Evaluation of the National Cannabis Prevention and Information Centre (NCPIC)

Prepared for the Drug Strategy Branch of the Commonwealth Department of Health and Ageing

FINAL REPORT

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urbis

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FIGURES:

TABLES:

Acronyms

AA	Alcoholics Anonymous
ADCA	Alcohol and other Drugs Council of Australia
AIC	Australian Institute of Criminology
AOD	Alcohol and Other Drugs
ATSI	Aboriginal and Torres Strait Islander
CALD	Culturally and Linguistically Diverse
CIH	Cannabis Information and Helpline
D&A	Drug and Alcohol
DoCS	Department of Community Services
DoHA	Department of Health and Ageing
EA	Executive Assistant
FTE	Full Time Equivalent
GP	General Practitioner
MaG	NCPIC Management Group
NA	Narcotics Anonymous
NAC	NCPIC Advisory Committee
NCETA	National Centre for Education on Training and Addiction
NCS	National Cannabis Strategy
NCPIC	National Cannabis Prevention and Information Centre
NDARC	National Drug and Alcohol Research Centre
NDRI	National Drug Research Institute
NDS	National Drug Strategy
NDSHS	National Drug Strategy Household Survey
NSW	New South Wales
UNSW	University of New South Wales

1 Introduction

1.1 Introduction

The Drug Strategy Branch of the Commonwealth Department of Health and Ageing (DoHA) commissioned Urbis to undertake an evaluation of the National Cannabis Prevention and Information Centre (NCPIC). This evaluation will be used to inform the Australian Government about how to proceed with NCPIC following the end of the current funding agreement on 30 June 2010.

This is the Final Report for the evaluation.

1.2 Terms of Reference for the evaluation

The Terms of Reference for this evaluation are to:

- establish whether NCPIC has increased access to information on cannabis, supplied service providers with support and interventions to respond to cannabis use and specifically engaged young people, as a contribution to reducing the demand for, and harms associated with cannabis
- examine the effectiveness of NCPIC in achieving its goals
- examine the efficiency of NCPIC in conducting its activities
- examine the effectiveness and efficiency of NCPIC's governance arrangements
- examine NCPIC's contribution to achieving the outcomes of the *National Cannabis Strategy* (NCS)
- develop recommendations for improving NCPIC's efficiency and effectiveness.

1.3 Overview of methodology

The methodology for the evaluation consisted of the following stages, as set out in Table 1. Appendix A provides a detailed description of the methodology.

Table 1 – Overview of methodology

Stages	Activities
Phase 1 – Project planning	▪ inception meeting with DoHA ▪ initial discussion with the NCPIC Director ▪ developing the program logic (and hierarchy of outcomes)
Phase 2 – Background research	▪ review of key documents ▪ data review ▪ quality assessment of information ▪ literature scan
Phase 3 – Fieldwork consultations	▪ workshop and follow-up one-on-one interviews with consortium members (n=13) ▪ workshop with NCPIC staff (n=20) ▪ key stakeholder interviews (including stakeholders who have directly participated in NCPIC activities) (n=37) ▪ interviews with NCPIC clients (n=21) ▪ focus group with young people aged 14-18 years old (n=10) ▪ focus group with young cannabis users aged 20-29 years old (n=11)
Phase 4 – Analysis and reporting	▪ data and fieldwork analysis ▪ development of a Draft and Final Report

1.4 Limitations

There are several key limitations to the methodology which should be considered in interpreting the findings presented in this report. These relate to: the short timeframe for conduct of the evaluation, and the limited number of participants involved in the client consultations and the focus groups.

1.4.1 Short timeframe for conduct of the evaluation

This evaluation was conducted within a relatively short timeframe. The evaluation was undertaken within a three month period from the inception meeting to the delivery of the Report. Although Urbis reached the desired number of stakeholder consultations, some stakeholders were unable to be contacted within the designated period. There was also a slightly lower number of clients consulted than originally planned (see sub-section below).

1.4.2 Client consultations

Some challenges were experienced in recruiting NCPIC Cannabis Information and Helpline (CIH) clients to participate in telephone interviews. It had originally been intended to interview 30 NCPIC clients. In total, contact details for 30 clients were received from the Helpline, but some clients were unable to be contacted within the timeframe required despite repeated attempts (or in one case their phone was disconnected). In total 21 interviews were conducted.

Interviews with CIH clients explored their interactions with and experiences of the Helpline. Where possible, clients were also asked to comment on other NCPIC resources that they had seen or used. Because there was a short turn around between contact with the Helpline and their interview with Urbis, clients often indicated that although they had been referred to the NCPIC website or had been sent materials in the post, they had not yet viewed these resources and had limited capacity to comment.

Therefore in practice the feedback from clients primarily related to their use of the Helpline (rather than other aspects of NCPIC's activities).

1.4.3 Focus groups

The methodology only allowed for two focus groups with young people to be conducted. Although the findings from these groups provide useful insights regarding the appropriateness and effectiveness of NCPIC materials for engaging with this particular demographic group, given the relatively small number of participants overall (21), the findings from these groups should be regarded as providing useful qualitative insights, rather than definitive conclusions.

