Social Development Committee

Inquiry into addressing cannabis-related harm in Queensland

Report 10

November 2010
SOCIAL DEVELOPMENT COMMITTEE

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Ms Rachelle Stacey – Acting Research Director (from 18 October 2010)
Ms Erin Pasley – Principal Research Officer
Mrs Gail Easton – Executive Assistant (until 21 May 2010)
Ms Stephanie Cash – Executive Assistant (from 10 August 2010)

CONTACT DETAILS

For further information please contact the committee secretariat:

Telephone: 07 3406 7230
Fax: 07 3406 7500
Email: sdc@parliament.qld.gov.au

Information on the committee, copies of committee reports and the terms of reference for current inquiries are available on the committee's Internet site: http://www.parliament.qld.gov.au/sdc
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LIST OF ABBREVIATIONS

ACC  Australian Crime Commission
ACT  Australian Capital Territory
AM   Member of the Order of Australia
ATODS Alcohol, Tobacco and Other Drugs Services
CBD  cannabidiol
CBT  Cognitive Behavioural Therapy
CIH  Cannabis Information and Helpline
CMC  Crime and Misconduct Commission
CRYPAR Coordinated Response to Young People at Risk program
DEM  Director, Emergency Medicine
DSM  Diagnostic and Statistical Manual of Mental Disorders
MET  Motivational Enhancement Therapies
MP   Member of Parliament
MTF  Monitoring the Future program
NCPIC National Cannabis Prevention and Information Centre
NDC  National Drugs Campaign
NGO  Non-governmental Organisation
NOAH narcotics, opiates, amphetamines (and) hashish
PLoS Public Library of Science
QMERIT Queensland Magistrates Early Referral and Treatment Program
QPRIME Queensland Police Service recording system
QPS  Queensland Police Service
Qld  Queensland
QUT  Queensland University of Technology
SA   South Australia
THC  delta-9-tetrahydrocannabinol (the main psychoactive ingredient in cannabis)
UN   United Nations
WA   Western Australia
WHO  World Health Organization
## Glossary

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<tr>
<td>amotivational syndrome</td>
<td>A pattern of behaviour characterised by a lack of motivation, energy and initiative.</td>
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<td>amphetamine</td>
<td>Any of a class of drugs that have stimulant and vasoconstrictor activity.</td>
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<td>Meth(yl)amphetamine</td>
<td>A synthetic drug that acts as a powerful central nervous system stimulant, e.g. ice, speed and ecstasy.</td>
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<td>bong</td>
<td>A water pipe used to smoke cannabis (may also be used with tobacco).</td>
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<td>cannabidiol (CBD)</td>
<td>A cannabinoid found in cannabis. It is a major constituent of the plant, representing up to 40 per cent in its extracts. It is found in inverse ratio to THC. That is, as the level of THC rises that of CBD falls.</td>
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<tr>
<td>cannabinoid</td>
<td>A chemical that acts upon the same receptor sites in the brain as THC.</td>
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<td>carcinogen</td>
<td>A substance that causes cancer.</td>
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<td>cone</td>
<td>The section of a water pipe that contains cannabis is the cone piece. Therefore the unit of measurement is referred to as a 'cone'.</td>
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<td>ecstasy</td>
<td>A 'street' term commonly used for tablets containing MDMA, or 3,4-methylendioxymethamphetamine.</td>
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<td>epidemiological research</td>
<td>Research that studies the occurrence of disease or risk factors for disease in the general population.</td>
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<td>joint</td>
<td>Herbal cannabis or resin (sometimes mixed with tobacco or other plant material) rolled into a cigarette.</td>
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<td>longitudinal study</td>
<td>A study design in which people who have and have not been exposed (e.g. to cannabis) are followed up to see how many develop a disease.</td>
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<td>opiates (opioids)</td>
<td>The generic term applied to alkaloids and their derivatives obtained from the opium poppy (Papaver somniferum), including methadone, morphine, heroin, and codeine.</td>
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<tr>
<td>psychoactive</td>
<td>Affecting the mind or mood or other mental processes.</td>
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<tr>
<td>delta-9-tetrahydrocannabinol (THC)</td>
<td>The main psychoactive ingredient in cannabis) i.e. the cannabinoid that is responsible for the 'high'.</td>
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Chair’s Foreword

CHAIR’S FOREWORD

Cannabis is an illicit drug that provokes a wide divergence of public opinion. Some people consider it to be a relatively benign substance that they argue is no more harmful than legal drugs such as alcohol or tobacco. Others see cannabis as an extremely dangerous substance responsible for a wide range of serious physical and mental harms.

During its inquiry the committee received a wide range of evidence and has attempted to get a balanced understanding of the risks associated with cannabis use and the steps that need to be taken to reduce the level of cannabis use in the community.

Research is increasingly indicating that there are risks associated with using cannabis, particularly where that use begins at a young age or where the level of use is regular and heavy. The most significant risks are the risk of developing dependence, vehicle accidents, poor educational attainment, cardiovascular and respiratory problems in older users, and psychosis. While the chance of developing psychosis or schizophrenia is not statistically high, the consequences for an individual are so serious that it is important people, particularly young people, are clearly warned of the association between cannabis use and serious mental illness.

It is true that cannabis is the most commonly used illicit substance in Australia. Fortunately, however, cannabis use appears to be declining and most people who try cannabis do not go on to use frequently. While it is important to get a clear, balanced message to the general community, it is also vital to target responses to those most at risk, namely young people and people who use cannabis at harmful levels such as older, long-term users; people with mental health problems; and people in Aboriginal and Torres Strait Islander communities.

To this end the committee has made 28 recommendations that aim to reduce the level of cannabis use in Queensland. They include strategies to better understand the nature of the drug and its effects; to enhance law enforcement strategies; to improve drug education in schools; to extend the reach and impact of the National Drugs Campaign; to optimise treatment opportunities; and to enhance responses in Aboriginal and Torres Strait Islander communities.

I thank submitters and witnesses to this inquiry, as well as those who took the time to meet with the committee and discuss this issue. I also thank my fellow committee members for their dedication and tireless effort in contributing to this report and to the secretariat for assisting the committee.

I commend the information in this report to the House.

Lindy Nelson-Carr MP

Chair
RECOMMENDATIONS

Recommendation 1
The committee recommends that the Minister for Health work through the Ministerial Council on Drug Strategy to address concerns about the validity and reliability of the National Drug Strategy Household Survey and the Australian Secondary Students' Alcohol and Drug Survey to ensure the collection of high-quality data about changing patterns of drug use in the Australian population, particularly among young people. 17

Recommendation 2
The committee recommends that the Queensland Government consider the feasibility of adopting a nationally consistent approach to the systematic scientific testing of samples of cannabis seizures in order to monitor chemical consistency, potency (THC and CBD content) and contamination. Data collected should include information about whether the samples are from bush crops or indoor enhanced cultivation. 36

Recommendation 3
The committee recommends that in addition to the important research that is currently being undertaken to understand cannabis-related harms, the Queensland Government also encourages and considers research that examines the neuroscience of cannabis use. 38

Recommendation 4
The committee recommends that the Queensland Government consider establishing a consultative committee consisting of representatives from relevant government agencies and community sector agencies to have input into developing, monitoring and evaluating Queensland drug policy. 42

Recommendation 5
The committee recommends that the Queensland Government clarify the key objectives of the cannabis diversion initiatives and ensure evaluations clearly address these objectives. 54

Recommendation 6
The committee recommends that the Queensland Government investigate ways to expand the diversion opportunities for minor cannabis offences, including addressing issues relating to: the requirement that offenders admit the offence; limits on the number of times diversion can be offered; administrative procedures that may discourage diversion; and barriers to Aboriginal and Torres Strait Islander people being involved in diversion. 54

Recommendation 7
The committee recommends that the Queensland Government ensure any expansion of diversion opportunities for minor cannabis offences is accompanied by expanded funding to the alcohol and other drug sector to meet increased demand for services. 55

Recommendation 8
The committee recommends that the Queensland Police Service implement a system to record whether seized cannabis has been grown indoors (hydroponically or otherwise) or as a bush crop. 59
Recommendation 9
The committee recommends that the Queensland Government monitor developments in the hydroponics industry in Queensland and the effectiveness of the South Australian legislation regulating the hydroponics industry in that state. 60

Recommendation 10
The committee recommends that the Queensland Government ensure police are educated about the risks associated with cannabis use and treatment options and are proactive in providing this information to individuals, families and community groups. 62

Recommendation 11
The committee recommends that the Queensland Government use a person being charged following a positive roadside drug test as an opportunity to also provide the person with information and educational material about the risks associated with cannabis use and options for seeking help with their cannabis use. 64

Recommendation 12
The committee recommends that the Department of Education and Training review the drug education that is being provided in schools to ensure that it follows the national Principles for School Drug Education. 67

Recommendation 13
The committee recommends that the Queensland Government through the Ministerial Council on Education, Early Childhood Development and Youth Affairs ensure the inclusion of consistent, age-appropriate drug education be part of the national Health and Physical Education curriculum development. 67

Recommendation 14
The committee recommends that the Department of Education and Training ensure that drug education is being provided to all students in years 11 and 12 regardless of subject selection. 67

Recommendation 15
The committee recommends that the Queensland Government ensure the cannabis education programs that are available to Queensland schools are evidence based and thoroughly evaluated and consider providing access to CRUfaD Schools and MAKINGtheLINK programs in Queensland schools. 72

Recommendation 16
The committee recommends that the Queensland Government ensure teachers are provided with ongoing professional development and support to assist teachers to provide high-quality, consistent drug education in schools. 73

Recommendation 17
The committee recommends that the Queensland Government ensure school staff, including guidance counsellors and school-based health nurses, are aware of the risks associated with cannabis use and the appropriate referral pathways for students to prevent cannabis-related harms. 75
Recommendation 18
The Committee recommends that the Queensland Government extend the reach and impact of the National Drugs Campaign through a targeted cannabis social marketing campaign aimed at young people, which provides links to treatment and support services.

Recommendation 19
The Committee recommends that the Queensland Government support further research into the advancement of pharmacological treatments for the management of cannabis withdrawal.

Recommendation 20
The committee recommends that the Queensland Government investigate the efficacy of cannabis clinics as a treatment option.

Recommendation 21
The committee recommends that the Queensland Government optimise and promote the use and availability of web-based delivery of treatment for cannabis users.

Recommendation 22
The committee recommends that the Queensland Government facilitate greater awareness and use of the Cannabis Information and Helpline in Queensland.

Recommendation 23
The committee recommends that the Queensland Government promote routine opportunistic screening for problem cannabis use in primary healthcare settings and ensure that medical practitioners and healthcare workers have the appropriate information and tools.

Recommendation 24
The committee recommends that the Queensland Government enhance treatment opportunities for cannabis users with co-occurring drug and mental health problems by ensuring better integration between mental health services and drug and alcohol services.

Recommendation 25
The committee recommends that the Queensland Government ensure the Weed it Out project and associated demand reduction and capacity building initiatives are consistently and appropriately funded.

Recommendation 26
The committee recommends that the Queensland Government promote Indigenous community projects to encourage Aboriginal and Torres Strait Islander people to raise awareness of the harms associated with cannabis use and spread the message that cannabis is not part of Aboriginal and Torres Strait Islander culture.

Recommendation 27
The committee recommends that the Queensland Government ensure adequate, accessible and culturally appropriate cannabis treatment services are provided in Aboriginal and Torres Strait Islander communities.
Recommendation 28
The committee recommends that the Queensland Government provide incentives for Aboriginal and Torres Strait Islander people to train as Indigenous health workers to work in the area of addiction and provide support for Aboriginal and Torres Strait Islander cannabis users.

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PART 1 Introduction

CHAPTER 1 – THE INQUIRY

1.1. Social Development Committee

1. The Social Development Committee (the committee) is a select committee of the Queensland Legislative Assembly, established by resolution on 23 April 2009 to monitor and report on issues in the policy areas of health, education and training, social welfare services, community development, housing, child safety, and Aboriginal and Torres Strait Islander policy.1

2. The committee is also responsible for monitoring and reporting on the Family Responsibilities Commission, the Commission for Children and Young People and Child Guardian, and the Health Quality and Complaints Commission.2

1.2. Inquiry terms of reference

3. In March 2009, Drug Free Australia released a publication entitled Cannabis – suicide, schizophrenia and other ill-effects, which highlighted certain mental and physical risks associated with cannabis use. It also made eleven recommendations intended ‘to provide advice and strategies to politicians, decision-makers and researchers to ensure that the level of cannabis use in Australia is markedly reduced.’3

4. On 20 May 2009, Mr Peter Wellington MP, an independent member of the Queensland Parliament, moved a motion in the Legislative Assembly to refer the Cannabis – suicide, schizophrenia and other ill-effects research paper ‘to the Social Development Committee for investigation and report.’4 The motion was debated and agreed to with bipartisan support.5

5. Although the Drug Free Australia publication provided the impetus for the inquiry, the committee saw the referral as an opportunity to broadly review the current evidence about the risks associated with cannabis use (particularly for young people), and assess the most appropriate strategies to reduce the level of cannabis use in Queensland.

1.3. Inquiry process

6. Prior to formally commencing the inquiry, committee members attended the 1st National Cannabis Conference in Sydney in September 2009. The committee also met informally with Professor Wayne Hall to discuss the review he and

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Professor Louisa Degenhardt had conducted on the adverse effects of non-medical cannabis use, which was published in *The Lancet* in late 2009.6

7. On 11 March 2010, the committee published an issues paper to provide information about the scope of the inquiry, stimulate public discussion, and invite public submissions. In keeping with the terms of the referral, the committee used the Drug Free Australia publication as the starting point for the issues paper, but was very conscious of the fact the publication presented only one view of the issues. The paper therefore posed a number of general questions in order to open the topic up to broad debate and encourage a wide range of responses.

8. The inquiry was advertised in the *Courier-Mail*, *Gold Coast Bulletin*, *Sunshine Coast Daily*, *Toowoomba Chronicle*, *Gladstone Observer*, *Rockhampton Morning Bulletin*, *Townsville Bulletin*, and *Cairns Post* on Saturday 13 March 2010, and in the *Koori Mail* on Wednesday 24 March 2010. A copy of the advertisement is attached at Appendix 1.

9. The committee released a media statement and wrote to interested individuals and organisations advising them of the inquiry and inviting them to make a submission.

10. Sixty-two submissions were received, details of which are listed at Appendix 2. The committee agreed to suppress the names of five individuals who made submissions in order to prevent the identification of individuals who may have used cannabis.7

11. The committee collected further evidence at public hearings held on Thursday 3 June and Friday 4 June 2010 at Parliament House in Queensland. Witnesses included representatives from both government and non-government agencies, doctors, researchers, drug reform advocates, witnesses representing parents, and school principals, as well as individuals appearing in a private capacity. The committee heard from a number of interstate witnesses via teleconference. A full list of witnesses is attached at Appendix 4. A copy of the advertisement for the public hearings is attached at Appendix 3.


1.4. Committee's approach

13. During the course of the inquiry a number of organisations expressed concern about the Drug Free Australia publication being used as the basis for the inquiry.8 The scientific quality of the publication has been questioned,9 and its recommendations have been criticised for ignoring the scientific evidence and extensive community consultation set out in the *National Cannabis Strategy 2006-2009*, and for failing to recognise the work currently being done in

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7 Submissions no. 10, 17, 18, 19, and 28.

8 HEMP Embassy, *Submission no. 36*, p. 2; Alcohol and other Drugs Council of Australia, *Submission no. 47*.

9 Mr Bob Green, *Submission no. 12*; Queensland Institute of Medical Research, *Submission no. 24*; Professor David Kavanagh and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, *Submission no. 42*; National Cannabis Prevention and Information Centre, *Submission no. 48*, pp. 2-3.
this area by government and non-government agencies. The committee understands these criticisms but notes also that two submissions praised Drug Free Australia's work.

14. Although the terms of the referral required the committee to investigate and report on the Drug Free Australia publication, the committee took this as an opportunity to consider the issue of cannabis-related harm more broadly. The committee's issues paper used the Drug Free Australia publication as a starting point. Rather than endorsing Drug Free Australia's approach, the issues paper attempted to pose a range of broad questions that would stimulate discussion and debate.

1.5. This report

15. This report is not a critique of the Drug Free Australia publication, nor does it pretend to be a scientific review of the evidence. Rather it is an attempt to inform the Queensland Parliament of the current state of knowledge about the risks and harms associated with cannabis use, and the strategies that are required to address those risks and harms, and to reduce the use of cannabis in Queensland. The committee does this primarily by drawing on the evidence the committee received from submitters and witnesses.

16. The report has three parts: the first considers the nature of cannabis and patterns of use; the second reviews the risks associated with cannabis use; and the third examines strategies to reduce the level of cannabis use in Queensland.

17. The report makes recommendations for action by the Queensland Government. The Parliament of Queensland Act 2001 (Qld) requires the responsible Ministers to respond to the recommendations within three to six months of the report being tabled. A copy of section 107 of the Act is attached at Appendix 5.

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10 National Cannabis Prevention and Information Centre, Submission no. 48, p. 3; Queensland Network of Alcohol and Drug Agencies, Submission no. 59.
11 Dr Stuart Reece, Submission no. 9; FamilyVoice Australia, Submission, no. 44.
CHAPTER 2 – OVERVIEW OF CANNABIS, ITS USE, AND AVAILABILITY

2.1. What is cannabis?

18. Cannabis comes from the plant *cannabis sativa* and takes three main forms: marijuana, hashish, and hash oil.

19. Marijuana consists of the dried flowering tops and leaves of the plant. Hashish is made from dried resin from the cannabis plant and compressed cannabis flowers. Hash oil is a thick oil extracted from hashish.12

20. The *cannabis sativa* plant is easily cultivated in Australia and the Crime and Misconduct Commission (CMC) reports that the climate and environment in Queensland supports the growth of substantial bush crops.13

2.2. How is cannabis used in Australia?

21. Marijuana is by far the most common form of cannabis used in Australia. In 2007, 65 per cent of recent users14 used the dried heads of the plant, while almost 38 per cent of recent users used the leaves of the plant. Only 11 per cent used hashish and 5.6 per cent used hash oil.15

22. Cannabis is most frequently consumed by smoking, either in a water pipe (bong) or as a cigarette (joint). In 2007, 84.3 per cent of recent users reported smoking cannabis as a joint, while 81.7 per cent reported smoking a bong or pipe.16 Almost two-thirds of these users combined the cannabis with tobacco.17

23. Marijuana, hashish, and hash oil can also be added to food or drink, and consumed orally. This form of consumption is uncommon in Australia.18

2.3. Why do people use cannabis?

24. Cannabis contains cannabinoids that produce a psychoactive or mind-altering effect. The cannabinoid with the strongest psychoactive effect is delta-9-tetrahydrocannabinol, commonly referred to as THC.

25. People use cannabis for a wide range of reasons, including: to feel good;19 because of natural curiosity to experience an altered mind state;20 to enhance

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14 Recent user is defined as a person who used the drug in the previous year.
19 Queensland Council for Civil Liberties, Submission no. 52, pp. 1-2.
20 Mr Bhima Emz, Submission no. 7; Name suppressed, Submission no. 10.
creativity;\textsuperscript{21} to cope with problems;\textsuperscript{22} for relaxation and to get to sleep;\textsuperscript{23} to relieve the side effects of medication;\textsuperscript{24} to relieve boredom;\textsuperscript{25} and because of peer pressure.\textsuperscript{26}

26. The most common reasons given by participants in a recent evaluation of Queensland drug diversion programs were: to relax or relieve tension (81 per cent); to have a good time with friends (71.6 per cent); and to feel good or get high (70.6 per cent).\textsuperscript{27}

27. During focus group sessions conducted by BoysTown, cannabis, along with alcohol, was identified as the main drug of choice among young people aged 16 years and over, many of whom saw it as 'a cheap, mild and harmless substance suitable for recreational purposes.'\textsuperscript{28}

2.4. How prevalent is cannabis use?

28. Cannabis is the most commonly used illicit drug in Australia. Although cannabis use was relatively rare in Australia forty or fifty years ago, its popularity grew rapidly from the early 1970s,\textsuperscript{29} so that in 2007 an estimated 5.7 million Australians or 33.5 per cent of the population had used the drug at least once in their lives and an estimated 1.5 million people or 9.1 per cent of the population had used cannabis in the previous year.\textsuperscript{30} It has been noted that 'cannabis has become assimilated into the Australian culture as a recreational intoxicant second only to alcohol in its popularity.'\textsuperscript{31}

\begin{footnotesize}
\begin{enumerate}
\item Name suppressed, Submission no. 18; BoysTown, Submission no. 39; Mr Ben Griffiths, Submission no. 43.
\item BoysTown, Submission no. 39, p. 11.
\item BoysTown, Submission no. 39, p. 11.
\item BoysTown, Submission no. 39, p. 15.
\item BoysTown, Submission no. 39, p. 15.
\item BoysTown, Submission no. 39, p. 6.
\end{enumerate}
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PART 1 Introduction

Chapter 2 - Overview of cannabis, its use, and availability

Figure 1 Drug use patterns in Australia, proportion of the population aged 14 years or older, 2007.


29. In 2007, recent cannabis use (including use in the previous year, month, and week) was most prevalent among Australians aged between 20 and 29 years, declining in later age groups. Recent use was also more prevalent among males than females. These patterns of use support the view that cannabis is generally a phenomenon of young adulthood, and that most users stop once they enter their mid to late 20s.

Figure 2 Recent cannabis use, persons aged 14 years or older, 2007.


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33 Queensland Alcohol and Drug Research and Education Centre, Submission no. 31, p. 2; Professor Jake Najman, Queensland Alcohol and Drug Research and Education Centre, Hearing Transcript, 4 June 2010, p. 23.
30. Although the number of people who use cannabis is high compared to other illicit drugs, there is evidence to suggest cannabis use is declining in Australia. The number of people reporting past-year use in 2007 (9.1 per cent) was significantly lower than the number reporting past-year use in 2004 (11 per cent).34 Similar patterns were evident in Queensland.35

Figure 3 Cannabis use in the previous 12 months, proportion of the population aged 14 years or older, Australia and Queensland, 1993 to 2007.


31. Data from the Australian Secondary Students' Alcohol and Drug Survey also shows that the proportion of school students reporting lifetime, monthly, and weekly use of cannabis steadily declined between 1996 and 2005.36 For Queensland students, cannabis use at least once in a student's lifetime decreased significantly from 30 per cent in 1996 to 20 per cent in 2005; and in 2005, 95 per cent of students had not used cannabis in the week prior to the survey, compared with 90 per cent in 1996.37

32. The reasons for the decline are unclear. They may include: the success of prevention and education messages;38 a reduction in the number of people who are smoking generally;39 factors related to global youth popular culture and the

37 Queensland Health (2007) Illicit Drug Use Among Queensland School Students Aged 12 to 17 Years 2005, Queensland Government: Brisbane. It should be noted that school surveys do not reach many young people who are particularly at risk, namely those who are not attending school. National Drug Research Institute, Submission no. 60, p. 5.
39 National Drug Research Institute, Submission no. 60, p. 5.
representation of cannabis in music, films and magazines; an increasing awareness of the capacity of cannabis to cause harm; the increased popularity of other drugs such as ecstasy; and the shift towards more problematic alcohol use.

33. Most cannabis users do not go on to use cannabis frequently. It is estimated that: about a half of all people who try cannabis are experimenters who only use once or a handful of times in their lifetimes; about a quarter become regular users who typically use recreationally at weekends or social occasions and are unlikely to become dependent; while the remaining quarter use cannabis frequently, more often than once a week.

34. Even though past-year cannabis use may be declining, there are signs that the rate of frequent, heavy use may be increasing in certain groups of users. For example, a recent study suggests the rate of harmful use, including daily use, has increased markedly since 1995, particularly among users aged between 40 and 49 years. The study also found daily users aged between 14 and 19 years were more likely to use larger amounts of cannabis on each occasion (10 or more cones or joints each day) and report difficulties controlling their use.

35. Concerns have also been expressed about the level of use: in remote communities, including Indigenous communities, among young people who are in contact with the juvenile justice system; and among people with mental health problems.

2.5. Monitoring trends in drug use

36. Since the advent of the national approach to drug policy in 1985 Australia has put in place mechanisms to regularly monitor drug use trends in order to evaluate the impact of the National Drug Strategy. As a consequence there are a number of sources of drug information available nationally, including the National Drug Strategy Household Survey and the Australian Secondary Students' Alcohol and Drug Survey.

evaluation of the National Drug Strategy noted concerns about falling survey response rates and the implications for the validity of survey findings.  

38. The Australian Secondary Students' Alcohol and Drug Survey has collected data on illicit drug use every three years since 1996. The survey is a collaboration between federal, state, and territory health departments, and state cancer councils. The evaluation of the National Drug Strategy reported concerns about undocumented variations in the methodology of the survey on a school-by-school basis. The evaluation recommended the validity and reliability of both the National Drug Strategy Household Survey and the Australian Secondary Students' Alcohol and Drug Survey be reviewed.

39. The committee heard about the value of accurately and consistently monitoring the level of illicit drug use in Queensland schools in order to determine the extent of the problem, and assess whether particular programs are working. Professor Jake Najman from the Queensland Alcohol and Drug Research and Education Centre made the committee aware of the Monitoring the Future (MTF) program in the United States. The MTF survey has been conducted annually by the University of Michigan's Institute for Social Research since 1975. Each year approximately 50,000 8th grade, 10th grade and 12th grade students complete questionnaires administered in-class by University personnel following standardised procedures. Annual follow-up questionnaires are sent to a sample of graduates for a number of years after they leave school. Results provide valuable information about trends in drug use; perceptions of risk; and approval of, and availability of, drugs.

40. The committee acknowledges that Australia has been recognised to be among the world's leaders in collecting data that can be used to monitor drug related issues and trends. It recognises, however, that there is a need for a more regular and methodologically rigorous collection of data about drug use and attitudes among school children. This is particularly important for a drug such as cannabis, given the young age at which people begin to use the drug and the risks associated with early initiation. It seems anomalous that annual data is collected about drug use by injecting drug users, regular ecstasy users, and police detainees, but not school students.

55 Professor Jake Najman, Queensland Alcohol and Drug Research and Education Centre, Hearing Transcript, 4 June 2010, p. 25.
56 Data for 8th and 10th graders has been collected since 1991.
41. The committee recognises that the National Drug Strategy Household Survey already includes information about people aged 14 and over, and that school surveys would not capture the group of adolescents who may have dropped out of school. Patterns of drug use are changing constantly with the emergence of new drugs and changing messages about existing drugs. For example, Professor Najman informed the committee there was anecdotal evidence that young people use ecstasy because they see it as healthier and less risky than cannabis.

42. Given Australia's national approach to drug policy, any change to data collection would ideally be introduced nationally as part of a national drug information system; however, if a national approach is not adopted, the surveys should be implemented in Queensland.

Recommendation 1
The committee recommends that the Minister for Health work through the Ministerial Council on Drug Strategy to address concerns about the validity and reliability of the National Drug Strategy Household Survey and the Australian Secondary Students’ Alcohol and Drug Survey to ensure the collection of high-quality data about changing patterns of drug use in the Australian population, particularly among young people.

2.6. Availability

43. Cannabis is reported to be 'widely, easily and consistently available' throughout Queensland. The 2007 National Drug Strategy Household Survey found nationally that 36 per cent of all respondents, and over 80 per cent of recent cannabis users, reported that cannabis was easy to obtain.

