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A cannabis reader: global issues and local
experiences

Perspectives on cannabis controversies, treatment and
regulation in Europe

Editors

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Chapter 14

Cannabis treatment in Europe: a survey of services

Keywords: cannabis – early intervention – psychosocial intervention – treatment provision

Setting the context

Scientific literature on the treatment of cannabis-related disorders is scarce, particularly when compared with opioid treatment. While there have been some synthetic overviews (Hall et al., 2001; Steinberg et al., 2002; Loxley et al., 2004), analysis has generally been peripheral to wider works on cannabis or restricted to adolescents (e.g. SAMHSA's Cannabis Youth Treatment series in the USA; Elliott et al., 2002; Liddle et al., 2002).

Scarcity also seems to characterise research on the treatment of cannabis-related problems in the European Union. This could be explained by a common belief that cannabis problems are not a primary problem for people in drug treatment. Yet Europe, like the USA, is recording a trend in which cannabis is mentioned at an increasing rate in the context of treatment demand indicators (EMCDDA, 2004, 2006; UNODC, 2006). Another explanation is that cannabis does not produce the pharmacological dependence syndrome associated with alcohol, nicotine and opioid use. However, as the chapters by Witton and Hall in Volume 2 of this monograph indicate, somatic and mental problems related to cannabis use affect thousands of people.

Indications do, however, exist, which point towards new directions in regards to cannabis treatment. At the level of healthcare policy, domestic and international research, cannabis treatment has for some years been gaining a higher level of visibility and public funding. In July 2004, the European Council adopted a resolution on cannabis proposed by the *Horizontal Working Party on Drugs*, which called for the EMCDDA to continue to monitor 'conditions for effective prevention and treatment, and examples of best practice' and encourages Member States to 'promote networking'.

In many ways, EU-wide monitoring into cannabis treatment has already benefited from scientific collaboration, both in terms of defining a 'PCU' (problematic cannabis user) and establishing standard treatment indicators. In June 2003, EMCDDA hosted expert meetings on the 'Quality and coverage of TDI and analysis of cannabis client profiles' ⁽¹⁾ and 'The profile of cannabis clients in different regions of the world'⁽²⁾. In parallel, the EMCDDA commissioned a report on 'Regular and intensive use of cannabis and related problems: conceptual framework and data analysis in the EU member states' (Simon, 2004). The Centre also published a selected issue, titled 'Cannabis problems in context: understanding the increase in European treatment demands' in its 2004 Annual Report (EMCDDA, 2004).

Supranational networking is taking place on a number of levels, and is increasingly crossing the linguistic barriers which have at times acted as an obstacle to collaboration. Cannabis is increasingly mentioned in EMCDDA's EDDRA ⁽³⁾ database, including specialised cannabis treatment in Lund, Sweden⁽⁴⁾, and Berlin, Germany⁽⁵⁾. A supranational project focused on adolescent therapy, INCANT (International Cannabis Need of Treatment Study) has completed pilot phases at centres in Belgium, Germany, France, the Netherlands and Switzerland, with the main phase being run from 2006 to 2009. Cannabis mental health issues and treatment options were covered in a 2006 Beckley Foundation report ⁽⁶⁾. Meanwhile, recent forums for international research have included the annual *HIT Perspectives on cannabis* conference in the United Kingdom, Therapieladen's Cannabis — Quo vadis⁽⁷⁾ conference in 2005 in Germany, not to mention cannabis presentations within general drug treatment conferences, such as ICTAB (the International Conference on Treatment of Addictive Behaviors). In terms of best practice, Germany's CaRED ⁽⁸⁾ project, managed from 2002 to 2004, represents a thorough analysis of cannabis treatment, albeit with a domestic focus, and in turn has helped stimulate innovative cannabis treatment provision studies, such as CANDIS ⁽⁹⁾.

