Funded by the European Union

Cannabis: health and social responses

COPOLAD III is a consortium formed by:

Collaborating partners:

Authors

This miniguide is based on **Cannabis: health and social responses**, published by the European Union Drugs Agency (EUDA) — formerly the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) — as part of its **Health and social responses to drug problems: a European guide.**
The adaptation of this miniguide was prepared by Débora Álvarez, under contract CT.23.COPIII.0071.1.0 of the Cooperation Programme between Latin America, the Caribbean and the European Union on Drug Policies (COPOLAD III). The EUDA cannot be held responsible for the content of this adaptation.

Funding

This adaptation was financed by the European Union. Its content does not necessarily reflect the views of the European Union.

Acknowledgments

The EUDA would like to express its sincere thanks and appreciation to the experts from the Latin American and Caribbean countries listed below, who have contributed to the focus groups and the whole adaptation process:

Antigua and Barbuda

Argentina

Bahamas

Barbados

Bolivia

Chile

Colombia

Costa Rica

Dominican Republic

Ecuador

El Salvador

Guatemala

Haiti

Honduras

Jamaica

Mexico

Panama

Paraguay

Peru

Saint Vincent and the Grenadines

Trinidad and Tobago

Uruguay

Venezuela

Introduction

This miniguide helps health professionals and policymakers address the negative consequences of drug use. It provides an overview of aspects to consider when planning or delivering health and social responses to specific cannabis-related problems, and reviews available interventions and their effectiveness. It also considers implications for policy and practice.

Overview

Key issues

Cannabis is the most commonly used illicit drug globally. It is estimated that of 296 million people who consume drugs in the world, almost three out of four use cannabis[1]. In addition to herbal cannabis and cannabis resin, an increasing range of new forms of the drug can now be observed on the illicit market.

In addition, a variety of commercial products containing extracts of the cannabis plant, but with low levels of tetrahydrocannabinol (THC), have appeared in many countries. Regulatory responses are also increasingly variable and complex, as several countries allow cannabis products to be available under certain circumstances for therapeutic purposes, and some propose tolerance for some forms of personal use. Therefore, while most health and social concerns remain focused on illicit cannabis use, this area is becoming more complex both in terms of definition and response.

Also, in the Latin America and Caribbean (LAC) area, some countries are producers of cannabis and its derivatives. The availability of the substances largely complicates the prevention of the use of the substances, especially among younger people. Substances can be purchased at very low prices and are accessible to young people, so access to cannabis is easy in certain contexts.

Cannabis use is socially associated with a low perception of risk. However, the use of cannabis can create or aggravate a number of economic, social, physical and mental health problems. These problems are more likely to evolve if consumption starts at an early age and becomes regular, turning into long-term use. Therefore, the main objectives of health and social responses addressing cannabis use and associated problems should include:

- preventing use, or delaying its onset from adolescence to early adulthood;
- preventing occasional cannabis use from turning into regular use;
- reducing the incidence of use;
- offering interventions, including treatment, for people whose cannabis use has become problematic;
- increasing the number of people with problem drug use entering treatment;
- reducing the impact of cannabis on individuals through the implementation of risk and harm reduction actions.

Response options

- *Holistic interventions*, which integrate various types of intervention with the aim of repairing rights violations.
- *Prevention programmes*, such as multi-component school-based interventions (which develop social competences and refusal skills, as well as healthy decision-making and response strategies and which correct normative misperceptions about drug use); family and community interventions; and structured online interventions.
- *Community environment interventions*, incorporating them to strengthen healthy and lower risk development environments.

[1] UNODC World Drug Report 2023. https://www.unodc.org/unodc/en/data-and-analysis/world-drug-report-2023.html

- *Treatment interventions*, including cognitive-behavioural therapy, motivational interviewing and contingency management; some computer-based and online interventions. Multidimensional family therapy is an option for young patients.
- *Occupational health therapies,* whose objective is based on human occupation and uses it as an intervention tool to achieve the independence of the individual. Occupational therapy uses the activity to help people acquire the knowledge, skills and attitudes needed to develop the required day-to-day tasks and achieve maximum autonomy and integration.
- *Harm reduction interventions*, for example, interventions addressing harm associated with the use of smoking cannabis, especially when used together with tobacco.

