

# Treatment of cannabis-related problems in the Nordic countries



Nordic Welfare  
Centre

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# Preface

During the last two decades, demand for cannabis use related treatment has increased in all Nordic countries, mirroring a global trend (WHO, 2016). Treatment and supportive measures for persons with cannabis related problems has a fairly short history in the Nordic countries. It is not until the beginning of this millennium that cannabis has been noted as a third focus of the treatment system, in addition to the traditionally, and still dominating, alcohol problems and the often more dramatic opioid problems.

Nordic cooperation between researchers and professionals has over time resulted in a number of reports describing and comparing treatment of alcohol and drug problems. Most of them have been initiated by Nordic Welfare Centre, or its predecessor, the Nordic Centre for Alcohol and Drug Research. These reports have produced insights into the similarities and variations in how the Nordic welfare systems handle substance use related problems. They have also disseminated knowledge about challenges for treatment and about good – and sometimes less good – practices; information that is important for decision makers.

This report on treatment of cannabis use related problems in the Nordic countries continues this series of reports and is a first attempt to fill a know-

ledge gap. It identifies some challenges for treatment of cannabis use related problems in the Nordic countries, in terms of resources, for information and preventive efforts and in tackling the polarized discussion about and stigma of cannabis use, but also possibilities in the local anchorage of interventions and in established good practices that could deserve to be spread.

In a situation where there are no signs of decreasing availability of cannabis, it is likely that the need for cannabis treatment will continue to be substantial or increasing. We hope that this report will contribute to the development of Nordic treatment of cannabis problems.



**Eva Franzén**  
**Director**  
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# Summary

Denmark is still the country with highest cannabis consumption, with Finland in the second place, with steady consumption increase since the 1990s. Iceland, Norway and Sweden have the lowest consumption in Europe. In general, consumption last year is highest among the younger age groups, and is rare among those over 45 years. Problem use is also largely regarded as a "youth problem".

Most persons who use cannabis will not develop problems or dependence. Risky use is mainly measured as frequent use. Even if one can find that risky use seems to be linked to positive attitudes to cannabis, less close relations to parents among the young users and sociopsychological problems, it is important to note that problem users form a very heterogeneous group.

Cannabis problems are today prevalent in the substance problem use treatment systems in all Nordic countries: in Denmark cannabis is by far the primary problem among newcomers to drug treatment, in Iceland, more than one third of all addiction patients have cannabis as primary problem, in Finland, 33% of newcomers to drug treatment have cannabis as their main drug problem. In Norway and Sweden, the figures we have indicate that about 10% of patients/clients in substance problem use treatment are primarily cannabis problem users. In all Nordic countries, the cannabis figures among the very young in treatment are especially high.

According to available statistics and reports, those in treatment for cannabis problems in the Nordic countries share as a group many of the common complications of others in substance abuse treatment today: multidrug use, prevalence of psychiatric problems, and a lack of social resources. In addition, cannabis problem users in treatment are often very young and predominantly male. Cannabis problem use is for most persons in treatment not the only problem, and

for some not the primary problem. Both support, care and treatment professionals helping persons with cannabis related problems need to possess a broad, multidisciplinary competence.

Denmark has today probably the most developed and comprehensive treatment system for cannabis problems. In Iceland access to treatment is relatively good, but there is a growing demand for interventions among the very young with multiple problems. There are identifiable gaps in all Nordic countries in the support and treatment offered to persons with cannabis-related problems, but it appears that the lack of cannabis care and treatment resources in relation to need is especially obvious in Finland.

The support and treatment systems in all Nordic countries struggle with some similar problems: Prevention is crucial but difficult. Neither the young users themselves nor their parents or school staff have enough knowledge about the effects of cannabis on body and mind. Information about the risks with cannabis must, however, be presented in a communicative way. This would be an area for Nordic collaboration and development.

The relation between control and stigma is complicated. Young persons with a risky or an incipient problematic use are not necessarily themselves motivated to change their consumption patterns or seek treatment. Formal or informal control can be necessary. Stigma may be a greater obstacle for treatment seeking among older persons with more developed dependence, with some control measures adding to the stigmatisation. Outreach and low threshold services, and offers of anonymous treatment can be especially useful interventions. The balance between control and stigma in cannabis treatment would be an important topic for comparative research and development.

# "There are identifiable gaps in all Nordic countries in the support and treatment offered to persons with cannabis-related problems..."

The Nordic social framing of drug problems is a good starting point for addressing cannabis problems. Both interviews and reports on preventive and clinical interventions stress the importance of local cooperation between schools, vocational training, youth work, social services, psychiatry, the police and specialised addiction treatment. This should be possible in service systems with a strong local anchorage and where municipalities have the overall responsibilities for most of these services. It is as important, if not even more so, in the case of very young persons, that the families and the close social networks are included and involved. Local models of good practices should be spread across the Nordic countries.

The present cannabis discussion climate, with clashes between the restrictive side and those who advocate for decriminalization or legalisation is a challenge also for treatment decision makers and professionals in the Nordic countries. The liberalised climate, contend the critics, creates a situation where those who use cannabis as a

stimulant have more voice than those for whom cannabis is a medication. In a polarised discussion it is also difficult to present facts convincingly. The risk is that attitudes to cannabis will be more positive, and as a consequence both use and problem use among young persons will increase. On the other hand, the present debate has also led to revisions of control measures that has contributed to stigmatisation. An analysis of the impact of the different national debates on treatment practices would be welcome.

This report identifies several existing good practices, that could deserve broader implementation and locally tailored adoption in the Nordic countries. Among them, to mention some examples, are the Swedish HAP-program, the Norwegian app, partly based on HAP, the Icelandic Multisystemic Intervention experiences and the Danish U-turn and U 18 models. The ongoing Finnish cannabis intervention project will also result in models the knowledge of which could be disseminated to neighbouring countries.







# Introduction

Societies have responded to perceived problems related to use of illegal drugs in two main ways: policing and treatment. This regime of control and care is one where the two elements are intimately connected, influencing both one another and the way in which users of illegal drugs are viewed. While treatment has been relatively readily available, the perspective of control has been for decades and by far the more dominant of the two in the Nordic countries. Cannabis use is still a criminal offence in Finland, Norway, and Sweden, possession in all Nordic countries.

Recently, however, the (effects of the) control policies have been increasingly critiqued in the Nordic countries. Several countries or regions in the world have depenalised, decriminalised, or even legalised the use and possession of cannabis. The discussion about control policy has thus come to a new and a more liberal phase. This has had an impact on cannabis control and treatment in the Nordic societies, too. In traditionally restrictive drug policy systems, with relatively much and accessible (normative) treatment, the result has been not only a search for a new balance between control and treatment, but also a polarised, at times heated debate about cannabis policy.

Globally, demand for cannabis treatment has increased in high- and middle-income countries (WHO, 2016), the Nordic countries included. After alcohol, cannabis is the second most common intoxicant also in the Nordics. It is the primary substance of problematic use for newcomers into the Danish drug treatment system, and also for a large share of new clients with problematic consumption of illegal drugs in the Finnish, Icelandic, Norwegian, and Swedish treatment systems – particularly among younger persons.

The Nordic countries have a short history of treatment and care specifically focusing on cannabis problems, dating back only to some

15 years. Also, there are many circumstances that pose a special challenge to treating cannabis-related problems. Cannabis is an illegal drug, and criminal control as well as stigma are considerable aspects of how the treatment is framed. Cannabis is primarily used by young persons (in Finland most commonly among 25–34-year-olds), most of whom are males. As most cannabis users will be able to quit on their own, dependence is a fairly rare consequence of use. Still, there is increasing evidence of the possible problems linked to use and damages from intensive use, especially in adolescents and young adults.

