Alcohol and Drug Foundation

Alcohol and Drug Foundation Submission

Inquiry into the Use of Cannabis in Victoria

Founded in 1959, the Alcohol and Drug Foundation (ADF) has contributed 60 years of continuous service to communities across Australia. Our focus is on prevention and early intervention and our strategies include community action, health promotion, education, information, policy, advocacy, and research.

The Alcohol and Drug Foundation is pleased to make this submission to the Inquiry into the Use of Cannabis in Victoria.

Summary of Recommendations

1. Recommendation: That the Committee support the retention of criminal penalties for the supply of cannabis by adults to minors.

2. Recommendation: That the Committee note that punishing young people for cannabis use risks being counterproductive.

3. Recommendation: That the Committee focus on addressing the social determinants as risk factors for AOD harms and the critical role of prevention in reducing the harms associated with cannabis use and other AOD harms.

4. Recommendation: That in relation to cannabis harms, the Committee recognise the value of investing in evidence-based community prevention programs such as Good Sports and Local Drug Action Teams.

5. Recommendation: That any changes to cannabis laws be accompanied by public information campaigns aimed at: i) awareness raising on the risks of taking non prescribed cannabis for medical purposes and; ii) the risks associated with driving while affected by cannabis.

6. Recommendation: That the Committee recommend work to ensure Victorian drug information services are adequately meeting needs of Victorians across the continuum of use (from early use to misuse to dependency) through robust evaluation.

Level 12
607 Bourke Street
Melbourne VIC 3000

PO Box 818
North Melbourne
VIC 3051
-
T 03 9611 6100
F 03 8672 5983
adf@adf.org.au
adf.org.au ABN 66 057 731 192

7. Recommendation: That the Victorian government's approach to cannabis drug law reform be informed by developments pertaining to the New Zealand Government's Cannabis Legalisation and Control Bill and learnings from the Canadian model.

8. Recommendation: That the Committee recommend formal steps are taken to ensure evidence-based alcohol and drug programs are included in the Victorian Education curriculum.

9. Recommendation: That the Committee recommend a formal evidence-based investigation of the merits of further decriminalisation of illicit drugs, including specific reference to the Portugal model.

10. Recommendation: That the Committee recommend that Drug and Alcohol Courts continue to be expanded.

11. Recommendation: That the Committee recommend a coordinated approach to assessing the impact of cannabis use in Victoria through the sharing of data collected by AOD services, mental health providers, police and hospitals.

12. Recommendation: That the Committee propose funding to pilot evidence-based models from international jurisdictions, such as Planet Youth.

Response to Terms of Reference

a. Prevent young people and children from accessing and using cannabis in Victoria;

A Canadian study published in 2018 confirmed that cannabis use is related to impaired and lasting effects on adolescent cognitive development. The research team followed a sample of 3,826 Canadian adolescents over a period of four years. "Of particular concern was the finding that cannabis use was associated with lasting effects on a measure of inhibitory control, which is a risk factor for other addictive behaviours, and might explain why early onset cannabis use is a risk factor for other addictions. Some of these effects are even more pronounced when consumption begins earlier in adolescence."[i] People who begin use of cannabis in adolescence face higher risks of serious effects including cannabis dependence, impaired educational attainment and an increased risk of mental health problems. [ii] [iii]. Much of the evidence about adverse consequences originates in studies of young adults who initiated daily cannabis use in adolescence and continued to use regularly throughout young adulthood, the period with the highest risk of developing psychotic disorders. [iv]

The evidence is clear that a key focus in reducing cannabis related harms needs to be on preventing the uptake and delays in uptake in children and young people.

Supply

Supply reduction, such as legislation and law enforcement, is one of three pillars of the Harm Minimisation approach used by federal and state Australian governments since the mid-1980s. Under the Victorian Drugs, Poisons and Controlled Substances Act 1981, trafficking in a drug of dependence to a child and supply of drug of dependence to a child are illegal, punishable by jail and fines. This appears reasonable. Young people (particularly adolescents) are susceptible to permanent damage from alcohol and other drug use as their brains are still developing, which makes them a vulnerable population."[v]

Most national illicit drug seizures (52.4%), and most arrests (48.8%), are for cannabis. There were 72,381 national cannabis arrests in 2017–18, with the number of national cannabis arrests increasing 30% over the previous decade. The number and weight of national cannabis seizures have also increased over the decade. The number of seizures increased from 46,875 in 2008–09 to 59,139 in 2017–18 and the weight of seizures increased from 5,573 kilograms in 2008–09 to 8,655 kilograms in 2017–18. However, despite this, access to cannabis remains relatively easy in Australia.[vi]

Cannabis is the most used illicit substance among secondary students, according to the 2017 Australian Secondary Students' Alcohol and Drug Survey (ASSAD). Among the 14% of students who had used cannabis in the past year, 30% of males and 37% of females had used cannabis once or twice, while 38% of males and 29% of females had used it on 10 or more occasions (regular use). Regular use tended to be more common among older than younger students (10% of 12-year old's; 37% of 17-year old's), and among male rather than female students (from age 13). The Australian

Child and Adolescent Survey of Mental Health and Wellbeing showed that in 2013–14, 45% of young people with major depressive disorder had used cannabis or other drugs.[vii]

According to the National Drug Strategy Household Survey 2019, the median age of people who used cannabis was 26 years of age in 2001 and increased to 31 years of age in 2019. People in their 20s continued to be the most likely to use cannabis although the rate of use is declining —from 29% in 2001 to 24% in 2019. Overall, lifetime and recent use of cannabis increased between 2016 and 2019, driven largely by older people. Recent use among those aged 50–59 and 60 and over is at the highest level since 2001. These age groups were also the most likely to use cannabis regularly, with almost half using it once a week or more.[viii]

While cannabis use should be discouraged due to its associated risks and harms, careful consideration is required to ensure the appropriate response in the management of this issue. Some responses, in addition to failing to reduce or decrease cannabis use, can result in greater and lasting harm being cause, in addition to the harms caused by drug use. These responses should be based on the evidence around what works in addressing and reducing harm to individuals, families and communities. As an example, a criminal record and incarceration can do long-term damage to an individual's long-term prospects and militate successful integration with society. [ix]

Protective factors and social determinants

Prevention plays a critical role in reducing the risk factors associated with problematic cannabis use. Prevention also plays a key role in targeting and strengthening personal and community protective factors to keep people healthy and well. These approaches focus on promoting and improving positive mental, social and physical health outcomes.[x] The evidence base highlights a range of factors that prevent AOD harms in young people including: I) assisting young people maintaining positive relations with parents and other family members; ii) enjoying school, completing school or leaving to take up employment pathways; iii) having firm attachment to adult role models outside the home such as teachers, sporting coaches and/or youth leaders; iv) developing future-oriented recreational pursuits; and v) living in communities with lower levels of drug use.