1.5 This report

The structure of the report is as follows:

- Chapter 1: Introduction
- Chapter 2: Overview of NCPIC and its policy context
- Chapter 3: Key themes from the literature for this evaluation
- Chapter 4: Program Logic
- Chapter 5: Key achievements
- Chapter 6: Limitations
- Chapter 7: Staffing and governance issues
- Chapter 8: Conclusions and ways forward.

2 NCPIC overview and policy context

This section provides an overview of NCPIC and its policy context. This includes:

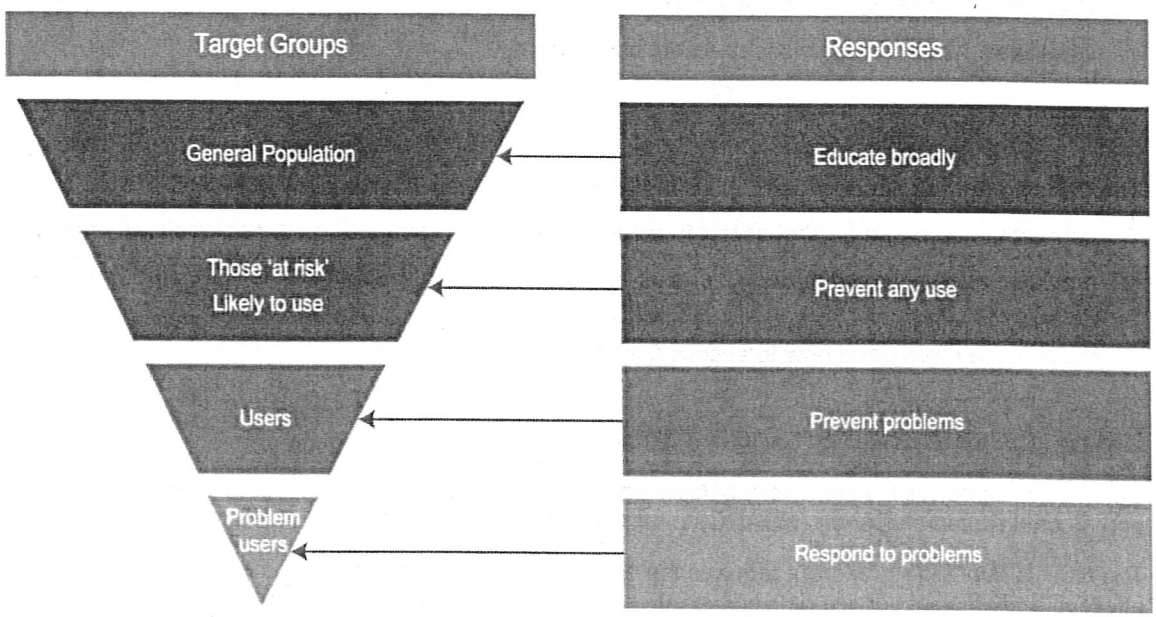
- the policy context for NCPIC
- the aims of NCPIC
- the governance arrangements for NCPIC
- an overview of NCPIC activities
- priority audiences for NCPIC
- resource allocation for NCPIC.

2.1 Policy context

The 2006 Federal Budget allocated $14 million over four years to establish NCPIC with the aim of reducing the use of and harms associated with cannabis in Australia. NCPIC was officially opened by the Minister for Health and Ageing, Hon. Nicola Roxon, in April 2008.

NCPIC is a key Australian Government initiative implemented to support the objectives of the *National Cannabis Strategy 2006-2011*. The Strategy is intended to cover a breadth of responses and address a continuum of need. This is conceptualised through the identification of priority target groups and corresponding responses, as demonstrated in the diagram below.

Figure 1 – Continuum of responses and target groups



Commonwealth of Australia, *National Cannabis Strategy 2006-2011*, 2006

The *National Cannabis Strategy* outlines the following priority areas:

- *Increase community understanding of cannabis.* Increase community knowledge about cannabis and associated harms, and influence the level of acceptability of cannabis use within the Australian community.
- *Prevent the use of cannabis.* Prevent the uptake of cannabis and minimise use in individuals and the community.

- *Prevent problems associated with cannabis*. Prevent and minimise the social, physical, mental and financial harms to individuals and the community that are associated with cannabis use.
- *Respond to problems associated with cannabis*. Provide effective and accessible interventions, tools, treatment and support for those who develop problems associated with their cannabis use:

The *National Cannabis Strategy 2006-2011* was developed under the umbrella of the *National Drug Strategy 2004-2009* (NDS). The *National Drug Strategy* provides an overarching framework for dealing with drug issues in Australia. The Strategy is a collaboration between Federal, State and Territory Governments and the non-government sector. The mission of the Strategy is 'to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of drugs in Australian society'.

The Strategy is underpinned by the principle of harm minimisation. This involves three key streams: supply reduction, demand reduction and harm reduction.