Situation in Latin America and the Caribbean

Universal prevention is the most widespread approach to delaying and reducing cannabis use, but the approaches adopted do not always reflect an evidence base. It has been noted that well-designed prevention programmes implemented in schools have reduced cannabis use.

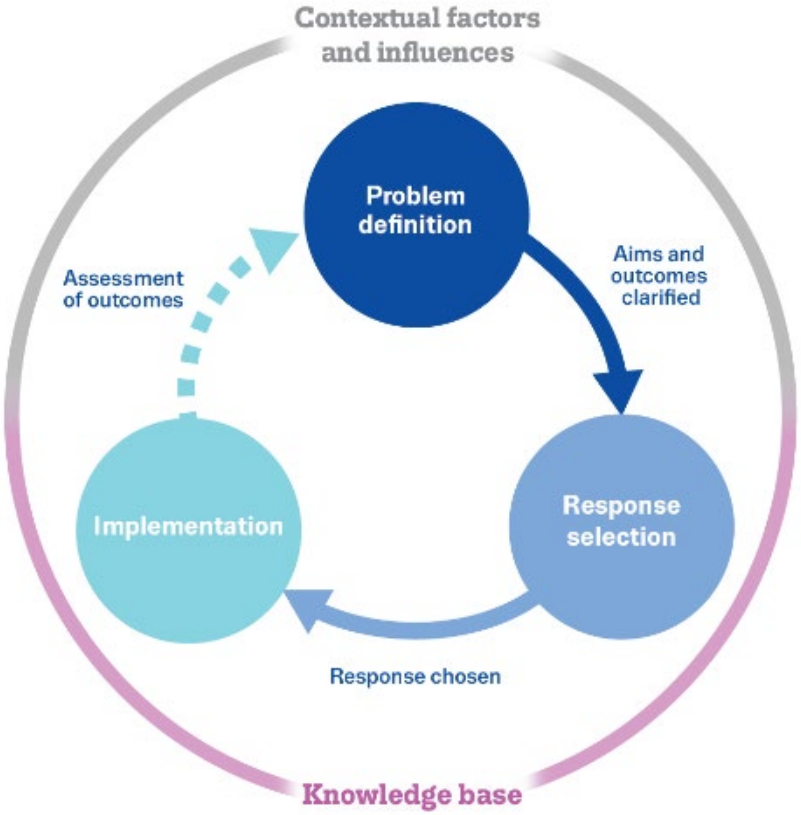
Selective prevention approaches, targeting groups at higher risk, are used in some countries, depending on their psychological and contextual characteristics (e.g. among young offenders or young people in care institutions), but little is known about their effectiveness.

Indicated prevention approaches are aimed at those who, due to situations of vulnerability, present risk factors and who are already involved in problem drug use.

Some LAC countries have data on specific treatments for cannabis. Treatment is often provided in community or outpatient settings and, increasingly, in interventions delivered online, through computers or mobile phone applications.

Action framework for developing health and social responses to drug problems

The three broad stages of developing responses to drug problems



Health and social responses to drug-related problems any actions or interventions taken to address the negative health and social consequences of illicit drug use, such as deaths, infectious diseases, dependence, mental health problems and social exclusion. The development and implementation of these responses, whether at national, local or individual level, involves three basic steps:

- *definition of the problem*: identifying the nature of the drug problems to be addressed;
- *selection of the response*: selecting possible effective interventions to address these problems;
- *implementation*: implementing, monitoring and evaluating the impact of these interventions.

The Action framework details the most important factors to be taken into account at each stage.

Key issues: patterns of cannabis use and related harms

Key issues to be addressed when identifying and defining a problem include who is affected, what types of substances and patterns of use are involved, and where the problem is occurring. Responses need to be tailored to the specific drug problems being experienced, and these may vary from country to country and over time. The wide range of factors to be taken into account at this stage of the process is addressed in the *Action framework for developing and implementing health and social responses to drug problems.*

Cannabis comes from the flowers or extract of a plant, *Cannabis sativa*. An increasingly wide range of cannabis products is observed in the LAC area, with a variety of compositions and forms. Indeed, there are more and more proposals in Ecuador that seek to formalise the sector and strengthen the opportunities offered by the non-psychoactive cannabis market, from research and cultivation to processing and export.

