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French Monitoring Centre for Drugs and Drug Addictions

Updates on current research

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Initial assessment of outpatient visits to the cannabis abuse clinics

Analysis of patients admitted for problems related to cannabis use or use of other drugs in 2005

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Cannabis is the most widely used illegal psychoactive drug in France, particularly amongst young people. In 2003, in the 17-18 age group, nearly one female in ten and one male in five reported regular cannabis use[1]. Within the framework of the government's action plan against illicit drugs, tobacco and alcohol (2004-2008), the Ministry for Health, Family and Social Affairs, the Interministerial Mission to Fight Against Drugs and Drug Addiction (MILDT), and the National Institute for prevention and health education (INPES) jointly set up a prevention programme against cannabis use. In February 2005, this programme included an awareness-raising media campaign[2] and the setting up of specific outpatient clinics in every sub regional area (French "départements"), targeting people who have, or think they may have, an addiction to cannabis. These "risk-assessment clinics" have been closely associated with the existing addiction treatment system: 75% of the clinics were opened in specialised drug addiction treatment centres (CSST), 8% in alcohol outpatient treatment centres (CCAA), 2% in mixed structures providing treatment for both drug and alcohol addiction and 15% were developed in hospital units[3].

The aim of these "clinics for young users"[4] has been to offer young people an assessment of their consumption and a diagnosis of harmful use; to offer personalised information and advice to "high risk" users, to provide short-term care to young people reporting harmful use without social or psychiatric complications; to accompany and provide counselling advice to young people if their situation warrants it; to offer support to parents having difficulties in coping with their children's consumption; to offer, if necessary, joint support for parents and children.

The objective of the present survey, which is at the very core of this issue of Tendances, is to provide an insight into the population attending the clinics during a one-month inclusion period, by comparison with cannabis users in the general population. It provides a qualitative insight into the activity of these cannabis treatment facilities as well as a description of the follow-up offered to the users of psychoactive drugs in accordance with their consumption profile. What specific treatment do these outpatient clinics offer to people with cannabis-related problems as compared to "standard" care systems? How are they effective as a means to access care structures?

Socio-demographic profiles of outpatients

From March 2005 to February 2006, approximately 15,200 users were admitted to outpatient cannabis abuse clinics (for one session or more), as well as some 12,400 relatives and friends (according to monthly collected data, cf. box p. 4). Among the cannabis users attending over a given month, (72 percent of the public), the majority are male (80 percent). Among the 28 percent of relatives or acquaintances of a user attending, generally parents, 68 percent are women and 32 percent are men.

The average age of the patients admitted in the "cannabis outpatient clinics" is 21 years and 2 months (20 years and 8 months among females, versus 21 years and 3 months among males).

The cannabis users attending the clinics are, generally, aged 14 to 25 (90 percent); in all age groups, boys represent at least three quarters of the outpatients. A quarter of the patients are minors (about fifteen of them are 10- to 13-year-olds, i.e. less than 1 percent

1. Cannabis use from 10 times a month to more in the 30 days prior to the assessment: see *Escapad 2003*, OFDT.

2. This campaign took several forms (http://www.drogues.gouv.fr)

3. Sources: monthly data, OFDT + summary of credits dedicated to approved consultations, Ministry for Health, Health Administration Board/SD6B.

4. The so-called "clinics for young users" is the institutional term mentioned in the project specifications and the circular DGS-DHOS dated 7th March 2005 relating to the information system concerning them. No age criteria are indicated. The expression "clinics for young users" is used here in the same way as "cannabis outpatient clinics" or "risk-assessment clinics".

of the total) who mostly came accompanied by a parent. These cannabis outpatient clinics have also reached users in older age groups: 13 percent are over 25 years old (the oldest patient is 59) and it may even be possible to say that this segment is slightly underestimated (cf. methodological indicators).

Before 20, the patients are mostly pupils or students (93 percent of users are aged 14 to 16 years and 77 percent are 17- to 19-year-olds), boys in slightly greater proportions than girls. The proportion of people from the working population (on the job market, whether they are currently employed or in search of a job) increases logically with the age of outpatients. The employed are mostly among outpatients aged 23 and up. Unemployed people represent approximately 20 percent of the outpatients attending aged 20 and up.

