SELECT COMMITTEE ON SUBSTANCE ABUSE IN THE COMMUNITY

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ALCOHOL AND OTHER DRUGS PROGRAM SUBMISSION

TO THE

SELECT COMMITTEE ON SUBSTANCE ABUSE

IN THE COMMUNITY

MAY 2002

CANNABIS.

The Department of Health and Community Services (DHCS) Alcohol and Other Drugs Program has been requested to provide this briefing to the Select Committee On Substance Abuse In The Community.

The briefing has been requested to include information identifying the extent of cannabis use in the Northern Territory, issues of policy, funding and past, present, and future directions.

This briefing outlines scientific and qualitative information from Frontline Workers relating to cannabis use across populations and settings.

Different people use different drugs for different reasons and no one reason or situation causes people to use drugs. Drug use, especially illicit drug use, is complex and emotive.

People engage in the use of alcohol, tobacco and other substances for a variety of reasons. While use of some substances can offer social and health benefits, there are frequently negative outcomes that can accrue in terms of health and wellbeing (NHMRC, 1992; NHMRC, 2001). These outcomes affect not only the individual user, but they can also impact on family and friends and the broader community. Alcohol and tobacco have the greatest impact.

The primary aim of the Alcohol and Other Drugs Program is to reduce the impact of substance misuse in the Northern Territory.

The mission of the Program is:
To promote individual and community well being by minimising the harm associated with alcohol, tobacco and other drugs through a coordinated range of approaches.

In pursuing this aim, the Program will focus on:

- increasing the knowledge and skills of individuals and the capacity of families, communities and services to address substance issues;
- engaging a range of resources to provide a variety of strategies and an optimum range of care and treatment services appropriate to meet the needs of people experiencing substance misuse problems; and
- supporting an environment, which encourages, enables and reinforces actions taken individually and collectively to minimise substance related harm.

The Issue:

Increased cannabis use has been identified across the NT and is of particular concern to health agencies, law enforcement, families, and remote Aboriginal communities, because of its link with mental health problems such as depression and suicide.

Cannabis as a public health problem does not have the same level of impact on families and the community to the degree that alcohol and tobacco do.

Prevalence:

The differences between 'drug use', 'drug misuse', 'drug abuse' and 'drug dependence' are important when reading prevalence data. Drug use can be reported as:

- experimental: use that might or might not continue
- functional: use that serves some purpose, such as for recreation, but does not cause problems to the user
- dysfunctional: use that leads to impaired psychological or social functioning
- harmful: use that is causing damage to the user's physical or mental health
- dependent: use that could involve tolerance, withdrawal if use is ceased, and continued use despite the consequences (Structural determinants of youth drug use. Spooner, Hall and Lynskey. NDARC, 2001).

Prevalence has been established through quantitative data from the following sources: 1999 Australian Secondary School Alcohol and Drug Survey: Northern Territory Findings (unpublished data); Young People and Substance Use in the Northern Territory in 1998 [O'Reilly and Townsend]; Northern Territory Drug Trends, 1999 [Rysavy et al]); Australian National Drug Survey, 1998; and National Drug Survey, 1994.

Qualitative information, has recently been collected from police and remote area nurses in the form of their observations and experience.

<u>Research: National</u>
There has been a global increase in the prevalence of cannabis use. Epidemiological studies have also noted that cannabis use is largely associated with adolescence and early adulthood (WHO 1997).

The Australian National Drug Survey, (1998), identified cannabis as the most widely used illicit drug and noted that usage is increasing (Miller and Draper, 2001). In 1991, around 33% of the population aged 14 years and over had tried cannabis. By 1998, this figure had increased to 39% (44% male and 35% female) with 18% using in the last 12 months. Most cannabis use is not regular; the majority of users did not use in the past year or had used less than weekly. The proportion of users who became weekly users was 7% of women and 15% of men. This was most common in the 20-24 age group.

As with the wider population, of all the illicit drugs, cannabis is the main illicit drug used by indigenous people. The 1994 National Drug Survey (urban indigenous people) identified 48% had tried cannabis with 22% being current users (NDS, Urban Aboriginal and Torres Strait Islander Peoples Supplement, 1994).

In the 1999 Australian Secondary School Alcohol and Drug Survey students reported that when using cannabis 80% of them also used another substance. Alcohol and tobacco were the substances most predominantly used in conjunction with cannabis by both males and females.

Research: Northern Territory

There is a fundamental lack of good information about cannabis use and misuse in the remote areas of the NT, particularly in Aboriginal communities. However, there are a number of trend surveys which indicate cannabis use is increasing in urban centres, particularly amongst younger users (Young People and Substance Use in the Northern Territory in 1998 [O'Reilly and Townsend]; Northern Territory Drug Trends, 1999 [Rysavy et al]).