The evidence also demonstrates the role of risk factors that predispose individuals to issues and harms related to AOD use. Notably the risk factors that promote alcohol and drug problems are strongly correlated to risk factors that dispose young people to offending. A systematic approach to addressing risk factors aligned to the "social determinants of health" are linked to the reduction of drug related harms and problems. Moreover, it also leads to improved overall health for individuals and communities. This reflects the understanding that the drivers of drug use are the confluence of the personal characteristics and attributes of the individual, the nature and properties of the substances consumed, and the environment and culture which creates norms and expectations of substance use. [xi] These include family conflict, peer influence, mental health problems, early and excessive alcohol and other drug use. Conversely by strengthening the personal and social protective factors the likelihood that people will engage in problematic drug use and antisocial and criminal behaviour is lowered.[xii]

Good Sports

International research has shown that regular participation in community sports clubs reduces adolescent use of alcohol and other drugs[xiii] in addition to a broad range of positive protective effects to physical and mental health. Specifically, there is a link between the risk and protective factors that influence adolescent drug use and adolescent antisocial behaviour. Drug use is a precipitating factor in antisocial behavior and participation in community sport reduces offending behaviour.

The Good Sports program is Australia's largest preventative health initiative in community sport and is adopted in more than 10,000 clubs nationally. Managed by the Alcohol and Drug Foundation, Good Sports is a three tier accreditation program which offers sporting clubs free tools, resources and practical support to implement policies for reducing and controlling the use of alcohol, educating their members about illicit drugs, and promoting healthy behaviour generally. Good Sports clubs are also supported to address illegal drug issues through the GS Tackling Illegal Drugs program by employing evidence-based practices and policies to prevent drug use and to manage incidents should they occur. In addition to reducing harmful drinking and rejecting illegal drug use, Good Sports clubs facilitate social bonding and engagement as well governed cubs attract and keep members. In many small towns across Australia, the local sports club is the social glue that maintains relationships and identity and protects the wellbeing of the whole community.

Local Drug Action Teams

The National Ice Taskforce Report (2015) emphasized the importance of providing support to local communities to respond to 'Ice' and develop solutions tailored to their local needs. Recommendation 2 of the Taskforce Report stated (p.vi) "The Commonwealth, state and territory government should provide additional funding to communities to empower them to develop locally-based solutions to ice and other illicit drug issues."[xiv] The Local Drug Action Team program (LDAT) was created under the subsequent National Ice Action Strategy to facilitate community action on 'Ice' and it is managed by the Alcohol and Drug Foundation (ADF) which ensures their work is informed by evidence and is regularly monitored and reviewed. The LDAT program is an evidence based program that has drawn upon the methodologies of proven community led prevention programs including the Midwest Prevention Program, Project Northland, COMPARI, Communities that Care and Planet Youth and tailored them to meet the local communities needs of the diverse range of Australian communities.

The program enables community organisations to form partnerships in their local area and implement activities that are proven in the evidence to prevent harms from AOD, including harms associated with 'Ice'. Community groups that form local consortia have been progressively accepted into the program over four rounds of applications since 2017. LDATs undertake a community needs assessment relating to AOD before receiving an initial grant of $10,000 and developing their Community Action Plan (CAP) which outlines the evidence-based activities they will use to address alcohol and other drug issues. Activities delivered by LDATs focus on reducing risk factors and strengthening protective factors such as connection to community, school, local sport and recreational clubs; creating a sense of belonging; development of skills and employment

opportunities and building resilience in individuals and communities. Activities are evaluated to ensure positive outcomes. These risk and protective factors are also strongly correlated with positive mental health so is likely to have a broad range of positive outcomes, in addition to the prevention of AOD related harms.

Specific initiatives and programs include peer support, mentoring, education in schools, supporting teenagers and parents. Priority is given to projects that: focus on preventing alcohol and drug-related problems before they occur; are community-driven, are sustainable, have strong community consultation and engagement; demonstrate collaboration and partnerships with local community partners. These approaches have been proven in the evidence as effective and supportive and responsive to local need through the use of local data and partnerships.

Recommendation: That the Committee support the retention of criminal penalties for the supply of cannabis by adults to minors.

Recommendation: That the Committee note that punishing young people for cannabis use risks being counterproductive and can result in further harms.

Recommendation: That the committee focus on the important role of community based primary prevention in preventing and reducing the harms associated with cannabis use.

Recommendation: That in relation to cannabis harms, the Committee recognise the value of investing in evidence-based community prevention programs such as Good Sports and Local Drug Action Teams.

b. Protect public health and public safety in relation to the use of cannabis in Victoria;

As States consider cannabis law reform, it is important that to consider potential outcomes such as access to unprescribed medicinal cannabis, drug driving, road traffic accidents, access to treatment and support for cannabis dependency. These matters need to be considered in the interests of public health and safety, supported by appropriate education, information and access to treatment. The referendum on the New Zealand Government's Cannabis Legalisation and Control Bill, which puts regulation in place to minimise the social and health harms of cannabis, should be used to inform approaches in Australia.[xv]

Medicinal cannabis

Unlike pharmaceutical cannabis, which is a standardised and regulated product, unregulated domestic cannabis has an unknown and potentially unstable content of cannabinoids and other active constituents. Unregulated cannabis and its products may be contaminated due to the

presence of metals in the soil or air, or due to adulterants and moulds from inadequate air circulation and drying, or from the residue of chemicals used to fertilise plants and protect them from pests. [xvi]

Despite the availability of cannabis for medical purposes in many countries, including Australia, the evidence and the physicians are not united on the efficacy of its use in certain conditions for which it is prescribed.[xvii] This is due to the lack of scientific knowledge of the full effects of the cannabinoids found in the cannabis plant, including interactions between them and differing views on the appropriate use of cannabinoids.

The ADF believes people deserve the most effective therapeutic treatments for managing illness. Furthermore, the ADF believes that the prescription of cannabinoids should be guided by the evidence and is ultimately a matter for the medical profession which has the knowledge, expertise and experience required to make the appropriate therapeutic judgment and to monitor the effect of treatment. The difficulty in lay people determining their need for medicinal cannabis requires self-diagnosis which may lead to potential error and harmful outcomes. A self-diagnosis can be based on a confusion of symptoms and causes, cause delay in seeking and gaining effective care and result in unanticipated side effects.[xix] And the self-administration of psychoactive drugs with inadequete regulation, controls and quality assurance processes could pose significant risks and unintended consequences.

A study of medical marijuana in 50 cities across California found the experience of cannabis-related harm rose as the population gained physical access to an official source of cannabis via medical marijuana dispensaries.[xx] Studies in multiple states report strong associations between ease of access to medical cannabis and higher levels of non-medical use by adolescents, with rates of past year cannabis use and cannabis dependence almost double for young people in states that have legal medical cannabis compared to states without legal medical cannabis.[xxi] These studies indicate young people gain increased access to cannabis when a legal supply becomes available.

