

## 13. Drugs and driving

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### 1. Policy. Cannabis: a new legal device

The policy against drug driving in France has been characterised by two major changes in recent years. In August 1999, the first law (and its decree of applicability in 2001) introduced compulsory drug testing (cannabis) in fatal accident cases for a period of two years (from September 2001 to October 2003), with the aim of carrying out an epidemiological study. After more than a year of debate, the legislating body finally decided on the creation of a specific offence of driving under the influence of drugs, and decided to link its eventual introduction to the conclusions of a vast preliminary epidemiological study. This would lead to a legal framework which would authorise the carrying out of screening tests on drivers (see the results of this study in section 2).

Finally, before the conclusions of this study were made public at the end of 2005, the debate was re-launched by one MP, via the proposal of a new law “relating to driving a vehicle under the influence of illegal and psychotropic drugs”, submitted to the National Assembly in September 2002. On February 3<sup>rd</sup> 2003, law no. 2003-87 relating to driving under the influence of substances or plants classed as drugs was adopted and published in the Official Journal on February 4<sup>th</sup> 2003.

This law ratifies the decision for compulsory drug screening for drivers involved in a fatal accident, but also contains major changes to the system. Firstly, it creates an offence of “driving after using plants classed as drugs” (whereas the previous system had made it compulsory only after an epidemiological study), punishable by two years in prison and a supplementary fine of €4,500 or above in the case of associated alcohol consumption. It also extends the compulsory drug screening to accidents causing physical harm, when there are reasonable grounds to suspect that the driver has used drugs<sup>41</sup>. Furthermore, it authorises the screening of drivers involved in any type of traffic accident, of those accused of certain road traffic offences (those which are punishable by suspension of the driving licence, those relating to speed limits, seat belts or safety helmets), for whom there are again reasonable grounds to suspect drug use. The screening and drug consumption confirmation system will be detailed later (section 3).

### 2. Benzodiazepines: essentially preventative measures

In terms of benzodiazepines (BZDs), the system set out in the law of June 18<sup>th</sup> 1999 states that, for fatal road accidents only, drivers may be searched for psychoactive medicines, but only if they have tested positive for drugs. Searching for medicines here serves only as a confusing factor when calculating the risk of being involved in an accident after consuming drugs. For cost reasons, searching for medicines was not extended to all drivers involved in a fatal accident. A specific study on the risk linked to the consumption of psychotropic medicines will have to be carried out in addition.

More generally, the consumption of BZDs by drivers is legal in France. The ban on an individual “driving a vehicle whilst under the influence of a substance or pathology which may hinder his/her performance and constitute a danger to others” is deemed to limit such driving,

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<sup>41</sup> An article of the law of November 15<sup>th</sup> 2001, entitled “daily safety”, had previously extended the scope for searching for drugs after an injury-causing accident, therefore not exclusively a fatal accident, without requiring the authority of the Court.

but its weakness when applied to medicines renders it relatively theoretical in nature (Cadet-Taïrou, 2006).

Finally, only preventative measures can limit this type of individual behaviour, but the implementation of such measures carries obligations for certain professionals (prescribers and manufacturers of psychotropic medicines):

- compulsory advertisements in the usage instructions of the medicines or the addition of a pictogram on the packaging itself for certain products (decree no. 99-338 dated May 3<sup>rd</sup> 1999). It is however impossible to know what the effects of such descriptions are on the practices of users. Some professionals called for a revision of this system of written notices or pictograms and proposed a new classification of psychotropic medicines according to their effect on driving, which would allow the information given to patients to be graded according to known risks. This classification would have no legal status in terms of the ability to drive, but would aim to help practitioners better to evaluate the risks of medical prescriptions to drivers (see the work of Charles Mercier-Guyon, especially Mercier-Guyon, 2001). The decree of July 18<sup>th</sup> 2005 (Official Journal of August 2<sup>nd</sup>) introduces new pictograms and a three-tier risk classification system (de la Sablière, 2005).
- The obligation for the doctor to prove that he has provided full and appropriate information to his patient about the risks (even highly unlikely risks) of the secondary effects linked to the medical treatments he has given or prescribed. The doctor's obligation for patient information was imposed by several decrees of the State Council.
- The medical aptitude criteria for the provision or renewal of driving licences, defined by decrees, and falls under the jurisdiction of the Primary Medical Commissions for driving licences of the Prefectures responsible for the application of this system. It applies to all drivers of lorries, public transport, taxis and ambulances and to drivers of motorbikes, cars and light trailers who are known to have an at risk pathology.

