
National Cannabis Strategy 2006-2009

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In November 2004, the Ministerial Council on Drug Strategy (MCDS) agreed to develop a National Cannabis Strategy (the Strategy) and on 15 May 2006 endorsed this National Strategy, as the first of its kind in Australia.

The National Cannabis Strategy 2006–2009 is based on consultations with key stakeholders around Australia and informed by existing literature and evidence. It has been developed on behalf of the Australian Government Department of Health and Ageing under the direction of a Project Management Group chaired by Professor Richard P. Mattick with input from supporting reference groups. Management and research for the project was provided by Ms Jennifer McLaren of the National Drug and Alcohol Research Centre, University of New South Wales, Sydney. The assistance of Eva Congreve and Kate Hetherington, and the comments provided by Jan Copeland, Greg Martin and Wendy Swift of the National Drug and Alcohol Research Centre are gratefully acknowledged. The advice of Jenny Hefford and Alison Rosevear from the Drug Strategy Branch, Australian Government Department of Health and Ageing, are also acknowledged with thanks.

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1. Introduction

1.1 Why does Australia need a National Cannabis Strategy?

Cannabis is the most widely used illicit drug in Australia. Although the use of cannabis has fallen since 1998, the latest household survey indicated that 5.5 million people over the age of 14 have tried cannabis at least once during their lives and almost 800,000 have used cannabis in the week preceding the survey. These figures are likely to underestimate the extent and frequency of use, as participants in household surveys may tend to under-report their cannabis use because of its illicit nature.

Despite the adverse health, social and economic consequences of cannabis use and the fact that cannabis possession and use is illegal in every jurisdiction of Australia, community surveys show that adult cannabis use is 'approved of' by a significant proportion of the Australian community (Australian Institute of Health and Welfare, 2005a). Yet, surveys also show that cannabis is the most common drug associated with having a 'drug problem'.

There are also legislative differences between states and territories, particularly with regards to penalties for cannabis use and possession. Confusion within the general community regarding the legal status of cannabis is sometimes attributed to this difference. All jurisdictions have schemes that divert minor cannabis offenders into health education and treatment, and/or allow for fines to be imposed for the possession of small quantities of cannabis, in recognition of the potential adverse social impact a criminal record can have for someone who would not otherwise come into contact with the criminal justice system. Penalties for the sale, cultivation or trafficking of large amounts of cannabis are, however, significant across all jurisdictions.

Although less well documented and understood than the extent of use, there are broad societal harms arising from cannabis use. Personal use of cannabis is not in isolation from a larger criminal economy. The purchase of cannabis can fund organised crime without the purchaser knowing so, suggesting the need to raise community awareness of this link. Other societal harms include the expenditure on cannabis and the drain of revenue from communities, and the resultant impact on quality of life (especially in small or remote communities).

At an individual level, there is growing evidence that cannabis use, particularly heavy regular use, has the potential to have a significant negative impact on mental and physical health. For example, cannabis use has been associated with: mental health problems; respiratory disorders; tobacco dependence; use of other illicit substances; injury from driving under the influence of cannabis; and educational or occupational failure due to adverse motivational and cognitive impacts. There is evidence that people are using cannabis for the first time at increasingly younger ages, which is of concern given the association between early initiation into drug use and subsequent dependence and negative effects. Additionally, evidence suggests that cannabis use is becoming increasingly more prevalent in Aboriginal and Torres Strait Islander communities, particularly the remote communities of the Northern Territory (Clough et al., 2004). Such communities suffer from the added burden of poor access to services when compared to metropolitan areas. The demand for interventions for cannabis-related problems is increasing, but there is a lack of clearly defined and evaluated treatment options, when compared to what is available for alcohol- or heroin-related problems.

The groups generally thought to be at greatest risk of suffering from problems associated with cannabis use are: young people (due to the decreasing age of initiation of cannabis use among young people and the association between early initiation into substance use and subsequent problems such as dependence, and the risks associated with using cannabis at a developmentally vulnerable age); Aboriginal and Torres Strait Islander peoples (due to high rates of use coupled with long-standing risk factors for poor health and social wellbeing); and people with mental health problems (due to the risk of cannabis exacerbating existing mental health issues). Many users, particularly the young, will be unaware of mental health predisposing factors which might apply to them. Although at-risk groups can be identified, it should be noted that each individual has a combination of risk and protective factors that influence the likelihood that they will go on to develop cannabis-related problems.

Cannabis use rarely occurs in isolation from other drugs, with the underlying causes of harmful cannabis use also underlying harmful patterns of alcohol and other drug use. These underlying causes, also known as the social determinants of drug use, could be a lack of educational, occupational and social opportunities, mental health issues and/or poor family relationships. Some of the social determinants are more common and pronounced within certain population groups, such as Aboriginal and Torres Strait Islander communities. Therefore, while the present Strategy suggests a variety of immediate approaches to address cannabis use, it recognises that cannabis (and indeed alcohol and other drug) use is often associated with these underlying social determinants (and ill health) in general, and supports existing initiatives that aim to address these social determinants.

Further background information about cannabis use in Australia and associated harms can be found in the following National Drug Strategy Monograph: *Cannabis in Australia: use, supply, harms and responses* (Mattick and McLaren, 2006). *The health and psychological effects of cannabis use* (Hall et al., 2001), and *Statistics on drug use in Australia 2004* (Australian Institute of Health and Welfare, 2005b) publications also provide useful background information.

1.2 What is the National Cannabis Strategy?

On 12 November 2004, the Ministerial Council on Drug Strategy (MCDS) agreed to the development of a National Cannabis Strategy (the Strategy) to consider the health, psychological, legal and public health issues associated with cannabis use. The MCDS is the primary body responsible for policy decisions in relation to licit and illicit drugs in Australia and comprises Australian, State and Territory Government ministers from health and law enforcement and the Australian Government Minister for Education Science and Training. This is the first cannabis strategy developed under the *National Drug Strategy 2005–2009*.

The Strategy has been developed within the existing legislative framework. It is consistent with a comprehensive approach to drug-related harm, involving a balance between demand reduction, supply reduction and harm reduction strategies, which is in line with the National Drug Strategy 2004–2009. It encompasses:

- **supply reduction** strategies to disrupt the production and supply of illicit drugs and to control and regulate licit substances;
- **demand reduction** strategies to prevent the uptake of harmful drug use, including abstinence-oriented strategies and treatment to reduce drug use; and
- **harm reduction** strategies to reduce drug-related harm to individuals and communities.

The National Cannabis Strategy also acknowledges and supports the priorities and key result areas of the following existing strategies and plans, which have relevance to the minimisation of cannabis-related harm:

- National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009
- National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing 2004–2009
- National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013
- National School Drug Education Strategy (1999) and Department of Education, Science and Training Principles for School Drug Education (2004)
- Northern Territory Police Remote Community Drug Strategy
- National Alcohol Strategy 2006–2009
- National Tobacco Strategy 2004–2009
- National Mental Health Plan 2003–2008
- National Action Plan for Promotion, Prevention, and Early Intervention in Mental Health 2000
- National Suicide Prevention Strategy

A number of responses suggested in the National Cannabis Strategy are specific to Aboriginal and Torres Strait Islander peoples. The Strategy recommends that the principles of the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009 should be used as a guide when adopting these responses.

1.3 How has the Strategy been developed?

1.3.1 Project management and reference groups

A Project Management Group (PMG) was established to lead the development of the Strategy. The PMG included members of the Australian National Council on Drugs, the Intergovernmental Committee on Drugs and representatives from the health, education and law enforcement sectors. Four discipline-based Reference Groups were also established to provide advice to the PMG throughout the development of the Strategy. These four Reference Groups were:

- Cannabis Law Enforcement Reference Group;
- Cannabis Health and Treatment Reference Group;
- Cannabis and Mental Health Reference Group;
- Cannabis Research Reference Group.

The development of the Strategy was informed by existing knowledge and research, and a comprehensive national consultation process, which involved consultation forums in metropolitan and regional areas and a written submission process.

1.3.2 Existing knowledge and research

A range of resources were available from previous efforts in Australia to inform the development of this National Cannabis Strategy. These include monographs on drug trends

(Australian Institute of Health and Welfare, 2005b, Australian Institute of Health and Welfare, 2005a, Australian Institute of Health and Welfare, 2002), approaches to prevention utilising law enforcement and other strategies (Loxley et al., 2004), and the health and psychological effects of cannabis use (Hall et al., 2001).

A National Drug Strategy monograph, *Cannabis in Australia*, was developed to provide an overview of cannabis use and problems in Australia at the present time. It drew on existing research and policy documents, as well as input from the PMG and Reference Groups, and provides information about current patterns of use in Australia and emerging trends, the harms associated with cannabis use, and the legislative status of cannabis around Australia and internationally.

1.3.3 Consultation process

Representatives from a range of sectors were invited to attend consultation forums that occurred around the country between September 2005 and February 2006. Attendees were given the opportunity to express their views on what should be considered when developing the National Cannabis Strategy. Feedback forms were also collected at the forums, which gave attendees the opportunity to suggest specific strategies that they thought should be included in the National Cannabis Strategy to address issues salient to their area.

At least two forums were held in each state and territory, usually in the capital city and in a regional or rural town. Separate forums were held for Aboriginal and Torres Strait Islander peoples, young people, and regular cannabis users, in addition to these groups being represented at the more general forums. Whilst the forums were open to members of the public, invitations also targeted experts in the field including those from health, law enforcement, education and community organisations.

As well as the face-to-face consultation forums, organisations and members of the general community were invited and encouraged to submit their views in written form. Additionally, a number of organisations and expert individuals were consulted separately from the forums.