Recreational use

Efforts to prevent and reduce alcohol and other drug related harms often aim to reduce harms by seeking to reduce number of people progressing to the problematic use of substances (or dependence). They include increasing an understanding of AOD including awareness of the potential harms; signs of early dependency; and where to go to get help. This increased awareness of risky consumption will be able to reduce the risk of dependence through behaviour change and the initiation of earlier help seeking behaviours. And yet, only 29% of the general public seek information on alcohol and/or drug use.[xxii] Early intervention approaches are key in reducing the risk of dependence and associated harms by ensuring at-risk populations get the information at the right time

People seek information in various ways and have different information needs depending on where and how they access information and support. And whether they are seeking assistance for themselves or for others. Information resources and services must consider these aspects and be

evidence based. Moreover, it must be accessible to a range of different populations through the use of simple, everyday language and available in different formats; this can help to reduce the barriers to access and may greatly help to increase knowledge about AOD harms.

In addition to the provision of robust information and support, careful consideration must be given to the role of stigma. Stigma is a major barrier to seeking help. Effective efforts to encourage and normalise early help seeking behaviour and the use non stigmatising language and images is important. Given the stigmatising nature of the topic, anonymous channels are very important in supporting help seeking behaviours. Live chat is growing in popularity as it provides instant anonymised access to information.

Unfortunately, much of the information that Australians access is not through reliable sources. They can often be sensationalised and are not based on appropriate evidence around what works. Furthermore, Australians access this information via a fragmented and confusing system which undermines the likelihood individuals will seek reliable, accessible and non-judgmental information and support. For example, information often relates to a single drug despite drug use typically involving several substances. Websites provide conflicting information, and sensationalism from the media acts to reinforce stigma and exacerbate fear, confusion and uncertainty.

Current information services are predominantly offered via state-based services and often focused on crisis or with significant dependencies at which point it is much harder and too late to reduce related harms. These services are not typically used by people seeking general information in earlier stages of use. For instance, groups such as parents of children experimenting with AOD, young adults initiating use, and health professionals seeking the latest evidence, have few reliable and useful sources from which to seek valid information. Stigma also reduces the likelihood that these services targeted at those in crisis will be used.

Further, currently available information services are not well targeted. They do not adequately reflect demographic characteristics, type of drug use or an individual's relative position on the continuum of use. Digital innovations exist in some areas but are poorly used and often fail to point people in the right direction to receive appropriate support or fail to provide urgent responses when they are required.

Drug driving

The ACT commenced Australia's most progressive cannabis legal regime on January 31 2020. It remains illegal to drive with any cannabis in your system, as well as to smoke or consume cannabis in a public place.[xxiii] In Victoria in 2016, 41 drivers killed on the roads had drugs in their system, compared with 26 drivers who died behind the wheel with a BAC over 0.05. Public information campaigns have a role to play in educating the public about the impacts of cannabis on driving [xxiv]

Random roadside saliva tests can detect THC (the active ingredient in cannabis) for around twelve hours after use for people who use cannabis infrequently or 'recreationally'. However, for people

who frequently use cannabis THC can be detectable for around 30 hours. It is important for people who use cannabis frequently to know that THC can be detected in urine samples for around a month after cannabis was last used – this is because the body stores THC in fat cells for a period of time.

A contentious aspect of drug driving laws vis-à-vis drink driving laws is that the former is based on "any concentration of the drug present in the blood or oral fluid of that person", while drink driving laws are based on an impairment threshold. A Victorian parliamentary inquiry noted "insufficient evidence to support a causal relationship between specific concentration levels, particularly low levels, of illicit substances and driving impairment" and recommended investigation of "the current drug driving laws and procedures to determine their effect on road crashes and as a deterrent strategy".[xxv]

Canada

Canada has legalised the recreational use of cannabis. Canadians over 19 years old (18 in Alberta and Québec) are now allowed to carry 30 grams of cannabis in public, share (not sell) up to 30 grams with other adults and grow four cannabis plants per household (regardless of the number of occupants). The Cannabis Act, however, prohibit a range of activities in the interests of public health; namely:

- making concentrates is prohibited (using a solvent like butane to manufacture wax, budder, shatter, etc.)
- it's illegal for cannabis companies to sponsor people, events and facilities
- packaging is regulated
- promotion is restricted and limited to places where under 19s are not permitted.

Recommendation: That there is a focus on prevention and early intervention for drug dependency through the promotion of information and support that focusses on early intervention (identification of warning signs).

Recommendation: That any changes to cannabis laws be accompanied by public information campaigns aimed at: i) awareness raising on the risks of taking non prescribed cannabis for medical purposes; and ii) the risks associated with drug driving.

Recommendation: That the Committee recommend work to ensure Victorian drug information services are adequately meeting needs of Victorians across the continuum of use (from early use to misuse to dependency) through robust evaluation.

Recommendation: That the Victorian government's approach to cannabis drug law reform be informed by developments pertaining to the New Zealand Government's Cannabis Legalisation and Control Bill and learnings from the Canadian model.

c. Implement health education campaigns and programs to ensure children and young people are aware of the dangers of drug use, in particular, cannabis use;

The prevention of alcohol and drug harms for young people is strongly tied to schools. Education and programs that aim to promote protective factors and reduce risk factors for young people typically occur through educational, health promotion and pastoral care programs. There are several evidence-based drug education programs, detailed below, which provide accurate information about drugs, focuses on social norms, and takes an interactive approach which assists students in the development of interpersonal skills. A Cochrane Review found the most effective programs focus on teaching social and coping skills and comprise of between 10–20 sessions. [xxvi]

Efforts to support the inclusion of evidence based alcohol and drug education programs in the curriculum are important as is the exclusion of non-evidence based programs as the evidence has highlighted some programs have unintended consequences including increased drug use.[xxvii] Programs that simply provide information on drugs have no impact and presentations by ex-drug users may also be counterproductive.[xxix] Some Australian programs, the School Health and Alcohol Harm Reduction Project and the CLIMATE alcohol and drug programs, have reported reductions in student drug use (alcohol, tobacco and cannabis) and related harms. [xxx] [xxxi]

Schools have access to these programs via the internet through the Positive Choices website that is funded by the Commonwealth government and coordinated by the National Drug and Alcohol Research Centre. Importantly the programs do not claim to eliminate drug use and students respond differently: some students moderate their drug use, some defer drug use, while other students do not change their behaviour and continue to use alcohol and other drugs.

Recommendation: That the Committee recommend formal steps are taken to ensure evidence-based alcohol and drug programs are included in the Victorian Education curriculum.

d. Prevent criminal activity relating to the illegal cannabis trade in Victoria;

Both Australian and international literature has highlighted the strong association between substance use and criminal activity. However, the nature of the relationship is widely debated with very little consensus on how crime and substance use influence each other. The evidence linking cannabis to crime is no exception.

