Cannabis Inquiry

Sub 015

Received: 22/4/10

20 April 2010

Ms Lindy Nelson Carr MP
Chair
c/-The Research Director
Social Development Committee
George Street
Brisbane QLD 4000
Or by facsimile to 07 3406 7500
Or by email to sdc@parliament.qld.gov.au

Dear Madam

(1)What are the shot term and long term risks associated with cannabis use? Particulary:

(a) **The risk to a user's mental health, physical health and brain function;**
(b) **The risk of addiction and dependence;**

(c) **The risk of cannabis use leading to the use of other harmful substances**

(2)How are these risks influnced by factors such as:
(a) **The age at which a person first uses cannabis?**
(b) **The frequency of use?**
(c) **The potency of the cannabis used?**

In regards to the paper called "*Cannabis-suicide, schizophrenia and other ill-effects*"

Throughout the paper we return to the issue of age of first use. Overwhelming evidence exists to support the fact that the age of first cannabis use is an important predictor of progression to heavier drug use and need for treatment (for example, see Pope et al, 2003; Anthony et al, 1994; Warner et al, 1995; Kandel et al, 1997). Clearly, there is a significant problem when boys aged 9 and 10 are discovered with cannabis in Brisbane schools3.

It does appear to the writer that the debate regarding cannabis research is following along the lines of the Tobacco debate in the fifty's, sixty's, and seventy's. You hear time and time again the cry that there is not enough evidence to prove the harmful effects of cannabis, yet if we look back on the debate regarding tobacco, the research evidence on their harmful effects could fill a large number of shipping containers, but yet we had those with many letters after their name during this period claiming that there was not enough proof on tobacco harmful effects. In our e-mail you will find evidence that has come to hand since the paper called "*Cannabis-suicide, schizophrenia and other ill-effects"* was presented to the Queensland Parliament.

The DFA position is if we must err then it should be on the side of caution.

Young people who smoke cannabis or marijuana for six years or more are twice as likely to have psychotic episodes, hallucinations or delusions than people who have never used the drug,

The findings add weight to previous research which linked psychosis with the drug – particularly in its most potent form as "skunk" -- and will feed the debate about the level of controls over its use.

John McGrath 2010 (1) of the Queensland Brain Institute in Australia studied more than 3,801 men and women born between 1981 and 1984 and followed them up after 21 years to ask about their cannabis use and assessed them for psychotic episodes. Around 18 percent reported using cannabis for three or fewer years, 16 percent for four to five years and 14 percent for six or more years.

"Compared with those who had never used cannabis, young adults who had six or more years since first use of cannabis were twice as likely to develop a non-affective psychosis (such as schizophrenia)," McGrath wrote in a study published in the Archives of General Psychiatry journal.

They were also four times as likely to have high scores in clinical tests of delusion, he wrote, and a so-called "dose-response" relationship showed that the longer the duration since first cannabis use, the higher the risk of psychosis-related symptoms.

McGrath 2010 (1) said, early cannabis use is associated with psychosis-related outcomes in young adults. The use of sibling pairs reduces the likelihood that unmeasured confounding explains these findings. This study provides further support for the hypothesis that early cannabis use is a risk-modifying factor for psychosis-related outcomes in young adults.

A study by British scientists Di Forti, M. 2010 (2) suggested that people who smoke skunk, which contain 18% THC are almost seven times more likely to develop psychotic illnesses such as schizophrenia than those who smoke "hash" or cannabis resin which contain 4% THC.

Previous studies had also suggested smoking cannabis can double the risk of psychosis, but the British study was the first to look specifically at skunk. Skunk has higher amounts of the psychoactive ingredient THC which can produce psychotic symptoms such as hallucinations, delusions and paranoia.

The finding that people with a first episode of psychosis had smoked higher-potency cannabis, for longer and with greater frequency, than a healthy control group is consistent with the hypothesis that Delta 9-THC is the active ingredient increasing risk of psychosis. This has important public health implications, given the increased availability and use of high-potency cannabis.

Korver, N. 2010 (3) conclusions: Cannabis-using (ultra-high-risk) UHR patients have more basic symptoms than non-using patients. In addition, healthy cannabis users have more subclinical UHR and basic symptoms and more neuropsychological dysfunctions than non-cannabis users. More frequent cannabis use was related to increased severity of certain UHR symptoms.