⁽¹⁾ www.emcdda.europa.eu/?nnodeid=1861

⁽²⁾ www.emcdda.europa.eu/?nnodeid=1881

⁽³⁾ www.emcdda.europa.eu/themes/best-practice

⁽⁴⁾ EDDRA link:

www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=1293&tab=overview

Home page: www.droginform.com/

⁽⁵⁾ EDDRA link:

www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=2915&tab=overview

Home page: www.drogen-und-du.de

⁽⁶⁾ www.internationaldrugpolicy.net/reports/BeckleyFoundation_Report_08.pdf

⁽⁷⁾ www.therapieladen.de/

⁽⁸⁾ Simon, R., Sonntag, D. (2004), *Cannabisbezogene störungen: umfang, behandlungsbedarf und behandlungsangebot* [Cannabis-related disorders (CareD): prevalence, service needs and treatment provision], Bundesministerium für Gesundheit und soziale Sicherung, Munich www.bmg.bund.de/nn_604826/SharedDocs/Download/DE/Themenschwerpunkte/Drogen-und-Sucht/Cannabis/cannabisbezogene-stoerungen,templateld=raw,property=publicationFile.pdf/cannabisbezogene-stoerungen.pdf

⁽⁹⁾ www.candis-projekt.de/

This chapter is based on a survey that answered the basic question: What type of treatment is available for cannabis use disorders in Europe today? While the results are not exhaustive, they help to inform the road ahead.

Further reading

Copeland, J. (2004), 'Developments in the treatment of cannabis use disorder', *Current Opinion in Psychiatry* 17(3): 161–167.

EMCDDA, *Annual reports*, published each year in November.

UNODC and EMCDDA (2006), *Guidance for the measurement of drug treatment demand*, UNODC and EMCDDA, Vienna and Lisbon.

Cannabis treatment in Europe: a survey of services

Sharon Rödner Sznitman

Introduction

In response to an identified lack of data about cannabis treatment provision in Europe, the Centre for Social Research on Alcohol and Drugs (SoRAD), in cooperation with EMCDDA, conducted a survey on cannabis treatment provision in Europe in 2005. The study was designed to provide a base for a preliminary description of cannabis treatment in Europe, to examine the availability and nature of different specialist treatments for cannabis users, and to profile their clients' characteristics.

Research method and sample design

The study was conducted in two phases. In phase I, key informants were contacted through the EMCDDA's coordinating network of national focal points. This provided access to informants from the 25 Member States and Norway; Switzerland also participated. A questionnaire was emailed to these informants in which they were asked to provide contact information for key position holders in treatment centres which are likely to see cannabis cases. Informants for phase II were thus identified and these were contacted by email.

The criterion for including a key expert in the study was 'any person who is a holder of a key position at any centre offering treatment for patients with cannabis use as the primary problem'. Respondents were asked to indicate whether their service treated cannabis as the primary drug problem but also included other drugs, or solely treated cannabis-related problems. The questionnaire asked for information regarding the particular treatment offered to the cannabis clients and for summary data on agency's clients.

Problematic issues

Methodological limitations should be considered: since the survey was voluntary only some countries responded and they are not proportionately represented in the survey (e.g. Sweden returned eight questionnaires, Norway six, while some countries returned only one and others did not reply).

Over 100 questionnaires were sent out in Phase II of the survey, yet only 45 were returned. The results of the survey should, thus, be read with caution. They cannot claim to be representative of cannabis treatment in Europe overall. In the questionnaires, cannabis cases were defined as people who receive treatment mainly due to their cannabis use. This definition does not include polydrug users who use cannabis as a secondary drug together with other substances (e.g. heroin). The total number of people using cannabis is, therefore, underestimated.

Important definitions

For the purposes of the survey a treatment programme for cannabis cases is defined as any treatment at the agency for persons who are receiving treatment primarily for problems related to their cannabis consumption. Cannabis cases are defined as persons who are enrolled at the agencies mainly for their cannabis consumption and do not include patients with, for instance, heroin problems who also use cannabis.

Results

Responses were received from 45 individuals representing 45 different treatment agencies, from 19 EU Member States, Norway and Switzerland. Member States which did not respond and are hence not included in the study are: Estonia, Spain, Ireland, Slovenia, Luxembourg and the Netherlands. The respondents hold a wide range of positions in their treatment centres, including therapists, coordinators, heads of treatment centres, social workers, psychologists and nurses.

Description of the treatment centres

The majority of the responding treatment centres deal with a range of drug-related problems, and most of the treatment centres were fairly large. Six centres saw under 100 clients per year. Twenty-one centres saw between 100 and 500 patients per year, with the remainder treating over 500 patients per year. The majority, 72% (31), of the centres treated all or many patients in outpatient ambulatory counselling settings. A total of 36% of the centres treated all or some of their patients in long-term inpatient treatment. Short-term, inpatient treatment, treatment in a day clinic or in the community was less common.