Current data (up to end of March 2020) released by the Victorian Crime Statistics Agency records the number of cannabis dealing/trafficking offences and use/possession offences. Of 4884 total illicit dealing/trafficking offences over a 12-month period ending March 2020, only 825 related to cannabis (in comparison to 1809 related to methamphetamine). Cannabis use/possession offences during the same time frame number 9195 (with methamphetamine offences numbered 6547). [1]

[1] https://www.crimestatistics.vic.gov.au/crime-statistics/latest-crime-data/recorded-offences

In reviewing the data around Australians who encounter the criminal justice system, cannabis remains the most widely used and most detected drug. Young people who are caught in criminal activity associated with cannabis and go on to spend time in custody, continue to use cannabis at high rates despite any legal action. Law enforcement in the management of cannabis and prevention of harms is ineffective.

More research is required that specifically focusses on the role of social factors and the environment on initiation to cannabis use; first involvement in crime; and the bi-directional relationship between the two.

Drug Law Reform

Support for drug law reform is driven by a body of evidence that identifies growing human and financial costs of an endless 'war on drugs'. In 2008, the United Nations Office on Drugs and Crime (UNODC) stated illicit drug prohibition has many unintended negative consequences:

- The creation of a black market that provides criminals with substantial revenue.
- "Policy displacement" where resources are directed from health services to law enforcement.
- "balloon effect" where drug production, transit and supply shifts from place to place under pressure from law enforcement efforts but continues to supply a constant demand for drugs.
- "Substance displacement" where enforcement measures on one drug results in consumption of other substances.
- Stigmatisation of drug use which prevents people in need from accessing treatment and support.

<u>Decriminalisation</u>

The main argument for reform of Australian drug laws in general, and decriminalisation in particular, is the intractability of illicit drug use. Half a century of concerted action to prevent use of illicit substances has not succeeded in preventing drug use and there is no prospect that it will; secondly most drug related arrests are related to the minor offences of personal possession and/or use. Decriminalisation of drugs is a policy option that has been adopted to reduce harms related to drug use under the policy of prohibition. Typically, under drug decriminalisation the production, manufacture, distribution, sale and purchase of drug/s remain outside the law and the producers and distributors continue to face criminal penalties, including incarceration; however, people who (merely) consume the drug/s are not charged or convicted of a criminal offence. Instead they face civil administrative penalties or sanctions.

The major harm that decriminalisation prevents is the criminal convictions acquired by people who are found guilty of personal possession and use of drugs. Conviction disrupts lives seriously, including closing off career, employment and travel options and causing problems with personal relationships.[xxxiii] Drug decriminalisation prevents those harms and collateral benefits include putting people who use drugs in touch with health and welfare services and lessening the stigma on illicit drug use that can prevent people from seeking help. Another benefit is the reduction of pressure

on the law enforcement, judicial and correctional systems as fewer people are subject to processing. This enables police to better focus on the large-scale suppliers of illegal drugs.

Although decriminalisation represents a more liberal approach to drug policy, the fear that it will encourage drug use and worsen the drug problem appears to be unfounded. After assessing drug policy regimes across the world the UK Home Office reported there was no obvious relationship between levels of drug use in a country and the strictness of its drug laws[xxxv]. Similarly, a review of the South Australian decriminalisation of cannabis possession reported that none of the studies 'found an increase in cannabis use in the South Australian community which is attributable to the introduction of the Cannabis Expiation Notice scheme'.

Drug courts operate in New South Wales, Victoria, Western Australia and South Australia. They are a form of diversion from the criminal justice system for offenders whose criminal behaviour was triggered by or related to drug dependence and who would otherwise be sentenced to a term in prison. The rationale for the work of drug courts is the view that substance dependence is a chronic, relapsing health disorder rather than a moral or behavioural issue and that the prospect of avoiding a term of imprisonment may motivate a substance dependent offender to make a commitment to drug treatment in lieu of incarceration. Referral to a drug court is reserved for people who are considered high risk for continued offending due to their use of alcohol and/or other substances. Drug courts are often described as drawing on the "therapeutic jurisprudence" model in which the law is utilised as a therapeutic agent to improve the health and wellbeing of those who are affected by the law and in need of such help.[xxxvii]

Evaluations of drug courts in Victoria and New South Wales provide evidence that the Drug Court system is an effective alternative to imprisonment.[xxxviii] [xxxix] [xl]Those reports indicate that Drug Courts are meeting their aims of reducing recidivism, reducing AOD use, increasing full-time employment, and reducing unemployment among participants. A report by KPMG found a 31 per cent lower rate of reoffending in the first 12 months, and a 34 per cent lower rate of reoffending within 24 months for offenders.[xli] Another study found participants were significantly less likely to commit any further offence.[xlii] A review in 2006 found that full-time employment among participants doubled upon the completion of the program and unemployment lessened by 32 per cent. The structure of the program means that offenders are not separated from society and the period of readjustment upon completion is less onerous than the consequent readjustment necessitated by imprisonment.[xliv]

There is no single model for the decriminalisation of drugs, although the example of Portugal has attracted much attention. Portugal decriminalised drugs from 2001 so that while the production, manufacture and large-scale distribution of illicit drugs remains a criminal offence, their possession and use is treated as an administrative matter[xlv]. The Portugal system aims to divert people who use drugs from that path and to provide those whose use is problematic with an early pathway to treatment. Individuals found in possession of a small volume or 'personal supply' of an illicit drug or found to have consumed a drug, are referred to a tribunal known as the Commission for the Dissuasion of Drug Addiction. The Commission's role is to make an assessment of the meaning of the drug use for each individual who is referred to it: drug dependent people can be referred to drug

treatment services, while those who are unimpaired by drug use are offered other options: these include having the proceedings suspended, being required to attend a police station, being referred for psychological or educational intervention, or paying a fine[xlvi]. The intent of this system is to emphasise the therapeutic response to a drug problem rather than punishment and to avoid stigmatising the individual.

While drug use rose in some adult cohorts after 2001 it has declined in recent years to levels below 2001.[xlvii] Moreover a 2017 study suggested drug use in Portugal has fallen lower than the European average, including drug use among secondary school students. One clear benefit was the decline in criminal drug offences in Portugal from around 14000 per annum in 2000 to around 5500 and the proportion of people incarcerated for low level drug offences fell from 44 per cent in 1999 to 24 per cent in 2013[xlix]. Decriminalisation should not be considered an inexpensive drug policy option, despite a claim that Portugal achieved social cost savings in the first years due to savings in the health and legal systems, and improved employment and productivity from reducing the prison population[l]. The Portugal model is based on the notion of transferring people with problematic drug use into drug treatment and processing other consumers of drugs through administrative or education programs. For Australian jurisdictions to adopt drug decriminalisation similar to Portugal would require a substantial investment in the various legal, health and education services necessary for the new system.

