



Research paper

Qualitative research in Spanish cannabis social clubs: “The moment you enter the door, you are minimising the risks”



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ABSTRACT

Background: Cannabis social clubs (CSCs) in Spain are non-profit organisations that connect regular adult cannabis users. One of their functions is to supply cannabis to the closed circuit of members. The CSCs do not breach any international treaties. The aim of the paper is to present the findings of a qualitative study among Spanish CSCs in order to assess their potential for minimising the harm resulting from cannabis use (such as respiratory and mental health risks, the risk of dependence, and social risks).

Method: A convenience sample of 11 CSCs was selected from four regions of Spain – the Basque country, Catalonia, the Balearic Islands, and Galicia. 94 respondents took part in 14 focus groups (FGs). The number of participants in a FG ranged from two to 12. A semi-structured interview guide and a structured questionnaire were used in the FG.

Findings: Members described a variety of risk minimising features of the CSCs: the availability of a quality product and mechanisms for its control, availability of different strains of cannabis and knowledge about their different psychoactive effects, increased control over personal cannabis use, informal information sharing and interaction, reduced stigma, and reduced criminal risks.

Conclusions: The fact that the CSCs have no incentive to increase members' consumption means that they should be considered to be feasible spaces for the implementation of public health policies. Policy objectives could include a requirement that CSC members have control over the quality of cannabis, that different strains of cannabis are available together with information on their effects, that quantity of cannabis at intake is restricted and planned for each member, and that harm minimisation activities are both formally and informally implemented in the clubs.

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Introduction

The “cannabis social clubs” (CSCs) are (non-profit) associations of cannabis users that supply their members with cannabis and its derivatives, allowing them to avoid the black market and the risks involved in it. While each cannabis social club might have a specific *modus operandi*, the concept is based on several assumptions, including that the association is officially registered, no profit is being made, cannabis is supplied to a closed circuit of adults who are regular cannabis users, and cannabis cultivation serves solely the personal consumption needs of the members. The amount consumed is rather small, with an annual limit being pre-set for each member (production is according to the forecast of the shared consumption

of the members). Information about the negative effects of cannabis use and their minimisation is provided (Barriuso, 2005, 2011; Muñoz & Soto, 2001; Room, Fischer, Hall, Lenton, & Reuter, 2008).

Several authors have argued, in line with the advocacy that has accompanied the establishment of CSCs on the national and international level (Blickman, 2014; ENCOD; FAC, 2010, 2014; Gutiérrez, 2008), that the clubs minimise the risks to public health and safety. This is assumed to happen through the avoidance of the black market, the use of quality cannabis, the CSCs' harm reduction activities, and the reduction of the stigma associated with cannabis use (Barriuso, 2005, 2011; Coombes, 2014; Decorte, 2015). Despite CSCs having been in existence since 2001 (Barriuso, 2011; Blickman, 2014) – with first attempts in the 1990s that were later backed up by a juridical analysis in their favour (Parés & Bouso, 2015) – and their numbers now growing into the hundreds (Blickman, 2014), there has been little empirical research into the realm of the operation of the social clubs and their actual impact on cannabis users and the related harms.

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The implementation of CSCs seems to be feasible in countries where the national drug legislation allows for joint cannabis cultivation (Arana & Sánchez, 2011; Decorte, 2014). The CSC model originated in Spain, where there are at least 400 CSCs currently, with the majority in Catalonia and the Basque region (Barriuso, 2011; Decorte, 2014). Recently, CSCs have been introduced into Belgium (Decorte, 2015) and Uruguay (Coombes, 2014); experiments with this model can be found in Chile, Colombia, Argentina, the United Kingdom, and France (Bewley-Taylor, Blickman, & Jelsma, 2014), and cannabis social clubs serve medicinal cannabis users in Slovenia, Switzerland, New Zealand, and Italy (Decorte, 2015).

Contrary to recent developments in cannabis market regulation that have occurred in several US states and Uruguay, the operation of cannabis social clubs does not seem to be in breach of the UN drug conventions, notably the Single Convention on Narcotic Drugs (UNODC, 1972). Although the UN conventions do not distinguish between cultivation for supplying others and cultivation for personal use, an implication could be made that cultivation for personal use could be treated non-criminally (Bewley-Taylor et al., 2014), the same as possession for one's own use (Kilmer, Kruithof, Pardal, Caulkins, & Rubin, 2013; UNODC, 2013). In Spain, CSCs are currently using the grey area of federal legislation. According to the Spanish criminal law, consumption itself, as well as the possession of a drug, is not considered a crime but rather an administrative offence (Herrero-Alvarez, 2000). However, it only applies to private places as it is regulated by Organic Law 1/1992 on the Protection of Citizens. CSCs started to expand all over Spain after the Spanish Supreme Court determined that cultivation for personal use (even shared) is not considered a crime if no trafficking is intended. Precedents of users acquiring a drug for fellow-users who were not subjected to criminal prosecution also informed the process of the establishment of CSCs (Arana & Sánchez, 2011).