Table 1 reports respondents' rating of the importance of modalities provided by their service. Short-term psychosocial interventions, long-term psychosocial interventions and long-term rehabilitative drug therapy were seen as the most important. In addition, on-the-spot psychosocial crisis intervention was rated as a very important or important

Table 1: Key informant rating of the importance of the different tasks at the agencies

	<i>n</i>	1: very important task, % (<i>n</i>)	2: important task, % (<i>n</i>)	3: relatively unimportant task, % (<i>n</i>)	4: no task at all/not on offer, % (<i>n</i>)
a On-the-spot psychosocial crisis intervention	(42)	24 (10)	38 (16)	31 (13)	7 (3)
b Short-term psychosocial interventions: short-term counselling	(43)	41 (18)	52 (23)	7 (3)	0
c Long-term psychosocial interventions: long-term counselling	(45)	49 (22)	45 (20)	5 (2)	2 (1)
d Long-term rehabilitative drug therapy: long-term psychotherapy	(43)	40 (17)	42 (18)	7 (3)	12 (5)
e Medical intervention for somatic problems	(42)	12 (5)	26 (11)	29 (12)	33 (14)
f Detoxification	(42)	24 (10)	26 (11)	21 (9)	29 (12)
g Harm reduction (e.g. syringe exchange, educating safer-use strategies, etc.)	(42)	31 (13)	17 (7)	24 (10)	29 (12)
h Methadone or buprenorphine substitution	(43)	30 (13)	19 (8)	9 (4)	42 (18)
i Heroin prescription	(42)	2 (1)	0	0	98 (41)
j Naltrexone prescription	(41)	5 (2)	11 (5)	17 (7)	66 (27)

task by many informants. Fewer identified detoxification, harm reduction, medical intervention for somatic problems, methadone or buprenorphine substitution, heroin and naltrexone prescription as very important or important tasks of their agencies.

Description of cannabis treatment

Although the recruitment strategy of the study attempted to ensure that questionnaires were sent to treatment agencies that include cannabis cases, four of the centres included in the study did not currently have any cannabis cases. Thus, the following results are based on only 41 treatment centres.

It is evident from the survey results that cannabis cases for the most part represented a minority of the overall clientele in the agencies. In 63% (25) of the centres cannabis cases represented 0–25% of the entire patient case load. Some centres did, however, seem to exclusively treat cannabis cases. In six centres (15%) — from Belgium, Denmark, Sweden, Cyprus and Germany — cannabis cases represented 75–100% of the patient case load.

Out of all the treatment centres, nine (23%) treated at least some of the cannabis cases in a programme within a unit not exclusively for cannabis cases. Fourteen centres (35%) treated the cannabis cases as individual cases among drug users of all sorts. Thus, it is evident that a substantial proportion of the agencies do not have a specific cannabis treatment programme. It is, however, also evident that treatment programmes exist which have an exclusive focus on cannabis cases. Six of the centres (15%) treated the cannabis cases in a unit exclusively for cannabis cases. Three of these were located in Sweden, and there was one such unit in each of Belgium, Germany and Italy.

Evidently, units exclusively for cannabis clients exist in Europe, but these must be regarded as a scarce phenomenon. This claim is further evidenced by the fact that only 10 of the respondents knew of only one treatment unit exclusively for cannabis in their city while three respondents reported that there were two such units in their city. One respondent reported that there were none and 14 respondents did not know how many there were.

Treatment

Most of the treatment provided to cannabis cases lasts no longer than 20 sessions. Fifteen of the treatment centres treated cannabis cases on average in 1 to 10 treatment sessions. Fifteen centres treated the clients in 11 to 20 treatment sessions. Treatment over 20 sessions was rare. As such, current treatment seems to correspond well with the literature on evidence-based cannabis treatment. Although the literature is scarce, the few existing studies mainly indicate that the most useful treatment for cannabis users is brief intervention (Stephens et al., 2000; Babor et al., 2004).

The aims of cannabis treatment reported as very important by most of the agencies were abstinence (20 agencies, 50%) and reduction of cannabis use (19 agencies, 48%). Seven agencies (18%) reported harm reduction (e.g. solving practical life problems and no attempt to change cannabis consumption) as a very important aim. Quite a few agencies (15), however, reported that harm reduction was an important, but not a very important, aim of the cannabis treatment.

