

Three-year assessment of the counselling cannabis clinics for young users (2005-2007)

Analysis of the outpatients admitted for their cannabis use or for other addictions: recruitment sectors and public response

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Cannabis is the most widely used illegal substance in France, particularly in young people, despite a fall in use since 2002 after ten years of continuous increase. In 2007, 5% of 16-year-old males and 2% of 16-year-old females reported that they used cannabis regularly¹.

Three years after the introduction of the "clinics for young users" (CYU) and following an initial survey [1], this work reviews the change in the outpatients' profiles (see box) based on the responses of professionals who managed the outpatients in 226 of the 274 CYU identified in 2007 (or 82%). The analyses are based on a sample of 3,788 people, of whom 2,938 were substance users (77.6% of the public in a given month), 79% of whom

attended alone, and 850 people from the person's family or close friends (22.4%). These allow the new trends and features of the public seen to be identified by recruitment sector. The results presented include previously unpublished findings about the nature of the requests, the reasons for use, criteria used to assess dependency, responses offered to the different user profiles and the change in their use trajectory during the sessions.

Monthly attendance and structure of the public

The monthly information forms completed on line by the CYU between March 2005 and December 2007 shows that the overall volume of activity fell between March 2005 and December 2007. The average number of people admitted each month per structure fell from 20.3 to 16.5². This fall in attendance was accompanied by a change in the structure of the public: the proportion of users has increased from 70.1% to 81.2%, whereas the proportion of family and close friends (particularly parents) has fallen by 10 points.

Since its launch at the end of 2004, the CYU system has offered support for young cannabis users and users of other psychoactive substances and for their families [2]. The CYU are now operating within the CSAPA [3] and are intended to provide information and assessment in the initial stages of use (use, harmful use) and to instigate a short period of care or referral if necessary. They have to receive all members of the public (older people or family and close friends), taking young people as a priority, and to respond to any substances in addictology (alcohol, cannabis, cocaine, psychostimulants) together with non-substance addictions (gambling, Internet, etc.). Although the CYU were initially centred on one substance, so much so that they were once referred to as "cannabis clinics", they have a general vocation.

Between March 2005 and December 2007, the CYU saw approximately 70,000 people. The first survey conducted by OFDT [1] showed that the public consisted of substance users (70%), between 14 and 25 years old (90%), with a large proportion of outpatients sentenced to drug treatment orders (38%) who had less problematic user profiles (22% dependants vs. 52% in spontaneous requests). The drop-out rate during follow-up appeared to be satisfactory (approximately 30%) and the risk of drop-out appeared to be greater at the start of the follow-up period, increasing with the length of time between two appointments and appearing to be reduced by the presence of a doctor during the first visit.

The proportion of new outpatients has fallen considerably (from 51.7% in March 2005 to 34.4% in December 2007), despite an increase in the access time (average monthly opening hours of 61.6 per structure increasing to 64.1). The increased attendance by substance users is therefore explained more by the ability of the scheme to keep its existing patients rather than recruit new ones. The 2007 survey illustrates these indicative figures to support the individual descriptive findings.

1. At least 10 episodes of use during the last 30 days (source: ESPAD 2007 survey results, OFDT, in press).

2. Source: Monthly information system on cannabis clinics (SIMCCA), from March 2005 to December 2007. Since then, the annual new patient intake figures of a part of the CYU (those linked to the CSAPA) are available in the CSAPA activity reports.

Predominance of men, young people of age and persons subject to trial

As in 2005, the majority of the public was male (81% vs. 19% females) despite regional differences (more females in Ile-de-France, Franche-Comté, Languedoc-Roussillon). Most users were between 18 and 25 years old (57%), whereas 26% were over 25 years old³ and 17% were minors. Average age was 23.2 years old: this main trend, however, hides a contrasting breakdown by age (standard deviation 6.8 years).

