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Female-oriented programmes in addiction care

Results from the Ad-femina survey

Carine Mutatayi

Women presenting with addictions are among the vulnerable groups who are seen as a priority by recent governmental and European strategies [1, 2]. As a minority in specialised care services, they represent 23% and 18% of the public seen in specialised drug treatment centres (CSAPA) and harm reduction facilities (CAARUD) respectively [3, 4]. However, these women show, more than men, many social and health vulnerability factors (suicidal history, psychiatric comorbidity and an abnormally high death rate related to drug use, single parenthood, violence, etc.) and report a greater fear of being stigmatised [5-8]. When facing these situations, which can be exacerbated during pregnancy or when children are involved, addiction care services have sometimes developed specific care arrangements to meet women's needs (see box). These specific answers take various forms: from ad hoc interventions to the implementation of a framework of follow-up and appropriate care. Here, to simplify the language, the generic terms female-oriented programmes or support have been chosen to name this variety of approaches.

In 2018, the French Monitoring Centre for Drugs and Drug Addiction (OFDT) launched the Ad-femina online survey to provide an overview of addiction schemes tailored specifically to women in 2017 in France. As the scope of these schemes was unknown, the questionnaire was sent to all drug addiction facilities, with the support of several national professional networks in the field (see methodology p. 5). Therefore, 146 CAARUDs and 425 CSAPAs in mainland France and overseas, but also some 320 hospital-based Addiction liaison and treatment teams (ELSA) and 350 hospital-based addiction services were invited to participate in the survey, on a voluntary basis. At the end of the data collection campaign conducted in spring 2018, 338 facilities gave feedback, representing a participation rate of 26%. Of these, 137 reported that they had already implemented a women's programme, 80 of which (24% of respondents) were involved in this field in 2017. It is likely that non-respondents account for a large proportion of entities that have not set up such schemes. The activities of these 80 facilities or services are presented here. These responses come from 23 CAARUDs, 37 outpatient CSAPAs, either community-managed (23) or hospital-managed (14), 4 CSAPAs with residential inpatient care, as well as 5 hospital-based addiction services, 5 ELSAs and 6 other social or health facilities.

Despite limitations due to its non-exhaustive nature, the Ad-femina survey provides valuable elements for the cross-sectional analysis of the principles for taking action with regards to female-oriented programmes/schemes in France. It questions the implementation modalities, the beneficiaries and the field actors involved. All these points are discussed in this issue of Tendances.

Support and programmes for drug addicted women. Focus on 2017

Programmes aimed at "mothers" or at "women"

Among the 80 women's programmes identified by the survey, two main areas of action stand out:

- The first is maternity and parenting support, including responses provided in relation to perinatal follow-up. Of the group studied, 31 female-oriented programmes focus on this and are referred to as "maternal programmes".

- The second area, while still working on the mother-child bond, focuses on addressing the physical, psychological and social vulnerabilities observed in women with addictions, particularly situations of domination or even oppression by relatives (partners, parents) and the fact these women often feel

stigmatised. There are 49 such programmes in the Ad-femina survey, which focus less on maternity to concentrate on other issues and are referred to here as "women's programmes" to distinguish them from the generic term «female-oriented programmes».

Two thirds of the programmes provided had been in place for less than six years at the time of the survey, which can be linked to how recent this institutional focus on women is. Indeed, nearly half of these women's programmes were set up less than two years ago (37). However, nine, mainly women's programmes, report to have more than ten years' experience.

Most of these programmes operate on an outpatient basis (65, or 81%, four of which work through home visits), while 12 are part of a residential setting, sometimes involving a partner facility. Nine out of ten facilities have adapted the way they work to develop support services specifically for women whilst being a general mixed programme. Only nine facilities (3 CAARUDs, 3 CSAPAs, 1 ELSA, a clinic and a Maternal and child protection facility (PMI) have exclusively or mainly been addressing women, six of which have been doing so for more than ten years, of which four have been doing so for over twenty years. Two thirds of the female-oriented programmes formalised their actions in their mission and organisational planning (30 of them) or in a written intervention protocol (35), while a quarter of them took an informal approach.