Accurate prevalence figures in the NT are limited. In National Surveys low sample sizes are used. This coupled with the NT's low population base and issues surrounding the illegality of cannabis means that any figures should be treated with caution, as they ***may be unreliable*** (AIHW, 2000). The 1998 National Drug Survey reported 59% of people aged 14 years and over had ever tried cannabis with 36% reporting use in the last 12 months Reported figures suggest that the NT prevalence rates are higher then the national figures (Miller and Draper, 2001).

Certainly this increase has been identified in a March 2000 East Arnhem study (Clough et al, 2001) where 43% of the indigenous population from one community were using cannabis. This is a two and a half fold increase from previous consumption patterns identified in 1994-7. The 2000 study found the mean duration of cannabis use was four years and matched health worker reports of cannabis now becoming available for sale in remote areas during the last three to five years.

Most cannabis use is not regular; however, some remote communities are reporting high levels of problematic use and are increasingly concerned about its substantial impact on young people.

The analysis of indicator data and key informant surveys, as documented in the Northern Territory Drug Trends, 1999 (Rysavy et al 1999) reports that:

- Cannabis use was common and increasing throughout the Northern Territory and particularly in Darwin
- Patterns of use varied widely
- More young people and women were smoking cannabis
- Cannabis use was causing concern on some aboriginal communities
- There was a wide age range of users
- Cannabis was not viewed as a dangerous drug
- There had been an increase in cannabis users presenting with mental health and behavioural problems
- Polydrug use was common, particularly among young users. Alcohol was the other drug most often used
- In the Top End more locally grown, including hydroponic, cannabis was available
- Potency was high and costs were stable at approximately $25 per gram and $250 to $300 per ounce
- Availability was easy.

The same report states that the profile of cannabis users including

- people in their early teens to 50's
- mainly males and females aged 15-35
- mostly caucasian
- 10-25% Aboriginal
- less then 5% Culturally and Linguistically Diverse backgrounds (CALD)
- mostly users had a high school education
- few users are in treatment or prison and less than 40% had a criminal justice history.

Use by younger people is of particular concern to the Department of Health and Community Services (DHCS). This use is putting younger people in contact with the criminal justice system at an early age. Contact with the court system has implications for future employment prospects. Regular use could also impact on future work and the academic prospects of users.

Anecdotal Evidence: NT remote areas

In an effort to improve currently available information in April 2002, the Alcohol and Other Drug Program (AODP) undertook a snapshot of cannabis patterns and prevalence in the remote context. Information was gathered from remote health centres and police stations. Because of the potential effect of cannabis use and the illegal nature of cannabis possession and use, collecting good data is a particular problem.

- In Alice Springs Rural cannabis use is widespread in the more remote communities. The main user group is young men, however, more women are using cannabis. Police are noticing small, irregular use in the western desert, and restricted use in the eastern desert region.

- In the Barkly the use of cannabis is increasing in larger communities (>200) with both men and women using cannabis regularly. Smaller communities have a relatively stable population of cannabis users.

- In Katherine men of all ages, including boys as young as 12, are using cannabis. Women are also users of cannabis. It is an ongoing problem, with numbers increasing.

- In East Arnhem cannabis use has increased over the last 5-10 years at, what is claimed by both police and health staff, an "alarming rate". Use is continuing and the numbers are increasing. Both men and women are smoking cannabis, with young people as young as 10 years participating, but seemingly stopping by age 35. It is in this region that there has been widespread speculation of the links between cannabis use, mental health and rates of suicide.

From this snapshot of the districts, it is concluded that cannabis is available in almost all communities, with a range of youth being regular cannabis users. Both men and women are using cannabis and the numbers using cannabis are increasing. It is recognised however, that not all cannabis use has been identified as problematic.

Cannabis and the law

In the NT cannabis has been 'decriminalised'. It is still against the law in the NT to use, grow or supply others with cannabis.

Under the NT Misuse of Drugs Act (1993) the NT police can give the user an infringement notice for having or using small amounts of cannabis. They can also have discretion to refer people using small amounts of cannabis to a diversionary program. Infringement notices can only be given if the person is 18 years old or over and:

- The amount of cannabis found on the person (possession) is not more than 50 grams of cannabis plant material, 10gm of plant resin or 1gm of oil. OR
- The amount of cannabis being grown is not more than two plants.

People caught with more than the amounts above will be charged with a criminal offence and have to appear at court. Individuals **under 18 years** of age will be charged with having or growing cannabis. Anyone caught selling cannabis on a licensed premise or around schools will be prosecuted.

What are the implications for the government's health system?

Costs

The financial impact of cannabis use on the health system appears relatively low compared to the costs associated with other substance misuse. There is some cost to the public health system in responding to requests for dealing with cannabis issues, however this is dealt with on an ad hoc basis. It is likely that there exist a number of hidden costs associated with cannabis usage such as mental illness.