The following eight priority areas are identified as specific areas for future action within the Strategy:

- prevention
- reduction of supply
- reduction of drug use and related harms
- improved access to quality treatment
- development of the workforce, organisations and systems
- strengthened partnerships
- implementation of the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009*
- identification of and responses to emerging needs.

2.2 NCPIC aims

The Funding Agreement between DoHA and NDARC stipulates that the aims of NCPIC are to:

- support the drug and alcohol sector to respond to people experiencing cannabis related problems
- provide evidence based materials and information to the public about cannabis related problems
- specifically engage young people to increase their knowledge and understanding about cannabis, the law, the effects and how to access assistance.

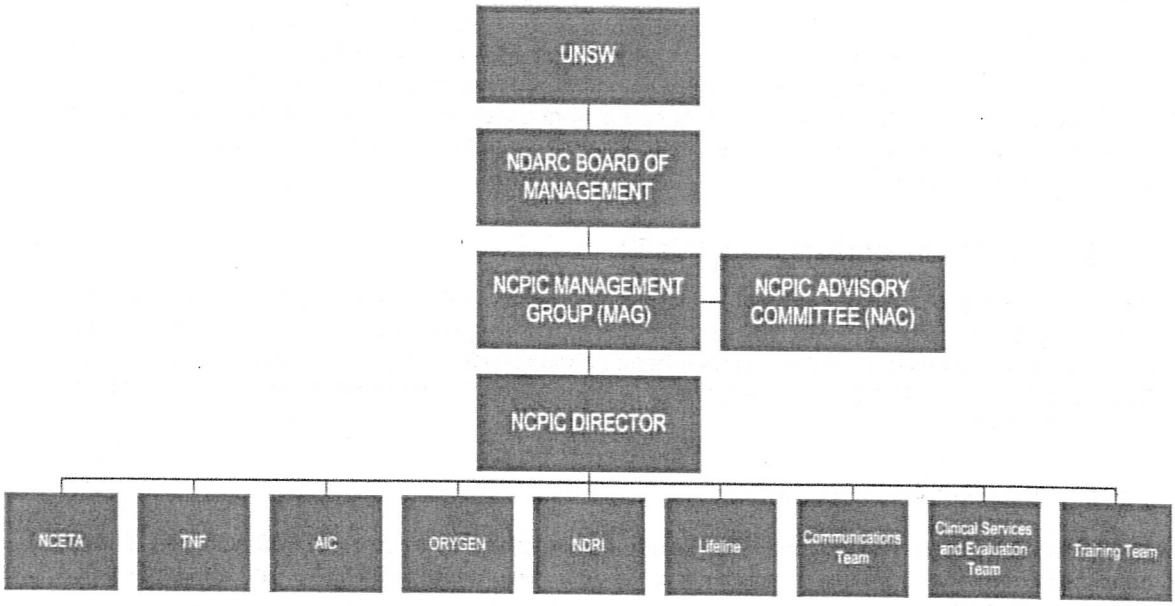
2.3 Governance arrangements

DoHA currently funds the University of New South Wales (UNSW), as represented by the National Drug and Alcohol Research Centre (NDARC) to manage and operate NCPIC.

The NCPIC Funding Agreement requires the establishment of governance structures that enables effective and efficient service delivery, ensures appropriate decisions are made, communicated, monitored, and addressed, and facilitate management responsibility and accountability.

An overview of the governance structure is demonstrated in the diagram overleaf.

Figure 2 –NCPIC governance structure



This diagram is explained in further detail in the text below.

2.3.1 The consortium model

NCPIC is operated by a consortium led by NDARC and six partner agencies. The consortium was established to ensure national coverage and the utilisation of a range of skills and knowledge.

Table 2 – Roles of the NCPIC consortium partners

Consortium partner	Location	Role
National Drug and Alcohol Research Centre (NDARC)	University of New South Wales, Sydney	Responsible for consortium leadership, evidence based information, intervention development and dissemination.
National Drug Research Institute (NDRI)	Curtin University, Perth	Responsible for effective prevention and culturally appropriate responses (ie supporting and leading NCPIC efforts relating to Indigenous people and communities).
National Centre for Education on Training and Addiction (NCETA)	Flinders University, Adelaide, South Australia	Responsible for providing information and support on workforce development issues.
Australian Institute of Criminology (AIC)	Canberra, Australian Capital Territory	Responsible for providing information and support on cannabis use and criminal justice issues, systems, and approaches.
ORYGEN	University of Melbourne	Responsible for providing information and support regarding mental health and substance abuse, especially for young people.
Ted Noffs Foundation	Sydney, New South Wales	Responsible for providing information and support on adolescent treatment responses.
Lifeline	Canberra, Australian Capital Territory	Responsible for operating the CIH.

2.3.2 The Advisory Committee (NAC)

The consortium partners, as well as a range of other organisations[1], are on the NCPIC Advisory Committee (NAC) which meets quarterly to provide guidance on directions and progress of NCPIC. The Committee is intended to facilitate advice to help inform decisions made by the Management Group. The NAC is one of the key mechanisms for consortium collaboration. The Director also holds half day workshops with consortium partners on key topic areas in addition to visits by the Director and key staff to all consortium partners.