Legalization

Upon passage of Canada's Cannabis Act, which legalized recreational cannabis, the Prime Minister said it would "keep the money out of the pockets of organised crime". More cannabis users reported obtaining cannabis from legal sources in the second and third quarters of 2019 (53%) compared with corresponding estimates from the same period in 2018 (23%), when non-medical cannabis was not yet legal. The percentages of consumers reporting only obtaining cannabis legally also rose, to 28% from 10% one year earlier. Examples of legal sources of cannabis include authorized retailers and online licensed producers. In contrast, fewer users reported obtaining cannabis from illegal sources such as a dealer in 2019 (42%) than in 2018 (52%), or from friends and family (39% in 2019 versus 49% in 2018). From mid-August to mid-September, nearly 5.2 million or 17% of Canadians aged 15 and older reported using cannabis in the previous three months. This was unchanged from one year earlier (before legalization). Despite stability in the national rates, cannabis use did increase in the third quarter of 2019 compared with the third quarter of 2018, in some age groups and regions, including seniors and among persons aged 25 to 44 years of age.[li]

Some parts of the United States have legalised recreational use of cannabis. One study found that "that although marijuana legalization advanced social justice goals", there was a small increase in risk for Cannabis Use Disorder (CUD) among respondents aged 12 to 17 years and increased frequent use and CUD among adults 26 years or older. "To undertake prevention efforts, further studies are warranted to assess how these increases occur and to identify subpopulations that may be especially vulnerable."[lii]

Recommendation: That the Committee recommend a formal investigation of the merits of further decriminalisation of illicit drugs, based on the evidence including specific reference to the Portugal model.

Recommendation: That the Committee recommend that Drug and Alcohol Courts continue to be expanded.

e. Assess the health, mental health, and social impacts of cannabis use on people who use cannabis, their families and carers;

The short term and long-term effects of cannabis have been widely studied. Short term effects include intoxication marked by disturbances in the level of consciousness, cognition, perception and behaviour. Acute use of cannabis impairs driving and contributes to an increased risk of traffic injuries. Long term, dependence is possible, increased risk of other mental and physical health and social issues including an increased risk of myocardial infarction. There is growing evidence that heavy use during adolescence is associated with more severe and persistent negative outcomes.[2]

The short term and long-term effects of cannabis have been widely studied. Short term effects include intoxication marked by disturbances in the level of consciousness, cognition, perception and behaviour. Acute use of cannabis impairs driving and contributes to an increased risk of traffic injuries. Long term, dependence is possible, increased risk of other mental and physical health and social issues including an increased risk of myocardial infarction. There is growing evidence that heavy use during adolescence is associated with more severe and persistent negative outcomes.[3] There is no evidence to suggest that changes to cannabis legislation that removes the criminality of minor offences will lead to an increased incidence of health-related harms. The recently released National Household Drug Strategy Survey found that 78% of those surveyed said they would not use cannabis even if it were legal and only 3% said their use would increase. [4] It is, however, important to acknowledge that cannabis use is not without risk and that a number of health, mental health and social impacts correlate with heavy cannabis use.

There is no evidence to suggest that changes to cannabis legislation that removes the criminality of minor offences will lead to an increased incidence of health-related harms. The recently released National Household Drug Strategy Survey found that 78% of those surveyed said they would not use cannabis even if it were legal and only 3% said their use would increase. [5] It is, however, important

[2] https://www.who.int/substance_abuse/publications/cannabis_report/en/index11.html

[4] Australian Institute of Health and Welfare 2020. National Drug Strategy Household Survey 2019. Drug Statistics series no. 32. PHE 270. Canberra AIHW.

to acknowledge that cannabis use is not without risk and that a number of health, mental health and social impacts correlate with heavy cannabis use.

It must be noted that cannabis is a psychoactive substance that affects people in different ways according to how much is used, how strong it is, how it is ingested (smoked, edibles, vaped etc), how a person is feeling, the environment, where it is sourced from and if it is mixed with other substances.

Regular prolonged use may cause dependence, withdrawal symptoms, anxiety, and depression. Studies have consistently shown a relationship between heavy or repeated cannabis use and experiences of psychosis, in particular in adolescent use.[6] There is a dose-response relationship with those who consume large amounts of cannabis. Heavy, consistent cannabis user are four times more likely to develop schizophrenia than non-users and 'average' cannabis users around twice as likely as a non-user to develop a psychotic disorder.[7] People who have experienced childhood trauma, or have paranoid personality type and carry a certain gene variant appear also at increased risk of cannabis induced psychosis. Further, adolescents who use cannabis, whose brains are still growing and developing, are also at increased risk.[8]

It is therefore important to develop harm reduction measures that seek to reduce heavy and risky use of cannabis among young people. This is particularly pertinent noting that cannabis was the most common principle drug of concern (58%) for clients aged 10 – 19 years accessing treatment in Victoria in 2018-19.[9] A further consideration relates to regionality. Victoria Crime data has consistently seen a higher rate of cannabis offences in both regional and rural Victoria compared to metropolitan Melbourne for much of the past ten years. Understanding trends such as this is essential when looking to reduce harm and understand where to focus research and policy interventions.

Regular prolonged use may cause dependence, withdrawal symptoms, anxiety, and depression. Studies have consistently shown a relationship between heavy or repeated cannabis use and experiences of psychosis, in particular in adolescent use.[10] There is a dose-response relationship with those who consume large amounts of cannabis. Heavy, consistent cannabis user are four times more likely to develop schizophrenia than non-users and 'average' cannabis users around twice as likely as a non-user to develop a psychotic disorder.[11] People who have experienced childhood

[6] Mustonen A, Nielma S, Nordstrom, T, et al Adolescent cannabis use, baseline prodromal symptoms and the risk of psychosis. *Br J Psychiatry.* 2018;212(4):227-233.
[7] Marconi A, Di Forti M, Lewis CM, Murray RM, Vassos E. Meta-analysis of the Association between the level of cannabis use and risk of psychosis. *Schizophrenia Bulletin,* Volume 42, Issue 5, September 2016, Pages 1262-1269.
[8] Colizzi M, Murray R. Cannabis and psychosis: what do we know and what should we do? *Br J Psychiatry.* 2018;212(4):195-196
[9] Australian Institute of Health and Welfare 2020. Alcohol and other drug treatment services in Australia: 2018-19. Drug treatment series no. 34. Cat. No. HSE 243. Canberra: AIHW

trauma, or have paranoid personality type and carry a certain gene variant appear also at increased risk of cannabis induced psychosis. Further, adolescents who use cannabis, whose brains are still growing and developing, are also at increased risk.[12] It is therefore important to develop harm reduction measures that seek to reduce heavy and risky use of cannabis among young people. This is particularly pertinent noting that cannabis was the most common principle drug of concern (58%) for clients aged 10 – 19 years accessing treatment in Victoria in 2018-19.[13] A further consideration relates to regionality. Victoria Crime data has consistently seen a higher rate of cannabis offences in both regional and rural Victoria compared to metropolitan Melbourne for much of the past ten years. Understanding trends such as this is essential when looking to reduce harm and understand where to focus research and policy interventions.

It is important to note that while recognising the distinct mental health links, that most research looking into the link between psychosis and cannabis examined use of illicit cannabis. Usually from unknown sources and with unknown chemistry and unknown levels of THC (psychoactive cannabinoid found in plant). Further, research does not always differentiate when organic or plant-based cannabis is used as the most common type versus synthetic cannabis with its range of adulterants and often higher levels of THC. This is significant to address when looking at policy levers to reduce harm as unknown strength, adulterants and other residues in an unregulated product can undoubtedly contribute to harms. A regulated market may offer an opportunity to standardize formulations and produce a product with negligible effects on psychosis risk.