Female polydrug users, addicted and poorly monitored

In 2017, the 80 facilities studied received 2,643 women. For one third of women's programmes and two thirds of maternal programmes, a large proportion of this public was not previously monitored by the teams. Improving their ability to identify women in need early on is a priority for one-third of the teams, who often intervene in times of crisis. The difficulty to engage women, especially in the long term, is highlighted.

Like the overall female population in addiction care [8], the programme participants are predominantly polydrug users, addicted, and have many comorbidities and social and family vulnerabilities. The primary substances most often involved when entering treatment are alcohol (referenced by 79% of facilities), opioids (68%), tobacco (58%) and crack or cocaine (49%). Cannabis is mentioned in 14% of cases. In most cases, the women are not targeted based on socio-economic, judicial or health criteria. However, some schemes have a specific focus. 18 are fully dedicated to pregnant women and their newborns and 13 are only for women with young children (aged 4 to 10) or infants (under the age of 3). Furthermore, two teams work with female prostitutes. Even if there is no age discrimination, hardly any programmes have received minors (8).

Half of the schemes have a framework for relatives accompanying the programme attendees. Therefore, 28 are open to the users' children, six of which are only able to receive children under the age of 3. In eight schemes, teenagers are sometimes welcomed. Counting the children involved is complex. The 18 programmes able to provide an estimation reported that 261 children came with their mothers. In addition, 24 schemes (mainly maternal programmes) involve the women's partners rather directly, while 16 integrate the couple into the care offered. Finally, nine are open to the parents of the attending users.

Strengthening medico-social care...

Four out of ten schemes - the majority of which are maternal programmes (18 vs 11) - focus first on improving addiction care. In this case, three-quarters of the teams provide prevention advice, counselling or motivational approaches. Half of them improve their work in psychosocial skills development, withdrawal assistance, therapeutic treatment (opioid substitution treatment, psycho-medical support). Four out of ten programmes focus on giving harm reduction (HR) advice or materials and on early identification and brief interventions. One quarter of female-oriented programmes aim to improve users' uptake of harm reduction measures (Figure 1).

Almost half of the women's programmes provide socio-administrative assistance for entitlements and integration (44%) or focus on socio-educational assistance (43%) (Table 1). A dozen, including eight maternal programmes, provide accommodation for the women involved in their programme. One third of the schemes provide practical assistance to programme attendees, either occasionally or in case of emergencies. Mediation and coordination with general care services are an important part of the job for 40% of the teams. Previous publications have already highlighted the time-consuming nature of these crucial tasks [7, 11].

Naturally, around half of maternal programmes frequently provide perinatal follow-up and three in ten offer gynaecological consultations. These services are less common among the women's programmes. Maternal programmes are characterised by their main priority to initiate addiction care (for 18 of them) and to improve the mother's and child's/foetus's health (17 of them) (Figure 1).

... Or better preparing women for care

As part of a general harm reduction and care mission, women's programmes are working towards various intermediate objectives. Just

Awareness and pioneering schemes

For some addiction care facilities, the commitment to female-oriented programmes is the result of a recognition: the under-representation of women in their patient intake is not only a reflection of an epidemiological reality but also the result of singular obstacles restraining their use of help services.

Pioneering initiatives dedicated to women in addiction care were introduced in France at the end of the 1970s. Mainly focused on pregnant users, today they are still marginal in the care system. The urgency of protecting the unborn child is not the only driving force, as for these women, pregnancy is conducive to better addiction treatment [9]. Towards the beginning of the 2010s, new forms of social and medical support for addiction developed, integrating gender-specific needs in order to improve women's access to care and continuity of treatment. For these schemes, it is a question of setting up a proactive approach, integrating various aspects of femininity to encourage bonding and develop adapted clinical practices in an environment that was historically predominated by male clients [7, 10-12].

over half of the teams (43) make the most of the particular framework of women's programmes to deploy care modalities that complement therapeutic follow-up and other preventative measures. Therefore, it is a question of psychologically preparing women to sign up to or stay in treatment. Many women's programmes focus primarily on this objective.