There is no known evidence-based medical cure of cannabis dependence. Importantly, many persons with cannabis-related problems also use other intoxicants. Moreover, a substantial share of the group that is reached by the service system suffer from mental health problems. Simultaneous use of various intoxicants or co-occurring substance use and mental health or social problems are acknowledged to present special challenges for the treatment system.

Nordic comparisons of treatment of substance use related problems can be very fruitful. Our control and treatment systems are sufficiently similar for us to understand each other and different enough in terms of practical solutions so that we can learn from our neighbours. This brief report hopes to increase the knowledge about the Nordic situation and stimulate discussions and further development of good solutions for the support, care, and treatment of the Nordic cannabis problem.



# Use of cannabis and treatment demand

## Use

Cannabis is clearly the most commonly used illegal substance in the Nordic countries. It is easy to access in most parts of the Nordics, and a large share of the youth will have the opportunity to start using cannabis.

Cannabis use – and last month use in particular – is still more common in Denmark than in the other Nordic countries. According to the 2015 figures from the European School Survey Project on Alcohol and Other Drugs (ESPAD), 12% of the 15–16-year-olds in Denmark and 7–8% in the other Nordic countries had ever tried cannabis. While 5% of the Danish 15–16-year-olds had used cannabis last month, the figure for the other countries was 2%.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) country reports from 2018 released the most recent figures for cannabis use during last year for the 16–34 age group in Denmark (15,4%), Finland (13.5%), Norway (8.6%), and Sweden (7.3%). Iceland is unfortunately not a reporting country in the EMCDDA.

Until the year 2000, last-year use of cannabis increased in **Denmark**, followed by a fairly stable consumption until 2010, a slight increase and now possibly a decrease again. The picture for monthly use is fairly similar. In 2013, 4.6% of those aged 16–44 in Denmark had used cannabis during the last month (Sundhedsstyrelsen, 2016). Even if Denmark has higher levels of cannabis use than the other Nordic countries, recent ESPAD studies nevertheless also show a decrease of use among Danish 15–16-year-olds (EMCDDA, 2017).

**Finland** is today not very far behind Denmark in lifetime use of cannabis among the 15–34 age group. A steady increase started in the 1990s. Use among 15–16 years, however, decreased slightly between 2011 and 2015. In **Norway**, lifetime cannabis use has fluctuated somewhat, as can be seen in the EMCDDA country reports, but the overall level of use among 16–34-year-olds and among school children has remained stable since 2014. In **Sweden**, lifetime use among young adults has possibly slightly increased during the last ten years. Both Norway and Sweden have clearly lower figures of cannabis use among young adults than do Denmark and Finland, and are at the bottom of the European consumption scale, possibly together with Iceland. For Iceland, we have no time series for

TABLE

## Use of cannabis in the Nordic countries

Year	Country	Lifetime use (%)		Use last year (%)	
		Total	Male	Female	Total
2015	Denmark (15-16 year olds) <sup>1</sup>	12	9.5	5.7	8
2017	Denmark (16-34 year olds) <sup>2</sup>	almost 50	20.5	11.7	15.4
2015	Finland (15-16 year olds) <sup>1</sup>	8	7.2	5.7	7
2014	Finland (15-34 year olds) <sup>2</sup>		17.9	9	13.5
2017	Norway (15-16 year olds) <sup>1</sup>	7	9.5	3.9	8
2016	Norway (16-34 year olds) <sup>2</sup>		11.5	5.7	8.6
2015	Sweden (15-16 year olds) <sup>1</sup>	7	9.9	6.4	8
2016	Sweden (15-34 year olds) <sup>2</sup>		9	5.6	7.3
2015	Iceland (15-16 year olds) <sup>1</sup>	7	14.5	12.7	14

<sup>1</sup> Kraus & Nociar, 2016

<sup>2</sup> EMCDDA Country report 2018

lifetime use among adults. Lifetime cannabis use among schoolchildren has, however, remained fairly stable for the last 20 years, with a reported increased use among high-risk adolescents (Arnarsson, Kristofersson, & Bjarnason, 2017).

Use of cannabis is more common among boys/males than among girls/females in all countries.

Last-year use among the very young – those under 25 – has gained most attention. Cannabis use among older age groups is less common. Only 3–5% of Danish men, and 0–2% of women, aged 40–44 years had used cannabis during the last year in 2000–2013. It is in the younger age groups that the Danish consumption has fluctuated and increased over time:

last-year consumption varies between 19% and 29% among those aged 16–19 years, and between 14% and 30% among 20–24-year-olds (Sundhedsstyrelsen, 2016: Table 11.2, figures for 1994, 2000, 2005, 2008, 2010, 2013). A recent Swedish report noted that last-year use increased in the whole population (17–84 years) between 2013 and 2017, and is now 4.4% among men and 2.6 among women. For women, the increase was significant in the age groups 17–29 (rising from 5.2 in 2013 to 9.3% in 2017) and 30–49 year olds (from 0.9 to 1.8% in 2017), for men only among 30–49 years (from 2.4 to 4.9% in 2017) (Sundin, Landberg & Ramstedt, Table 14, 2018).



These numbers and the fact that cannabis consumption in Finland is now relatively more common among the 25–34-year-olds than among younger persons, and that it is also quite common among those aged 35–44 years (Hakkarainen & Karjalainen, 2017), indicates that there may be differences between the Nordic countries in the age distribution of consumption.

The reasons for use are varied. Research sometimes separates recreational use from use as self-medication. According to a Finnish survey (Hakkarainen & Karjalainen, 2017), as many as a fifth of cannabis users report using the substance partly or only as self-medication.

## Resilience

Not all persons who are exposed to cannabis start using it. Increased availability of the drug will likely increase the use and, as a result, the need for support and treatment. With increased availability in the Nordic countries, partly due to home growing, it has become more and more relevant for prevention to understand why some remain non-users in spite of exposure to cannabis. A Norwegian study (Burdzovic Andreas, Pape, & Bretteville-Jensen, 2016) showed that while 7.6% of 16-year-olds had ever used cannabis, a further 10.4% had been offered cannabis during the last year, but had never used. The exposed non-users had less often close friends among or close relations to cannabis users than the users, and they had fewer signs of problem behaviour, such as truancy. Not drinking to intoxication or not smoking were also associated with resilience. It was especially important from a prevention point of view, say the authors, that the non-users had close and positive relations to their parents and held negative beliefs about drug use and users. Supporting good communication within the family and increasing factual information about the risks with cannabis use could thus be significant features of preventive measures.

A Swedish study (Karlsson, Ekendahl, Gripe, & Raninen, 2018) points at similar predictors of non-use of cannabis. An Icelandic ESPAD study of adolescents' alcohol and cannabis use in 1995–2015 (Arnarsson et al., 2017) found that while the share had slightly decreased of schoolchildren who had ever used cannabis, the proportion of those who had used cannabis 40 times or more had increased. There was no change in perceived availability of cannabis during the ten-year period, but parental monitoring of young persons in Iceland increased.

Interestingly, the attitudes towards cannabis became more positive at the same time. The authors call for more information to young persons about the known health risks of cannabis use at a young age, especially about the risks to mental health.

## Risky use

Most cannabis users have no or only few problems related to their use, and stop using after early adulthood. The consumption figures, which show a decline in use with increasing age, is a sign of this. In US studies, about 10% of those who use cannabis as very young become daily users, and an additional 20–30% start using weekly. As with other substances, regular and heavy use increases the risk for problems, and persons with additional psychological or social problems are more at risk for developing serious problems with cannabis (WHO, 2016).