Mata,I. 2010 (4) These results suggest that cannabis use in adolescence and early-adulthood might involve a premature alteration in cortical gyrification similar to what is normally observed at a later age, probably through disruption of normal neurodevelopment.

Van Hell, H.H. 2010 (5) Our findings imply that chronic cannabis use as well as nicotine, may cause an altered brain response to rewarding stimuli.

Bartholomew, J. 2010 (6) The findings from the present study suggest that cannabis use has a detrimental effect on prospective memory ability in young adults but users may not be aware of these deficits.

Cornelius, J.R. 2010 (7) Findings suggest that (Post Traumatic Stress Disorder) PTSD contributes to the etiology of (Cannabis use disorder) CUD among teenagers making the transition to young adulthood beyond the effects of deviant peers, the TLI (Transmissible Liability Index, a measure of risk for (substance use disorder) SUD, and demographic factors.

Ehlers,C.L. 2010 (8) These findings suggest that within this population that cannabis use and dependence, as well as individual cannabis dependence symptoms have a significant heritable component, that cannabis dependence is more likely to occur when use begins during adolescence, and that the cannabis dependence syndrome includes a number of heritable untoward psychiatric side effects including withdrawal.

Compton, M.T. 2009 (9) Pre-onset cannabis use may hasten the onset of psychotic as well as prodromal symptoms. Age at onset is a key prognostic factor in schizophrenia, and discovering modifiable predictors of age at onset is crucial.

Lutz B 2009 (10) Gives clear directions in the public discussion on the potential danger of the recreational use of cannabis, in particular, during pregnancy, puberty and adolescence, in the context of the devastating disorders psychosis and schizophrenia. In addition, it may also define possible undesired effects in medicinal use of cannabis.

Besides the exciting insight that endocannabinoids and their receptors are involved in numerous central steps in neural development, these investigations have also shed new light on the mechanisms underlying the devastating effects of cannabis consumption during critical phases of brain development. As endocannabinoid levels are tightly regulated in time and space to execute their ascribed roles, D9-THC consumption leads to a strong disturbance of the endocannabinoid system. D9-THC activates all CB1 receptors in the body irrespective of there current intrinsic activation pattern.

Secondly, while endocannabinoids undergo a fast degradation, D9-THC is rather stable and occupies CB1 receptors for a long time. It is expected that in future studies in animal model systems D9-THC-induced disturbances in brain development will obtain distinct molecular signatures, which will help to understand D9-THC-induced psychosis and schizophrenia as neurodevelopmental disorders.

Ehlers suggest that within this population that cannabis use and dependence, as well as individual cannabis dependence symptoms have a significant heritable component, that cannabis dependence is more likely to occur when use begins during adolescence, and that the cannabis dependence syndrome includes a number of heritable untoward psychiatric side effects including withdrawal.

Pujazon-Zazik, M. 2009 (11) Stronger literature has identified an association between marijuana use and psychiatric problems. Clinical and program interventions for adolescents have potential to prevent marijuana use, as well as screen for and treat marijuana abuse. Improved research is needed, such as research with greater consistency in defining levels of use and greater emphasis on gender differences.

Fibey F.M. 2009 (12) Activation of the orbitofrontal cortex and nucleus accumbens was also positively correlated with problems related to marijuana use, such that greater activation was associated with a greater number of items on a marijuana problem scale. Thus, cue-elicited craving for marijuana activates the reward neurocircuitry associated

with the neuropathology of addiction, and the magnitude of activation of these structures is associated with severity of cannabis-related problems. These findings may inform the development of treatment strategies for cannabis dependence.

Realini, N 2009 (13) Adolescence is the period between childhood and adulthood, encompassing not only reproductive maturation, but also cognitive, emotional and social maturation and is characterized by a brain in transition that differs anatomically and neurochemically from that of the adult. The endocannabinoid system plays an important role in this critical phase for cerebral development, therefore a strong stimulation by the psychoactive component of marijuana, delta-9-tetrahydrocanabinol, that acts through the cannabinoid system, might lead to subtle but lasting neurobiological changes that can affect adult brain functions and behaviour.