Improving self-image and resocialisation

Half of the women's programmes are looking to improve how participants see themselves. This «improved self-imaging» process prevails among the 49 women's programmes, and was cited by two thirds of them (Figure 1). For this same category, contributing to better socialisation is the second most important objective (mentioned by 22 programmes). Improving personal or social skills (20) ranks at the third position. This objective is also a major issue for half of maternal programmes (15), as is strengthening mother-child bonds and parenting skills (13).

Out of all the women's programmes, almost one-third strive to improve the resilience - psychological reconstruction capacity - of the women receiving care, many of whom are facing psychotrauma related to family violence, domestic violence or other kinds of violence. Beyond that, other health objectives or mediation with the general care system are raised by less than a third of the teams.

Women's relationship with themselves is at the heart of discussions

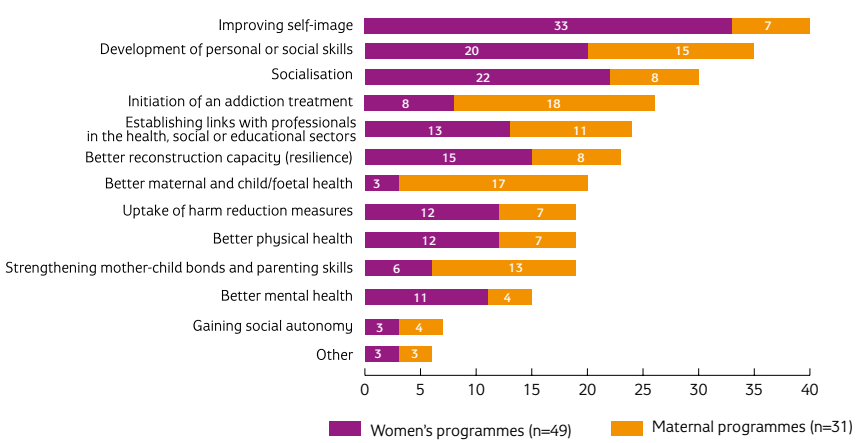
Although all teams are part of care facilities, half of them do not discuss health directly with participants, making the most of the women's programme time to discuss more specific related issues (Table 2). Based on the outlined priorities, it is not surprising that discussions with the participants at female-oriented programmes are most often based on self-esteem and individual skills in half of maternal programmes and two thirds of women's programmes. How they see themselves, femininity and their relationship with their body are the most common subjects, particularly in women's programmes, where 80% of them mentioned these subjects, compared to a third of maternal programmes.

Many teams are also working on the issue of parenthood, those targeting mothers or future mothers more than others (two thirds vs. half). In a third of maternal programmes, the staff also discuss parental projects with the patients. Couple life and sexual health are regularly discussed in four out of ten women's programmes.

Spousal or family domination and violence are often mentioned by a third of programmes and slightly more often in maternal programmes than in others. Overall, 20% of the teams bring women's psychological trauma into the discussions. Finally, difficulties in working life or studying while using drugs or even being involved in prostitution are more marginal subjects, mentioned by around 15% of respondents.

Three-quarters of the teams, particularly the women's programmes, organise group activities, with a

Figure 1. Main health objectives of female-oriented addiction programmes



Source: Ad-femina, OFDT 2018

Table 1. Services offered by dedicated female-oriented addiction programmes, excluding addiction treatment and harm reduction measures