The World Health Organisation report on health and social effects of non-medical cannabis use cites 'disturbances on the level of consciousness, cognition, perception, affect or behaviour' (WHO, 2016, p. 6) as short-term health effects of cannabis use. These can be linked to injuries, accidents, psychosis, and some acute physical effects. Long-term effects from regular cannabis use during a longer period are dependence, cognitive impairment (memory, verbal learning, attention), mental health problems, and some physical ailments (WHO, 2016).

Daily or almost daily use has been applied as a proxy measure of risky use in the absence of more precise survey data. Of the **Danish** population aged 15–64 years, 0.4% used cannabis daily or almost daily in 2013. In **Norway**, the prevalence of daily or almost daily cannabis use was 0.3% among the 16–64 age group and was higher among marginalised groups, such as the homeless (EMCDDA, 2017). About 0.2% of **Finnish** 15–64-year-olds, amounting to 5000–6000 persons, are estimated to use cannabis daily; around 35,000 Finns use cannabis at least once a week (Hakkarainen & Karjalainen, 2017). We have no information about daily use in Sweden. In 2016, 0.9% of **Swedish** adults had used cannabis during the last month (an increase from 2012) (Folkhälsomyndigheten, 2018). We have unfortunately no relevant figures from Iceland.

How hazardous risky use is depends not only on the frequency of use but also on the strength of the cannabis product (Vindenes, Bramness, Bretteville-Jensen, Mørland, & Bachs, 2016). Documents and several expert interviews estimate that the strength of cannabis products has increased during the last

years. Intensive indoor growing may increase the potency. (WHO, 2016). The increased potency is confirmed by police reports on the level of tetrahydrocannabinol (THC) in seizures (see, e.g., Nordgaard & Lundquist, 2016).

Critics of the criminalisation or penalisation of cannabis use would add that certain control measures increase the risk of use. Controls can marginalise and stigmatise users, prevent them from seeking help, and become an obstacle for integration, for instance on the job market. Thus control policy in itself, which more often targets weaker groups in society, may imply a risk for users not to seek help when they have problems or may make them develop more serious problems (see for instance Hakkarainen & Tammi, 2018). On the other hand, as we will see below, social pressure related to control measures, such as pressure from the police or social services, is often important in terms of contacts with the service system, particularly among the very young.

### **Problem users a heterogeneous group**

Cannabis users are not a homogenous group, and users can be found in many different age and social groups (see for instance Hakkarainen & Karjalainen, 2017). Problem users are similarly a heterogeneous population. Two main risk groups, with different routes to treatment, have been identified by clinical staff in Oslo and Kristiansand in Norway: there are the teenagers with psychosocial problems, found to being at risk in schools, by parents or the social services and police, and then there are those over 25 who themselves acknowledge their dependence or seek help to establish themselves as adults in society. Ann-Sofie Johansson from the Swedish Cannabis Network (Cannabisnätverket) identifies two different groups of users in treatment: those who started to use cannabis as a recreational drug and those who began to use it to handle psychosocial problems. She also recognises that users who have a socially well-established life do not seek help to the same extent despite having cognitive or/and emotional problems.

Further, many cannabis users are polydrug users and use also alcohol and sometimes other illegal drugs – but there are a few for whom only cannabis use is reported. Alcohol consumption is particularly common. The Finnish population survey from 2014, for instance, showed that 1/3 of those who had used cannabis during the last year had also drunk at least 4-6 drinks at a single occasion at least once a week and 2/3 drank above the Audit-C risk limit (Hakkarainen & Karjalainen, 2017).













# The treatment population

## A significant group in treatment

It is a well-known fact that only a small part of those who have a problematic use of substances or are dependent ever seek and/or get treatment. This is true also for persons with cannabis-related problems. On the other hand, treatment systems will also always treat some people whose problems are not substance use related, but for instance mental health or other psychosocial problems (Hirschovits-Gerz, T. Kuussaari, K., Stenius, K. & Tammi, T., 2019). We have no estimates of the relation between those who have problems with their cannabis use and those that are in treatment in the Nordic countries.

Cannabis users seem to be a notable group in the service system and not only in the specialised treatment system of problematic substance use. The Finnish Survey of Intoxicant Cases from 2015, counting all persons in the entire health care and social service system on one day, who either are known as having substance use related problems or are intoxicated, reported 1% as using only cannabis, while around 4% used only cannabis and alcohol, and 16% used several kinds of illegal drugs and alcohol in addition to cannabis. The frequency of reported cannabis users in the service system has gradually increased since the 1990s. (Tigerstedt, Karjalainen & Kuussaari, 2015). This may be both a consequence of increased use of cannabis in Finland, and of increased awareness in the social and health care system of cannabis problems.

**Denmark** reports most persons with cannabis-related problems in treatment, and cannabis is indeed becoming the dominant problem of newcomers to treatment for drug-related problems. Annually about 6000–8000 of those who are in treatment in Denmark for drug-related problems have cannabis as their primary problem drug (M.U. Pedersen, personal communication 2017). In 2014, 79% of those first time in treatment for drug-related problems in Denmark had cannabis as their primary drug (Sundhedsstyrelsen, 2016). Cannabis is especially dominant among the very young in treatment. Of persons aged 18–24 years in drug treatment, 86% had cannabis as the primary drug (Sundhedsstyrelsen, 2016).

In **Finland**, approximately 8% of persons in outpatient substance abuse treatment (including alcohol) in the six biggest cities in 2014 had cannabis as their primary drug (Tigerstedt, Karjalainen, & Kuussaari, 2015). In the most recently reported national data from drug treatment units (both in- and outpatient) in 2014, cannabis was the primary drug for 18% of all patients and the main substance for as many as 33% of those in drug treatment for the first time (Terveyden ja hyvinvoinnin laitos, 2017). These figures are probably an underestimation (S. Rönkä, personal communication, 2018). Most of those with cannabis as the primary drug also used alcohol (Terveyden ja hyvinvoinnin laitos, 2017, Liitetäulukko 2a), and around 40% of those whose primary drug of abuse were opioids, stimulants, or tranquillisers also used cannabis. In Finland, in spite of increasing cannabis use, cannabis problems are not (yet) as dominant as in Denmark as the primary problem drug in treatment.

In **Iceland**, the main treatment unit for addiction problems is the Vogur inpatient clinic. There is also a psychiatric clinic that treats persons with psychiatric comorbidity, encompassing about 10–20% of all persons treated for drug-related problems (Hansdóttir, Rúnarsdóttir, & Tyrfingsson, 2015). The number of individuals annually treated for cannabis dependence in Vogur has since 2002 fluctuated between 600 and 700 (Tyrfingsson & Rúnarsdóttir, 2018). Considering that the population in Iceland is only about 330,000 (1/17 of the Danish population), Iceland has the highest relative number of cannabis patients in treatment of all the Nordic countries. The proportion of Vogur inpatients (including alcohol problem users) that have cannabis dependence as their main diagnosis was about 37% in 2017; this figure has remained fairly stable since the early 2000s. Among patients under 20 years, as many as 80% suffer from cannabis-related problems.