Chabrol 2010(14) Study was to evaluate the contribution of cannabis to the prediction of delinquent behaviors. Participants were 615 high-school students who completed self-report questionnaires. Hierarchical multiple regression analyses showed that cannabis use was a significant independent predictor of delinquent behaviors after adjustment for alcohol use, psychopathological and socio-familial variables. Cannabis use was associated with greater numbers of delinquent behaviors among adolescents with higher scores on psychopathic traits or depressive symptoms.

De Dios, M.A. 2009 (15) Results found persistent smokers and smoking initiators to have significantly greater odds of alcohol and marijuana relapse compared with quitters. Furthermore, persistent smokers and smoking initiators were also found to have distinctively shorter periods to marijuana relapse at follow-up. Implications for the implementation of tobacco cessation treatment in the context of substance abuse treatment for adolescents are discussed.

Hides, L. 2009 (16) These findings indicate that different levels of cannabis exposure were differentially associated with (psychotic-like experiences) PLEs and highlight the need for early detection and treatment strategies for PLEs and cannabis use in adolescents.

Indlekofer, F. 2009 (17) More frequent cannabis use and more extensive alcohol consumption were associated with a higher degree of impulsiveness.

Netherland increase in cannabis addiction (NOS) TV 2010 (18).

http://www.rnw.nl/english/article/teenage-cannabis-addiction-rise

The number of Dutch under-18s addicted to cannabis is on the increase. Many of them begin smoking pot regularly at age thirteen, and get into such difficulties that they have to be admitted to a rehab clinic.

The young smokers are getting into conflicts with their parents, are dropping out of school and many of them are known to the police. They often steal to get money to finance their habit.

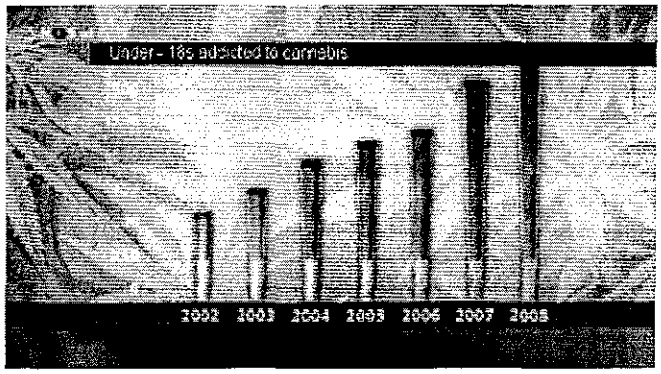
In the past year, 370 teenagers diagnosed with a cannabis addiction were staying in three specialised rehab clinics, a survey by NOS public TV has shown. Three more treatment centres are being built to cope with the rising number of young addicts. Since 2002 the number has increased fourfold.

One of the reasons behind the increase is the THC content of the drug, which keeps increasing as cultivators crossbreed powerful variants of the plant. THC is the active ingredient of cannabis. Figures from Jellinek Clinic show that "netherweed" contained 8.6 percent of THC in 2000, having almost doubled to 15.2 percent in 2002, making the drug much stronger - very much stronger than the "soft drug" that the parents of today's addicts remember from their own teenage years.

Cannabis use is widespread in the Netherlands. Statistics Netherlands, the government statistics office, found in August 2009 that half of all adult men between 20 and 25 had smoked at least one joint, and one third of women of that age. One in ten of the women and twice as many men were still smoking regularly, the statistics show.

Age nine

"Some of the problem cases smoked their first joint at age nine, in the school playground," youth worker Eric de Vos told NOS. "The majority of cannabis users are taking the drug for a reason, as a sort of self-medication to fall asleep easily, to forget misery or quarrels in the family, or problems at school. It's no longer innocent. When those kids are received into the clinic, they are often suffering from psycho-social problems."



The Crime and Misconduct Commission 2010 (19) "illicit drug markets in Queensland-Cannabis use in remote Indigenous communities outline from a demand perspective" that

•The issue of most concern is that cannabis use by Indigenous Australians, particularly those in remote communities, is following the opposite trajectory to the decline observed in the general community.

• Initial research indicates that levels of cannabis use in Cape York and Torres Strait Island communities will be at least as high as those found in Northern Territory communities in recent years (around 60% of residents using cannabis at least weekly and many reporting 'heavy' daily use).