	Women's programmes (n = 49)	Maternal programmes (n = 31)	Together (n = 80)	%
Integration or socio-administrative assistance (entitlements, etc.)	21	14	35	44
Socio-educational assistance	20	14	34	43
Mediation, coordination between specialised or non-specialised treatment sectors	18	14	32	40
Brief intervention or emergency practical help	16	11	27	34
Somatic medicine consultations (general medicine, podiatry, etc.)	10	6	16	20
Accommodation	4	8	12	15
Legal aid	6	2	8	10
Gender-related activities				
Pregnancy or perinatal follow-up	5	13	18	23
Gynaecological consultations	6	9	15	19
Psychological support (including socio-aesthetics)	7	4	11	14
Other (physiotherapy, osteopathy, nutritional advice)	2	0	2	3

Source: Ad-femina, OFDT 2018

third of them favouring this collective approach (Figure 2). Three out of ten set up support groups. The socio-aesthetic workshops (aesthetic care for vulnerable populations as relational and self-image support) are being used even more (43%), particularly by the women centres, half of which organise such workshops. Sometimes adapting to female patients means organising practical workshops or domestic training (cooking, sewing, etc.), involving almost 20 programmes. Offering cultural, physical or sporting activities helps participants work on their well-being and their relationship with their body. To a lesser extent, artistic mediation or role-playing are also reported. In general, all these activities support the development of self-esteem and psychosocial skills among the targeted women.

Some of the professions involved in existing programmes differ from those that are normally gathered in addiction services and help work on women's relationship with their body, image or self-esteem: socio-aestheticians (13), particularly in women's programmes, art therapists or comedians (8), early childhood educators (6), midwives or gynaecologists (5), sports teachers (4), sophrologists (3), osteopaths (2) or other practitioners (occupational therapy, physiotherapy, psychomotricity or nutrition).

Accessibility: a major challenge

One of the challenges of these programmes is to reach out to female drug users to facilitate their access to schemes and encourage them to ask for care. The first step is to promote this type of service.

The need for communication

A third of the facilities, which more often than not are community- rather than hospital-based (36% vs. 30%), carry out important communication work aimed at professionals in the health and social services sector but also at the targeted public in order to make the programmes known and to counter the stigma associated with addiction facilities. Communication and coordination between sectors are important issues to date, identified by 40% of the teams.

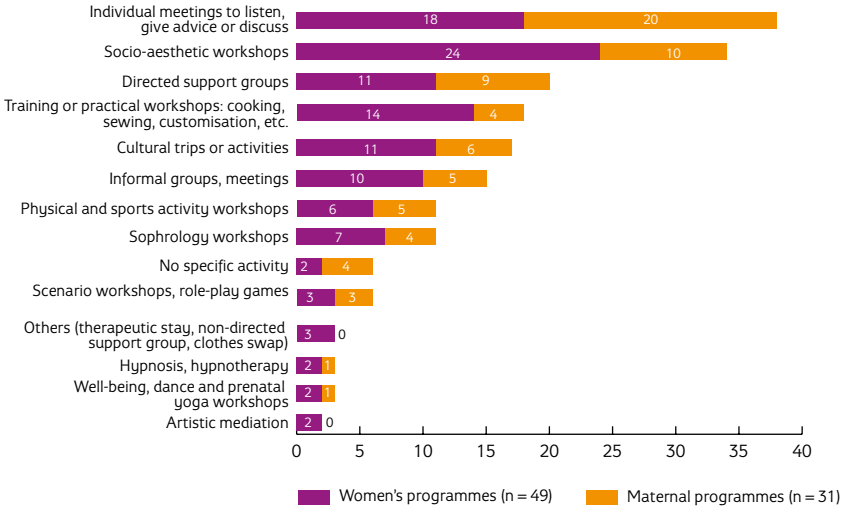
Generally, the programme participants discover the existence of women's support services by way of programme teams or other professionals in the facility (for 71% of the schemes), as well as by cooptation or word of mouth between users (46%). Referral from external partners in the general social and health care or specialised addiction treatment centres is also relatively frequent (40%). Three programmes in ten provide emergency assistance that helps make contact or keep in touch with the women, for instance by distributing hygiene and beauty products, clothing, and on rare occasions food.