The 2019 Global Drug Survey (55,000 respondents) evaluated 6 cannabis health information labels addressing risk of dependence, smoking harms, effects on those aged 21 years and under, driving risk, and the impact on memory and motivation. One quarter of the respondents indicated that risk of dependence and risk of cannabis smoke was new information for them; 50% reported that messaging about risk of “driving when stoned” would make them think about not driving and over one third said labels highlighting impact on memory and motivation would make them think about using less. [14]

The absolute risk of adverse chronic health outcomes, including dependence, withdrawal symptoms and the early onset of and/or exacerbation of pre-existing psychotic symptoms is low with most people who use cannabis unlikely to sustain long term / chronic harm. Short term effects however can and do present risks to the safety of users and others due to the impairment on cognitive and perceptual functioning however these risks can be further mitigated by ensuring an emphasis on best practice education and information campaigns. This would seem to be prudent to any policy / law change to ensure that people are aware of the potential impact and understand risk and harm minimisation information – including but not limited to risk of traffic crashes, workplace injuries, social impact on family, secondary harms such as passive smoke and impact of stigma.

[14] https://www.globaldrugsurvey.com/wp-content/themes/globaldrugsurvey/results/GDS2019-Exec-Summary.pdf

In 2018-19, for clients in Victoria receiving treatment episodes for their own alcohol or drug use cannabis was the principal drug of concern for 18% and a further 14% of clients named cannabis as an additional drug of concern. [15] Cannabis is the most commonly used illicit drug in Victoria with one survey reporting 11.7% of the population aged over 14 years having recently used (previous 12 months).[16] Among this 11.7%, 9.3% were aged 14 – 17 years and 27.8% aged 18 – 24 years. Given the risk of developing cannabis use disorder increases with early age of initiation, this gives further weight to the need to develop effective, and targeted education and health promotion messaging to this group and to parents and guardians of minors.

In 2018-19, for clients in Victoria receiving treatment episodes for their own alcohol or drug use cannabis was the principal drug of concern for 18% and a further 14% of clients named cannabis as an additional drug of concern. [17] Cannabis is the most commonly used illicit drug in Victoria with one survey reporting 11.7% of the population aged over 14 years having recently used (previous 12 months).[18] Among this 11.7%, 9.3% were aged 14 – 17 years and 27.8% aged 18 – 24 years. Given the risk of developing cannabis use disorder increases with early age of initiation, this gives further weight to the need to develop effective, and targeted education and health promotion messaging to this group and to parents and guardians of minors.

Individual risk factors for cannabis use include sex (more male than female), personality trait, poor school performance, early school leaving, association with other peers who use drugs and parental conflict. These factors have been identified and consideration of these, and protective factors (positive parenting, engagement with school, involvement in extracurricular activities) are critical when addressing cannabis use in community.

Understanding any association between cannabis use and health outcomes is an essential part of determining how best to respond. It is important to acknowledge the bi-directional relationship of between illness and cannabis use. Cannabis can cause poor mental and physical health but can also be used to self-medicate from illness (including pain disorders, trauma, mental unwellness). These causal inferences are important to acknowledge in order to best respond to any health-based legislation changes or considerations.

15 Australian Institute of Health and Welfare 2020. Alcohol and other drug treatment services in Australia: 2018-19. Drug treatment series no. 34. Cat. No. HSE 243. Canberra: AIHW

16 Australian Institute of Health and Welfare 2020. National Drug Strategy Household Survey 2019. Drug Statistics series no. 32. PHE 270. Canberra AIHW.

Recommendation: That the Committee recommend a coordinated approach to assessing the impact of cannabis use in Victoria through the sharing of data collected by AOD services, mental health providers, police and hospitals.

f. And further requires the Committee to assess models from international jurisdictions that have been successful in achieving these outcomes and consider how they may be adapted for Victoria.

THE COMMUNITIES THAT CARE (CTC) PROGRAM

Research has demonstrated the CTC program has been effective in the prevention and minimization of AOD related harms. Research demonstrated that the CTC system run in the United States increased the probability of sustained abstinence from gateway drug use by 49%, reduced lifetime violence by 18% and reduction in antisocial behavior by 18%. In male participants, the CTC system also increased the likelihood of sustained abstinence from tobacco use by 30% and marijuana use by 24%, and reduced lifetime incidence of inhalant use by 18%. [liii] [liv]

In Victoria, the ADF has partnered with CTC on some LDAT projects. For example, the Colac Schools and Community Together Group (SACTG) in Victoria's Western District. The group developed a a community action plan that identified primary prevention strategies aimed at promoting healthy development of children and young people in four priority areas: 1. Improving Year 12 (or equivalent) completion rates; 2. Improving social, emotional and physical wellbeing; 3. Improving community understanding, attitudes and acceptance of the harms caused by alcohol and other drug use; and 4. Increasing community connectedness. There may be potential for CTC's to put greater emphasis on preventing cannabis related harms in Victoria.

THE MIDWEST PREVENTION PROGRAM AND PROJECT NORTHLAND

In the USA the Midwest Prevention Program and Project Northland are two examples of successful community led AOD prevention programs. Project Northland was conducted between 1991 and 1998 in six counties in Minnesota, a 'high risk' area for alcohol use. The project followed grade 6 students through to high school, and involved 3 years of social behavioural classroom curricula, parent involvement programs, peer leadership opportunities, media campaigns and community task forces around alcohol consumption and alcohol associated risky behaviour. Onset of alcohol was delayed in participating school districts for year 7 and year 8 cohorts as well as significant delays in the onset of tobacco and cannabis in students who were non-users of alcohol at baseline.[lv]

The Midwest Prevention Project combined coalition led community mobilisation strategies such as media advocacy and support for prevention strategies with school curricula to prevent tobacco, alcohol and cannabis use among grade 6 and 7 students.[lvi] [lvii] Results were recorded at one and three year follow ups. After one year, positive impacts on mediating factors such as attitudes, knowledge, skills and peer influence were demonstrated, as well as initiation and escalation of use of alcohol,

tobacco and cannabis. At the three year follow up, the program demonstrated efficacy in regard to escalation of use (recorded as recent use in 30 days) of tobacco and cannabis, but not alcohol [lviii] [lix]

PLANET YOUTH - THE ICELAND MODEL

The evidence has highlighted the value of a long term, broad, community-based prevention programs. The Planet Youth model from Iceland is clear example with strong outcomes demonstrated over the past two decades. This model combines community action with policy changes designed to promote factors that are proven in minimising adolescent substance use of all types. A sustained implementation of interlinked, community-based health promotion programs has contributed to an impressive reduction in adolescent use of tobacco, alcohol and cannabis [lx] while also resulting in improved relationships between parents and children, and the development of communities' social capital. [lxi] [lxii]

Iceland's Planet Youth primary prevention work builds a social environment that is high in protective factors and low in risk factors and facilitates positive behaviours. It reflects the understanding that major determinants of youthful drug use are peer involvement in drugs, the level of parental monitoring and supervision, and the strength of social capital in the local community. It is informed by research findings that protective factors for young people include involvement in sport and other forms of organised activities, time spent with parents during the week and strong linkages between parents, schools and other local agencies. Young people in Iceland are actively supported to participate in organised extracurricular and recreational activities, such as sport, artistic endeavors, hobbies, and in supervised work alongside a responsible adult. Parents in Iceland are encouraged to spend substantial time with their adolescent children, to provide emotional support and reasonable levels of monitoring, and to participate in school, social and community events.