These three disposals are not specific to BZDs.

### Prevalence and epidemiological methodology

The following information about cannabis is taken from: Biecheler M.-B., *Cannabis, conduite et sécurité routière : une analyse de la littérature scientifique*, Observatoire national interministériel de sécurité routière, February 2006, 23 p.

[\[http://www.securiteroutiere.equipement.gouv.fr/IMG/pdf/Cannabis.pdf\]](http://www.securiteroutiere.equipement.gouv.fr/IMG/pdf/Cannabis.pdf)

At the end of 2005, the results of the SAM (acronym standing for *drugs and fatal road accidents*) study were published in France. Due to its size, this study revolutionises French research in this field, both in terms of results and methodology. Previous French studies will be mentioned comparatively.

### The reference study for cannabis: The SAM study (drugs and fatal accidents)

Published at the end of 2005 (SAM group, 2005; Laumon, 2005), the SAM study deals with more than 17,000 accidents and 11,000 drivers involved in fatal accidents between September 2001 and 2003. It is by far the largest study in France. It also represents another first in that it is based on a quasi-exhaustive sample of road accidents (all the instantly fatal accidents which took place during the two years studied) and concerns drivers who were killed, injured or unhurt, whereas previous studies only looked at injured and hospitalised drivers.

### How many drivers test positive for cannabis?

It was found that 7% of drivers were positive for cannabis (blood THC level of more than 1ng/ml), 2.8% of whom had also consumed alcohol. The prevalence of cannabis rises to 17% among the under-25s. Although not its main objective, the study also suggests that the prevalence of cannabis among all “currently active” drivers is 2.8%. The SAM study, however, goes much further than the calculation of prevalence levels due to the presence of a control group...

### Are drivers who test positive for cannabis more likely to be responsible for a fatal accident?

To answer this line of questioning, the analysis compares those drivers who are responsible for such accidents and those who are not responsible<sup>42</sup>. Drivers under the influence of cannabis (blood THC level > 1ng/ml) are 1.8 times<sup>43</sup> more at risk of being responsible for a fatal accident than those testing negative, with the odds ratio rising to 14 [8.0 – 24.7] if they have consumed alcohol as well. In addition the study is the first to demonstrate that the risk of being responsible for this type of accident increases slightly with higher blood THC levels, with the odds ratio rising from 1.6 [0.8 – 3.0] for a level of under 1ng/ml, to 2.1 [1.3 – 3.2] for a level above 5ng/ml. This dosage effect strengthens the case for the existence of a causal link.

### Final question: How many road accident deaths can be attributed to cannabis?

Taking all concentrations together, the proportion of fatal accidents which can be attributed to a positive cannabis test is in the region of 2.4% [1.5 – 3.4]. The annual number of victims directly attributable to the risks attached to driving under the influence of cannabis is in the region of 170 deaths, based on 6,000 fatal accidents per year. In terms of proportions, young men (18-24 years old) are more likely to be the victims of such accidents than those killed in accidents where the driver has not consumed cannabis. In addition, the study shows that the risk of death for a driver is increased by a positive cannabis test, even if he is not responsible for the accident. The annual number of victims attributable to this specific vulnerability of drivers under the influence of cannabis is in the region of 50 deaths. The annual number of victims attributable to cannabis, either through their direct responsibility for the accident, or through their increased vulnerability, is in the region of 230 deaths.