44. This was confirmed by a survey of regular injecting drug users, which found that, in 2009, over 80 per cent of regular injecting drug users reported both hydroponic and bush cannabis as very easy or easy to obtain in Queensland. A similar survey of regular ecstasy users found that over 90 per cent of respondents reported hydroponic cannabis was very easy or easy to obtain, but only 55 per cent of respondents reported bush cannabis as very easy or easy to obtain in Queensland.

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62 National Drug Research Institute, Submission no. 60, pp. 12-14.
63 Detective Senior Sergeant Johnson, Queensland Police Service, Hearing Transcript, 3 June 2010, p. 7; Professor Jake Najman, Queensland Alcohol and Drug Research and Education Centre, Hearing Transcript, 4 June 2010, pp. 23-24; Ms Kathleen Florian, Australian Crime Commission, Hearing Transcript, 4 June 2010, p. 34.
64 Professor Jake Najman, Queensland Alcohol and Drug Research and Education Centre, Hearing Transcript, 4 June 2010, pp. 23-24.
66 Recent user is defined as a person who used the drug in the previous 12 months.
45. The price of cannabis appears to be fairly stable with participants in a recent survey of regular injecting drug users reporting that in 2009 the median price for a gram of bush cannabis was $20, and $25 for a gram of hydroponically grown cannabis. The median price for an ounce of bush cannabis was $280 compared to $300 for hydroponically grown cannabis.\(^70\) The low cost of cannabis compared to other drugs makes it attractive and accessible to a wide range of users.\(^71\)

46. The Crime and Misconduct Commission reported that cannabis is cost-effective and relatively easy to cultivate.\(^72\) The market is supplied by a combination of personal, social, and commercial cultivators,\(^73\) which means the level of sophistication ranges from rudimentary to fairly complex operations.\(^74\) Personal cultivators grow cannabis for their own use, whereas social cultivators produce more than they need for themselves, and provide the excess to friends, either as a gift or for a small fee.\(^76\) Commercial cultivators include family-based syndicates, friendship-based syndicates, and traditional organised criminal groups such as outlaw motorcycle gangs.\(^76\)

47. The 2007 National Drug Strategy Household Survey found nationally that 68.5 per cent of recent users\(^77\) usually obtained cannabis from a friend or acquaintance, 19.5 per cent usually obtained cannabis from a dealer, and only 3.1 per cent grew the cannabis themselves.\(^78\) The Crime and Misconduct Commission has noted a steady increase in the proportion of recent cannabis users nominating a dealer as their usual source of supply, which may indicate a change in the proportion of commercial cultivators supplying the market.\(^79\)

48. According to the Australian Crime Commission, hydroponic or other enhanced indoor cultivation methods are the most commonly detected method of cultivation. Indoor cultivation allows a plant to be grown throughout the year resulting in a higher yield of 'head' or 'buds' in a shorter period of time.\(^80\) Although there have been reports of increases in the level of hydroponic cannabis detections in Queensland, bush crops appear to remain a significant method of cultivation due to the state's climate and geography.\(^81\)


\(^74\) Australian Crime Commission, Submission no. 55, p. 2.


\(^77\) Recent user is defined as a person who used the drug in the previous 12 months.


\(^80\) Australian Crime Commission, Submission no. 55, p. 2.

49. The majority of cannabis seized in Australia is domestically produced. The relatively cheap and abundant supplies from domestic cultivation and the risk of detection at the border makes the importation of cannabis into Australia financially unattractive.\textsuperscript{a2}

2.7. Committee comments

50. Cannabis, usually in the form of marijuana, is widely available and commonly used both nationally and in Queensland. The committee notes that, although cannabis is the most commonly used illicit drug, most people who try the drug do not go on to use frequently. There is also evidence that rates of use are declining in the general population and this may be due to an increasing community awareness that cannabis is not as harmless as was once thought. The committee notes, however, concerning trends including: declining age of first use and higher rates of use among certain groups such as: older long-term users; people in Aboriginal and Torres Strait Islander communities; and people with mental health problems.

\textsuperscript{a2} Australian Crime Commission, Submission no. 55, p. 2.
PART 2  Cannabis-related Harm

CHAPTER 3 – FINDINGS ON CANNABIS-RELATED HARM

3.1. What do we mean by cannabis-related harm?

51. Cannabis-related harm can be broadly defined as any adverse social, physical, psychological, legal or other consequence of cannabis use that is experienced by the person using cannabis or by people living with or otherwise affected by the actions of a person using cannabis.83

52. There is a growing concern that cannabis may not be as harmless as was previously thought.84 In the last ten years there has been a significant increase in epidemiological and clinical research into the effects of cannabis, particularly on adolescents and young people.85

53. A major challenge in interpreting this research is to exclude alternative explanations for the findings, particularly explanations that relate to the characteristics of users, and the effect of other drug use.86 For example, in 2007 over 87 per cent of Australians who reported having used cannabis in the previous year reported having used alcohol at the same time.87 It is therefore often difficult to definitively attribute a particular harm to cannabis use.

3.2. Risks associated with cannabis intoxication

54. Cannabis has a low level of acute toxicity compared to other drugs including alcohol.88 This is due to the fact cannabis does not depress respiration like opioids or have toxic effects on the heart and circulatory system like cocaine and other stimulants.89 The estimated lethal dose of THC (the main psychoactive ingredient in cannabis) is between 15 grams and 70 grams, which is far greater than even heavy users would consume in a day.90

55. Some users, particularly inexperienced users, report negative short-term effects such as anxiety, panic reactions and, when the dose is high, psychotic symptoms.91

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56. Cannabis (THC) use has been found to impair reaction time, information processing, perceptual-motor coordination, motor performance, attention and tracking behaviour. This has serious implications for cannabis users who drive motor vehicles or operate similar machinery while intoxicated, and has led commentators to identify the increased risk of motor vehicle crashes as one of the most probable adverse effects of cannabis use.

3.3. Risks of addiction and dependence

57. Cannabis dependence is a well accepted disorder that is documented in the relevant classification systems of mental health disorders, including the Diagnostic and Statistical Manual of Mental Disorders (DSM). Dependence is characterised by tolerance to the effects of cannabis, withdrawal symptoms if use is stopped or reduced, and difficulty controlling consumption despite associated physical and psychological problems.

58. The American Psychiatric Association is currently revising the DSM and there is a proposal to include cannabis withdrawal as a disorder and cannabis dependence criterion in DSM-5.

59. Cannabis has a lower dependence potential than other drugs. The risk of dependence by people who have used cannabis at least once has been estimated to be 9 per cent, compared to 32 per cent for nicotine, 23 per cent for heroin, 17 per cent for cocaine, 15 per cent for alcohol, and 11 per cent for stimulant users. The risk of dependence rises to 16 per cent if cannabis use begins in adolescence, and increases with regularity and extent of use.

60. Dependence has been identified as the largest public health concern associated with cannabis. In 2007 it was estimated that 0.4 per cent of Australians were dependent on cannabis, and 0.6 per cent were using cannabis in a harmful

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95 National Cannabis Prevention and Information Centre, Submission no. 48, p. 9. See also: Professor David Kavanagh and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, Submission no. 42.


100 Professor Jan Copeland, Director, National Cannabis Prevention and Information Centre, Hearing Transcript, 3 June 2010, p. 42; Mr Bob Green, Submission no. 12, pp. 2-3.

101 Professor Jan Copeland, Director, National Cannabis Prevention and Information Centre, Hearing Transcript, 3 June 2010, p. 41.
manner, with harmful use and dependence more common in males than females.\(^{102}\)

61. It has been suggested that cannabis dependence is fairly mild compared to other forms of dependence,\(^{103}\) that most people who abuse cannabis or experience cannabis dependence stop using cannabis without treatment,\(^{104}\) and in the absence of treatment a person will experience the cannabis use disorder for about two years.\(^{105}\)

62. The National Cannabis Prevention and Information Centre is developing the first valid and reliable measure of cannabis withdrawal for use in clinical and research settings, and in exploring the disability associated with cannabis withdrawal.\(^{106}\)

3.4. Risks to physical health

3.4.1. Brain function

63. Some studies have found that regular and long-term cannabis use is associated with subtle cognitive impairment,\(^{107}\) particularly in relation to verbal learning and memory, sustained attention, and executive functioning.\(^{108}\)

64. The reason for this is unclear and may be related to acute drug effects, residual drug effects, or the effects of cumulative THC exposure.\(^{109}\) There are also suggestions that impairment may relate to the age at which a person first used cannabis, with people who start using cannabis before the age of 17 having greater impairment.\(^{110}\) More research is needed to determine whether cognitive impairment in long-term users is related to structural changes in the brain.\(^{111}\)

65. It is unclear whether cognitive function recovers after a person stops using cannabis.\(^{112}\)


\(^{103}\) Dr Alex Wodak, Australian Drug Law Reform Foundation, *Hearing Transcript*, 3 June 2010, p. 29.

\(^{104}\) Families and Friends for Drug Law Reform (ACT), *Submission no. 45*, p. 4; Family Drug Support, *Submission no. 58*, p. 5.

\(^{105}\) Queensland Alcohol and Drug Research and Education Centre, *Submission no. 31*, p. 6.

\(^{106}\) National Cannabis Prevention and Information Centre, *Submission no. 48*, p. 10; Professor Jan Copeland, Director, National Cannabis Prevention and Information Centre, *Hearing Transcript*, 3 June 2010, pp. 42-43.


\(^{108}\) National Cannabis Prevention and Information Centre, *Submission no. 48*, pp. 6-7; National Drug Research Institute, *Submission no. 60*, p. 7.


\(^{110}\) National Cannabis Prevention and Information Centre, *Submission no. 48*, p. 7.


3.4.2. Cardiovascular health

66. An immediate effect of using cannabis is that it elevates a user's heart rate between 20 and 50 per cent, which puts considerable stress on the cardiovascular system.\textsuperscript{115} This is most noticeable in inexperienced or occasional users as regular users develop a tolerance to the effect.\textsuperscript{114} While cannabis use does not generally have a negative effect on the cardiovascular health of healthy young people in the short term, there do appear to be risks for people with cardiovascular disease.\textsuperscript{115}

67. The Heart Foundation expressed concern about the negative consequences of smoking cannabis on cardiovascular health.\textsuperscript{116}

68. Professor Jan Copeland of the NCPIC acknowledged that the effect of cannabis on the long-term cardiovascular health of users may become a significant public health concern as the group of regular cannabis users age.\textsuperscript{117} This is particularly concerning given that older users probably use more episodically than other groups of users and may not develop tolerance to the stimulatory effects cannabis has on the cardiovascular system.\textsuperscript{118}

3.4.3. Respiratory health

69. Like tobacco smoke, cannabis smoke contains harmful chemicals and substances that are inhaled by smokers. This is exacerbated by the fact cannabis smokers typically inhale more smoke, inhale deeper into the lungs, and hold the smoke in the lungs for longer periods than tobacco cigarette smokers.\textsuperscript{119}

70. Studies have found regular cannabis smokers report more symptoms of chronic bronchitis such as wheeze, sputum production, and chronic coughs than non-smokers, and cannabis-only smokers have been found to have an increased use of health services for respiratory infections.\textsuperscript{120} This is supported by anecdotal evidence from the 2009 evaluation of the illicit drug court diversion and police diversion programs, which found that respiratory problems were the most commonly reported health risks associated with drug use.\textsuperscript{121}

71. The National Cannabis Prevention Information Centre referred to evidence of an association between bullous lung disease (which involves the presence of holes...
in normal lung tissue) and smoking cannabis, although a causal link has not been established. 122

72. Dr Stuart Reece referred to his experience with patients who had smoked cannabis and experienced lung damage. 123

73. It is important to note that the link between smoking tobacco and cannabis makes it difficult to determine the impact of cannabis alone on respiratory health. According to the National Cannabis Prevention and Information Centre, many people who try cannabis have previously smoked tobacco, and many current cannabis smokers are also current cigarette smokers. 124 Smoking both cannabis and tobacco appears to increase health risks compared to smoking either cannabis or tobacco alone. 125

3.4.4. Cancer

74. Cannabis smoke contains many of the same carcinogens as tobacco smoke, with some occurring in higher concentrations. 126

75. The Cancer Council Queensland referred to research that suggests long-term, heavy users of cannabis show a higher frequency of inflammatory and precancerous changes to the bronchial tubes than non-users. Reference was also made to studies that concluded there are good grounds for believing chronic cannabis smoking carries a significant risk of cancer, including cancer of the digestive and respiratory systems and lung cancer in young adults who start smoking at an early age. 127

76. Professor David Kavanagh and Professor Ross Young noted that although 'cannabis smoke has tar and other compounds that have been linked to cancers, some cannabinoids appear to have anti-tumour qualities that reduce the risks otherwise posed by those compounds.' 128

77. Dr Stuart Reece informed the committee that ‘cannabis has been associated with eight different cancers affecting the lung, head and neck, larynx, prostate, testes, brain and urinary tract and 'linked with hereditary cancers of the brain, muscles, and various leukaemias.' 129

78. A recent review of the adverse health effects of cannabis use published in The Lancet assessed respiratory cancers as a possible adverse effect of regular cannabis use with unknown causal relations. 130 Conflicting results have been found in studies that have investigated the association between smoking cannabis and the risk of developing respiratory cancers. It has been suggested

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122 National Cannabis Prevention and Information Centre, Submission no. 49, p. 10.
123 Dr Stuart Reece, Hearing Transcript, 4 June 2010, p. 10.
124 National Cannabis Prevention and Information Centre, Submission no. 48, p. 10.
125 National Cannabis Prevention and Information Centre, Submission no. 48, p. 10.
127 Cancer Council Queensland, Submission no. 49.
128 Professor David Kavanagh and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, Submission no. 42, p. 2.
129 Dr Stuart Reece, Submission no. 9, p. 4; Dr Stuart Reece, Hearing Transcript, 4 June 2010, pp. 10-12.
that further research using larger cohorts and designed to exclude the impact of cigarette smoking is needed to clarify the risks.  

3.4.5. Reproductive health

79. Women who use cannabis during pregnancy risk having babies with a low birth weight, which is one of the principal causes of loss of life of premature babies and can lead to health and related problems in later life.  

80. The Lancet review concluded that effects of prenatal cannabis exposure on the behaviour of children seem modest, and the causal interpretation of any such effects is weakened by the inability of the studies to 'control for the confounding effects of other drug use during pregnancy, poor parenting, and genetic factors. Professor Jake Najman informed the committee that there was sufficient evidence to suggest the health of children may be compromised by the maternal use of cannabis during pregnancy.  

81. The National Cannabis Prevention and Information Centre referred to a study that suggested an association between cannabis use during pregnancy and an increased risk of serious birth defects. Professor Jan Copeland stressed, however, that this is a very early study and there is not a lot of evidence at the population level at this stage.  

82. The National Cannabis Prevention and Information Centre referred to a range of other possible risks to reproductive health from cannabis use including: decreased fertility; increased risk of complications during pregnancy; and a range of negative outcomes for the baby, both at birth and later in life. Heavy cannabis use has been associated with decreased fertility in both men and women. Cannabis use may disrupt the menstrual cycle and decrease sperm quality and mobility.

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133 Professor Jan Copeland, Director, National Cannabis Prevention and Information Centre, Hearing Transcript, 3 June 2010, p. 43.  
134 Dr Stuart Reece, Hearing Transcript, 4 June 2010, p. 11; Professor John McGrath, Queensland Centre for Mental Health Research, Hearing Transcript, 4 June 2010, p. 23.  
136 Professor Jake Najman, Queensland Alcohol and Drug Research and Education Centre, Hearing Transcript, 4 June 2010, p. 19.  
137 National Cannabis Prevention and Information Centre, Submission no. 48, p. 12.  
138 Professor Jan Copeland, Director, National Cannabis Prevention and Information Centre, Hearing Transcript, 3 June 2010, p. 43.  
139 National Cannabis Prevention and Information Centre, Submission no. 48, p. 11.  
3.5. Risks to mental health

3.5.1. Schizophrenia and psychosis

83. The committee heard from a number of experts that cannabis use is strongly associated with an increased risk of schizophrenia and psychosis. The nature of this association remains unclear and it cannot be said conclusively that cannabis use causes schizophrenia and psychosis.

84. The National Cannabis Prevention and Information Centre referred to a review of longitudinal studies of cannabis use and subsequent psychotic outcomes, which found that the risk of psychosis increased by 40 per cent among people who had used cannabis at some point in their lives, and increased by between 50 and 200 per cent for heavy cannabis users. The National Cannabis Prevention and Information Centre made the point, however, that, while cannabis use roughly doubles the risk of psychosis, the absolute risk is small, increasing from 7 cases per 1000 to 14 cases per 1000.

85. Anecdotal evidence from BoysTown clients who contacted Kids Helpline suggests that, where only one substance is being used by clients affected by psychosis, cannabis is frequently the substance being used and, although clients displaying psychotic symptoms often have multiple risk factors, cannabis use is the one risk factor that is commonly reported.

86. Although there appears to be a strong association between cannabis use and the risk of developing schizophrenia or psychosis, it is not clear what the basis for this association is and whether cannabis use actually causes schizophrenia and psychosis. The committee has been informed that if there was a direct causal relationship you would expect rates of schizophrenia to have increased as rates of cannabis use increased from the 1960s onwards; this has not occurred.

87. Professor John McGrath emphasised that schizophrenia is a poorly understood group of illnesses and Professor Jan Copeland noted that scientists do not
know what causes schizophrenia.\textsuperscript{148} There are also many people who develop schizophrenia without ever using cannabis.

88. It has been suggested that cannabis may act in conjunction with genetic or other environmental factors that make some people particularly vulnerable to developing a psychotic illness.\textsuperscript{149} The Royal Australian and New Zealand College of Psychiatrists noted that 'a contributory causal relationship is biologically plausible because psychotic disorders involve disturbances in the dopamine neurotransmitter system with which the cannabinoid system interacts.'\textsuperscript{150}

89. Studies also suggest that the earlier a person uses cannabis the greater the risk of getting a psychotic illness.\textsuperscript{151}

90. In those who may have a predisposition to developing schizophrenia it has been suggested that the onset of psychosis may be about five years earlier for cannabis users who develop the disorder. Delaying the onset of the disorder until a person is in their mid-20s provides important 'opportunities for affected people to have obtained a greater level of functional skills and for their brain development to be further advanced before they become affected by the disorder.'\textsuperscript{152}

91. The committee has been informed that using cannabis makes psychosis worse and is a major factor in progressing and prolonging psychotic episodes.\textsuperscript{153} This could be exacerbated by the fact cannabis use may interact pharmacologically with medication prescribed for mental illness and may reduce compliance with treatment.\textsuperscript{154}

3.5.2. Other mental health risks

92. Although a relationship between cannabis use and depression and anxiety disorders has been found in a number of studies,\textsuperscript{155} the committee has been informed that the association appears to be less clear than for psychotic

\textsuperscript{148} Professor Jan Copeland, Director, National Cannabis Prevention and Information Centre, \textit{Hearing Transcript}, 3 June 2010, p. 41.

\textsuperscript{149} National Cannabis Prevention and Information Centre, \textit{Submission no. 48}, p. 5; Professor David Kavanagh and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, \textit{Submission no. 42}, p. 1; National Drug Research Institute, \textit{Submission no. 60}, p. 8.

\textsuperscript{150} Royal Australian and New Zealand College of Psychiatrists, \textit{Submission no. 50}, p. 6.

\textsuperscript{151} Professor Jan Copeland, Director, National Cannabis Prevention and Information Centre, \textit{Hearing Transcript}, 3 June 2010, p. 41; Professor John McGrath, Queensland Centre for Mental Health Research, \textit{Hearing Transcript}, 4 June 2010, pp. 19 and 21.

\textsuperscript{152} Professor David Kavanagh and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, \textit{Submission no. 42}, p. 1.

\textsuperscript{153} Professor David Kavanagh and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, \textit{Submission no. 42}, p. 1; National Cannabis Prevention and Information Centre, \textit{Submission no. 48}, p. 5; Royal Australian and New Zealand College of Psychiatrists, \textit{Submission no. 50}, p. 6; Professor Jan Copeland, Director, National Cannabis Prevention and Information Centre, \textit{Hearing Transcript}, 3 June 2010, p. 41.

\textsuperscript{154} Royal Australian and New Zealand College of Psychiatrists, \textit{Submission no. 50}, p. 6.

\textsuperscript{155} For example see: Queensland Alcohol and Drug Research and Education Centre, \textit{Submission no. 31}, p. 3; Royal Australian and New Zealand College of Psychiatrists, \textit{Submission no. 50}, p. 6.
illnesses,\textsuperscript{156} and it has been suggested that more research is needed to understand the link.\textsuperscript{157}

93. In relation to amotivational syndrome, the committee heard that the research is "far from convincing"\textsuperscript{158} and the behaviour is more likely to be the result of other factors\textsuperscript{159} such as chronic intoxication. According to Mr Bob Green, 'if a person is consuming cannabis throughout the day they will be chronically intoxicated, which can include feelings of sedation and lethargy.'\textsuperscript{160}

94. Similarly, although there have been studies linking cannabis to suicide it is unclear whether the link is causal because many of the factors associated with cannabis use are also associated with suicide.\textsuperscript{161} The association and complexity of the relationship is borne out by information provided by the Commission for Children and Young People and Child Guardian. The Commission's \textit{Reducing Youth Suicide in Queensland Project} found that 27 of the 65 young people aged between 10 and 17 years who suicided between 2004 and 2007 (42 per cent) had used cannabis. The Commissioner noted however that 'it is impossible to determine the extent to which their drug use impacted on their decision to suicide. Suicidal behaviours in young people are not often the result of a single cause, but are multiplicative and frequently occur at the end point of adverse life consequences in which several interacting risk factors combine, resulting in feelings of hopelessness and a desire to "make it all go away."\textsuperscript{162}

3.6. Social and community risks

95. Cannabis use has been associated with poor educational attainment, increasing the chances of leaving school without qualifications, failing to enter university and failing to secure a university degree.\textsuperscript{163} Adolescent cannabis users who leave school early have been found to be more likely to be unemployed and depend on social welfare and to be less satisfied with their lives and their relationships than their peers in their late 20s.\textsuperscript{164} The relationship between cannabis use and poor educational attainment has been identified as 'an extremely important and neglected issue when considering the lifelong psychosocial consequences of early cannabis use and resultant costs to the individual and the community.'\textsuperscript{165}

96. It has been suggested that by far the biggest risk encountered by individual cannabis users is a possible encounter with the criminal justice system,\textsuperscript{166} and

\begin{footnotesize}
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\item[150] Professor David Kavanagh and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, Submission no. 42, p. 1; National Cannabis Prevention and Information Centre, Submission no. 48, pp. 5-6.
\item[157] Royal Australian and New Zealand College of Psychiatrists, Submission no. 50, p. 6; National Drug Research Institute, Submission no. 60, p. 8.
\item[159] Mr Bob Green, Submission no. 12, p. 4.
\item[159] Professor David Kavanagh and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, Submission no. 42, p. 1.
\item[160] Mr Bob Green, Submission no. 12, p. 4.
\item[163] National Cannabis Prevention and Information Centre, Submission no. 48, pp. 7-8.
\item[165] National Cannabis Prevention and Information Centre, Submission no. 48, p. 8.
\end{enumerate}
\end{footnotesize}
that harms associated with the actual use of cannabis pale by comparison.\textsuperscript{97} Negative social impacts of conviction for a cannabis offence include negative employment consequences, further problems with the law, negative relationship consequences and accommodation consequences.\textsuperscript{98}

97. A significant level of harm has also been associated with the criminal nature of the cannabis market. For example, the Crime and Misconduct Commission recently upgraded its assessment of the level of risk posed by the cannabis market in Queensland from medium to high risk "based on the size and entrenched nature of the cannabis market, the levels of criminality, and the risk associated with further expansion of the hydroponic cannabis sector."\textsuperscript{99} The cannabis market was described as 'entrenched', 'very large' and 'very profitable' with a "high level of criminality involved in things like armed crop sitters."\textsuperscript{100} The CMC also referred to concerns that 'organised criminal groups view cannabis as a reliable, consistent and low-risk source of income providing funding for other kinds of criminal activity."\textsuperscript{101} This is demonstrated by the fact $45.5 million has been restrained from cannabis-related offences since the civil confiscation regime began in 2003. This represents 41.5 per cent of the total value of all assets restrained.\textsuperscript{102} The involvement of serious and organised crime in the cannabis market was confirmed by the Australian Crime Commission.\textsuperscript{103}

98. The Crime and Misconduct Commission also identified a range of health and safety issues and other community costs associated with hydroponic cannabis cultivation. These included: the illegal diversion of electricity; house fires caused by tampering with electrical systems; the costs of remediating rental properties that have been damaged by indoor cannabis cultivation; and toxic contaminants and chemical hazards resulting from hydroponic cultivation.\textsuperscript{104}

99. Cannabis use can also have adverse effects on the financial situation of both individuals and communities. The economic cost of cannabis use can be substantial depending on the level of use and existing community resources. The impact has been found to be particularly pronounced in certain populations such as remote Aboriginal and Torres Strait Islander communities.\textsuperscript{105} For example, Associate Professor Alan Clough has estimated that, in the Arnhem Land communities he studied, around one out of every six dollars available in the local cash pool was being directed into the local cannabis trade.\textsuperscript{106}

\begin{footnotes}
\item[105] Associate Professor Alan Clough, James Cook University, \textit{Submission no. 61}, p. 10.
\end{footnotes}
3.7. Risks associated with the age a person first uses cannabis

100. There is evidence that the age of first use of cannabis has been declining. Analysis of data from the 1998 National Drug Strategy Household Survey found the prevalence of cannabis use by age 15 years increased from 13 per cent of those born between 1970 and 1974, to 20.4 per cent of those born between 1975 and 1979, to 31.3 per cent of those born between 1980 and 1984. The same trend was evident for licit and other illicit drugs.

101. A decrease in the age of initiation may be explained by an increased availability of the drug and social changes that have reduced the level of adult supervision and given adolescents greater freedom to make their own decisions.

102. People who begin using cannabis at an early age are more likely to become dependent on the drug, develop problems with brain function, develop schizophrenia and psychosis, have poor educational attainment and go on to use other drugs.

3.8. Committee comments

103. The committee acknowledges that most cannabis users use infrequently and experience few harms. It is therefore important not to overstate the risks and levels of harm, as this can detract from the credibility of the message. It is also important to distinguish between possible, probable, and definite risks and recognise that there are different levels of harm associated with different levels of use.

104. There do appear to be significant risks associated with regular heavy use, particularly when it begins at a young age or involves people who are otherwise vulnerable. The most significant risks appear to be risks of dependence, vehicle accidents, poor educational attainment, cardiovascular and respiratory problems in older users, and psychosis.

105. In relation to the risk of developing a psychotic illness, the committee endorses the recent statement by Professor Wayne Hall and Professor Louisa Degenhardt that although the risk of psychosis may be modest from a public health

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179 Queensland Alcohol and Drug Research and Education Centre, Submission no. 31, p. 2.
180 Professor David Kavanagh and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, Submission no. 42.
181 Dr Alex Wodak, Australian Drug Law Reform Foundation, Hearing Transcript, 3 June 2010, p. 28.
182 Queensland Alcohol and Drug Research and Education Centre, Submission no. 31.
185 National Cannabis Prevention and Information Centre, Submission no. 48, p. 8.
186 Professor Jan Copeland, Director, National Cannabis Prevention and Information Centre, Hearing Transcript, 3 June 2010, p. 41.
viewpoint, the potential effects of a psychotic illness on a young person's life chances are so substantial that it would be socially irresponsible not to advise young people about this possible risk.188

3.9. Risks of cannabis acting as a gateway to other drug use

106. There has been significant debate for many years about whether cannabis acts as a 'gateway' to other drugs such as heroin and cocaine. While there appears to be a strong association between cannabis use and the use of other illicit drugs, the exact nature of this relationship is still unclear.