On average, the females were older (24.2 years vs. 23.0 years) and more consulted spontaneously compared to males (34.7% vs. 18.9%)⁴. Conversely, more males, who made up the majority of those between 18 and 25 years old (sex ratio 5.3 in the 18-25 group vs. 3.5 under 18 years old and 3.3 over 25 years old) were referred by the criminal justice system (54.8% vs. 20.8% for females), particularly young males of age (39.9% under 18 years old; 61.5% between 18-25 years old and 48.5% over 25 years old).

Socio-occupational or educational status of the public differed depending on age [4]: up to 20 years old (38%), the majority were still at school, (93% between 14-16 years old, 77% between 17-19 years old) and contained a high proportion of those in apprenticeships compared to the general population (41.3% of 17-year-old patients vs. 11.4% [5]) and there were higher proportions of unemployed people amongst the young people who had left the educational system (15.9% at 17-19 years old). Two out of five outpatients under 20 years old were referred by the legal services (43%) whereas 26% were referred by their families, 21% by a non-family third party and 10% attended spontaneously. From 20 years old onwards, the majority were part of the working population (62%, or 33% in active work, 29% unemployed): the proportion of those who were working became increasingly larger than the proportion of unemployed/not working with age (35.9% vs. 29.7% at 20-22 years old, 55.3% vs. 35.6% at 26-28 years old). The proportion of referrals from the legal services rose to become the majority (58%) over spontaneous attendees (22%) between 20 and 28 years old: the difference became less in those over 28 years old (32% vs. 53% judicial referrals)

Renewal of the client public with judicial referrals

The most significant change in the profile of the public was the increase in patients referred by the legal services (48% vs. 38%), renewing the new patient intake numbers: 54% of first-time outpatients were under legal orders compared to 18% of spontaneous attendees. The second change was in the 18-25 year old public (predominantly judicial referrals) in which the proportion of those who were part of the working population, particularly those actively working (32.9% vs. 27.4%), was higher than in 2005. Conversely, the proportion of outpatients at school was lower (16.5% vs. 19.3%). The third change was in the proportion of patients at school, in which the pro-

portion of pupils in the professional sector appeared to be higher than in 2005 (14.2% at 17-19 years old vs. 7.7% in 2005, 9.1% at 20-22 years old vs. 7.3% in 2005), particularly amongst females, contrasting even more markedly with the general population than in 2005: in 2007, one third of the 17-year-old patients seen were in apprenticeships (34.0% vs. 6.8% of the general population).

Multidisciplinary clinics

The substance motivating attendance at a specialist clinic was cannabis in 92% of cases (n=2,702) associated with one or more substances (often alcohol) in more than ten per cent of cases (n=331). Approximately 3% described multiple substance use with a combination of cannabis and another illegal drug (n=96), heroin or cocaine, more often in females (4.3%, vs. 3.0% in males) and in outpatients over 25 years old (4.6%, vs. 2.8% in 18-25-year olds and 3.0% under 18 years old). The most common substances reported other than cannabis were alcohol (3.0%), heroin (2.7%), cocaine (0.7%) and tobacco (0.6%), the remainder making up less than 0.5% of cases (including video games, either alone or as part of a network, Internet: 0.1%).

Almost 40% were daily cannabis smokers

Outpatients can be divided into 43% occasional cannabis users over the previous month (less than 10 occasions), 19% regular but non-daily users (between 10 and 29 episodes of use) and 38% daily users. A further 16% of outpatients had not used any cannabis during the previous month (10% in 2005): significantly more of these "abstainers" over the last 30 days" were referred by the legal services (p<0.001).

Although fewer in number, females of all ages reported high user rates, which need to be interpreted in light of different recruitment methods: more females attended spontaneously than males (42.1% vs. 23.1%; p<0.001), who were more likely to be referred by the legal services (44.8%.) and reported at least regular consumption (61.3% vs. 56.1% of males). In parallel, females used more on average (apart from those who had abstained over the last 30 days): the group which can be distinguished most clearly were the daily users between 18 and 25 years old who smoked an average of almost 7 joints per day compared to 5½ in males. Males had more moderate user profiles in this age group because of the high prevalence of judicial referrals [4].