In terms of what type of treatment is offered to cannabis cases, there seems to be a wide range of interventions available. As Table 2 shows, the main treatments reported by most of the agencies were: individual counselling, talk therapy/counselling about cannabis, relapse and treatment, and talk therapy/counselling about conditions of life. Also a regular part of treatment in many agencies were detox⁽¹⁰⁾ from cannabis, family therapy, therapeutic community⁽¹¹⁾ and mutual help groups.

Table 2: Content breakdown of cannabis interventions, based on number of respondents reporting specific treatment types

	<i>n</i>	1: main part of treatment, % (<i>n</i>)	2: regular part of treatment, % (<i>n</i>)	3: not a part of treatment, % (<i>n</i>)
a Detox from cannabis	(41)	24 (10)	42 (17)	34 (14)
b Peer group counselling	(40)	13 (5)	24 (11)	77 (24)
c Individual counselling	(41)	78 (32)	22 (9)	0
d Family therapy/ counselling	(41)	22 (9)	71 (29)	7 (3)
e Milieu therapy/ therapeutic community	(37)	0	24 (9)	76 (28)
f Talk therapy/counselling about cannabis, relapse and treatment	(41)	73 (30)	24 (10)	2 (1)
g Talk therapy/counselling about conditions of life (relationship problems, aggression training, etc.)	(41)	63 (26)	37 (15)	0
h Practical help with daily life (to get social allowances, clothes, housing, education, job)	(40)	13 (5)	48 (19)	40 (16)
i In-patient treatment	(39)	8 (3)	21 (8)	72 (28)
j Mutual help group (e.g. Narcotics Anonymous)	(41)	0	15 (6)	85 (35)

⁽¹⁰⁾ Detox refers to the process of abstinence to clear cannabis from the body, accompanied by social and environmental support during the associated physiological and psychological changes.

⁽¹¹⁾ Therapeutic community is a term applied to a participative, group-based approach to drug treatment that includes group psychotherapy and practical activities, and which may or may not be residential.

Characteristics of cannabis cases

Gender

As in drug treatment in general, cannabis cases are predominantly male. Only one treatment agency reported having less than 50% males. Four agencies reported only a slight male dominance (51–59% of all cannabis cases). Nine agencies reported that 60–69% were male, 13 agencies reported that 70–79% were male, 10 agencies reported that 80–89% were male and six agencies reported that 90–99% were male.

Age

The majority of cannabis cases are fairly young. Sixteen agencies (39%) reported that all or the majority of their cannabis cases were 20 years old or younger. Thirteen agencies (32%) reported that all or the majority of their cannabis cases were between 21 and 30 years old. Only four (8%) of the agencies reported that the majority of their cannabis cases were over 30 years old.

Referral channels

Worries have been expressed concerning increasing demand for cannabis treatment evident in many parts of the EU. It has, however, been pointed out that the rise might not be due to an increase in cannabis problems or dependence in the population. Instead, the rise might, among other things, be due to policy changes, which in turn lead to more referrals to treatment by police and school systems. While this study is unable to measure any trends over time, it provides indications of which are the most common referral channels to treatment for cannabis cases (Table 3).

The most common source of referrals reported was the client's family and friends. Many agencies also reported that self-referrals were most common. However, more agencies than not reported that cannabis clients do not enter treatment on their own initiative. Other referral sources were also reported; among them the most common were the criminal justice system, schools, psychiatrists, psychologists, social workers and general practitioners. It must, however, be noted that the separation between self-referrals and external referral channels is far from clear-cut. Research from Sweden, for instance, has shown that there is a large overlap between reporting self-motivation to treatment and reporting pressure from unofficial or official sources to enter treatment (Storbjörk, 2004).

Table 3: Reported common referral channels for cannabis cases

	<i>n</i>	1: most common, % (<i>n</i>)	2: common, % (<i>n</i>)	3: not at all common, % (<i>n</i>)
a Self-referrals	(39)	31 (12)	33 (13)	36 (14)
b Client's/patient's family/friends	(39)	38 (15)	53 (21)	8 (3)
c School	(40)	8 (3)	40 (16)	52 (21)
d Work	(38)	3 (1)	18 (7)	80 (31)
e General practitioner (family doctors)	(41)	12 (5)	32 (13)	56 (23)
f Psychiatrist/psychologist/social worker (out-patient or private practice)	(39)	8 (3)	67 (26)	26 (10)
g Courts, probation, parole, police	(39)	18 (7)	41 (16)	41 (16)
h Drug counselling agency or drug treatment units	(40)	5 (2)	24 (11)	68 (27)

Twenty-eight respondents reported that 50% or more of the cannabis clients received treatment for their substance abuse for the first time in their life when they came into contact with the agency. In fact, as many as 12 respondents reported that 90% or more of their cannabis cases received help for their substance abuse for the first time.