107. A typical sequence of drug use initiation has been identified, which sees users beginning with alcohol and tobacco, and then moving on to cannabis, before progressing to other illicit drugs. Recent research has found, however, that the sequence is not fixed and may only be relevant in countries with a high prevalence of cannabis use.189

108. In the United States, Australia and New Zealand, regular cannabis users have been found to be more likely to go on to use heroin and cocaine, particularly if they start using cannabis at an early age.190 It should be noted however that, although Australian population surveys indicate the majority of heroin users have used cannabis, only a small percentage (4 per cent) of cannabis users have used heroin.191

109. A recent New Zealand study suggested that the development of illicit drug use and dependence in adolescence and young adulthood involves a range of factors including exposure to adversity in childhood, childhood adjustment, personality and individual factors, the use of cannabis, affiliation with substance-using peers, and alcohol use. The study noted that, of these factors, the use of cannabis appeared to play the strongest role, particularly for young users and heavy users of cannabis. The authors argued that the results strongly suggested that cannabis acts as a gateway drug that increases risks of other forms of illicit drug use, although the role of cannabis in facilitating the transition to other forms of illicit drug use is poorly understood.192

110. A variety of explanations have been proposed for the association between cannabis use and the use of other illicit drugs. These include the possibility of biological or pharmacological mechanisms that predispose regular cannabis users to use other intoxicating drugs;193 the existence of a genetic vulnerability to

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193 Dr Stuart Reece, *Submission no. 9*, p. 5; National Cannabis Prevention and Information Centre, *Submission no. 48*. 

Social Development Committee Page 32 Addressing Cannabis-related Harm
use cannabis and other illicit drugs;\textsuperscript{194} the appeal of cannabis and other illicit substances to certain types of people, particularly those who exhibit risk-taking and non-conformist behaviours;\textsuperscript{195} and the increased likelihood that a cannabis user will be socialised into the illicit drug culture which will bring them into contact with people who use other illegal substances.\textsuperscript{196}

111. A long-time cannabis user who made a submission to the inquiry stated that he had never been tempted by, or used, other illegal drugs but did recognise the possibility that drug dealers could try to sell cannabis users other drugs such as cocaine, heroin or amphetamines if there was no cannabis readily available.\textsuperscript{197}

112. In its submission to the inquiry, BoysTown noted that, although their experience with cannabis use by young people did not seem to indicate that using cannabis led young people to use other harmful substances, cannabis use does not occur in isolation. BoysTown suggested that poly-substance use may be related to a more general attitude towards drug use and ‘that cannabis use is a reflection of a user’s growing acceptance of substance use.’\textsuperscript{198}

113. Professor Jake Najman suggested that it would be more helpful to replace the concept of the ‘gateway’ with the idea of common pathways to substance use, namely the same things lead to tobacco, alcohol, cannabis and other illicit drug use. He suggested that these may be genetic or environmental factors.\textsuperscript{199}

114. The committee notes that disputes about the reason for the association detract from the main message, which is that early and heavy use of cannabis appears to increase the risk of a person going on to use other drugs.

115. Rather than focusing on specific patterns of initiation or the use of particular drugs in order to prevent transitions to other drug use, prevention efforts may be better targeted at all types of drug use, particularly among young people who are already dealing with other challenges or risk behaviours, as this may be the group most at risk of developing problems in the future.\textsuperscript{200}

3.10. Risks associated with changes in the potency of cannabis

3.10.1. Introduction

116. There have been claims that the availability of high-potency cannabis has increased the risks associated with cannabis use, particularly the risks of harm to a user’s mental health.\textsuperscript{201} This raises two related questions, namely: whether the potency of cannabis has changed over time; and whether these changes result in more harm to users.

\textsuperscript{194} National Cannabis Prevention and Information Centre, \textit{Submission no. 48}, p. 8.
\textsuperscript{195} Hall, W. et al. (2001) \textit{The Health and Psychological Effects of Cannabis Use}, National Drug and Alcohol Research Centre: Sydney, at pp. 104-106; Professor Jan Copeland, Director, National Cannabis Prevention and Information Centre, \textit{Hearing Transcript}, 3 June 2010, p. 41.
\textsuperscript{196} Name suppressed, \textit{Submission no. 10}; Mr Bob Green, \textit{Submission no. 12}, p. 2.
\textsuperscript{197} Name suppressed, \textit{Submission no. 17}.
\textsuperscript{198} BoysTown, \textit{Submission no. 39}, p. 12.
\textsuperscript{199} Professor Jake Najman, Queensland Alcohol and Drug Research and Education Centre, \textit{Hearing Transcript}, 4 June 2010, p. 22.
\textsuperscript{200} National Cannabis Prevention and Information Centre, \textit{Submission no. 48}, p. 9.
\textsuperscript{201} Drug Free Australia (2009) \textit{Cannabis – Suicide, Schizophrenia and Other Ill-effects}, Drug Free Australia: Elizabeth, SA, pp. 10-11.
3.10.2. Potency

117. The *cannabis sativa* plant contains almost 500 compounds, including 70 cannabinoids, which produce the psychoactive effect.\(^{202}\) The potency of cannabis is generally measured by the concentration of delta-9-tetrahydrocannabinol (THC) in a particular sample as THC is the cannabinoid with the strongest psychoactive effect. It has been suggested that levels of other cannabinoids, particularly cannabidiol (CBD), may also influence potency as CBD appears to have antipsychotic and anti-anxiety effects that may offset some of the psychoactive effects of THC.\(^{203}\)

118. The THC levels in particular cannabis products are influenced by a wide range of factors including: the plant variety (industrial hemp contains less than 3 per cent THC\(^{204}\) whereas hybrids have been developed to produce high levels of THC); the parts of the plant that are used (the flowering heads have higher THC concentrations than the leaves); cultivation techniques (for example, growing female plants in isolation so they are seedless, thereby increasing THC levels and indoor intensive cultivation, which can optimise cultivation conditions and produce cannabis of a consistently higher potency); the way the cannabis is prepared for administration (hash oil is highest in THC followed by hashish and then marijuana); and the way the cannabis is stored (THC degrades over time particularly if not stored in airtight conditions).\(^{205}\)

3.10.3. Changes in potency

119. In 1993 the Australian Bureau of Criminal Intelligence reported that a cannabis variety known as skunk was gaining popularity in Australia. It was claimed that, whereas standard cannabis has a THC content of about 1 per cent to 5 per cent, skunk had been known to contain as much as 30 per cent.\(^{206}\)

120. The National Cannabis Prevention and Information Centre noted that ‘there have been occasional reports of high-potency cannabis in Australia since the 1960s.’\(^{207}\) As there has been no systematic testing of cannabis potency in Australia the committee has been informed that ‘it cannot be definitively determined whether the cannabis used here in Australia has become more potent over time’\(^{208}\) and ‘care has to be taken into claims regarding cannabis potency.’\(^{209}\)

121. Surveys in other countries provide mixed results, with increases found in the United States, the United Kingdom, the Netherlands and Italy but not in other

\(^{202}\) National Cannabis Prevention and Information Centre, Submission no. 48, p. 12.


\(^{204}\) Queensland Minister for Primary Industries, Fisheries and Rural and Regional Queensland, Submission no. 32.


\(^{207}\) National Cannabis Prevention and Information Centre, Submission no. 48, p. 12.


\(^{209}\) Mr Bob Green, Submission no. 12, pp. 1-2.
European countries or New Zealand.\textsuperscript{210} Methodological issues further complicate interpretation of this data.\textsuperscript{211}

122. It has also been noted that, where testing has occurred, there have been enormous variations between samples.\textsuperscript{212} For example, analysis of the THC content of 168 samples of cannabis seized by police in Western Australia between March and May 1996 found the samples that consisted of the flowering tops of cannabis plants had mean THC levels of 6.4 per cent with a range of between less than 1 per cent and 20 per cent whereas samples made up of leaf material had mean THC levels of 2.2 per cent with a range between less than 1.0 per cent and 6.0 per cent.\textsuperscript{213}

123. For some time now there have been calls for the introduction of systematic scientific testing of cannabis samples in Australia to monitor trends in cannabis potency and also determine whether cannabis is contaminated.\textsuperscript{214}

124. The National Cannabis Prevention and Information Centre informed the committee that consortium members have been attempting to conduct research into questions about the potency of cannabis for more than two years but have experienced problems accessing cannabis seizures for testing in a timely manner. The Centre called urgently for national legislation to allow this testing to take place.\textsuperscript{215} The Centre has most recently been negotiating with the New South Wales Government and hopes to start testing seizures from cannabis cautions in October 2010 to reflect the growing season in northern New South Wales.\textsuperscript{216}

3.10.4. Harms from changes in potency

125. Whether changes in levels of THC have increased harms to cannabis users is a separate issue.

126. The committee heard that cannabis users may be able to adjust the way they use cannabis to regulate the amount of drug that is taken in thereby reducing the harmful effects, including minimising adverse respiratory effects.\textsuperscript{217} The committee heard from one daily cannabis user that ‘potency has a direct effect on how much I use: i.e., if it is ‘good’ cannabis (high THC levels), I need far less, far less often. Low quality cannabis (low THC levels), I need more a bit more, a

\textsuperscript{210} National Cannabis Prevention and Information Centre, Submission no. 48, p. 13; National Drug Research Institute, Submission no. 60, p. 10.


\textsuperscript{215} National Cannabis Prevention and Information Centre, Submission no. 48, pp. 13-14.

\textsuperscript{216} Professor Jan Copeland, Director, National Cannabis Prevention and Information Centre, Hearing Transcript, 3 June 2010, p. 42.

\textsuperscript{217} Australian Drug Law Reform Foundation, Submission no. 30, p. 4; National Drug Research Institute, Submission no. 60, p. 11.
bit more often.\textsuperscript{216} This may only be relevant to experienced and moderate users, with higher potency cannabis posing the greatest risk to the youngest and most vulnerable users.\textsuperscript{219}

127. There have also been suggestions that, regardless of whether there has been an increase in the potency of the plant itself, changes in the way people use cannabis may result in users taking in higher levels of THC than in the past. People are now smoking the more potent parts of the plant, namely the flowering heads rather than the leaves, and are smoking cannabis in a bong, which can also increase THC intake.\textsuperscript{220}

3.10.5. Committee comments

128. The committee notes that, in a similar way to the debate about whether cannabis is a gateway drug, the debate about changes in potency may detract from the important message that early, heavy use is associated with an increase in harms.\textsuperscript{221} The committee considers, however, that reliable information about the potency of cannabis available throughout the State would be invaluable to monitoring changes in the drug and its potential harms.

\begin{center}
\textbf{Recommendation 2}
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The committee recommends that the Queensland Government consider the feasibility of adopting a nationally consistent approach to the systematic scientific testing of samples of cannabis seizures in order to monitor chemical consistency, potency (THC and CBD content) and contamination. Data collected should include information about whether the samples are from bush crops or indoor enhanced cultivation.

3.11. Research

129. Queensland has significant research capacity in the drug and alcohol sector including specialist research organisations such as the Queensland Alcohol and Drug Research and Education Centre, the Queensland Brain Institute and the Queensland Institute of Medical Research.

130. The Queensland Alcohol and Drug Research and Education Centre is a joint venture between Queensland Health and the University of Queensland that was established in 1996. The Centre, which is situated within the University of Queensland's School of Population Health in the Faculty of Health Sciences, specialises in research designed to increase understanding of the determinants and contexts of alcohol and drug-related problems.\textsuperscript{222}

131. The Queensland Brain Institute is one of the largest neuroscience institutes in the world dedicated to understanding the mechanisms underlying brain function.

\textsuperscript{218} Submission no. 17.
\textsuperscript{219} National Drug Research Institute, Submission no. 60, p. 11.
\textsuperscript{221} National Drug Research Institute, Submission no. 60, p. 12.
\textsuperscript{222} Queensland Alcohol and Drug Research and Education Centre website – \url{www.qld.edu.au/gadrec}
The Institute is actively exploring the developmental causes of, and possible therapeutic treatments for, schizophrenia.

132. The Queensland Institute of Medical Research recently established a Division of Mental Health Research which focuses on scientific research to improve the diagnosis and management of serious mental health disorders as they emerge in adolescence.223

133. Queensland researchers also have invaluable information sources for longitudinal, epidemiological research including the cohort of mothers and their babies who were born at the Mater Hospital over almost 30 years.224

134. The committee heard, however, that there is a strong research emphasis on the epidemiology of addiction but little basic sciences research in the area of cannabinoid physiology, pharmacology and toxicology.225 Dr Stuart Reece argued that most Australian experts working in the field have 'either a psychological or medical background'226 and suggested this led to a professional bias against cannabinoid research.227

135. The Queensland Institute of Medical Research encouraged support for further research into the harm associated with cannabis use, using both epidemiological and neuroscientific approaches.228 The Queensland Institute of Medical Research stated, 'in addition to epidemiological studies, this research should also include further research into the shared neurobiology of serious mental health disorders and cannabis use.'229

136. Professor John McGrath stressed the importance of 'building on the capacity for research within this state'230 at the epidemiological level but also research relating to the neuroscience and genetics of cannabis use.231

137. Dr Kevin McNamara, representing the Royal Australian and New Zealand College of Psychiatrists, supported the call for research, particularly in order to improve the capacity, range and quality of pharmacological treatments.232

138. The committee recognises the importance of conducting both epidemiological research and neuroscience research in order to help identify people who are particularly vulnerable to developing health problems if they use cannabis233 and also to develop effective treatments, including pharmacological treatments.234

223 Queensland Institute of Medical Research, Submission no. 24.
224 Professor John McGrath, Queensland Centre for Mental Health Research, Hearing Transcript, 4 June 2010, p. 25.
225 Dr Stuart Reece, Submission no. 9, p. 8, Dr Stuart Reece, Hearing Transcript, 4 June 2010, p. 9.
226 Dr Stuart Reece, Hearing Transcript, 4 June 2010, p. 9.
227 Dr Stuart Reece, Submission no. 9, p. 8.
228 Queensland Institute of Medical Research, Submission no. 24.
229 Queensland Institute of Medical Research, Submission no. 24.
230 Professor John McGrath, Queensland Centre for Mental Health Research, Hearing Transcript, 4 June 2010, p. 25.
231 Professor John McGrath, Queensland Centre for Mental Health Research, Hearing Transcript, 4 June 2010, pp. 25-26.
232 Dr Kevin McNamara, Royal Australian and New Zealand College of Psychiatrists, Hearing Transcript, 4 June 2010, p. 28.
233 Professor John McGrath, Queensland Centre for Mental Health Research, Hearing Transcript, 4 June 2010, p. 21.
234 Royal Australian and New Zealand College of Psychiatrists, Submission no. 50, p. 4; Dr Kevin McNamara, Royal Australian and New Zealand College of Psychiatrists, Hearing Transcript, 4 June 2010, p. 28.
Recommendation 3

The committee recommends that in addition to the important research that is currently being undertaken to understand cannabis-related harms, the Queensland Government also encourages and considers research that examines the neuroscience of cannabis use.
PART 3 Strategies to Reduce Cannabis Use

CHAPTER 4 - POLICY CONTEXT

4.1. Australian drug policy

139. Australia has had a consistent national approach to drug policy since 1985. The most recent national framework, the National Drug Strategy 2004-2009, was endorsed in 2004 by the Ministerial Council on Drug Strategy, which is made up of Australian government, state and territory ministers responsible for health and law enforcement and the Australian government minister responsible for education. The strategy is currently being updated for the next five-year phase.

140. The national framework has supported the development of a number of sub-strategies, including the National Cannabis Strategy 2006-2009. In November 2004 the Ministerial Council on Drug Strategy agreed to the development of a national cannabis strategy in recognition of the fact cannabis is the most widely used illicit drug. The Ministers expressed their concern that cannabis use can result in acute effects and may trigger psychotic illness and schizophrenia. Following extensive consultation and the consideration of existing knowledge and research the strategy was endorsed by the Ministerial Council on 15 May 2006.

141. The National Cannabis Strategy 2006-2009 identifies four priority areas that address a continuum of need throughout the community. The first aims to increase community knowledge about cannabis and influence the level of acceptability of cannabis use. The second targets those at risk and those likely to use cannabis and aims to prevent the uptake of cannabis use. The third targets users and aims to prevent and minimise the social, physical, mental and financial harms to individuals and the community that are associated with cannabis use. The fourth aims to provide effective and accessible interventions, tools, treatments and support for those who develop problems associated with their cannabis use. Recommended responses and examples of good practice are provided for each priority area.

142. The Queensland Drug Strategy 2006-2010 provides the policy framework for Queensland Government activities to prevent and respond to alcohol, tobacco and illicit drug use and harm. It identifies seven priorities for action, namely: alcohol, young people and young adults; tobacco control; Indigenous alcohol and drug use; treatment services, including services for those with a dual diagnosis;

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volatile substance misuse, vulnerable and marginalised young people; effective law enforcement, including liquor licensing; and innovative criminal justice responses.242

143. A report on the midpoint implementation of the Queensland Drug Strategy 2006-2010 was issued in October 2008.243

4.2. Harm minimisation

144. The National Drug Strategy 2004-2009, the National Cannabis Strategy 2006-2009 and the Queensland Drug Strategy 2006-2010 are based on the principle of harm minimisation. This principle encompasses both licit and illicit drugs and aims to balance supply reduction, demand reduction and harm reduction strategies. Supply reduction strategies disrupt the production and supply of illicit drugs and the control and regulation of licit substances. Demand reduction strategies prevent the uptake of harmful drug use, including abstinence-oriented strategies and treatment to reduce drug use. Harm reduction strategies reduce drug-related harm to individuals and communities.244

145. An independent evaluation of the National Drug Strategy 2004-2009 noted that there was concern in the community about what was meant by harm minimisation,245 particularly the perception that the concept does not focus adequately on the prevention of drug use or the importance of abstinence-oriented interventions.246 Although the evaluation recommended replacing ‘harm minimisation’ with a term that explicitly highlights both the prevention and reduction of drug-related harm, it also emphasised the importance of retaining the three pillars of supply reduction, demand reduction and harm reduction.247 The evaluation also recommended that greater emphasis be put on preventing harmful drug use.248

146. The focus on harm minimisation was also criticised in submissions to the current inquiry. For example, FamilyVoice Australia argued that the current focus on harm minimisation should be replaced with a focus on harm prevention and treatment that has the aim of achieving permanent drug-free status for individuals with the goal of enabling drug users to be drug free.249 Reference was also made to two federal parliamentary committees that recommended replacing...

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249 FamilyVoice Australia, Submission no. 44, p. 5.
the National Drug Strategy focus on harm minimisation with a focus on harm prevention and treatment.\textsuperscript{250}

147. A number of submissions to the current inquiry supported the Swedish approach to drug policy,\textsuperscript{251} which has an overall objective of achieving a drug-free society by: reducing recruitment to drug abuse; inducing people with substance abuse problems to give up their abuse; and reducing the supply of drugs.\textsuperscript{252} Although Sweden has a relatively low prevalence of recreational drug use,\textsuperscript{253} it has been suggested that 'the extent to which this is due to Sweden's drug policy, or to wider social, historical and geographical factors, cannot be easily surmised from the available information.'\textsuperscript{254}

148. There is, however, support for the current Australian policy framework.\textsuperscript{255} The Royal Australian and New Zealand College of Psychiatrists support retention of the harm minimisation approach but make the point that 'adequate resources are needed to meet the public health need of this approach.'\textsuperscript{256}

149. The committee acknowledges the importance of a national approach to drug policy to ensure consistency and efficiency. As the national policy is currently being updated the committee considers it is most appropriate to work within this policy framework in conducting this inquiry.

4.3. Policy coordination in Queensland

150. In its submission, the Queensland Network of Alcohol and Drug Agencies suggested the establishment of a new consultative structure in Queensland to enable intergovernmental and community sector agencies to address the complexity of drug use.\textsuperscript{257}

151. The Queensland Drug Policy 2006-2010 indicated that a body consisting of representatives from various government agencies was responsible for overseeing drug policy in Queensland.\textsuperscript{258}

152. The committee notes that the Australian Capital Territory (ACT) Government established a broad consultation group consisting not only of government representatives but representatives from relevant non-government organisations,


\textsuperscript{251} Mr John Malouf, Submission no. 22; Drug Free Australia, Submission no. 15; FamilyVoice Australia, Submission no. 44, p. 4-5; Mr John Malouf, Hearing Transcript, 3 June 2010, pp. 1-2.


\textsuperscript{255} Royal Australian and New Zealand College of Psychiatrists, Submission no. 50, pp. 7-8; Queensland Network of Alcohol and Drug Agencies, Submission no. 59, p. 3.

\textsuperscript{256} Royal Australian and New Zealand College of Psychiatrists, Submission no. 50, p. 7; Dr Kevin McNamara, Royal Australian and New Zealand College of Psychiatrists, Hearing Transcript, 4 June 2010, p. 28.

\textsuperscript{257} Queensland Network of Alcohol and Drug Agencies, Submission no. 58, p. 1.

to assist with the development, monitoring and evaluation of the Territory's drug strategy.  

153. The committee recognises the complexity and interdisciplinary nature of issues relating to cannabis use and endorses the establishment of a new consultative structure in Queensland for drug policy that includes representatives from government and community sector agencies.

**Recommendation 4**

The committee recommends that the Queensland Government consider establishing a consultative committee consisting of representatives from relevant government agencies and community sector agencies to have input into developing, monitoring and evaluating Queensland drug policy.

[^259]: Private communication with Mr Brian McConnell, Families and Friends for Drug Law Reform, 9 June 2010.
CHAPTER 5 - LEGAL RESPONSES

5.1. Introduction

154. There is considerable divergence of opinion about the role and effectiveness of current legal responses to illicit drugs (including cannabis) across the Western world.

155. Reference was made in submissions to the legal regimes in various countries including Sweden, the Netherlands, Portugal and the United States in an attempt to equate particular legal approaches with levels of use and levels of harm. The committee notes the difficulty in comparing jurisdictions given the unique interplay of historical, social, cultural and legal factors in each country.

5.2. Current Queensland legal response

156. Cannabis is classified as a dangerous drug under the Drugs Misuse Act 1986. It is an offence to traffic in, supply, produce or possess cannabis and the maximum penalty for these offences ranges from 15 to 20 years imprisonment.

157. A person who carries on a business of unlawfully trafficking in cannabis is liable for up to 20 years imprisonment.

158. A person who unlawfully supplies cannabis to another person is liable for up to 15 years imprisonment unless the offence is one of aggravated supply in which case the maximum penalty is 20 years imprisonment. Aggravated supply includes supply by an adult to a child or to an intellectually impaired person. It also applies where the supply occurs within an educational institution or a correctional facility.

159. A person who produces or possesses cannabis faces a maximum penalty of 20 years imprisonment where the quantity of cannabis produced or possessed

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260 Mr John Malouf, Submission no. 22; Drug Free Australia, Submission no. 16; FamilyVoice Australia, Submission no. 44, p. 4-5; Mr John Malouf, Hearing Transcript, 3 June 2010, pp. 1-2; Mr Gary Christian, Hearing Transcript, 3 June 2010, pp. 34-35; Mr Bill Bush, Families and Friends for Drug Law Reform, Hearing Transcript, 3 June 2010, p. 38.

261 Queensland Institute of Medical Research, Submission no. 24; Australian Drug Law Reform Foundation, Submission no. 30, pp. 3-4; Mr Andrew Whaites, Submission no. 38; Families and Friends for Drug Law Reform, Submission no. 45, pp. 69-70; Family Drug Support, Submission no. 58, pp. 67-69.

262 Mr Andrew Whaites, Submission no. 38; Families and Friends for Drug Law Reform, Submission no. 45, pp. 65-68; Family Drug Support, Submission no. 58, pp. 64-67; Mr Brian McConnell, Families and Friends for Drug Law Reform, Hearing Transcript, 3 June 2010, p. 38; Professor Jan Copeand, National Cannabis Prevention and Information Centre, Hearing Transcript, 3 June 2010, p. 43.

263 Queensland Institute of Medical Research, Submission no. 24; Australian Drug Law Reform Foundation, Submission no. 30, pp. 3-4; Mr Andrew Whaites, Submission no. 38; Families and Friends for Drug Law Reform, Submission no. 45, pp. 64-65; Family Drug Support, Submission no. 58, pp. 63-64.

264 Drugs Misuse Act 1986 (Qld) s 4; Drugs Misuse Regulation 1987 (Qld) Schedule 2.

265 Drugs Misuse Act 1986 (Qld) s 5.

266 Drugs Misuse Act 1986 (Qld) s 6.

267 Drugs Misuse Act 1986 (Qld) s 8.

268 Drugs Misuse Act 1986 (Qld) s 9.

269 Drugs Misuse Act 1986 (Qld) s 5.

270 Drugs Misuse Act 1986 (Qld) s 6.
exceeds 500 grams or 100 plants. For production or possession of less than 500 grams or 100 cannabis plants the maximum penalty is 15 years imprisonment.271

160. Offences of supply, production and possession that would attract a maximum penalty of 15 years' imprisonment may be dealt with summarily in the Magistrates Court. In these cases the maximum penalty that may be imposed is three years imprisonment.272

161. Diversion to assessment and education can be offered by police and courts as alternatives to punitive responses in certain cases where people are found in possession of small amounts of cannabis (50 grams or less).273

5.3. Criticisms of the current legal response

162. The committee heard from people who believe a stronger approach to drug law enforcement is required to address cannabis-related harm,274 with calls for increased penalties for cannabis offences, particularly offences of production, supply and trafficking275 and supply to children,276 the reduction of the threshold amount for diversion,277 and increased opportunities for people to report drug offenders to police.278 These issues are discussed further in Chapter 6.