Patient profiles and reasons for use

Daily use was significantly associated with patient age (23% at 12-15 years, 34% at 16-17 years, 37% at 18-25 years and 46% after 25 years old, p<0.001) but also with their reasons for use, which the survey examined for the first time. More than half of users reported that they used the substance(s) to control anxiety (56.3%) or for pleasure (51.5%) whereas 34.2% smoked through mere habit and repor-

ted a perception of cannabis dependency. Self-medication uses ("to combat anxiety and stress, to sleep better or to hold up") and routine uses ("habit, with perceived substance dependency") which were closely correlated (p<0.001), and more prevalent among daily users than more occasional users (67.3% vs. 34.1% and 54.6% vs. 9.9% amongst occasional users; p<0.001). Conversely, recreational uses ("for pleasure, friendship, sharing") were lower amongst daily users (33.5% vs. 55.7% amongst occasional users; p<0.001).

The extent of use appears to correlate with frequency of use (daily users smoked an average of 5.8 joints per episode vs. 2.3 by occasional users) but also with reasons for use: 37.6% of self-medication uses and 47.9% of habitual uses accompanied by a perception of substance dependency were associated with intensive smoking of more than 5 joints on a typical day of use (vs. 22.7% of uses for sociability reasons).

High levels of use of other psychoactive substances

As in 2005, smoking, not surprisingly, was increasingly prevalent with regular cannabis use: 90% of regular or daily cannabis users were daily tobacco smokers (vs. 81% of occasional users) and, in parallel, almost all users deemed to be dependent were daily tobacco smokers (91%). Heavy daily smoking was found more widely in females, associated with regular or daily cannabis use. Conversely more females did not drink alcohol (16.4% vs. 13.1%; p<0.001). Similar daily alcohol use rates (15%) were found in daily cannabis users. Overall, 23% of patients drank alcohol regularly.

The public seen differs from the general population in its excessively high use of other illegal drugs during the 12 previous months, excluding poppers: cocaine (11.8% vs. 0.6% in the general population), ecstasy (11.1% vs. 0.5%), hallucinogenic mushrooms (4.3% vs. 0.3%) and heroin (5.4% vs. 0.1%). More females experimented than males, in contrast to the general population, as did those over 25 years old (the effect of age and sex being related): 15.4% of females seen had used ecstasy during the previous year (vs. 0.2% in the general population and 10.1% of male patients) and 14.2% had used cocaine (vs. 0.3% in the general population and 11.3% of male patients) [7].

More heroin, cocaine or ecstasy experimenters were regular or daily cannabis smokers (approximately 75% vs. 55% in non-experimenters), had started earlier (14.8 years vs. 15.5 years), and were daily cigarette smokers (94% vs. 87%) and daily drinkers (10% vs. 4 to 5%).

3. As no age limit was present either in the terms of reference to set up the "clinics for young users" [2], or in the second circular stipulating their CYU intervention framework [3], since it began the current system has seen a proportion of older patients. This proportion was underestimated in the previous survey which did not specify whether age was or was not an inclusion criterion (13% in 2005, 26% in 2007).

4. All of the differences discussed in this section were significant (p<0.001).

The majority request help to stop their use

Regardless of frequency of use, the main request for help from by the patients was to help stop their use (43.8%). Beyond this, expectations varied significantly depending on the level of use and sources of the referral ($p < 0.001$) [8]. Amongst daily users, requests for help to reduce use without stopping completely came second (22.0%), ahead of no requests (17.6%) related to legal service or family pressure and requests for information or advice (13.8%). This sub-group made more requests for psychological or psychiatric support (2.8% vs. 2.3%) and urgent requests for immediate detoxification (2.8% vs. 1.5%), many of which came from spontaneous requestors (41.9%).