Interestingly, during the last years, the proportion of problematic cannabis use among the very young has somewhat decreased, while the relative share has been increasing among patients in the age group of 30–39 years (ibid). In Iceland, inpatient treatment has a particularly strong role. Treatment of addictions usually starts with an inpatient detoxification, followed by intensive outpatient treatment for one third of the patients and by rehabilitation in an institutional setting for another one third (one third has no further treatment after detoxification) (Hansdóttir et al., 2015). In early prevention measures and for the very young with drug problems, however, there is an increasing emphasis on outpatient interventions (H. Hauksson, personal communication,

September 10, 2018; S. Örn Magnússon, personal communication, November 2, 2018).

In **Norway**, the number of patients in specialist health care with cannabis as primary drug increased by 40% in 2009–2015 (Vindenes et al., 2016). Even though the overall number of patients treated for substance use problems also increased by around 14% during this period the cannabis related treatment seeking has grown in importance. There were 3426 patients with a cannabis diagnosis (ICD-10) in specialist health care in 2015, representing about 12.5% of all in- and outpatients in specialist substance use problem care (Norsk pasientregister/A. Skretting, personal communication, November 1, 2017). This data includes only specialist treatment by state-owned regional hospitals, not treatment or care provided by the municipalities.

In **Sweden**, about 10% of all those entering substance use treatment (including alcohol), around 3900 persons reportedly had cannabis as the primary drug in 2015. The number of first-time treatment entrants with cannabis as a primary drug was 2100; the level has fluctuated above and below this number since 2010. As the number of first-time entrants for opioid problems has dropped dramatically during this period, cannabis problems are now, according to these statistics, the most common primary drug among first-timers with drug-related problems in Sweden (EMCDDA, 2017). The cannabis problem is the dominant issue among young persons in treatment.

For the very young cannabis problem users in care or treatment, the adolescents, we do not have national statistics on treatment. In child protection institutions in Iceland, among those treated between 2013–2015, 96,5 % had used cannabis (H. Hauksson, personal communication, October 31, 2018). In the Swedish institutions for compulsory treatment of young persons, 37% used cannabis at least weekly in 2015 (SiS, 2017). These figures indicate that cannabis use is common among adolescents with serious psychosocial problems.

While these figures are not comparable, have in some cases a less than perfect coverage, and at times only cover parts of the treatment system, they nevertheless show that cannabis use among persons with problematic substance use and cannabis as an identified primary drug problem are common in treatment in all Nordic countries. Iceland and Denmark have a more pronounced demand for cannabis treatment than the other countries. It is not possible to say, with our present knowledge, to what extent the differences between the countries reflects

# "Those in treatment are often very young and predominantly male."

different needs for treatment, or the fact that some treatment systems are more accessible for person with cannabis problems or more prone to diagnose cannabis problems than in other countries.

## Young men the largest group

Cannabis use – including risky use – is more common among men. The EMCDDA report (2015) on cannabis treatment notes that even if boys/men use cannabis more than girls/women, the gender gap among those in treatment is even bigger. This may also be true for the Nordic countries. According to Christiansen and Bretteville-Jensen (2018), 74% of patients in Norwegian specialist health care with cannabis as their main problem were male. This was attributed to men having heavier and more frequent use than women (ibid). Another possible reason to explore could be that the control measures behind treatment entry are more often directed at men.

Most persons with primary cannabis problems in treatment are young (under 30 years), which corresponds fairly well to consumption patterns but may also reflect a societal concern for the youngest users. In the **Norwegian** study conducted by Christiansen and Bretteville-Jensen (2018), the mean age of cannabis patients was 27 years (14% were under 20; 56% were aged 20–29 years; 20% were in the

30–39 age group; and 10% were 40+). In **Denmark**, the mean age was 26 years of persons in treatment for cannabis-related problems in 2014 (Pedersen, 2017). We have above noted the high proportion of cannabis dependence among young persons in the Icelandic Vogur clinic. In **Finland**, the annual data gathering of clients in substance abuse treatment yielded a mean age of 20 years for those in cannabis treatment for the first time (Forssell & Nurmi, 2014). It is notable, and natural, that first-timers are particularly young; this is true also in Denmark (M.U. Pedersen, personal communication, 2017).

## Multidrug use, mental health and psychosocial problems common

In **Denmark**, dramatically many more persons are now treated in psychiatry with cannabis problems as a main or a secondary diagnosis; about 43% of those treated in psychiatry with a drug disorder as a primary diagnosis reported cannabis as their problem drug. In 2006–2015 there was a threefold increase in the number of patients with cannabis problems as a secondary psychiatric diagnosis (about 4000 individual persons) (Sundhedsstyrelsen, 2016).

In the **Finnish** Survey of Intoxicant Cases in 2011, almost 60% of persons who had visited social and

health services for their cannabis use had mental health problems other than drug abuse or dependence (Tigerstedt et al., 2015). In **Norway** (Christensen & Bretteville-Jensen, 2018), 53% of those treated in specialist health care for cannabis-related problems also had a psychiatric diagnosis, women more often than men, and 57% had a diagnosis for other substance use problems in addition to the cannabis problem. In a **Swedish** study of youth in substance abuse treatment where 71% had cannabis as the primary drug (Anderberg et al., 2015), 28% reported depression during the last 30 days, 33% reported anxiety (girls in particular), and 41% said that they had had memory and concentration problems.

Persons treated for cannabis-related problems seem generally to have fewer social resources than those in the general population. In the Finnish Survey of Intoxicant Cases, more than half of those who were reported as using cannabis were unemployed in 2011 (Tigerstedt et al., 2015). Christensen and Bretteville-Jensen (2018) found no significant difference in the ethnic background among Norwegian cannabis patients in specialist health care compared to 'twins' in the general population. A smaller proportion of those in treatment were married, and more had parents with only basic education. Also, more of those in treatment had only basic education themselves. At the time of treatment only 43% of the patients were studying or had a job, compared to 84% among the 'twins'. In Anderberg and colleagues' (2015) Swedish study of adolescents in substance abuse treatment (71% cannabis users, mean age 17 years), 50% had problems in school and 17% faced economic problems at home.

The relative lack of social resources among those treated for cannabis problems may reflect the known fact that users with a more resourceful social background more often stop using cannabis after a period of experimentation, and do not end up with more serious problems or dependence (cf. Christensen & Bretteville-Jensen, 2018).

To summarise, those in treatment for cannabis problems share as a group many of the common complications of others in substance abuse treatment today: multidrug use, prevalence of psychiatric problems, and a lack of social resources. In addition, cannabis problem users in treatment are often very young and predominantly male. Cannabis problem use is for most persons in treatment not the only problem, and for some not the primary problem. Support, care and treatment of persons with cannabis related problems need to be based on a broad, multiprofessional competence.

## Why increasing demand for treatment?

The increasing number of persons in treatment with cannabis as a primary problem is a fact both in countries with rising cannabis consumption, such as Finland, and where no increase in cannabis use is visible, as in Norway. Several possible explanations have been suggested. Christensen and Bretteville-Jensen (2018) summarise some of them. One reason could be an increasing awareness of the risks with cannabis use and beliefs that problems can be helped by the service system. This hypothesis also emerged in interviews in Iceland and Denmark. According to Danish experts, there has been a clear shift in the view upon cannabis among young people. It is increasingly viewed as a risky product where use may require help to solve problems of lack of control. The increase in help-seeking can thus be linked to broader cultural changes towards a 'diagnostic culture' (D. Orbe, personal communication, April 9, 2018).

In Finland, however, the perceptions of cannabis in the general population seem to move in the opposite direction: the drug is perceived as less dangerous than before (and the use is increasing) (Tigerstedt et al., 2015). At the same time, the growing support for depenalisation of use in Finland also points towards a more 'medicalised' or treatment-oriented view on how to solve cannabis problems (Hakkarainen & Karjalainen, 2017).