163. By contrast the committee also heard from many individuals and organisations who believe that law enforcement and punitive responses are not having the intended effect and can actually increase the level of harm experienced by users.279 Many claim a public health approach rather than a legal approach is required to address issues associated with cannabis use.280

164. It has been asserted that traditional punitive responses are ineffective in reducing levels of use and levels of harm.281 Although cannabis is a prohibited substance

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271 Drugs Misuse Act 1986 (Qld) ss 8 and 9, Drugs Misuse Regulation 1987 (Qld) Schedule 3.
272 Drugs Misuse Act 1986 (Qld) s. 13. When new section 14 of the Drugs Misuse Act 1986 comes into force it will allow charges for possession offences to be dealt with summarily at the election of the prosecution where the offender is liable to more than 15 years imprisonment, provided no commercial purpose is alleged by the prosecution. See: Civil and Criminal Jurisdiction Reform and Modernisation Amendment Act 2010 (Qld) s 62.
273 Diversion programs are discussed in more detail below.
274 Mr Rob Lavers, Submission no. 4; Mrs Jeanette Reinecke, Submission no. 11; Name suppressed, Submission no. 18; Mr Ross Harty, Submission no. 27; Ms Jeannette Durret, Submission no. 54.
275 Mrs Jeanette Reinecke, Submission no. 11; Name suppressed, Submission no. 18.
276 Name suppressed, Submission no. 19; Queensland Independent Schools Parents' Council, Submission no. 23.
277 FamilyVoice Australia, Submission no. 44, p. 10.
278 Ms Eva Lai, Submission no. 3; Drug Free Australia, Submission no. 15; FamilyVoice Australia, Submission no. 44, pp. 8-9.
279 Mr Howard Teems, Submission no. 29; Queensland Alcohol and Drug Research and Education Centre, Submission no. 31; Families and Friends for Drug Law Reform, Submission no. 45, p. 22; Australian Drug Foundation, Submission no. 51, p. 14; Family Drug Support, Submission no. 58, p. 23; Dr Kevin McNamara, Royal Australian and New Zealand College of Psychiatrists, Hearing Transcript, 4 June 2010, p. 28; Dr Alex Wodak, Australian Drug Law Reform Foundation, Hearing Transcript, 3 June 2010, p. 28.
280 Dr Peter Thompson, Submission no. 2; Mr Paul French, Submission no. 14; Name suppressed, Submission no. 17; Queensland Institute of Medical Research, Submission no. 24; Australian Drug Law Reform Foundation, Submission no. 30, pp. 5-7; HEMP Embassy, Submission no. 36; Mr Andrew Whaites, Submission no. 36; Professor David Kavanagh and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, Submission no. 42, p. 2; Families and Friends for Drug Law Reform (ACT) Inc, Submission no. 45; Australian Alcohol and other Drugs Council of Australia, Submission no. 47; Queensland Council for Civil Liberties, Submission no. 52; Family Drug Support, Submission no. 58; Queensland Network of Alcohol and Drug Agencies, Submission no. 59, p. 5; Mr John Ransley, Queensland Council for Civil Liberties, Hearing Transcript, 3 June 2010, p. 14.
281 Dr Peter Thompson, Submission no. 2; Queensland Institute of Medical Research, Submission no. 24; Australian Drug Law Reform Foundation, Submission no. 30, pp. 5-6.
and cannabis-related police activity is high, cannabis remains readily available and levels of use in the community, although declining, are still significant. Studies have found that both criminal and civil penalties have a limited impact on subsequent cannabis use and there is no evidence that increasing penalties on cannabis users is likely to further deter use. Critics of the current system argue that the vast sums of money spent on law enforcement would be better spent on treatment and education.

165. It is also claimed that punitive responses increase the harms through a range of unintended negative consequences including: creating and perpetuating a criminal economy; encouraging police corruption; and the various social harms that flow from coming into contact with the criminal justice system.

166. The committee heard that the black market and criminal economy surrounding a prohibited drug encourages crime and corruption. This is well illustrated by the fact the Crime and Misconduct Commission's assessment of cannabis-related harm is based largely on the criminal nature of the drug rather than harms to the health of users. It has been suggested that the value of the cannabis black market increases as a multiple of the cost of drug law enforcement. Dr John Jiggens has argued that 'because prohibition is a supply side solution, all that is achieved by increasing the amount spent on drug law enforcement is to increase the price of the drug, so the value of the black market rises as a multiple of drug law enforcement'.

167. A range of social harms have also been identified with conviction for a cannabis offence. A study that compared the consequences of receiving an infringement notice for a minor cannabis offence in South Australia with a criminal conviction for a minor cannabis offence in Western Australia found a range of negative consequences associated with the criminal conviction. More of the group who received a criminal conviction, compared to the group who received an infringement notice, reported negative employment consequences (32 per cent compared to 2 per cent), further problems with the law (32 per cent compared to 0 per cent), negative relationship consequences (20 per cent compared to 5 per cent), and accommodation consequences (16 per cent compared to 0 per cent) as a result of their apprehension for minor cannabis offences. Serious

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283 Mr Howard Teems, Submission no. 28.

284 Mr Howard Teems, Submission no. 29.

285 Mr Peter Thompson, Submission no. 2; Mr Andrew Whaites, Submission no. 38.

286 Dr Peter Thompson, Submission no. 2; Mr Andrew Whaites, Submission no. 38.

287 Name suppressed, Submission no. 10; Mr Paul French, Submission no. 14; Mr Howard Teems, Submission no. 29.


consequences of a drug conviction can include the inability to get a job in the public service and travel restrictions to countries such as the United States.291

168. It has also been argued that the criminal status of cannabis impedes efforts to educate young people about the health implications of the drug as teachers may not want to appear to condone illegal drug use292 and may make people less likely to seek treatment for fear they will be prosecuted.293 Involvement with the criminal justice system also alienates people, and decreases their feelings of belonging and their connection to society,294 factors which, ironically, increase a person’s risk of using illicit drugs.

5.4. Alternative approaches

169. As mentioned earlier, Queensland’s legal approach to cannabis is one of prohibition supported by criminal penalties with diversion available for the possession of minor amounts of the drug. Solutions to what are seen as the failings of this current regime fall into three categories: making cannabis a legal substance that can be controlled in the same way as tobacco and alcohol through regulation and taxation; making the possession of small amounts of cannabis for personal use an offence that can be dealt with by a civil penalty such as a fine rather than a criminal charge; or increasing the opportunities to divert people into assessment, education and treatment.

5.4.1. Control through regulation and taxation

170. The committee received a number of submissions that suggested the most effective way to address cannabis-related harm would be to make cannabis a legal substance regulated in the same way as alcohol and tobacco.295

171. The Queensland Council for Civil Liberties suggested that regulation should apply to all aspects of cannabis production, supply and consumption.296 Dr Alex Wodak from the Australian Drug Law Reform Foundation suggested licences for cultivation should be short-term, hard to get and easy to lose and taxation should be set at a level that would discourage the black market.297

172. It is argued that such a system would allow governments to reduce consumption by under age persons, ensure health warnings and provision of help seeking information on packages, establish a system of hard-to-get and easy-to-lose licences for cultivation and sale, ensure THC concentration is contained within certain bands, provide consumer protection (as for other commodities) and generate government revenue, which could in part be hypothecated to fund

291 Professor Jake Najman, Queensland Alcohol and Drug Research and Education Centre, Hearing Transcript, 4 June 2010, p. 20.
293 Mr Paul French, Submission no. 14.
294 Mr Jeff Cheverton, Queensland Alliance, Hearing Transcript, 4 June 2010, p. 18.
295 Dr Peter Thompson, Submission no. 2; Name suppressed, Submission no. 17; Australian Drug Law Reform Foundation, Submission no. 30, p. 1; Queensland Council for Civil Liberties, Submission no. 52; Mr John Ransley, Queensland Council for Civil Liberties, Hearing Transcript, 3 June 2010, p. 14; Dr John Jiggens, HEMP Embassy, Hearing Transcript, 3 June 2010, p. 18; Dr Alex Wodak, Australian Drug Law Reform Foundation, Hearing Transcript, 3 June 2010, pp. 28-29.
297 Dr Alex Wodak, Australian Drug Law Reform Foundation, Hearing Transcript, 3 June 2010, pp. 28-29.
alcohol and drug prevention and treatment.\textsuperscript{296} It has been suggested that the reduction in the number of Australians who smoke in recent years has been achieved largely because tobacco is a legal drug, which governments have been able to control through mechanisms such as taxation, regulation of packaging (including health warnings), advertising and education campaigns.\textsuperscript{299}

173. The Criminal Justice Commission (the Commission) rejected legalisation of cannabis in its 1994 report on cannabis and the law for three reasons. Although at that time research suggested cannabis may not be significantly more harmful than some licit drugs, this was not considered sufficient reason to add to the list of available drugs, particularly given the health costs associated with licit drugs. The Commission considered legalisation would probably lead to an increase in the use of cannabis in the community, which would be concerning given the uncertainty about the long-term health effects of cannabis use and the effects short-term impairment could have on road and workplace safety. It also noted that Australia would be precluded from legalising cannabis under various international drug conventions.\textsuperscript{300}

174. Legalisation is predicated on the belief that cannabis is a relatively safe substance. While the committee acknowledges that the harms posed by cannabis are not necessarily as immediate or potentially life-threatening as many other drugs, there is an increasing awareness that cannabis is not as harmless as may have previously been thought. It would therefore be extremely unwise to create a situation in which rates of cannabis use could potentially increase. The present difficulties governments encounter trying to address harm caused by legal substances, most particularly alcohol and tobacco, also make it unwise to contemplate legalisation.

5.4.2. Civil penalty schemes

175. Four Australian jurisdictions have made minor cannabis offences civil rather than criminal offences. South Australia,\textsuperscript{301} Western Australia,\textsuperscript{302} the Australian Capital Territory\textsuperscript{303} and the Northern Territory\textsuperscript{304} have replaced criminal penalties with fines for minor possession offences and small-scale cultivation. There is no uniformity in the amounts of cannabis eligible for these civil penalty provisions or the fines that are imposed. The amount of cannabis eligible for civil fines ranges from 100 grams in South Australia\textsuperscript{305} to 25 grams in the Australian Capital Territory.\textsuperscript{306} Plant limits also vary from 2 plants (regardless of cultivation method) in the Northern Territory,\textsuperscript{307} to one plant (not grown by artificially enhanced cultivation) in South Australia.\textsuperscript{308} Fines range from $300 in South Australia,\textsuperscript{309} to

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\begin{enumerate}
\item Australian Drug Law Reform Foundation, Submission no. 30, p. 5. See also: Dr Peter Thompson, Submission no. 2.
\item Mr John Ransley, Queensland Council for Civil Liberties, Hearing Transcript, 3 June 2010, p. 15.
\item Controlled Substances Act 1984 (SA) s 45A.
\item Cannabis Control Act 2003 (WA); Cannabis Control Regulations 2004 (WA). Note: This legislation will be repealed when the Cannabis Law Reform Bill 2009 (WA) is enacted.
\item Drugs of Dependence Act 1989 (ACT) s 171A.
\item Misuse of Drugs Act 1990 (NT) Part IIB.
\item Controlled Substances Act 1984 (SA) s 45A(8); Controlled Substances (General) Regulations 2000 (SA) s 9B.
\item Drugs of Dependence Act 1989 (ACT) s 171A;
\item Misuse of Drugs Act 1990 (NT).
\item Controlled Substances Act 1984 (SA) s 45A(8)(a); Controlled Substances (General) Regulations 2000 (SA) s 9B(1).
\end{enumerate}
$100 in the Australian Capital Territory. These schemes typically have no restrictions on repeat offenders.

It is interesting to note that plant limits have gradually been reduced in South Australia from 10 plants, to three plants, to one plant and finally to one plant that is not grown by artificially enhanced cultivation. The committee was informed that this was in response to problems created by the syndication of hydroponic cannabis crops by organised criminal groups.

Interestingly, only a small number of submissions suggested the adoption of such a scheme in Queensland. The Queensland Council for Civil Liberties specifically rejected this approach arguing that it would not address the unregulated black market governing supply and the associated levels of criminality.

There is, however, a bill before the Western Australian Parliament that will repeal the existing civil penalty scheme in that jurisdiction and replace it with a diversionary program that will enable people who are found in possession of not more than 10 grams of cannabis to attend a cannabis intervention session rather than be prosecuted for the criminal offence of possession. The committee has been informed that the Western Australian police have effectively stopped issuing infringement notices while awaiting implementation of the new scheme.

5.4.3. Expansion of diversion programs

There are a range of programs that divert people apprehended for certain minor drug offences from the criminal justice system and into drug assessment, education and treatment. Diverting offenders from the criminal justice system has the potential to reduce the burden on the system and reduce the harms to individuals associated with coming into contact with the criminal justice system, whereas diverting offenders into assessment, education and treatment potentially reduces the level of drug use and drug-related crime. Thus diversion can have both criminal justice and health outcomes.

Although diversion programs began in some Australian jurisdictions during the 1980s they expanded rapidly when the Council of Australian Governments agreed to the Illicit Drug Diversion Initiative in April 1999. This established a nationally consistent approach to the diversion of drug offenders by police into compulsory assessment.

309 Controlled Substances Act 1984 (SA) s 45A(3); Controlled Substances (General) Regulations 2000 (SA) s 9A and schedule 5.
310 Drugs of Dependence Act 1989 (ACT) s 171A(8).
311 National Drug Research Institute, Submission no. 60, p. 16.
313 Ms Louise Norman, Crime and Misconduct Commission, Hearing Transcript, 4 June 2010, p. 3.
314 Name suppressed, Submission no. 17; Mr Howard Teems, Submission no. 29; Mr Andrew Whaites, Submission no. 38.
315 Queensland Council for Civil Liberties, Submission no. 52, p. 24.
316 Cannabis Law Reform Bill 2009 (WA), which will repeal the Cannabis Control Act 2003 (WA).
317 National Drug Research Institute, Submission no. 60, p. 16.
181. In Queensland there are two types of diversion programs: those that apply to minor drug offences and those that apply to offenders who are drug dependent and therefore involve more intensive interventions. The Police Drug Diversion Program and the Illicit Drug Court Diversion Program fall into the first category while the Queensland Magistrates Early Referral and Treatment Program (QMERIT) and the Drug Court Program are in the second category.

i) Police Drug Diversion Program

182. The Police Drug Diversion Program is available throughout the state to eligible adults or young offenders found in possession of small quantities of cannabis (50 grams or less) or related drug equipment. A police officer must offer all eligible adults (and young offenders who have previously been cautioned for a minor drugs offence) the opportunity to attend a Drug Diversion Assessment Program. An offer may also be made to a young offender who has not been cautioned. A diversion offer can only be made once. A person is ineligible to be offered the opportunity to attend the program if they have committed another indictable offence in circumstances related to the minor drug offence; had previously been sentenced to imprisonment for a serious drug offence; or been convicted of an offence involving violence against a person. The offender must admit to the offence and sign an agreement to attend a diversion program. Diverted offenders must attend the Drug Diversion Assessment Program. Compliance results in the offender not being charged with the drug offence. Non-compliance, however, can result in the offender being charged with contravening a requirement or direction of a police officer.320

183. The Drug Diversion Assessment Program involves the offender attending a two-hour assessment, education and counselling session with a specially trained health service worker. During the session: the offender’s drug use is assessed; information is provided about the health effects of illicit drug use and the legal consequences of continued use; and a personal plan is developed to help the offender stop using illicit drugs. An offender may be given information about, and access to, a treatment program for illicit drug dependence. Attending a treatment program is, however, entirely voluntary and not a requirement of the Drug Diversion Assessment Program.322 This approach has been characterised as one that aims to educate and persuade people to stop using cannabis.323

184. Since its introduction in June 2001, over 70,000 offenders have been offered an opportunity to participate in counselling.324

ii) Illicit Drug Court Diversion Program

185. The Illicit Drug Court Diversion Program was introduced in 2002 to complement the Police Drug Diversion Program by providing Magistrates with the option to divert offenders charged with possession of small amounts of illicit drugs including, but not limited to, cannabis. Where an adult or young offender is

320 Police Powers and Responsibilities Act 2000 (Qld) s 379.
321 Police Powers and Responsibilities Act 2000 (Qld) s 791.
323 Professor Jake Najman, Queensland Alcohol and Drug Research and Education Centre, Hearing Transcript, 4 June 2010, p. 20.
324 Queensland Government, Submission no. 41, p. 10.
325 Explanatory Notes issued with the Drug Diversion Amendment Bill 2002 (Qld), p. 2.
charged with, and pleads guilty to, an eligible drug offence (including possession of not more than 50 grams of cannabis for personal use or cannabis equipment) a Magistrate may, with the consent of the offender, impose a condition that the offender must attend a drug assessment and education session. If the offender attends the session, the order ends and no conviction is recorded. If the offender fails to attend, the order is breached and the offender is sentenced.

186. Drug assessment and education sessions are single, one-on-one sessions provided by an approved provider involving assessment of the offender’s drug use, drug education and identification of any appropriate treatment options for the offender. Although treatment options may be identified as part of the session, attending a treatment program is voluntary and is not part of the requirement of the court order. This diversion alternative is not available to certain offenders who have a charge for a disqualifying offence pending or have ever been convicted of a disqualifying offence including an offence of a sexual nature, certain serious drug offences and certain indictable offences involving violence against a person. A person can only be offered two diversion alternatives including the Police Drug Diversion Program.

187. As at 31 January 2010, 22,624 offenders had been assessed for the program and 20,050 had been diverted into an assessment and education session, including 488 juveniles. Of those diverted, 17,907 successfully completed their order and 259 offenders were pending. Compliance in attending sessions is reported to be consistently high at 90 per cent.

iii) Other forms of diversion to treatment

188. Programs of diversion to treatment are available to certain drug-dependent offenders through the Drug Court Program and the Queensland Magistrates Early Referral into Treatment (QMERIT) program.

189. The Drug Court Program offers eligible drug-dependent offenders an intensive drug rehabilitation order as an alternative to prison. The order includes court-enforced and supervised drug rehabilitation treatment programs. The program operates in the Beenleigh, Southport, Ipswich, Townsville and Cairns Magistrates Courts.

190. QMERIT is a 12 to 16 week bail-based diversion program conducted in the Maroochydore and Redcliffe Magistrates Courts. The program helps eligible individuals charged with drug-related offences undergo treatment for their illicit drug use problems. Successful completion of the program must be taken into account at sentencing.

326 Penalties and Sentences Act 1992 (Qld) s 15C, 15D and 19(2A); Youth Justice Act 1992 (Qld) ss 166, 169, 172; Penalties and Sentences Regulation 2005 (Qld) s 5 and schedule.
327 Penalties and Sentences Act 1992 (Qld) s 15B; Youth Justice Act 1992 (Qld) s 167.
328 Penalties and Sentences Act 1992 (Qld) s 15E; Youth Justice Act 1992 (Qld) s 170.
330 Penalties and Sentences Act 1992 (Qld) s 15E; Youth Justice Act 1992 (Qld) s 170.
331 Penalties and Sentences Act 1992 (Qld) s 15C; Youth Justice Act 1992 (Qld) s 166.
332 Queensland Government, Submission no. 41, p. 12.
333 Queensland Government, Submission no. 41, p. 11.
account by the Magistrate when sentencing the offender and participation in the program demonstrates the individual’s suitability for community-based orders.334

iv) Program evaluation

191. The success of diversion programs can be measured in different ways depending on the primary objectives of the program. These may include: reducing drug use; improving the health and wellbeing of offenders; reducing the number of minor drug offenders entering the court system; and reducing drug-related crime.

192. The Australian Institute of Criminology has examined rates of reoffending following police drug diversion across Australia. A study of 470 individuals diverted to the Queensland Police Drug Diversion Program between 1 January and 30 June 2005 found high compliance levels, with 82 per cent of those referred to diversion attending the compulsory drug assessment session.335 The study also found that one-third (37 per cent) of offenders were re-apprehended within 12 months of being diverted; with 20 per cent of all individuals committing a fresh drug offence.336 The study concluded that the findings were generally positive, with indications that the majority of people referred to a police-based illicit drug diversion initiative do not offend post-program.337

193. A recent evaluation of the Queensland illicit drug court diversion and police diversion programs found the percentage of participants who used cannabis decreased from 80.3 per cent immediately after the diversion program to 66.7 per cent six weeks later. The number of days on which cannabis was used in the previous month decreased from a mean of 13.84 days immediately after the diversion program to 9.81 days six weeks later. The amount of cannabis usually consumed on those days decreased from 7.93 cones or joints to 4.46 cones or joints.338

194. The researchers concluded that the findings were ‘consistent with the view that the process of diversion is creating a positive change with regard to drug intake and possible associated resulting harms.’339 The results of this evaluation must, however, be considered in the light of methodological issues340 such as the relatively short follow-up time (six weeks) and the fact the outcomes were assessed on the basis of self-reporting and not substantiated by other data.

334 Queensland Government, Submission no. 41, p. 11.
v) Evidence to the committee

195. The committee heard a significant level of support for the concept of diversion\textsuperscript{341} with a number of submissions and witnesses calling for diversion initiatives to be expanded.\textsuperscript{342} According to the Queensland Alcohol and Drug Research and Education Centre, ‘drug diversion is a relatively inexpensive and effective approach to dealing with the problems associated with cannabis use.’\textsuperscript{343}

196. Some concern was expressed, however, about the potential for drug diversion programs to actually increase the number of people coming into contact with the criminal justice system, particularly people from vulnerable groups such as younger, Indigenous and homeless people.\textsuperscript{344} This could occur as police, knowing people may be diverted, may be less likely to deal with offenders informally as they would have in the past. The National Drug Research Institute noted that since the Queensland Illicit Drug Diversion Initiative was introduced ‘there has been a rapid increase in the number of cannabis arrests from 13,178 in 2000/01 to a high of 23,335 in 2004/05, followed by a two year gradual decline and a rapid drop to 17,130 in 2007/08.’\textsuperscript{345} Although this ‘net widening’ may be due to the mandatory nature of the police cautioning scheme, it is of concern because ‘once people have their name in the criminal justice system this can result in increased police attention and further criminalisation.’\textsuperscript{346}

197. The committee heard about a range of factors that potentially reduce the effectiveness and availability of diversion programs including: factors preventing the involvement of Indigenous offenders such as the fact that offenders have to admit culpability; strict limits on the number of times an individual can be offered diversion; and the complexity of administrative procedures that may discourage police from offering diversion.

198. There is concern that diversion programs are not being utilised effectively in relation to Indigenous offenders.\textsuperscript{347} The Australian Institute of Criminology study of individuals diverted to the Queensland Police Drug Diversion Program between 1 January and 30 June 2005 found only eight per cent of those diverted were Indigenous.\textsuperscript{348} It has been suggested that this may be due to factors such as the ineligibility of some Indigenous people due to their criminal histories or the need to admit to the offence and consent to the intervention, which has

341 Queensland Alcohol and Drug Research and Education Centre, Submission no. 31, pp. 2, 8-9; Queensland Council of Social Services, Submission no. 33, pp. 2-3; BoysTown, Submission no. 39, p. 18; Professor David Kavanagh and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, Submission no. 42, p. 2; Australian Drug Foundation, Submission no. 51, pp. 3, 14; Australian Association of Social Workers, Submission no. 56, p. 23; DRUG ARM Australesia, Submission no. 57, p. 7-8; Queensland Network of Alcohol and Drug Agencies, Submission no. 59, p. 5; Professor Jan Copeland, National Cannabis Prevention and Information Centre, Hearing Transcript, 3 June 2010, p. 40; Mr Jeff Cheverton, Queensland Alliance, Hearing Transcript, 4 June 2010, p. 18.

342 Queensland Alcohol and Drug Research and Education Centre, Submission no. 31, pp. 2, 8-9; Queensland Council of Social Services, Submission no. 33, pp. 2-3; BoysTown, Submission no. 39, p. 18; Queensland Network of Alcohol and Drug Agencies, Submission no. 59, p. 5.

343 Queensland Alcohol and Drug Research and Education Centre, Submission no. 31, p. 9.


345 National Drug Research Institute, Submission no. 60, p. 17.

346 National Drug Research Institute, Submission no. 60, p. 17.

347 Queensland Council of Social Services, Submission no. 33, p. 2.

Part 3 Strategies to Reduce Cannabis Use

Chapter 5 – Legal responses

frequently been demonstrated to exclude Indigenous people.\textsuperscript{349} The fact that people have to admit culpability to access diversion was also raised as a general barrier to wider use of diversion as people may consider they are more likely to ‘get off’ if they do not admit to the offence.\textsuperscript{350}

199. Strict limits on the number of times an individual can be offered diversion was also seen as a limitation on the effectiveness of the system, particularly for young offenders. In its submission, BoysTown stated that ‘based on our experience, these programs should be offered as often as needed by young people to help them keep out of detention rather than as a “one strike” legislative regime.’\textsuperscript{351}

200. The committee was also informed that ‘current police administration requirements relating to diversion options for cannabis offenders are not a simple system and, in many instances these do not readily encourage diversion to be the option of choice.’\textsuperscript{352} It was suggested that ‘a simplified system that easily triggers a diversion referral would need to be established.’\textsuperscript{353}

201. Queensland diversion programs for minor cannabis offences are voluntary, with offenders having the option to reject an offer of diversion. Drug Free Australia and DRUG ARM Australasia support compulsory diversion of young offenders on the basis that it ‘will yield greater short and long term benefits for the individual.’\textsuperscript{354} DRUG ARM Australasia recognised, however, that this would increase the demand for treatment services and the associated financial implications to government.\textsuperscript{355} By contrast, Families and Friends for Drug Law Reform and Family Drug Support questioned the value of compulsory drug treatment for young offenders given the size of the potential ‘market’ and the financial implications for government\textsuperscript{356} and the availability of treatment places.\textsuperscript{357}

202. The committee heard a call for the threshold amount to be reduced from 50 grams to 10 grams. FamilyVoice Australia suggested 50 grams was a significant amount to consider minor personal use because 50 grams of cannabis could make about 100 joints and although it may be worth about $300 it could be sold in three-gram lots for about $50 each to make about $500 profit.\textsuperscript{358} Thresholds vary in other jurisdictions from 15 grams in New South Wales to 50 grams in Tasmania, Victoria and Queensland.\textsuperscript{359} The legislative change proposed in Western Australia will set the threshold for diversion at 10 grams of cannabis.\textsuperscript{360}

\textsuperscript{350} Mr Jeff Cheverton, Queensland Alliance, Hearing Transcript, 4 June 2010, p. 18.
\textsuperscript{351} BoysTown, Submission no. 39, p. 18.
\textsuperscript{352} DRUG ARM Australasia, Submission no. 57, p. 8; Dr Dennis Young, DRUG ARM Australasia, Hearing Transcript, 3 June 2010, pp. 22-23.
\textsuperscript{353} DRUG ARM Australasia, Submission no. 57, p. 8.
\textsuperscript{354} DRUG ARM Australasia, Submission no. 57, p. 7.
\textsuperscript{355} DRUG ARM Australasia, Submission no. 57, p. 8. Also: Queensland Network of Alcohol and Drug Agencies, Submission no. 59, p. 5.
\textsuperscript{356} Families and Friends for Drug Law Reform, Submission no. 45, pp. 59-63; Family Drug Support, Submission no. 88, pp. 58-62.
\textsuperscript{357} Mr Bill Bush, Families and Friends for Drug Law Reform, Hearing Transcript, 3 June 2010, p. 38.
\textsuperscript{358} FamilyVoice Australia, Submission no. 44, p. 10.
\textsuperscript{359} National Cannabis Prevention and Information Centre (2009b) Cannabis and the Law: Factsheet 2, NCPIC: Sydney, p. 3.
\textsuperscript{360} Cannabis Law Reform Bill 2009 (WA) s 6.
vi) Committee comments

203. The committee supports the use of diversion programs for people found in possession of small amounts of cannabis as a way of reducing the harms associated with involvement in the criminal justice system. Diversion also provides a valuable opportunity to present users with information about the harms associated with cannabis use and offer access to treatment.

204. The committee notes that the effectiveness of diversion initiatives is difficult to gauge given the diversity of possible outcomes to be achieved. For example, FamilyVoice Australia suggested that ‘the goal of the program should be to get all cannabis users drug free’ whereas the Queensland Council for Civil Liberties suggested that diversion does not provide the incentive to stop using if people do not recognise they have a problem with cannabis. The committee was informed that ‘if all of their experience and the experience of their peers, family and so on is that there are no problems with the use, why are they going to change?’

205. It has been observed that it is not really feasible to expect one-off interventions to have long-term impacts on drug use and it may be more realistic to focus on diverting individuals away from the formal justice system as the primary aim of such interventions. This is reinforced by media reporting of the evaluation of the illicit drug court diversion and police diversion programs, which indicated that ‘despite the limited success of the program, researchers said it needed to continue because the only other alternative for offenders was jail.

206. The committee therefore recognises there is a need to clarify the objectives of the diversion programs and ensure the programs are evaluated against those objectives.