• Early initiation into cannabis use (**with children as young as 10 years of age using regularly**), a high level of 'spinning' (combining tobacco with cannabis), the use of 'bucket bongs', and high levels of poly drug abuse are all troubling aspects of cannabis use in remote Indigenous communities.

• Local dealers see the cannabis market in remote Indigenous communities as a lucrative one, with the cost of cannabis much higher than that in the wider community.

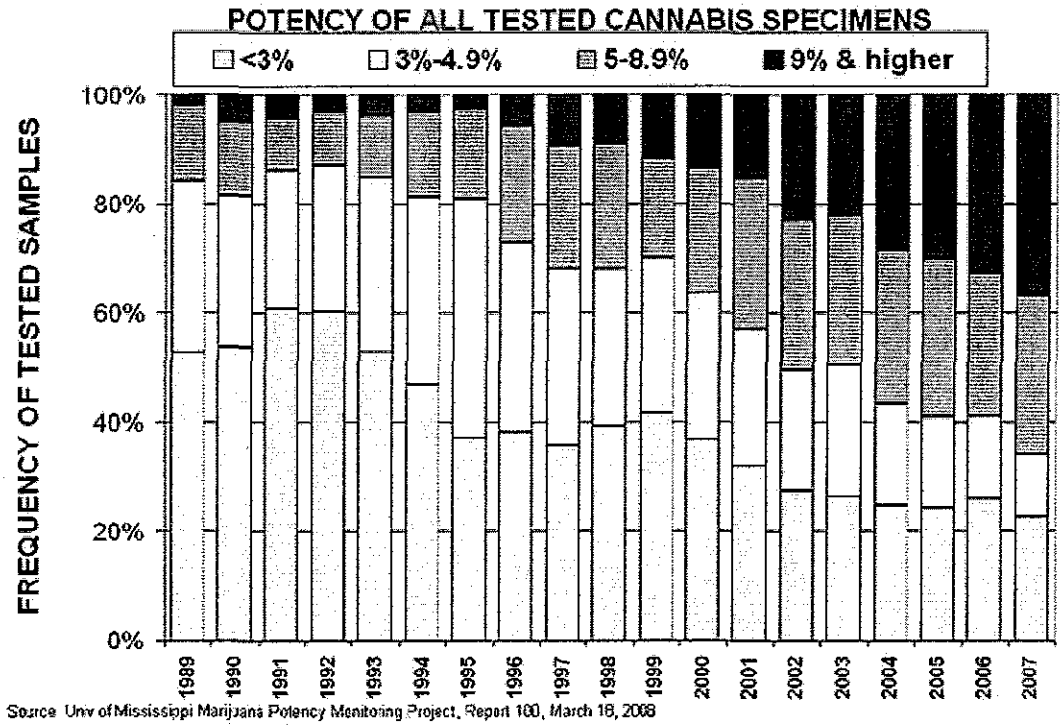
• It is unlikely that traditional organised criminal groups will directly supply cannabis into remote Indigenous communities, because of the need for strong family and/or cultural connections. However, although the local supply networks may not function in a manner traditionally associated with organised crime, they are nonetheless 'organised' and operate for profit.

• QPS Far Northern Region, in partnership with James Cook University and the National Cannabis Prevention and Information Centre, is working with communities in Cape York and the Torres Strait to reduce cannabis use and availability and strategically address the prospect of amphetamine-type stimulants being introduced to those communities.

Potency

Mississippi University 2008 (20) The chart on cannabis potency of all tested cannabis specimens at the University of Mississippi Potency monitoring project Report 100 March 18 2008. The report shows that in 1992 around 60% of all cannabis tested was less than 3% THC and cannabis tested that was over 9%, THC was only 2%.

In 2007 the cannabis tested less than 3% THC was only 22% of total where the over 9% THC had now increase to around 38% the committee should be aware that the Skunk variety available in Australia has been tested to have a THC level of up to30%.



Source Univ of Mississippi Marijuana Potency Monitoring Project, Report 100, March 18, 2008

REFERENCES

(1)McGrath J *"Association Between Cannabis Use and Psychosis-Related Outcomes Using Sibling Pair Analysis in a Cohort of Young Adults"* Arch Gen Psychiatry 2010.67: 111-112.

(2)Di Forti M; Murray R *"High-potency cannabis and risk of psychosis"* The British Journal of Psychiatry (2009) 195:488-49.