2.3.3 The Management Group (MaG)

The role of the NCPIC Management Group (a sub-committee of the Advisory Committee) is to oversee: the strategic direction, annual workplans, budgets and arising projects of the NCPIC. This Group meets quarterly and comprises the following members: an independent chair, the Director of NCPIC, the Executive Director of NDARC, the Director of NDRI, and the Assistant Secretary of the Drug Strategy Branch within DoHA.

2.3.4 NDARC Advisory Board

The NDARC Advisory Board's role is to provide high level governance of NCPIC activities. The Board consists of members from senior academic positions, senior state and Australian Government positions, and external members.

2.3.5 NCPIC staff

There are currently 21 NCPIC staff members across three teams: the Communications Team, the Clinical Services and Evaluation Team, and the Training Team.

2.4 Activities

Table 3 – Overview of the NCPICs key activity areas

Activity area	Examples	Intended purpose
Research and clinical studies	▪ postal interventions study ▪ barriers and facilitators study ▪ collaborative dissemination models ▪ web-based brief intervention study ▪ successful and unsuccessful quitters study ▪ potency study	▪ supply service providers with evidence based interventions to respond to cannabis problems. ▪ improve referral pathways and access to treatment for cannabis users.
Social marketing	▪ national launch of NCPIC and launch of resources to target groups ▪ poster, film and music competitions ▪ mainstream media coverage ▪ promotion at conferences ▪ liaising with stakeholders for the dissemination of resources ▪ e-zines, bulletins and email updates ▪ promotional materials (posters, mouse pads, stickers, pens, drink bottles and	▪ develop widespread community awareness of NCPIC, its functions, aims and activities ▪ to provide targeted materials to a range of stakeholders on cannabis related harms and interventions ▪ promote the centre and maintain a high profile amongst a range of sectors and target audiences.

[1] An independent Chair, stakeholder representatives (from Department of Health and Ageing (DoHA), Department of Education, Employment and Workplace Relations (DEEWR), Intergovernmental Committee on Drugs (IGCD), Australian National Council on Drugs (ANCD), and a law enforcement representative from Victoria) and independent members (Professor Ted Wilkes and Professor Wayne Hall).

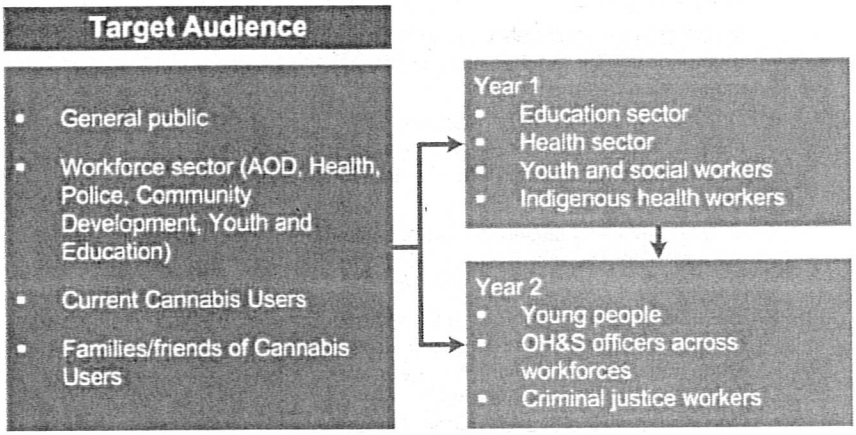
Activity area	Examples	Intended purpose
	stress balls) ▪ Sports Campaign ▪ Cannabis and Driving Campaign	
Workforce training	▪ clinical training sessions, community education sessions and youth training sessions ▪ developing and implementing a TAFE certificate IV module a nationally recognised Unit of Competency on cannabis and mental health for use in Certificate IV courses for a range of professionals ▪ MakingtheLink materials on cannabis and mental health for teacher-based early intervention in school settings ▪ Quick Fix materials on cannabis and mental health brief intervention for primary care settings (including a one day training workshop program) ▪ development and dissemination of clinical guidelines for the management of cannabis use disorder ▪ development and roll out of a Workplace training program on cannabis and other drugs in the workplace which targets Executive staff, generalist staff, Occupational Health and Safety staff and supervisors, and Employee Assistance Providers ▪ development of psycho-education materials on cannabis and mental health for mental health clinicians ▪ development of cannabis mental health first aid guidelines for the general community	▪ increase the capacity of workers and organisations to address cannabis related problems across a broad range of professional settings, including when mental health issues coexist ▪ increase the capacity of community members to identify problem cannabis use and facilitate professional help seeking
CIH	▪ the provision of a nationally available free call service operating Sunday to Friday from 2-11pm.	▪ provide evidence based information on cannabis to the community ▪ provide information and targeted advice (ie communication and intervention engagement strategies) to families and concerned others ▪ provide brief assessment, advice and referrals to cannabis users ▪ provide a four sessions brief intervention for those wishing to make changes in their cannabis use but do notwish to engage in traditional treatment services.
Resource development and dissemination	▪ resources for the workforce including: clinician guidelines, assessment tools, criminal justice bulletins, and materials designed for teachers ▪ resources for the general public including: factsheets, what's the deal booklets, fast facts series, and smoking and driving messages ▪ liaise with stakeholders for the dissemination of resources.	▪ increase the capacity of workers to address cannabis related problems ▪ provide the Australian community with access to evidence based information on cannabis use and related harms.