## **3. Other epidemiological studies on cannabis**

The majority of French epidemiological studies on driving whilst under the influence of cannabis have been carried out on injured, hospitalised drivers. They show that cannabis is present in approximately 1 in 10 of these drivers (variable results of between 6% and 14%; see Biecheler, 2006):

- The oldest study (Schermann, 1992) was carried out on a large sample (2,471 drivers involved in accidents and hospitalised in 1989-1990). Its conclusions were that there was a cannabis prevalence of 6.3%, with an insignificant relative risk (responsible/not responsible) of 1.1 for cannabis alone, and 6.9 for cannabis and alcohol together. The technique employed at that time for analysing blood samples has today been

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<sup>42</sup> The risk of death for the driver being significantly heightened by a positive cannabis test, drivers not responsible for the accident, but who died in it, are not included.

<sup>43</sup> Odds ratio of between 1.4 and 2.2, with a confidence interval of 95%

called into question, although this study was based on a sample which was not balanced out over several years.

- Two further studies (Pélissier, 1996; Marquet, 1998) were carried out on smaller samples (60 and 296 injured and hospitalised drivers). The cannabis prevalence levels (THC and its derivatives) were higher (10% and 14%) because cannabis testing was only carried out on urine (more/less sensitive) and on young adults (18 – 35 years old). The presence of a control group in the two studies (recruited from patients who had been hospitalised for other reasons than a traffic accident) meant that it was not possible to conclude that cannabis consumption was higher among those involved in traffic accidents (higher prevalence in one study, and lower prevalence in the other).
- The next survey (Mura, 1999) should not be taken into account because the samples were taken at the request of the judiciary authorities, and therefore from those who were under suspicion of having consumed psychoactive substances. As a result, the prevalence is much higher (26%). The Kintz study (2000) is interesting in its comparison of detection methods (it is part of the European Rosita project). Of 198 drivers involved in injury-causing accidents, 9.6% had THC in their blood, demonstrating driving under the influence, while 13.6% had metabolites on their urine, which can sometimes demonstrate past consumption.
- Several publications (Mura, 2001 and 2003) have mentioned a large, multi-centric study on the blood samples of 900 drivers involved in an injury-causing accident and subsequently hospitalised, in which these samples were compared to those of 900 patients who had been hospitalised for other reasons. At the intermediary stage (analysis of 420 drivers and 381 control samples) the prevalence levels were 11.2% among the drivers and 10.8% among the control samples, with the only differences appearing among younger drivers (18.6% of 18-20 year-old drivers were positive for cannabis in the blood, compared with only 8% among the control samples). The final analysis revealed prevalence levels of 10% among drivers and 5% among the control samples, with the gap appearing even larger among the under-27s (24.8% of drivers were positive for THC against 8% of the control samples). The limitation of these studies rests on the lack of information available about the representativeness of the drivers' and control patients' samples.

Finally, the samples carried out on drivers involved in a fatal accident, within the framework of the law of June 18<sup>th</sup> 1999, have also been analysed by certain laboratories which are responsible for providing blood analysis (outside of screening results). Given that system for detecting cannabis in drivers was compulsory for the first time in France, the samples analysed are even more important. The results of 3,751 blood samples were brought together in October 2001 and October 2002 (Pépin, 2003). They appear to show the presence of cannabis (THC and/or THC-COOH) in 13.8% of drivers who underwent an immediate blood test, with this prevalence rising to 27.2% among the under-27s.

The most recent survey was also carried out by toxicologists, on a wide sample of 2,003 blood tests from drivers killed in road accidents between January 2003 and December 2004 (Mura, 2005). All samples were from drivers under the age of 30. The prevalence of cannabis was found to be 28.9% for THC in the blood. By comparing these results to those of the previous study (Pépin, 2003), the authors concluded that there was an increase in the prevalence of cannabis among French drivers, although the sample was not identical (drivers killed as apposed to those involved in a fatal accident who were killed, injured or unhurt) and the THC detection threshold was higher in the 2<sup>nd</sup> study (0.2ng/ml instead of the 0.1ng/ml set out in the legal system).

