Turning Point
TREATMENT · RESEARCH · EDUCATION

SUBMISSION: INQUIRY INTO CANNABIS USE IN VICTORIA

Turning Point & Monash Addiction Research Centre
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GREAT HEALTH AND WELLBEING

Submission to the Inquiry into Cannabis use in Victoria

About Turning Point and the Monash Addiction Research Centre

Turning Point is a national addiction treatment centre, dedicated to providing high quality, evidence-based treatment to people adversely affected by alcohol, drugs and gambling, integrated with world-leading research and education. Turning Point is auspiced by Eastern Health and is formally affiliated with Monash University.

Turning Point reduces the harms caused by alcohol, drugs and gambling and promotes recovery through integrated activity that:

1. Increases access to support and evidence-based practice through the use of innovative technologies.
2. Delivers high quality evidence-based practice.
3. Supports health care professionals nationally and internationally to provide high quality evidence-based practice.
4. Delivers workforce and community education programs to a broad range of populations.
5. Undertakes policy and practice relevant research and provides key national population level data.
6. Provides policy advice to state and federal governments as well as expert comment.

The Monash Addiction Research Centre (MARC) brings together world-leading expertise from across Monash University and the sector to provide solutions to the challenges of addiction. MARC draws on the multidisciplinary strengths and capabilities of researchers across the University to develop and test novel, scalable prevention and treatment approaches. MARC's mission is to provide national solutions to addiction. Its expertise leverages experts in basic and social science, clinical and epidemiological research, to develop new knowledge to shape government policy and evidence-based approaches.

Recommendations for achieving outcomes (c) and (e)

(c) Best means to implement health education campaigns and programs to ensure children and young people are aware of the dangers of drug use, in particular, cannabis use

1. *Drug education in schools should take a strength-based approach and ensure young people develop critical health literacy in relation to drug use and mental health*
2. *School-based health education programs should draw on existing evidence-based Australian interventions, such as the Climate Schools and MAKINGtheLINK, which highlight the importance of adopting a social influence approach and building young people's help-seeking skills*
3. *Public health campaigns should avoid fear-based strategies, as they can be counter-productive, as well as reinforce stigma and discrimination. Focussing on social inclusion and emphasising that people experiencing harms are not to blame for their problems can reduce prejudice and promote help-seeking*

(e) Best means to assess the health, mental health, and social impacts of cannabis use on people who use cannabis, their families and carers

4. *Assessment and treatment of cannabis and other drug use disorders needs to be embedded as a core competency in undergraduate and postgraduate teaching at all levels of health practitioner training, with opportunities for hands-on training placements within addiction settings*
5. *Criminalisation of cannabis creates long-lasting harm for young people and diversion options should be pursued at every opportunity*

This submission only addresses outcomes (c) and (e) identified by the inquiry for input.

(c) Best means to implement health education campaigns and programs to ensure children and young people are aware of the dangers of drug use, in particular, cannabis use

Ensuring young people develop critical health literacy

Adolescence is a time of major brain development, and there is growing research to suggest that the adolescent brain may be particularly sensitive to the effects of cannabis and other drug use during this period[1]. Epidemiological research consistently shows that early cannabis use has impacts on mental health and educational outcomes, and improving awareness of the harms associated with cannabis and other drug use during adolescence, as well as their underlying drivers (such as mental health and peer pressure), is central to primary prevention efforts.

However, it is important to note that research indicates that Australian adolescents are aware of the negative impact of drug use on mental health problems[2], suggesting that knowledge of harms alone is not sufficient to deter use. This finding is consistent with research evaluating previous substance misuse awareness and education campaigns in Australia, which found that awareness of key messages was not consistently associated with changes in behaviour[3]. At the same time, the proliferation of misinformation related to the effects of cannabis use through the internet and social media, particularly since the legalisation of cannabis in many parts of the world, highlight the importance of ensuring young people have the opportunity to develop critical health literacy[4], ensuring that they have the skills to identify, analyse, use and critique health information generally, and information related to cannabis use in particular.