Activity area	Examples	Intended purpose
NCPIC website development	▪ a dedicated cannabis website that provides public access to information resources and interventions.	▪ Provide reliable, evidence based information about cannabis to meet the needs of a range of target audiences.

2.5 Priority Audiences

The following diagram outlines the priority audiences as identified in the NCPIC Communications Strategy for the Centre's first two years of operation.

Figure 3 – the NCPIC target audiences



2.6 Resource allocation

2.6.1 Human resources

Table 4 below outlines the relative distribution of human resources across the various NCPIC teams.

Table 4 – Distribution of NCPIC human resources in Sydney at March 2010

Team	Number of staff members	Total FTE	% of Total FTE
Director and Executive Assistant (EA)	2 staff members	2	14.3%
Finance Officer	1 staff member	0.5	
Clinical Services and Evaluation Team	10 staff members	8.1	46.3%
Communications Team	4 staff members	2.7	15.4%
Training Team	5 staff members	4.2	24%

2.6.2 Financial resources

Table 5 presents an approximate breakdown of the proportion of budget allocations across activity areas for 2009-2010. [2]

Table 5 – NCPIC Resource Allocation 2009-2010

Activity Area	UNSW	Other Consortium Partner	Total
Research and clinical resource development	12.7%	22.5%	35.2%
Workforce training	14.5%	3.6%	18.1%
Cannabis Information and Helpline (CIH)		15.8%	15.8%
Resource development/ dissemination	15.7%		15.7%
Website development/ Intervention	14%		14%

This table is based on figures provided by NCPIC in their submission to Urbis. The figures provide an approximate breakdown of resources and do not include administration.

To contextualise the 2009-10 resource allocation Table 6 sets out the allocation for the first year of operation.

Table 6 – NCPIC Resource Allocation 2007-2008

Activity Area	UNSW	Other Consortium Partner	Total
Research and clinical resource development	3.1%	30%	33.1%
Workforce training	13.7%		13.7%
Cannabis Information and Helpline (CIH)		22.9%	22.9%
Resource development/ dissemination	20.3%	2.1% (ADCA)	21.4%
Website development/ Intervention		7.9%	7.9%%

[2] Resource allocation data was provided to Urbis for 09/10 and 07/08. Averages across the three financial years were unable to be calculated.

3 Key themes from the literature for this evaluation

This chapter outlines key themes that emerged from a brief scan of the current research. The purpose of this chapter is to provide an evidence base to inform the qualitative evaluation findings. The research scan also contributes to an analysis of the relevance and appropriateness of the NCPIC policy and service delivery approaches and the identification of priority target audiences.

3.1 Patterns of cannabis use

3.1.1 The prevalence of cannabis use in Australia

Cannabis is the most commonly used illicit drug in Australia[i]. In 2007, approximately one third (33.5%) of the population aged 14 years or older had used cannabis in their lifetime and 9% reported cannabis use in the previous 12 months[ii]. According to Copeland and Swift[iii] most cannabis use remains experimental and irregular. Recent users were most likely to use cannabis once or twice a year (33.5% of recent users). However, there are a notable proportion of those who use cannabis on a more regular basis. 19.8% of recent users use cannabis once a week or more and 14.9% of recent users use cannabis every day.[iv]

Australia has seen a gradual and steady decline in cannabis use over the last decade. In 1998, the percentage of people reporting cannabis use in the previous 12 months was 18%, compared with 9% in 2007. The proportion of school students reporting past year use has also declined markedly, halving from 32% in 1996 to 14% in 2005. [v]

3.1.2 Initiation of use

For those who have used cannabis during their lifetime, the mean age of first use is approximately 19 years old[vi]. The literature suggests, however, that the age of cannabis use initiation is decreasing. [vii] According to Copeland and Swift,[viii] initiation generally occurs in the teenage years and cannabis is used sporadically during adolescence and early adulthood before declining and ceasing in use from the mid to late 20's. An American study found that approximately one tenth to one third of those who used cannabis at least once a month at age 20 were doing so in their early 30's.

3.1.3 Polydrug use

Cannabis is the most commonly used illicit drug among polydrug users.[ix] Cannabis is most commonly used with alcohol and tobacco. According to the National Drug Strategy Household Survey (NDSHS),[x] 87.3% of recent cannabis users (those who had used within the previous 12 months) had used alcohol at the same time (ie on at least one occasion within a 12 month period) and 64.8% had combined cannabis with tobacco. McAtamney and Willis[xi] also report that a small, but significant, proportion of regular cannabis also use other illicit substances. For example, cannabis is sometimes used to reduce the 'coming down' effects from ecstasy, amphetamines or cocaine. The National Drug Strategy Household Survey indicates that 28.3% of recent cannabis users had used ecstasy or a designer drug (Ketamine and GHB) at the same time, and 23.8% had also used meth/amphetamines.