Changes in risk perceptions among users can possibly also be caused by stronger cannabis products or new use patterns. This is mentioned as a possible explanation for increased treatment seeking by experts in all Nordic countries.

Increased awareness of cannabis-related problems among professionals, with an impact on referral practices, can also be part of the equation (Christensen & Bretteville-Jensen, 2018). Finally, designated cannabis treatment and support offers have expanded and diversified in Denmark, Norway, and Sweden over the last 15 years. This in itself attracts more persons to treatment. In Iceland, cannabis use problems are viewed as one addiction among others that can be efficiently addressed by a generous treatment system. Treatment resources for the very young increased after a peak in demand around the millennium (V. Runarsdóttir, personal communication, May 2018). An indirect effect of this can be that cannabis problems are more easily addressed by treatment.







# Treatment

## Organisational frame of cannabis treatment – development of interventions

The Nordic treatment system of problematic drug use has been securely anchored in municipal social services, close to other municipal services and to local preventive measures. This system has been supplemented by regional or national health care in all the Nordic countries. Drug problems are, however, essentially viewed as societal. Treatment which is mostly financed from public funds has always had a mix of public and private providers. Today, there are some organisational differences of the treatment between the Nordics.

In **Finland** and **Sweden**, primary responsibility for treatment of alcohol and drug problems still rests with the municipalities. In **Norway**, the responsibility for specialised treatment of alcohol and drug use problems was transferred to regional state hospitals in 2004, while the municipalities retain responsibility for primary and secondary prevention, aftercare, and social integration. This centralisation reform made the Norwegian treatment system a part of the health care frame, even if the specialist care of substance use-related problems is expressly multiprofessional.

In **Denmark**, treatment responsibility shifted from the counties to the municipalities in 2007, representing a decentralisation at a time when the municipalities grew bigger. And in **Iceland**, municipal efforts, primary care, and psychiatric care have since the 1980s been supplemented by treatment in the Twelve Step-inspired third-sector organisation SÀÀ (National Center of Addiction Medicine). Established on the AA philosophy and its disease concept, SÀÀ is now the dominant specialised treatment organisation. It has become eclectic in terms of treatment methods and offers different options for different populations, including medication-assisted therapy and specific approaches for the young, for women, etc. The SÀÀ today views addiction as a chronic but treatable brain disease, with complex causes and diverse consequences.

A larger share of the Icelandic population than in any other country has been in specialist addiction treatment. Iceland has notably more beds for treatment of alcohol and drug use problems than any other country in the world (Hansdóttir

et al., 2015). The treatment at Vogur addiction hospital is intended to deal with a diagnosed moderate to severe cannabis use disorder. Interventions for less severe problems are handled in primary health or social care, at school, or within the social and child protection services. These interventions take place at home with homecare teams and a family focus – only in more serious cases in institutions (usually only when harder drugs are involved) (V. Runarsdóttir, personal communication, May 2018; H. Hauksson, personal communication, September 10, 2018; S. Örn Magnússon, personal communication, November 2, 2018).

### **Iceland – focus on young problem users since 1995**

Cannabis problems became more prevalent in Iceland from 1995. Use of cannabis and stimulants increased suddenly and dramatically and this was described as a pronounced generational issue. Societal changes, such as the breakthrough of social media and mobile phones are viewed as having enhanced the diffusion of drug use (V. Runarsdóttir, personal communication, May 2018). Of the age group born in 1982, as many as 5% of the males had been in treatment for cannabis problems before the age of 20. This experience, Runarsdóttir says, forced the treatment system to focus more on treatment of young persons. Notably, this happened within a treatment system that does not separate patients according to the problem drug, but in terms of age and gender and relapse risk. All addictive drugs are treated as leading to similar problems and changes in the brain, although the consequences of use and comorbidities vary.

In child protection, and in preventive work, one important focus in Iceland is on supporting parents and strengthening the family. In Reykjavik, the social services inform school children about risks with cannabis use and offer guidance for children with drug use problems. A voluntary organisation, in cooperation with the municipality, works with parents and teenagers who have started using cannabis, and who need guidance. In child protection, for children under 18 with more serious drug problems, in recent years interventions have moved somewhat away from institutional treatment. The number of institutions and beds have decreased.

Today, the goal is to avoid separating the child or young person from their family. Instead, Reykjavik city uses outpatient Multisystemic Therapy (MST)

in some cases. The therapist works intensively within the family and with the entire network of the child/adolescent for a period of ca 5 months, to try to change behavioural patterns and strengthen the social support. One therapist treats no more than 4-5 children at a time. The demand for these interventions has grown, and there is now a long waiting list. However, in some cases where the scope of the problem and drug abuse of the child is extensive, treatment in institutions is used. Experts perceive that even if drug consumption in general perhaps is not on the rise, some children start using drugs and harder drugs at an ever younger age, with bigger problems as a consequence. (S. Örn Magnússon, personal communication, November 2, 2018). As in specialised treatment, also in prevention and child protection the focus of treatment is not in general specifically on cannabis, but on drugs in general and other social or psychological problems. Cannabis use in problem groups seem however to be very prevalent.

### **Sweden – Hashish Rehabilitation Programme and a national network**

Before the late 1990s, and already in the mid-1980s, Thomas Lundqvist and Dan Ericsson at Lund University in Sweden developed a cognitive method for treating patients with cannabis addiction (Lundqvist & Ericsson, 1988). Having identified around the turn of the millennium an increasing need to treat persons aged 25 years and younger, they developed the manual-based Hashish Rehabilitation Programme (Haschavvänjningsprogrammet HAP) in collaboration with youth clinics in Uppsala and Stockholm. The programme included a full treatment cycle, a shorter version, brief interventions and intervention talks for those who only experiment with cannabis, and a self-help guide. These offered a broad focus on different young cannabis users in outpatient treatment. The main focus is on helping the cannabis users to redirect cognitive patterns and regain intellectual control and social and psychological competence through cognitive educative techniques. The programme builds on Lundqvist's and Ericsson's experiences of cognitive changes among chronic cannabis users, and on the different phases in the detoxification from cannabis, and is based on a view that abstinence is necessary under treatment. The detoxification period is calculated as lasting from six to ten weeks – much longer than in the case of alcohol. Only after detoxification will the treatment handle the underlying causes of addiction. (Lundqvist & Ericsson, 2007).





In the year 2000, a meeting took place on cannabis treatment with nine Swedish substance use treatment units and around 30 persons on the initiative of Stockholm County and Uppsala City. This marked the start of the Swedish Cannabis Network (Cannabisnätverket), established for clinicians, practitioners, and researchers interested in competence improvement for the treatment of cannabis problems. Today, in 2018, the network has around 900 members in about 300 substance use treatment units all over the country (U. Hermansson & A-S. Johansson, personal communication, March 5, 2018).

The network has also produced a cannabis programme manual for younger persons, CPU (Cannabisprogram för unga), and launched a randomised control trial on the effects of a web-based intervention, both funded by the Public Health Agency of Sweden (Folkhälsomyndigheten). Members of the network are predominantly based in municipal social services or addiction treatment units, but also at units run by the medical county councils, and some members work at private treatment centres. The network organises annual national meetings and training with the support of the Public Health Agency.

The work by Lundqvist and Ericsson as well as the Hashish Rehabilitation Programme or parts of it have been influential not only in Sweden but also in Denmark and particularly in Norway, albeit in various local adaptations and with less absolute emphasis on abstinence. Iceland has not adopted the programme, and while the manual has been translated into Finnish, it does not seem to be in current use in Finland.

