Youth at Risk Network
Briefing for Network Workshop, Nov 23rd, 2017-11-03

A summary of issues, evidence and challenges arising in relation to youth at-risk and cannabis use

1. **Drugs.ie – summary of website information on Cannabis**
2. **EMCDDA[1] Policy and Practice Briefings on**
    a. **Young people and**
    b. **Cannabis use,**
3. **Appendices on:**
    a. **Youth vulnerability**
    b. **Prevention modalities**
    c. **Levels of Evidence**

DLR DATF, November 16, 2017, for circulation to prospective attendees.

[1] *European Monitoring Centre for Drugs and Drug Addiction www.emcdda.europa.eu*

1. Drugs.ie: Briefing on Cannabis

<table>
<tr><th colspan="2">Cannabis</th></tr>
<tr><td>Also called:
Hash, hashish, blow, pot, ganja, marijuana, grass, joint, THC, bhang, blang, black, blast, blunts, Bob Hope, bush, dope, draw, hemp, herb, puff, northern lights, resin, sensdi, shit, smoke, soap, spliff, wacky backy, weed, zero, afgan, moroccan</td><td>How Cannabis is used
• You can smoke it with tobacco in a joint, inhale through a pipe or bong, or make into a tea or food
• Herbal cannabis (grass or weed) is common and is generally made from the dried leaves and flowering parts of the female plant, and looks like tightly packed dried herbs
• Skunk is a general term given to stronger forms of cannabis that contain more THC, cannabis's active ingredient, than resin or more traditional herbal cannabis
• Resin/hash is a black/brown lump made from the resin of the plant</td></tr>
<tr><th colspan="2">Effects of Cannabis use</th></tr>
<tr><td>Short-term
• You may feel sedated, chilled out and happy
• Some people feel sick
• You may get the munchies or feel hungry
• Your pulse rate speeds up and blood pressure goes down
• Bloodshot eyes, dry mouth
• Tiredness</td><td>Long-term
• May damage lungs: breathing problems
• Linked to mental health problems: depression, schizophrenia
• May lower sperm count, suppress ovulation
• Regular use may affect memory, mood and motivation and ability to learn
• May cause anxiety and paranoia
• May affect coordination & reaction: more at risk of accidents, especially if combined with alcohol</td></tr>
</table>

Other Cannabis issues	
Other dangers • As with tobacco, smoking hash may cause cancer • Cannabis Psychosis – when you disconnect from reality and start showing symptoms such as delusions and hallucinations even when not using drugs • Addictive: you can get psychologically addicted to cannabis, in this case, you might find it hard to cope without it. If you smoke it with tobacco you may get physically addicted to tobacco	***If you are pregnant*** If you smoke cannabis while you are pregnant the risk to your baby is the same as smoking – smaller birth weight, higher risk of premature (early) birth, higher risk of miscarriage, your baby may get less oxygen through the placenta. After the birth, your baby is at more risk of cot death and early health problems, such as asthma
Withdrawal • Anxiety, irritability • Urge or cravings to smoke • Sleep problems, restlessness • Loss of appetite	***How long does it stay in your system?*** Cannabis will show up in a urine test for 2-28 days (The length of time depends on the test used, the amount you take, if you have other medical conditions and your own metabolism)

2. EMCDDA POLICY & PRACTICE BRIEFINGS

	1. Young people	*2. Cannabis*
Overview	• Many young people experiment with drugs but only a minority become dependent on drugs in young adulthood. • Those who are most vulnerable to drug dependence are socially disadvantaged young people and those having family members and peers who use drugs (see Appendix 1 for EMCDDA definition of youth vulnerability) • Individual factors, such as poor impulse control, also increase vulnerability, as does the use of substances at an early age. • Vulnerable young people who develop drug dependence are more likely to report anxiety and depressive disorders; psychotic symptoms and disorders; suicidal ideation and suicide attempts; blood-borne infections; and failure to complete their schooling and secure employment. It is not always clear to what extent these problems increase the risk of drug problems, or having a drug problem causes these problems	• Cannabis can result in, or exacerbate, a range of physical and mental health, social and economic problems. • Problems are more likely to develop if use begins at a young age and develops into regular or long-term use. • Key aims of intervening across three domains are: *Domain 1* • preventing or delaying onset (from adolescence into early adulthood) *Domain 2* • preventing escalation from occasional into regular use *Domain 3* • providing treatment for those whose use has become problematic