Cannabis is often the first illicit drug an adolescent will try, and is seen by some commentators as a gateway drug to other illicit drugs and polydrug use behaviour. Others, however, have indicated that the associations between cannabis and other illicit drug use may also be explained by common underlying factors including a predisposition to risk taking behaviour, increased access to drugs, social context and peer influence.[xii] Nonetheless, there is clearly a strong association between use of cannabis and other drugs.

3.1.4 Population groups of interest

Young people aged 20-29 years old have the highest prevalence of recent (but not lifetime) cannabis use[xiii] and those aged 14-19 years old are more likely to demonstrate heavy patterns of use (defined as smoking ten cones or joints per day).[xiv] Early initiation is an identified risk factor for developing subsequent problems such as dependence, and there are risks associated with using cannabis at a developmentally vulnerable age.[xv]

Males have a higher prevalence of cannabis use than females. Males were more likely than females to have used cannabis within the previous year (11.6% compared with 6.6%) and to use cannabis on a daily basis (16.4% compared with 12.3% for females).[xvi]

There is evidence to suggest that cannabis use is increasing within some Aboriginal and Torres Strait Islander (ATSI) communities.[xvii] Indigenous Australians who are involved in drug use typically begin use from a younger age, therefore increasing the risk of subsequent problems[xviii]. High rates of cannabis use within Indigenous communities are coupled with longstanding risk factors for poor health and social wellbeing[xix].

Older age groups (those in their 30's and 40's) were more likely to use cannabis on a regular basis (everyday or once a week).[xx] Older people who use cannabis frequently are likely to have been using it over a longer period of time, may be more entrenched users, and may have increased risk of experiencing cannabis related problems. Older users may also play an important role as parents to young people who may potentially use cannabis. Parents are identified as key audiences for a prevention strategy in the National Cannabis Strategy 2006-2011. Research relating to other drug use, for example tobacco, has found that adult attitudes and behaviours have a significant normalising effect, and some young people may model their attitudes and behaviours regarding drug use on adult role models[xxi].

Young offenders are continuing to use cannabis at high rates despite an overall decline in the use by young people at the general population level[xxii]. Young people involved in the criminal justice system are often characterized as vulnerable and at risk – many come from background of economic disadvantage, parental imprisonment and substance use, and disengagement from education, training and employment. For young offenders, experimental and regular cannabis use generally occurs at a much younger age and this early initiation is associated with increased harm[xxiii].

People with existing mental health problems are at greater risk of experiencing cannabis related harms due to the association between cannabis use and mental health problems. The causal link between cannabis use and mental health issues is still unclear; however, the evidence suggests that cannabis use can exacerbate existing mental health problems. People with a genetic vulnerability may also be at increased risk of developing mental health problems associated with cannabis use[xxiv].

3.2 Community attitudes towards cannabis

According to the NDSHS, cannabis is the drug most likely to be associated with a 'drug problem' second to heroin. This trend applied to all age groups with the exception of people aged 14-19 years, where cannabis was more highly associated. People aged 40-49 years were least likely of all age groups to associate cannabis with a 'drug problem'. [xxv]

When Australians aged 14 years or older were asked which of a range of specified substances they regard as being of most serious concern for the general community, overall cannabis was ranked the seventh out of nine categories. This followed excessive drinking of alcohol (32.3%), tobacco smoking (17.2%), meth/amphetamine use (16.4%), heroin use (10.5%), cocaine use (8.3%) and ecstasy use (6.0%). [xxvi] Only a small proportion (5.7%) of Australians regarded cannabis as the substance of most concern to the general community, compared to all other substances about which they were asked.

Although only 6.6% of Australians aged 14 years or older approved of the regular use of cannabis by an adult, cannabis was the illicit drug most commonly approved of with the exception of pharmaceuticals. [xxvii]

The extensive community consultations undertaken to inform the development of the *National Cannabis Strategy 2006-2011* indicate that there is a lack of knowledge and understanding concerning cannabis use and associated problems. There was a strong perception by many people in the community that cannabis is a relatively harmless drug. There was also confusion about the risks of cannabis use and the legal status and implications of cannabis use and possession.

3.3 Problems associated with cannabis use

Not everyone develops problems when using cannabis, and most cannabis users will not require treatment. Some people are more at risk of developing problems (ie physical problems, psychological problems and dependence) with their cannabis use than others. [xxviii] Many of the documented cannabis harms are associated with regular use. Early initiation, heavy and regular use is associated with an increased risk of experiencing cannabis related problems. [xxix]

It is estimated that approximately 1 in 10 people who have ever used cannabis will become dependent on it.[xxx] Cannabis dependence is characterised by psychological symptoms such as having a great desire to use cannabis, using regularly (often daily), and an inability to cut down use; physiological signs, such as tolerance and withdrawal; and behavioural symptoms, such as using cannabis in inappropriate circumstances[xxxi]. The risk of dependency increases with frequent use, with one in two daily users likely to become dependent. The onset of dependence most commonly occurs in adolescents or young adults within 10 years of cannabis initiation, and the rates of dependence tend to be higher among young people. [xxxii]