In Argentina, for example, it is managed with certain home-made modalities of use, such as cannabis food, in addition to the sale of oil for medicinal use and pharmaceutical products (creams) to reduce inflammation or pain.

Cannabis is the most commonly used illicit drug globally and also in the LAC area. Cannabis use is higher among young adults and the age of first cannabis use is lower than for most other illegal drugs. Reported consumption levels vary significantly from country to country and between regions. It is estimated that around 13 % of young people in North America use it, compared to 7 % in South America and Central America, and 5 % in the Caribbean. For Argentina, the latest survey in the general population (2022) showed that the current prevalence rates (non-therapeutic use) for the 16–24 age group is 10 %.

Cannabis use is often experimental, and usually occurs only during a short period of time in early adulthood. However, a minority of people do develop more persistent and problematic patterns of use, and these problems are associated with regular, long-term, high-dose cannabis use. These problems can include:

- impaired physical health (e.g. chronic respiratory symptoms);
- mental health problems (e.g. dependence on cannabis and psychotic symptoms);
- social and economic problems arising from poor school performance, school failure, school dropout, declining work performance or involvement in the criminal justice system;
- possible adverse effects on the unborn child when consumed during pregnancy;
- deterioration in social relations and overall functioning of the person.

The negative impact of problematic cannabis use on people's mental and physical health, and on their social and economic lives, is more likely if regular use begins in adolescence, while the brain is still developing. Risks may increase with the use of higher potency cannabis products, especially those with high concentrations of the main psychoactive component, tetrahydrocannabinol (THC). There is some evidence to suggest that concentrations of another component, cannabidiol (CBD), may mediate some of the negative effects associated with high doses of THC. In addition, cannabis use may cause acute symptoms leading to visits to hospital emergency services. However, despite widespread use worldwide, deaths related to cannabis use are rare.

On the other hand, there are specific negative consequences for young people, such as the risk of criminal records for offences involving the use or possession of cannabis. This issue has also raised concerns in some countries that criminal penalties may be disproportionate to the harm caused by cannabis use itself, known as 'disproportionality of penalties'. This is one of the factors driving experimentation with different regulatory models in this area.

In addition, in cases where cannabis is consumed by smoking mixed with tobacco, additional health risks can occur and associated nicotine-related dependence may even make treatment more difficult. This also points to the need for a more holistic approach when analysing policies and responses related to cannabis mixed with tobacco.

Driven, at least in part, by the introduction of new models of cannabis regulation, there has been rapid growth in recent years in both the range of available cannabis-based products and patterns of use. Increasingly, capsules, oils, different edibles and vaporisers are available. These new products and modes of use may bring specific health risks. For example, edibles may pose an increased risk of overdose, even among young children who are accidentally attracted to products such as cakes, sweets and chocolate. In addition, the use of highly concentrated extracts through 'dabbing'[2] appears to be associated with significant adverse health effects. There are many types of vaporisers that can be used with a variety of cannabis extracts and products and may therefore present different risks. The outbreak of serious lung injury in North America in 2019–2020 associated with the use of electronic cigarettes with cannabis vaping liquids appears to have been due to an additive or contaminant in illegal vaping cartridges.

[2] A process consisting of vaporising and inhaling highly concentrated cannabis concentrates, oils and extracts, products made from cannabis flowers [royalquenseeds.es, drugfree.org].

There is also growing concern about problems associated with high-potency synthetic cannabinoid receptor agonists, commonly referred to as synthetic cannabinoids. Despite acting on the same cannabinoid receptors in the brain, these substances are very different from cannabis, and their use may be associated with more serious consequences, including death.

The main objectives of health and social responses to address cannabis use and the associated problems can be:

- preventing use, delaying its onset from adolescence to early adulthood;
- preventing occasional cannabis use from turning into regular use;
- reducing harmful patterns of use;
- preventing and controlling the sale or disposal of drugs outside educational settings;
- increasing the number of people with problem cannabis use accessing treatment;
- increasing the number of treatment service units for cannabis use;
- reducing the likelihood of people driving after using cannabis or engaging in other activities where cannabis intoxication may increase the risk of accidents.