Developing critical health literacy[5] is vital for young Australians to be able navigate the aforementioned often complex and contradictory information that exists in relation to cannabis use.

[1] Lubman, D. I., Cheetham, A., & Yücel, M. (2015). Cannabis and adolescent brain development. Pharmacology & therapeutics, 148, 1-16.

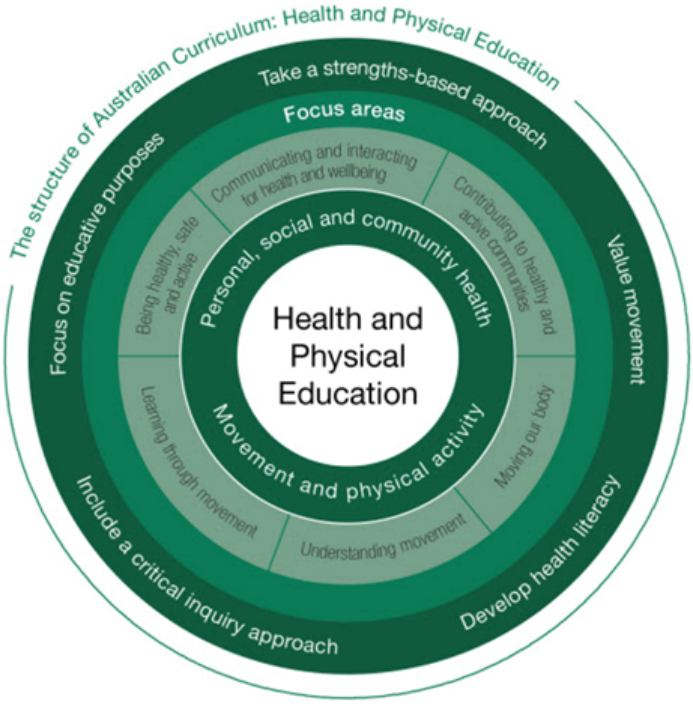
[2] Lubman, D. I., Hides, L., & Jorm, A. F. (2007). Beliefs of young people and their parents about the harmfulness of alcohol, cannabis and tobacco for mental disorders. Medical journal of Australia, 187(5), 266-269.

[3] Toumbourou, J., Stockwell, T., Haines, B., Scott, K., Godfrey, C., ... & Marshall, J. (2004). The prevention of substance use, risk and harm in Australia: a review of the evidence. Commonwealth of Australia.

[4] Alfrey, L. G., & Brown, T. D. (2013). Health literacy and the australian curriculum for health and physical education: A marriage of convenience or a process of empowerment? Asia-Pacific Journal of Health, Sport and Physical Education, 4(2), 159 - 173.

[5] Nutbeam, D. (2000). Health literacy as a public health goal: A challenge for contemporary Health Education and communication strategies into the 21st century. Health Promotion International, 15, 259_267.

Drug education is a compulsory component of the Health and Physical Education (HPE) curriculum (VCAA, n.d.) and is taught through the compulsory 'Alcohol and other drugs' Focus Area (see Figure 1). Moreover, 'Develop health literacy' is one of the five 'Key Ideas' that underpin the HPE curriculum and which are expected to guide the teaching of HPE (see [4]), inclusive of drug education/alcohol and other drugs (see Figure 1). So whilst the policy/curriculum context is relatively optimal in terms of prompting opportunities for youth to develop critical health and drug/cannabis literacy, and there some highly regarded resources available (e.g. Get Ready), little is known about how this is being translated into practice in either teacher education or schools.