1.3.4 Principles of strategy development

The National Cannabis Strategy used the same principles as the National Alcohol Strategy 2005–2009, including: building on existing efforts and plans; broad consultation; drawing on available empirical research evidence; considering trends to date and issues and concerns about cannabis use; focusing on key areas (including at-risk groups, prevention, supply reduction, harms associated with cannabis use, treatment provision); and identifying responses which could realistically be implemented in a timely fashion. In some areas clear empirical evidence was not always available, and indeed for this reason the Strategy also includes areas for research to assist future policy and program development.

As used elsewhere, the main method used in the development of the Strategy was an analysis of information and opinions collected from:

- the Project Management Group and four Reference Groups;
- comments on the publicly available Consultation Paper (available on a web site advertised in major newspapers around the country);
- national consultation forums with key stakeholders;

- consultations with members of the community;
- consultations with organisations and experts;
- written submissions put forward by organisations and members of the general public;
- a review of local and international literature;
- a review of recent trends in cannabis consumption and harm in Australia;
- a review of current policies and programs related to cannabis around Australia.

Snapshot of consultations

-
- Consultations with 814 stakeholders
 - 21 consultation forums around Australia
 - 307 feedback forms received
 - 106 written submissions received
-

2. Strategic Framework

2.1 What are the priority areas of the Strategy?

The four Priority Areas that have been identified are derived directly from the numerous and varied issues and responses that were raised through the national consultations and from the literature and evidence in this area, as well as from the advice of the Project Management Group and Reference Groups.

Developing priority areas for the National Cannabis Strategy initially led to dividing them into the traditional areas of prevention, education, law enforcement/supply reduction, treatment, mental health, harm reduction, and research. However, activities in one area or by one sector may have impacts in other areas. For example, although the law enforcement sector has the important role in reducing the supply of cannabis, it also plays an important role in preventing the use of, and harms related to, cannabis in Australian society. An example of this role is the Illicit Drug Diversion Initiative, which is part of the national approach to early intervention and prevention of illicit drug use. Similarly, treatment or intervention may reduce demand and thereby reduce offending.

The following four Priority Areas have been determined as the focal points for the National Cannabis Strategy 2006–2009:

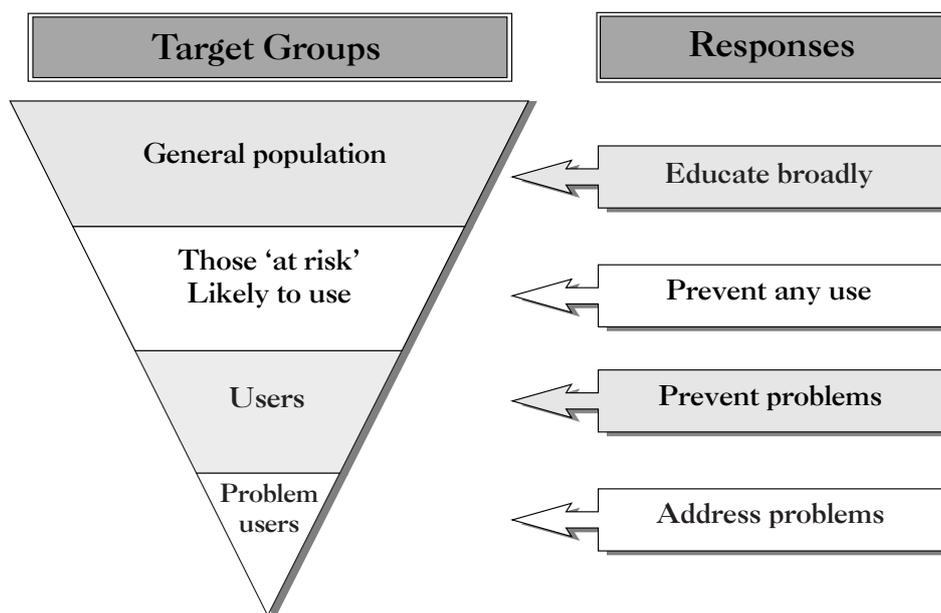
- Priority Area 1: Community understanding of cannabis
- Priority Area 2: Preventing the use of cannabis
- Priority Area 3: Preventing problems associated with cannabis
- Priority Area 4: Responding to problems associated with cannabis

These areas address a continuum of need from provision of simple information to the broad community, to preventing any use, to preventing problems associated with use, and to dealing with problems that arise from use (e.g., dependence). The Strategy aims at: the broad population; the at-risk groups (young people, Aboriginal and Torres Strait Islander peoples, and those with mental health problems); all users of cannabis (even occasional users); and finally those with significant problems associated with use of cannabis (see Figure 1). The objective and aims are set out in the next section, but the broad thrust of the Strategy includes recognition of the need to:

- educate the community about cannabis use patterns, associated harms and problems and reduce the level of acceptability of cannabis use within the community;
- prevent use in the community through prevention strategies including supply reduction through law enforcement, since the most effective way of preventing the harms associated with cannabis use is to avoid using cannabis at all;
- assist those who already use cannabis, to decrease use and prevent the graduation from occasional to frequent cannabis use, and therefore minimise the harms associated with this pattern of use;
- reduce the individual and broad societal problems associated with cannabis use.

The Strategy includes a set of responses under each Priority Area, which encompass supply, demand and harm reduction strategies. Table 1 below shows the way that the current Priority Areas map to the Priority Areas of the National Drug Strategy.

Figure 1. Continuum of responses and target groups within the National Cannabis Strategy



While there are different ways of organising the priorities into domains, the four Priority Areas presented above seemed to best deal with the breadth of the responses generated in the consultation process. In the consultation process, the ideas generated appeared to fit most naturally into these four domains. Consultation participants advocated for the four Priority Areas as the best way of communicating the Strategy whilst recognising that the broader National Drug Strategy 2005-2009 provided the framework for the Strategy (see Table 1). This being the first national strategy for cannabis, future strategies may choose to utilise different ways of conceptualising and organising issues and responses.

Table 1. Relationship between National Drug Strategy and National Cannabis Strategy Priority Areas

National Drug Strategy Priority Areas	National Cannabis Strategy Priority Areas
Prevention	Priority Area 2: Preventing the use of cannabis Priority Area 3: Preventing problems associated with cannabis
Reduction of supply	Priority Area 2: Preventing the use of cannabis
Reduction of drug use and related harms	Priority Area 1: Community understanding of cannabis Priority Area 2: Preventing the use of cannabis Priority Area 3: Preventing problems associated with cannabis Priority Area 4: Responding to problems associated with cannabis
Improved access to quality treatment	Priority Area 4: Responding to problems associated with cannabis
Development of the workforce, organisations and systems	'Workforce development' is addressed in a special section in the National Cannabis Strategy
Strengthened partnerships	'Partnerships' are addressed in a special section in the National Cannabis Strategy.
Implementation of the National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan	The Aboriginal and Torres Strait Islander Peoples Complementary Action Plan is included and supported in the National Cannabis Strategy. Responses targeting Aboriginal and Torres Strait Islander peoples is included in each priority area across the Strategy.
Identification and response to emerging trends.	This Priority Area relates to two sections in the National Cannabis Strategy: Building the evidence base (research), and Monitoring and evaluation.

2.2 What is the objective and what are the aims of the Strategy?

Objective:

Reduce the availability and demand for cannabis, and minimise related harms within the Australian community.

Aims:

-
- increase community knowledge about cannabis in Australia and associated harms and influence the level of acceptability of cannabis use within the Australian community;
 - prevent the uptake of cannabis use and minimise use in individuals and the community;
 - prevent and minimise the social, physical, mental and financial harms to individuals and the community that are associated with cannabis use;
 - provide effective and accessible interventions, tools, treatments and support for those who develop problems associated with their cannabis use.
-

2.3 What type of response is recommended?

Under each Priority Area there is a set of specific responses and actions recommended to implement the responses. Some of the recommended actions are more detailed than normally found in a National Strategy. This is due in part to the nature of cannabis: being an illicit substance, there is a narrower range of measures that can be put into place for cannabis than are available for regulated legal substances such as alcohol or tobacco. However, there are also a range of law enforcement responses that are not available with legal substances.

Within each Priority Area, examples of good practice are cited to alert the reader to already existing responses. The examples of good practice are not meant to be an exhaustive list of the available responses in Australia.

In developing the responses through the consultation and other processes, some guiding principles were used.

1. Evidence-based responses drawing on existing knowledge or seeking further information to support the response.
2. A mixture of short-term responses to the issues identified under each Priority Area, and medium- or long-term solutions that can be substantially carried out within the time-frame of the Strategy.
3. A range of community-wide and targeted responses.
4. Link to or build upon existing strategies or plans.

3. Priority Areas

3.1 Priority Area 1: Community understanding of cannabis

Aim:

Increase community knowledge about cannabis in Australia and associated harms, and influence the level of acceptability of cannabis use within the Australian community

3.1.1 What is the issue?

A consistent theme raised throughout the consultations was the lack of clear knowledge and understanding within the community concerning cannabis use and problems associated with use. There is a strong perception that many people in the community view cannabis as a relatively harmless drug, even though recent media coverage has emphasised that there are harms associated with cannabis use. It was argued that there is confusion about the risks of cannabis use and that there is a need to have clear and accurate information available to the community.

Repeatedly, consultation participants raised the issue that some members of the community believe that cannabis possession and use is not illegal. It was thought that the differing penalty options for cannabis possession and use in each jurisdiction may have compounded the lack of understanding of the illegal status of the substance.