Public policymakers could also analyse how to reduce the involvement of young people who use cannabis in the criminal justice system. Furthermore, when products derived from cannabis are lawfully placed on the market, it is necessary to ensure product safety and enforce regulatory safeguards, such as the prevention of sale to minors.

Evidence and responses to cannabis-related problems

Choosing appropriate responses that can be effective in addressing a particular drug-related problem requires a clear understanding of the primary objectives of the intervention or combination of interventions. Ideally, interventions should be supported by the strongest evidence available; however, when evidence is very limited, or not available, expert consensus may be the best option until more conclusive data is obtained. The *Action framework for developing and implementing health and social responses to drug problems* analyses in more detail what aspects should be taken into account when selecting the most appropriate response options.

Prevention

Prevention programmes that have proven to be effective in relation to cannabis use often take a developmental perspective, which identifies and analyses behavioural and psychological changes of people in different contexts and at each stage of life, and are not substance-specific. Prevention programmes for adolescents often aim to reduce, or delay, the use of cannabis in addition to the use of alcohol and tobacco, which are often the starting substances.
Prevention actions aim to reduce the likelihood of use of psychoactive substances both among people who do not use them and among those who use them. Prevention of the use of psychoactive substances can be classified as:

- *Universal prevention*: actions to prevent the use of psychoactive substances aimed at the entire population, regardless of the level of risk to which they are exposed;
- *Selective prevention*: actions targeting a sub-group of the population considered to be at increased risk of drug-related problems because of their personal characteristics, social, family and/or sociocultural background;
- *Indicated prevention*: actions targeted at a specific sub-group of the community that is considered to be already experiencing problematic use of psychoactive substances. These interventions aim to reduce substance use, frequency or quantity and promote harm reduction strategies.

Well-designed prevention programmes, delivered in schools, have been found to have reduced cannabis use. These programmes are manual-based (i.e. their implementation is standardised through the use of

protocols and manuals for those delivering them) and generally have multiple objectives. These can include: developing social competences and social, emotional or cognitive skills; improving decision-making and responsiveness; raising awareness of social influences on drug use; correcting normative misperceptions that drug use is common among peers; and providing information about the risks involved in drug use. Programmes delivered in schools, which focus only on increasing students' knowledge of the risks of drug use, have proven ineffective in preventing the use of cannabis and other drugs.

Brief interventions usually aim to reduce the intensity of drug use or prevent it from becoming problematic. These interventions are limited in time, and the methods of selecting objectives and delivery vary considerably. Part of the attractiveness of this approach is that it can be used in different contexts, for example by general practitioners, advisers, young workers or police officers, as well as in treatment centres. This type of intervention mainly incorporates elements of motivational interviewing. Recent revisions have shown that, while having some effects on alcohol consumption, they do not reduce cannabis use and therefore require further studies and research.

More and more studies are evaluating the effectiveness of digital interventions and there is promising, but still limited, evidence that structured interventions delivered via computers and the internet can help prevent cannabis use. However, it is important to bear in mind that in Latin America and the Caribbean, internet access is still limited in various regions and for certain vulnerable groups.

Overview of the evidence on interventions to prevent or delay cannabis use

Overview of the evidence on ... interventions to prevent or delay cannabis use

Statement	Evidence	
	Effect	Quality
Multicomponent interventions can reduce cannabis use when delivered in schools using social competence and influence approaches, correcting normative misperceptions and developing social competences and refusal skills.	Beneficial	High
Digital interventions increase the accessibility to programmes and the reach of people who may be using cannabis	Beneficial	Low
Standalone school interventions, knowledge-based or solely based on social influence models, do not reduce cannabis use (more than usual curricula).	Unclear	Moderate
Digital prevention interventions may reduce cannabis use	Unclear	Low
Brief interventions (e.g. motivational interviewing) may produce either very small or no benefits in reducing cannabis use among young adults who are not already involved in regular illicit drug use.	Unclear	Low
Brief interventions delivered in schools do not have a significant effect on cannabis use	Unclear	Moderate

Evidence effect key:
Beneficial: Evidence of benefit in the intended direction. **Unclear:** It is not clear whether the intervention produces the intended benefit. **Potential harm:** Evidence of potential harm, or evidence that the intervention has the opposite effect to that intended (e.g. increasing rather than decreasing drug use).