Categories of cannabis use

The diagnostic criteria for harmful use and abuse of psychoactive substances were defined in the WHO International Classification of Diseases (ICD-10) and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

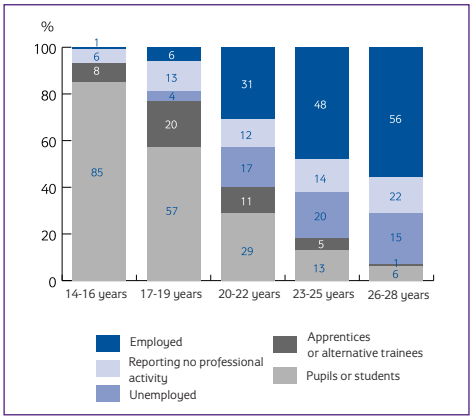
Simple, "one-off" use refers to the consumption of a psychoactive substance without, however, fulfilling the criteria of high-risk use, harmful use, or cannabis addiction.

The notion of **high-risk** use applies to an outpatient whose consumption is not harmful in the short term but has potential consequences due to particular circumstances of use (behaviour) or factors of use (early age of onset, intensive use or solitary use). A patient is also considered as being at risk if he reports levels of use exceeding determined thresholds (such as a need for daily use of cannabis).

Abuse (DSM-IV) or **harmful use** (ICD-10) of a substance is defined as repeated consumption which results in psychoaffective, social or somatic harm, without meeting the criteria for addiction. This condition appears most often in complaints from family and friends as well as the subject himself regarding his consumption and its consequences (difficulties at school, problems with the law, etc.).

Addiction encompasses a whole series of cognitive and physiological behavioural phenomena, arising as a result of repeated consumption of a psychoactive substance, typically associated with compulsive use of the substance, with consumption lasting longer than anticipated, a persistent desire or unsuccessful efforts to diminish or control it, a reduction in social, professional or leisure activities, the pursuit of intoxication despite physical, psychological or social complications.

Educational or professional level of users aged 14 to 28 (n=2489)



N.B.: the 1 percent of users aged 14 to 16 stating that they are "employed" may be CAP or BEP pupils currently participating in a work experience scheme. The 6 percent of users reporting no professional activity may be out of school youths under 16 or young people having left school at 16.

Source: Survey on outpatients admitted in cannabis clinics over a given month in 2005

Moreover, the educational profile of the outpatients admitted in "cannabis outpatient clinics" differs from that of the young people polled in the 2003 Escapad survey[5]: at 18, the youths admitted in cannabis clinics are less often attending school (78 percent, vs. 96 percent); when they are, they are more often apprentices or "sandwich" trainees (25 percent vs. 12 percent in the Escapad survey).

Reported cannabis use

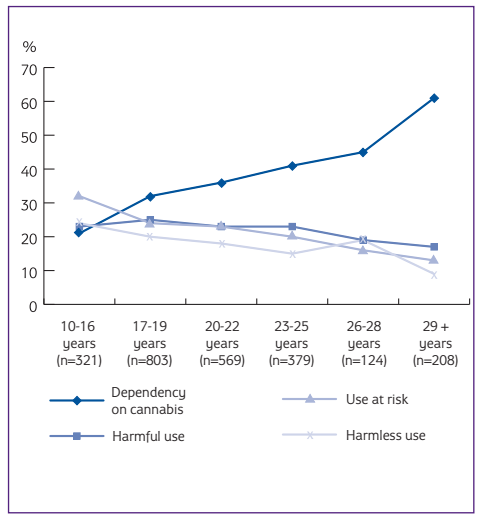
In all cases, the reason why outpatients enter these clinics is their cannabis use: 92 percent of those admitted (excluding family and friends) report at least occasional or repeated cannabis use. The remaining 8 percent are, barring exceptional circumstances, non-responses to the question of the frequency of use per substance.

Reported cannabis consumption levels are high: 45 percent of outpatients admitted are daily users, 20 percent are regular users but not on a daily basis (drug taken 10 to 29 times over the past month) and 35 percent are occasional users, having used the drug less than 10 times over the past month (10 percent had not used cannabis at all during the 30 days prior to entering the programme).