(3)Korver, N., Nieman, D.H., Becker, H.E., van de Fliert, J.R., Dingemans, P.H., de Haan, L., Spiering, M., Schmitz, N., & Linszen, D.H. (2010). *"Symptomatology and neuropsychological functioning in cannabis using subjects at ultra-high risk for developing psychosis and healthy controls". The Australian and New Zealand Journal of Psychiatry 44*, 230-236.\r\n

(4)Mata, I., Perez-Iglesias, R., Roiz-Santiañez, R., Tordesillas-Gutierrez, D., Pazos, A., Gutierrez, A., Vazquez-Barquero, J.L., & Crespo-Facorro, B. (2010). *"Gyrification brain abnormalities associated with adolescence and early-adulthood cannabis use". Brain Research 1317*, 297-304.\r\n

(5)van Hell, H.H., Vink, M., Ossewaarde, L., Jager, G., Kahn, R.S., & Ramsey, N.F. (2010). *"Chronic effects of cannabis use on the human reward system":* An fMRI study. *European Neuropsychopharmacology 20*, 153-163.\r\n

(6)Bartholomew, J., Holroyd, S. & Heffernan, T.M. (2010). *"Does cannabis use affect prospective memory in young adults?* Journal of Psychopharmacology 24, 241-246.\r\n

(7)Cornelius, J.R., Kirisci, L., Reynolds, M., Clark, D.B., Hayes, J., & Tarter, R. (2010). *PTSD contributes to teen and young adult cannabis use disorders.* Addictive Behaviors 35, 91-94.\r\n

(8)Ehlers, C.L., Gizer, I.R., Vieten, C., Gilder, D.A., Stouffer, G.M., Lau, P., & Wilhelmsen, K.C. (2010). *"Cannabis dependence in the San Francisco Family Study: Age of onset of use, DSM-IV symptoms, withdrawal, and heritability".* Addictive Behaviors 35, 102-110.\r\n

(9)Compton, M.T., Kelley, M.E., Ramsay, C.E., Pringle, M., Goulding, S.M., Esterberg, M.L., Stewart,T., & Walker, E.F. (2009). *Association of pre-onset cannabis, alcohol, and tobacco use with age at onset of prodrome and age at onset of psychosis in first-episode patients.* The American Journal of Psychiatry 166, 1251-1257.\r\n

(10)Lutz, B. (2009). *From molecular neurodevelopment to psychiatry: New insights in mechanisms underlying cannabis-induced psychosis and schizophrenia. European Archives of Psychiatry and Clinical Neuroscience 259*, 369-370.

(11)Pujazon-Zazik, M. & Park, M.J. (2009). *Marijuana: Use among young males and health outcomes. American Journal of Men's Health 3*, 265-274.

(12)Filbey, F.M., Schacht, J.P., Myers, U.S., Chavez, R.S., & Hutchison, K.E. (2009). *Marijuana craving in the brain.* Proceedings of the National Academy of Sciences of the United States of America 106, 13016-13021

(13)Realini, N., Rubino, T. & Parolaro, D. (2009). *Neurobiological alterations at adult age triggered by adolescent exposure to cannabinoids.* Pharmacological Research: The Official Journal of the Italian Pharmacological Society 60, 132-138.

(14)Chabrol, H., Rodgers, R.F., Sobolewski, G., & van Leeuwen, N. (2010). *Cannabis use and delinquent behaviors in a non-clinical sample of adolescents.* Addictive Behaviors 35, 263-265.

(15)de Dios, M.A., Vaughan, E.L., Stanton, C.A., & Niaura, R. (2009). Adolescent tobacco use and substance abuse treatment outcomes. Journal of Substance Abuse Treatment 37, 17-24.

(16)Hides, L., Lubman, D.I., Buckby, J., Yuen, H.P., Cosgrave, E., Baker, K., & Yung, A.R. (2009). The association between early cannabis use and psychotic-like experiences in a community adolescent sample. *Schizophrenia Research 112*, 130-135.

(17)Indlekofer, F., Piechatzek, M., Daamen, M., Glasmacher, C., Lieb, R., Pfister, H., Tucha, O.,

Lange, K., Wittchen, H., & Schütz, C. (2009). Reduced memory and attention performance in a population-based sample of young adults with a moderate lifetime use of cannabis, ecstasy and alcohol. Journal of Psychopharmacology 23, 495-509.