Recommendation 5

The committee recommends that the Queensland Government clarify the key objectives of the cannabis diversion initiatives and ensure evaluations clearly address these objectives.

Recommendation 6

The committee recommends that the Queensland Government investigate ways to expand the diversion opportunities for minor cannabis offences, including addressing issues relating to: the requirement that offenders admit the offence; limits on the number of times diversion can be offered; administrative procedures that may discourage diversion; and barriers to Aboriginal and Torres Strait Islander people being involved in diversion.

361 FamilyVoice Australia, Submission no. 44, p. 10.
362 Mr John Ransley, Queensland Council for Civil Liberties, Hearing Transcript, 3 June 2010, p. 16.
Recommendation 7

The committee recommends that the Queensland Government ensure any expansion of diversion opportunities for minor cannabis offences is accompanied by expanded funding to the alcohol and other drug sector to meet increased demand for services.
CHAPTER 6 – LAW ENFORCEMENT ACTIVITY

6.1. Enforcement activity

207. Cannabis dominates drug-related law enforcement activity in terms of seizures and arrests both in Queensland and nationally.\(^{365}\) This activity is particularly high in Queensland.

208. In 2008-09, 36.4 per cent of all cannabis seizures and 29.8 per cent of all cannabis arrests occurred in Queensland.\(^{366}\) Queensland has accounted for the largest proportion of national cannabis-related arrests since 2003-04.\(^{367}\) It is important to note that the statistics may reflect Queensland policing priorities and not necessarily the relative level of problems compared to other jurisdictions.\(^{368}\)

209. The committee heard from a number of people who believe a stronger approach to drug law enforcement is required to address cannabis-related harms.\(^{369}\) They called for increased penalties for cannabis offences, particularly offences of production, supply and trafficking\(^ {370}\) and supply to children.\(^ {371}\)

6.2. Use compared to supply

210. In Queensland almost 70 per cent of drug-related arrests in 2008-09 involved cannabis, with the majority of these arrests (89 per cent) for user-type (consumer) offences rather than supply-type (provider) offences.\(^{372}\)

211. The committee was informed that, although the Drug Squad targets suppliers, traffickers and producers, they get a 'by-catch' of possession\(^ {373}\) because 'in just about every search warrant execution there will be a bag of marijuana and a smoking utensil.'\(^ {374}\) The committee was also informed that, 'generally, the number of supply offences will be smaller because you do not generally get as many offences out of one arrest for supply whereas you can get a number of offences for consumer type offences out of that same arrest.'\(^ {375}\)


\(^{367}\) Australian Crime Commission, Submission no. 55, p. 3.

\(^{368}\) Detective Senior Sergeant Johnson, Hearing Transcript, 3 June 2010, p. 6.

\(^{369}\) Mr Rob Lavers, Submission no. 4; Mrs Jeanette Reinecke, Submission no. 11; Name suppressed, Submission no. 18; Mr Ross Harty, Submission no. 27; Ms Jeannette Durret, Submission no. 54.

\(^{370}\) Mrs Jeanette Reinecke, Submission no. 11; Name suppressed, Submission no. 18; Mr John Malouf, Submission no. 22.

\(^{371}\) Name suppressed, Submission no. 19; Queensland Independent Schools Parents’ Council, Submission no. 23. See also: Drug Free Australia (2009) Cannabis – Suicide, Schizophrenia and Other Ill-effects, Elizabeth, SA: Drug Free Australia, p. 27.

\(^{372}\) Detective Senior Sergeant Johnson, Queensland Police Service, Hearing Transcript, 3 June 2010, p. 10.

\(^{373}\) Mr John Callanan, Crime and Misconduct Commission, Hearing Transcript, 4 June 2010, p. 3.

\(^{374}\) Ms Louise Norman, Crime and Misconduct Commission, Hearing Transcript, 4 June 2010, p. 3.
212. Another reason for the disproportionate number of user-type offences may be the fact that it is easier to prove possession than supply.376 Detective Senior Sergeant Johnson explained that because a person ‘gets caught being what is termed as a user, in other words, a possession charge, does not necessarily mean they are not a supplier. It just means the evidence sufficiency rule meant that we could only go to that part.’377 The Crime and Misconduct Commission stressed the difficulty of ‘securing convictions on a commercial rather than personal use basis without clear evidence of commercial transactions or supply intent’ such as customer lists.378 For example, a supplier was recently sentenced on a personal use basis for having over 1,700 cannabis plants and 30 kilograms of dried cannabis.379

213. Some other jurisdictions have legislative provisions that deem a person who has more than a certain amount of a drug in their possession (the ‘trafficable quantity’) to have the drug in their possession for supply unless they prove otherwise.380

214. The Crime and Misconduct Commission suggests that the current situation ‘is likely to make Queensland an attractive operational base for organised criminal groups seeking to mitigate their risk’ and proposes a legislative remedy, ‘possibly in the form of deeming provisions.’381

215. The committee notes that such provisions have the potential to negatively affect the fundamental rights of an accused person.382 It would therefore be important to ensure any provision appropriately balances the rights of the accused with the public interest in having supply offences successfully prosecuted by, for example, ensuring that the trafficable quantity is set at an appropriate level.

216. The committee also notes that the Queensland law currently provides a maximum penalty of 20 years imprisonment for cannabis possession where the quantity is, or exceeds, 500 grams or 100 plants (where the aggregate weight of the plants is less than 500 grams).383 Accordingly, a court will exercise its discretion in determining the appropriate sentence within the maximum range, depending upon the particular circumstances of each case.

376 Detective Senior Sergeant Johnson, Queensland Police Service, Hearing Transcript, 3 June 2010, p. 10; Ms Louise Norman, Crime and Misconduct Commission, Hearing Transcript, 4 June 2010, p. 3.
377 Detective Senior Sergeant Johnson, Queensland Police Service, Hearing Transcript, 3 June 2010, p. 10.
378 Ms Louise Norman, Crime and Misconduct Commission, Hearing Transcript, 4 June 2010, p. 3.
379 Ms Louise Norman, Crime and Misconduct Commission, Hearing Transcript, 4 June 2010, p. 3.
380 Ms Louise Norman and Mr John Callanan, Crime and Misconduct Commission, Hearing Transcript, 4 June 2010, pp. 3-5; Crime and Misconduct Commission, Submission no. 6: Crime and Misconduct Commission (2010) Illicit Drug Markets in Queensland: A Strategic Assessment, CMC: Brisbane, p. 54. See for example: Drug Misuse and Trafficking Act 1985 (NSW) s 29, schedule 1 (300g of cannabis leaf); Misuse of Drugs Act 1981 (WA) s 11, schedule V (100g of cannabis or 80 cigarettes containing cannabis).
382 For example, the Legislative Standards Act 1992 (Qld) s 4(b)(d) provides that legislation should not reverse the onus of proof in criminal proceedings without adequate justification.
383 Drugs Misuse Act 1986 (Qld) s 9(c); Drugs Misuse Regulation 1987 (Qld) Schedule 3.
6.3. Hydroponic cultivation

217. Anecdotal evidence suggests an increase in the cultivation of cannabis by enhanced indoor methods including hydroponic techniques. Hydroponic cultivation raises a range of issues including: potential increases in potency; harms related to increased potency and contamination; the involvement of organised criminal groups; and risks to the occupational health and safety of police and other professionals posed by toxic chemicals and dangerously modified electrical equipment used at hydroponic growing sites.

218. The Crime and Misconduct Commission made the point that it is not possible to get accurate figures on seizures of hydroponically cultivated cannabis because the Queensland Police Service (QPS) recording system (QPRIME) does not record the method of production.\(^{384}\) The Crime and Misconduct Commission supported a recommendation of the QPS State Intelligence Group for the inclusion of a QPRIME marker to record the method of production and location (rural, residential or industrial) of cannabis crops.\(^{385}\)

219. Given the apparent increase in enhanced indoor cannabis crops and the issues specific to those crops, including questions of potency, contamination and levels of criminality, the committee supports the introduction of a system by which the QPS records whether cannabis that has been seized was grown indoors (hydroponically or otherwise) or as part of a bush crop.

Recommendation 8

The committee recommends that the Queensland Police Service implement a system to record whether seized cannabis has been grown indoors (hydroponically or otherwise) or as a bush crop.

220. The *National Cannabis Strategy 2006-2009* recommended assessing the feasibility of regulating the sale of hydroponic equipment, similar to regulation of the liquor and second-hand dealer industries.\(^{386}\) South Australia recently became the first Australian jurisdiction to license hydroponic equipment retailers and require records of sales of hydroponic equipment, including the identification of purchasers, to be provided to police.\(^{387}\) The purpose of the legislation is to 'prevent criminal infiltration of the hydroponics industry and the misapplication of certain types of hydroponics equipment by monitoring its sale and supply.'\(^{388}\) The legislation came into force on 1 March 2010 and its operation and effectiveness will be reviewed after three years.\(^{389}\)

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387 Hydroponics Industry Control Act 2009 (SA).
389 Hydroponics Industry Control Act 2009 (SA) s 37.
221. The Crime and Misconduct Commission claims there has been significant growth in the number of hydroponic retailers in Queensland over the last three years and the unregulated sale of hydroponic supplies in Queensland facilitates both small-scale and commercial hydroponic cannabis cultivation.\textsuperscript{390} The Crime and Misconduct Commission asserts that 'Queensland needs legislation and penalties comparable to those of other Australian jurisdictions to ensure that it does not become a more attractive operational environment for criminal groups, particularly for the cultivation of hydroponic cannabis.'\textsuperscript{391}

222. The committee notes that the South Australian response may be the result of a situation created by the state's drug laws, which allowed the offence of producing cannabis to be expiated if the number of plants was under a certain level and they were being grown for personal use. The South Australian police considered the expiation system assisted the development of growing syndicates operated by organised crime and the proliferation of hydroponically cultivated cannabis. There was also intelligence that specialist hydroponic retailers and customers had connections with cannabis trade.\textsuperscript{392}

223. In the absence of similar evidence in Queensland the committee recommends that the Queensland Government monitor the prevalence of hydroponic cannabis throughout the state and the effectiveness of the South Australian legislation.

\begin{center}
\textbf{Recommendation 9}
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\begin{quote}
The committee recommends that the Queensland Government monitor developments in the hydroponics industry in Queensland and the effectiveness of the South Australian legislation regulating the hydroponics industry in that state.
\end{quote}

\section*{6.4. Policing}

224. Drug Free Australia recommended the implementation of NOAH (narcotics, opiates, amphetamines, hashish) blitzes every three months for a two-year period.\textsuperscript{393} The recommendation refers to Operation NOAH, which was conducted in various jurisdictions including Queensland over a 24-hour period each year and encouraged the general public to provide police with information about drug offences.\textsuperscript{394}

225. The committee heard support for an anonymous call centre where people, including school-age children, can provide information about the use and sale of marijuana in schools and the general community.\textsuperscript{395}

\begin{small}
\textsuperscript{393} Drug Free Australia (2009) \textit{Cannabis – Suicide, Schizophrenia and Other Ill-effects}, Elizabeth, SA: Drug Free Australia, p. 28.
\textsuperscript{395} Ms Eva Lai, \textit{Submission no. 3}.
\end{small}
226. The committee notes that the 24-hour crime reporting hotline *Crime Stoppers* provides the opportunity for the general public to anonymously report crime, including drug-related crime.\(^{396}\) The Queensland Police Service reported that, during August 2010, calls to the *Crime Stoppers* hotline resulted in seizures of drugs (including cannabis) valued at $490,429.\(^{397}\)

227. The Queensland Police also run targeted drug campaigns utilising the *Crime Stoppers* hotline. For example, Central Region Police ran a week-long 'Dial in a Druggie' campaign in November 2009, which encouraged people to use the anonymous telephone hotline to provide confidential information about drug use.\(^{398}\) The committee heard support for this type of initiative as a way of reminding the public about cannabis-related crime.\(^{399}\)

228. The committee heard the importance of local-level policing, particularly the coordination of policing activities with health, community and education initiatives.\(^{400}\) Research indicates that successful drug law enforcement depends on the ability of police to build partnerships with other groups in the community such as schools, health services, and community groups rather than merely increasing police activity or focusing on arrests at drug hotspots.\(^{401}\) Strengthening community partnerships and initiatives has the potential to decrease punitive responses and increase diversionary and intervention measures relating to cannabis use.\(^{402}\)

229. Police are well placed to assist in addressing the wider social issues that can lead to drug use. For example, the committee heard about the *Coordinated Response to Young People at Risk* (CRYPAR) program that is run by the Child Protection and Investigation Unit.\(^{403}\) The program aims to assist young people address issues that contribute to the development of criminal and self-harming tendencies and anti-social behaviour.\(^{404}\)

230. The *Weed it Out* project in Cape York is another excellent example of police working with local community groups and taking a strong public health approach.\(^{405}\)

231. As surveys of police detainees and prisoners indicate that cannabis use (including problematic use) among these groups is more prevalent than among the general community, police can potentially play a role in referral to treatment services. A bulletin produced by the National Cannabis Prevention and Information Service and the Australian Institute of Criminology suggested that "for those already using cannabis and experiencing problems with their use,"

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Referenced by:
- Associate Professor Alan Clough, James Cook University, *Submission no. 61*, p. 30.
police can provide information about treatment options and this may help users to seek treatment. Informing families and community groups about options for treatment may also influence those with cannabis use problems to access assistance."406

232. The committee commends the work the Queensland Police Service is doing to reduce the supply of cannabis in Queensland but recognises that, by working with communities, the police have the potential to also play a significant role in reducing demand for cannabis.

### Recommendation 10

The committee recommends that the Queensland Government ensure police are educated about the risks associated with cannabis use and treatment options and are proactive in providing this information to individuals, families and community groups.

### 6.5. Drug driving

233. Cannabis intoxication produces physical and cognitive impairment that can negatively affect driving performance and increase the risk of motor vehicle accidents.

234. The 2007 National Drug Strategy Household Drug Survey found that 20.9 per cent of Australians aged 14 years and over had driven a motor vehicle while under the influence of illicit drugs in the previous 12 months.407

235. The Queensland Government introduced random roadside drug testing for cannabis (THC), methylamphetamine and MDMA on 1 December 2007.408 The testing, which involves saliva samples, operates in all eight police regions.409 It is an offence for a person to drive with any of these drugs present in their blood or saliva, irrespective of the concentration.410

236. Between December 2007 and 5 April 2010 the Queensland Police Service Roadside Drug Testing Unit conducted 29,713 roadside saliva tests during which 602 drivers tested positive to cannabis, methylamphetamine and/or MDMA, a detection rate of approximately 2 per cent.411 Cannabis was detected in more than 62 per cent of the 602 drivers, either as a single drug detected (predominantly, i.e. 35 per cent), or as one of two illicit drugs (significant proportion, i.e. 24 per cent), or as one of three illicit drugs detected (less likely, i.e. 3 per cent).412

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409 Transport Operations (Road Use Management) Act 1995 (Qld) s 79(2AA); Traffic Regulation 1962 (Qld) s 172.
237. Studies have also found the prevalence of cannabis (THC) in saliva samples of screened drivers was higher than for alcohol. For example, a study of drivers in regional Queensland found 1.7 per cent of drivers tested positive for THC compared to a usual detection rate of 0.8 per cent for random breath testing for alcohol at the same location.

238. It has been noted that saliva tests appear to be less effective at picking up cannabis (THC) than other drugs such as amphetamines or ecstasy because THC does not pass as easily from the blood stream into saliva. This means that if someone tests positive for THC it is likely they have used cannabis recently. It also means that a number of drivers experiencing cannabis intoxication may go undetected.

239. The Queensland random drug testing scheme was intended to enhance road safety. It was based on research that showed drug testing to be a more effective deterrent against drug driving than either increasing sanctions or providing factual or educational information about the risks associated with drug driving.

240. Unlike breath testing for alcohol, roadside saliva testing tests for the presence of the drug regardless of concentration and not driver impairment. This has led to suggestions that the road safety benefits are secondary to enforcement of drug laws. It should be noted, however, that in Queensland the saliva samples can only be used to detect drug driving and will only result in a traffic offence if a positive result is returned.

241. Commentators have also questioned the contribution of drug testing to reducing the road toll and called for rigorous and independent evaluation of the scheme.

242. It was suggested to the committee that roadside testing be expanded to provide diversion or intervention pathways. Although it may not be practical or appropriate to require assessment, education or treatment following a positive roadside drug test, being charged with such an offence may present an opportunity to also provide information about the health consequences of cannabis use and treatment options.

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413 National Drug Research Institute, Submission no. 60, pp. 20-21.
415 National Cannabis Prevention and Information Service, Submission no. 48, p. 28.
416 National Drug Research Institute, Submission no. 60, p. 21.
421 National Drug Research Institute, Submission no. 60, pp. 20-22.
422 DRUG ARM Australasia, Submission no. 57, p. 8.
Recommendation 11

The committee recommends that the Queensland Government use a person being charged following a positive roadside drug test as an opportunity to also provide the person with information and educational material about the risks associated with cannabis use and options for seeking help with their cannabis use.
CHAPTER 7 – SCHOOL-BASED RESPONSES

7.1. Introduction

243. Schools can play an important role in preventing cannabis use by providing both drug education and a supportive environment that increases the social connectedness of young people.

244. Drug education is recognised as a key preventative measure to reduce cannabis-related harm, and schools are regarded as an appropriate setting to deliver drug education and health messages to young people.

245. The 2005 Australian Secondary Students’ Alcohol and Drug Survey found that cannabis was the most commonly used illicit substance among secondary school students, although the use of cannabis has been steadily declining. There is evidence to suggest, however, that the age of first use of cannabis is also declining, meaning the drug is being used at younger ages.

246. Cannabis use is associated with poorer educational outcomes, particularly for those who use cannabis early. A 25-year longitudinal study conducted in New Zealand found that people who used cannabis at a young age were 3.1 times more likely to leave school compared to non-users. Those who started to use cannabis by 16 years were at a higher risk of leaving school without qualifications and were unlikely to enter university or obtain a university degree.

247. Further research in New Zealand found that the association between cannabis use and poor educational outcomes was due to the social context in which cannabis is used, such as peer association that may encourage school dropout attitudes. The National Cannabis Prevention and Information Centre indicated that this finding is extremely important and often neglected when considering the consequences of early cannabis use.

248. As discussed in Chapter 3, as well as poor educational attainment, those who begin using cannabis at an early age are more likely to become dependent, risk developing problems with brain function, and are at increased risk of developing schizophrenia and psychosis. It is therefore important that young people are educated about the risks associated with cannabis use, and encouraged to avoid using the drug. This chapter will outline evidence received by the committee.

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423 Queensland Department of Education and Training, Submission no. 62.
426 National Cannabis Prevention and Information Centre, Submission no. 48, p. 7.
427 National Cannabis Prevention and Information Centre, Submission no. 48, p. 7.
428 National Cannabis Prevention and Information Centre, Submission no. 48, p. 7.
429 National Cannabis Prevention and Information Centre, Submission no. 48, p. 7.
430 National Cannabis Prevention and Information Centre, Submission no. 48, p. 8.
431 Professor John McGrath, Submission no. 1; Australia and New Zealand College of Psychiatrists, Submission no. 50, p. 8.
relating to the school curriculum; drug education programs; social and emotional learning; school policies; and drug testing in schools.

7.2. Queensland curriculum

249. All state primary and secondary schools in Queensland are required to implement drug education programs under the Drug Education and Intervention in Schools Policy (CPR-PR-005). Drug education is included within health and physical education.

250. The committee notes that a national curriculum is currently being developed for years K-10 which will include, as part of the third phase, health and physical education. It is currently understood that there may be a nationally consistent framework for the inclusion of drug education as part of this curriculum, however consultation on the third phase of the national curriculum development will confirm whether drug education will be included as part of health and physical education. The consideration of a national curriculum framework for senior secondary years will occur after the third phase of development.

251. Currently, the Queensland Curriculum, Assessment and Reporting Framework Years 1-9 Health and Physical Education Essential Learnings facilitates an opportunity for schools to develop drug education programs. Opportunities also exist in years 10 to 12 in school-based programs such as pastoral care. Programs must align with the 12 principles set out in the national Principles for School Drug Education.

252. The current Queensland curriculum policies and frameworks provide the foundations for a consistent approach to drug education, while also giving schools the flexibility to develop specific curriculum programs that meet the diverse needs of students and the school community. "School-based curriculum development" means, however, that it is difficult to determine what is actually occurring at the local school level. The "crowded curriculum", and the competing demands and priorities on schools, potentially reduces the capacity of schools to provide adequate drug education.

253. The committee acknowledges that flexibility for schools to implement the curriculum according to their local needs and context is essential, however the committee has concerns regarding the specific implementation of drug education in schools.

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432 Queensland Department of Education and Training, Submission no. 62.
434 Committee correspondence from the Minister for Education and Training received 11 November 2010.
435 Queensland Department of Education and Training, Submission no. 62.
436 Queensland Department of Education and Training, Submission no. 62.
437 Queensland Association of State School Principals, Submission no. 35.
438 Queensland Government, Submission no. 41, p. 6; Queensland Department of Education and Training, Submission no. 62.
439 Dr Trish Glasby, Education Queensland, Hearing Transcript, 3 June 2010, p. 8; Mr Norm Hart, Queensland Association of State School Principals, Hearing Transcript, 4 June 2010, p. 41.
440 Queensland Secondary Principals’ Association, Submission no. 46; Australian Drug Foundation, Submission no. 51, p. 9; Dr Trish Glasby, Education Queensland, Hearing Transcript, 3 June 2010, p. 8; Mr Norm Hart, Queensland Association of State School Principals, Hearing Transcript, 4 June 2010, p. 41.
254. The committee was informed that drug education programs are monitored at the school level where staff are best placed to understand the needs of students and tailor programs accordingly, therefore there is variation in school-based drug education and modes of delivery. The committee was also informed that process evaluation during the implementation of drug education programs would occur as part of the teaching and learning cycle of individual schools. All Queensland state schools are reviewed over a four-year cycle and their implementation of Department guidelines and policies form part of their review.  

255. The committee notes that variations in the way programs are implemented by individual teachers is a well-recognised factor which influences program effectiveness. In addition to ensuring schools are providing drug education as a requirement under current policy, the committee believes the Department of Education and Training should monitor that what is being provided by schools follows national guidelines.

256. In regards to senior years in Queensland, during the hearing the committee heard that, because health and physical education is optional in years 11 and 12, there is a risk that some students may not receive drug education. It was suggested that drug education should be seen as a topic that can be interwoven into all parts of the curriculum, and that teachers could be encouraged to acknowledge that and make use of it.

Recommendation 12
The committee recommends that the Department of Education and Training review the drug education being provided in schools to ensure that it follows the national Principles for School Drug Education.

Recommendation 13
The committee recommends that the Queensland Government through the Ministerial Council on Education, Early Childhood Development and Youth Affairs ensure that the inclusion of consistent, age-appropriate drug education be part of the national curriculum development.

Recommendation 14
The committee recommends that the Department of Education and Training ensure that drug education is being provided to all students in years 11 and 12 regardless of subject selection.

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441 Committee correspondence from the Minister for Education and Training received 11 November 2010.
443 DRUG ARM Australasia, Submission no. 57, p. 3; Ms Caroline Salom, DRUG ARM Australasia, Hearing Transcript, 3 June 2010, p. 20.
444 Ms Caroline Salom, DRUG ARM Australasia, Hearing Transcript, 3 June 2010, p. 20.
7.3. Drug education programs in schools

257. Schools are commonly viewed as appropriate settings for delivering drug education to young people. Evaluations of school-based drug education programs have, however, found mixed results. Some evaluations have found no measureable effect and, in some cases, school-based programs have been associated with an increased use of drugs or increased delinquency.\textsuperscript{445} The committee was informed that ‘the best estimate we have is that we can reduce cannabis use by about 10, 20 or maybe 30 per cent by having strong, early school-based programs.’\textsuperscript{446}

258. As many young people start using cannabis around the age of puberty, it is important that any educational intervention begin before that age.\textsuperscript{447} There is a strong case for drug education to begin when a child is 10 to 12 years old, however, there is little known about effective drug education programs for this age group.\textsuperscript{448}

259. The committee notes suggestions from submitters that education about cannabis-related harms should be incorporated within programs about the harmful effects of substance use generally,\textsuperscript{449} as well as a suggestion that single-drug education programs are more effective.\textsuperscript{450}

260. The National Cannabis Prevention and Information Centre suggests that a generic approach to substance use prevention is useful up to year 8, but a more cannabis-specific approach is required with older students.\textsuperscript{451} BoysTown also supported recommendations to introduce cannabis-related drug education programs in Queensland schools from year 8.\textsuperscript{452}

7.3.1. Effective drug education

261. The information received by the committee identified a range of components of effective drug education interventions.

262. Although information about the harms and risks associated with drug use may increase students’ drug knowledge it has not been found to decrease levels of use,\textsuperscript{453} therefore multifaceted educational approaches are required.\textsuperscript{454} Ideally these should include knowledge, social, and life skills; normative approaches;

\textsuperscript{446} Professor Jake Najman, Queensland Alcohol and Drug Research and Education Centre, Hearing Transcript, 4 June 2010, p. 20.
\textsuperscript{447} Queensland Alcohol and Drug Research and Education Centre, Submission no. 31.
\textsuperscript{448} Queensland Alcohol and Drug Research and Education Centre, Submission no. 31, p. 6; Mr Sam Hunt, Alcohol and other Drugs Council of Australia, Hearing Transcript, 4 June 2010, p. 15.
\textsuperscript{449} Mr Bob Green, Submission no. 12, p. 5; Queensland Alcohol and Drug Research and Education Centre, Submission no. 31, p. 7.
\textsuperscript{451} BoysTown, Submission no. 39, p. 15.
\textsuperscript{452} Queensland Alcohol and Drug Research and Education Centre, Submission no. 31, p. 7; Professor David Kavanagh and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, Submission no. 42; Australian Drug Foundation, Submission no. 51, p. 10; Australian Association of Social Workers, Submission no. 56, p. 13.
\textsuperscript{453} Queensland Alcohol and Drug Research and Education Centre, Submission no. 31, p. 7. 
and negotiation skills. Programs should be interactive, allowing students to discuss ideas and develop social skills that enhance their ability to refuse drugs and resist peer pressure. As young people tend to overestimate drug usage by their peers, it is also important that they receive information about the actual prevalence of cannabis use, to highlight that the majority of young people do not use cannabis, and reinforce that cannabis is not socially acceptable.

Programs should be delivered in a longitudinal fashion, providing age-appropriate education at various stages of a young person's development and potential exposure to drugs.

The majority of views stated that cannabis-related education needs to be factual, balanced, and provide up-to-date information about cannabis-related harms that is also age appropriate. Programs that adopt a 'scare-tactics' approach or provide a one-off lecture do not work effectively. In a recent review of drug education, it was suggested programs that adopt a 'scare-tactics' approach are likely to continue as an approach to drug education, as they have a moral and theatrical appeal; fulfil a community's responsibility to protect young people; and capture attention.

To avoid education programs being dismissed as 'irrelevant propaganda', they should be based on the reality of students' lives and acknowledge what students already know through direct or indirect experience. Professor Jake Najman, from the Queensland Alcohol and Drug Research and Education Centre, informed the committee that programs need to acknowledge that drug use may be seen as pleasurable for the user, and a decision to use a drug will be based on perceived gains and losses. It has been suggested that 'well-received drug education programs deal openly with both sides of the decision-making equation.' Drug education should therefore continue to be based on harm minimisation principles.


Queensland Association of State School Principals, Submission no. 35; Australian Association of Social Workers, Submission no. 56, pp. 13-14; National Drug Research Institute, Submission no. 60, p. 12.