Lifestyles

Most cannabis cases in treatment had a socially well-integrated life before entering treatment. A large majority of the agencies reported that it was not at all common that the cannabis cases had been homeless or lived in a sheltered environment before entering treatment. The most common living conditions among the cannabis cases were living with parents or living alone.

A majority of the agencies reported that it was common that the cannabis cases had attended school or university or had been employed before entering treatment. There were, however, slightly more agencies that reported that it was common that cannabis cases were school drop-outs or unemployed prior to treatment.

In terms of mental well-being, less than a majority (30%) (Table 4) of the respondents reported that it was common that cannabis cases had psychiatric problems (based on

Table 4: Reported situations for cannabis treatment before entry to treatment

	<i>n</i>	1: most common, % (<i>n</i>)	2: common, % (<i>n</i>)	3: not at all common, % (<i>n</i>)
a Were homeless	(41)	0	7 (3)	93 (38)
b Lived in a sheltered environment (e.g. home for psychiatric cases)	(41)	0	7 (3)	93 (38)
c Lived with their parent(s) or guardian(s)	(41)	46 (19)	46 (19)	7 (3)
d Lived alone	(40)	30 (12)	48 (19)	23 (9)
e Lived with friends	(40)	3 (1)	28 (11)	70 (28)
f Lived with their own family	(41)	10 (4)	49 (20)	42 (17)
g Went to school/ university	(41)	15 (6)	63 (26)	22 (9)
h Dropped out of school	(41)	7 (3)	73 (30)	20 (8)
i Worked	(41)	7 (3)	61 (25)	32 (13)
j Were unemployed	(41)	15 (6)	66 (27)	20 (8)
k Had psychiatric problems	(40)	23 (9)	30 (20)	28 (11)
l Had health problems	(41)	5 (2)	29 (12)	66 (27)
m Had problems with the criminal justice system	(40)	23 (9)	65 (26)	13 (5)
n Had family problems	(41)	42 (17)	59 (24)	0
o Had financial problems	(40)	15 (6)	58 (23)	28 (11)

an affirmative response 'had psychiatric problems' to the question 'According to your experience, how common are the following situations for cannabis cases before they enter treatment at your agency?'). Many agencies, but less than the majority, also reported that it was common for cannabis cases to have problems with the criminal justice system prior to treatment entry. Family problems were rated as common for cannabis clients by slightly more than half of the respondents. Lastly, most agencies (66%, see Table 4) reported that it was not at all common that the cannabis clients had health problems ⁽¹²⁾.

⁽¹²⁾ The questionnaire is annexed to this chapter.

Cannabis use and polydrug use

The study shows that cannabis cases for the most part have been using cannabis for more than 5 years before entering treatment. Fifteen respondents (37%) reported that all or the majority of the cannabis cases had been using for 5 years or more before entering treatment. Nevertheless, cannabis use for less than 5 years was also reported. Two respondents reported that the majority of their cannabis cases had used cannabis for less than a year and seven respondents (22%) reported that half of their cannabis cases had used cannabis for this period.

In this study the respondents were asked to report on cannabis cases, meaning people in their agencies who received treatment mainly for their cannabis consumption. This does, however, not exclude the possibility that the cannabis cases also use other drugs. Indeed, as shown in the epidemiological section of this issue, polydrug use is far from the exception in regards to cannabis consumption (Table 5).

In terms of substance use other than cannabis, the majority of the respondents reported that heavy use of cigarettes (more than 20 per day) occurred very often among their cannabis cases. Heavy use of alcohol was reported very often by slightly fewer agencies. Only one respondent reported that heavy use of cigarettes never occurred, and no agency reported that heavy use of alcohol never occurred among their clients.

All other substances were reported as less often used. Cocaine, for instance, was reported as very often used by only two of the agencies. This substance was, however, reported as sometimes used by the majority of the agencies. Nine agencies also reported that cocaine was never used by the cannabis clients.