	1. Young people	*2. Cannabis*
Response Options	• Selective and indicated prevention interventions (see Appendix 2 to differentiate prevention models) to prevent vulnerable young people initiating use and progressing to regular and problematic drug use. • Brief screening questionnaires to detect illicit drug use problems in adolescents in primary care settings • E-health approaches to screening and brief interventions to reach vulnerable young people who are reluctant to seek help from health services. • Treatment services for young people who have developed severe drug problems • Syringe programmes for young injectors to prevent blood-borne infections • Hepatitis B vaccination to young injectors. • Prisons, outreach programmes, needle and syringe programmes and health clinics may be good settings in which to intervene with young people at risk of injection- related harms.	• *Prevention programmes*, such as multicomponent school interventions to develop social competences and refusal skills, healthy decision- making and coping, and correct normative misperceptions about drug use; family interventions; and computer interventions. • *Brief interventions*, for example, motivational interviewing delivered in emergency departments or primary care settings. • *Treatment*: cognitive behavioural therapy, motivational interviewing and contingency management to reduce cannabis use and harm in the short term; multidimensional family therapy to reduce use in high-severity young patients; and web- and computer-based interventions to reduce cannabis use in the short term. • *Harm reduction* interventions, for example, addressing the harms associated with smoking cannabis, especially when used together with tobacco.

	1. Young people	*2. Cannabis*
Evidence (see Appendix 3. Levels of Evidence, HQE, MQE and LQE)	• No HQE reported under this heading • MQE that a number of personality traits that increase vulnerability can be detected and mitigated early in life, for example, by programmes that improve self- and impulse-control. • LQE that screening and brief intervention for indicated prevention (already using) but remains to be evaluated. • LQE that the e-delivery of screening and brief interventions using both computer and mobile phone approaches also appears potentially valuable, but needs further research to assess its effectiveness. • LQE for approaches for vulnerable youth that consist of providing support for educational success in general (especially for males), personal and social competence training, and training families in better managing and monitoring their offspring, and that mentoring programmes can be helpful for vulnerable youth. • MQE in support of home visiting programmes and other intensive measures for vulnerable and socially excluded families.	• No HQE reported, under this heading *<u>Domain 1: Interventions to prevent or delay cannabis use</u>* • MQE that multi-component interventions can reduce cannabis use when used in schools using social influence approaches, correcting normative misperceptions and developing social competencies/refusal skills. • MQE that universal family interventions, such as Familas Unidas, Focus on Kids, and Strengthening Families, 10-14, may be effective in preventing cannabis use when used across multiple settings. • LQE that structured computer-based interventions may be effective in preventing cannabis use when delivered in schools or to family groups.

		Domain 2: Preventing escalation from occasional into regular cannabis • LQE that motivational interviewing interventions targeting cannabis use may be effective when delivered in emergency departments or primary care. • LQE that school-based brief interventions can reduce substance misuse but limited impact on cannabis use. *Domain 2/3: providing treatment for those whose use has become problematic* • MQE that behavioural interventions (eg cognitive behavioural therapy, motivational interviewing and contingency management) can reduce use and improve psycho-social functioning in short-term • MQE that multidimensional family therapy helps reduce use and keep patients in treatment especially in high severity young patients • LQE that web- and computer-based interventions may be effective in reducing cannabis use, at least in the short term, and are a cost-effective way of reaching a large number of cannabis users

	Implications for policy and practice	
	1. Young people	*2. Cannabis*
Basics	• The main vulnerable groups of young people in Europe are young offenders, youth out of school or at risk for dropping out, youth with academic and social problems, homeless youth, youth in care, youth from marginalised ethnic groups and vulnerable families. • Evidence-based selective and indicated prevention approaches targeting substance use among vulnerable young people should be provided rather than only awareness-raising and informational approaches. Go-approaches (approaching the target group at home or on the street) are more appropriate than come-approaches (where people are expected to show up to services). • Treatment and harm reduction services need to be provided for the small group of young people with severe problems. •	• Core responses in this area include general prevention approaches aimed at discouraging use or delaying onset, brief interventions for those with minor problems and formal treatment for those with more serious problems.
Opportunities	• Indicated programmes that target behavioural and temperamental vulnerabilities of neurobiological origin are rare in Europe but have high effect sizes in studies in North America. Expanding provision in Europe has the potential to make a significant impact.	• More attention should be paid to harm reduction approaches to cannabis use, particularly with respect to the patterns of use and co-use with tobacco. • Greater use of e-health approaches. • The new regulatory models for cannabis that are emerging globally can provide valuable information on the pros and cons of different options for regulation and their likely impact on responses to cannabis problems.