## Denmark – systematic and bottom-up development of youth interventions

Problematic use of cannabis was visible in the Danish drug treatment system already in the late 1990s. By 2003, cannabis was registered as the main drug for 46% of the 18–24-year-olds in drug treatment and for 25.6% of all persons undergoing treatment (Sundhedsstyrelsen, 2016, Tabell 3.4.1). After the treatment responsibility was decentralised to the municipalities in 2007, a number of local treatment initiatives were set up and evaluated with funding from the National Board of Social Services (Socialstyrelsen) in order to improve the quality of drug treatment. (Pedersen and Mulbjerg Pedersen, 2013; Lauridsen and Nyboe, 2013; Holm and colleagues, 2017; Termansen, Dyrvig, Korgsgaard Niss, and Hyld Pejtersen, 2015; and Pedersen and colleague, 2017).

In Copenhagen, the need for interventions targeted at primarily cannabis users under 25 was recognised already in 2004. Today, the city has a staff of 50 persons working with young persons who have cannabis or related problems. Rather than working primarily with 'treatment', the staff offer anonymous support and counselling, mostly individually but also in groups; provide information and social support programmes; are engaged in outreach work with group meetings in schools; and work with parents, and also with an emphasis on documentation of the interventions. The Copenhagen U Turn programme has an open and anonymous counselling service for anyone who wants a contact. After five to six meetings the need for further treatment is assessed. If there is such a need, the anonymity ends and there will be a proper treatment needs assessment, followed by six to eight months of treatment for those under 18, and by four to six months for anyone older than 18. The treatment has two goals: to reduce or end the use of cannabis and to integrate the young person in school or working life (D. Orbe, personal communication, April 9, 2018).

The materials produced by Lundqvist and Ericsson in Sweden (2007) on the effects of cannabis on the body and the duration of the intoxication are also used in Denmark. Cognitive behavioural therapy and motivational interviewing are integrated but the emphasis is more on systemic narratives. The social context and relations of the young person are viewed as crucial for improvement. Abstinence is not key. The U Turn model has been copied as such in seven other Danish cities and parts of it in 15 cities, also outside Denmark.

U18 is another intervention model in several Danish cities. It uses cognitive, dynamic, or behavioural therapeutic methods based on evidence or documented expertise. Information to and work with parents is an important ingredient.

Mads Uffe Pedersen (personal communication, 2017) characterises Danish cannabis treatment today as balancing between social pedagogy and social treatment of substance-related problems: treatment takes place in cooperation between schools, various social services, and specialised addiction treatment. It is a combination of interactive information and various interventions, often with a more general focus than just on cannabis.

Both Danish and Swedish intervention models have spread with government support, but it is possible to see an interesting difference between the two countries. In Sweden, the national guidelines on substance abuse treatment known as 'Knowledge to

Practice' (Kunskap till praktik, launched in 2005) and now the Public Health Agency of Sweden have played key roles in this, while project funding from the National Board of Social Services has been decisive in Denmark.

The development in Denmark has been a bottom-up phenomenon, with the state financing and evaluating local projects, and spreading good models. Local variety is encouraged. Sweden has seen a more centrally unified development, where the focus has been on spreading knowledge about nationally recommended evidence-based methods, such as cognitive behavioural therapy, motivational interviewing, and family treatment. Treatment is individual and applies the Hashish Rehabilitation Programme or the programme manual for younger persons (CPU) to the extent that it is in accordance with the perceived needs of the individual.

### **Norway – local interventions and outreach projects since early 2000s**

In Norway, several local initiatives started in the early 2000s. In Kristiansand, a broad coalition of professionals from local authorities, including schools, social services, primary health care and specialist health care, and the police started a cannabis programme with an explicit focus on the relation between drug use and absence from school. Inspiration and knowledge came from Thomas Lundqvist and the Swedish Cannabis Network, with the support of specialists in psychiatry and psychology at Sørlandet Hospital. Funding was local. Soon the group also established cooperation with the University of Agder, which now provides education in addictions and dependencies.

The municipality now has an established unit for interventions/treatment and works in cooperation with specialist health care for persons with additional mental health or other substance use



problems. In both the municipal cannabis programme and the specialist health care system the primary methods are cognitive behavioural therapy and motivational interviewing. Treatment is individual, and uses the HAP manual to the extent that accords with the needs of the individual.

In Oslo, lack of support and treatment for persons with primarily cannabis-related problems was acknowledged in the early 2000s. In 2006, the municipality's outreach sections initiated a low threshold programme for persons who wished to stop using cannabis. Thomas Lundqvist's work and the Hashish Rehabilitation Programme model have been influential from the start also in Oslo. Initially, the outreach section provided group sessions with local project funding. A new project, 'Out of the Haze', started in 2010 with individual, manual-based treatment, which uses motivational interviewing and cognitive behavioural therapy, and provides information on the effects of cannabis use. Since 2013, the services have been a permanent part of the municipal services system. Also, an app is available for persons who want to cut down or stop using cannabis, reaching out to those who hesitate to seek treatment. The app is used all over Norway.

The national network is less comprehensive in Norway than in Sweden, but there are informal networks of contacts throughout Norway with an interest in prevention and treatment of cannabis use. Regional and local networks have regular meetings. Exchange of local experiences has been especially important in the development work. The local models vary in terms of organisation and somewhat in their emphasis on how important abstinence is as a sole/immediate goal in the treatment process. For instance, Oslo has its own Hashish Rehabilitation Programme manual that is being revised and where cannabis dependence is described as a long-term rather than as a chronic problem. Compared to Sweden and Denmark, national funding has not been as important in Norway. Cannabis development work is based on local funding and active professional individuals.

## **Finland – first development project for cannabis interventions focussing young users has started**

In Finland, where addiction treatment has thus far been a municipal responsibility, cannabis has not yet been properly recognised as a matter requiring special attention in the treatment system. The focus has traditionally been on alcohol, or drugs

in general. Special efforts have during the last decades been made primarily in opioid treatment and most recently in the treatment of gambling problems. For persons with cannabis-related problems, the so-called youth clinics have been the primary treatment resource in the bigger cities. Several clinics have, however, closed down during the last years.

The Hashish Rehabilitation Programme is not unknown, but is not used, systematically at least. A European Social Fund project started in 2018, under the leadership of a national NGO (EHYT – the Finnish Association of Substance Use Prevention) with additional funding from the Ministry of Health and Social Affairs, following growing concern about the relation between cannabis smoking and dropping out of school. 'Cannabis intervention for young users' is a three year-project based in two Finnish cities, aiming at developing professional competences and an intervention model for users. The main target group are aged 15–21 years as well as users that have no previous contact with the service system. The project seeks to train staff for light interventions, and to develop self-help or mutual help instruments. The development work will incorporate schools and other local authorities (K. Kannussaari, personal communication, January 12, 2018).

## **Treatment guidelines**

The Nordic national guidelines for treatment of cannabis problems have a lot in common, particularly in terms of methods, but there are also some differences in the emphasis on the goal of the treatment.

**Denmark** does not have designated guidelines for treatment of cannabis problems in particular, but there are guidelines for the treatment of drug problems in general (Socialstyrelsen, 2016). These guidelines are based on the social service responsibility for drug treatment. They stress the importance of comprehensive and coordinated treatment, focus on recovery and rehabilitation based on best knowledge, and to involve the user with integration of social support. Systematic documentation is required. The guidelines cover the route, content, and the organisational frame of treatment. It is stressed that total abstinence is not necessarily the right goal for all.