## 4. Comparison with the SAM results relating to cannabis

As with international studies, the comparison between the French studies is limited due to differences of scale: populations studied (drivers involved in an accident, killed, hospitalised, etc.), screening methods employed (urine and/or blood, testing for THC and/or THC-COOH) and the size of the samples.

Overall, across comparable studies, the prevalence levels given by the SAM study are slightly below those normally found in French studies, because the research deals with blood THC, and excludes THC-COOH on its own (a narrower search).

The main difference, however, lies in the size of the population studied and this explains the lower prevalence levels. The SAM study is the only one to use an exhaustive driver base (those involved in an instantly fatal accident), which acts as a denominator for calculating prevalence levels.

The recent toxicology studies use only results from blood tests (with or without a preliminary positive urine screening). They therefore have a vastly reduced population sample to use as a denominator than the SAM study (which automatically increases prevalence levels). They also deal with a specific population sample, mainly comprising drivers who were unable to undergo preliminary urine screening due to their condition (killed or seriously injured). The SAM study showed that a driver under the influence of cannabis, even if not responsible for the accident, is more likely to die as a result of the accident than another driver (increased vulnerability). These drivers will be more highly represented in the population sample of toxicology studies, which also increases the prevalence of cannabis.

In addition, the other studies which adopt an approach based on the risk attributable to cannabis use a control group comprising patients hospitalised for a reason other than accidents on public highways. According to the Mura et al. (2003) study, which looks at under-27s, the accidents would be 2.5 times more frequent with cannabis alone and 4.8 times more frequent with cannabis and alcohol. There remain reservations about the choice of control group: can it really be said to be free from cannabis consumption?

## 5. The results of declaratory surveys

The data produced by epidemiological surveys can be complemented by certain declaratory surveys which look at the general population or cannabis users:

The 2005 OFDT ESCAPAD survey, looking at the health and behaviour of young people aged 17-18 during call-up and preparation for defence day<sup>44</sup>, shows that 4.3% of these young people said they had driven a vehicle (mainly two-wheeled vehicles) after smoking cannabis (5.8% having also drunk alcohol), but less than 1% said they did so often. Finally, 0.4% said they had had a road accident after smoking cannabis and 0.2% after smoking and drinking alcohol (although it is not possible to confirm whether or not these events were separate) (Beck, 2006).

Another survey carried out in 2004 by OFDT, this time on regular cannabis users<sup>45</sup>, shows that 71% of these users said they had driven a vehicle (car, two-wheeled vehicle) whilst or

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<sup>44</sup> A day introduced in France as a replacement for national military service. In 2005, this survey questioned 37,512 young people aged 17-18 in mainland France.

<sup>45</sup> 1,633 people aged between 15 and 29 years old who had consumed at least 20 joints in the previous 30 days, questioned in 2004 in 11 French towns or cities, recruited in specialised centres for drug addicts, in the street, from within the dance music scene or privately.

after (within 4 hours) consuming cannabis, at least once in the last 12 months: 35% did so often, 23% from time to time and 13% had done so once or twice (Bello, 2005).

## 6. Epidemiological studies relating to benzodiazepines

Several studies have measured the consumption prevalence levels of benzodiazepines among drivers involved in accidents in France (information from: Assailly, 2001; Mura, 1999; Cadet-Tairou, 2006):