These views, expressed by those consulted as part of the development of this Strategy, were confirmed by research. In a national survey published in 1995, it was found that one in four Australians did not know whether there are any negative health effects of cannabis use, and that almost all people interviewed thought that the government should educate the community about cannabis and its effects (Hall & Nelson, 1995). More recently, the National Drug Strategy Household Survey revealed that over one-quarter of Australians ‘approved of’ regular use of cannabis among adults (AIHW, 2005). However, a similar proportion of respondents thought cannabis was the most likely substance to be associated with a ‘drug problem’. It is this diversity of opinion that creates confusion in the community about the real harms associated with cannabis. It is important to provide the community with consistent, evidence-based messages about cannabis (such as legal status, harms, signs of dependence, treatment options, etc.) so that people are aware of the risks associated with cannabis use and can seek advice or help when required.

A range of approaches is needed to deliver this information to identifiable at-risk groups within the community, including users (in particular those who are considered heavy users), young people, Aboriginal and Torres Strait Islander peoples, and people with mental health problems, as well as to parents, families, carers, those from culturally and linguistically diverse backgrounds, health, education and law enforcement professionals, and key decision-makers including politicians. It would be wrong to focus only on young people (or any other population sub-group, such as Aboriginal and Torres Strait Islander peoples or only those with mental health problems), as harmful cannabis use is experienced by all age groups and sectors of society.

3.1.2 What responses are recommended?

1A Determine current community knowledge about cannabis use and health and social risks

- Benchmark community understanding of the health and psychological effects of cannabis use, the legal status of cannabis, and their attitudes towards cannabis, through the use of population survey(s).
- Use these results to develop and disseminate a variety of information resources to meet the needs of and engage with a range of target audiences, with a particular focus on at-risk groups (including Aboriginal and Torres Strait Islander communities, young people, and those with mental health problems).

1B Use social marketing campaigns to raise public awareness of the health and social consequences of cannabis use

- Develop and implement ongoing social marketing campaigns (similar to the Quit tobacco campaigns). These campaigns should allow for differences in communication methods, literacy levels and content for different groups (e.g., Aboriginal and Torres Strait Islander peoples, those from culturally diverse backgrounds, family/carers, young people including those not in school, and users) and should convey messages to increase knowledge of:
 - the legal status of cannabis, the differences in legislation (between states and territories, and between the Commonwealth and the states and territories), the fact that cannabis possession/use is illegal across Australia, and that the continued prohibition of cannabis is due to dangers surrounding its use;
 - the true extent of regular cannabis use (to reduce the perception that frequent cannabis use is a normal behaviour);
 - harms associated with supply (economic drain to communities) and cannabis use (mental health problems, dependence, impact on driving skills, etc.);
 - the most risky patterns of use, particularly the relationship between early cannabis use, daily or near daily use, and the range of adverse outcomes;
 - signs and symptoms of cannabis problems (i.e., abuse and dependence);
 - treatment options for dependent users; and
 - the link with tobacco use.
- Work with the television and other electronic media industries to utilise popular television shows, such as teenage drama, advertising and press, to convey accurate and realistic messages about cannabis use and the associated harms.
- Involve Aboriginal and Torres Strait Islander peoples in the creation of a tailored social marketing campaign through Aboriginal and Torres Strait Islander peoples networks (e.g., *Imparja network*, *Koori Mail*, *National Indigenous Times*, *Deadly Vibe*), using appropriate language and using Aboriginal and Torres Strait Islander actors to demonstrate harms.

1C Provide information on the harms associated with cannabis use

- Promote a “Cannabis Line” to provide information to parents, friends and users to enhance public knowledge about cannabis. This Cannabis Line would utilise existing infrastructure and could operate in a similar manner as the tobacco Quitline; people suffering from cannabis-related problems, as well as their families or carers, could call the telephone line to obtain information or referral. See response 4A for more information.

- Use pamphlets and/or advertising in primary health care settings such as general practices, pharmacies and hospital waiting rooms to alert the public to the harms associated with cannabis use, including the message that the patients (users or friends/relatives) should ask their doctor/pharmacist/nurse for advice.
- Encourage communities to engage in informed debate about the impacts of cannabis and possible local solutions, especially in remote and regional Aboriginal and Torres Strait Islander communities.
- Ensure that cross-linking occurs between the range of cannabis-related web sites with relevance to different sectors of the community, such as Aboriginal and Torres Strait Islander peoples sites, youth sites, mental health sites, research sites, government sites, and general drug information sites.
- Provide every municipal council in Australia with copies of resources, especially outstanding Australian work, and access to electronic resources on cannabis use and harms, for use in their local libraries and community centres, and ensure resources go to all other public libraries and parliamentary libraries.
- Provide key decision makers and policy makers in Australia with copies of resources, especially outstanding Australian work, and access to electronic resources on cannabis use and harms, to enhance the accuracy of the information available to them. Key decision- and policy-makers should include all members of the Ministerial Council on Drug Strategy and the Intergovernmental Committee on Drugs, senior health, education and law enforcement officers, members of the judiciary, and health, education, law enforcement and corrections ministers.
- Ensure that law enforcement, in partnership with community controlled organisations, health institutions and/or community leaders, has an active role in providing information to be used in education of communities about the social, criminal and financial harms associated with cannabis production, trafficking and use within their community. Aboriginal and Torres Strait Islander communities are an area of particular focus.
- Educate the judiciary and prosecutors about the harms associated with cannabis production and trafficking through judicial training courses, and through community impact statements presented by prosecutors in court.
- Inform individuals with a personal or family history of mental illness that cannabis use can exacerbate symptoms of anxiety, depression and psychosis, based on current research. Encourage discussion of this information with other family members.

1D Influence the social acceptability of cannabis use

- Educate the community that parental cannabis use provides a negative role model for young people, and there is a need to emphasise to parents that their use of cannabis is likely to influence their children's use of cannabis, as well as their attitude towards other drug usage. Parental influence on young people's drug use should not be underestimated, and there is a need to treat parents and families as a primary target audience for education and support as a prevention strategy.
- Increase community awareness and understanding of the greater harms associated with current patterns of use compared to past patterns of use, due to the use of more potent parts of the plant and more frequent use.
- Capitalise on existing government and community success in preventing uptake of smoking tobacco, by informing the community about the link between cannabis use and tobacco dependence.

- Increase community awareness of the legal consequences for drug possession and the potential for cannabis users to be drawn into criminal activity to support heavy or dependent use.
- Investigate if the public display of devices for smoking cannabis influences community perceptions about the legal status and harms caused by cannabis, and assess what additional interventions could be considered by jurisdictions to improve the effectiveness of prevention and education messages about the illicit nature and harms of cannabis - especially for children and young people.

3.1.3 Examples of good practice

Below are examples of good practice gleaned from the consultation process that can be used as exemplars of approaches that may prove helpful within this Priority Area.

Somazone: A web site by young people for young people

- A program of the Australian Drug Foundation in Victoria, Somazone is a web site for young people (aged 12 to 25 years), developed by young people. It covers a wide variety of issues relevant for young people, including cannabis.
- It includes anonymous, non-judgemental advice and information from experts as well as peers.
- It uses up-to-date techniques for information sharing, such as podcasts.
- Over 50,000 young people access the site each month, including a significant proportion of 'hard to reach' young males and people in regional and remote areas.

Australian Drug Foundation

Strong Spirit, Strong Mind. What our people need to know about gunga: The Aboriginal Cannabis Education Session

- The development of culturally secure resources for Aboriginal and Torres Strait Islander peoples has been a priority of the Aboriginal Alcohol and other Drugs Program at the Drug and Alcohol Office, Western Australia.
- The Aboriginal Cannabis Education Session includes a video resource, brochures, and booklet. The content is culturally secure and based on evidence-based practice for alcohol and other drugs, particularly as it relates to working with Aboriginal people, their families and communities.
- This program includes information about the laws relating to the use, possession, and cultivation of cannabis in WA.
- The program can be used as an educational and therapeutic tool to enhance awareness about the health and social consequences of cannabis use for Aboriginal people, their families and communities.
- Furthermore, the program is designed to develop ways that individuals can evaluate their cannabis use, access support and gain appropriate skills to make changes.

Drug and Alcohol Office, Government of Western Australia

Illicit Drugs Community Awareness and Advertising Campaign

- This campaign was developed in response to concerns that many young people were not aware of the harms caused by drug use and how it can affect them physically, emotionally and socially.

- From July 2001 to February 2002, television, cinema and radio advertisements, print media and mobile billboards focused on cannabis, heroin and ecstasy, supported by an information, counselling and referral helpline.
- The campaign was developed from consultation on the place of drugs in the lives of young people. The successful targeting and structuring of the campaign was evident by the 4,600 calls to the 1800 helpline for information, counselling and referral. Of these, where drug use was identified, 61 per cent were current drug users. Significantly, the cannabis advertisement inspired cannabis users, and young male cannabis users, in particular, to make a call to the helpline. An evaluation showed significant recall by the community of the campaign's messages.

Department of Human Services, Victoria

Cannabis Information Campaign

- This campaign aimed to target early and potential users of cannabis, encourage discussion about cannabis use, and help young people become more aware of its social and other effects. It involved a three-phase campaign using posters and radio advertisements.
- In June 2004, phase three was rolled out and included a series of six posters featuring young people, outlining possible impacts on friendships and relationships, physical health, driving ability, workplace behaviour and finances. High schools across New South Wales received copies of these posters for display.
- The evaluation findings indicate a significant increase in teenage perceptions that cannabis: is a major cause of social problems; has serious negative effects on health; and can lead to missing out on opportunities.