Table 2. Main topics discussed with women receiving care female-oriented addiction care programmes

	Women's programmes (n = 49)	Maternal programmes (n = 31)	Together (n = 80)	%
Self-image, "femininity", relationship with body	39	11	50	63
Individual skills, self-esteem	33	17	50	63
Parenthood, family life	24	20	44	55
Overall health	21	14	35	44
Family or domestic control or violence	14	11	25	31
Relationships, sexuality, sexual health	18	5	23	29
Psychological trauma	11	6	17	21
Contraception	9	7	16	20
Family planning	4	10	14	18
Working life and drug use	6	5	11	14
Prostitution	5	5	10	13
Others: home economics, instability, discomfort at work, women's rights, stigmatisation, etc.	8	5	13	16

Source: Ad-femina, OFDT 2018

Figure 2. Specific activities offered by female-oriented addiction programmes



Source: Ad-femina, OFDT 2018

Developments to encourage women to seek help

In order to prompt women to use the schemes, teams make adjustments to time or place, or even rearrange the activities of the service. It is crucial to offer a relatively serene environment to women and their children, compa-

red to the normal environment of an addiction treatment centre, which is often marked by a certain aggressiveness, mainly related to the predominance of male users [13]. Therefore, 45 facilities (56%) set specific times for their female-oriented programmes, which are separated from their general mixed admission, whether it is specific hours (9), specific days (7) or both (27, 34%). Some teams (17) implement these programmes over a wide range of opening hours. Around fifteen, mainly CAARUDs, temporarily stop opening their doors to men while women are participating in the programme.

For 28% of the teams (22), responsiveness - their ability to respond in a short time frame, usually less than a week - is crucial. The average 6-day waiting period is related to the fact that this specific kind of programme is more often than not periodic. While ten schemes offer permanent or almost daily support services for women, 21 operate on a weekly basis and 11 on a monthly basis. Nine women's schemes are implemented even less regularly throughout the year (around once every two to three months). Finally, 18 schemes adapt to the patients' requests and have waiting times of less than 15 days.

A quarter of the women's programmes identified by the survey have a room reserved for them and a small part (10%) have a room or place outside the facility. A few CAARUDs or outpatient CSAPAs are able to offer women a different form of entry or access from the general admission (6%). Others rely on the team's mobility (home visits, etc.) to facilitate women using these services (23%).

A dozen maternal or women's programmes (16%) have set up a reception area for accompanying children (adapted equipment and furniture). Of these, six offer mothers activities that they can do with children around. Five have staff dedicated to welcoming children (keeping them busy, entertaining them, listening to them) and one offers a service that fully involves the children in the process by having a professional who conducts consultations with them.

A rare offer

The structuring of responses specifically for women in addiction treatment remains rare. This rareness can be attributed to the fact that these concerns about difficulty of care-access or factual or even ideological barriers (e.g. not adhering to a differentiated response) are relatively new. In the end, only one third (24) of the 80 respondents consider that their women's programme is implemented in good conditions. A quarter of the entities report a lack of institutional support and negative representations of them. About ten of them highlight a lack of human resources and budget.

Finally, nearly half of the teams advocate the idea of a professional exchange network dedicated to women's support. One of the first topics debated would be ways to engage women and refer them to specialists when facing their avoidance behaviours.

Methodology

The Ad-femina survey mainly addresses staff in addiction care facilities: in specialised drug treatment centres (CSAPAs), harm reduction facilities (CAARUDs), hospital consultations or hospital-based Addiction liaison and treatment teams (ELSAs), rehabilitation (post-cure), etc. It documents the modes of intervention of female-oriented programmes implemented in 2017, the profile of the participants and the characteristics of the care facilities that implement such programmes. Developed in participation with professionals in the field, the survey is based on an online questionnaire that can be completed in several stages. This questionnaire was disseminated via the OFDT's contact database and among the members of several national networks working in the field of addiction care (see 'Acknowledgements').