Evidence quality key:
High: We can have a high level of confidence in the evidence available. **Moderate:** We have reasonable confidence in the evidence available. **Low:** We have limited confidence in the evidence available. **Very low:** The evidence available is currently insufficient and therefore considerable uncertainty exists as to whether the intervention will produce the intended outcome.

Harm reduction

Harm reduction for cannabis use has received less attention than for other substances but is nevertheless important. Abstaining from use is the most effective way to avoid the risks of cannabis use, and this is especially important for children and adolescents. However, for those who choose to use cannabis, harm reduction interventions can focus on avoiding more problematic patterns of use, limiting use and raising awareness of the need to monitor possible negative impacts of use in other areas of life, e.g. school performance or social relationships. A literature review conducted to update *Canada's Lower-Risk Cannabis*

Use Guidelines provides relevant evidence-based recommendations. This, and other, recently developed guidelines highlight the following key areas for reducing risks associated with cannabis use.

Addressing the specific harm associated with smoking cannabis, especially in combination with tobacco, is an important but neglected topic.

There are alternatives to tobacco use, such as vaporisers or edible products, but these methods represent specific health risks. The use of edibles eliminates respiratory risks, but late onset of a psychoactive effect may result in people taking higher doses than expected and experiencing acute adverse reactions. There is little evidence to analyse the impact of the use of new, or well-established, technologies in this area. However, as indicated above, the use of some types of vaporisers may be associated with significant health risks, especially when highly concentrated extracts are used.

Some practices commonly used when smoking cannabis, such as 'deep inhalation' and breath-holding, increase the inflow of toxic products into the lungs. People who use cannabis should be encouraged to avoid these practices.

The diversity of cannabis products increases the importance of users understanding the impact of variations in the nature and composition of these substances. Products with a higher THC content are associated with a higher risk of developing acute and chronic problems. There is some experimental evidence suggesting that CBD may moderate the psychoactive and potentially adverse effects of THC, so the use of cannabis containing lower levels of THC and higher levels of CBD may be preferable. Some people, for a variety of reasons, such as lower costs and concerns about evidence, may substitute synthetic cannabinoids for cannabis. However, these synthetic versions are of variable content and act differently from cannabis, and can also be associated with very serious acute effects, including death. A recent concern has been the emergence of cannabis products that have been adulterated with synthetic cannabinoids, so that people who use them may be unknowingly exposed to a variety of chemicals.

Frequent, or intensive, cannabis use (daily or near-daily use) is associated with an increased risk of health and social harm, so people who use cannabis should try to limit their intake as much as possible, for example by using only on weekends or one day a week.

Studies indicate that driving a vehicle under the influence of cannabis increases the chances of an accident, and this risk is likely to be significantly higher if alcohol or other psychoactive substances are also consumed. Studies also indicate that people should refrain from driving (or operating dangerous machinery) for several hours after using cannabis. People who use cannabis should also be aware of, and respect, the locally applicable legal limits defining cannabis-impaired driving and recognise that THC remains in the body for a long time and may therefore remain detectable in tests long after the effects have worn off.

In particular, certain groups of the population should avoid using cannabis, as they appear to be at higher risk of suffering harm related to this substance. These include adolescents, people with a personal or family history of psychosis or a substance use disorder, as well as pregnant women, to avoid adverse effects on the foetus.

Treatment

Treatment of cannabis-related problems is mainly based on psychosocial approaches, including, in the case of adolescents, multidimensional family therapy. Psychosocial approaches comprise a range of structured therapeutic processes that address psychological and social aspects of behaviour related to drug use. These measures vary in format, duration and intensity, but include approaches such as cognitive and behavioural therapy, contingency management and motivational interviews.

More specifically, the available evidence supports the use of cognitive-behavioural therapies in the treatment of cannabis use and dependence in adults. The cognitive-conduct therapy promotes the development of alternative adaptation capacities and focuses on changing behaviours related to the consumption of substances through self-monitoring, social skills and training for preventing relapse.