The changes in Iceland's social environments were accompanied by legislative and regulatory changes that were designed to lessen access to substances by young people; these included bans on advertising of alcohol and tobacco products, national media campaigns that discouraged adolescent drinking and smoking, a school based anti-smoking campaign, warning labels on cigarette packets and the age of maturity was raised from 16 to 18 years. However, while drug use declined for Icelandic youth generally over the period, research that compared experimental and control communities found those communities with the interventions for adolescent participation in sport and for closer parental monitoring and supervision of young people saw greater reductions in drug use than did the control communities.[lxiii] The country has also seen reductions in bullying, juvenile crime and youth entering drug treatment.

This indicates the community action programs, designed, developed and led by the Icelandic Centre for Social Research and Analysis (ICSRA) were successful in lowering alcohol and drug use. Significantly, the community led intervention modelled by Planet Youth was also accompanied by dramatic declines in the anti-social behaviours of bullying and theft by tenth graders in Iceland during 1997-2016. It is evidence that drug prevention and crime prevention operate on the same adolescent risk and protective factors. Iceland's model takes advantage of its idiosyncratic demographic, political

and social features, but it also demonstrates that creation of positive social environments that reduce the likelihood of young people engaging in substance use is within the grasp of communities.

Recommendation: That the Committee consider propose funding to pilot evidence-based models from international jurisdictions, such as Planet Youth in Victoria.

[i] https://nouvelles.umontreal.ca/en/article/2018/10/03/teen-cannabis-use-is-not-without-risk-to-cognitive-development/
[ii] Hall W, D. L. (2009). Adverse health effects of non-medical cannabis use. The Lancet, 374: 1383-91., 374: 1383-91.
[iii] van Ours, J. C., & Willams, J. (2009). Cannabis use and mental health problems. Discussion Paper No. 2009-60. Tilberg: CentER, Tilburg University.
[iv] Degenhardt, L., Coffey, C., Carlin, J. B., Swift, W., Moore, E., & Patton, G. C. (2010). Outcomes of occasional cannabis use in adolescence: 10-year follow-up study in Victoria, Australia. The British Journal of Psychiatry, 196, 290–295.
[v] https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/young-people
[vi] https://www.aihw.gov.au/reports/phe/221/alcohol-tobacco-other-drugs-australia/contents/drug-types/cannabis?fbclid=IwAR3EiTlx5KTAp6c0Yk2PYlS1PaPZMFen1wLZ5EQRQGzHaTbLq5ZD7tvkWNg&fbclid=IwAR3EiTlx5KTAp6c0Yk2PYlS1PaPZMFen1wLZ5EQRQGzHaTbLq5ZD7tvkWNg
[vii] Lawrence D, Johnson S, Hafekost J, Boterhove de Haan K, Sawyer M, Ainley J & Zubrick SR 2015. The mental health of children and adolescents: Report on the secondary Australian Child and Adolescent Survey of Mental Health and Wellbeing. Canberra: Department of Health.
[viii] https://www.aihw.gov.au/getmedia/9569b88d-3326-46e2-8df8-bf88a93e2d22/aihw-phe-270-Chapter4-Illicit-drugs.pdf.aspx
[ix] https://www.parliament.vic.gov.au/file_uploads/LSIC_Inquiry_into_a_legislated_spent_convictions_scheme_X6gThHPf.pdf
[x] J. Hawkins, R. Catalano and J. Miller, “Risk and protective factors for alcohol and drug problems in adolescence and early adulthood: implications for substance abuse prevention,” Psychological Bulletin, vol. 112, no. 1, pp. 64-105, 1992.
[xi] L. Degenhardt, E. Stockings, G. Patton, W. D. Hall and M. Lynskey, “The increasing global health priority substance use in young people,” The Lancet Psychiatry, no. 3, pp. 251-264, 2016.
[xii] J. Hawkins, R. Catalano and J. Miller, “Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention,” Psychological Bulletin, vol. 112, no. 1, pp. 64-105, 1992.
[xiii] A. L. Kristjansson, J. E. James, J. P. Allegrante, D. Sigfusdottir and A. R. Helgason, “Adolescent substance use, parental monitoring, and leisure time activities: 12-year outcomes of primary prevention in Iceland,” Preventive Medicine, vol. 51, pp. 168-171, 2010.
[xiv] Commonwealth of Australia, Department of the Prime Minister, “Final Report of the National Ice Taskforce,” Commonwealth of Australia, 2016.
[xv] https://www.drugfoundation.org.nz/policy-and-advocacy/vote-yes/
[xvi] Belackova, V., Ritter, A., Shanahan, M., Chalmers, J., Hughes, C., Barret, M., & Lancaster, K. (2015). Medicinal cannabis in Australia- Framing the regulatory options. Sydney: Drug Policy Modelling Centre.
[xvii] Zolotov, Y., Vulfson, S., Zarhin, D., & Sznitman, S. (2018). Medical Cannabis: An oxymoron? Physicians' perception of medical cannabis. International Journal of Drug Policy, 57: 4-10.
[xviii] Martin, J., & Bonomo, Y. (2016). Medical cannabis in Australia - the missing link. 204(10)
[xix] Better Health. (2019). Health information and health products online. Retrieved March 18, 2019, from Better health: https://www.betterhealth.vic.gov.au/health/HealthyLiving/health-information-andhealth-products-online
[xx] Freisthler, B., & Gruenewald, P. J. (2014). Examining the relationship between the physical availability of medical marijuana and marijuana use across fifty California cities. 143, 244-250.
[xxi] Sobesky, M., & Gorgen, K. (2016). Cannabis and adolescents exploring the substance misuse treatment provider experience in acclimate of legalisation. 33.
[xxii] ADF Info Services Survey 2019, unpublished
[xxiii] https://www.act.gov.au/cannabis/home
[xxiv] https://www.tac.vic.gov.au/about-the-tac/media-room/news-and-events/2017/tac-drug-driving-campaign-hits-close-to-home#:~:text=Drug%20driving%20now%20outstrips%20drink,feeling%20of%20impairment%20has%20passed.