Table 5: Reported level of other substance use than cannabis among the cannabis cases

	<i>n</i>	1: very often used, % (<i>n</i>)	2: sometimes used, % (<i>n</i>)	3: never used, % (<i>n</i>)
a Heavy use of alcohol	(38)	45 (18)	55 (20)	0
b Heavy use of cigarettes (more than 20 cigarettes per day)	(40)	63 (25)	35 (14)	3 (1)
c Cocaine	(40)	5 (2)	73 (29)	23 (9)
d Amphetamines	(40)	20 (8)	68 (27)	13 (5)
e Ecstasy/hallucinogens	(40)	15 (6)	80 (32)	5 (2)
f Heroin	(40)	8 (3)	50 (20)	43 (17)
g More than three different substances	(39)	8 (3)	64 (25)	28 (11)

Use of amphetamines, hallucinogens and ecstasy were also more often reported as sometimes used than very often used. A majority reported that amphetamines were sometimes used by the cannabis clients and almost all the agencies reported that hallucinogens and ecstasy were sometimes used by the cannabis clients. Also important to note is that five agencies reported that amphetamines were never used, and two agencies reported that hallucinogens and ecstasy were never used by the cannabis cases.

Heroin use seems to be less prevalent among the cannabis cases, but still a substantial part of cannabis users seems to use heroin sometimes. Half of the respondents reported that the substance was sometimes used by cannabis clients. Nevertheless, also a substantial amount reported that heroin was never used by the cannabis clients.

Evidently, cannabis users in treatment tend to be polydrug users, although 11 informants indicated that three or more different substances were never used at the same time.

General trends in cannabis cases

According to the informants' evaluation, there has not been a decrease in cannabis cases in the agencies. Twenty-nine respondents (67%) reported that there had been an increase the last 5 years, and 14 respondents (33%) reported that there had been a stable number of cannabis cases in their agencies.

Thirty respondents (67%) reported that there had been policy changes in their country towards cannabis use during the previous 5 years. These changes were overall reported as an increasing treatment emphasis and less emphasis on punitive approaches to cannabis users. Eighteen respondents reported that there had been more emphasis on treatment for cannabis users. Sixteen respondents reported there had been more attention to cannabis in treatment agencies, while 14 respondents reported that there had been emphasis on less punitive approaches. The policy changes do not, however, seem to follow a clear-cut unidirectional trend across Europe. Nine of the respondents described the policy changes in terms of more emphasis on punitive approaches (including respondents from Belgium, the Czech Republic, Denmark, France, Latvia, Austria, Poland and Switzerland).

Summary and conclusion

In this report, various themes in connection with cannabis treatment and cases in Europe have been discussed. Based on a small sample of treatment centres, this study is only meant to provide a few indicators concerning the current state of cannabis treatment in Europe, and the material is not suited for generalisations or comprehensive in-depth analysis.

Overall, it seems that specialised cannabis treatment is a rare phenomenon in Europe today. Of the 41 centres which had cannabis cases, 23 had no programme exclusively for them. Thus, it can be concluded that many cannabis cases across Europe are treated within the same setting as persons with other drug problems. This may be regarded as problematic, especially in view of the above findings which indicate that cannabis cases are relatively young. Research shows that much drug treatment is built for the adult population and does not thereby fit younger ages, and supporting material is often based on adult patterns of substance use (regular alcohol use, heroin, cocaine) rather than adolescent patterns (primary use of cannabis and alcohol bingeing). It is also based on adult experiences (parenting, health problems and adult dialogue examples) rather than adolescent experiences (peer pressure and adolescent dialogue examples) (Dennis et al., 2002a,b). Another problem which may arise when cannabis cases are placed in the same setting as other drug users is stigmatisation and exclusion (Sloboda, 1999).

While most people who use cannabis do not end up in treatment, there are those who do. Furthermore, it is evident that the demand for cannabis treatment is increasing. This may be due to any number of reasons: increased availability of treatment; an increased pressure to seek treatment; increased cannabis-related problems in the general population. Indeed, for the people who do end up in treatment it is not totally evident whether or not they actually have a cannabis problem. People might enter treatment due to pressures from friends, family or the criminal justice system. These complex issues are addressed in more detail by Simon (this monograph) but are also shortly touched upon in this study as the above findings indicate that there are many different referral channels of cannabis cases. Although there may be many cannabis cases that require treatment after awareness of personal cannabis problems, self-referral is not necessarily easily interpreted as such, as a person might seek treatment by himself after receiving demands from family, friends or the criminal justice system to do so.