Cannabis use has been linked to depression, anxiety, psychotic episodes and schizophrenia. The causal relationship between cannabis use and mental health is still unclear but the evidence suggests that cannabis use can exacerbate existing problems and may trigger mental health problems in people who are already predisposed or genetically vulnerable to such problems. [xxxiii]

Cannabis is most commonly smoked, and therefore has the potential to have adverse effects on the respiratory system. Due to the common practice of mixing tobacco with cannabis when smoked, cannabis use can play a role in contributing to tobacco dependence and the harms associated with tobacco use. [xxxiv] The short term effects of cannabis intoxication can also lead to an increased risk of motor vehicle accidents – due, for example, to the impacts of cannabis use on time perception, attention, reaction time and higher cognitive functioning. [xxxv]

It has also been reported that cannabis use can have a negative impact on educational and occupational outcomes, particularly for regular users. Users experience impaired cognitive abilities while under the influence of the drug, which has the potential to affect performance at school or work. Another social harm of cannabis use is the risk that individuals become involved in the criminal justice system due to cannabis possession. Regular cannabis use or cannabis dependence is also associated with financial difficulties due to users spending a significant proportion of their income on cannabis. [xxxvi]

3.4 Cannabis prevention and treatment

3.4.1 Cannabis prevention

The reasons for commencing cannabis use are not straightforward. Each individual is subject to a number of risk factors and protective factors that increase or reduce the likelihood that they will use cannabis, experience problems with their cannabis use, or become dependent.[xxxvii] Due to the range of influencing factors, *The National Cannabis Strategy 2006-2011* outlines a number of prevention strategies including: school based education campaigns, early childhood interventions, crime prevention initiatives, responsible parenting initiatives, and initiatives aimed at ensuring school retention and connecting at risk young people with training and employment opportunities.

Schools are a prominent setting for the delivery of cannabis prevention methods. Schools are regarded as an ideal setting for communicating health messages to young people, because they can achieve a broad reach and are seen to be a credible source of health education messages. Research into the

effectiveness of school based cannabis prevention approaches indicates that a mix of program approaches is most effective in changing drug use behaviour. It has been suggested that effective programs are those that: are interactive in design and delivery, incorporate social influence strategies, are based on social learning principles, and are supplemented with a parenting or community level component. Research suggests that a generic approach to substance use prevention (ie one that incorporates alcohol and tobacco) is useful up to Year 8 but a more cannabis-specific approach is required with older students. One of the challenges associated with effective delivery of school based cannabis prevention is variations in delivery at the classroom level, particularly in relation to the implementation of interactive learning strategies. These challenges can be minimised by providing teachers with high quality training and practical support. [xxxviii]

3.4.2 Harm minimisation

Drug policy in Australia has been based on minimising drug related harms since the initiation of the National Campaign against Drug Abuse in 1985[xxxix]. The *National Drug Strategy 2004-2009*, which provides the overarching framework for the *National Cannabis Strategy 2006-2011*, is underpinned by the principle of harm minimisation. This involves three key streams: supply reduction, demand reduction and harm reduction. [xl] While harm minimisation does not condone drug use, it recognises the benefits of reducing the adverse effects of drugs on the individual and the broader community, while acknowledging that drug use will occur. [xli] Examples of harm minimisation approaches may include: substance education, safer use practices, effective treatment, controlling supply, and legal flexibility. [xlii]

3.4.3 Treatment seeking behaviour

Only a minority of problem cannabis users (those experience physical, psychological, social problems or dependence) seek treatment.[xliii] Typically, adults seeking treatment for cannabis use disorder have used cannabis nearly daily for more than ten years and have made more than six serious attempts to reduce or stop.[xliv] General practitioners were most likely to be consulted by users experiencing cannabis related problems. [xlv]

It has been reported that there has been an increase in the proportion of people seeking treatment for their cannabis use[xlvi] . In terms of cannabis use by those receiving an episode of specialist drug treatment in 2007-08:[xlvii]

- Cannabis was the second most common principal drug of concern for which treatment was provided (reported in 22% of all treatment episodes), following alcohol (reported in 44% of all treatment episodes) and 44% of all episodes involved cannabis as a drug of concern.
- Clients aged 10-19 years were the only age group to most commonly report cannabis (as opposed to alcohol) as their principle drug of concern. For this age group, cannabis represented 43% of all treatment episodes.
- For treatment episodes where cannabis was reported as the principle drug of concern, 70% of episodes were for male clients and the median age of persons receiving treatment was 26 years.
- Approximately 11% of episodes involved clients who identified as being of Indigenous origin.[xlviii]

Barriers to cannabis users seeking specialist treatment include:

- low levels of treatment readiness and resistance to stopping use
- lack of interest in, knowledge of, and motivation for treatment
- fear of stigmatisation
- a belief that treatment for cannabis is unnecessary
- users being unaware of cannabis specific treatment options. [xlix]

Facilitators to cannabis treatment have been identified as:

- improving the amount of information available for cannabis treatment

- making treatment admissions an easier process
- offering additional help with life skills.