The risks of overdosing on cannabis are very small, with no deaths from overdosing being reported in medical literature. (Hall et al, 1998). However, as cannabis is regularly used with tobacco, the costs to the health system increase rapidly.

Mental Health

According to Hall et al (2002) there is reason to suspect that cannabis use may be a cause of psychotic disorders, ie mental illnesses in which sufferers experience hallucinations and delusions and show impaired reality testing. THC produces symptoms found in some psychotic disorders, namely, euphoria, distorted time perception, and cognitive and memory impairments.

While it remains uncertain whether cannabis use can cause schizophrenia that would not have occurred in its absence, there is a growing body of evidence that suggests that cannabis use and mental health problems are linked (Hall et al, 2002). This has implications for future health care planning. Hospital admissions (NT) for cannabis psychosis are relatively low. There were 125 admissions in 98/99, 96 admissions in 99/00 and 132 in 00/01. No visible trends can be extrapolated from the current available data. While these figures are low numbers, they do represent about 15% of total admissions to mental health acute services.

Cannabis use has been linked to a number of suicide deaths in remote Top End communities, leading to high profile coronial inquiries and requests from community leaders for assistance to address the problems that communities are facing with regard to cannabis use. Research from WA indicates that the drugs most commonly associated with youth suicide were alcohol and cannabis, with cannabis detected in 20% of males and 11% of females who successfully suicided (Hillman et al, 2000).

DHCS Services Development Division reports that no alcohol and other drug services have sought additional funds to address cannabis issues.

Additionally, of the $154,000 of Remote Area Alcohol Strategy (RAAS) funds specifically allocated to address substance misuse in remote Central Australia, no submissions have been received in relation to cannabis.

What is the Department of Health and Community Services currently doing about cannabis use in the community?

Services funded through the Department such as prevention, treatment and rehabilitation, community education and training are based on an integrated service model that supports action across a range of substances.

Health and Community Services currently employ a team of Community Support Officers (CSOs) in each district. They deal with a range of substance misuse issues, by providing education and early intervention strategies to the community and health staff. They are not required to have any specific cannabis knowledge at the time of recruitment, and their specific skills and knowledge in the field of cannabis, and prevention activities, are unknown.

A range of alcohol and other drug treatment services are available to the community, usually in an urban setting. Territory wide, 335 people attended an alcohol and drug agency due to their cannabis use, last financial year. This figure is almost double the number of people who presented two years prior. Increases have been particularly notable in Katherine and Alice Springs. This could reflect the numbers using cannabis, or that user friendly services that make clients more comfortable are provided in the Districts.

DHCS have produced a small range of cannabis education resources, or accessed these resources from other sources. These resources include flip charts, pamphlets and training information, and are disseminated through Alcohol and Other Drug services. The resources have been developed in collaboration with workers from remote communities.

Training sessions and workshops, including formal cessation training sessions, have been delivered to frontline workers in remote communities by departmental staff.

How could Health and Community Services do things better?

<u>Research</u>

DHCS needs to improve its research capacity into the issue of cannabis use. Currently there is little known quantitative data on use in the NT.

Possible options include:

- establishing current levels of cannabis use in the Northern Territory;
- investigating perceptions of cannabis use within "drug, set, setting" framework; and
- updating current resources by undertaking a literature search on what cannabis health education resources are available both nationally and internationally.

<u>Prevention</u>

Education and early intervention and prevention activities tend to be poorly targeted, and delivered irregularly. Often the need is not community identified, but driven by external influences.

Possible options could include:

- addressing the myths regarding drug use in the community through an education process grounded in current research and facts about all drugs, including cannabis;
- producing general health messages regarding the association between levels of drug use and increased risk for suicide and make them available to young people, their parents and the community;
- increasing knowledge in the community about the short term and long term effects of drugs, including cannabis use through an educational initiative; and
- implementing evidence based prevention programs focusing on groups most at risk.

Intervention

The relationship between drug use and mental health issues needs to be addressed broadly by a range of people.

Efforts are required to:

- ensure interventions are provided to those who request it by resourcing current AOD service providers in the community appropriately.
- provide training for professionals involved in cannabis issues for staff and community
- continue to provide cannabis cessation training opportunities to AOD service providers, health staff and community members
- reduce the harm associated with introducing people – especially youth – to the criminal justice system
- Youth programs as alternatives to drug use

Treatment

In general it is not appropriate to develop cannabis specific services. In line with best practice, an integrated treatment service is better able to provide for the whole community, rather then drug specific services.

Possible options include:

- Provide further resourcing to current AOD/mental health services to treat those affected by drug use and provide support to families.

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