[xxv] https://www.parliament.vic.gov.au/images/stories/committees/lrrcsc/Drugs_/Report/LRRCSC_58-03_Full_Report_Text.pdf
[xxvi] F. Faggiano, F. D. Vignat-Taglianto and E. Versino, "School based prevention for illicit drugs," The Cochrane Database of Systematic Reviews, 2005.
[xxvii] S. Hopfer, D. David and J. A. Kam, "A Review of elementary school-based substance use prevention programs," J Drug Education, pp. 11-36, 2010.
[xxviii] F. Faggiano, F. D. Vignat-Taglianto and E. Versino, "School based prevention for illicit drugs," The Cochrane Database of Systematic Reviews, 2005.
[xxix] M. Ashton, "Boomerang Ads," Drug Alcohol Findings, 2005.
[xxx] McBride, N. McBride, F. Farrington, R. Midford, L. Meulners and M. Phillips, "Harm minimisation in school drug education: final results of the School Health and Alcohol Harm Reduction Project (SHAHRP)," Addiction, pp. 278-291, 2004.
[xxxi] M. Teeson, N. C. Newton and E. L. Barrett, "Australian school based prevention programs for alcohol and other drugs: A systematic review," Drug and Alcohol Review, pp. 731-736, 2012.
[xxxii] N. Lee, J. Cameron, S. Battams and A. Roche, "Alcohol education for Australian schools: What are the most effective programs?," National Centre for Education and Training in Addictions., Adelaide, 2014.
[xxxiii] D. Manderson, From Mr Sin to Mr Big, Oxford University Press, 1993.
[xxxiv] J. Buchanan, "Ending drug prohibition with a hangover?," British Journal of Community Justice, vol. 13, no. 01, pp. 55-74., 2015.
[xxxv] UK Home Office, "Drugs: International Comparators," UK Home Office, 2014
[xxxvi] Drug and Alcohol Services Council, "The impact of cannabis decriminalisation in Australia and the United States," DASC, Adelaide, 1999.
[xxxvii] C. Cappa, "The social, political and theoretical context of drug courts," Monash University Law Review, vol. 32, no. 1, pp. 145-176, 2006.
[xxxviii] S. Taplin, "The New South Wales Drug Court evaluation: a process evaluation.," NSW Bureau of Crime Statistics and Research, Sydney, 2002.
[xxxix] B. Lind, D. Weatherburn, S. Chen, M. Shanahan, E. Lancsar, M. Haas and R. De Abreu Lourenco, "New South Wales Drug Court Evaluation: Cost-effectiveness.," NSW Bureau of Crime Statistics and Research, Sydney, 2002.
[xl] Victorian Association of Alcohol and Drug Agencies, "Drug Courts in Victoria: Evidence & options," VAADA, Melbourne, 2013.
[xli] KPMG, "Evaluation of the Drug Court of Victoria, Final Report.," Magistrates Court of Victoria, Melbourne, 2014.
[xlii] D. Weatherburn, C. Jones, L. Snowball and J. Hua, "The NSW Drug Court: A re-evaluation of its effectiveness," NSW Bureau of Crime Statistics and Research, Sydney, 2008.
[xliii] Victorian Association of Alcohol and Drug Agencies, "Drug Courts in Victoria: Evidence & options," VAADA, Melbourne, 2013.
[xliv] K. Freeman, "New South Wales Drug Court evaluation: health, well-being and participant satisfaction," NSW Bureau of Crime Statistics and Research, Sydney, 2002.
[xlv] C. Hughes and A. Stevens, "Effects of decriminalisation of drug use in Portugal," The Beckley Foundation, 2007.
[xlvi] C. Hughes and A. Stevens, "What can we learn from the Portuguese decriminalization of illicit drugs?," British Journal of Criminology, vol. 50, pp. 999-1022, 2010.
[xlvii] [25] UK Home Office, "Drugs: International Comparators," UK Home Office, 2014.
[xlviii] European Monitoring Centre for drugs and Drug Addiction and Servico de Intervencaos nos Comportamentos, "Portugal Drug Report 2017," Publications Office of the European Union, Lisbon, 2017.
[xlix] Global Commission on Drug Policy, "Advancing Drug Policy Reform: A new approach to decriminalisation," 2016.
[l] R. Goncalves, "A social cost perspective in the wake of the Portuguese strategy for the fight against drugs," International Journal of Drug Policy, vol. 26, 2015.
[li] https://www150.statcan.gc.ca/n1/daily-quotidien/191030/dq191030a-eng.htm
[lii] https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2755276
[liii] https://www.emcdda.europa.eu/system/files/publications/3934/TI_PUBPDF_TDAU17001ENN_PDFWEB_20170224164629.pdf
[liv] https://ajph.aphapublications.org/doi/10.2105/AJPH.2018.304320

[lv] C. Perry, C. Williams, K. Komro, S. Veblen-Mortenson, M. Stigler, K. Munson, K. Farbakhsh, R. Jones and J. Forster, "Project Northland: long-term outcomes of community action to reduce adolescent alcohol use," vol. 17, no. 1, 2002.
[lvi] A. Fagan, D. Hawkins and R. Catalano, "Engaging Communties to Prevent Underage Drinking," vol. 34, no. 2, 2011.
[lvii] M. Pentz, D. MacKinnon, J. Dwyer, E. Wang, W. Hansen, B. Flay, D. Phil and C. Anderson-Johnson, " Longitudinal Effects of the Midwestern Prevention Project on Regular and Experimental Smoking in Adolescents'," vol. 18, 1989.
[lviii] M. Pentz, D. MacKinnon, J. Dwyer, E. Wang, W. Hansen, B. Flay, D. Phil and C. Anderson-Johnson, " Longitudinal Effects of the Midwestern Prevention Project on Regular and Experimental Smoking in Adolescents'," vol. 18, 1989.
[lix] D. MacKinnon, C. Anderson Johnson , M. Pentz and J. Dwyer, "Mediating mechanisms in a school based drug prevention program: first-year effects of the Midwestern Prevention Project.," vol. 10, 1991.
[lx] A. L. Kristjansson, I. D. Sifusdottier, T. Thorlindsson, M. J. Mann, J. Sigfusson and J. P. Allegrante, "Population trends in smoking, alcohol use and primary prevention variables among adolescents in Iceland, 1997-2014.," Addiction, pp. 643-652., 2016.
[lxi] I. D. Sigfusdottier, T. Thorlindsson, A. L. Kristjansson, K. M. Roe and J. P. Allegrante, "Substance use prevention for adolescents: the Iceland model, 1997-2014.," Health Promotion International, pp. 24: 1; 643-652., 2008.
[lxii] D. Sigfusdottir, A. L. Kristjansson, M. L. Gudmundsdottir and J. P. Allegrante, "Substance use prevention through schools and community based health promotion: a transdisciplianry approach fro iceland," Global Health Promotion, vol. 18, no. 3, pp. 23-26, 2011.
[lxiii] A. L. Kristjansson, J. E. James, J. P. Allegrante, D. Sigfusdottir and A. R. Helgason, "Adolescent substance use, parental monitoring, and leisure time activities: 12-year outcomes of primary prevention in Iceland," Preventive Medicine, vol. 51, pp. 168-171, 2010.