- A survey carried out in 1987 on 341 subjects involved in accidents (half of whom were victims of road traffic accidents) via a questionnaire about the consumption of medications and samples of blood and urine, showed that psychotropic drugs were present in 14.5% of those involved in road traffic accidents, with BZDs the most common of all (Larcen, 1987).
- A study carried out on blood samples from 363 road accidents (including pedestrians), between June and September 1998 in a general hospital (the Angers CHU) demonstrated a prevalence of BZDs of 7.7% (Merlin, 1991). The role of the BZDs in causing the accident, as well as the absence of alcohol consumption, could not be confirmed (insignificant result).
- The same year, a study carried out in the Toulouse region on 570 drivers who had been the victim of a road traffic accident and hospitalised showed a prevalence of declared consumption of medications (via a questionnaire) of 7.7%, which was confirmed by blood analyses (Monstatruc, 1988).
- Two prevalence studies were carried out by the same team, one published in 1989 (Deveaux, 1989), which looked at 501 injured subjects (drivers or pedestrians) via BZD blood and urine screening. This study found that 15.3% were under the influence of psychotropic medicines, especially BZDs (no precise detail given). The other study was published in 1991, following the analysis of the results of the blood samples of 132 people who had been killed in traffic accidents. This showed the presence of psychotropic drugs in 10.6% of drivers, with BZDs the most common (Deveaux, 1991).
- A study focusing on BZDs (and alcohol), carried out on 2,010 subjects injured in all types of accidents (41% of which were road traffic accidents), showed the prevalence of BZDs among 9.6% of victims of road accidents (Girre, 1988). This figure was similar to that observed across the general population.
- A wider, multi-centric study carried out on 3,147 drivers involved in accidents, both responsible and not responsible for the accident, shows that BZDs were found in 7.9% of those involved in accidents, and does not show any significant difference based on responsibility for the accident (8.1% for those responsible, and 7.1% for those not responsible) ('Benzodiazepine/Driving' Collaborative Group, 1993).

Together, these rather old studies demonstrate a use level of approximately 10% of drivers involved in accidents. Few studies give clear proof of a correlation between BZD consumption and the likelihood of an accident or the driver's responsibility for such an accident, due to problems with the control group or significant differences between the groups of those involved in/responsible for the accident and the control groups.

Another difficulty in establishing the causality link between the consumption of medications and the likelihood of an accident is that the role of the pathology which causes the taking of

the medication remains unknown, as does the user's ability to drive in the absence of this treatment.

## **7. Detection, measurement and law enforcement.**

### Testing conditions

In France, the current legal framework allows for the drug screening of drivers (and not passengers or pedestrians) involved in a road accident<sup>46</sup>. In order that new testing methods may be carried out in the future, the law of 2003 does not specify which screening method should be applied, although only urine tests are currently valid in France. There is wide debate on the effectiveness of saliva tests for drug consumption screening but, in the absence of any consensus, such tests have not yet been adopted by law enforcement authorities.

The current system therefore allows for urinary screening for drugs (cannabis, amphetamines, cocaine, opiates), to be carried out as follows: the law enforcement authorities must take the driver, if his conditions permits, to a medical premises (hospital, doctor's surgery, clinic) to urinate; the equipment required for this screening (sterile beaker, test) is provided by the hospital or by the law enforcement authorities if the screening is not carried out in a hospital.

If the screening is positive (immediate result), if the driver refuses to be subjected to this test (rare), or if (more frequently) he is unable to urinate (killed or seriously injured driver), a blood test is carried out (also at the medical premises) and the quantity of blood taken is divided into two samples, one of which is preserved should there be a need for a second opinion. The blood sample is sent to a laboratory which is designated as an expert by the public prosecutor (since this process takes place within a legal framework). The laboratory is responsible for determining the dosage level of any drug products found in the driver's blood, as well as the nature and quantity of any psychotropic medications. The screening and blood test results must be stored in files provided for this purpose, attached to the police road traffic accident files. These measurements are in addition to the compulsory alcohol test, which has been standard in France since 1978; the legal limit has been set at 0.5g/l of blood since 1995.

Within the framework of this system, testing for possible consumption of benzodiazepines is only carried out in the event of a positive drugs test, via the examination of the blood sample taken; the information provided in this case is: a positive or negative medication test and the nature of the medication and/or metabolites found.