The available evidence also supports the use of the multidimensional family therapy (MDFT) in the treatment of cannabis use among young people. MDFT is an integrated, holistic and family-centred approach to addressing young people's problems. It works with the adolescent and their family and community to improve young people's ability to solve problems and make decisions, as well as to improve the functioning of the family.

Digital and online interventions are increasingly being used to reach people who use cannabis, and there is growing evidence that they can be effective in reducing use and facilitating face-to-face treatment (where necessary). Better quality evidence is needed on the effectiveness of this approach.

Several ongoing experimental studies are investigating the potential usefulness of pharmacological interventions for cannabis-related problems. These include the potential for using THC and its synthetic versions, in combination with other psychoactive medicines, such as antidepressants, anxiolytics and mood stabilisers, among others. However, the results to date have been inconsistent and no effective pharmacological approach to treating cannabis dependence has yet been identified.

For a small number of people, cannabis use may be associated with serious mental health problems. It is not uncommon for people with schizophrenia or bipolar disorder to receive an additional diagnosis of cannabis dependence, and cannabis is one of the substances most commonly used by people with psychosis. It is important that mental health and substance misuse services recognise these cases and ensure that appropriate interventions are in place. People with psychotic disorders should avoid cannabis and receive counselling against its use.

Overview of evidence on treating problem cannabis use

Overview of the evidence on ... treating problematic cannabis use

Statement	Evidence	
	Effect	Quality
Psychosocial interventions may reduce cannabis use and related problems, with more intensive interventions (> 4 sessions over > 1 month) producing better outcomes.	**Beneficial**	Low
Digital interventions increase the accessibility to programmes and the reach of people who may be using cannabis	**Beneficial**	Low
Digital interventions may reduce cannabis use.	**Unclear**	Low
Brief behavioural interventions (e.g. motivational interviewing) have not been found to reduce cannabis use in adolescents who are already using it at problematic levels.	**Unclear**	Moderate

Evidence effect key:
Beneficial: Evidence of benefit in the intended direction. **Unclear:** It is not clear whether the intervention produces the intended benefit. **Potential harm:** Evidence of potential harm, or evidence that the intervention has the opposite effect to that intended (e.g. increasing rather than decreasing drug use).

Evidence quality key:
High: We can have a high level of confidence in the evidence available. **Moderate:** We have reasonable confidence in the evidence available. **Low:** We have limited confidence in the evidence available. **Very Low:** The evidence available is currently insufficient and therefore considerable uncertainty exists as to whether the intervention will produce the intended outcome.

Overview in the LAC area: availability of cannabis-related interventions

In this section, interventions implemented in LAC area are shown as examples, without implying whether they are effective or not.

Prevention

Universal prevention programmes can be manual-based and aimed at developing social competencies and tools to develop and strengthen life skills such as managing emotions, decision-making, interpersonal relationships, among others, as well as addressing social influences and correcting normative misperceptions about drug use. In addition, evidence-based family programmes also exist. In some locations, different prevention approaches have been prioritised, for example environmental prevention measures or community-based approaches.

Selective prevention responses for vulnerable groups are another response option to develop cannabis-related interventions. These responses address both individual behaviours and social contexts, while at the local level they often involve multiple services and stakeholders (e.g. social services, families, young people and police). The most common target groups are young people who have committed crimes, students with academic or social problems, and institutionalised young people. Little is known about the content of these prevention strategies and evaluations of their effectiveness are limited.

Use of *indicated prevention* approaches and short interventions varies from country to country.
For example, they are widely used in Mexico. However, in Ecuador work has been carried out only very rarely with indicated prevention because it is far more costly and perhaps less efficient with the populations. In Argentina, for example, Sedronar offers indicated prevention programmes from an integrated perspective that takes into account the individual, the context and the problem substance use, in this case cannabis use.

Examples of interventions to prevent cannabis use include the video 'A Different Kind of Weed' in Trinidad and Tobago aimed at improving information on cannabis among schoolchildren.