In **Finland**, the treatment of cannabis problems is mentioned in a special section of the (relatively short) guidelines for treatment of drug problems issued by the Finnish Medical Society Duodecim and the working group set by the Finnish Society of

Addiction Medicine (Suomalaisen Lääkäriseuran Duodecimin ja Päihdelääketieteen yhdistyksen asettama työryhmä, 2012). The guidelines emphasise that the criminalisation of drug use may be a hinder to treatment seeking and to creating a therapeutic alliance. Treatment is based on psychosocial methods, even if evidence is scarce. It is also acknowledged that psychiatric expertise and special attention to social aspects and the immediate environment are necessary. Recommended psychosocial methods are basically the same as for alcohol problems.

It is noted that cannabis causes physical and psychological dependence, and that withdrawal can be particularly difficult for smokers or persons with psychiatric problems. The increased risk for schizophrenia after cannabis use has a correlation with early onset of smoking, genetic disposition, and previous psychotic experiences. It is also noted that there is no medical treatment to cannabis dependence, and that dependence is often mild with mild withdrawal symptoms. Psychosocial treatment can be effective for reducing harms; the length and intensity of treatment does not seem to be important. Cognitive behavioural therapy and motivational interviewing are recommended, in some cases together with contingency management interventions.

In the **Icelandic** model, primary-level interventions aim to initiate change or motivation; there are many levels of care, and abstinence is not the only immediate goal. Group or individual treatment at the Vogur clinic regards addiction as a biopsychomedical condition and as a chronic disease. The treatment draws on principles of cognitive behavioural therapy and motivational interviewing, where the protocols are based on the recommendations of the US National Institute on Drug Abuse (NIDA) (Hansdóttir et al., 2015). Relapse prevention is important and re-admissions are expected in the long-term treatment plan. Multisystemic Therapy (MST) is a favoured intervention method among children and adolescents with serious problems.

The **Norwegian** guidelines for treatment and rehabilitation of addiction problems and dependence (Helsedirektoratet, 2014) have no special recommendations for treatment of cannabis problems. They start off with a chapter on user involvement, emphasised in Norway as in Denmark, and continue with recommendations for different stages in the treatment process, on therapeutic methods and treatment levels, psychosocial conditions in treatment, and on treatment of different groups. Case studies are also discussed. The guidelines emphasise

that the patient should normally define the individualised treatment goal, which can be total abstinence or controlled/reduced use. In a decentralised system, local adaptations are important. In relation to abstinence from cannabis during treatment, the Oslo variant of the programme recommends a break in the use, but not as an absolute. The Oslo app is also targeted to reducing the use. Experience shows that the treatment goal for the patients changes during treatment, and total abstinence can become a goal later on (M. Rørendal & L. Ambiyos, personal communication, March 13, 2018).

The **Swedish** guidelines (Socialstyrelsen, 2015) note that the risk of developing dependency on cannabis is relatively low, below 10%, and is mainly linked to social or psychological functioning, as in long-term or regular use. The recommended treatment methods are similar to recommendations in the other countries – cognitive behavioural therapy, motivational interviewing, relapse prevention, or contingency management – even if they all are regarded as having only a moderate or small effect. The Hashish Rehabilitation Programme and the Cannabis Programme for Young Persons (Cannabisprogram för unga, CPU) are also recommended as supported by experience and a 'systematic consensus procedure' (p. 138), although the scientific evidence is insufficient. The local recommendations of Stockholm county council also mention community reinforcement therapy, assertive community treatment, and family therapy. Given that abstinence is a major element of the Swedish Haschavvänjningsprogrammet, abstinence plays a bigger role in the treatment system in Sweden than in the other countries.

## Estimated coverage of treatment

Coverage and access to treatment and support for cannabis related problems vary across the countries and it is not possible to get an exact overview of the situation. Based on EMCDDA reports and expert interviews, it seems that Denmark performs relatively well: treatment and support are widely available, access is fairly good, and the system is being developed continuously. In Norway and Sweden, access to support and treatment varies locally, but there is increasing recognition of the needs and national and/or regional efforts to develop intervention activities. In Iceland, addiction treatment for diagnosed problems (including cannabis treatment) is relatively well accessible at the Vogur clinic.

Treatment access varies, however, across the vast



# "Informal or formal pressure has an important role for treatment entry."

country, and the need for interventions for children with more serious problems seems to grow. Finland has no specialised cannabis treatment units, and support/low threshold activities have just started to develop. There is an obvious lack of both treatment and support. This can partly be explained by the prolonged efforts to reform the Finnish social and health care system, which has led to uncertainty and confusion, and has hampered concerted development efforts.

## **Routes to treatment – pressure and anonymity**

Observations from Denmark, Finland, Norway, and Sweden indicate that informal or formal pressure from family, school, social services, and the police has an important role for treatment entry, especially among young persons. While external pressure seems crucial among the youngest, inner pressure is prominent among somewhat older cannabis users with a longer use history. "Grown-up users have experienced more negative consequences and are more motivated, but are also more in need of treatment" (A-S. Johansson, personal communication, 2018). In Denmark, clinicians report that very young cannabis users now seek help after experiencing a

problematic lack of control over their own behaviour. Many come because their friends say that they behave strangely (K. V. Gilberg, personal communication, April 10, 2018).

There are no statistics about routes to treatment for **Iceland**. Referrals to treatment come from diverse directions: social services, child protection services, emergency rooms, primary care doctors, the police, and prison settings. The patients can also seek treatment themselves or the initiative comes from the family. The exceptionally high level of treatment without a corresponding high level of consumption may imply that treatment seeking is less stigmatised here than in the other Nordic countries (V. Runarsdóttir, personal communication, May 2018; Hansdóttir et al., 2015).

In **Finland** in 2016, those counted in the annual survey of drug treatment clients with only cannabis or cannabis and alcohol use as problem drugs, came to treatment most often through the police, the prison, or after being given a court decision (29%); 13% came on their own initiative or with the support of close ones, 18% after referral from child protection or other social services, about 10% from specialised addiction treatment, 14% from health care, and only 2% from schools. For 15% of the entrants, the reason was unknown. Compared to

other drug users, the role of the criminal control system and the child protection system was more emphasised, and the role of specialised addiction treatment smaller (Forssell, & Nurmi, 2016).

In the other countries, we need to rely on local studies for information on routes to treatment. Reports from the Kristiansand municipality in **Norway** in 2017 show that the youngest entrants of those under 18 most often get in contact with treatment through the guardians, health services, school, social services, and the criminal justice system. Kristiansand offers them fairly long-term treatment in the Hashish Rehabilitation Programme. The statistics suggest that older adolescents and young adults more often apply for treatment on their own initiative (Skårdal, 2018).

A study of young persons (<25 years) in substance abuse treatment in Stockholm, Göteborg, and Malmö, the three biggest cities in **Sweden**, where 74% reported cannabis as the primary drug, showed that 10% entered treatment on their own initiative, almost half came after pressure from family or friends, a quarter were referred from the social services, and 17% mentioned other initiators, such as the school or the police (Anderberg et al., 2015).

Most pronounced in Sweden, but also expres-

sed by some experts in Finland and Norway are worries over a possible decriminalisation of use. Would this send a signal to very young users in particular that cannabis is not very dangerous? Could it increase the availability and use of cannabis through changed attitudes and thus also cannabis-related problems? The scepticism can also be linked to the acknowledged role of formal control – including the police – for routes to treatment among the youngest. It is also noted, however, that for persons with longer experiences of cannabis use and more long-lasting problems, decriminalisation may decrease the stigma and encourage treatment seeking.