While the Spanish national laws do not preclude the operation of a cannabis social club, CSCs are, for the most part, not formally recognised or regulated (and thus, explicitly allowed) in most municipalities. So far, only a few cities or autonomous communities have adopted the local regulation of CSCs: the provinces of Girona and of Navarra, the municipality of San Sebastian, and the Parliament of Catalonia. Others are proposing to do so in the near future (Marks, 2015). All over Spain, CSCs have federated in order to encourage regulation, which means to be legally recognised. In order for national or local-level policymakers in Spain and elsewhere in the world to decide whether cannabis social clubs are a favourable option for their national situation, and to be able to design appropriate regulations, a better understanding of the model and its impact on public health and safety is needed.

This paper aims to depict the operation of CSCs and their impact on cannabis users and communities from the perspective of their members. In this sense, it aims to assess the potential of CSCs to reduce the harms associated with cannabis use. It is based on qualitative accounts from cannabis users who took part in focus groups as a part of a pilot study conducted in social clubs in different regions in Spain between September 2013 and May 2014.

This paper takes the perspective of harm reduction (Rhodes & Hedrich, 2010, Chap. 1; Hall & Fischer in Rhodes, 2010). In this sense, it aims at a pragmatic assessment of the potential of CSCs to prevent the harms caused by cannabis use to those already using the substance. As these clubs operate in a closed circuit, it is not expected that they would promote or, by any means, increase cannabis use in people who have not previously used cannabis. It is, however, beyond the scope of this paper to discuss the wider impact of the “normalisation” of cannabis that could occur through the fact that an authorised supply of cannabis, and an environment for its use, exist. It shall be stressed, however, that the non-profit nature of CSCs, as well as the closed-circuit provision, should prevent any such effect from happening.

Background

The harms resulting from cannabis use, as depicted in the literature, pertain to individual health, public health, and to harms related to the illegal market (Roffman & Stephens, 2011). The potential negative implications of cannabis are respiratory risks, mental health risks, the risk of car crashes, the risk of dependence, and social risks (Hall & Fisher in Rhodes, 2010; Hall & Degenhardt, 2009; Hall & Solowij, 1998).

Respiratory risks resulting from cannabis use and other risks to health

The predominant way of administering cannabis is by smoking. Smoking cannabis is similar to smoking tobacco in that it affects the airways and can lead to cancer, chronic bronchitis, chronic obstructive pulmonary disease (COPD), and other health damage; while the daily smoking of cannabis has been shown to increase the risk of pulmonary symptoms (for example sputum, coughing, etc.), the risk of COPD has not been confirmed and no direct link between smoking cannabis and cancer has been found (Owen, Sutter, & Albertson, 2013).

Several studies focused on the comparison between smoking tobacco and smoking cannabis (Roth et al., 1998; Wu, Tashkin, Djahed, & Rose, 1988). Some also compared the effects of different consumption methods, e.g. water pipes, cannabis cigarettes with and without filters, and vaporisation (Abrams et al., 2007; Gowing, Ali, & White, 2000; Hazekamp, Ruhaak, Zuurman, van Gerven, & Verpoorte, 2005). The impact of puffing habits, as well as breathhold, has also been analysed (Azorlosa, Greenwald, & Stitzer, 1995; Zacny & Chait, 1991).

The composition of cannabis exhaust is similar to that of tobacco (Novotny, Lee, & Bartle, 1976; Rickert, Robinson, & Rogers, 1982), with possibly higher concentrations of benzo(a)pyrene and polycyclic aromatic hydrocarbons (Hoffmann, Brunnemann, Gori, & Wynder, 1975), and of tar and carbon monoxide (Gowing et al., 2000).

In addition, as cannabis is commonly acquired on the illegal market or from other non-controlled cultivation settings, a variety of contaminants or adulterants may be present in the product that is smoked. Fungi, bacteria, and mould are frequent contaminants in cannabis, mostly *Aspergillus* fungi (Kurup, Resnick, Kagen, Cohen, & Fink, 1983) or *Penicilium* species (Verweij, Kerremans, Voss, & Meis, 2000). The contaminants of cannabis samples from Dutch coffee shops (thus, grown illegally – see Belackova, Maalste, Zabransky, & Grund, 2015) were the following: *Pseudomonas aureginosa*, *Staphylococcus aureus*, *Escherichia coli*, *Penisillium*, *Cladosporium*, and *Aspergillus* species. Some of these bacteria can produce hazardous mycotoxins such as Aflatoxin B, Ochratoxin A and B, and Sterigmatocystine, which are known to have carcinogenic, neurotoxic, and immune-suppressive effects (Hazekamp, 2006). As a result, it has been demonstrated that cannabis smokers show a higher prevalence of fungi antibodies, compared to tobacco smokers (Kurup et al., 1983).

Besides mould, cannabis can also be contaminated with pesticide residues, heavy metals, or any other substances – especially for cannabis grown indoors in bulk for commercial purposes. Pesticide residues have been found in 38% of the cannabis samples seized in Luxembourg (Schneider, Bebing, & Dauberschmidt, 2013). In areas with soil contamination, heavy metals can be found in cannabis (McLaren, Swift, Dillon, & Allsop, 2008). Serious lead poisoning resulting from cannabis use in Germany was described by Busse et al. (2008); retrieved cannabis samples actually contained visible pieces of lead. According to Cole et al. (2010), the reason for adding such an adulterant could be to increase the weight and so increase the profit. Adulterants found in dried cannabis were glass and aluminium (Exley, Begum, Woolley, & Bloor, 2006).

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