Video: Trinity S.M.A.R.T. Episode 4 - A Different Kind of Weed

https://www.youtube.com/watch?v=Jc5aCx76Wh

Similarly, interactive tools have also been developed to improve information for young people on substances such as cannabis. This is the case for an online intervention carried out in Colombia 'More mind, more prevention'. It is an information tool on the prevention of psychoactive substances for children, girls, adolescents, young people and families.

'More mind, more prevention' a briefing tool on psychoactive substance prevention, targeting children, adolescents, young people and families

https://www.minsalud.gov.co/salud/publica/SMental/paginas/convivencia-desarrollo-humano-sustancias-psicoactivas.aspx

In Ecuador, to strengthen public policy, a strategy to prevent use of alcohol and other drugs in girls, boys and adolescents at national level called 'NEW-MIND' was developed. The main objective of this document — based on evidence that considered planning, management, monitoring and evaluation processes — is to promote an environment of wellbeing for children, girls and adolescents, promoting healthy lifestyles, through the implementation of comprehensive prevention actions to reduce the risk factors associated with drug use.

Prevention programmes that are implemented in multiple contexts and settings (e.g. school, family, community) seem to be the most effective. Independent media campaigns (such as television, radio, written press and Internet) that use social marketing principles and disseminate information on the risks of drug use tend to be considered ineffective with respect to behavioural change. It is therefore generally recommended that they should only be considered as part of a broader set of programmes incorporating a wider range of approaches, and that they should also be carefully evaluated. This is the example of interventions carried out in Panama under the slogan 'Consumption consumes you', although not specifically aimed at the prevention of cannabis use, but at the prevention of drug use as a whole.

Videos on substance use on social media

https://twitter.com/PGN_PANAMA/status/1568724748531441664

https://www.instagram.com/reel/CxqDFawuxfs/

ECUADOR

In Ecuador, several educational communication campaigns have been carried out at the national level on different dates and with different themes:

Cantonal festivities:

- https://www.facebook.com/share/p/XCAtDHwYQbmxsGoo/?mibextid=qi2Omg
- https://www.facebook.com/share/p/zi3jAZ77N7Lgstqd/?mibextid=qi2Omg
- https://x.com/Salud_Ec/status/1736800997375357269?t=PW9LBvHnkNpD5o-u1Q25iA&s=08

Risk and harm reduction:

- https://x.com/Salud_Ec/status/1733148917259247993?t=PlLYSp15cgh5vk9Q-_zlbw&s=08
- https://x.com/Salud_Ec/status/1732431761018110187?t=VJkLddWki89FhIGMLACBIQ&s=08

Training workshops:

- https://twitter.com/Salud_Ec/status/1694792610999587270?t=sPv8cQAFEl7qrgCjHzgqEQ&s=08
- https://twitter.com/Salud_CZ5/status/1763622354326888697?t=BzGQVOxIqpnIBIfo43PbIA&s=19
- https://x.com/Salud_CZ5/status/1762212247860904360?t=K9dKiwZGQpoEfzgWuCAUKA&s=08

Awareness-raising meetings:

- https://x.com/saludcz6oficial/status/1766100457242443990?t=Xtw83B5tr62p_hRL1Phljw&s=08
- https://x.com/Salud_CZ7/status/1765435136378610127?t=qU-5duoQ6Cq3pNf88bOXww&s=08
- https://x.com/Salud_Ec/status/1761118620359315913?t=3yCwohEXDpyLXJ3mJ7Repw&s=08

Treatment

In the LAC area, there are data sources, such as the National Drug Observatories, that provide information on the number of users entering treatment for the first time for cannabis problems. However, in some countries, data may be derived from registries that may not cover all treatments offered in different settings. In some countries in recent years, cannabis has been the most frequently reported main drug among newly treated patients. This increase may be due to a number of factors, including: changes in cannabis use in the general population, especially intensive use; changes in risk perceptions; increased availability of more powerful cannabis products; and changes in derivation practices and the provision of treatment. The data is also influenced by different national definitions and practices with respect to what constitutes treatment for cannabis-related disorders, which can range from a short online intervention session to admission to residential care. Argentina has a study on profiles of patients in treatment dating from 2019, which provides this information.