More than a third of outpatients were diagnosed as having an addiction to cannabis, regardless of the age group; this proportion increases with the age of the cannabis users. Users addicted to cannabis are mostly among outpatients aged 17 and older (cf. graph): their proportion culminates between 29 and 34 years (around 80 percent). The proportion of "harmful" uses is relatively steady in the different age groups (around 20 percent in each age group), while the proportion of occasional non-harmful uses decreases considerably with the age of the outpatients.

Additionally, frequency and intensity of use are closely associated: 53 percent of daily cannabis users reported smoking at least 5 joints a day versus "only" 28 percent of regular cannabis users.

Diagnostic assessment at entry by age group (percent)



Source: Survey on outpatients admitted in cannabis clinics over a given month in 2005

"Cannabis outpatient clinics" and monitoring system

OFDT has been commissioned by public health and anti-drug authorities to set up a monitoring system assessing the activity of the cannabis outpatient clinics throughout the first year of their implementation (Ministry for Health and the Interministerial Mission to fight against drugs and drug addiction).

This monitoring system is based upon 3 series of assessment data : a specific survey (presented herein) aimed at characterising the public (cannabis users and their family/friends), describing the nature of the sessions (average number of sessions per cannabis user, type of monitoring, reception staff, follow-up counselling proposed), and professional practices (screening methods, follow-up counselling proposed, etc.) – cf. methodological indicators; a routine activity monitoring system relying on a monthly collection (March 2005- March 2006) - cf. box page 4); an information system, currently being set up, based on an "outpatient record", filled in by the professionals in charge, called the RECAP system (Shared Report system on addictions and care) – which is already in force in drug addiction treatment centres and alcohol treatment units.

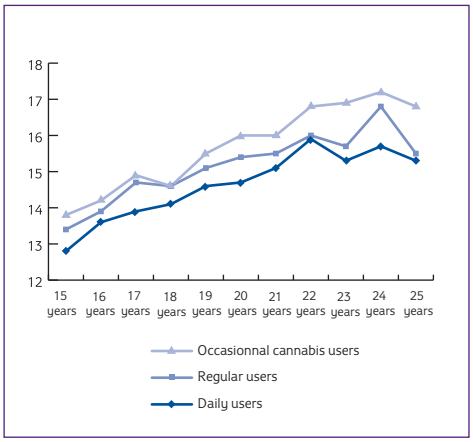
Early first use seems to be a major predictor of later heavy use: as a matter of fact, the earlier cannabis has been experimented with, the greater the frequency of current use.

Cannabis users attending clinics report an earlier age of onset than the adolescents featured in the Escapad survey: at 18, boys report their first cannabis use at 14.5 years (vs. 15.2 years of age), whereas girls report an average age of onset around 14.7 years (vs. 15.3 years of age)[6]. At 17 and 18, the average age of

5. Source *Escapad 2003*, OFDT.

6. See *Escapad 2003*, OFDT.

Average age of onset according to current age and frequency of cannabis use



N.B.: The scale has been truncated to 12 years (minimal average age of experimentation) in order to make the graph more legible.

Source: Survey on outpatients admitted in cannabis clinics over a given month in2005

cannabis first use is 14.7 years among the outpatients reporting "high-risk" use, 14.4 years among outpatients diagnosed with "harmful" use: the age of onset for those addicted to cannabis falls as low as 13.9 years. Among 18-year-old daily users, 36 percent tried cannabis before the age of 14 ("only" 10 percent among occasional users, that is neither regular nor daily).

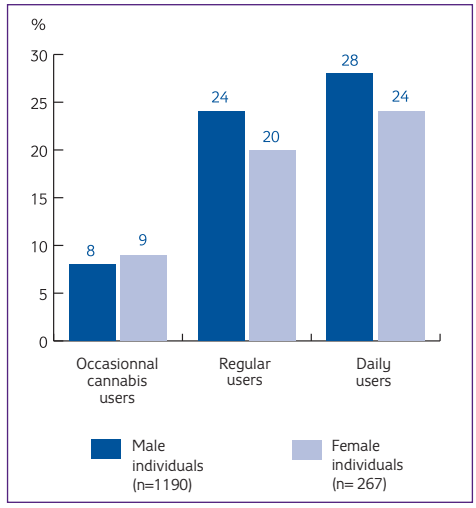
Use of other substances

The use of legal psychoactive substances is common among the outpatients admitted in cannabis clinics. Expectedly, tobacco use is almost systematically reported: 90 percent of regular cannabis users and 93 percent of daily cannabis users smoke tobacco on a daily basis (vs. 82 percent of occasional cannabis users)[7]. Moreover, almost all users diagnosed as addicted to cannabis are daily cigarette-smokers (vs. 73 percent among users whose consumption has been deemed neither harmful, nor "high risk").