Focus areas
Alcohol and other drugs (AD)
Food and nutrition (FN)
Health benefits of physical activity (HBPA)
Mental health and wellbeing (MH)
Relationships and sexuality (RS)
Safety (S)
Active play and minor games (AP)
Challenge and adventure activities (CA)
Fundamental movement skills (FMS)
Games and sports (GS)
Lifelong physical activities (LLPA)
Rhythmic and expressive activities (RE)

Figure 1: Image retrieved from Australian Curriculum Assessment Reporting Authority (ACARA) (https://www.australiancurriculum.edu.au/)

While there are a number of case studies showcasing individual school approaches to teaching drug education, we suggest more can done in terms of developing critical health and drug literacy as part of HPE, and whole-school approaches to drug education more broadly (e.g. [6]). Youth need more of a personalised, context specific approach to drug education. More specifically, and drawing on the Key Ideas underpinning the HPE Curriculum (see Figure 1), drug education needs to:

[6] Markham, W.A., Bonell, C., Fletcher, A. and Aveyard, P. (2017). How can schools help to reduce the harm associated with teenage substance use? Development of a theoretically driven whole-school approach. Drugs and Alcohol Today, Vol. 17 No. 1, pp. 1-11.

- *Include a Critical Inquiry Approach* – youth should be positioned as critical inquirers of health and drug/cannabis information. For example, 'If I wanted to find out information about cannabis where would I go? If I needed support related to taking cannabis where could I go?'. A critical inquiry approach presents an opportunity for youth to develop critical health and drug literacy skills.
- *Developing Health Literacy* – youth need opportunities to learn how to identify (First Step), analyse (Second step), use and critique (Third step) health and drug/cannabis information.
- *Take a Strengths-Based Approach* – in an attempt to redress the traditional risk-based approaches (e.g. 'do not smoke cannabis you will become a criminal and/or develop mental illness;') or a typical blanket prohibition (e.g. "all drugs are always bad for everyone all the time") a more strengths-based, individualised, and holistic approach should prove more effective in equipping youth with the knowledge and skills they need to make decisions related to cannabis use.

Furthermore, schools should adopt an evidence-based whole-school approach, including families and community partnerships to support the process of drug education. For all of the above to happen, we need to understand:

- how drug education is being taught in Initial Teacher Education and schools;
- how teachers are being supported in the shift toward more strengths-based, critical drug literacy;
- what students learn about drugs, where they learn it and how it enables safe critical decision making about cannabis (and all drugs) use.

The importance of a social influence approach and building young people's help-seeking skills

Evidence from school-based prevention and intervention programs also suggests that educational strategies may be more effective when combined with a social influence approach[7]. Early school-based programs focussed on providing students with information about drug-related harms alone, leading to improvements in knowledge that did not translate into actual changes in drug-related attitudes or behaviours. In contrast, a social influence approach emphasises the importance of social and psychological factors in the initiation and progression of drug use. In the CLIMATE Schools program, adolescents are provided with accurate information about drug use, in addition to

[7] Cheetham, A., & Lubman, D. I. (2017). The Role of Peers on School-Based Prevention Programs Targeting Adolescent Substance Use. Current Addiction Reports, *4*(4), 379-385.

normative education (to address the misperception that the majority of young people use drugs) and resistance skills training (to help identify and resist sources of pressure to use drugs). This evidence-based program has been found to increase knowledge about alcohol and cannabis, as well as demonstrating a greater capacity to decrease drug use and associated harms than education-based programs alone[8], [9].

Training adolescents to help their peers may be a novel way of increasing awareness of the dangers of drug use, as well as ensuring they recognise any harms arising in the peer group and how and where to access professional help. The award-winning MAKINGtheLINK intervention[10,11] was developed in order to improve students' ability to help their peers, as young people often prefer to access informal sources of support (i.e. friends) rather than seeking professional treatment. Peers may play an important role in responding to drug use during adolescence as they are often considered more credible sources of information than adults, while professional help may be avoided due to concerns about punishment[12]. Peer influence has also been studied extensively in relation to cannabis: a high number of cannabis-using peers is one of the strongest predictors of use[13]. Adolescents are therefore ideally positioned to play a 'gate-keeping' role by helping their friends identify signs of problematic use, as well as overcoming barriers to accessing appropriate professional support. Indeed, a recent NHMRC-funded Victorian trial of the *MAKINGtheLINK* intervention found that the program effectively improved the help-seeking behaviour, attitudes and intentions of young people experiencing mental health problems, equipping them to not only support their peers, but also themselves[14].