New South Wales Health

Drugs and mental illness: Public awareness campaign

- This is a project aimed to provide evidence-based advice about the comorbidity of mental illness and drugs, with particular emphasis on cannabis, through a public awareness campaign.
- The target audience is young people aged 12 to 25 years.
- The proposed campaign is consistent with the objectives of the National Comorbidity Initiative.

Department of Health and Human Services, Tasmania

Cannabis and the law brochure and information card

- ACT Health and ACT Policing have joined forces to develop the Cannabis and the Law brochure, as well as a wallet size information card to provide information to cannabis users in the ACT of the legal implications of using cannabis.
- This brochure has been distributed widely through treatment centres, community organisations and police stations.

ACT Police and ACT Health

3.2 Priority Area 2: Preventing the use of cannabis

Aim:

Prevent the uptake of cannabis use and minimise use in individuals and the community

3.2.1 What is the issue?

The reasons for commencing substance use are rarely straightforward; thus, preventing use is a broad and complex task. Research has shown that there is no single risk factor that leads to substance use; rather, environmental and societal factors impact on the individual and affect health and social outcomes, including problematic drug use such as harmful cannabis use (Spooner, 2005). Each individual is subject to a combination of risk factors (e.g., poor family functioning, unemployment, and local drug availability) and protective factors (e.g., positive peer influences, positive family functioning, education, and high socio-economic status) that increase or reduce the likelihood that they will go on to develop a substance use disorder.

Comprehensively addressing the social determinants of cannabis use is an enormous task that is beyond the scope of the National Cannabis Strategy. Thus, effective preventive responses that minimise use and harms in individuals and the community, and are evidence-based and achievable within the Strategy's time-frame, are recommended. These responses can be built upon in future iterations of the National Cannabis Strategy. Additionally, the social determinants of cannabis use need to be recognised and methods to address them supported.

The role of law enforcement in prevention has been highlighted through the consultation process. The preventative role played by law enforcement professionals of disrupting the supply of cannabis is perhaps obvious, but law enforcement does also influence community attitudes about drug use and prevent early offenders from starting more problematic cannabis use through diversion programs (see Priority Area 3). This role is strongly emphasised by drug law enforcement groups: the activities of the law enforcement sector act to reduce supply of, but also demand for, illicit drugs by increasing costs associated with use, reducing funds to purchase drugs by investigating and prosecuting acquisitive crimes, and by imparting a message to the community that illicit drug use is not condoned (Australasian Centre for Policing Research, 2003).

Information provided to young people via school-based education is an important component of prevention of uptake of cannabis use (Loxley et al., 2004). Information should also be provided to young people who may not be engaged in education. In addition to the school-based education responses suggested in this Priority Area, the responses suggested in Priority Area 1 will affect uptake of cannabis by educating those in the broader community about the harms associated with use.

3.2.2 What responses are recommended?

2A Reduce the availability of cannabis in Australia

- Continue to support the reduction of cannabis supply and availability at all levels, through the:
 - ongoing efforts of the Australian Customs Service and the Australian Federal Police (AFP) to reduce the supply of cannabis at the Australian border and internationally;

- efforts by state and territory police to reduce the supply of cannabis grown within Australia;
- appropriate joint initiatives between Customs and the AFP and individual state and territory police services to protect Australia's borders from drug trafficking.
- Continue to support and encourage intelligence sharing:
 - between jurisdictions and through regional and international joint agency investigations;
 - through improved intelligence monitoring strategies, to build on the existing information base on organised criminal networks that distribute cannabis and underpin cross-jurisdictional and intelligence-led responses;
 - by encouraging information exchange between the community and law enforcement.
- Recognise that intelligence and law-enforcement strategies specifically designed for remote Aboriginal and Torres Strait Islander communities are needed, given the high visibility of police in these communities and consequent difficulty in carrying out normal police and intelligence practices.
- Encourage the real estate industry, local government, electricity and other utility providers, as a part of a police intelligence process, to provide information regarding suspected cannabis production and trafficking.
- Recognise the commerciality of cannabis production and target organised production/crime. When considering investigations, law enforcement should put their resources into those investigations that will have the greatest impact on reducing harms within the general or specific communities, including in remote Aboriginal and Torres Strait Islander communities.
- Assess the feasibility of the regulation of the sale of hydroponic equipment, similar to regulation of the liquor and second-hand dealer industries, at a national level whereby: businesses selling hydroponic equipment need to register on a police-controlled database; business owners must be judged to be of good character; and the identification details of purchasers need to be recorded. Evaluate the impact of these increased regulatory controls.
- Ensure penalties consistent with the penalties contained in the Model Criminal Code (Model Criminal Code Officers Committee, 1998) for drug offences, which provide an appropriate deterrent to production and trafficking of commercial quantities of cannabis.
- Apply relevant international best practice examples and strategies in relation to cannabis supply reduction and prevention.
- Support knowledge-sharing between jurisdictional law enforcement bodies through, for example:
 - sharing current best practice as well as developing experimental methodology for linking large seizures;
 - an examination of cross-jurisdictional information collections and needs concerning cannabis drug markets and organised crime, monitoring cannabis consumption and trafficking trends, and how this information may be best accessed nationally.

2B Address the causes of illicit drug use and poor health and social outcomes.

- Support and expand existing early intervention programs that have been shown to be effective in improving health outcomes such as reducing or preventing later problematic cannabis use, and investigate potential new programs.
- Acknowledge and support existing State Government-wide initiatives to address disadvantage.

- Provide information to ensure all decision-makers in all governments are aware that illicit drug abuse and the poor health and social outcomes experienced in marginalised populations are driven significantly by the ways that policies structure our society (i.e., the social determinants of health). Promote local resources and reviews that demonstrate this relationship.
- Support national initiatives to identify at-risk children to target early childhood interventions, crime prevention initiatives, responsible parenting initiatives, and programs to ensure retention in school.
- Support national initiatives to connect at-risk young people with training and employment opportunities.
- Expand successful early childhood parent education programs (such as the Triple P Positive Parenting Program) and investigate the effectiveness of these programs for Aboriginal and Torres Strait Islander peoples and the long-term effect of these programs on problematic cannabis and other substance use.
- Support programs aimed at improving schools' responses to at-risk children.
 - Develop or support strategies for improving retention in school, especially for those at risk of school failure and/or expulsion associated with cannabis use.
 - Support the current development and implementation of policies within schools, guided by the *National Framework for Protocols for Managing the Possession, Use and/or Distribution of Illicit and Other Unsanctioned Drugs in Schools* (Department of Education Science and Training, 2000), that provide evidence-based alternatives to suspension/exclusion/expulsion such as diversion to accredited counselling.
- Utilise the available evidence on social determinants and risk and protective factors in the development of prevention initiatives to address issues underlying cannabis use.

2C Ensure that effective school-based education on cannabis is delivered

- Support state/territory and national efforts to ensure that school-based drug education is effectively implemented across schools.
- Support state/territory and national initiatives that are already in place to ensure that any school-based drug education is consistent with current best practice, as identified in existing reviews (e.g., Midford et al., 2000) and government documents, such as the *Principles for school drug education* (Department of Education Science and Training, 2004).
- Ensure schools have access to and are encouraged to use up-to-date resources and web sites.
- Attempt to influence Technical and Further Education (TAFE) courses to incorporate information about cannabis into courses, or ensure that TAFE students are exposed to such information.
- Ensure that teacher training at university includes training in drug education issues.
- Whilst building on and acknowledging existing evaluations at a national, state and territory level, assessments of the effectiveness of school-based drug education within the Australian context should continue to be conducted and the results used to further improve existing programs. When conducting assessments, realistic outcomes for school-based drug education should be acknowledged, given many other influences in young people's lives that affect drug use.

3.2.3 Examples of good practice

Below are examples of good practice gleaned from the consultation process that can be used as exemplars of approaches that may prove helpful within this Priority Area.

Remote Community Drug Desk

- The Drug Enforcement Section Remote Community Drug Desk (RCDD) was tasked with the coordination, implementation and leadership of strategic and tactical operations aimed at disrupting the distribution of drugs to and within remote communities.
- These operations take on the following forms of intelligence-led approaches to problem solving: tactical deployments; covert investigations; targeting operations; developing partnerships; seasonal strategy; community impact; review and development.
- Since its inception, and with assistance from Operations Command members and the Drug Detector Dog Unit, the RCDD has been highly successful in targeting, investigating and prosecuting those involved in the distribution of drugs to remote communities.
- Over the past twelve months the RCDD has arrested or summonsed over 100 people in relation to over 130 drug- and firearm-related charges and has intercepted cannabis destined for Northern Territory remote communities. In addition, the RCDD has seized cash and assets from persons involved in the distribution of drugs to remote communities.

Northern Territory Police

Substance Abuse Intelligence Desk

- The Australian Government recently entered into an agreement with the Northern Territory, South Australia and Western Australia police to introduce a supply reduction strategy to address the issue of licit and illicit substances (including petrol, drugs and alcohol) being supplied to the cross-border region of central Australia.
- The establishment of a tri-state Substance Abuse Intelligence Desk (SAID), which is based in Alice Springs, serves as a collection point for intelligence and associated investigations.
- The SAID is responsible for coordinating joint policing operations which focus on identifying and apprehending those persons responsible for supplying licit and illicit substances to the cross-border region. These operations are supported by education campaigns, innovative problem-solving techniques and inter-agency collaboration.

South Australia, Northern Territory and Western Australia Police Services

Partnerships between law enforcement and housing rental authorities

- In a number of jurisdictions (for example, South Australia, Western Australia and Victoria), partnerships between the police service and housing rental authorities or organisations have been established to help police become aware of, and stop the use of, rental properties as sites for hydroponic cannabis production.
- Victoria, South Australia and Western Australia Police have developed booklets outlining how property managers and owners, community housing groups and rental housing cooperatives can work with the police to tackle the problems associated with the illegal cultivation of cannabis in rental properties.