Regular alcohol consumption is reported by almost 20 percent of users admitted in clinics (20 percent among male individuals, 18 percent among female outpatients). The levels of alcohol use are linked to cannabis use: 27 percent of daily cannabis users are regular drinkers, vs. 23 percent of regular users and 8 percent of occasional cannabis users. Hence, 14 percent of daily cannabis users also drink alcohol on a daily basis (14 percent among male outpatients, 12 percent among female outpatients).

Ecstasy experimentation is reported by one cannabis user in four among outpatients aged 17 to 18 years (vs. 4 percent in the general population at 17 and 18)[8]. Nevertheless, this level of experimentation is only slightly higher than among regular cannabis users within the general population: 21 percent of regular cannabis users aged 17 to 18 polled in Escapad 2003 report having used ecstasy at least once in their life. This similarity of profiles is confirmed for ecstasy use in the past 30 days (9 percent of female cannabis clinic outpatients, vs. 9 percent of regular female smokers in Escapad, and 7 percent of male cannabis clinic outpatients, vs. 12 percent of regular male smokers).

Regular use of alcohol (at least 10 times in the past thirty days) according to the frequency of cannabis use among outpatients



Source: Survey on outpatients admitted in cannabis clinics over a given month in 2005

Referral sources

Some 38 percent of family and friends call upon the clinics to seek advice on how to deal with a young cannabis user of their acquaintance. In roughly equal proportions are requests for treatment for the young user or psychological support (approximately 30 percent) and requests for information on the effects of the drug or on the existing treatment methods (26 percent). Family and friends frequently have multiple requests.

The reasons for calling upon clinics among individual cannabis users are gender-structured: 40 percent of male outpatients are referred by the criminal-justice systems[9] whereas 30 percent come to the clinics following suggestions made by family, friends, social workers or medical personnel at school and 30 percent are self-referred. Among female outpatients, self-referrals top the list (41 percent), slightly ahead of referrals following suggestions made by a third party (40 percent) and far ahead of criminal-justice systems referrals (19 percent).

The referral sources are also different by age group:

- Under the age of 20, almost 50 percent of outpatients requested admittance to the clinics based on suggestions from a third party;
- Between 20 and 28, cannabis users tend to go to the clinics following referral from the criminal justice system (46 percent), particularly among male outpatients;
- After 29, self-referrals predominate (more than 60 percent of referral sources).

I Methodological indicators I

The survey on people admitted to cannabis outpatient clinics was conducted with an anonymous questionnaire addressed to the professionals having received them (or their family/friends) between 15th March and 15th April 2005 and follow-up data for these people were collected until 30th June 2005.

having seen patients (or their family and friends): data were collected from this population was subsequently monitored up to

Approximately 70 percent of questionnaires contained information relating to a user attending alone, 20 percent provide joint information (user and family and friends) and 10 percent concerns only family and friends coming to discuss consumption of a third party user.

Complete data were obtained from 95 percent of the original sample (out of a total of 266 outpatient cannabis abuse clinics designated by the regional préfets at the time of the survey). The actual sample includes 299 clinics having admitted at least one patient during the inclusion period, which happens to cover 95 departments (mainland France + overseas French territories*). The usable response rate reached 100 percent in three quarters of the departments.

Data were collected from 4,202 people attending in a given month: 72 percent of whom were users (monitored over 10 to 14 weeks) and 28 percent members of family and friends of a user – parent(s) of users in almost 9 cases out of 10. However, the survey does not cover all users, certain clinics having explicitly chosen to take only "young people" under the age of 26 into account in the questionnaire.

* At the time of the survey, Guadeloupe had not reported any "clinics for young users".