Name suppressed, Submission no. 10; Name suppressed, Submission no. 17; Mr Bob Green, Submission no. 12; Mr Deepika Ratnaike, headspace: National Youth Mental Health Foundation, Submission no. 37; Mr John Malouf, Submission no. 22.


National Drug Research Institute, Submission no. 60, pp. 12-13.

Queensland Alcohol and Drug Research and Education Centre, Submission no. 31, p. 7.

National Cannabis Prevention and Information Centre, Submission no. 45, p. 17.

Australian Association of Social Workers, Submission no. 56, pp. 11-12; DRUG ARM Australasia, Submission no. 57, p. 3.
266. It has also been recognised that school-based drug education should be supplemented with a parent and community component where appropriate.\(^{467}\)

267. The committee notes that Education Queensland provides *Guidelines for Selecting Drug Education Resources*, which incorporates similar advice for schools.\(^{468}\) It is unclear what is being implemented in schools, and whether programs follow these guidelines.

268. It should also be acknowledged that effective drug education programs will achieve results at a high cost for limited benefits.\(^{469}\) A review conducted by the Cochrane Collaboration in 2005 found that, for every 33 students exposed to drug education, one will abstain from drug use.\(^{470}\) This study maintains that programs based on life skills are the most effective in reducing drug use.\(^{471}\)

269. It is also important to be realistic about what can be achieved through school-based drug education programs,\(^{472}\) and recognise that they are just one of a number of approaches that are required to effectively address cannabis-related harms.

### 7.3.2. Specific drug education programs

270. Given the flexibility Queensland schools have in providing drug education, it is important that principals and teachers are directed to resources that are proven to be effective.\(^{473}\)

271. The Queensland Department of Education and Training provides a link to the Australian Government website *REDI: A drug information resource for Australian school communities*.\(^{474}\) The website includes an information database with links to resources, policies, and materials for drug education and incident management designed for school principals and administrators, as well as teachers and other school staff. It includes a link to *Cannabis and Consequences*, which is produced by the Drug Education Section of Schools Group, Department of Education, Science and Training (DEST), and is a resource that the Queensland Department of Education and Training provides to support teachers and parents in educating students in the middle years of schooling.\(^{475}\)

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\(^{467}\) National Cannabis Prevention and Information Centre, *Submission no. 48*, p. 17; DRUG ARM Australia, *Submission no. 57*, p. 4.


\(^{469}\) Queensland Alcohol and Drug Research and Education Centre, *Submission no. 31*, p. 6.


\(^{472}\) Australian and New Zealand College of Psychiatrists, *Submission no. 50*, p. 9; Australian Drug Foundation, *Submission no. 51*, p. 9.

\(^{473}\) Or Stuart Reece, *Submission no. 9*, p. 7.


272. A number of submitters made reference to other programs, including a computer-based drug prevention program, CLIMATE Schools (renamed CRUfaD Schools), which is currently operating in New South Wales and the Australian Capital Territory.\(^{476}\) There are two modules within CRUfaD Schools, namely: the Alcohol and Cannabis Module, and the Cannabis and Psychostimulant Module. Both of these modules have been scientifically evaluated.

273. The program consists of six lessons that each have two components. The first is a 15- to 20-minute computer-based component that involves students navigating their way through a cartoon-based teen drama. The second component is a range of prepared class activities for teachers and students including role plays, small group discussions, decision making and problem solving activities, and skill rehearsal.\(^{477}\)

274. These programs have been found to decrease cannabis use. As mentioned previously, most education programs are found to be effective in increasing drug knowledge rather than decreasing drug use. The evaluation of each module within the CRUfaD Schools program found increases in cannabis-related knowledge and decreases in cannabis use up to 12 months following the interventions.

275. The evaluation also found that both the design and the delivery of the modules were positively received by students and teachers.\(^{479}\) It should be noted here that variations in the way programs are implemented by individual teachers is a well-recognised factor which influences program effectiveness. These programs were developed with extensive input from teachers, students, and health professionals and are structured in a way that limits such variations.\(^{479}\) The committee notes the successful framework of the CRUfaD Schools program.

276. MAKINGtheLINK is a curriculum-based program for senior secondary school students to promote help-seeking for cannabis use and mental health problems,\(^{469}\) and is recognised by the NCPIC as a ‘very good example of best practice.’\(^{480}\) The program was developed by Orygen Youth Health, Centre for Youth Mental Health, the University of Melbourne, in collaboration with the NCPIC. The program aims to reduce the barriers for young people seeking professional help by promoting a ‘mates help mates’ mentality, and educates teachers about assisting students to seek professional help.\(^{481}\) The NCPIC suggests that existing school resources do not effectively overcome barriers to help-seeking, or teach help-seeking skills.

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\(^{476}\) National Cannabis Prevention and Information Centre, Submission no. 48, p. 17; Drug Free Australia, Submission no. 15; DRUG ARM Australasia, Submission no. 56, p. 4; Professor Jan Copeland, National Cannabis Prevention and Information Centre, Hearing Transcript, 3 June 2010, p. 42; Mr David Templeman, Alcohol and other Drugs Council of Australia, Hearing Transcript, 4 June 2010, p. 14.


\(^{481}\) Professor Jan Copeland, Director, National Cannabis Prevention and Information Centre, Hearing Transcript, 3 June 2010, p. 42.

277. Results from surveys of the implementation in a Victorian pilot school indicate that 75 per cent of the 101 students surveyed were more confident to seek help for themselves or a friend; and 65 per cent of the 40 teachers surveyed were more confident to assist students to seek help.\(^{483}\) Despite positive results, it was acknowledged that the sample size used was small and no booster session was given. However, it was indicated that a second data set was being collected and the pilot was planned to be expanded in 2010.\(^{484}\)

278. The committee urges the Queensland Government to consider what has been learnt from the evaluations of the programs mentioned, and notes that any new drug education initiatives need to be carefully tested.\(^{485}\)

279. The committee acknowledges the many programs operating at the local level that are not mentioned in the context of this report.

280. The committee stresses the importance of adopting school-based educational interventions that are evidence based and thoroughly evaluated, and commends the CRUfaD Schools and MAKINGtheLINK programs.

**Recommendation 15**

The committee recommends that the Queensland Government ensure the cannabis education programs that are available to Queensland schools are evidence based and thoroughly evaluated and consider providing access to CRUfaD Schools and MAKINGtheLINK programs in Queensland schools.

7.3.3. Teacher training

281. Well-trained and supported teachers are vital to the success of school-based drug education. With their knowledge of the needs and abilities of individual students, teachers are well placed to target the messages appropriately and effectively.\(^{486}\)

282. Teachers can find the interactive components of drug education programs difficult to implement, therefore modifications in content or delivery can be made which may unintentionally adversely affect the outcomes of the program.\(^{487}\)

283. Cahill (2007) identified that variation in the dissemination of the program may create program breakdown.\(^{488}\) It is also important to note that, while programs

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\(^{485}\) Queensland Alcohol and Drug Research and Education Centre, Submission no. 31, p. 2.

\(^{486}\) Queensland Secondary Principals' Association, Submission no. 46.


can be delivered in optimal conditions to produce good effects, the context in which these programs are delivered can change, affecting the intervention. Teachers exercise their professional judgement about how to modify the intervention based on ‘... the needs and contributions of the class members, competing ideological influences, a range of organisational pressures relating to curriculum and timetable, pedagogical challenges relating to teaching style, and the challenges of managing the behaviour of the class group.’

284. It was suggested to the committee that teachers need training and support to implement such programs to be able to interrogate the covert messages communicated within the drug education curriculum.

285. The committee heard that primary school teachers are given limited preparation during their undergraduate degrees to teach within the health education area.

**Recommendation 16**
The committee recommends that the Queensland Government ensure teachers are provided with ongoing professional development and support to assist teachers to provide high-quality, consistent drug education in schools.

### 7.4. Social and emotional learning

286. In addition to specific drug education, it is important to recognise the role schools can play in building students’ resilience and preventing drug use.

287. During the committee’s public hearing, representatives from the Queensland Government indicated that research from Monash University has shown that 40 per cent of students have low levels of social and emotional learning capabilities, which may contribute to later drug taking. The Department of Education and Training has developed a *Guide to Social and Emotional Learning in Queensland State Schools* to assist in the selection and implementation of social and emotional learning programs.

288. Social and emotional programs are recognised as beneficial for building skills such as resilience, problem solving, social awareness, and organisation and persistence, which may influence an individual’s decision to use cannabis or...
other drugs. Schools currently make their own decisions about how they develop such programs to respond to their own needs and local context.

289. Education Queensland indicated that future work may look at embedding social and emotional learning strongly within the curriculum. The committee supports the work of the department in this direction.

7.5. School policies

290. As school failure is a strong predictor of adolescent illicit drug use, school-based drug intervention strategies should aim to promote social inclusion and prevent school failure, while ensuring a safe environment for all students.

291. Queensland schools address drug-related incidents on school premises or during school-related activities either passively or actively.

292. A passive approach requires the development of a Responsible Behaviour Plan for students under the SMS-PR-021 Safe, Supportive and Disciplined School Environment policy; responses to specific drug-related incidents may be detailed in the plan.

293. An active approach to dealing with drug-related incidents, rather than handing the issue over to police, considers a range of issues such as the origin of the substance, and friendship networks.

294. The committee heard that school policies should 'make clear reference to the use and possession of drugs being unacceptable, and the consequences for breach of those policies.'

295. The committee notes that it was suggested that suspension from school should be strongly discouraged as a disciplinary measure as, during the time of suspension, students are most likely to be unsupervised and engage in activities with illicit substances. Responses to drug-related incidents based on suspension are also likely to discourage students from seeking help from within their school.

296. It was also suggested to the committee that school policies should outline referral pathways that support a student's particular circumstance surrounding any use or misuse of cannabis. In terms of referral pathways, it is important for students...

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496 Queensland Department of Education and Training, Submission no. 62.
497 Queensland Department of Education and Training, Submission no. 62.
499 Australia and New Zealand College of Psychiatrists, Submission no. 50, p. 9.
503 Queensland Independent Schools Parents’ Council, Submission no. 23; Ms Fleur Creed, Queensland Independent Schools Parents’ Council, Hearing Transcript, 4 June 2010, p. 5.
504 Queensland Independent Schools Parents’ Council, Submission no. 23.
505 National Drug Research Institute, Submission no. 60, p. 12.
506 DRUG ARM Australasia, Submission no. 56, p. 4.
to have access to the necessary support and treatment through the school system. The committee heard that the fact most schools use suspension as the predominant consequence of being caught for using cannabis, may deter students from seeking help with cannabis use through the school system. Teachers have also indicated that the support structures available in schools do not encourage young people using cannabis to access them. It is therefore important for staff, particularly guidance counsellors and youth health workers, to have the knowledge and expertise to help students who may be experiencing problems with cannabis use, by referring them to appropriate services.

297. The committee also notes that schools dealing with behavioural policies at the local level find it difficult to address issues surrounding the potential for stigmatisation of students and negative perceptions within the local community.

**Recommendation 17**

The committee recommends that the Queensland Government ensure school staff, including guidance counsellors and school-based health nurses, are aware of the risks associated with cannabis use and the appropriate referral pathways for students to prevent cannabis-related harms.

7.6. Drug testing in schools

298. Discussions of the role of schools in preventing drug use among young people have included debate about the value of drug testing in schools. Currently, the Queensland Government does not support drug testing in schools.

299. Arguments for drug testing assume that it is an effective strategy to deter initiation of drug use, detect users, and refer them to treatment, and thereby provide a mechanism for reducing drug-related harm. However, the evidence supporting these assumptions is not strong. A recent Australian review of student drug testing programs in the United States and the United Kingdom concluded 'there is insufficient evidence to suggest that drug detection programs deter the initiation of, or encourage cessation of, drug use in school children.'

300. The National Centre for Education and Training on Addiction recently undertook a comprehensive review of the issues involved in drug testing in schools. The review found strong evidence against drug detection and screening strategies being utilised in schools. It succinctly concluded that drug testing is an unreliable tool to utilise in school settings; it is expensive, creates significant legal and
moral concerns, is an ineffective deterrent, and attracts substantial public and professional opposition.\footnote{513}

301. Only a very small number of submissions to the current inquiry supported drug testing of school students. Drug Free Australia referred to the use of student drug testing in the United States and the United Kingdom and argued that schools should have the option of drug testing 'if negative behaviour is associated with drug use – including decreased motivation, failing grades, violence, and student absence – cripple the learning process and adversely affect the entire student body.'\footnote{514} The Queensland Independent Schools Parents’ Council suggested that drug testing should only be administered by trained health professions and only if a student's behaviour indicated that he or she was under the influence of an illicit substance.\footnote{515} Similarly, FamilyVoice Australia indicated that ‘drug testing of students for cannabis use can be useful where there is evidence, or reasonable suspicion of, cannabis use at a particular school’ and could assist in enforcing a zero tolerance policy for cannabis possession, use, and distribution.\footnote{516}

302. By contrast, the committee heard overwhelming opposition to the introduction of drug testing in schools.\footnote{517} Reasons for this opposition include: its ineffectiveness as a deterrent,\footnote{518} a significant potential for the infringement of a student’s right to privacy,\footnote{519} the fact drug testing is not seen as the role of schools;\footnote{520} and concerns about cost, consent, and the accuracy of test results.\footnote{521}

303. Another very significant reason for opposing school drug testing is that it would damage the relationship between schools and students,\footnote{522} potentially alienating those students most at risk, and providing a reason for them to disengage from school.\footnote{523} This would be counterproductive as it would create an environment in which illicit drug use thrives, and students are not receptive to other preventative measures.

\footnote{514}{Drug Free Australia, Submission no. 15.}
\footnote{515}{Queensland Independent Schools Parents’ Council, Submission no. 23.}
\footnote{516}{FamilyVoice Australia, Submission no. 44, pp. 7-8.}
\footnote{517}{Mr Bob Green, Submission no. 12, p. 6; Queensland Law Society, Submission no. 13; Queensland Association of State School Principals, Submission no. 35; Queensland Government, Submission no. 41, p. 7; Professor David Kavanagh and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, Submission no. 42, p. 2; Families and Friends for Drug Law Reform, Submission no. 43, p. 53; Queensland Secondary Principals’ Association, Submission no. 48; National Cannabis Prevention and Information Centre, Submission no. 49, p. 27; Royal Australian and New Zealand College of Psychiatrists, Submission no. 50, p. 9; Australian Drug Foundation, Submission no. 51, p. 11; Australian Association of Social Workers, Submission no. 56, p. 12; DRUG ARM Australasia, Submission no. 57, p. 5; Family Drug Support, Submission no. 58, pp. 52-53; Queensland Network of Alcohol and Drug Agencies, Submission no. 59, p. 5; National Drug Research Institute, Submission no. 60, p. 14; Queensland Department of Education and Training, Submission no. 62.}
\footnote{518}{Australian and New Zealand College of Psychiatrists, Submission no. 50, p. 9; Australian Drug Foundation, Submission no. 51, p. 11; DRUG ARM Australasia, Submission no. 57, pp. 5-6; National Drug Research Institute, Submission no. 60, p. 12; Queensland Department of Education and Training, Submission no. 62.}
\footnote{519}{Queensland Law Society, Submission no. 13; DRUG ARM Australasia, Submission no. 57, pp. 5-6.}
\footnote{520}{Mr Bob Green, Submission no. 12; Queensland Secondary Principals’ Association, Submission no. 46.}
\footnote{521}{Department of Education and Training, Submission no. 62.}
\footnote{522}{Queensland Association of State School Principals, Submission no. 35; Queensland Secondary Principals’ Association, Submission no. 46.}
\footnote{523}{Professor David Kavanagh & Professor Ross Young, Institute of Health & Biomedical Innovation, Queensland University of Technology, Submission no. 42, p. 2.}
304. Due to the potential disadvantages associated with testing, the lack of public support, and lack of evidence of its effectiveness, the committee does not support the introduction of drug testing in schools as a strategy for reducing the use of cannabis.
CHAPTER 8 – COMMUNITY-BASED RESPONSES

8.1. Introduction

305. Community-based responses are an important part of a multifaceted response to reducing cannabis use, to contribute to the prevention of the uptake of cannabis use, and encourage users to seek help.

306. It is well accepted that drug use is not an isolated problem, and it occurs within the broader social context. The committee acknowledges that a number of submitters supported programs which address the wider social determinants of drug use by reducing risk factors and enhancing protective factors. The committee also acknowledges it is essential that interventions need to strengthen prosocial family and community influences on individuals, rather than focusing just on cannabis.

307. The committee notes that under the Queensland Drug Strategy 2006-2010, the Queensland Government is addressing what is recognised as the common determinants of social and health problems through a range of initiatives across departments.

308. Although the committee considers the significance of social determinants in all social and health issues, to comprehensively address these in relation to cannabis use is an enormous task that is outside the scope of the committee’s current inquiry.

309. This chapter will therefore focus on the role social marketing campaigns have in addressing cannabis use.

310. Social marketing campaigns are supported under the National Cannabis Strategy 2006-2009, which recommends their use 'to raise public awareness of the health and social consequences of cannabis use; and influence the social acceptability of cannabis use.'

8.2. Social marketing campaigns

311. Social marketing campaigns are generally accepted as an important part of a multifaceted approach to issues of public health. Social marketing campaigns are considered an effective strategy to address the prevalence of drug use and harms related to drug use, especially to at-risk groups such as young people.
8.2.1. National Drugs Campaign

312. The National Drugs Campaign (NDC) is part of the National Drugs Strategy 2004-2009 and has been implemented in four phases since 2001. The current stage of the NDC, launched in February 2010, is aimed to reduce the uptake of ecstasy, marijuana, methylamphetamine, and other illicit drugs among young people by reinforcing negative perceptions of illicit drugs through advertising, public relations, online activities, and information resources. Its aim is to help young people and parents understand the harmful effects and consequences of drug use. The key target groups include teenagers aged 15 to 17 years, young people aged 18 to 25 years who are 'at risk' of use, people 25 years and over who currently use, and parents of 15 to 25 year olds. It is also targeted at current users to reconsider their use and direct them to support, counselling, and treatment services. Each phase of the NDC targets emerging drug trends.

313. The key messages of the NDC are:

- There are specific risks and harms associated with using ecstasy, marijuana, and methylamphetamine;
- There are specific risks and harms associated with using illicit drugs (generally);
- There are real benefits to not using ecstasy, marijuana, methylamphetamine, and other illicit drugs;
- There is a range of information available about illicit drugs including ecstasy, marijuana, and methylamphetamines; and
- There are a range of support and treatment options available to help people stop using illicit drugs.

314. An evaluation of the fourth phase of the NDC (Young Methamphetamine Users Campaign) was conducted in 2009. The evaluation found, of the 1,409 young people aged 15 to 24 years interviewed, 74 per cent felt the campaign had influenced what they did or thought about illicit drugs, and 56 per cent felt the campaign made it easier to talk to their parents about illicit drug use.

315. The committee acknowledges that the Queensland Government supports continued action to extend the reach and impact of the NDC and believes the government should enhance local health promotion activities through its own state-based social marketing campaigns.

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532 Queensland Government, Submission no. 41, p. 7.
537 Queensland Government, Submission no. 41, p. 7.
317. Submitters have referred to the implementation of specific cannabis campaigns by other state governments which have been held in high regard, with examples in New South Wales in 2007 and Victoria in 2009.\textsuperscript{538} For example, the Victorian highsnlows online campaign is a collaboration between the Australian Drug Foundation, Orygen Youth Health and the Department of Human Services Victoria, which is aimed at informing young people aged 15 to 19 years about the effects of cannabis use on mental health. It also provides links to information and access to mental health and drug services.\textsuperscript{539}

318. The National Cannabis Prevention and Information Centre also contributes to the national dissemination of cannabis information, messages, and interventions based on current research evidence. In 2009, the NCPIC launched a Smoke and Drive and you're as good as drunk: Don't dope and drive poster campaign to increase community awareness of the dangers of smoking cannabis and driving.\textsuperscript{540}

319. In relation to specific components of social marketing campaigns, submitters have raised a number of issues relating to: addressing the misconceptions about cannabis harms within the community; providing links to treatment; and using campaigns as part of a sustained approach and as an effective way of reaching disengaged high-risk youths.

320. Despite recent incremental changes in understanding about cannabis harms, a specific cannabis media campaign has been called for to address the contentions and misunderstandings about cannabis-related harm within the community.\textsuperscript{541} Submitters informed the committee that the misconceptions around the harms related to cannabis use need to be dispelled, and the real risks need to be communicated to the whole community, in order to alter any generalised public opinions about the risks of cannabis use.\textsuperscript{542}

321. In communicating messages about cannabis-related harms through social marketing campaigns, it was stressed to the committee that messages be portrayed using a balanced approach. It should be acknowledged that the understanding of cannabis harms is evolving, and it is important that messages about the harms of cannabis use are accurate and reflect current evidence, particularly in relation to the association with mental illness.\textsuperscript{543}

322. Submitters have also suggested that, to be effective, it is essential that social marketing campaigns provide links to treatment and support services for cannabis users, to raise awareness of services and enhance treatment engagement.\textsuperscript{544}

\textsuperscript{538} National Cannabis Prevention and Information Centre, Submission no. 48, p. 18; Mr Peter Lewis, Deakin University, Submission no. 20.
\textsuperscript{541} Australian Association of Social Workers, Submission no. 56, p. 6.
\textsuperscript{542} Australian Association of Social Workers, Submission no. 56, p. 21; BoysTown, Submission no. 39, p. 16.
\textsuperscript{543} Dr Alex Wodak, Hearing Transcript, 3 June 2010, p. 29; Mr Mathew Bell, Submission no. 8; Name suppressed, Submission no. 10; BoysTown, Submission no. 39.
\textsuperscript{544} Mr Bob Green, Submission no. 12; Queensland Government, Submission no. 41, p. 7; Professor David Kavanagh and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, Submission no. 42, p. 3; Australian Association of Social Workers, Submission no. 56, p. 26.
323. Submitters also noted that social marketing campaigns should be part of a sustained approach and not occur as a one-off response. The success of the QUIT campaign for tobacco is believed to have some merit in achieving a reduction in cannabis use, as it was part of a multifaceted response and provided links to targeted prevention services.

324. Submitters also raised concerns regarding the effectiveness of social marketing campaigns and believed that some campaigns may appeal to risk takers or encourage the use of experimentation, and suggested the use of scare tactics is ineffective in achieving behaviour change in relation to cannabis use.

325. Within community-based responses to reducing cannabis use, there is also the difficulty of communicating messages to high-risk youths who may be disengaged with school and the community. Social marketing strategies could provide a useful way of providing information to this group, who are otherwise difficult to identify and support.

326. The committee acknowledges two general programs directed at this group of youth, particularly: the Coordinated Response to Young People at Risk (CRYPAR) mentioned in Chapter 6, a program used by police as part of a referral process for encounters with young people at risk of developing further criminal behaviours, and the Party Safe initiative, and information disseminated by the Queensland Police Service Drug and Alcohol Coordination Unit to assist young people, parents and the community.

327. The development of social marketing campaigns should consider current research evidence to enhance their effectiveness. Recent research from the Drug Policy Modelling Program addressed media reporting and the impacts on youth attitudes towards illicit drug use.

328. It found that the most effective portrayals for reducing pro-drug attitudes were those which portrayed negative health and social consequences such as cannabis use and mental health problems.

329. Although this research was not specifically focused on advertising or social marketing campaigns, the study gives insight into broader implications and understanding of youth attitudes which may be useful for social marketing campaigns.
330. The study's recommendations to governments included 'supplement[ing] all social marketing campaigns about illicit drugs with targeted news coverage. This should enhance efforts to prevent illicit drug use and related harms.' The committee would urge the Queensland Government to consider recent research, such as this from the Drug Policy Modelling Program, to inform its development of social marketing campaigns.

**Recommendation 18**

The committee recommends that the Queensland Government extend the reach and impact of the National Drugs Campaign through a targeted cannabis social marketing campaign aimed at young people which provides links to treatment and support services.

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CHAPTER 9 – TREATMENT

9.1. Introduction

331. The two most vulnerable groups who require targeted treatment interventions are young people and those with co-occurring mental illness. Currently, much remains to be learnt about specific cannabis treatment strategies, with most cannabis-specific treatments still in the early stages of development.

332. It has been recognised that the early onset of drug use and mental health problems are risk factors for later dependent drug use, and that comorbid mental health problems also escalate the risk of developing dependence once drug use begins.

333. There is a high demand for treatment among cannabis users, and it is important to continue research within this area to develop knowledge around specific cannabis treatments.

334. Current treatment strategies to reduce cannabis use are mainly addressed within current counselling and psychological interventions, self-help and support groups, and treatment and screening within the primary health-care setting. There is also evolving research on cannabis-specific treatments including pharmacological treatment of cannabis withdrawal.

9.2. Demand for treatment

335. In 2007-08, 44 per cent of all drug treatment episodes in Australia included cannabis as a drug of concern. Cannabis was the principal drug of concern in 22 per cent of these cases.

336. In 2008-09, Queensland Health’s community-based Alcohol, Tobacco and Other Drugs Services (ATODS) conducted 14,745 assessments of clients and provided treatment matched to their needs and circumstances. Of these clients, 2,244 (15.2 per cent) indicated that cannabis was their primary drug of concern and 2,259 (15.3 per cent) of clients nominated cannabis as an additional drug of concern.

337. Although a significant number of people are seeking treatment for their cannabis use, the majority of cannabis users do not seek professional help. This may be because most cannabis users manage to quit on their own, so treatment is seen as unnecessary and many cannabis users are not motivated to stop. Treatment-seeking behaviour may also be affected by the fact many cannabis users do not see themselves as typical ‘drug users’ and are therefore hesitant to approach mainstream drug treatment agencies. In contrast, cannabis users often present...
to primary treatment providers such as general practitioners about a secondary concern such as anxiety or depression, rather than their cannabis use.564

338. Treatment should not just target users who are dependent on cannabis. As 'earlier treatment of frequent cannabis users may reduce the incidence of mental illness and prevent subsequent recruitment to polydrug use,'565 it is important to make people aware of the risks they are taking and provide opportunities for them to seek help with their cannabis use before they reach the point of dependence.

9.3. Dependence and withdrawal

9.3.1. Cannabis dependence and cannabis withdrawal disorders

339. There has been contention surrounding the health concerns associated with cannabis use, particularly the issue of cannabis dependence and withdrawal. The scepticism seems to stem from arguments that cannabis is not a harmful drug, and therefore does not cause dependence or withdrawal. However, as discussed in Part 2 of this report, it is recognised that cannabis is not as harmless as once thought.

340. Cannabis dependence is considered by some to be the largest public health concern associated with cannabis use.566 As such, cannabis dependence is recognised as a disorder in the Diagnostic and Statistical Manual of Mental Disorders Version IV (DSM-IV-TR). The DSM-IV-TR includes clinical criteria for cannabis dependence, which is 'characterised by marked distress resulting from a recurring cluster of problems that reflect impaired control over cannabis use and continuing cannabis use despite harms arising from it.'567

341. The debate on cannabis dependence is further supported by significant draft revisions to the fifth version of the Diagnostic and Statistical Manual (DSM-5) that are currently underway. The draft revisions are based on recent research that provides additional support for 'the contention that cannabis withdrawal is a valid and reliable syndrome that can negatively impact abstinence attempts of heavy cannabis users.'568

342. It is now recognised that without cannabis in their system, heavy users may feel certain withdrawal symptoms, which may indicate some degree of physical dependence. '... Studies have demonstrated that deprivation of THC causes the symptoms, and that symptoms abate with re-administration of THC.'569 Those experiencing withdrawal can present with symptoms such as: restlessness,

565 Royal Australian and New Zealand College of Psychiatrists, Submission no. 50, p. 13.
566 Professor Jan Copeland, Director, National Cannabis Prevention and Information Centre, Hearing Transcript, 3 June 2010, p. 41.
irritability, and anxiety; trouble sleeping; perspiration and night sweats; nausea and stomach problems; and cravings and recurring thoughts about smoking.\textsuperscript{570}

343. The committee notes that the publication of the final text of the DSM-5 is not expected to be until 2013, after significant trials and revisions.