More occasional use in people subject to trial

Half of the users came through the legal services route (48%), generally as an alternative measure to court proceedings (66%): closing of procedures under conditions of health referral (33%), court ordered treatment (18%) or return to legality (15%) - completion of which would result in court proceedings being suspended. On the other hand, one quarter were patients who had been convicted and subject to mandatory care (26%): an alternative measure to imprisonment, for which failure to follow the mandatory care results in immediate imprisonment⁵.

Judicial referral was the main reason for attendance by males (55% vs. 21% in females). The public subject to trial contained 4 times more males (91.9% vs. 8.1% females, $OR = 3.84$; $p < 0.001$), reflecting the sex ratio in the breakdown of prosecution for cannabis use from the Ministry of the Interior statistics (92.6% of the 97,460 users arrested were men [6]).

Logistic analysis⁶ [8] confirms that there were twice as many people subject to trial who were young patients of age (between 18 and 25 years old) than minors ($OR = 1.92$). They were more often out of school or unemployed than

in school ($OR = 0.38$). More were occasional than regular ($OR = 0.65$) or daily ($OR = 0.53$) users and more were motivated by pleasure and sociability ($OR = 1.59$) rather than the management of psychological problems ($OR = 0.63$). Patients under legal orders were less likely to be seen by a psychologist ($OR = 0.58$), even less likely to be seen by a doctor ($OR = 0.38$) and were more likely to be seen by an educator, nurse or social worker: only 7% of patients referred by the legal services were seen by a doctor in the first consultation compared to 23% of spontaneous patients and 21% of those referred by a health professional. Finally, those referred by the legal services were more likely to have only one single assessment session ($OR = 0.25$) with a certificate of attendance being handed out as evidence that the person had met their legal requirement, and which could be given to the legal services. Even fewer of these people were referred to another system or service ($OR = 0.16$).

Clinical criteria used to assess dependency

More than a third of patients were considered to be cannabis "dependent" (mean 36%, this proportion increasing with patient age, rising to 48% in those over 25 years old), 25% were considered to be in an at risk user situation, 22% to be in the uncomplicated use situation and 17% to be in a harmful use (or abuse) situation [Cf. diagram]. The 2007 survey confirmed that the two variables most closely linked to the diagnosis of dependency were frequency of use (63% of daily users were considered to be dependent) and the number of joints smoked (these however are not absolute criteria for dependency): 5% of occasional users were considered to be dependent and more than a third of daily users were considered to be users with harmful use (17%), at risk use (14%) or even uncomplicated use alone (4%), with no clear dependency on the substance.

The clinical assessment criteria for harmful use and dependency appear to be variably effective. More than 8 out of 10 diagnoses were confirmed between the first and second sessions, particularly for dependency (84%) and at risk use (82%). The assessment of harmful use is based on less clear criteria, as this diagnosis was revised in 67% of cases in the second session (25% were reduced to at risk use and 8% increased to dependency).

The under-utilisation of identification tests for problem use limits the comparability of these results: 32% of patients were diagnosed without reference to a test screening dependence for cannabis and 20% with an in-house clinical grid (particularly when they were seen by a psychologist, which ap-

plied to 40% of patients). Of the cannabis use disorders screening tools, the most widely used were the French Cannabis abuse screening test (for 19% of patients, particularly those seen by a doctor), the ALAC (12%), CAGE (6%), DEP-ADO (5%) and CRAFFT (3%) questionnaires [8].

Logistic analysis⁷ [8] shows that more of the "dependent" patients used the system to reduce their cannabis consumption and significantly even more expressed the aim of stopping completely. Dependent users could be clearly distinguished by their reasons for use: more of them smoked to combat anxiety than the others and even more perceive a habit and addiction to cannabis. They were also more likely to be defined as dependent when an identification test such as the ADOSPA or DETC-CAGE was used to ask them about their use.