Furthermore, it cannot be disregarded that increased cannabis treatment demand is an artefact of reporting measures. From this study, it is evident that polydrug use is common among cannabis cases, which is important in terms of how cannabis cases are registered. Indeed, since cannabis users also use other drugs, it cannot be discounted that the cannabis cases may have a complex substance use problem not derived solely from one substance. Many might be registered as cannabis cases, based on the criteria that cannabis is the drug used most frequently and most heavily. This criterion does, however, not exclude the possibility that they also receive or should receive treatment for other drug use.

According to the above results, cannabis treatment in Europe focuses on counselling about conditions in life in addition to counselling about cannabis use and relapse. Furthermore, a substantial proportion of the agencies reported that family therapy was

an important part of the treatment offered. In view of the heterogeneous make-up of cannabis cases, a variety of treatment offers is probably a useful approach, particularly as cannabis cases may have problems which are not directly related to cannabis use. Nevertheless, the effect of type of treatment offered should not be overemphasised. Indeed, as Bergmark (this monograph) highlights, there is no conclusive evidence for any specific treatment intervention for cannabis cases.

There are indications, on the other hand, that anything works, that the context of treatment and the individual's choice to enter treatment is important to treatment outcome. A summary of cannabis treatment studies by the Beckley Foundation notes that the effectiveness of cannabis treatment is not yet clear, but that there is growing evidence that it may fulfil a useful role (Hunt et al., 2006). The report further remarks that there is evidence which notes that there may be reason to move towards individual and targeted treatment through focusing on 'high risk' groups and even genetic screening. Indeed, it is a seductive idea that screening and targeting individuals may create cannabis treatment effectiveness. In light of the above result, and in light of the scarce available information, it does, however, seem that individualised solutions is a simplistic way forward that overlooks the complicated horizon related to cannabis treatment indicators, embedded in societal disapproval, in criminalisation of cannabis use, polydrug use and the highly heterogeneous make-up of the relevant clientele. In sum, this report, together with other evidence, suggests that our current understanding of and available cannabis treatment is scarce and a much more in-depth understanding of the relevant issues is needed.

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Questionnaire

Section A: Information on the agency and key-informant

In this section we would like to ask you some questions about your agency, and yourself and your position in the agency.

- A1 Please give your agency's name and address.
- A2 Please give your position in the agency.
- A3 What is your profession?
 - a Nurse
 - b Social worker/youth worker
 - c Clinical psychologist
 - d Psychiatrist
 - e Other medical doctor
 - f Other (please specify): _____

Section B: Information on the treatment programmes

In this section we would like to get information on the structure and the type of treatment agency you are working in.

- B1 How many patients/clients does your agency treat? You can answer this in whichever way you have the data:
 - a Number of 'active' patients/clients (currently in a treatment episode)
 - b Number of patients/clients seen in a week
 - c Number of patients/clients seen in a 12-month period
- B2 How many of the patients/clients at your agency do you treat in one of the following settings? *Please tick off for each setting.*

	1: All	2: Many but not all	3: Approximately half	4: A few	5: None
a In the field (e.g. street work, prison work)					
b Ambulatory (e.g. outpatient, ambulatory counselling)					
c Day clinic (at least 3 hours per visit)					
d Short-term inpatient (≤ 1 month)					
e Long-term inpatient (> 1 month)					
f Other (please specify)_____					

B3 Please specify the importance of the different tasks at your agency. Please tick off for each task.

	1: Very important task	2: Important task	3: Relatively unimportant task	4: No task at all/not on offer
a On-the-spot psychosocial crisis intervention				
b Short-term psychosocial interventions: short-term counselling				
c Long-term psychosocial interventions: long-term counselling				
d Long-term rehabilitative drug therapy: long-term psychotherapy				
e Medical intervention for somatic problems				
f Detoxification				
g Harm reduction (e.g. syringe exchange, educating safer-use strategies, etc.)				
h Methadone or buprenorphine substitution				
i Heroin prescription				
j Naltrexone prescription				
k Other (please specify)_____				

Section C: Information on cannabis treatment

In this section we would like to get information on treatment programmes for cannabis cases at your treatment centre. A *treatment programme for cannabis cases* is defined as any treatment at your agency directed towards persons who are receiving treatment first of all for their cannabis consumption. By *cannabis cases* we mean persons who are enrolled at your agency mainly for their cannabis consumption. Hence, we do not want you to include patients with, for instance, heroin abuse problems who also use cannabis.