[8] Newton, N. C., Teesson, M., Vogl, L. E., & Andrews, G. (2010). Internet-based prevention for alcohol and cannabis use: final results of the Climate Schools course. Addiction, 105(4), 749-759.

[9] Newton, N. C., Tee Newton, N. C., Andrews, G., Teesson, M., & Vogl, L. E. (2009). Delivering prevention for alcohol and cannabis using the internet: A cluster randomised controlled trial. Preventive medicine, 4*8*(6), 579-584.

[10] Lubman, D. I., Berridge, B. J., Blee, F., Jorm, A. F., Wilson, C. J., Allen, N. B., ... & Wolfe, R. (2016). A school-based health promotion programme to increase help-seeking for substance use and mental health problems: study protocol for a randomised controlled trial. Trials, 17(1), 1-10.

[11] Alcohol and other Drugs Excellence and Innovation Awards (2017) - Prevention and Education https://www.medianet.com.au/releases/135550/

[12] Berridge, B. J., McCann, T. V., Cheetham, A., & Lubman, D. I. (2018). Perceived barriers and enablers of help-seeking for substance use problems during adolescence. Health Promotion Practice, 19(1), 86-93.

[13] Chabrol, H., Chauchard, E., Mabila, J. D., Mantoulan, R., Adèle, A., & Rousseau, A. (2006). Contributions of social influences and expectations of use to cannabis use in high-school students. Addictive Behaviors, 31(11), 2116-2119.

[14] Lubman, D. I., Cheetham, A., Sandral, E., Wolfe, R., Martin, C., Blee, F., ... & McKay-Brown, L. (2020). Twelve-month outcomes of MAKINGtheLINK: A cluster randomized controlled trial of a school-based program to facilitate help-seeking for substance use and mental health problems. EClinicalMedicine, 18, 100225.

In raising awareness of cannabis and other drug-related harms, it is essential that campaigns avoid perpetuating harmful stereotypes of users[15]. Stigma and discrimination are powerful barriers to help-seeking, particularly among adolescents, and can lead to substantial delays in accessing treatment. Focussing on social inclusion and emphasising that people experiencing harms are not to blame for their problems may reduce prejudice,[16] and facilitate helping behaviour. Campaigns should also avoid fear-based strategies that highlight the negative effects of drug use in an anxiety-provoking way, as they can be counter-productive if dangers are perceived as unrealistic or exaggerated[17].

[15] Lancaster, K. ,Seear, K., & Ritter, A. Reducing Stigma and Discrimination for People Experiencing Problematic Alcohol and Other Drug Use: Final Report (A report for the Queensland Mental Health Commission, 2017).

[16] Clement, S., Lassman, F., Barley, E., Evans-Lacko, S., Williams, P., Yamaguchi, S., ... & Thornicroft, G. (2013). Mass media interventions for reducing mental health-related stigma. Cochrane Database of Systematic Reviews, (7).

[17] Soames Job, R. F. (1988). Effective and ineffective use of fear in health promotion campaigns. American Journal of Public Health, 78(2), 163-167.

(e) Best means to assess the health, mental health, and social impacts of cannabis use on people who use cannabis, their families and carers

Effective treatment of cannabis use disorder requires a skilled workforce

Cannabis use disorder commonly co-occurs with other mental health problems, including depressive disorders, conduct disorders, personality disorders, and anxiety[18,19]. These patterns of comorbidity highlight the need for services that provide multidisciplinary care, however the separation of the alcohol and other drug (AOD) and mental health service sectors is as a significant barrier to access[20]. Both sectors face considerable demand for services and are significantly under-resourced. Pressure to place young people in the 'correct' system based on a primary diagnosis can lead to treatment of one disorder at the expense of the other, despite evidence that the relationship between substance use disorders and other mental problems is bidirectional[21]. Finally, treatment of comorbidity requires a highly skilled workforce. While building AOD workforce capabilities has been identified as a priority for the Victorian Government[22], a lack of skills and experience to appropriately assess and manage co-occurring disorders remains a key barrier to effective service provision.