Victoria, South Australia and Western Australia Police Services

ConnectUs

- This program is an initiative of the Premier's Drug Prevention Council in Victoria and aims to prevent problematic alcohol and other drug use in young people who are disengaged from education.
- ConnectUs provides access to employment, education and training opportunities to young people aged 16-20 showing signs of risk indicators such as truancy, being enrolled in an employment agency, or showing no intention of completing secondary studies.
- ConnectUs works via partnerships with business, community organisations and labour market program providers.
- In 2005, the program has been improved to reflect a review conducted in 2004. Monitoring and evaluation of the program continues.

Premiers Drug Prevention Council, Victoria

Improved partnership between schools and police in responding to drug-related incidents in schools

- Tasmania Police established memorandums of understanding with the Department of Education, the Catholic Education Office and the Association of Independent Schools of Tasmania setting out protocols for managing drug-related incidents in schools, including the use and possession of cannabis.
- The protocols clarify roles and steps to be taken in terms of notifying police, securing drugs and related paraphernalia, levels of response to match the circumstances of an incident, and formalise arrangements to ensure procedural fairness and ongoing management and liaison, including responding to the media.
- Police officers may also be requested by schools to provide input into school-based drug policies by providing advice about drugs and the law and supporting School/Community Forums convened by schools.

*Tasmania Police, Tasmania Department of Education,
Catholic Education Office, and Association of Independent Schools of Tasmania*

Partnerships between law enforcement and industry: The Frontline program

- The Frontline program is a voluntary cooperative link between Customs and industry groups and companies involved in international trade and transport. The program, which has been running since 1990, aims to increase the cooperation, exchange of information and mutual education between Customs and industry members in order to prevent illicit drug trafficking and the entry of illegal and harmful goods into Australia.
- Customs and the industry member sign a memorandum of understanding which sets out the agreed expectations and interests of the parties. Frontline members and their employees are given awareness training and provided with information to assist them identify activities or incidents that are of interest to Customs.
- There are in excess of 750 Frontline members Australia-wide, from a variety of industries including shipping, freight forwarding, airlines, couriers, and postal services. Information reports received from Frontline members generate a range of seizures of prohibited substances and goods including seizures of cannabis.

Australian Customs Service

Cannabis education in schools

- The NSW Department of Education and Training has developed resources, based on extensive focus group testing with parents, teachers and students, to help teachers to deliver cannabis education consistent with best practice.
- Evaluation of these materials indicated that the cannabis education lessons improved the students' knowledge about cannabis, their confidence in their ability to make informed decisions about drug use, and their refusal skills in relation to cannabis. Overall, teachers and students responded positively to the interactive nature of the lessons, which catered for a variety of learning styles.
- Feedback from the evaluation was used to refine the education materials before they were provided to schools. A training program offered state-wide was then available to teachers to assist them to implement the materials.
- Materials include: Cannabis: Know the risks!, for teaching secondary school students about cannabis in Years 7 to 10; and Primary Prevention – A cannabis education resource for Stage 3, for teachers wishing to include cannabis education as part of drug education for upper primary school in communities where this is a local need.

NSW Department of Education and Training

3.3 Priority Area 3: Preventing problems associated with cannabis

Aim:

Prevent and minimise the social, physical, mental and financial harms to individuals and the community that are associated with cannabis use

3.3.1 What is the issue?

Although cannabis does not cause death due to toxicity in humans, there is growing evidence that cannabis use has the potential to have adverse physical, psychological and social outcomes, and that it contributes to mortality and morbidity. These harms should be prevented where possible, but need to be minimised in those who currently use cannabis (National Drug Strategy, 2004).

The harms that can occur from cannabis use are varied. For example, the short-term adverse effects of cannabis intoxication can lead to an increased risk of vehicle collisions. Cognitive abilities are compromised while under the influence of cannabis, which has the potential to affect performance at work or school. There can be adverse life impacts associated with having a criminal record for cannabis possession. All jurisdictions have the option of police diversion programs or infringement notice systems in place that means that someone caught for the first time with a small amount of cannabis for personal use may not end up with a criminal record if this was the only offence committed. However, the penalties for the sale, cultivation or trafficking of larger amounts of cannabis are significant.

The community can suffer from harms from the illicit cannabis trade, such as fires and property damage as a result of rental properties being used to cultivate hydroponic cannabis. Violence and other criminal activity is associated with attempts to steal cannabis products or crops, which cause community harm and place added drain on police resources. Other community or societal harms include the expenditure on cannabis and the drain of revenue from communities, and the resultant impact on quality of life (especially in small or remote communities).

Those who progress to heavy, long-term cannabis use are most at risk of cannabis-related harms. Frequent cannabis use can lead to dependence, which may mean that most of someone's time and money is spent obtaining cannabis. It can also lead to adverse psychological consequences (Hall, 2006). Recently, there has been much attention given to the relationship between cannabis use and mental health, especially psychosis. There is reliable research indicating that cannabis is a risk factor for psychosis, in particular for those who are predisposed to developing a psychotic disorder. There is still debate about whether cannabis alone will lead to a psychotic disorder such as schizophrenia.

The most common route of administration of cannabis is smoking, which has the potential to have adverse effects on the respiratory system. Additionally, there is a risk of becoming dependent on nicotine and suffering from the known adverse effects of tobacco, due to the common practice of mixing tobacco with cannabis when smoked. There is also some evidence that frequent cannabis use can lead to long-term cognitive problems.

When the Strategy mentions 'cannabis problems', or 'problematic cannabis use', this refers to disorders such as 'cannabis abuse', which is a pattern of use that causes physical or

psychological harm, or ‘cannabis dependence’, which is a persistent harmful pattern of use that is preoccupying and is difficult to cease. Cannabis abuse and cannabis dependence can both have adverse impacts on social, occupational, and educational functioning.

Strategies employed to prevent the problems associated with cannabis use need to be diverse and targeted correctly (e.g., those at risk of becoming heavy users, since heavy use is associated with cannabis problems). The Strategy recognises the issues of remote communities, such as geographical isolation, limited service provision, and difficulty in recruiting and retaining appropriately trained staff.

3.3.2 What responses are recommended?

3A Ensure that cannabis users are aware of harms associated with cannabis use and know how to minimise problems associated with cannabis use.

- Ensure that information about harmful patterns of use are available widely, included in school-based education, tertiary education settings, juvenile justice settings, youth work settings, police stations, workplaces, entertainment venues, and health services. The increased risk of developing cannabis-related problems, such as mental health problems, with more frequent cannabis use (e.g., weekly use) needs to be advertised to those who use cannabis through these settings.
- Recognise and convey the harms associated with the very high rates of use of cannabis in some Aboriginal and Torres Strait Islander communities.
- For those jurisdictions that allow the sale of cannabis smoking equipment, the feasibility of regulating the sale of these products should be investigated.
 - For example, consider preventing the public display of such equipment, on the basis that it detracts from educational messages about the illicit nature of cannabis and its harms.
 - Regulation could also require retailers selling smoking paraphernalia to adhere to a set of minimum requirements including the display of a health warning about cannabis use, provision of information on the harms associated with cannabis use, and the prohibition of selling equipment to minors.
 - Include harm reduction messages in the information offered to those buying smoking equipment, such as:
 - v use of cannabis with tobacco may lead to tobacco dependence;
 - v use of cannabis everyday or multiple times a day may lead to cannabis dependence;
 - v if suffering from a mental disorder, or if family history of a psychotic disorder is present, the risk that use of cannabis may cause mental health problems is increased;
 - v using cannabis and alcohol together increases the risks of short-term harm, such as injury or accident, from intoxication.

3B Develop and promote the use of strategies for prevention of cannabis problems among those individuals who are likely to make the transition from occasional to heavy cannabis use

- Promote programs that recognise and emphasise: the damage that can occur with frequent heavy use and prolonged and uninterrupted cannabis smoking; use of cannabis in combination with other drugs; and the signs and symptoms of dependence. To reach

at-risk individuals, a range of novel approaches will be required and may include mail-outs, internet sites, and telephone advice. Culturally secure and specific methods for reaching Aboriginal and Torres Strait Islander peoples will be necessary.

- Consider the use of appropriate self-report and other brief self-administered tools for screening and identification of cannabis problems.

3C Develop strategies to prevent and reduce concurrent cannabis intoxication and driving

- Trial and evaluate the appropriateness, accuracy and impact on drug-driving of emerging roadside drug testing technologies.
- Improve knowledge about the effects of cannabis on driving through research assessing the involvement of cannabis and other drugs and polydrug use in fatal and non-fatal accidents, to more rigorously evaluate the relationship between cannabis use and other drug use and risk of road trauma, taking into account other factors such as risk-taking behaviour.
- Support “drug-driving” initiatives and their expansion nationally using best-practice procedures for detection. Additionally, examine the deterrent effect of such initiatives (e.g., random drug testing, standardised field sobriety assessments, or other methods of drug recognition).
- Provide safe-driving messages (i.e., do not smoke cannabis and drive) to all drivers via the roads and traffic authorities in each jurisdiction.

3D Recognise and build on the success of the Illicit Drug Diversion Initiative, as a means to link suitable offenders to health services, provide early intervention to reduce use, and prevent the adverse life impacts associated with having a criminal record for minor cannabis offences.