7. When tobacco is exclusively consumed with cannabis (in a joint), tobacco use is not reported as such, which explains why 7 percent of outpatients state that they do not smoke tobacco.

8. Questions relating to reported use and frequency were only made explicit for three drugs (alcohol, cannabis, ecstasy). The field "other" enables the provision of additional information on other associated substances but only a small number of clinics filled in this field. It is therefore difficult to assess precisely the extent of associated consumption of illegal drugs other than cannabis and ecstasy.

9. Those attending under legal compulsion referred by the Public Prosecutor following police questioning for infringement of the law regarding drugs (the other alternatives being: educational referral for minors, closing of procedures with health referral, closing of procedures under conditions of health referral or court ordered treatment; compulsory treatment before proceedings when legal action is taken). The investigation method does not allow for categorisation based on the type of judicial referral in question here.

Monthly review in the "cannabis outpatient clinics"

Description of the system

The monthly monitoring system in the cannabis outpatient clinics (SIMCCA) makes it possible to monitor the effectiveness of the clinics for "young users", the take-up of their services, to analyse their development and thus to provide feedback on the system to decision makers and professionals in relatively short timescales.
Each month, four categories of information are sent to OFDT by professionals responsible for clinics for "young users". The first concerns the number of people admitted: young users (see note 4 p.1) with sessions at least once a month, parents, and other people. The professionals in the clinics for young users of cannabis and other substances then provide information on the average waiting period for an initial appointment. The third item of information concerns the number of weekly opening hours at the clinic. The last item of information investigated applies to the type of techniques used to pinpoint problem cannabis users.
When the clinics have Internet access, information on the activity of a given month is entered directly in a form that can be accessed from the OFDT site by using a specific username and password for each centre. For centres without Internet access, a paper version of the form is filled in and sent on a monthly basis to OFDT where it is stored. Data received via the website or on paper is integrated into a database which allows the results to be made available to professionals and public decision makers for the whole of France by region and by department. Each clinic can access its own monthly data.

Results

Level of participation

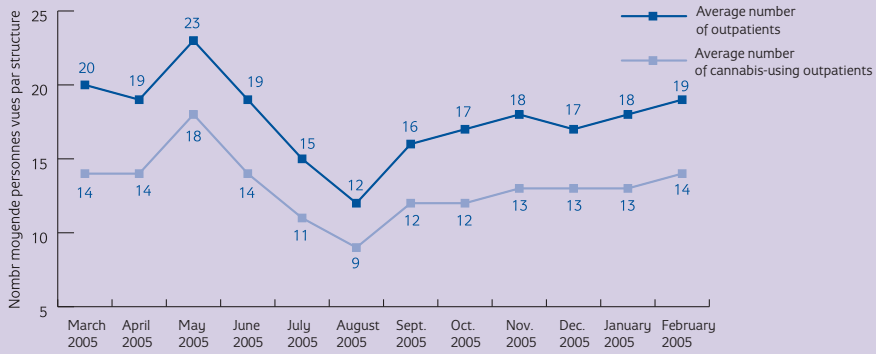
When SIMCCA was set up in March 2005, there were 259 clinics for "young users". Over the first twelve months of activity, the proportion of clinics providing monthly reports on their activity was satisfactory: on average, 80 percent of agencies sent usable information. Others sent no information or sent incomplete forms which were excluded from the analyses to avoid any bias in national, regional and departmental aggregate information.

Outpatient typology

The majority of people found at the centres are young users (73 percent). There may also be parents (approximately 21 percent) or other types of participants (6 percent) (people present at the session with or without the young user). The proportion of young users seen for the first time in the past month is 44 percent on average in the first twelve months of the report. Except for the month of March 2005 where the proportion of users seen for the first time is higher (52 percent) and the month of May where it is lower (35 percent). This indicator is stable with regard to the whole period.

Number of people received

From March 2005 to February 2006, it is estimated that more than 4,000 people (users, parents, others attending) are admitted each month in the cannabis outpatient clinics. The average number of those attending each month per structure has risen to almost 18 people.
If we only take users into account (without family and friends), the average number of individuals received per month and per structure is approximately 13 people.
These average figures hide, nevertheless, significant disparities: more than half of all clinics (56 percent) receive fewer than 15 people per month and 3 percent receive more than 60. More precisely, almost one centre in four receives a maximum of 5 people per month, a third of all clinics receive between 5 and 15 people, another third between 15 and 40 people and 10 percent receive more than 40 people per month.