An association between cannabis use and psychosis or schizophrenia has been recognized for over two decades. To date, the strongest evidence suggests that a link exists between cannabis use and the development of psychotic disorders in vulnerable individuals, due to underlying genetic and familial factors[23]. Recent research suggests that the rate of conversion from cannabis-induced psychosis to schizophrenia could be as high as 50% of cases, almost double the rate associated with psychosis induced by other drugs[24]. Evidence of a dose-response relationship points towards cannabis-induced psychosis being a specific risk factor for converting to schizophrenia, particularly amongst younger people (16-25 years) and males.

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[18] Goodman, M., & George, T. (2015). Is There a Link Between Cannabis and Mental Illness?. *Foreword by Rita Notarandrea 1 Foreword by Joy Johnson 3 Introduction 5 Joanna Henderson 1 What Are the Brain and Behavioural Effects of Cannabis Use in Youth? 16*, 32.

[19]Swift, W., Hall, W., & Teesson, M. (2001). Characteristics of DSM-IV and ICD-10 cannabis dependence among Australian adults: results from the National Survey of Mental Health and Wellbeing. *Drug and Alcohol Dependence*, *63*(2), 147-153.

[20]Submission to the Royal Commission into Victoria's Mental Health System, Turning Point (July 2019)

[21] Teesson, M. Mental Health and Substance Use: Opportunities for Innovative Prevention and Treatment (Mental Health Commission of New South Wales, 2014).

[22] Department of Health and Human Services. Victoria's Alcohol and Other Drugs Workforce Strategy Victoria, 2018).

[23] Kendler, K. S., Ohlsson, H., Sundquist, J., & Sundquist, K. (2019). Prediction of onset of substance-induced psychotic disorder and its progression to schizophrenia in a Swedish national sample. American Journal of Psychiatry, 176(9), 711-719.

[24] Starzer, M. S. K., Nordentoft, M., & Hjorthøj, C. (2018). Rates and predictors of conversion to schizophrenia or bipolar disorder following substance-induced psychosis. American journal of psychiatry, 175(4), 343-350.

However, despite the high conversion rate, many young people with a drug-induced psychosis are excluded from mental health services, due to limited knowledge and skills in managing cannabis and other drug presentations. This active discrimination of young people with substance use disorders, including cannabis, is an unintended consequence of deinstitutionalisation, where alcohol and drug services were separated from the rest of the health system, resulting in limited undergraduate and postgraduate training in managing alcohol, drug and addiction presentations as well as few opportunities to work clinically within addiction settings[25]. As a result, since the 1990s across Victoria, there has been a generation of medical, nursing and allied health practitioners who have not had the opportunity to train in addiction settings or interact with Victorians in recovery, and as such, do not have the skills or knowledge to provide evidence-based care to this population, irrespective of setting. This gap in knowledge and experience has led to health practitioners having little confidence in AOD interventions or the treatment system and being pessimistic, even nihilistic, in their views around treatment and recovery. Today, there are limited opportunities across Victoria that allow medical, nursing and allied health practitioners to rotate through addiction services, and to have the opportunity to hear from those with lived experience of what works and what doesn't — even for GPs and mental health practitioners — despite frequent requests to training bodies for training placements. As a result, there is a fundamental failure in translating evidence around the treatment of substance use disorders into practice across the Victorian health system, contributing to the poor health outcomes that we see for this population, and the limited number of medical practitioners willing to offer evidence-based interventions.