(18)Netherland Increase in cannabis addiction (NOS)TV http://www.rnw.nl/english/article/teenage-cannabis-addiction-rise

(19)Crime and Misconduct Commission *"Illicit drug markets in Queensland"* Crime Bulletin Series Number 12, February 2010. http://www.cmc.qld.gov.au/data/portal/00000005/content/054720012 68613924685.pdf

(20)University of Mississippi 2008 Marijuana Monitoring Project Report 100, March 18, Potency of all tested cannabis specimens.

END

Herschel M Baker
Director
Drug Free Australia
c/-Mr. Craig Thompson
PO Box 497
Elizabeth SA 5112

12 April 2010

Ms Lindy Nelson Carr MP
Chair
c/-The Research Director
Social Development Committee
George Street
Brisbane QLD 4000
Or by facsimile to 07 3406 7500
Or by email to sdc@parliament.qld.gov.au

Strategies for reducing cannabis use

3. What role should schools play in reducing cannabis use?

DRUG TESTING IN SCHOOLS

Drug use among school students has been a matter of increasing concern in recent years. To examine the effectiveness and impact of drug detection and screening measures in schools, its important for Drug Free Australia to make clear its position in regards to the paper called "*Cannabis-suicide, schizophrenia and other ill-effects*" and how we reach our conclusion for this recommendation. What do some experts in the drug testing field say in regards to drug testing in schools? It is very important that all Queensland school communitys, have drug testing in schools as an option if negative behaviour is associated with drug use including decreased motivation, falling grades, violence and student absence, cripple the learning process and adversely affect the entire student body.

Prevention
Not Punishment
RANDOM STUDENT DRUG TESTING

www.PreventionNotPunishment.org

Why Drug Test Students?

The following are some of the reasons schools are implementing Random Student Drug Testing programs:

To Deter & Prevent Drug Use
Drug tests give students one more good reason not to use illegal drugs. Students know that if they test positive for illegal drugs, they could miss athletic practices and games, be temporarily removed from a club to which they belong, or be subject to an evaluation. Students commonly use their school's drug testing program as a tool to stand up against peer pressure to use drugs.

To Identify Drug Problems Early
When illegal drug use is identified through drug testing, students and their families receive support, counseling, and follow-up testing to insure that the student becomes and stays drug-free. Early intervention and treatment are powerful weapons against addiction and the damage drug use poses to students, their families, their schools and their communities.

To Prevent Adolescent Addiction
Not only does almost all drug use begin during the teenage years, but teenagers become addicted more rapidly to drugs than do adults. Recovery is also more difficult. The National Center on Addiction and Substance abuse's 1997 Annual National Survey of American Attitudes on Substance Abuse reports that if children reach the age of 21 without abusing drugs, alcohol, or tobacco, they seldom start using drugs later on in life. (http:www.mediacampaign.org/whatsyourantidrug/fact_sheets_teens.html)

To Help High Risk Groups
Since 2001, there has been a decline in the self-reported use of illegal drugs by students; however, the rates of use remain unacceptably high. The groups at most risk for illegal drug use are adolescents and young adults.
The following rates of use were reported by students in the 2007 Monitoring the Future Study:

Past 30-Day Use of:	**8th Grade Students**	**10th Grade Students**	**12th Grade Students**
Illicit Drugs	7.4%	16.9%	21.9%
Alcohol	15.9%	33.4%	44.4%

These same data show that the majority of high school students do not use alcohol or other illegal drugs. Even among high school seniors a majority of students had not used alcohol in the prior 30 days.

To improve the Quality of School Education

Negative behaviour associated with drug use including decreased motivation, falling grades, violence and student absence, cripple the learning process and adversely affect the entire student body. Through deterring drug use,RSDT programs help improve schools' learning environments, while also help to those students who are using illegal drugs to ensure that they stop drug use.

To Decrease Athletes' Risk of Injury

Vernonia School District v. Acton, 1995 Supreme Court case ruled in favor of Vernonia allowing the public schools to test athletes in a mandatory random testing program in part because drug use was determined to increase the risks of sports-related behaviors.

Among other problems, stimulant use can be associated with feelings of invincibility characteristic of stimulant highs sometimes leading to more risky behaviors.