C1a At your treatment centre, are there currently any cannabis cases?

Yes

No

C1b *If no*, please jump to section E of the questionnaire. *If yes*, please proceed to the next question.

C2 Approximately what proportion of the patient case load at your agency are cannabis cases?

- a 0–10%
- b 11–25%
- c 26–50%
- d 51–75%
- e 76–100%

C3 In which setting(s) are cannabis cases at your agency treated? *More than one option is possible.*

- a In a unit/service exclusively for cannabis cases
- b In a programme within a unit not exclusively for cannabis cases
- c As individual cases among drug users of all sorts
- d Other (please specify) _____

C4 What is the average number of treatment sessions that cannabis cases at your treatment centre attend in the course of a treatment episode?
_____sessions per client/patient

C5 What are the aims for treatment of cannabis cases at your agency? *Please tick off one box for each aim.*

	1: very important aim	2: important aim	3: relatively unimportant aim	4: no aim at all
a Abstinence				
b Reduction of cannabis use				
c Harm reduction or solving practical life problems (no attempt to change cannabis consumption)				
d Other (please specify) _____				

C6 To what extent does the treatment centre emphasise the following interventions for cannabis cases? *Please tick off for each intervention.*

	1: Main part of treatment	2: Regular part of treatment	3: Not a part of treatment
a Detox from cannabis			
b Peer group counselling			
c Individual counselling			
d Family therapy/counselling			
e Milieu therapy/therapeutic community			
f Talk therapy/counselling about cannabis, relapse and treatment			
g Talk therapy/counselling about conditions of life (relationship problems, aggression training, etc.)			
h Practical help with daily life (to get social allowances, clothes, housing, education, job)			
i In-patient treatment			
j Mutual help group (e.g. Narcotics Anonymous)			
k Other (please specify) _____			

Section D: Information on the 'typical' cannabis case

In this section we wish to obtain information about how your typical cannabis cases can be characterised.

D1 What is typically the percentage of males among cannabis cases at your agency?

Male: _____ %

D2 According to your experience, how many cannabis cases are receiving help for their substance use for the first time in their life when they come in contact with your agency?

_____ % of cannabis cases treated in our agency.

D3 How many of the cannabis cases at your agency...

	1: All	2: Majority	3: Half	4: Minority	5: None
a					
b					
c					
d					
e					

D4 Typically, how common is it that the cannabis cases are referred from the following sources? Please tick off for each source.

	1: Most common	2: Common	3: Not at all common
a			
b			
c			
d			
e			
f			
g			
h			
i			

D5 According to your experience, how common are the following situations for cannabis cases before they enter treatment at your agency? *Please tick off for each situation.*

	1: Most common	2: Common	3: Not at all common
a			
b			
c			
d			
e			
f			
g			
h			
i			
j			
k			
l			
m			
n			
o			

D6 Apart from cannabis, what are the most often used substances by cannabis cases? *Please tick off for each substance.*

	1: Very often used	2: Sometimes used	3: Never used
a			
b			
c			
d			
e			
f			
g			
h			

Section E: Information on general cannabis-related trends

In this section we would like to obtain more general information related to cannabis than the above sections.

E1a According to your knowledge, how many units exclusively for cannabis cases are there in your city?
_____(enter number)

E1b Please guess how many cannabis cases they treat altogether at one time.
_____ per week
I cannot even guess

E2 Please provide contact information for one or two other centres in your country that treat cannabis cases.

E3 Please evaluate the trend over the last 5 years. In regard to your agency, has there been:

- a An increase in numbers of cannabis cases
- b Stable numbers of cannabis cases
- c A decrease in numbers of cannabis cases

E4a Please evaluate the trend over the last 5 years. In your country, has there been any policy change towards cannabis use?
Yes
No

E4b *If yes, which of the following options best describe the change? More than one option is possible.*

- a More emphasis on treatment for cannabis users
- b Less emphasis on treatment for cannabis users
- c More emphasis on punitive approaches towards cannabis users
- d Less emphasis on punitive approaches towards cannabis users
- e More attention to cannabis in treatment agencies
- f Less attention to cannabis in treatment agencies

E5 In your opinion, which alterations or developments would be desirable for a better treatment of your cannabis cases?

E6 We would be grateful for any further comments or observations. If you have any please indicate them below.