Accessibility of clinics for "Young users"

Over the last 12 months, the average waiting period for an appointment is 7 to 8 days. The average number of opening hours for a clinic is 14 hours per week. These results are generally stable over twelve months.

Laure Vaissade and Dominique Lopez

Diagnosis of use and reasons for attending

Three quarters of self-referred outpatients are considered to have harmful cannabis use or an addiction to cannabis (31 percent of all outpatients). Cannabis users who are deemed to be "addicts" represent half of the self-referrals.

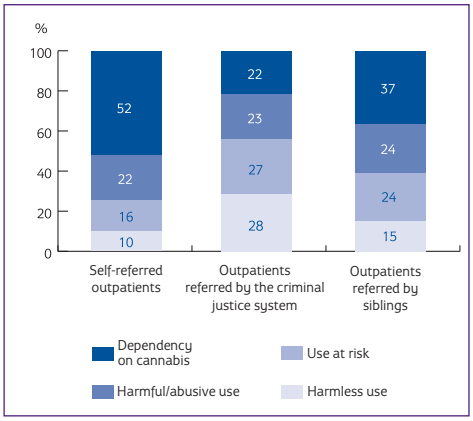
On the other hand, among the outpatients referred by the criminal justice system (38 percent), the proportion of users with a diagnosis of substance abuse or addiction is low. Within this population, the consumption profiles are often occasional use or "high risk" use.

Finally, cannabis users sent to cannabis clinics by a third party (31 percent) are "problem" users (approximately 60 percent) and occasional users (40 percent). They are generally younger than the outpatients referred by court or even self-referred.

Indeed, cannabis users tend to go to cannabis clinics spontaneously when they are experiencing "serious" problems. Female outpatients are more often self-referred: the proportions of regular or daily cannabis users among females are higher than among males (almost 70 percent of the 17- to 19-year-old girls, as opposed to 60 percent of the boys of the same age). The key explanation of this structural difference lies in the gender-structured distribution of the referral sources: referrals from the criminal justice system are the majority among boys while referrals from the criminal justice system are mostly associated with «simple" uses (28 percent vs. 10 percent of self-referrals and 15 percent of referrals from a third party). Logically, there is a lower proportion of problem users among boys. The male preponderance in criminal justice system referrals may be explained by the greater numbers of boys among those arrested for drug-related offences[10].

10. For more a detailed explanation of this hypothesis, see full report (to be published).

Cannabis risk-assessment according to the source of referral (n=2457)



Source: Survey on outpatients admitted in cannabis clinics over a given month in 2005

Follow-up offered in the cannabis outpatient clinics

Two clinical methods are currently in force, relying either on individual interviews (about 90 percent of outpatients of all ages) or group meetings (several outpatients received simultaneously, most often at entry).

The average number of sessions per person throughout the course of the survey (14 weeks) is slightly higher than 2. Almost half of first-time outpatients (visiting for the first time during the inclusion period, family and friends put aside) only visited once. A quarter of outpatients attended 2 sessions.

In the remaining quarter, 21 percent had an average number of 3 to 4 sessions and 9 percent went through longer follow-up processes (5 sessions or more).

Expectedly, the number of sessions is associated with the diagnosis at entry. Among the outpatients reporting one single session, almost 70 percent are "simple" users, whereas mainly users with a diagnosis of harmful use or addiction (73 percent) are to be found amongst those reporting 4 sessions or more. We need to stress that the proportion of users followed up through 5 sessions or more seems underestimated, due to the limited duration of the survey: at the end of the survey, a number of outpatients had not completed their monitoring, which would have to be longer than recorded.

The average duration of the monitoring11 offered to first-time outpatients is 31.3 days. Obviously, it depends on the number of sessions: outpatients reporting two sessions were in contact with the clinics over an average period of 17 days, while five-session attendees were actually monitored over 51 days on average.

The average waiting period for a first session is 8.2 days. The average time between two sessions is 15 days: the greater the number of sessions is, the longer the waiting periods between two sessions are.