Reinforce all other Prevention Efforts

RSDT reinforces the no-drug-use messages of all other school and community drug prevention programs. Hand-in-hand with drug education and drug prevention campaigns, RSDT improves and strengthens the success of all prevention efforts. Far from being in conflict with drug education and other prevention efforts, RSDT reinforces and enhances all of them.

Prepare Students for Workplace Drug Tests

Students are likely to learn upon entering the workplace that drug use is unacceptable and that serious consequences are imposed if drug use is detected. Pre-employment drug tests are routine, just like the random tests of RSDT programs. However, in RSDT programs, if drug use is detected, a student does not lose his or her job (or get expelled from school); rather, an opportunity is offered for evaluation and treatment if needed.

Drug Free Australia has made an electronic submission to NCETA and it is our view that it clearly document Drug Free Australia position in regards to **recommendation 10** of the paper called *Cannabis-suicide, schizophrenia and other ill-effects.* The submission and attachment are included.

Drug Free Australia's Submission for the Research into Drug Detection and Screening in Schools.

July 2007

Introduction:

There is a wide range of evidence that shows high level drug use amongst Australia's youth: For example:

- Cannabis is the most commonly used illicit drug with 26% of 14-19 year olds having used cannabis at least once. (Source: 2004 National Drug Strategy Household Survey)
- The lifetime prevalence of ecstasy use increased from 1% in 1988 to 7.5% in 2004.
- The United Nations Office of Drugs and Crime reports that, compared to a country such as Sweden, Australia has a rate of amphetamine use that is 20 times higher – i.e. Age group 14-64 years, prevalence of drug abuse, % of population the rate is 0.2 for Sweden and 4% for Australia. (Source: UNODC: World Drug Report, 2005)
- Results from the 2005 ASSADA indicate that almost one in five secondary students (18%) aged 12-17 years had used marijuana/cannabis at least once in their lifetime; 7% in the last month.

- Most drug related deaths of young Australians are due to alcohol. In 2002 63% of teenagers had consumed alcohol at the age of 14 years. (Source: 2004 National Drug Strategy Household Survey).
- Results from the 1999, 2002 and 2005 ASSADS Surveys show that almost 90% of secondary students aged 12-17 had consumed alcohol at least once in their lifetime; 50% in the last month and 33% in the last week.

These statistics provide the basis for Drug Free Australia's contention that there is a place for drug testing in Secondary Schools.

Theme 1: Drug Detection and Screening – Viability, Effectiveness, Impact and Implications (Social, Economical, Psychological, Ethical, Legal Perspectives)

1. Are you in favour / not in favour of drug detection and screening in schools?

In order to place Drug Free Australia's response into context we would like to define what we understand to be:
(a) drug detection
(b) drug screening

- Drug detection, for the purposes of this submission, is defined as a policy in secondary schools which is designed to be part of a drug deterrent strategy to student drug use.
- Drug screening is the specific test or tests used to detect alcohol and illegal drugs.

Drug Free Australia makes a further distinction in terms; those of 'mandatory testing' and 'random drug testing'.

1. Mandatory testing, as used in some schools in the United States, is where a teacher has reason to believe that a student is using alcohol and/or illegal substances. This is done as part of the school's Duty of Care for both the individual student who may be using drugs and for fellow students who may be influenced to experiment

   This approach has already been adopted by Geelong Grammar in Victoria, as part of their Drug Policy. *The school's policy on drugs states "students who are thought to be using drugs or other harmful substances may be required at the sole discretion of the Principal or the respective Head of Campus to submit to a urine test."*

Random testing is that which uses onsite screening methods, where students are tested randomly and where there is no link to whether or not a teacher believes students are using substances. This is similar to the concept and practice of random breath testing for alcohol (and in some states, drugs) on Australia's roads.

(Please refer to **Attachment 1** for three (3) Case Studies, the first of which describes both types of testing; the second describes a structured voluntary, random approach; and the third gives a comprehensive policy outline and costing of the process in their school system).