- Better understand the effects of the Illicit Drug Diversion Initiative (IDDI) with respect to cannabis use by documenting the extent of engagement of individuals (i.e., the number of individuals diverted and their suitability), the intervention received, and, where possible, the outcomes in terms of ongoing cannabis use and harms and unintended consequences.
- Create education programs for law enforcement officers about the underlying principle behind illicit drug diversion schemes and their importance as an alternative to criminal proceedings.
- Facilitate law enforcement knowledge of diversion treatment options and of the short- and long-term effectiveness of these strategies, which are aimed to reduce uptake and continued use of cannabis (e.g., feedback the effects of the IDDI interventions).
- Identify potential barriers (e.g., eligibility/exclusion criteria, treatment suitability) and assess the extent to which they may impact on participation in the various diversion programs.
- Provide and improve access for Aboriginal and Torres Strait Islander peoples to cannabis diversion programs.
- Support the evaluation of the Illicit Drug Diversion Initiative to examine the programs implemented under the IDDI to ensure they accurately reflect recent concerns linking cannabis to poor mental health outcomes, that they provide education about the legal and health (including mental health) risks associated with cannabis use, and that, where appropriate, they provide access to suitable treatment.

3.3.3 Examples of good practice

Below are examples of good practice gleaned from the consultation process that can be used as exemplars of approaches that may prove helpful within this Priority Area.

Diversion programs

- The Australian Government funds Illicit Drug Diversion Initiatives (IDDI) in each jurisdiction. The fundamental aim of the IDDI is to increase the likelihood that drug users will enter treatment at the earliest possible stage. Other aims include decreasing the adverse social impact of illicit drug use and preventing drug-related crime, since drug treatment programs have been found to reduce criminal behaviour associated with drug use.
- Diversion programs (either at the police or court level) are run in each state and territory in Australia. Following are examples of police diversion programs that target cannabis users.

Queensland Police Diversion Program

- The state-wide Queensland Police Diversion Program offers eligible adult and juvenile offenders attendance at a two-hour session that provides assessment, education and referral where needed, as an alternative to being charged and attending court. It is available for offences involving possession of less than 50 grams of cannabis and/or a utensil for smoking cannabis where offenders admit the offence and accept the offer.
- The key success factor is the legislative requirement for police to offer the diversion option to all eligible offenders and to arrange an agreed appointment to attend the diversion session.
- Between commencement on 24 June 2001 and 31 March 2006, more than 34,000 offenders accepted the offer of the diversion alternative.
- Characteristics of the program which contribute to its success include: a service delivery location that is convenient for the offender from a central database; assessment and education sessions are available on an outreach basis in remote areas; the diversion session is a tailored one-on-one intervention; and a high level of cooperation between all government and non-government stakeholders.

Queensland Police Service and Queensland Health

Victoria Police Cannabis Cautioning Program

- The Victoria Police Cannabis Cautioning program involves police providing an official police cautioning notice for use or possession of cannabis. The person is referred to a voluntary educational program (“Cautious with Cannabis”), operated by a community-based drug treatment agency. It is a two-hour interactive group educational session that assists participants to understand the effects of cannabis and to reduce use. Participants can be referred to further assessment and treatment services if appropriate.
- Since commencing in November 2000, over 6500 people have been diverted from the criminal justice system and the program is well-received by police members and participants.

- A key to its success is that it is administratively easy to deal with from a police perspective. Victoria Police supports this program with education, training and resources to issue cannabis cautions at point of arrest.

Victoria Police and Success Works (in press)

Screening and Brief Intervention reduces cannabis use in primary health care clients: the World Health Organisation ASSIST program

- The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) is a brief screening questionnaire developed for use in primary health care and other settings (such as mental health services and corrections) where there is potential to detect problems associated with drug use, which may otherwise go undetected or become worse.
- The ASSIST can help identify cannabis use as a cause of presenting problems, and can warn people that they may be at risk of developing problems related to their cannabis use in the future.
- Preliminary findings of the program from the Australian site show that the 15 minute screening and brief intervention is effective at getting people to reduce their cannabis and other drug use. This is the first time that this has been demonstrated in an Australian setting and is a highly cost-effective way of reducing harms associated with cannabis use.

Drug and Alcohol Services, South Australia

Responding to drug driving

- In response to emerging evidence about the prevalence of drug driving, the Tasmanian Parliament enacted to provide for oral fluid testing of drivers for illicit drugs, including cannabis.
- The legislation commenced on 1 July 2005.
- Random and targeted oral fluid testing of drivers is conducted by Tasmania Police, and blood sampling is used as the medium for confirmatory laboratory analysis.

Tasmania Police

3.4 Priority Area 4: Responding to problems associated with cannabis

Aim:

Provide effective and accessible interventions, tools, treatments and support for those who develop problems associated with their cannabis use

3.4.1 What is the issue?

When harms resulting from cannabis use do occur, appropriate measures need to be in place in order to reduce them.

Alcohol and other drug use often co-occurs with mental health disorders such as psychosis, depression and anxiety. The need for better integration between mental health and alcohol and other drug treatment services was mentioned in the majority of the consultation forums and by many of the experts, organisations and members of the public who provided input into the

Strategy development process. Regardless of the exact relationship between cannabis use and mental health disorders (and there is still debate about the nature of this relationship among experts and in the literature), there is clearly a need for improved treatment of clients with complex needs such as those with coexisting cannabis problems and mental health disorders.

Given the rise in rates of presentations for cannabis problems through treatment agencies in Australia, there is recognition that the management of cannabis problems (including cannabis abuse and cannabis dependence) is an increasing issue. Associated with that is the need for sufficient infrastructure to be available to deal with this problem as it continues to emerge. Thus, where possible and appropriate, recommendations take advantage of and build upon existing programs and infrastructure. Unfortunately, to date, research on pharmacotherapies for cannabis dependence have not yielded a proven pharmacological treatment. This situation is analogous to that which occurred for alcohol until the introduction of pharmacotherapies over the last decade.

3.4.2 What responses are recommended?

4A Establish an adequate, appropriate and accessible range of treatment options

- Ensure there is a range of evidence-based treatment options including brief, and more intensive, treatment options (such as cannabis clinics), to support users in reducing harmful patterns of use.
- Establish a “Cannabis Line” (analogous to the existing tobacco Quitline) to assist users who wish to quit or cut-down cannabis use. Use the existing infrastructure (e.g., state/territory Quitline program telephone line or Australian Drug Information Service telephone line) and train staff in informing users of strategies to quit or cut-down cannabis use. Note that these staff should and would also be equipped to advise cannabis users about other drug use issues and this may require further training and resources.
 - Promote the Cannabis Line in primary health care facilities such as general practice surgeries, pharmacies, Aboriginal Medical Services, Aboriginal Legal Services, and in hospital waiting-rooms via posters/pamphlets.
 - Recognise that promoting the Cannabis Line, as well as assisting those with cannabis use problems to access assistance, will have the effect of communicating to the general public that quitting cannabis can be something which warrants assistance, that cannabis can cause problems including dependence, and that dependence is one of the harms associated with cannabis use.
- Promote and provide education on the range of effective treatments available by using the media, health professionals, law enforcement, and education agencies.

4B Develop capacity in the health sector to address cannabis problems

- Improve the knowledge and skills of health professionals about cannabis use and the harms associated with use, and the treatment options available.
- Conduct an audit of existing resources for use in treating cannabis dependence. Based on the result of the audit mentioned above, develop or promote resources which can be adapted easily to allow jurisdictions to modify resources to meet their local needs and also to have ownership of the resources. Develop complementary resources which can be used in Aboriginal and Torres Strait Islander communities, and which can be readily adapted to the needs of different communities such as culturally and linguistically diverse communities, which have relevance to local groups.

- Develop clinical guidelines on methods of intervention for cannabis dependence.
 - These guidelines should use the existing approaches taken for other drugs such as amphetamines, alcohol and opioids.
 - Guidelines should be developed for use by generalist health workers, specialist agencies, and mental health workers, including procedures for supporting and treating clients with comorbid mental health disorders and cannabis dependence.
 - Culturally secure and specific guidelines should be developed for Aboriginal and Torres Strait Islander peoples, that are distinct from mainstream resources, to build capacity to provide a full range of treatment and rehabilitation options and resources to these peoples in collaboration with mainstream services, especially in rural and remote areas.
 - Disseminate the guidelines effectively to specialist agencies, generalist workers, mental health and allied health workers, including those in juvenile justice and youth work settings, and also to parents, users, and media, through user groups or other avenues.
 - Consider having guidelines endorsed by suitable organisations (e.g., Australasian Chapter of Addiction Medicine, National Health and Medical Research Council, Australasian Professional Society on Alcohol and other Drugs).
- Provide self-help materials for users and relatives/friends to be distributed through primary health care services, Aboriginal and Torres Strait Islander peoples community-controlled health services, and specialist alcohol and other drug agencies. This self-help kit could be supported by the suggested Cannabis Line.
- Provide information about interventions for those with cannabis dependence to counsellors in the tertiary education sector.
- Support should be provided to families, parents and carers through the mechanisms listed above (e.g., positive parenting and early intervention programs, education to parents, families and carers about the harms and effective interventions for cannabis problems).