At the end of the data collection campaign, from 1 March to 15 May 2018, 338 facilities provided feedback, with varying participation rates depending on the type of structure: 56% of CSAPAs with residential care, 51% of CAARUDs, 36% of outpatient CSAPAs, 13% of ELSAs, 12% of hospital-based addiction services and 7% of Addiction follow-up and rehabilitation centres (SSRA). Of these 338 facilities, 137 (41%) reported to have previous experience with female-oriented support, including 80 in 2017 (24%). These 80 supporting facilities that detailed the activities of their female-oriented programmes in 2017 are mainly community-managed outpatient CSAPAs and CAARUDs (29% for each category) or hospital-managed outpatient CSAPAs (18%). The other categories of respondents are hospital-based addiction services (6%), hospital-based Addiction liaison and treatment teams (ELSAs, 6%), centres with collective or individual residential care (5%) and others (7%, PMI - Maternal and child protection facilities, community networks, private clinics, etc.). Further details are provided in French on the OFDT website (www.ofdt.fr/enquetes-et-dispositifs/enquete-ad-femina/).

Conclusion

Today, it is difficult to know exactly how many addiction programmes or facilities are involved in the development of responses specifically for women. The Addiction Federation (an NGO representing professionals in the field of addiction) identifies 55 of them in its national network. The Ad-femina survey documents the activities of 80 women's programmes operating in 2017, mainly in CSAPAs and CAARUDs. Given the respective low participation rates, this work does not allow for extrapolating the activity of hospital-based addiction liaison and treatment teams (so-called ELSA). Although they are not exhaustive, these results still provide an order of magnitude with regards to the dissemination of female-oriented programmes in CSAPAs and CAARUDs on a national level and useful details on the modes of intervention involved in these facilities.

However, this number forces us to limit the comparative analysis to two subgroups, women's and maternal programmes, grouping activities or services provided on perinatal care and the mother-child bond under the latter term. For the sake of interpretative rigour, the results for these two segments are expressed in accordance with the observed numbers and not in percentages.

The addiction programmes specifically for women aim to improve care for this public. To this end, those qualified here as maternal programmes work on protecting the child or foetus (through perinatal follow-up) and strengthening the mother-and-child bond. The aforementioned women's programmes carry out psychosocial work on the women's main vulnerabilities to get them to start a treatment or to support them while they are undertaking it. Reinforcing self-esteem («improved self-image») and the (re)socialisation of participants are key objectives for both types of scheme. These skills are meant to improve women's parental skills and their willingness to sign up to care. As such, a variety of activities are implemented, particularly in women's programmes - socio-aesthetics, practical workshops, cultural or sports activities, etc. - which are rarely used in addiction treatment centres in general. These women's programmes are somewhat characterised by group activities, many of which pursue psychosocial objectives.

About 2,650 women were seen in these 80 schemes in 2017, a modest number compared to around 72,000 women who annually attend CSAPAs and CAARUDs [4, 14]. Like all women received in specialised services, these beneficiaries are mainly polydrug users, often misuse alcohol and have social and health vulnerabilities, deterring them from asking for care. Finding ways to get them into care, in this case as part of a dedicated programme, as early as possible and keeping regular contact with them are some of the main challenges faced by the teams. Half of the structures engaged in female-oriented programmes adjust opening hours, or even places (rooms, dedicated access) so they can welcome female users, sometimes with their children, in a serene setting that is relatively isolated from male users.

Important work on providing information and raising awareness is being carried out with the targeted women, but also with local health care networks. The fact that these specific initiatives are generally voluntary and formal may explain why only around ten sites indicate insufficient resources.

While medical and social programmes specifically aimed at drug addicted women have received some attention over the last few years, both from practitioners and public authorities, it remains a field of clinical innovation. In addition, because this field is relatively new and difficult to investigate with quantitative tools, further study on professional practices is needed, particularly by using sociological methods to complete this first level of analysis.

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French Monitoring Centre for Drugs and Drug Addiction
69 rue de Varenne - 75007 Paris - France
Tel. : (+ 33) 1 41 62 77 16
e-mail : ofdt@ofdt.fr

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