There were fewer single consultations in dependent patients: dependent users were three times more likely to be encouraged to return for a second consultation and four to five times more likely to be referred to another CYU service or external organisation. The system is therefore playing a successful role as a platform to identify problem users and then to refer them to the specialist addiction management services.

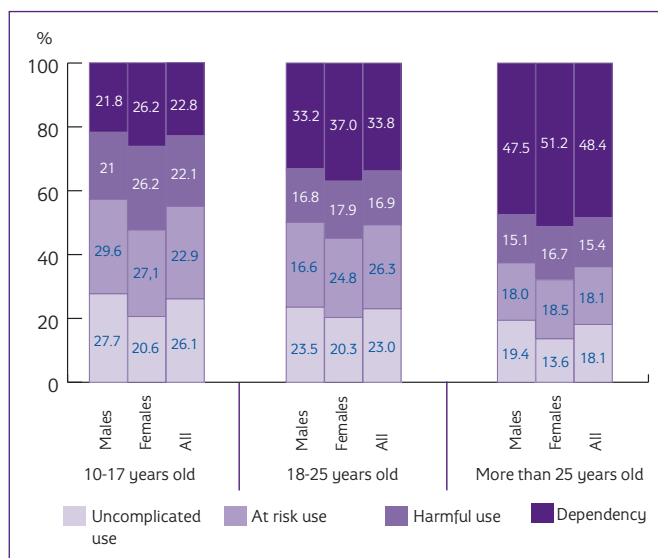
Health care trajectories and conditions for effective action

Of the patients encouraged to return after the initial visit, 30% did not return, confirming the drop-out estimate made in 2005. The analysis also shows that all other things being equal, more males drop out than females [8].

Of those patients who returned after the initial visit ($n = 1,028$), half reported that they had reduced their levels of use at the second interview: 47% had stabilised their use and 3% had increased it. The highest levels of short-term reduction in use were found in patients referred by a health professional or who attended spontaneously (56% vs. 43% of patients in the stabilisation phase), i.e. in the two populations reporting the highest prevalence of daily use in the initial visit (66% and 59% daily use of cannabis vs. less than 50% in other first-time outpatients respectively).

The largest reduction in cannabis use levels was seen in the patients who attended for a third or fourth session (almost 60%): users who reached this stage of the counselling session

Figure - Structure of public by age, sex and diagnosis of user status (n=2726)



5. In the remaining 8% of cases the legal measure was a mandatory visit (3%), punishment (1%), legal control (1%) or in less than 1% of cases, penal plea bargain, reprieve subject to testing, educational activities (AEMO), a consultation on the advice of a lawyer, formal legal referral or part of a commuted punishment.

6. The regression variables included in the model were sex, age, current status, frequency of cannabis use, reasons for use, diagnosis, type of professional seen and planned outcome after the inclusion consultation. All of the differences discussed in this paragraph were significant ($p < 0.001$)

7. The regression variables included in the model were sex, age, coming alone or accompanied, how long the patient had been attending the CYU, nature of request, current status, whether or not the patient had experimented with cannabis under 14 years old, frequency of cannabis use, reason for use, professional seen, whether or not diagnosed with an identification test and the planned outcome following the inclusion consultation.

process were logically amongst the most motivated. These success rates however fall after the fourth session stabilising at around 40%. In other words, the number of sessions beneficially influences the chances of reducing cannabis use up to the fourth: from the fifth onwards the likelihood begins to decline, possibly indicating a change in the nature of the problem at this stage of follow up (from the challenge of reduction to one of withdrawal)

In addition, the process of reducing cannabis use is non-linear and often punctuated by relapses. Whilst 50% of patients reduced their use after the first session, only 51% of these continued to reduce it thereafter. The others reported that their level of use had stabilised in the next session (13%) and 35% reported that their level of use had increased, cancelling out the effects of the first consultation.