4C Improve the partnership between drug and alcohol and mental health sectors

- Require mental health services (through a top-down process) to screen for excessive alcohol and other drug use in their clientele as part of their standard assessment. Mental health services should be provided with information through the above-mentioned clinical guidelines on assessment procedures, the brief intervention/information to provide to mental health patients concerning illicit drug use, and training in referral of patients to specialist agencies where required. Screening tools will need to be developed/disseminated.
- Require alcohol and drug treatment workers (through a top-down process) to screen for mental health disorders, including psychosis, anxiety, and depression in their clientele as part of their standard assessment. Screening tools will need to be developed/disseminated.
- Ensure that for each mental health presentation in hospitals and health services, the use of alcohol and other drugs, including cannabis and the relevance to the presentation, is routinely recorded. Similarly, for each alcohol and other drug presentation in hospitals and other health services, the presence of mental health disorders and their relevance to the presentation should be routinely recorded.
- Engage with national mental health groups such as the Mental Health Council of Australia and its members, to better educate them about the relationship between cannabis and other drug use and mental health disorders such as anxiety, depression and psychosis.

3.4.3 Examples of good practice

Below are examples of good practice gleaned from the consultation process that can be used as exemplars of approaches that may prove helpful within this Priority Area.

Brief intervention for cannabis problems for primary health care providers

- In the late 1990s the National Drug and Alcohol Research Centre (NDARC) identified the need for a trial of a brief intervention for cannabis-related problems.
- This trial was one of the first in the world and compared two versus six sessions of motivational and skills-based therapy with a group that received treatment at a later date. It was found that such brief interventions were attractive and led to a significant reduction in levels of cannabis use and related problems.
- The treatment manual and intervention materials have been disseminated widely and training in the use of the intervention is still available from NDARC (see: <http://ndarc.med.unsw.edu.au>).

National Drug and Alcohol Research Centre, University of NSW

Trial of Cannabis Clinics

- Four Cannabis Clinics funded by NSW Health are operational and provide individual psychotherapy and pharmacotherapy treatment for cannabis dependent people and group interventions for dependents and families of cannabis dependent people.
- The clinics specifically target young people and young adults who are at risk of dependence and/or mental health problems, and provide outreach clinics to surrounding communities.
- Preliminary outcome data indicate that individual clients are responding well to treatment. An official evaluation of the program, currently being established, will determine the overall efficacy of the program.

New South Wales Health

Cannabis Abstinence Program

- Taking into consideration key psychosocial constructs derived from alcohol research and the effective elements of the brief-cognitive behavioural interventions published to date, the Princess Alexandra Hospital's Alcohol and Drug Assessment Unit in Brisbane has developed a six-week, five session, cognitive-behavioural cannabis abstinence program.
- The program comprises: assessment of duration and quantity of cannabis use; motivational interviewing; a focus on ability to refuse cannabis in a range of settings; the development of realistic goal-setting and effective problem-solving strategies; the introduction of relevant coping strategies to assist in the management of stress, utilizing cognitive interventions (education on the influence thoughts have on feelings) and behavioural strategies (e.g., relaxation techniques, etc); and relapse prevention.

Queensland Health

Aboriginal Alcohol and Drug Worker Training Program

- The WA Drug and Alcohol Office, Aboriginal Alcohol and other Drugs Program, has customised the support materials for the Certificate III in Community Services Work qualification to be culturally secure and relevant to the needs of Aboriginal AOD workers from remote, rural and metropolitan areas.

- The course provides the opportunity to develop strong professional boundaries, gain knowledge and understanding of culturally secure AOD theoretical models that underpin evidence-based practice, and consolidates AOD counselling and community development skills.
- Participants attend four blocks of training, each one week in duration, within a 12-month period. This program is nationally recognised under the Australian Quality Training Framework (AQTF).
- The success of the program in WA gained national interest and support, will be expanded to be delivered in other jurisdictions, and forms part of the Indigenous National Alcohol and Drug Workforce Development Program (see Workforce development section, below)

Drug and Alcohol Office, Western Australia

The Dual Diagnosis Initiative

- This initiative aims to support the development of better treatment practices and collaborative relationships between drug treatment and mental health services, thereby improving service delivery to clients with coexisting alcohol and drug and mental health problems.
- The three major projects in the Dual Diagnosis Initiative are: the reciprocal rotation project, which allows alcohol and other drug and mental health workers to undertake rotations in the other service; strengthening psychiatrist support, which increases the availability of psychiatrist advice and support for bio/psycho/social assessment, treatment and management of clients with complex needs; and state-wide education and training enhancement, which involves the development and implementation of a state-wide dual diagnosis education and training strategy.

Department of Human Services, Victoria

4. Where to from here?

4.1 Integrated and coordinated responses

In order for the National Cannabis Strategy to have a positive impact on the minimisation of harm associated with the use of cannabis, the recommendations need to be implemented in an integrated and coordinated way. As outlined in the National Drug Strategy 2004–2009, the responsibility for action to reduce drug-related harm lies with government agencies at each level, non-government and community-based organisations, business and industry, the community, the media, research centres and individuals. The National Cannabis Strategy will need to be disseminated, communicated and promoted to all key stakeholders, and partnerships built and strengthened to ensure a coordinated response and a clear implementation schedule.

In addition to building new partnerships and enhancing existing ones, the strategies that are already developed need to be affirmed and linked to the National Cannabis Strategy. In particular, the following strategies and plans have relevance to the National Cannabis Strategy:

- *The National Drug Strategy 2004–2009* and the National Drug Strategy — Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009 set the National Cannabis Strategy in a broader context. The range of strategies to address cannabis use and its harmful effects among Aboriginal and Torres Strait Islander peoples should reflect those employed across the community. They should also include strategies that address the inequalities with which the elevated rates of misuse are associated, and be consistent with the National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009 and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing 2004–2009. These latter plans ensure a focus on the social determinants underlying substance misuse and emphasise a holistic approach incorporating comprehensive case management and joint care planning in terms of treatment. The Strategies also support multi-disciplinary Social Health Teams in community-controlled settings to address social determinants underlying substance use and related problems.
- The Northern Territory Police Remote Community Drug Strategy which encompasses the Remote Community Drug Desk, and is tasked with the coordination, implementation and leadership of strategic and tactical operations aimed at disrupting the distribution of drugs to and within remote communities. A tri-state Substance Abuse Intelligence Desk is currently being trialled that will address the issue of drug supply to the cross-border region of central Australia.
- The National Crime Prevention Program promotes innovative ways of reducing and preventing crime.
- The National School Drug Education Strategy (1999) and the Department of Education, Science and Training Principles for School Drug Education (2004) which provide strategies, policies and principles to ensure that school-based education is maximally effective.
- The *National Alcohol Strategy 2006–2009* to ensure that the national effort to enhance the capacity and legitimacy of health professionals and law enforcement officers is maximised.

- The *National Tobacco Strategy 2004–2009* to have the next iteration of the tobacco strategy include responses that recognise the role of cannabis in the uptake of tobacco use.
- The National Mental Health Plan 2003–2008, National Action Plan for Promotion, Prevention, and Early Intervention in Mental Health 2000, Youth Mental Health Foundation, and the National Suicide Prevention Strategy to ensure that the importance of cannabis use in mental health disorders is recognised.
- The Illicit Drug Diversion Initiative has an important role intervening with people who are using cannabis with the aim of preventing use of cannabis.

4.2 Building the evidence base

An integral part of good policy-making is basing policies and strategies on evidence. The responses listed above contain references to research needs, drawing on both current and new research. These are not reiterated here, but some research directions are suggested, associated with establishing the prevalence, patterns and harms associated with cannabis use and methods of responding to cannabis-related problems.

- Better understand the patterns and prevalence of cannabis use in Australia and potential associated harms (including dependence, mental health, occupational, cognitive, educational, and social harms including criminal activities and/or associated violence, motor vehicle accident or injury, and health effects for young people, and during pregnancy etc.).
- Include targeted questions on cannabis in the National Drug Strategy Household Survey such as patterns of use, including more questions on frequency, availability, and price.
- Investigate the patterns of cannabis use among Aboriginal and Torres Strait Islander peoples, both in urban and remote areas.
 - Survey Aboriginal and Torres Strait Islander peoples residing in urban areas.
 - Collect data on the use of cannabis among Aboriginal and Torres Strait Islander peoples living in remote communities across Australia.
 - Determine the extent to which cannabis use may contribute to family/community dysfunction, anti-social behaviour, domestic or family violence, suicidal behaviours and the financial burden to communities, in urban, regional and remote areas.
- Update the 2001 National Drug Strategy monograph *Health and psychological effects of cannabis use* (Hall, Degenhardt & Lynskey, 2001).
- Explore the link between tobacco and cannabis smoking by determining the prevalence of tobacco smokers who became dependent on nicotine by smoking cannabis mixed with tobacco, and examining the difference in health outcomes for non-tobacco cannabis users and cannabis/tobacco users.
- Disentangle the role that cannabis use plays in the development of psychological disorders, while taking into account the role of other potential risk factors.
- Improve knowledge about cannabis potency via the following mechanisms:
 - Measure and compare the potency of cannabis that is grown by artificial means (hydroponic cultivation and/or artificial lighting) with cannabis that is grown naturally out-of-doors. Additionally, determine whether the level of contaminants is significant in hydroponically-grown cannabis.
 - Assess the relationship between potency and smoking behaviour (i.e., titration of ‘cannabis dose’) if feasible.