344. The NCPIC indicated that they are currently ‘developing the first and valid reliable measure of cannabis withdrawal for use in clinical and research settings, and further exploring, for the first time, the disability associated with cannabis withdrawal.’\textsuperscript{571}

9.3.2. Risk of dependence

345. It has been estimated that as many as one in ten heavy cannabis users will become dependent.\textsuperscript{572} It is estimated that the lifetime risk of dependence in cannabis users is 9 per cent,\textsuperscript{573} which increases to one in six for those people who begin using during adolescence.\textsuperscript{574} The lifetime risk of dependence is lower compared to most other legal and illegal drugs (32 per cent for nicotine, 23 per cent for heroin, 17 per cent for cocaine, 15 per cent for alcohol, and 11 per cent for stimulant users).\textsuperscript{575}

346. The reasons for dependency are complex, as individuals have a combination of risk factors for developing the disorder.\textsuperscript{576} Risk factors for dependency can include: a history of poor academic achievement; deviant behaviour in childhood and adolescence; rebelliousness; poor parental relationships or a parental history of drug and alcohol problems.\textsuperscript{577} Importantly, it is those who use cannabis early, heavily, and frequently, and those who experience co-occurring mental health problems, who are at greater risk of dependency.\textsuperscript{578}

9.4. Approaches to treatment

347. Although the treatment demand for cannabis-related problems is significant, the difficulty is that there is ‘a lack of clearly defined and evaluated treatment options, when compared to what is available for alcohol or heroin-related problems.’\textsuperscript{579}


\textsuperscript{571} National Cannabis Prevention and Information Centre, \textit{Submission no. 48}, p. 10, Professor Jan Copeland, Director, National Prevention and Cannabis Information Centre, \textit{ Hearing Transcript}, 3 June 2010, p. 43.


9.4.1. Treatment for cannabis withdrawal

348. Pharmacological interventions (approved medications) for the treatment of cannabis dependence or withdrawal symptoms are in the early stages of development.

349. The committee was told that the management of withdrawal is problematic as there is "no medication to offer people for the management of withdrawal or craving post getting through that withdrawal phase." NCPI suggests this needs to be urgently addressed.

350. A number of drugs are in the experimental stages of development, including a promising pharmacological intervention involving the oral administration of THC, which reduces cannabis withdrawal symptoms (similar to methadone administration for opioid dependence). NCPI has also been given sole rights to investigate the use of Sativex in the management of cannabis withdrawal. Sativex is an oral spray which combines THC and CBD and has been used for chronic pain and multiple sclerosis.

351. It is recognised by the committee that pharmacological treatments for cannabis dependence are still in the experimental stages of development, and the range and quality of pharmacological treatments need to be improved through vigorous research and testing. The development of these treatments is important, as pharmacological treatments are generally found to be "better supported by evidence of effectiveness and perform better than non-pharmacological treatments in attracting and retaining people."

Recommendation 19

The committee recommends that the Queensland Government support further research into the advancement of pharmacological treatments for the management of cannabis withdrawal.

9.4.2. Treatment therapies

352. Through Alcohol, Tobacco and Other Drug Services, the Queensland Government provides evidenced-based psychosocial treatment for those with cannabis dependence disorders, which include Cognitive Behavioural Therapy (CBT) and Motivational Enhancement Therapies (MET). CBT and MET are counselling approaches which are used in a range of settings and are found to be useful for helping people to quit or reduce their cannabis use.
353. CBT involves teaching behavioural and cognitive skills to deal with situations that may lead to cannabis use, and MET works on building the motivation to change drug use. MET is considered quite successful for helping young people to reduce their cannabis use and address other related problems. 508

354. Engagement in the treatment process is seen as vital to successfully addressing drug abuse, as well as non-drug issues, in adolescents. 509 Intensive family-based therapies have shown early promise to address the complex psychosocial factors and substance use-related problems in young people. 509

355. Combining contingency management with CBT/MET approaches providing incentives, including money for attending appointments or returning a negative drug urinalysis, is seen to improve abstinence outcomes, however, it is unknown whether these combined approaches are cost effective. 591

356. The committee also acknowledges the many programs and services available within the community for the treatment of substance-related problems, and two programs in particular that were raised as part of the committee’s inquiry: the ‘Stop Pot’ cognitive behavioural intervention for cannabis dependence operating on the Gold Coast in Queensland, 592 and headspace, a national youth-focused service that integrates substance abuse, mental health, and other health and welfare concerns. 593

9.4.3. Coping strategies

357. As previously mentioned, most cannabis users can manage quitting alone, whereas others present with difficulties. The NCPIC suggests that interventions can be strengthened by examining the differences in demographics and quitting strategies of those who quit by themselves and the 9 to 15 per cent of users who have difficulties and become dependent. 594

358. The NCPIC has recently conducted an online survey of 78 individuals who had previously used cannabis at least once a week for at least a year, but had not used in the last year; and 87 individuals who currently used cannabis at least once a week and had made at least one unsuccessful attempt to quit.

359. Unsuccessful quitters tended to have less education; higher day-to-day exposure to other cannabis users (peer network); and a higher usage of cannabis prior to their most recent attempt to quit (greater frequency). 595

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509 Mr Ben Griffiths, Submission no. 43.
509 headspace: National Youth Mental Health Foundation, Submission no. 37.
360. With attempts to quit, the two groups did not differ in reducing their exposure to cannabis or use of distraction/substitution techniques. The research found that certain coping techniques were the most effective strategies to successfully quitting. Successful quitters were 2.1 times more likely to implement techniques such as planning ways to cope with aversive emotions, and avoiding situations that were a high risk for cannabis use.596

361. This study was conducted using what NCPIC referred to as a ‘relatively well educated sample’. The association between successful and unsuccessful quitters needs to be further explored, particularly in relation to education level, and factors that mediate quitting, such as impulsivity and problem-solving skills.597

9.4.4. Peer and family support

362. Self-help groups include mutual support groups and peer-support programs for people with cannabis-related problems.598 There has been little research on the success of peer-support programs, however, cannabis users may find these types of programs helpful in a similar way to people with alcohol problems.599

363. The NCPIC noted that, although there are Narcotics Anonymous (NA) meetings available to support people wanting to stop using drugs, there are few Marijuana Anonymous (MA) group meetings available in Australia outside of metropolitan areas.600 The committee acknowledges the benefits of family and peer support during treatment, and the need for more family- and peer-support programs to be trialled and evaluated.601

9.5. Identification and engagement with treatment

364. The identification and engagement with treatment is in itself complex for cannabis users. The majority of cannabis users do not voluntarily seek treatment.602 They often do not identify themselves as ‘drug users’ in need of typical treatment services, which unfortunately leads to a reduced number of users presenting to treatment.603 For example, BoysTown noted in data they collected and analysed that 32 per cent of cannabis-related Kids Helpline counselling contacts were in relation to another person’s cannabis use.604

365. The difficulty is, then, that some interventions may be opportunistic and users may be ambivalent about changing their drug use, and therefore difficult to


598 Queensland Government, Submission no. 41, p. 15.

599 Queensland Government, Submission no. 41, p. 15; National Cannabis Prevention and Information Centre, Submission no. 48, pp. 15-16.

600 National Cannabis Prevention and Information Centre, Submission no. 48, p. 15.


602 National Cannabis Prevention and Information Centre, Submission no. 48, p. 20.


604 BoysTown, Submission no. 39, p. 16.
engage. This group of users needs to be addressed through specially targeted interventions, which may include: cannabis clinics; the delivery of interventions remotely by telephone or the internet; the provisions of brief interventions in primary healthcare settings; and the delivery of programs in correctional settings.

9.5.1. Cannabis clinics

366. The National Cannabis Strategy 2006-2009 recommends the use 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.’ The NCPIC suggested to the committee that a further expansion of cannabis clinics nationally should be considered.

367. As a result of consultations during the New South Wales Drug Summit in 1999, the New South Wales Mental Health and Drug and Alcohol Office initiated a policy shift towards specific cannabis-related treatment. Moves were made towards the implementation of specific cannabis clinics to provide outpatient counselling services for people 16 years and over who wish to reduce or cease their cannabis use. The clinics also offer support to cannabis users with mental health issues, as well as parents and carers of cannabis users.

368. Six specific cannabis clinics currently operate in New South Wales in: Western Sydney; Central Coast; Central West; Sutherland; North Coast; and Hunter. In 2003-04 funding was provided for the establishment of new cannabis intervention and treatment clinics. Four dedicated cannabis clinics were established over four years. Each clinic was funded $250,000 per annum. The funding for each of the four clinics increased to $275,000 per clinic, per annum. New South Wales' Third Drug Budget (2007-08 to 2010-11) provided funding for the establishment of two more cannabis clinics.

369. It appears that 'the clinics have been set up to stand apart from the mainstream drug and alcohol treatment services and provide intensive clinical interventions and treatment to dependent cannabis users with complex needs, including clients with mental health issues.' The rationale for standing apart from mainstream drug and alcohol treatment services appears to be associated with cannabis being the most widely used illicit substance; to modify community perception that cannabis is not a 'soft drug'; to engage users in treatment who would not otherwise present to mainstream services; and to support parents and families of cannabis users.
370. Each clinic develops their treatment model according to the needs of the local area. For example, the clinic in Parramatta funds an NGO, FYRST Stop Program (Salvation Army) as a referral service for young people, where they may undertake a brief intervention or receive ongoing counselling.\textsuperscript{612}

371. The NCPIC also conducted a preliminary evaluation of the FYRST Stop Youth Cannabis Clinic in NSW using routinely collected data and found that young people who had more than one counselling treatment session showed a decrease in cannabis use between the first and last sessions.\textsuperscript{613}

372. Specific cannabis treatments could be useful to prevent problems with use, early. An independent evaluation of cannabis clinics conducted in 2007 by Jacq Hackett Consulting found that specialist cannabis clinics are attracting clients who would be unlikely to present to other drug and alcohol services.\textsuperscript{614}

373. The committee heard that in Queensland ‘there is not very much around that is just specifically looking at cannabis use, it is usually everything together.’\textsuperscript{615}

374. Cannabis clinics do appear to be providing some early promising results, however, the effectiveness of cannabis clinics as a sole treatment option for cannabis-related problems needs to be explored further, taking into account the placement of clinics and needs of the local areas.\textsuperscript{616} The committee urges the Queensland Government to note cannabis clinics as a treatment option and consider their viability in Queensland.\textsuperscript{617}

\textbf{Recommendation 20}

The committee recommends that the Queensland Government investigate the efficacy of cannabis clinics as a treatment option.

9.5.2. Web-based delivery of treatment

375. Web-based delivery is an emerging area of treatment for cannabis-related problems. Work is being conducted towards the development of online interventions and mobile phone applications for substance use and mental disorders.\textsuperscript{618}

376. Due to some of the restrictions of current treatment methods, including restrictive entry criteria,\textsuperscript{619} lack of transport and accommodation for those seeking treatment...
in rural and remote communities and current waiting periods, the committee recognises the potential that web-based interventions could have in improving service delivery and increasing engagement by young people, as well as having treatment available to coincide with a person deciding that they want to stop using cannabis.

377. The NCPIC is currently conducting a free, web-based treatment for people who are 18 years and older who want to quit or reduce their cannabis use. The effectiveness of the treatment is also being evaluated. The committee encourages the Queensland Government to monitor research developments within web-based treatment options for cannabis users, and notes that it will be important that any web-based treatment initiative be linked with marketing campaigns.

### Recommendation 21

The committee recommends that the Queensland Government optimise and promote the use and availability of web-based delivery of treatment for cannabis users.

9.5.3. Cannabis Information and Helpline

378. In January 2008, the National Cannabis Prevention and Information Centre, in conjunction with Lifeline Australia, began operating a national Cannabis Information and Helpline (CIH). The CIH provides confidential information and support to cannabis users and people who are concerned about cannabis use by those close to them. It provides counselling, information and referrals, and links people to appropriate support services and resources.

379. The NCPIC conducted an independent evaluation on the service using a sample of 200 interviewed participants, which found that participants were generally satisfied with the service provided.

380. The National Cannabis Strategy 2006-2009 outlines that the CIH should be promoted within primary healthcare facilities, such as general practice surgeries and hospital waiting rooms. The awareness of a specific CIH needs to be enhanced. The NCPIC indicated that community awareness of this service is not optimal and indicated that the

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620 Queensland Council of Social Service Inc., Submission no. 33, p. 2; DRUG ARM Australasia, Submission no. 56, p. 10.
621 Private correspondence, 15 June 2010, Queensland Network of Drug and Alcohol Agencies.
622 Australian Association of Social Workers, Submission no. 56, pp. 6 & 26-27.
623 Mr Bob Green, Hearing Transcript, 3 June 2010, p. 33; Queensland Alliance, Submission no. 34.
625 Professor David Keenan and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, Submission no. 42, p. 3.
626 National Cannabis Prevention and Information Centre, Submission no. 48, p. 21.
627 National Cannabis Prevention and Information Centre, Submission no. 48, pp. 21-23.
629 Mr Mathew Bell, Submission no. 8.
Queensland Government would have such a Cannabis Quitline available with minimal investment in advertising the existing national service and contributing to the hours of availability by a small amount of funding.630

Recommendation 22
The committee recommends that the Queensland Government facilitate greater awareness and use of the Cannabis Information and Helpline in Queensland.

9.5.4. Primary health-care interventions

382. Primary health-care settings are regarded as effective environments for the delivery of brief interventions for cannabis users.631 Ordinarily patients would not present to a general practitioner (GP) for cannabis-related help, therefore these settings can be useful for promoting information as well as for basic screening and detection.632 It is also suggested that screening for cannabis use could be improved in a variety of primary health-care settings including community health services and presentation to mental health workers and hospital workers.633

383. The committee notes that staff within primary health-care settings need education and training to identify and treat problem cannabis use.634 Practitioners need education about the agreed-up harms of cannabis use,635 in order to reduce the chance of patients being given 'benign or nonchalant advice on cannabis'.636

384. The Queensland Branch of the Royal Australian College of General Practitioners endorses a model of assessment via general practitioners to enhance therapeutic engagement with adolescents. The model proposes providing opportunities for the one-on-one consultation with their physician, with a support person if needed; the assurance of confidentiality; as well as the identification of contributing psychosocial factors.637

385. The committee notes that there are a number of resources available for use within primary health-care settings. The National Cannabis Prevention and Information Centre has developed guidelines for the assessment and management of cannabis use disorder for use by GPs and has indicated that a GP education package to encourage screening for cannabis use will be further developed in 2010.638

386. The committee considers that basic screening and detection within a primary health-care setting may be particularly useful for targeting the group of older

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630 National Cannabis Prevention and Information Centre, Submission no. 48, p. 23.
631 National Cannabis Prevention and Information Centre, Submission no. 48, p. 20.
632 National Cannabis Prevention and Information Centre, Submission no. 48, p. 21.
633 National Cannabis Prevention and Information Centre, Submission no. 48, p. 21.
634 Australian Association of Social Workers, Submission no. 56, p. 6.
635 Dr Stuart Reece, Submission no. 9, p. 9.
636 Dr Stuart Reece, Submission no. 9, p. 9.
cannabis users who are at greater risk of developing cardiovascular and respiratory problems.  

Recommendation 23

The committee recommends that the Queensland Government promote routine opportunistic screening for problem cannabis use in primary healthcare settings and ensure that medical practitioners and healthcare workers have the appropriate information and tools.

9.5.5. Programs in correctional settings

387. The committee notes that Queensland Corrective Services provides a number of programs and interventions to prisoners in correctional centres and offenders on probation and parole including:

- Getting SMART: Moderate intensity substance abuse program;
- Pathways (CBT approach to avoid recidivism and relapse);
- SMART Recovery: Substance abuse maintenance groups; and
- Ending Offending and Ending Family Violence (designed to target the needs of Aboriginal and Torres Strait Islander offenders).

388. A number of non-government bodies also provide treatment programs for offenders at Probation and Parole District offices including (but not limited to): Alcohol, Tobacco and Other Drug Services; DRUG ARM Australasia; and Narcotics Anonymous. The committee was not informed of the effectiveness of these programs, however, acknowledges the importance of providing treatment options for this group of users in correctional settings.

9.6. Treatment services for cannabis users with co-occurring mental health problems

389. The rate of cannabis users who also suffer mental health disorders is relatively high. The diagnosis and treatment of people with co-occurring substance abuse and mental illness is a complex task as comorbidity is reported to contribute to higher levels of disability, distress and burden on services. However, 'addressing the needs of people with mental disorders who also use cannabis is of critical importance.'

390. Providing services for people with a dual diagnosis is a priority area in the delivery of treatment under the Queensland Drug Strategy 2006-2010.

608 Professor Jan Copeland, National Cannabis Prevention and Information Centre, Hearing Transcript, 3 June 2010, p. 41.
612 Professor David Kavanagh and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, Submission no. 42, p. 1; Queensland Government, Submission no. 41, p. 16.
614 Professor David Kavanagh and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, Submission no. 42, p. 2.
Specifically, Queensland Mental Health Services and Alcohol, Tobacco and Other Drugs Services are expected to comply with Queensland Health's Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) policy.

391. Comorbidity (dual diagnosis) is generally defined as the 'co-occurrence of two or more disorders or problems, at least one of which is a mental health problem and at least one of which relates to the use of alcohol and other drugs'. \(^646\) The relationship between substance use disorders and mental disorders is complex, but what is known is that mental illness is likely to present alongside substance use disorders, which has significant implications for treatment. \(^647\)

392. Treatment for people suffering both substance use and mental health problems needs to be integrated and well coordinated. \(^648\) Comorbidity is a concern because the treatment of co-occurring cannabis use and mental illness has not been a large focus as compared to the treatment of cannabis dependence alone. \(^649\) The committee heard that 'at present there is insufficient evidence to recommend any specific psychological treatments for co-occurring mental illness and alcohol and other problems.' \(^650\) However, there is evidence to suggest that psychosocial treatments are effective in reducing the adverse effects of dual diagnosis. \(^651\)

393. The committee acknowledges that Queensland Health has recently provided recurrent funding for 21 Mental Health Dual Diagnosis Coordinators to enhance services available to those with dual diagnosis; and under the Queensland Plan for Mental Health 2007-2017, has funded two specialist Child and Youth Dual Diagnosis Coordinator positions. \(^652\) The committee also notes that the Queensland Health Dual Diagnosis Clinical Guidelines are due for release in late 2010. \(^653\)

394. Within the mental health service, Queensland Health provides programs for young people who are experiencing early psychosis which are guided by the Early Psychosis Model of Care for Queensland Health Mental Health Services. \(^654\) This service is focused on improving the outcomes for young people with early psychosis and substance use problems, through the mandatory training of clinicians; integration of mental healthcare and drug and alcohol treatments; and engaging families. \(^655\)

395. Although the committee acknowledges the steps the Queensland Government is taking to address issues related to dual diagnosis, significant concerns were raised during the inquiry about deficiencies in the integration of mental health and drug and alcohol services.

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642 Queensland Government, Submission no. 41, p. 16.
643 Queensland Government, Submission no. 41, p. 16.
644 Queensland Government, Submission no. 41, p. 16.
645 Queensland Government, Submission no. 41, pp. 16-17.
646 Queensland Government, Submission no. 41, p. 17.
647 Queensland Government, Submission no. 41, p. 17.
648 Queensland Government, Submission no. 41, p. 17.
396. The committee was told that 'the key issue is about concurrent treatment. What we hear from parents and clients is that they ping-pong between two systems.' and there were calls for 'merging drug and alcohol and mental health services’ to address this problem.

397. A representative of the Royal Australian and New Zealand College of Psychiatrists explained that 'the reason they were separated in the first place was that substance use disorder services went down the primary prevention road whereas mental health services went down the treatment road. Now we know that both need both and we desperately need to bring them back together for the good of the people that present with multiple problems.'

398. Cannabis users who also experience mental health problems need integrated treatment options. Not all counsellors and therapists have expertise in providing integrated treatment for comorbid drug use and mental illness. Therefore, treatment providers need to be willing to work together. The committee notes that some non-government organisations develop memorandums of understanding around their relationships with other agencies and local support, however acknowledges that significant concerns have been raised by submitters in relation to the treatment of comorbidity, and that '... significantly greater investment will be needed before optimal treatment can reliably be obtained by affected patients across the state.'

**Recommendation 24**

The committee recommends that the Queensland Government enhance treatment opportunities for cannabis users with co-occurring drug and mental health problems by ensuring better integration between mental health services and drug and alcohol services.
CHAPTER 10 – RESPONSES TO CANNABIS USE BY ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

10.1. Patterns of cannabis use

399. Patterns of cannabis use by Aboriginal and Torres Strait Islander people, particularly in remote communities, appear to differ from patterns of use in the general population in a number of significant ways. For instance, researchers have found a younger age of first use, higher rates of heavy regular use, and increased levels of dependence.663 Unlike trends in the general population where cannabis use is declining, use in Indigenous communities appears to have escalated rapidly in a relatively short time.664 Existing levels of disadvantage in many remote communities exacerbate the levels of health and social harm associated with this use.

400. Although there is limited data on cannabis use among Aboriginal and Torres Strait Islander people,665 it has been suggested that the rate of recent cannabis use is at least double that in the general community and is even higher in remote Indigenous communities.666 Studies of cannabis use in Arnhem Land in the Northern Territory provide some indication of the changing nature of use in remote Indigenous communities.

401. A survey of drug and alcohol use conducted in the 1980s across the Top End of the Northern Territory did not detect cannabis use.667 From the mid to late 1990s,668 however, when national levels of cannabis use was declining, there was a rapid rise in cannabis use and an expansion of supply links in Arnhem Land.669 A study conducted in 2001 found cannabis use was endemic, with over 70 per cent of males and 20 per cent of females aged between 13 and 36 years being current users. Cannabis was typically smoked with tobacco using a bucket bong, which resulted in a rapid and intense dose with little smoke lost. Regular heavy use, characterised by at least 6 cones a day, was found in almost 90 per cent of users. This was around twice the consumption of regular cannabis users elsewhere in Australia. About 90 per cent of the Indigenous users reported symptoms of cannabis dependence.670

664 National Cannabis Prevention and Information Centre, Submission no. 48, p. 25.
668 Queensland Government, Submission no. 41, p. 18.
669 Associate Professor Alan Clough, James Cook University, Submission no. 61, p. 7.
402. Cannabis did not appear to be a passing adolescent phase. A follow-up study in 2005-06 found that 87 per cent of the 60 cannabis users interviewed reported daily use of on average 7 cones each day. Almost 90 per cent reported symptoms of cannabis dependence.671

403. In 2007 the Queensland Police Service Far Northern Region became concerned about escalating cannabis use in Indigenous communities in Queensland.672 Cape York and Torres Strait Islander people indicated that rates of cannabis use in their communities would be the same or higher than those found in the Arnhem Land communities.673 The Cape York Institute for Policy and Leadership confirms similar trends to those found in Arnhem Land with cannabis use in Cape York communities being a recent occurrence as 'Elders (and even those over the age of 40) can remember when cannabis first came into the community.' The committee was informed that 'it is the social norm to smoke cannabis and there is no stigma attached to the practice.'674

404. The Cape York Institute for Policy and Leadership referred to anecdotal evidence that cannabis use has increased since the alcohol management plans were introduced in Cape York as a substitute to alcohol and that older community members who had not previously tried cannabis took up the habit.675 Associate Professor Alan Clough from James Cook University indicated that, while this may be what people think has happened, he has no direct evidence to date that this is actually the case.676

405. The Crime and Misconduct Commission confirmed that, in North Queensland communities, cannabis is generally smoked with tobacco using bucket bongs, which give users a rapid and intense dose with little lost smoke, increasing the amounts of carbon dioxide and tar inhaled.677

10.2. Impact of cannabis use

406. Cannabis is having serious health, social and economic impacts on individuals and communities that, in many cases, are already seriously disadvantaged.

407. The Arnhem Land studies found cannabis use had significant harmful effects for individuals and the communities in which they lived. As well as experiencing self-harm, psychotic episodes and symptoms of dependence, heavy regular users had a four times greater risk for depressive symptoms. Individuals also experienced negative financial effects, with between 30 and 60 per cent of their incomes used on cannabis. The studies also found cannabis use had a serious financial effect on communities with an estimated one in every six dollars available in the local cash pool being directed into the local cannabis trade.

671 Associate Professor Alan Clough, James Cook University, Submission no. 61, p. 6; Associate Professor Alan Clough, James Cook University, Hearing Transcript, 4 June 2010, p. 38. Associate Professor Clough notes that more work is needed to understand this level of dependence given that the quantities of cannabis trafficked in Arnhem Land communities appear to be very small.


674 Cape York Institute for Policy and Leadership, Submission no. 53. This view was supported by Associate Professor Alan Clough, James Cook University, Hearing Transcript, 4 June 2010, p. 37.

675 Cape York Institute for Policy and Leadership, Submission no. 53.

676 Associate Professor Alan Clough, James Cook University, Hearing Transcript, 4 June 2010, p. 37.

Users frequently put pressure on family members, threatening self-harm if cannabis or money to buy cannabis was not provided. The services provided by local health centres were seriously challenged by having to deal with acute psychosis and multiple admissions often requiring evacuations.  

408. These negative health and social impacts were confirmed by the Cape York Institute for Policy and Leadership, which added that cannabis use also results in: physical and emotional neglect of children; violence including domestic violence in order to get money to feed the addiction or while under the influence of cannabis; lower participation in education and training; and the inability to get and hold down a job.  

409. The price of cannabis in remote locations has been estimated to be between six and twelve times the price in urban areas. The Crime and Misconduct Commission suggested that 'the high profit margins are attractive to community members, particularly when people are on low incomes and some may be spending $100 a week or more using cannabis themselves.'  

410. The National Indigenous Violence and Child Abuse Intelligence Task Force reported that cannabis has been linked to the perpetration of child sex offences of sexual abuse in some communities and cannabis is being provided to young girls or their family members in exchange for sexual acts.  

411. Consultation conducted by James Cook University in Cape York and the Torres Strait between 2007 and 2009 identified the young and declining age of first use as the major issues of concern. Other issues included: serious mental health problems; violence associated with withdrawal and the need to access cash to purchase cannabis; the fact local cannabis issues had been ignored while alcohol restrictions were imposed without adequate community consultation; and the fact young people were not engaging with systems, which limited the effectiveness of school-based strategies.  

412. Associate Professor Alan Clough from James Cook University informed the committee that more recent research in Lotus Glen Correctional Centre confirmed the results of earlier consultations as the inmates were concerned about the young age of first use in their communities and the fact this propels young people on a pathway that involves crime.
Part 3 Strategies to Reduce Cannabis Use

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413. There is also concern that the full extent of the harm caused by the relatively recent introduction of cannabis into remote communities may not be evident for some time.686

10.3. Policy context

414. The Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009 has been developed as part of the National Drug Strategy. It complements the issues raised in the national plans and makes them more applicable to Aboriginal and Torres Strait Islander peoples.