## Concluding reflections

### Many similarities and possibilities for joint Nordic development work

There are many similarities between the Nordic countries in the perception of, reactions to, and challenges of treatment and care of cannabis related problems.

#### **Multiprofessionality**

In all Nordic countries the growing, mostly male, treatment-seeking population seems in fairly similar ways divided between the very young and those approaching 30 years. Still, it is primarily a problem of treatment for adolescents and young adults. And while the treatment-seeking population is absolutely not homogeneous, it seems clear that statistically users with other social or psychological problems are overrepresented in treatment and have more difficulties in reducing or quitting use. For many of those in treatment, cannabis is only part of a more complex problem picture. This calls for interventions with multiple professional specialities.

#### **Gaps, challenges and possibilities**

Denmark is still the country with most cannabis use and with probably the most developed and comprehensive treatment system. In Iceland access to treatment is relatively good, but there is a growing demand of interventions among the very young with multiple problems. There are identified gaps in all Nordic countries in the support and treatment offered to persons with cannabis-related problems, but it appears that the lack of cannabis care and treatment resources in relation to need is especially obvious in Finland.

The care and treatment systems in all Nordic countries also struggle with some similar problems: Prevention would be crucial but is difficult.





Some cannabis related problems are with all likelihood linked to social marginalisation and increased integration problems in our Nordic societies. Information about the risks with cannabis is important but hard to present in a communicative way. Young persons with a risky or an incipient problematic use are not necessarily themselves motivated to change their consumption patterns or seek treatment. Formal or informal control can be necessary. Motivation is not that big a problem among those who are older and have a more severe dependence. Stigma may be a greater obstacle for treatment seeking for this latter group, and some control measures add to the stigmatisation. Successful treatment requires also that the patient remains motivated – there is no simple fix for cannabis problem use and treatment is demanding in many ways.

The Nordic, social framing of drug problems is anyway a good starting point for addressing cannabis problems. With his long experience of clinical cannabis research, Thomas Lundqvist (personal communication, January 29, 2018) also finds that the Nordic countries offer high-quality clinical training, better than in most other countries.

### **Local anchorage**

What emerges from the interviews and reports is the importance of local cooperation between schools, vocational training, youth work, other social services, psychiatry, the police and specialised addiction treatment. This should be possible in service systems with a strong local anchorage and where the municipalities have the overall responsibilities for most of these services. It is as important, if not even more so in the case of very young persons, that the families and the close social networks are included and involved.

### **Outreach and low threshold**

Stigma remains a challenge in the Nordic systems, for it may be an obstacle to treatment and support seeking. The social stigma is linked to criminalisation of use, but exists in part independently. Use of cannabis has traditionally been a group behaviour among young persons. In Finland, the moral panic around detection of cannabis use in the community is a factor that increases stigma (K. Kannussaari, personal communication, January 12, 2018). Against this background, outreach and low threshold services, and offers of anonymous treatment can be viewed as especially welcome interventions.



## Effective information

The salient yet challenging role of information about the risks of cannabis use comes up in several countries. Neither the young users themselves nor their parents or school staff have enough knowledge about the effects of cannabis on body and mind. Information to young persons, it is stressed both in Finland and Denmark, must be given in a way that does not present an overly dramatic picture of cannabis smoking. The picture should not build on fear or clash too much with the experiences of the adolescents themselves. Still, it would be important to challenge overly positive images of cannabis, as risk-free, "natural", or even healing (cf medical cannabis). Dialogical information to young persons is an approach, situated between information and support, advocated in Copenhagen. A good alliance between the young person and the therapist, an understanding that cannabis is only one part of the life situation, and a focus on positive activities and aspects of life are important for the treatment motivation of a young user. Information about cannabis given in such a context and in the right way can be important and increase an existing but weak motivation (K. V. Gilberg, personal communication, April 10, 2018).

## Motivation and treatment goals

Motivation for treatment is a major challenge; dropping out of treatment is common. Motivation can sometimes be linked to or is even dependent on external control measures such as the need to prove one's sobriety to get back the driving licence, or the need to prove to the employer that one is clean.

When it comes to the goals of treatment, Sweden most clearly argues that abstention from cannabis use during treatment is crucial for success, while the attitude in the other countries is more tolerant in terms of individual or temporal goals of reduced use. The effects of cannabis smoking on the brain and on the cognitive functions is recognised in all countries, but the conclusions for the treatment plans are somewhat different. One argument for a more individualised treatment goal is that it increases motivation.

## Liberalised attitudes to cannabis

All countries, except possibly Denmark, face a particular challenge in the increasingly liberalised cannabis policy debate. Such liberalisation, contend the critics, creates a situation where those who use

cannabis as a stimulant have more voice than those for whom cannabis is a medication. In a polarised discussion climate it is difficult to present facts convincingly. The identified risk with a more cannabis-liberal discussion climate is that the attitudes to cannabis will be more positive, and that both use and problem use among young persons will increase.

## Good practices

This report identified several good practices, that could deserve broader implementation and locally tailored adoption in the Nordic countries, and possibly further abroad. Among them, to mention some examples, are the Swedish HAP-program, the Norwegian app, partly based on HAP, the Icelandic Multisystemic Intervention experiences and the Danish U-turn and U 18 models. The ongoing Finnish cannabis intervention project will also result in models the knowledge of which should be disseminated to neighbouring countries.

I will end this report by citing Ulric Hermansson and Ann-Sofie Johansson (personal communication, March 5, 2018) with statements that I believe all Nordic experts would agree with:

*We need a smorgasbord of different interventions to address the cannabis problems. Cannabis problems cannot be eliminated with treatment [as]... there is fertile ground for recruitment of new users among marginalised young persons. Only through social policy can the problems truly be alleviated.*

**Kerstin Stenius**

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## Personal communications (email)

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## Interviews

Pekka Hakkarainen, THL-National Institute for Health and Welfare, Finland, January 25, 2018

Halldur Hauksson, Government Agency for Child Protection, Iceland, September 10, 2018 (telephone)

Ulric Hermansson & Ann-Sofie Johansson, Cannabismätverket . The Cannabis Network, Sweden, March 5, 2018 (telephone)

Kim Kannussaari, EHYT – Finnish Association for Substance Abuse Prevention, Finland, January 12, 2018

Hans Larsson, Maria Ungdom Huddinge – Maria Youth Clinic, Sweden, March 29, 2018 (telephone)

Thomas Lundqvist, Lund, Sweden, January 29, 2018 (telephone)

Dan Orbe, Viden- og kompetencecenter - unge og rusmidler, Københavns kommune (Copenhagen City, Centre for knowledge and competence development – youth and substances), Denmark, April 9, 2018 (telephone)

Valgerdur Runarsdottir, Vogur Clinic, Iceland, May 2018 (telephone)

Malin Rørendal & Lydia Abiyos, Uteseksjonen, Oslo kommune (Oslo City, Outreach section), Norway, March 13, 2018

Kaarlo Simojoki, A-klinikka Oy (The A-clinics Ltd), Finland, February 5, 2018 (telephone)

John-Kåre Vederhus, Madelene Skårdal, & Helga Tveit, Kristiansand kommune and Sørlandet spesialisthelsetjenesten (Kristiansand City and Sørlandet Specialist Health Care), Norway, March 14, 2018

Kim Vedersø Gilberg, U-turn, Københavns kommune (U-turn, Copenhagen City), Denmark, April 10, 2018 (telephone)

Sigurður Örn Magnússon, Barnavernd Reykjavíkur , (Child Protection Agency, Reykjavik City), November 2, 2018 (telephone)