Referral after the first session

Whether the assessment entails follow-up depends on the diagnosis of cannabis-related problems at entry. Half of simple drug users never show up again after the first session. On the contrary, the drop out rate is low among users deemed to be addicts (cf. figure below).

Some 80 percent of outpatients with a diagnosis of harmful use or addiction are followed up within the cannabis clinics after a first contact.

In addition, the number of external referrals to more adequate structures increases as the diagnosis grows more severe. These referrals greatly favour drug addiction treatment centres, especially if the diagnosis shifts towards substance abuse or addiction: 58 percent of users with a diagnosis of addiction to cannabis who are referred outwards are redirected to a drug addiction treatment centre, vs. 45 percent of simple users. Simple users are most often in contact with an educator or a nurse in a clinic integrated into a drug addiction treatment centre, before they are "naturally" sent to the psychologist of the parent-structure. The proportion of outward referrals is greater for occasional users, sent to various external units: share or discussion groups, advice centres, sports centres, family therapy associations, etc.

Classically, drop-out levels from drug addiction treatment are high. The survey makes it possible to measure the drop-out level, defined as the percentage of outpatients who abandoned treatment or follow-up after the first, second or third session. This level is no higher than one third of outpatients, which is relatively low, and all the more satisfactory as it is probably overestimated since a number of non-responses are recorded as drop outs. The drop out phenomenon seems to reach a peak after the second session (more than half of outpatients): this can be explained partly by longer waiting periods after the second session.

Waiting periods between two sessions are also a strong predictor of drop out, particularly at the outset of follow-up: it has been proven that the longer the waiting period between two sessions is, the greater the chances of drop out.

In addition, the professional status of the clinician met at the first visit was found to be a significant predictor of drop out: for instance, a first contact with a health professional (physician, nurse or psychologist) halves the chances of dropping out. Throughout the first two sessions, physicians appear to be the professional most able to "retain" the outpatients in the treatment process.

After the third session, outpatients who "drop out" show contrasted profiles: young adults aged 23 to 25 years are three times as likely as minors to drop out; moreover, women tend to abandon treatment more often than men. The clinician's profession is, at this stage, no longer a predictor of drop out.

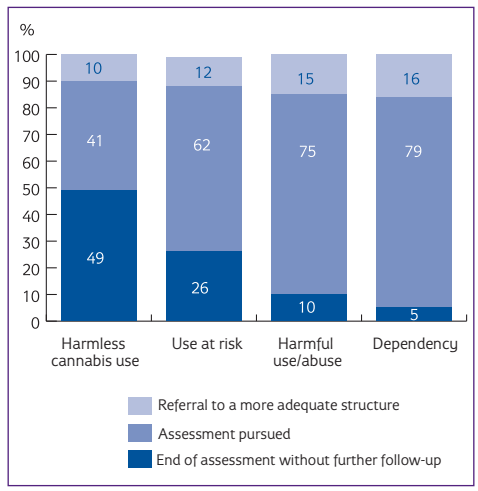
The referral source though (self-referral, suggestion from a third party or criminal justice system referral) does not influence the drop out level.

Defining problem cannabis use

The majority of "cannabis clinics" use a single screening tool to assess the risks related to cannabis use (58 percent). Almost 20 percent use two, 12 percent use three or more and 13 percent do not use any12.

Among the validated diagnostic tools (cf. box), CAST is the most frequently used (one third of clinics). The use of CAGE-cannabis is reported in one clinic in five, that is, far more often than the use of the DEP-ADO screening test (14 percent of clinics), the ALAC test (14 percent of clinics) or the ADOSPA test (12 percent of clinics)13. Almost 40 percent of clinics use internal assessment grids.

Follow-up after first contact, according to the cannabis use risk-assessment (n=1473)



Source: Survey on outpatients admitted in cannabis clinics over a given month in 2005

11. The average duration of monitoring is based on the average number of days between the first and the last consultation, over a period of survey of 10 to 14 weeks. It is calculated for the 950 users admitted for the first time between 15th March and 15th April 2005, who attended at least two consultations and whose consultation process has been carefully detailed in the questionnaire.

12. This percentage corresponds to consultations in which no defining test has been reported, for any users admitted: it is therefore probably overestimated since it comprises a proportion of non-responses to the question.