415. The Action Plan sets out six principles that must underlie any action to address the use of alcohol, tobacco and other drugs in Aboriginal and Torres Strait Islander populations including the need for: a comprehensive, holistic approach to health that includes physical, spiritual, cultural, emotional and social wellbeing, community development and capacity building; local planning; culturally valid strategies; central involvement of Aboriginal and Torres Strait Islander peoples in planning, development and implementation of strategies; community control over their health, drug and alcohol and related services; and resources available on the basis of need and at the level required to reduce disproportionate levels of drug-related harm by Aboriginal and Torres Strait Islander peoples.687

10.4. Considerations when developing strategies to reduce cannabis use

10.4.1. Broader social issues

416. It has been noted that the reasons for the high rate of cannabis use among Aboriginal and Torres Strait Islander people are likely to be complex and related to the social determinants of drug use.688 The committee heard about the need to reduce the gaps in health, social wellbeing, education, employment, housing and economic prosperity689 and use interventions that do not just focus on cannabis, but also strengthen prosocial family and community influences on individuals.690 It has been noted that ‘cannabis misuse is likely to be both a consequence of this type of social disadvantage and a perpetuating influence.’691 A recent review of Indigenous-specific alcohol and other drug interventions recommended that all levels of government enhance their efforts to develop more effective policies and


689 Australian Drug Law Reform Foundation, Submission no. 30, p. 8; Queensland Council of Social Service, Submission no. 33, p. 3; Royal Australian and New Zealand College of Psychiatrists, Submission no. 50, p. 15.

690 Professor David Kavanagh and Professor Ross Young, Institute of Health and Biomedical Innovation, Queensland University of Technology, Submission no. 42, p. 3.

strategies to address the structural inequalities that underlie the prevalence of harmful alcohol and other drug use among Indigenous Australians.692

417. The committee was informed that 'at the moment, there are just no good reasons for especially young people to avoid taking up and continuing to use cannabis.'693

418. The Australian Association of Social Workers noted that 'the stress associated with ..., extreme poverty, lack of opportunities and prospect of opportunities, have been identified as contributing to Indigenous people turning to cannabis use.'694

419. The committee recognises that cannabis use cannot be addressed in isolation from other social and economic issues and strongly supports initiatives to address Aboriginal and Torres Strait Islander disadvantage that are being undertaken at both a national and state level.

10.4.2. Community consultation and involvement

420. The committee was informed on many occasions about the vital importance of consultation with, and involvement of, the communities in the development of any initiatives.695 The committee heard that Indigenous interventions should be developed and implemented by both local regional Elders and representatives from local Indigenous service providers.696 A 'top-down non-negotiable' response is not appropriate.697

421. According to the Queensland Council of Social Service, programs need to 'use Indigenous language and cultural frameworks, build capacity of local Indigenous professionals, and improve understanding of the harms associated with cannabis misuse.'698

422. A recent report on Indigenous-specific alcohol and other drug interventions recommended that 'in the interest of providing more appropriate services, better client outcomes, and building capacity, all levels of government should re-commit themselves to the principle of Indigenous community control of service provision.'699

423. The Australian Association of Social Workers suggested that, given the importance of the family and community in Indigenous culture, a community development and community participation model would be most appropriate.700

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693 Associate Professor Alan Clough, James Cook University, Hearing Transcript, 4 June 2010, p. 36.
694 Australian Association of Social Workers, Submission no. 56, p. 32.
695 Dr Stuart Reece, Submission no. 9, p. 10; Mr Bob Green, Submission no. 12, p. 7; Queensland Government, Submission no. 41, p. 18.
696 DRUG ARM Australasia, Submission no. 57, p. 10; Name suppressed, Submission no. 18.
697 Associate Professor Alan Clough, James Cook University, Submission no. 61, p. 29; Associate Professor Alan Clough, James Cook University, Hearing Transcript, 4 June 2010, p. 38.
698 Queensland Council of Social Service, Submission no. 33, p. 3.
700 Australian Association of Social Workers, Submission no. 56, p. 32.
10.4.3. Combination of approaches

424. It is important that interventions include not only supply reduction strategies but also local prevention and treatment initiatives including improving understanding of the harms associated with cannabis misuse.

10.4.4. Other considerations

425. A consultation conducted by James Cook University in Cape York and the Torres Strait identified a number of opportunities to address cannabis issues including: existing community capacity in groups that command cultural respect including Elders; and the fact there is a strong desire for change. A significant range of challenges were also identified including: intergenerational effects flowing from the fact cannabis has become normalised and parents are providing poor role models; the pervasiveness of poverty and trauma, which can reinforce self-medication; the fact some key community role models are compromised by their alleged links with trafficking; and the challenges for police to effectively control trafficking over such a large and diverse region.

426. Key needs expressed during the consultation included: the need for education and awareness-raising to prevent the uptake of cannabis use at an early age providing young people with reasons to avoid cannabis; need for improved understanding of addiction and withdrawal both for users and their families; and the need for safety for users and their families while a user is suffering withdrawal.

427. The Cape York Institute for Policy and Leadership highlighted features in Cape York communities that make it more difficult to address cannabis use and cannabis-related harms. These include: the fact the majority of community members receive welfare and do not have regular employment, which means they have the funds and time to use cannabis and have no incentive to limit their cannabis use; social practices that endorse rather than limit cannabis use; and the feeling that drinking and drug taking are part of the culture.

428. The Cape York Institute for Policy and Leadership informed the committee that because cannabis use was the social norm in Cape York communities, any strategy to reduce cannabis use must re-establish that it is an unacceptable practice and the change in social standard must come from inside the community to be accepted.

429. The Cape York Institute for Policy and Leadership also stressed the link between tobacco, alcohol and cannabis use and indicated that these issues needed to be addressed together.

701 Legislative Assembly of the Northern Territory. Select Committee on Substance Abuse in the Community (2007) Substance Abuse in Remote Communities: Confronting the Confusion and Disconnection, Legislative Assembly of the Northern Territory: Darwin, p. 16.
703 Associate Professor Alan Clough, James Cook University, Submission no. 61, p. 22.
704 Associate Professor Alan Clough, James Cook University, Submission no. 61, pp. 23-24.
705 Associate Professor Alan Clough, James Cook University, Submission no. 61, pp. 25-28.
706 Cape York Institute for Policy and Leadership, Submission no. 53.
707 Cape York Institute for Policy and Leadership, Submission no. 53.
708 Cape York Institute for Policy and Leadership, Submission no. 53.
430. The committee was also informed that interventions should not just focus on young people in Indigenous communities. There is a need for parents to set a good example for their children to ensure that cannabis use is not modelled by parents.

10.5. Strategies to reduce use

10.5.1. Introduction

431. There have been some promising initiatives aimed at reducing cannabis use and associated harms in remote Indigenous communities, including initiatives in the Northern Territory and Far Northern Queensland.

432. Associate Professor Alan Clough reported that strategic Northern Territory police intervention from 2002 known as the Remote Community Drug Desk resulted in modest reductions in cannabis use and a decrease in adverse effects, with clinics reporting fewer suicide attempts and fewer psychotic patients. Strategies included: police activity cutting down supply; youth development and juvenile justice diversion programs; community organisations and mining companies supporting more employment and training; and communities taking action against local dealers.

10.5.2. The Weed it Out project

433. The Queensland Police Service Weed it Out project is a supply reduction strategy that aims to reduce cannabis availability and build greater crime prevention capacity across the Far Northern Region Police District, which includes Cape York and the Torres Strait. Following a period of community consultation undertaken by the Queensland Police Service and James Cook University, the Far Northern Region Drug Squad formed partnerships with local councils, signing shared responsibility agreements aimed at changing community attitudes to drug use and drug dealers. According to the Queensland Police Service 'officers from the Far Northern Region Drug Squad and Tactical Crime Squad are working with local police and community representatives to make Indigenous people aware of the Crime Stoppers program, legislation that protects informants, and policies enabling sources to be paid rewards for reliable information resulting in arrests.' A recent media release reported that 'figures for 2010 indicate that the reporting of drug activity to police will surpass previous increases of 3370 per cent, demonstrating a significant change in community attitude towards drug use and dealers and assisting police to reduce supply.'

434. A research team from James Cook University led by Associate Professor Alan Clough is working parallel to, and in partnership with, the Weed it Out project focusing on demand reduction. This includes a three-year study funded by the National Health and Medical Research Council of Australia into reducing demand
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for cannabis in Cape York communities.\textsuperscript{717} The research team will work collaboratively with existing service providers and key community stakeholders so demand reduction initiatives are developed with each community. It is anticipated that interventions will include: public meetings; provision of further training for health workers; working closely with schools and workplaces; resource development; and continued project feedback to communities.\textsuperscript{718}

435. Associate Professor Clough intends to extend the demand reduction research into Torres Strait Islander communities.\textsuperscript{719}

436. The National Cannabis Prevention and Information Centre has also joined the \textit{Weed it Out} partnership to assist in the development of demand reduction strategies. The Commonwealth Government has provided funding to the Queensland Police Service for three years to implement capacity building programs in each of the communities to assist them to develop their own harm minimisation strategies with the assistance of the QPS and James Cook University project teams. The programs emphasise drug awareness, the wide-ranging harms associated with drug use and crime prevention strategies and programs such as \textit{Crime Stoppers}.\textsuperscript{720}

437. The committee has heard support for the \textit{Weed it Out} project and the need to ensure appropriate levels of funding and continuation of the funding.\textsuperscript{721} The Cape York Institute for Policy and Leadership noted, however, that the \textit{Weed it Out} initiative should not be confined to specialist drug teams and every police officer in the community must participate.\textsuperscript{722}

438. The committee commends the \textit{Weed it Out} project and associated activities as an excellent example of innovation and best practice. The initiatives are evidence based, collaborative and address not only supply reduction but also demand reduction emphasising education and community development and capacity building.

\begin{center}
\textbf{Recommendation 25}

The committee recommends that the Queensland Government ensure the \textit{Weed it Out} project and associated demand reduction and capacity building initiatives are consistently and appropriately funded.
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\textsuperscript{717} Associate Professor Alan Clough, James Cook University, \textit{Submission no. 61}, p. 1.
\textsuperscript{718} James Cook University, School of Public Health, Tropical Medicine and Rehabilitation Sciences, \textit{Indigenous community action to reduce harms associated with heavy cannabis use in remote communities in the Cape York region (NHMRC Project Grant #601002)}, Accessed 22 September 2010 from www.jcu.edu.au/phtmrs/abcleverything/JCUPRD055084.html.
\textsuperscript{719} Associate Professor Alan Clough, James Cook University, \textit{Submission no. 61}, p. 1.
\textsuperscript{720} National Cannabis Prevention and Information Centre, \textit{Submission no. 48}, p. 27.
\textsuperscript{721} FamilyVoice Australia, \textit{Submission no. 44}, p. 12.
\textsuperscript{722} Cape York Institute for Policy and Leadership, \textit{Submission no. 53.}
10.5.3. NCPIC’s Indigenous community projects

439. The National Cannabis Prevention and Information Centre is involved in a number of Indigenous community projects including *Cannabis: It's not our culture*, an Indigenous music competition, and *Could it be the Gunga?*

440. The *Cannabis: It’s not our culture* project includes a website featuring artworks created by seven Indigenous communities around Australia on the theme of how cannabis impacts their communities and the solutions they see to cannabis-related issues. Factsheets are also available on the website for Indigenous healthcare workers and health services. This project is part of an ongoing community engagement and capacity building program and addresses the misconception that drug use is part of Aboriginal and Torres Strait Islander culture.

441. Indigenous inmates at Silverwater Correctional Centre designed posters for the 2009 NCPIC conference. The posters represented the inmates' reflections on how cannabis had affected their lives.

442. An Indigenous music competition invited Indigenous Australians to submit songs dealing with issues around the negative impact cannabis had on people's lives. The winning song and the two runners-up are posted on the NCPIC website.

443. The NCPIC is also involved in a pilot project that is being led by the National Drug Research Institute called *Could it be the Gunga?* This project is developing and evaluating screening for cannabis use at Aboriginal Medical Services nationally.

444. The committee commends these projects as providing valuable opportunities for Indigenous people to raise awareness of the harms associated with cannabis use and spread the message that cannabis use is not part of Aboriginal and Torres Strait Islander culture.

Recommendation 26

The committee recommends that the Queensland Government promote Indigenous community projects to encourage Aboriginal and Torres Strait Islander people to raise awareness of the harms associated with cannabis use and spread the message that cannabis is not part of Aboriginal and Torres Strait Islander culture.

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725 Refer to comments made in: Cape York Institute of Policy and Leadership, *Submission no. 53.*
10.6. Role of the Family Responsibilities Commission

445. The Cape York Institute for Policy and Leadership has suggested using the Family Responsibilities Commission to re-establish the social norm that cannabis use is not acceptable.729

446. The Commission applies to welfare recipients living in the Cape York Welfare Reform areas of Aurukun, Coen, Hope Vale and Mossman Gorge. The Commission currently receives notices from a range of government departments, authorities and the Magistrates Courts if: a person's child is absent from school three times in a school term without reasonable excuse; a person has a child of school age who is not enrolled in school without reasonable excuse; a person is the subject of a child safety report, is convicted of an offence in the Magistrates Court, or breaches his or her tenancy agreement.730 The Commission can then hold a conference with the person and can reach an agreement about an appropriate response. This may involve the person attending an appropriate community support service or having their income managed for between three and 12 months.

447. The Cape York Institute for Policy and Leadership has proposed adding cannabis use, possession or allowing others to use cannabis on a person's property to the referral criteria for the Family Responsibilities Commission. This would allow the Family Responsibilities Commission to make regular drug testing part of the family responsibilities agreement, a breach of which could lead to a person's income being managed.731

448. The Cape York Institute of Policy and Leadership sees this as an appropriate model of justice, preferable to criminalisation, as it would: rebuild social norms (community Elders would reinforce that cannabis use is not acceptable); result in better money management (if a person did not abstain from cannabis use their welfare payments would be managed through conditional income management); and address underlying reasons for any issues through case conferencing and referral to treatment when appropriate.732

449. Establishing cannabis use and possession as a trigger for an agency notice would require legislative amendment setting out the exact nature of the particular event that would result in the notice. Presumably this would be similar to police drug diversion for a minor drugs offence under the Police Powers and Responsibilities Act 2000 (Qld)733 as it would be important to exclude dealers from the regime.734

450. The committee notes that the Commission is currently expected to cease operation on 1 January 2012,735 which means there is little time for changes to be made to its powers and jurisdiction before the trial ends. The committee also notes that the Family Responsibilities Commission currently addresses drug and alcohol use in the Cape York Welfare Communities, referring people who come

729 Cape York Institute for Policy and Leadership, Submission no. 53.
731 Cape York Institute for Policy and Leadership, Submission no. 53.
732 Cape York Institute for Policy and Leadership, Submission no. 53.
733 Police Powers and Responsibilities Act 2000 (Qld) s 379 and schedule 6 definition of 'minor drugs offence.'
734 Cape York Institute for Policy and Leadership, Submission no. 53.
735 Family Responsibilities Commission Act 2008 (Qld) s 152.
before it to community support services for assistance with drug and alcohol addiction and related mental health problems. During the meetings the committee holds regularly with the Family Responsibilities Commissioner, the Commissioner indicated that local commissioners are determined to stop drug use and people are being referred to the wellbeing centres for counselling and help with their drug problems.\textsuperscript{736}

10.7. Treatment

451. The committee heard that the lack of drug rehabilitation and detoxification services is a major barrier to addressing drug and alcohol issues in Aboriginal and Torres Strait Islander communities.\textsuperscript{737}

Recommendation 27

The committee recommends that the Queensland Government ensure adequate, accessible and culturally appropriate cannabis treatment services are provided in Aboriginal and Torres Strait Islander communities.

452. There is also a need for addiction treatment services that take into account the unique conditions in Indigenous communities, particularly community-based addiction services, which include specific services for cannabis addicts.\textsuperscript{738}

453. The committee heard that Indigenous people may be reluctant to use treatment services that they see as culturally inappropriate and primarily intended for non-Indigenous Australians. The Royal Australian and New Zealand College of Psychiatrists suggested that the government investigate the training of Indigenous health workers to work in the area of addiction including the provision of support for cannabis users.\textsuperscript{739}

454. Reference was made to the Drop the Rock program, which trains Indigenous people from remote communities to obtain a Certificate IV in Mental Health Work (non clinical) and a Certificate IV in Community Development. Graduates can obtain employment in clinics, healing centres and the Wellbeing Centres operated by the Royal Flying Doctor Service.\textsuperscript{740} The Australian Association of Social Workers suggested there needs to be an Indigenous person employed within a community who has a current understanding of the family and community dynamics.\textsuperscript{741}

455. The committee notes that a recent report on Indigenous-specific alcohol and other drug interventions recognised that the demand for qualified Indigenous staff members cannot be adequately met within the alcohol and other drug sector and recommended that the Federal Government investigate ways of facilitating

\textsuperscript{736} Legislative Assembly of Queensland. Social Development Committee, \textit{Meeting with the Family Responsibilities Commissioner held on 26 March 2010}, Appendix B, pp. 3-4.

\textsuperscript{737} Queensland Council of Social Service, \textit{Submission no. 33}, p. 3.

\textsuperscript{738} Cape York Institute for Policy and Leadership, \textit{Submission no. 53}.

\textsuperscript{739} Royal Australian and New Zealand College of Psychiatrists, \textit{Submission no. 50}, p. 15.

\textsuperscript{740} Australian Association of Social Workers, \textit{Submission no. 56}, p. 32.

\textsuperscript{741} Australian Association of Social Workers, \textit{Submission no. 56}, p. 33.
increased direct entry of Indigenous Australians into vocational and tertiary education programs of relevance to the sector.\textsuperscript{742}

**Recommendation 28**

The committee recommends that the Queensland Government provide incentives for Aboriginal and Torres Strait Islander people to train as Indigenous health workers to work in the area of addiction and provide support for Aboriginal and Torres Strait Islander cannabis users.

Appendix 1 – Advertisement calling for submissions

Advertisement placed in
The Courier-Mail; Gold Coast Bulletin; Sunshine Coast Daily; Toowoomba Chronicle;
Gladstone Observer; Rockhampton Morning Bulletin; Townsville Bulletin; and Cairns Post
on Saturday, 13 March 2010
and
Koori Mail on Wednesday, 24 March 2010

Social Development Committee
Call for Submissions
Inquiry into addressing cannabis-related harm in Queensland

The Social Development Committee is undertaking an inquiry that will consider: the risks associated with cannabis use, particularly for young people; and strategies to reduce the level of cannabis use in Queensland.

The committee invites written submissions. An Issues Paper, which outlines the issues for comment and provides information about how to make a submission, is available online at http://www.parliament.qld.gov.au/sdc or by phoning the secretariat on (07) 3406 7230.

Please send your written submissions by Friday 23 April 2010 to:

The Research Director
Social Development Committee
Parliament House, George Street
Brisbane Qld 4000

Or by email to: sdc@parliament.qld.gov.au

Ms Lindy Nelson-Carr MP
Chair
Appendix 2 – Submissions

1. Professor John McGrath, Centre for Mental Health Research
2. Dr Peter Thompson
3. Ms Eva Lai
4. Mr Rob Lavers
5. Royal Australian College of General Practitioners
6. Crime and Misconduct Commission
7. Mr Bhima Emz
8. Mr Matthew Bell
9. Dr Stuart Reece
10. Name suppressed
11. Ms Jeanette Reinecke
12. Mr Bob Green
13. Queensland Law Society
14. Mr Paul French
15. Drug Free Australia
16. Ms Kayla M
17. Name suppressed
18. Name suppressed
19. Name suppressed
20. Mr Peter J Lewis, Deakin University
21. Professor Wayne Hall, University of Queensland Centre for Clinical Research
22. Mr John Malouf
23. Queensland Independent Schools Parents' Council
24. Queensland Institute of Medical Research
25. Dr Richard Mills, Yulu-Burri-Ba Aboriginal Corporation for Community Health
26. Heart Foundation Queensland
27. Mr Ross Harty
28. Name suppressed
29. Mr Howard Teems
30. Australian Drug Law Reform Foundation
31. Queensland Alcohol and Drug Research and Education Centre
32. Minister for Primary Industries, Fisheries and Rural and Regional Queensland
33. Queensland Council of Social Service
34. Queensland Alliance
35. Queensland Association of State School Principals Inc.
36. HEMP Embassy
Appendix 2

37 headspace: National Youth Mental Health Foundation
38 Mr Andrew Whaites
39 BoysTown
40 Commission for Children and Young People and Child Guardian
41 Queensland Government
42 Professor David Kavanagh and Professor Ross Young, Institute of Health & Biomedical Innovation, Queensland University of Technology
43 Mr Ben Griffiths
44 FamilyVoice Australia
45 Families and Friends for Drug Law Reform (ACT) Inc.
46 Queensland Secondary Principals' Association Inc.
47 Alcohol and other Drugs Council of Australia
48 National Cannabis Prevention and Information Centre
49 Cancer Council Queensland
50 Royal Australian and New Zealand College of Psychiatrists
51 Australian Drug Foundation
52 Queensland Council for Civil Liberties
53 Cape York Institute for Policy and Leadership
54 Ms Jeannette Durret
55 Australian Crime Commission
56 Australian Association of Social Workers
57 DRUG ARM Australasia
58 Family Drug Support
59 Queensland Network of Alcohol and Drug Agencies
60 National Drug Research Institute
61 Associate Professor Alan Clough, James Cook University
62 Queensland Department of Education and Training
Appendix 3 – Advertisement notifying of public hearings

Advertisement placed in the
*The Courier-Mail*

on Tuesday, 1 June 2010

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**Social Development Committee**

**Notice of Public Hearings**

The Queensland Parliament’s Social Development Committee invites members of the public to observe proceedings at hearings for its inquiry into addressing cannabis-related harm in Queensland on:

- **Date:** Thursday, 3rd June & Friday, 4th June 2010
- **Time:** 9.00am – 3.30pm
- **Place:** Dandiir Room, Level 5, Parliamentary Annexe, George Street, Brisbane
- **RSVP:** (07) 3406 7230
Appendix 4

Appendix 4 – Witnesses

Public hearing held on Thursday, 3 June 2010 and Friday, 4 June 2010
Dandiir Room, Level 5, Parliamentary Annexe, George Street, Brisbane Qld
Witnesses are listed in the order of appearance at the public hearing.

Thursday, 3 June 2010

Mr John Malouf (Private capacity)
Dr Sue Ballantyne, Senior Medical Adviser, Drugs of Dependency Unit, Preventative Health, Division of the Chief health Officer, Queensland Health
Dr Trish Glasby, Manager, Teaching and Learning Branch, Education Queensland
Detective Senior Sergeant Kerry Johnson, State Crime Operations Command, Queensland Police Service
Acting Inspector Brad Little, Officer in Charge, Drug and Alcohol Coordination Unit, Queensland Police Service
Mr Mark West, Acting Executive Director, Preventative Health, Queensland Health
Mr John Ransley, Queensland Council for Civil Liberties
Dr John Jiggens, HEMP Embassy
Ms Caroline Salom, Director, Centre for Addiction Research and Education, DRUG ARM Australasia
Ms Jody Wright, Senior Health Prevention Officer, DRUG ARM Australasia
Dr Dennis Young, Executive Director, DRUG ARM Australasia
Ms Lauren Trask, Research Coordinator, Queensland Network of Alcohol and Other Drugs Agencies
Ms Roslyn Walker, Health Policy Officer, Queensland Council of Social Service
Ms Karyn Walsh, President, Queensland Council of Social Service
Dr Alex Wodak, President, Australian Drug Law Reform Foundation
Mr Bob Green (Private capacity)
Mr Gary Christian, Secretary, Drug Free Australia
Mr Bill Bush, Families and Friends for Drug Law Reform
Mr Brian McConnell, President, Families and Friends for Drug Law Reform
Mrs Marion McConnell, Families and Friends for Drug Law Reform
Professor Jan Copeland, National Cannabis Prevention and Information Centre
Friday, 4 June 2010

Mr John Callanan, Assistant Commissioner – Crime, Crime and Misconduct Commission

Ms Louise Norman, Senior Research Officer – Policing, Research and Prevention, Crime and Misconduct Commission

Ms Fleur Creed, Executive Officer, Queensland Independent Schools Parents Council

Dr Stuart Reece (Private capacity)

Mr David Templeman, Chief Executive Officer, Alcohol and Other Drugs Council of Australia

Mr Brian Flanagan, Manager Strategic Communications and Policy, Alcohol and Other Drugs Council of Australia

Mr Sam Hunt, Policy/Project Officer, Alcohol and Other Drugs Council of Australia

Mr Jeff Cheverton, Chief Executive Officer, Queensland Alliance

Professor John McGrath, Director, Queensland Centre for Mental Health Research

Professor Jake Najman, Director, Queensland Alcohol and Drug Research and Education Centre

Dr Kevin McNamara, Royal Australian and New Zealand College of Psychiatrists

Ms Kathleen Florian, Brisbane Office Manager, Australian Crime Commission

Associate Professor Alan Clough, Researcher, School of Public Health, Tropical Medicine and Rehabilitation Services, James Cook University

Mr Norm Hart, President, Queensland Association of State School Principals
Appendix 5 – Ministerial Responses

s.107 of the Parliament of Queensland Act 2001

107 Ministerial response to committee report

(1) This section applies if--

(a) a report of a committee, other than the Scrutiny of Legislation Committee, recommends the Government or a Minister should take particular action, or not take particular action, about an issue; or

(b) a report of the Members’ Ethics and Parliamentary Privileges Committee recommends a motion be moved in the Assembly to implement a recommendation of the committee.

(2) The following Minister must provide the Assembly with a response--

(a) for a report mentioned in subsection (1)(a)--the Minister who is responsible for the issue that is the subject of the report;

(b) for a report mentioned in subsection (1)(b)--the Premier or a Minister nominated by the Premier.

(3) The response must set out--

(a) any recommendations to be adopted, and the way and time within which they will be carried out; and

(b) any recommendations not to be adopted and the reasons for not adopting them.

(4) The Minister must table the response within 3 months after the report is tabled.

(5) If a Minister can not comply with the subsection (4), the Minister must--

(a) within 3 months after the report is tabled, table an interim response and the Minister's reasons for not complying within 3 months; and

(b) within 6 months after the report is tabled, table the response.

(6) If the Assembly is not sitting, the Minister must give the response, or interim response and reasons, to the Clerk.

(7) The response, or interim response and reasons, is taken to have been tabled on the day they are received by the Clerk.

(8) The receipt of the response, or interim response and reasons, by the Clerk, and the day of the receipt, must be recorded in the Assembly's Votes and Proceedings for the next sitting day after the day of receipt.

(9) The response, or interim response and reasons, is a response, or interim response and reasons, tabled in the Assembly.

(10) Subsection (1) does not prevent a Minister providing a response to a recommendation in a report of the Scrutiny of Legislation Committee if it is practicable for the Minister to provide the response having regard to the nature of the recommendation and the time when the report is made.

Example--

If the committee recommends that a Bill be amended because, in the committee's opinion, it does not have sufficient regard to fundamental legislative principles and the Bill has not been passed by the Assembly, it may be practicable for the Minister to provide a response.

(11) Subsection (8) does not limit the Assembly's power by resolution or order to provide for the tabling of a response, or interim response and reasons, when the Assembly is not sitting.

(12) This section does not apply to an annual report of a committee.