Promoting treatment options and improving drug education may improve attitudes and motivation towards help-seeking behaviour. In addition it has been suggested that specialist cannabis treatment services can attract people who may be less willing to engage with generalist drug and alcohol services.[l]

3.4.4 Treatment approaches

The two main treatment behavioural treatment approaches for cannabis dependence are motivational enhancement therapy (MET) and cognitive behavioural therapy (CBT) both of which have been found to be effective in treating cannabis dependence and reducing cannabis related problems. MET uses a non-confrontational and non-judgemental approach to address ambivalence about quitting and strengthen motivation to change. CBT teaches skills for reducing or quitting cannabis use and managing other psychosocial or health problems. Contingency management (CM) is thought to be a potentially effective adjunct to MET and CBT. CM provides monetary based reinforcement contingent on abstinence during and post treatment when combined with MET and/or CBT. Currently, there is no approved pharmacotherapy for cannabis dependence[li].

As a treatment approach, court based drug diversion programs and police diversion interventions have been shown to have positive outcomes. Court based diversion programs respond to drug using offenders brought before the courts on different offences (usually property, driving and fraud offences). Police diversion interventions are designed to deal solely with drug charges (generally cannabis charges).[lii] Diversion generally involves redirecting offenders away from conventional criminal justice processes and towards education and treatment sessions. Results from an outcome evaluation of police diversion interventions undertaken by the AIC found that: the majority of diversion participants did not re-offend between 12 to 18 months after being cautioned; most diversion participants with prior offending records were not re-apprehended post-diversion and those that did re-offend had a decline in the rate of offending; and that there was a high rate of compliance with the majority of participants completing the required attendance of education sessions or treatment[liii].

In 2007-08 counselling was the most common main treatment received by cannabis users (33% of episodes), followed by information and education only (26%), and withdrawal management (detoxification) (12%).[liv]The prevalence of polydrug use among cannabis users has implications for treatment approaches. In 2007-08, at least one other drug of concern was reported in 60% of treatment episodes where cannabis was reported as the principle drug of concern. Other drugs of concern most commonly included alcohol (36%), nicotine (21%), and amphetamines (19%).[lv] Similarly, cannabis was most likely to be mentioned as a secondary drug of concern in alcohol focused treatments (making up 36% of other drugs). Treatment approaches that seek to address only the main drug of concern may not be as effective in addressing long-term, sustained drug using behaviour[lvi].

Particular population groups may also require tailored treatment approaches. Young people with multiple and complex needs (for example, young people involved in criminal behaviour and those suffering from mental illness) may benefit from more intensive treatments provided by interdisciplinary teams. Simpson et al[lvii] suggest that current public health messages about cannabis are not reaching or appealing to young offenders and more focused, specifically tailored intervention and prevention approaches may be required. Structured family based interventions can also be an effective option for adolescents.

3.4.5 Treatment outcomes

The literature suggests that cannabis dependent outpatients have similar problems initiating and maintaining abstinence as do those dependent on other illicit drugs. While dependent cannabis users may respond well to treatment, continued abstinence is a less common outcome than reduced cannabis use. Complete abstinence, however, is not necessary to achieve meaningful improvements and reductions in cannabis related problems. [lviii]

3.5 Chapter Summary

- Cannabis is the most commonly used illicit drug in Australia
- Most cannabis use remains experimental and irregular. Initiation generally occurs in the teenage years, used sporadically during adolescence and early adulthood before declining or ceasing in use from the mid to late 20's
- Cannabis is the most commonly used illicit drug among polydrug users, most frequently used with alcohol and tobacco. In 2007-08 at least one other drug of concern was reported in 60% of treatment episodes where cannabis was the principle drug of concern.
- Population groups of interest include: young people, ATSI populations, older users, parents, people with mental health issues, and young people with multiple and complex needs (young offenders, CALD).
- Community attitudes towards cannabis use are mixed – cannabis is often associated with a 'drug problem' while at the same time is not considered a substance of serious concern to the general community (comparative to other drugs). There is a lack of community knowledge and understanding of cannabis use and associated problems.
- Not everyone will develop problems when using cannabis. Many of the documented harms are associated with early initiation, heavy and regular use.
- Problems associated with cannabis use include dependence, mental health effects (depression, anxiety, psychosis and schizophrenia), and physical effects relating to the respiratory system, increased risk of motor vehicle accidents, negative educational and occupational outcomes and financial difficulties.
- Only a minority of cannabis of cannabis users seek treatment, Adults seeking treatment in Australia are generally males with a median age of 26 years. General Practitioners (GPs) are most likely to be consulted.
- In 2007-08 counselling was the most common treatment received by cannabis users, followed by information and education and withdrawal management.
- Particular population groups may require specifically tailored treatment options.
- Continued abstinence is a less common treatment outcome than reduced cannabis use however abstinence is not necessary to achieve a reduction in cannabis related problems.