of their own free will and boys are more often referred by court.

In the 10-15 age range, approximately half of all those attending (46%) state that they are an occasional cannabis user (consumption on less than 10 occasions in a month), 22% are regular users (between 10 and 29 times per month) and 32% are daily users. In comparison with other ages, the proportion of occasional users is particularly high in this age group.

Those aged between 10 and 15 attending cannabis clinics began to smoke at an average age of 13, for both boys and girls. One quarter experimented with cannabis before this average age. Around 60% of those attending aged between 10 and 15 are one-off or "at risk" users, and almost 40% are judged to be harmful users of, or dependent on cannabis[28]. Compared to use among adults, it is at this age that the proportion of those falling into the dependency category is the lowest, and the "at risk" category is the highest.

Table 25. Diagnostic of use among those attending aged between 10 and 15

	Use	"At risk" use	Harmful use/abuse	Dependency	
Boys	27%	37%	22%	13%	100%
Girls	20%	33%	23%	25%	100%
Total	25%	36%	22%	17%	100%

Source: Survey on those attending cannabis clinics, OFDT, 2006.

In a context where drug prevention is characterised by low-profile concrete interventionism by the State, there is so far no standard model of action for networks of professionals or institutions. Such a model may develop in the near future. In fact, the *Plan gouvernemental 2004-2008 de lutte contre les drogues illicites, le tabac et l'alcool* (2004-2008 government plan for the fight against illicit drugs, tobacco and alcohol) outlines the creation of effective prevention conditions which are adapted for all levels of education, echoing the principles set out in the *programme quinquennal 2003-2008 de prévention et d'éducation élaboré par le ministère de l'Éducation nationale*[29] (2003-2008 five-year plan for prevention and education developed by the Ministry for National Education). This political will from those in power was cemented in autumn 2005, with the finalisation of the "*Guide d'intervention en milieu scolaire pour la prévention des conduites addictives"* ("Guide for school-based intervention for the prevention of addictive behaviour"). The distribution of the recommendations made in this guide is aimed at standardising the preventative measures offered to young pupils, insofar as the majority of counter-dependency actions take place in an educational setting and involve the wider educational community in both the coordination and implementation of these actions.

[28] Classification under these categories was carried out by the person in charge of the adolescent. This could be a doctor, social worker… The person was able to utilise a grid to help them (CAST, DEP-ADO, CRAFFT, CAGE-cannabis, ALAC, or internal evaluation grid) but without using a reference threshold.
[29] Established by circular no. 2003-210- of December 11th 2003; NOR: MENE0302706C.

Since 1990, the Ministry of National Education has encouraged an approach to at risk behaviour which requires primary and secondary education establishments to deal with the question of drugs from a behavioural perspective rather than from one of the products themselves. The guide reaffirms this principle. It provides the key information needed to deal with all drug-related issues with pupils from *CM2* to *Terminale* (4th to 11th grades), deepening the principles of the legal and illegal psychoactive products consumed by these generations. The guide includes successive intervention plans, which deal with the following subjects:

- tobacco for pupils in *CM2* and *6ème* [30] (11 to 12 years old on average) ;
- alcohol for pupils in *5ème* et *4ème* [31] (13 to 14 years old on average) ;
- cannabis for pupils in *3ème* et de *2nde* [32] (15 to 16 years old on average)
- and finally, polydrug use in *1ère* -*Terminale*[33] (17 to 18 years old on average).

From the point of view of reference strategies for problematic use, as a general rule, the clinician takes the at risk consumption methods and the seriousness of the individual and environmental factors into account, looks for clinical signs and/or complications linked to the consumption of the product, refers to approved questionnaires and evaluates the patient's motivation to change. This evaluation strategy for the risks linked to the use of psychoactive substances is exactly the same for young adolescents. Several questionnaires permit the assessment and evaluation of the harmful consumption of psychoactive substances among adolescents, especially those which are illicit. The CRAFFT questionnaire, a 6-question tool which assesses harmful use of psychoactive products, has been subjected to a validity study across the general population of France (Karila *et al.*, 2006). Similarly, the CAST (Cannabis Abuse Screening Test) questionnaire, also containing 6 questions which are specific to cannabis consumption, has been subjected to a validity study across the general population, and is currently undergoing clinical tests. Standardised tools such as these are used more and more regularly, whatever the age of the respondent. They demonstrate that dependency is rare but abuse is relatively frequent in the under-16 age group (Reynaud, 2002). In any clinical approach, it is important to evaluate the patient's motivation. Motivational support is a therapeutic technique whose effectiveness has been proven to help addictive behaviour. It consists of a patient-centred approach, which aims to bring about a change in behaviour by helping the patient to explore and resolve his/her possible ambivalence. The therapist must force the patient to accept his/her problems, and to think of possibilities and ways of going about introducing change. This therapeutic technique is based on the principles of empathy, the exploration of ambivalence, the fight against resistance, the reinforcement of the feeling of self-empowerment, freedom of choice and the removal of obstacles. This approach can serve as a platform for pharmacotheraphy (Miller and Rollnick, 2002; Miller, 1996). It is well suited to young users who are already in problematic situations linked to their drug use.

[30] The final year of primary school and the first year of secondary school (corresponding to 4th and 5th grades).
[31] The middle two years of secondary school (corresponding to 6th and 7th grades).
[32] The last two years of secondary school (corresponding to 8th and 9th grades).
[33] The two years of sixth form college (corresponding to 10th and 11th grades).