13. The total percentage is greater than 100 percent due to multiple responses: some consultations use several tests together.

Defining harmful consumption

Several levels of testing for harmful use of drugs exist: they combine the description of the type of use and the context in which the patient uses them, research into the risks associated with consumption (individual and environmental) and clinical signs or complications linked to harmful use, and assessment of the motivation to quit (cf. "For further information", reference 2).

CAST (Cannabis Abuse Screening Test), drawn up by OFDT, has been used since 2002 in the Escapad survey: it indicates problem users through 6 questions (3 positive responses should lead the user to consider the consequences of his consumption, 4 or more should encourage seeking specialised advice).

DETC, the French adaptation of CAGE used in the United States (Cut, Annoyed, Guilty, Eye-opener) comprises 4 questions (a single positive response indicates that cannabis use presents a problem).

DEP-ADO (Detection of problem drug and alcohol use among adolescents) is a French adaptation of the test which uses 7 questions, prepared by RISQ (Research and Treatment for Psychoactive Substances - Quebec).

The New Zealand **ALAC** (Alcohol Advisory Council) sets out 11 questions (3 affirmative responses indicate problem use).

Finally, **ADOSPA** (Adolescents and PsychoActive Substances), translation of the American CRAFFT (Car, Relax, Alone, Forget, Family/Friends, Trouble), comprises 6 questions (2 affirmative responses indicate harmful use of psychoactive substances).

A survey in progress aims to test the validity of several questionnaires used for testing to determine harmful use (CAST, ALAC, ADOSPA): named ADOTECNO (Adolescents, Techniques for assessment of harmful consumption). It is carried out by OFDT, in partnership with the addictology service at the Paul Brousse Hospital in Villejuif, and aims to provide a means of evaluating problem use.

Conclusion

Cannabis outpatient clinics have succeeded in reaching the target population of youths since more than 70 percent of outpatients are under 25, while nearly 30 percent are family or friends (mostly parents who came to accompany their children during the session). However, this section of the public includes a significant proportion of users referred by the criminal justice system (38 percent), who seem less likely to show cannabis abuse disorders.

The majority of outpatients report regular or daily cannabis use (63 percent). Female outpatients are more likely to be self-referred, whereas male outpatients are more often referred by the criminal justice system.

Cannabis users benefit from a two-session-follow-up on average, with significant differences: 23 percent report 2 sessions, 21 percent three or four sessions and 9 percent five sessions or more.

Half of all first-time outpatients report a single session: almost 30 percent are referred to external units (discussion groups, advice centres, etc.). The others, whose situation is diagnosed as being more "alarming", are advised to continue with the assessment process ("high-risk" users) or are referred to specialised care centres (when diagnosed with harmful use or cannabis addiction), especially drug addiction treatment centres. The "drop out" rate is fairly satisfactory (30 percent approximately), even if the survey here provides a rough estimate: this drop out rate seems to reach a peak after the first and second session. Waiting periods between two sessions are indisputably a significant predictor of drop out: a one-week-waiting-period between the first and the second sessions multiplies the drop out rate by three. The presence of a physician at the first session increases the chances of "retaining" the outpatients within the treatment system.

Professional practices vary from one clinic to another: almost half of the clinics use validated screening tests to conduct risk assessment related to cannabis use. The other screening tests used are mostly screening grids designed in-house. The duration of treatment appears consistent with the results of risk-assessment.

The full report on this survey, to be published in autumn 2006, provides additional insight into the factors associated with different profiles of cannabis use. It also examines particular sub-groups (users addicted to cannabis or reporting harmful use, outpatients referred by the criminal justice system, etc.).

The analysis provided a description of professional practices, in terms of diagnostic criteria, and proposed a typology of the different practices in relation with the characteristics of the public.

Finally, the findings will be able to be compared with other data sources. The first edition of this survey has focused on the effectiveness of cannabis outpatient clinics, without trying to determine the added value they represent. After a couple of years of effective implementation, a comparison will be possible with the routine figures of patients at the specialised drug addiction treatment centres (CSST) or alcohol outpatient treatment centres (CCAA) in order to formulated hypotheses on the effects of forwarding people requesting treatment or on the mechanisms of selection of certain types of clients.

For further information

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