### Search methods used

The search for and dosage of drug products in the blood are carried out via the technique known as "gas chromatography coupled with mass spectrometry". A minimum detection threshold is set by decree (1 ng/ml of blood for  $\Delta 9$  tetrahydrocannabinol), below which the presence of drugs is judged as insignificant (uncertainty in measurement). Above this threshold, whatever the level found in the blood, the presence of  $\Delta 9$  tetrahydrocannabinol is considered an offence (see section 1.). A simple positive urine tests is however insufficient, it must be confirmed by a blood test.

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<sup>46</sup> For a description of the situations in which these tests may take place, see the legislative context in section 1.

The complementary search for psychoactive medications (including benzodiazepines) is carried out by techniques known as “high-performance liquid chromatography coupled with a diode array” and “gas chromatography coupled with mass spectrometry”.

### Behavioural examination?

In the system set out by the law of 1999, a clinical and medical examination was introduced should the drug screening be positive and when the condition of the driver allows it. This examination, formalised by a document which must be completed by the doctor and added to the police file, looks at: medical history (including the medical prescription of drugs, anaesthetics, withdrawals), alcohol or drug consumption, and a psychomotor test (breath, general behaviour, physical condition, speech, chrono-spacial orientation, balance, pupil dilation...).

This document is also interesting in that it creates a point of reference in terms of possible medical prescriptions. The behavioural test has no legal status (neither for verifying drug use, nor even for detecting it) and was introduced more as experimental measure. It is currently undergoing evaluation within the framework of the SAM study. The corresponding document was completed for the file of one in three positive drivers.

In the case of this system, therefore, no individual judgement is taken into consideration when determining that a person is driving after consuming cannabis; only the result of the blood analysis is taken as evidence. Since 2003, however, the judgement of the law enforcement authorities has been taken into account, in certain circumstances, when referring a candidate for screening (if they are suspected of driving under the influence of drugs). The criteria are not clearly defined (see section 1).

## 8. Police statistics: screening and offences

Since 2004, the Interior Ministry has published overall statistics on drug driving screening and offences, although it does not specify the product screened or the origin of the offence:

**Table 32. Screening for drug driving.**

	2004			2005		
	Number of screenings	No. positive	% positive	Number of screenings	No. positive	% positive
Accidents	9 563	1 052	11.0%	11 305	1 899	16.8%
fatal (immediate)	4 066	282	6.9%	5 248	629	12.0%
injuries (not fatal)	4 501	620	13.8%	5 547	1 041	18.8%
structural damage	996	150	15.1%	510	229	44.9%
Offences	1 198	548	45.7%	2 446	1 979	80.9%
Suspected use (no accident or offence)	5 144	1 878	36.5%	7 284	4 095	56.2%
<b>Total</b>	<b>15 905</b>	<b>3 478</b>	<b>21.9%</b>	<b>21 035</b>	<b>7 973</b>	<b>37.9%</b>

Source: Interior Ministry, "Bilan du comportement des usagers de la route, années 2004 et 2005" ([http://www.interieur.gouv.fr/rubriques/a/a7\\_statistiques\\_securite\\_routiere](http://www.interieur.gouv.fr/rubriques/a/a7_statistiques_securite_routiere))

In 2004, almost 16,000 drug screenings were carried out on the roads, the majority (60%) having been carried out following an accident, particularly for fatal accidents (compulsory screening) or injuries causing physical injuries (screening also compulsory if drug use is suspected). The number of screenings increased significantly in 2005 (21,000 – a rise of 38%). The increase was particularly marked for screening following a road traffic offence (+104%).



The rates of positive screenings should be interpreted carefully because they are affected by the way in which the population tested is targeted. The rates of positive screening are therefore highest among screenings carried out following suspected use, whether or not associated with an offence (for 2005, the Interior Ministry suggests the levels of positive screening recorded, which are particularly high in the case of an offence or suspicion, are effected by the fact that the law enforcement authorities only carried out screenings “when the general condition of the driver gave the undeniable impression that the level of probability was high”). These figures, and those relating to rates of positive screening in particular, may be taken neither as an indication of the level of drug consumption by drivers on French roads, nor of their driving under the influence of drugs on these same roads.