To ensure these competencies remain achievable over the long term, assessment and treatment of substance use disorders needs to be embedded as a core competency in undergraduate and postgraduate teaching at all levels of health practitioner training, with opportunities for hands-on training placements within AOD settings. However, this is harder than it sounds, as there are few clinical academics with expertise in addiction that can provide the teaching and training necessary within Victorian universities. This is a consequence of a lack of investment in tertiary addiction services in Victoria since deinstitutionalisation, as well as limited funding of clinical addiction academic positions. This deficit in clinical addiction academic positions across health disciplines means that there is limited addiction input into university health curricula and limited capacity to educate the next generation of health professionals. While AOD education was implemented across medical schools in Australia in the 1990s with funding from the Commonwealth, after this funding

[25] Lubman, D., Hides, L., & Elkins, K. (2008). Dual diagnosis: Dual disorders or a dual system?. In Drugs and public health: Australian perspectives on policy and practice (pp. 127-138). Oxford University Press.

ceased universities did not have the resources to continue offering this material in depth[26]. This helps explain why the Victorian health workforce has such limited capacity to respond to substance use disorders in an evidence-based manner. This critical gap in clinical addiction academic funding is underpinned by the failure to recognise addiction medicine and psychiatry as core medical specialties within the Victorian public health system and to adequately fund addiction medical training and consultant positions.

Criminalisation of cannabis creates long-lasting harm for young people

Over the decades, in both Australia and internationally, there have been mixed messages about the use of cannabis. Some Government and advocacy organisations have legalised adult use (e.g. California in USA) and suggest it can be helpful for certain medical conditions (e.g. for end of life pain relief or cancer treatments). Conversely, other states or countries have demonised its use, threatening extreme jail sentences or school suspensions which are not accompanied with education or mental health support. In Australia, the ACT became the first jurisdiction nationally to legalise cannabis for personal use in 2019, after it was decriminalised in 2004. Cannabis use was also decriminalised in Western Australia in 2004, however the reforms were repealed following a change in state government and the reintroduction of a 'tough on crime' approach in 2011.

Cannabis undeniably causes harm to some users, particularly adolescents and young adults. However, cannabis users experience long-lasting and disproportionate harms from the criminal justice system, particularly if they acquire a criminal record due to a minor cannabis offence (which can significantly impact their future ability to gain employment), and a significant minority are likely to be unaware of the legal sanctions and penalties that cannabis users can face[27]. Prohibition also criminalises what is, for many users, a health issue that would be better served by treatment or education. While the policy choice is often over-simplified, honest appraisals of both sets of harms are necessary, and ultimately a better understanding of both the health effects of cannabis and the costs and benefits of prohibition are key[28]. As a result, in most jurisdictions, diversion is the preferred mechanism for minimising long-lasting harm to young people related to cannabis possession, and it is critical that the most effective approaches are clearly identified and supported.

[26] Lubman, D. I., Hides, L., Jorm, A. F., & Morgan, A. J. (2007). Health professionals' recognition of co-occurring alcohol and depressive disorders in youth: a survey of Australian general practitioners, psychiatrists, psychologists and mental health nurses using case vignettes. Australian & New Zealand Journal of Psychiatry, 41(10), 830-835.

[27] Swift, W., Copeland, J., Lenton, S. (2000). Cannabis and harm reduction. *Drug and alcohol review*, *19*(1), 101-112.

[28] Hall, W. D. (2009). Challenges in reducing cannabis-related harm in Australia. *Drug and Alcohol Review*, *28*(2), 110-116.

Recent research indicates that diversion is associated with improved outcomes in regard to social consequences, employment prospects, and personal relationships, as well as reductions in cannabis use and offending. This evidence adds to a substantial body of literature supporting the inclusion of diversion as a core policy response to illicit drug use and related offending in Australia[29].

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[29] Shanahan, M., Hughes, C., & McSweeney, T. (2016). Australian police diversion for cannabis offences: Assessing program outcomes and cost-effectiveness. Canberra: National Drug Law Enforcement Fund.