Gaps	• There is a need to expand the evidence base on the effectiveness of treatment and harm reduction services for under-18s with severe drug problems and to identify and share models of good practice. • An improved understanding of the availability and levels of provision of drug treatment services for young people with drug problems is needed to identify where increased provision is required. •	• There is still a need to develop a better understanding of the nature of cannabis-related disorders and what constitutes the most effective and appropriate treatment options for different clients. • A better understanding is needed of the types of treatment being received by the increasing numbers of people entering treatment for cannabis use in Europe, in order to ensure that provision is appropriate and efficient.

Appendix 1
Youth vulnerability

What do we mean by YOUTH VULNERABILITY? ***EMCDDA DEFINITION***

Defining 'vulnerable groups of young people'

For the purposes of this selected issue, 'vulnerability' at the group level is interpreted in a purely sociodemographic sense, i.e. groups that can be described by sociodemographic or geographic characteristics with known concentrated risk factors for drug use.

The use of the word 'vulnerable' indicates a group's exposure to social disadvantage or inequality that may result in limited individual choice

Vulnerability should thus be distinguished from drug-using 'risk groups', e.g. 'heroin users', which usually implies that all members of the group engage in a particular risk behaviour. Settings where drug use is not linked to social exclusion, for example recreational settings [1] (e.g. clubs or music festivals) are beyond the scope of this report. Furthermore, a distinction should also be made with issues of vulnerability at the 'intrapersonal' level, for example vulnerabilities linked to an individual's psychological, genetic or behavioural traits, which are not considered here [2]. This distinction is particularly important in the area of prevention: indicated prevention addresses intrapersonal factors, while selective prevention addresses social vulnerability.

When defining group vulnerability, it is vital to underline that membership of a specific group implies no direct causal link to drug use or drug-related problems. Social vulnerabilities are only contextual factors that may moderate, trigger or attenuate young people's underlying psychological, personal and genetic risk factors. Nonetheless, the concept of vulnerable groups helps to identify and quantify the needs of populations who are socially excluded and are at the edge of society, where drug use is more likely to be a problem. Vulnerability in this sense is a proxy for 'susceptibility for drug problems', and is useful in guiding appropriate responses.

[1] Drug use in recreational settings was the subject of a 2006 selected issue, see: http://www.emcdda.europa.eu/html.cfm/index34883EN.html

[2] A body of scientific literature has sought to define social vulnerability factors, such as social exclusion and socioeconomic factors, together with the boundaries to be drawn with 'intrapersonal' risk factors. Examples include Rhodes et al., 2003 and Pearson et al., 2006.

Appendix 2
Types of prevention (young people)

Universal

- Universal preventive measures target the entire general population (e.g. All youth) at national, local or community levels, and are not directed at a specific riskgroups, usually using education, awareness strategies aimed at preventing or delaying young people's use of alcohol or drugs.

Selective

- Selective interventions target a sub-set of the population who are considered at higher-than-average risk for substance abuse, by virtue of their membership of a population sub-set, regardless of the risk of any individual member. Thus young people who leave school early would be targeted with interventions designed to have impact on their choices to use or not use drugs or alcohol.

Indicated

- Indicated interventions target those young people already using or engaged in other high-risk behaviors to prevent heavy or chronic use. Thus young people already using are targeted, through special programmes, in order to reduce or stop their use.

Appendix 3
Levels of Evidence

HQE: High quality evidence — one or more up-to-date systematic reviews that include high-quality primary studies with consistent results. The evidence supports the use of the intervention within the context in which it was evaluated.
MQE: Moderate quality evidence — one or more up-to-date reviews that include a number of primary studies of at least moderate quality with generally consistent results. The evidence suggests these interventions are likely to be useful in the context in which they have been evaluated but further evaluations are recommended.
LQE: Low quality evidence — where there are some high or moderate quality primary studies but no reviews available OR there are reviews giving inconsistent results. The evidence is currently limited, but what there is shows promise. This suggests these interventions may be worth considering, particularly in the context of extending services to address new or unmet needs, but should be evaluated.