Finally, if the levels of cannabis use change, the levels of use of other psychoactive substances also fluctuate: one out of ten patients increased their smoking habits during the cannabis self-restriction phase. Conversely, a number reduced their alcohol intake at the same time (16%). Despite the relatively high non-response rates (33.4%) which limit the power of the analysis, it is clear that the switch effect (switching from one substance to another) in patients is relatively limited in the short term. Increased smoking habits rise, on the other hand, with increasing initial frequency of cannabis use (12.5% of daily users vs. 11.4% of regular users and 9.4% of occasional users; $p < 0.01$).

Logistic analysis⁸ [8] shows that the public which succeeds in reducing its short-term cannabis use (although we can not determine whether this reduction is sustained) contains significantly more males and older people (over 25 years old vs. minors). For the same profile, people who reduce their use are educated to a higher level and/or are in work. More are occasional initial users rather than everyday users (OR=0.59, $p < 0.05$). Finally, the ability to reduce use is more clearly associated with early stages in the consultation pathway (up to the third session) and for reported self-medication uses (to control anxiety).

Discussion - Conclusion

The system, centred on a target clientele of substance users (80%), mostly concerned by cannabis use, (92%) is a legal requirement for half of its outpatients through which they avoid legal proceedings or imprisonment: this particularly applies to males most of whom (of all ages, but particularly between 18 and 25) are referred by the legal services. This trend towards legal services use of the system appears to have increased between 2005 and 2007.

The profiles of female users, seemingly more severe, are explained by different means of accessing the system: more females come spontaneously: (35% vs. 19%). It can be in-

ferred from the gender difference in profiles of use that faced with problems of "mild" use, that either females seek care elsewhere, rather than at the CYU, or that they do not seek care at all [9], or that the circumstances in which they use the substances (which are less often in public or on the street), keep them away from police prosecutions, which supply the CYU with most of its male patients [10].

It can also be concluded from the 2007 survey that several variables significantly influence the likelihood of reducing cannabis use after the first counselling session: gender (females being less inclined to reduce their use); age, users over 25 years old attending this setting have a 55% higher likelihood of reducing their use than minors, cannabis use undoubtedly being associated with a stage of adolescence: from 25 years old onwards former smokers who leave the educational system, start work, or start married or family life are all factors which encourage them to reduce use: patients who were in higher education or active work were twice as likely to reduce their cannabis use compared to those who had left school, were not in work or were unemployed: the number of visits also increased the likelihood of reducing use: the most significant effect the numbers of visits had was at the third session (those who continued being those who have the most firm intention of stopping). In terms of prevention, this reflects a need for support and training in the self-moderation process, hence the importance of keeping patients in the system beyond the first two sessions; the frequency of occasional cannabis use and the reason for using are strongly associated with a higher likelihood of reducing use: smoking to combat anxiety and stress is associated with a slightly higher likelihood of reducing cannabis use beyond the inclusion consultation. It is therefore at the start of the treatment trajectory in the system, when favourable conditions for reducing cannabis use are established and after the third consultation that the challenge of completely stopping becomes a plausible one.

The merits of this study are that it describes the public receiving counselling services and the response which is offered in a more global analysis of professional practices. Some care however must be taken in its interpretation which is based on the combination of reported data (frequency or reason for using cannabis) which carries a risk of incorrect reporting or under-estimation (particularly in patients who are subject to legal orders) and different ways of data collection (diagnosis, test used). The full report [8] will provide further information about the responses offered broken down by patient profile.

8. The regression variables included in the model were sex, age, coming alone or accompanied, how long the patient had been attending the CYU, nature of request, current status, whether or not the patient had experimented with cannabis under 14 years old, frequency of cannabis use, reason for use, professional seen, whether or not diagnosed with an identification test and the planned outcome following the inclusion consultation.

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