The only case where screening is (normally) automatic is following a fatal accident; the levels of positive screening here are 7% in 2004 and 12% in 2005. This trend, however, is probably not indicative of the behaviour observed across the entire population of drivers.

**Table 33. Recorded offences for driving after using drugs**

	<b>2004</b>	<b>2005</b>
Driving a vehicle after using drugs	1 577	4 246
Driving a vehicle after using drugs and under the influence of alcohol	528	922
Refusal to be subjected to drug product screening	112	435
<b>Total</b>	<b>2 217</b>	<b>5 603</b>

*Source: Interior Ministry, "Bilan du comportement des usagers de la route, années 2004 et 2005" ([http://www.interieur.gouv.fr/rubriques/a/a7\\_statistiques\\_securite\\_routiere](http://www.interieur.gouv.fr/rubriques/a/a7_statistiques_securite_routiere))*

In 2004, the first full year in which the drug screening system was in force, more than 2,000 statements were drawn up in relation to driving after using drugs, be they for drugs alone (1,577 cases) or associated with alcohol (528 cases). The figures for 2005 are incomparable, since more than 4,000 offences of driving after using drugs were recorded in that year, and almost 1,000 for using drugs and excessive alcohol.

These increases are a result of the implementation of the system, but the complexity of the screening process has been widely highlighted, and it does not encourage the law enforcement authorities to carry out these tests (in comparison, 11,387,829 alcohol tests were carried out in 2005, of which 9,017,161 were pre-emptive – i.e. not related to an accident or offence – and 140,000 offences of driving under the influence of alcohol were recorded).

## **9. Prevention**

### For cannabis...

Whilst drink driving has long been the object of preventative campaigns in France, the problem of drug driving has only recently been a topic of discussion, both in political/power circles (see section 1), and among road user victim support groups. This second category of individuals is particularly active in France, alerting public opinion to the problem of drug driving.

The first national prevention campaign against driving under the influence of cannabis was launched in 2006 (May 24<sup>th</sup> 2006 – June 10<sup>th</sup> 2006). It was organised jointly by the Inter-ministerial Mission for the Fight Against Drug Abuse (MILDT) and the Inter-Ministerial Delegation for Road Safety (DISR). It comprised an Internet site ([www.cannabisetconduite.fr](http://www.cannabisetconduite.fr)), a discussion forum (active throughout the period of the campaign), two radio slots, and posters and leaflets. Aimed mainly at young people, it

pointed to the main consequences of cannabis consumption when driving a car or two-wheel vehicle (loss of control, suppression of reflexes, lowering of vigilance) and gave warnings about the risk taken – both for oneself and others – when driving after consuming cannabis. The main statistical results of the SAM study were used as an epigraph: 230 cannabis-related deaths per year, the increased risk of being responsible for an accident, increased by a factor of 2 for cannabis and 15 for cannabis and alcohol together. The Internet site also reproduced recent legislation. The idea behind this campaign, according to the government, “was not to demonise cannabis but, in line with the government campaign launched in 2005, to highlight the fact that cannabis consumption is not harmless and to remind people of the problems and risks associated with driving a vehicle whilst under the influence of cannabis”. Its budget is rather small for a road safety campaign: €800,000 in total.

The prevention of cannabis use in France is generally the responsibility of several agencies, particularly the National Education departments or the Interior Ministry departments (police force). Little is known about the size and content of preventative measures. The information available to the OFDT suggests that the question of the ban on driving under the influence of cannabis is used to complement more traditional arguments in alerting young people to the dangers of this product. The police force suggests that the threat of driving licence withdrawal for driving under the influence of cannabis carries weight among young people (who may also feel they can consume it freely, despite the blanket ban) and that it is used in this way in certain prevention programs.

#### *For benzodiazepines...*

The problem relating to driving under the influence of medications is a much older one and, although it has not been widely communicated to the general public, information has been put in place for consumers of these medications, via a pictogram, which indicates the dangers of driving after consuming each particular medication (see section 1).