Overall, there is a need to develop a better understanding of the treatment of cannabis use, including those seeking help, the problems they are experiencing, the settings in which assistance is provided and the therapeutic responses offered. The availability and coverage of treatment options for people consuming cannabis differs from country to country and is difficult to estimate. Some countries report that their coverage is limited, sometimes despite high general levels of need. Less knowledge is available on accessibility to treatments for cannabis consumption disorders in countries where there are no specific interventions for this substance. The empirical assessment of treatment coverage is particularly difficult in this area, as the extent of cannabis-related problems in the general population has not been accurately measured.

Implications for policy and practice

Basics

The main responses in this area include general prevention approaches aimed at discouraging use or delaying onset, harm reduction actions and providing psychosocial treatment to people with more serious problems.

Opportunities

- More attention should be paid to harm reduction approaches to cannabis use, in particular in relation to patterns of use and concomitant use with tobacco.
- Training on evidence-based practices for implementers of prevention and treatment policies and programmes is essential to ensure the effectiveness of interventions. Patterns of cannabis use among different populations should also be present, particularly where polydrug use is involved.
- Greater use could be made of e-health and digital interventions, along with the evaluation of novel approaches.
- Emerging global cannabis regulatory models can provide valuable insights into the benefits and drawbacks of different regulatory options and their likely impact on responses to cannabis-related problems. However, there is still a gap in access to digital media, especially in segments of the population with fewer economic resources or living in isolated areas.

Gaps

- There remains a need to develop increased awareness of the nature of cannabis-related disorders and of the most effective and appropriate treatment options for different patients.
- It is also essential to implement comprehensive intervention programmes involving multidisciplinary teams to effectively address people with dual pathologies or multiple comorbidities.
- There is a need to better understand the types of treatment people receive when entering treatment for cannabis use, to ensure that provision is appropriate and efficient.
- There is a need for greater consensus on what constitutes an appropriate way of reducing cannabis-impaired driving.
- There is a need to provide continuous training to professionals dealing with these cases, in order to avoid stigmatisation of patients from the health system and promote evidence-based interventions that facilitate their reintegration into everyday life.
- It is necessary for the State to allocate resources for risk reduction and harm programmes where strategies are established in areas of prevention, diagnosis, treatment, rehabilitation and social inclusion, with the aim of reducing the harmful effects of drug use.

Data and graphics

Below, we provide key statistics on the use and treatment of cannabis based on estimates from the UNODC World Drug Report 2023. Caution should be exercised when interpreting these data, as they are collected using different methodologies and may therefore not be directly comparable. In addition, the date included is the date of publication of the UNODC report, but the actual year of the data can be a few years earlier and may vary from country to country.

Prevalence of cannabis use in the general population (%)

Region	Prevalence
Caribbean	5.73 % [IC: 3.46-12.56]
North America	17.36 % [IC: 17.21-17.51]
South America	3.58 % [IC: 3.49-3.72]
Central America	3.12 % [IC: 1.07-5.50]

Prevalence of cannabis use in the young population (%)

Region	Prevalence
North America	13.36 % [IC: 12.98-13.36]
Caribbean	5.28 % [IC: 4.71-5.79]
South America	7.04 % [IC: 6.80-7.13]
Central America	6.79 % [IC: 6.46-7.20]

Herbal cannabis, marijuana as primary drug for use among people treated for drug problems (World Drug Report 2022).

Country	Prevalence
Bahamas	82.30 %
Chile	27.27 %
Costa Rica	42.86 %
El Salvador	45.30 %
Guatemala	71.76 %
Honduras	78.37 %
Mexico	22.76 %
Nicaragua	49.35 %

In addition, it is worth noting the work being done in the National Drug Observatories, where more detailed data on the reality of each country can be found. For example, the Argentinian Drug Observatory has produced the 'Main findings on marijuana use' containing information on cannabis use, motivations and context of use.

This report provides data from the 2022 edition of the study on drug use carried out in Argentina in the general population. The aim of this study is to obtain updated information on the magnitude of psychoactive substance use in the urban population between 16 and 75 years of age in the country, the different patterns of use and the socio-demographic profile of users. In addition, this initiative also aims to analyse the perception of the risk associated with the use of different substances, the vulnerability of individuals in terms of exposure to the supply of drugs and the associated care practices.