- Understand the impact of cannabis laws with respect to individual and community harm:
 - Recognise existing research on the impact that laws and their enforcement have in terms of supply reduction, demand reduction and prevention outcomes for cannabis (and other illegal drugs).
 - Recognise existing research on the impact of changes to legislation concerning cannabis possession and use that have occurred in South Australia and Western Australia.
 - Conduct comparative evaluation of the impact of different legislative approaches in states and territories (taking into account baseline use) and changes in rates of use. Each jurisdiction has different models/legislative frameworks for dealing with cannabis possession and use but there has been no comprehensive evaluation of the impact of these legislative approaches that takes account of rates of use, impact of incarceration, entrenchment in the criminal justice system, processing and policing costs, deterrence, etc.
- Conduct research to identify examples of international best practice that can be drawn upon, particularly in relation to supply reduction and prevention.
- Conduct research into effective treatments for cannabis dependence:
 - Evaluate the nature and quality of the treatments and interventions currently provided for cannabis dependence under the Illicit Drug Diversion Initiative.
 - Explore alternative strategies for delivering treatment, such as mail-out interventions, internet-based treatment and telemedicine.
 - Determine the efficacy of psychological interventions with and without pharmacotherapies (antagonists, agonists, and anti-depressants) to treat cannabis dependence.
 - Further establish the efficacy and cost-effectiveness of brief interventions for cannabis dependence delivered in primary health care and specialist settings (e.g., psychiatric clinics, antenatal clinics, correctional facilities, etc.).

4.3 Workforce development

Workforce development is one of the Priority Areas in the National Drug Strategy, and is also of great importance to the Priority Areas of the National Cannabis Strategy. Specifically, the Strategy suggests the following areas of focus with respect to workforce development:

- Support the training of law enforcement officers in recognition and referral of offenders with cannabis (and other alcohol- and drug-related) problems, and drug and mental health comorbidity.
- Support professional development of remote alcohol and drug workers.
- Recognise the need for health workforce development with respect to cannabis treatment. Specifically:
 - Educate the health and alcohol and other drugs workforce on the nature and management of cannabis dependence, such as cognitive behavioural treatment. Clinical guidelines mentioned above would help achieve this result.
 - Promote existing tools, such as Alcohol and other drugs: A website for general practitioners and health professionals, which provides information and resources for assessing and managing alcohol and other drug problems.
- Support the training of alcohol and other drug workers in detecting mental health disorders and the training of mental health workers in detecting alcohol, cannabis and other drug problems as set out in recommendation 4D under Priority Area 4.

- Support the submission to the Productivity Commission on Health Workforce from the Royal Australia and New Zealand College of Psychiatrists.
 - This recommends that Aboriginal and Torres Strait Islander mental health workers are provided with registration throughout Australia to improve recognition of the profession and provide a clear and more effective career structure. Differences in state and territory registration requirements need to be acknowledged.
 - Support these workers with access to knowledge concerning illicit drug use — in this regard, cannabis use — so they can use this information in their communities.
- Support the recommendations contained within the National Alcohol Strategy 2006–2009 regarding the inclusion of alcohol and drug education in undergraduate nursing and midwifery curricula and the development of a nurse practitioner program in relation to alcohol and other drugs.
- Ensure that teachers, school counsellors, youth workers, psychologists and social workers receive relevant training in their undergraduate and/or professional development regarding recognition and referral of those with cannabis dependence.
- Encourage more recruitment into the Alcohol and Other Drugs sector via contextualised university degrees such as social work and psychology.
- Support the recommendation contained within the National Alcohol Strategy 2006–2009 regarding increasing the capacity of Aboriginal and Torres Strait Islander community health workers to respond to alcohol and other drug issues through the MCDS Indigenous Alcohol and other Drug National Train-the-Trainer Pilot Program.
- Support a wider range of approaches to workforce development, as reflected in state and territory plans for workforce development.

4.4 Partnerships

Effective partnerships between key stakeholders when addressing cannabis-related issues were identified to be of major importance to the success of the Strategy. In particular, the mental health field and the alcohol and other drug field need to improve their collaboration and integration (see response 4C). The education departments need to be aware of health and law enforcement initiatives with respect to school-based drug education. The positive links between health and law enforcement, which is such an important aspect of the National Drug Strategy and which is reflected in the membership of the Ministerial Council on Drug Strategy and the Intergovernmental Committee on Drugs, needs to be maintained and strengthened. In the context of drug law enforcement, especially in remote or regional communities affected by local cannabis trade, close cooperation and support from community leaders and sensitivity to the socio-cultural environment is required given that dealers are often community-based.

In addition to government agencies, the following groups need to be engaged in partnerships:

- Alcohol and other Drugs Council of Australia;
- other peak alcohol and other drug organisations;
- law enforcement;
- the judiciary;
- corrective services;
- Aboriginal Medical Services;
- Aboriginal Legal Services;

- professional bodies such as the Australasian Professional Society on Alcohol and Other Drugs, Royal Australian and New Zealand College of Psychiatrists, the Australian Psychological Society, the Royal Australian College of General Practitioners, the Royal Australasian College of Physicians (particularly the Australasian Chapter of Addiction Medicine), Drug and Alcohol Nurses Association, Pharmaceutical Society of Australia, Pharmacy Guild of Australia, and state and territory police academies;
- user groups;
- research institutions with an interest in alcohol and drug issues;
- health providers and social workers, including alcohol and other drug workers, general practitioners, nurses, pharmacists, psychiatrists, psychologists, youth workers, and crisis counsellors;
- welfare, housing and other social service groups;
- parent groups;
- mental health organisations, such as the Mental Health Council of Australia, Beyond Blue, NISAD Schizophrenia Research, and Sane Australia;
- road and traffic authorities;
- educators, schools, and tertiary education institutions to maximise the effectiveness of school-based education and student retention;
- local government;
- community groups;
- community services;
- utility companies;
- real estate organisations;
- sporting and other recreational bodies;
- media groups;
- anti-tobacco groups.

4.5 Monitoring and evaluation

Consistent with the process of the National Alcohol Strategy 2006–2009, jurisdictions will continue to share best practice examples of programs and strategies consistent with the priority areas of this Strategy. The National Cannabis Strategy should be evaluated by determining the extent to which each of the responses have been worked towards or undertaken. Changes in drug use, and particularly the incidence and prevalence of cannabis problems, may take longer to alter than the life of this Strategy, so that reliance on them may not be helpful in evaluating the extent to which the Strategy has been successfully implemented. However, indicators of cannabis use and associated problems should be assessed over time to contribute to the Strategy monitoring process.

A second National Cannabis Strategy should be considered in five years time and should include an evaluation of the effectiveness of the first National Cannabis Strategy. This Strategy was developed within the existing legislative framework, and, as such, issues surrounding drug law reform and the uses of cannabis for medicinal purposes are not addressed in the Strategy. Future iterations of the National Cannabis Strategy may wish to consider including medicinal uses of cannabis and cannabinoids, the best legal model for sanctions against personal cannabis use, and development of a harmonised national approach that minimises the net harm to individuals and the community.

Snapshot of consultations

- Consultations with 814 stakeholders
- 21 consultation forums around Australia
- 307 feedback forms received
- 106 written submissions received

Consultations with special interest groups and national bodies

- Western Australian Drug and Alcohol Office
- Western Australian Police Service
- Australian National Council on Drugs (ANCD)
- Tasmania Department of Health and Human Services
- Alcohol, Tobacco and other Drug Services, Queensland Health
- Intergovernmental Committee on Drugs (Members) and Intergovernmental Committee on Drugs (Executive)
- North Coast Area Health Service
- National Indigenous Drug and Alcohol Committee
- Council of Capital City Lord Mayors
- Commissioners' Drugs Committee
- Office of Aboriginal and Torres Strait Islander Health
- Aboriginal Drug and Alcohol Network Leadership Group

National consultation forums

- Perth
- Alice Springs
- Darwin
- Hobart
- Adelaide
- Port Augusta
- Brisbane
- Cairns
- Dubbo
- Lismore
- Sydney
- Canberra
- Melbourne
- Launceston
- Aboriginal and Torres Strait Islander peoples forums
- Youth and user forums
- Western Australian Alcohol and Other Drug Key Stakeholder Prevention Workshop
- Network of Alcohol and other Drug Agencies Conference
- Australasian Professional Society on Alcohol and other Drugs

Written submissions received

- Commissioners' Drugs Committee
- Central Australian Aboriginal Congress Inc.
- Endeavour Forum
- Families and Friends for Drug Law Reform
- Focus on the Family Australia
- Australian Family Association (NSW)
- Drug Advisory Council of Australia
- Ministerial Council on Education, Employment, Training and Youth Affairs
- SANE Australia
- NISAD Schizophrenia Research
- Australian Family Association
- Manly Drug Education and Counselling Centre
- Drug and Alcohol Nurses of Australia
- Aboriginal Health and Medical Research Council
- National Council of Women of Australia
- Hemp Embassy
- Youthsafe
- Australian Parliamentary Group for Drug Law Reform
- Turning Point Alcohol and Drug Centre
- New South Wales Bureau of Crime Statistics and Research
- Australian Family Association (Geelong branch)
- National Civic Council (Geelong branch)
- National Drug Research Institute
- Youth Substance Abuse Service
- Aids Council of New South Wales
- Parent and Friends' Federation of Western Australia
- Australian Institute of Criminology
- Beyond Blue
- Alcohol and other Drugs Council of Australia
- Northern Territory Office, Australian Government Department of Health and Ageing
- Australian Divisions of General Practice
- Australian Drug Foundation
- Victorian Rural Dual Diagnosis Forum
- Salvation Army
- Commissioners' Drugs Committee, Australian Centre for Policing Research, and National Drug Law Enforcement Research Fund
- NSW Users & AIDS Association
- Mental Health Council of Australia
- Australian Medical Association
- Premier's Drug Prevention Council
- Victoria Police
- Royal Australia and New Zealand College of Psychiatrists
- Australasian Chapter of Addiction Medicine
- Western Australian Department of Justice
- Australian Psychological Society
- National Local Government Drug and Alcohol Advisory Committee
- Submissions were also received from 61 members of the general community

Appendix 2

Project Management and Reference Groups for the development of the National Cannabis Strategy 2006-2009:

Project Management Group members

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