Drug Free Australia is in favour of the concept of drug detection and screening in schools, based on the following principles:

- that detection and screening is carried out as part of a comprehensive policy framework of drug prevention mechanisms that aim at deterring drug use in a local school community, where that community deems student drug levels have reached a point where such a deterrent would reduce the high levels of use evidenced in that community
- that it is random in secondary schools from Years 8-12
- that an integrated health and drug education programs inclusive of student and family (beginning in the first year of Secondary School) be part of that framework.
- that, where tests are positive, referral and treatment be followed through inclusive of parental involvement
- that confidentiality of all detection outcomes are of primary importance.
- That duty of care of students in terms of their safety, health and a sound educational environment takes precedence over arguments related to student privacy (given that the latter would be protected)

This last point was borne out in a statement on 2 July 2007 by policy makers in Mexico – *"Mexican students will take drug tests in schools as part of an effort to reduce narcotics use among young people", President Felipe Calderon said on Monday.*
"We must join forces to have ... permanent review of pupils' health to detect any addiction and to act immediately, not to punish them but to help them," Calderon said.

2. What do you believe would be the advantages of implementing drug detection and screening measures in schools?

- **Deterring drug use** - current research shows that random testing works in schools in the United States – please refer to Attachment 2
- **Identifying drug problems early**. When illegal drug use is identified through drug testing, students and their families receive support, counselling and follow-up care. Early intervention and treatment are the most powerful weapons against addiction and the damage drug use poses to students, their families, the educational system and the community.
- **Improving the quality of school education**. Distractions associated with drug use -- behavioural problems, increased violence, absences, etc. -- cripple the learning process and adversely affect the entire student body. Drug use does not only adversely affect the people who use drugs, it affects everyone around them.
- **Preventing adolescent addiction**. Random student drug testing is especially important in the teenage years because children and adolescents become addicted more rapidly than adults and for them recovery is more difficult. It is also important because almost all drug use begins during the teenage years. CASA's 1997 Annual National Survey of American Attitudes on Substance Abuse reports that if children reach the age of 21 without abusing drugs, alcohol or tobacco, they tend not to start drug use later on in life.
- **School administrators are enabled.** School teacher, counsellors and management must have reasonable means to deter conduct which can seriously disrupt the school environment.
- **Decreasing athletes' risk of injury**. *Vernonia School District vs. Acton*, 1995 Supreme Court case ruled in favor of Vernonia allowing the public school to test athletes in a mandatory, random testing program. It was determined that drug use increased the risk of sports-related injuries. Among other problems, stimulant use can be associated with a feeling of invincibility that often dominates stimulant highs and leads to more risky behaviours.

- **Drug testing reinforces the 'no-drug-use' message** of all of the other drug prevention programs used in schools. It also reinforces the values of most employers now requiring pre-employment drug tests.

- **Students have a valid and credible reason for declining social peer pressure to use drugs – (ie. saying 'No').** In fact reverse peer pressure can develop, as illustrated in a quote from the Principal, Pequannock Township Public Schools, United States: *"Our students themselves have been strong advocates for testing programs. In fact, student advocacy for random testing is one of the few examples of* ***positive*** *peer pressure relative to the question of the drug and alcohol problem".*

3. **What would be the disadvantages (including potential unintended harmful consequences) of implementing drug detection and screening measures in schools?**

There are a number of arguments put forward against drug testing. These are listed below, together with points to counter these arguments.

- **Argument 1 – An erosion of trust between students and teachers.** Firstly, in the model that is advocated in this submission, teachers and other school administrators are not involved in the testing process. Health professionals would be engaged and the tests would be administered in a similar way to flu vaccines or other health matters within the school systems. Secondly, student attitude would be influenced by the way the entire process was explained. If they see it as a way to improve the school environment, as has been done in the case study described in Attachment 1, there would be no evidence of an erosion of trust between students, parents and teachers.
- **Argument 2 – Schools that drug test are taking the responsibility out of the hands of the parents.** Fact – the model proposed in this submission is designed to support parents and provide another avenue to work with parents for positive outcomes. Many parents are not equipped to handle issues related to drug use (as, in many instances, it was not part of their generation). Our research indicates that they welcome leadership from schools in this complex area.
- **Argument 3 – School Drug Testing is targeting the wrong young people.** On the contrary, we submit that this presupposes that there is a stereotypical drug-using group in our schools. Research shows that any student could be at risk. At least by randomly testing students in a school cohort, the school is achieving the best case scenario of their Duty of Care.

4. **How viable, effective and appropriate are the following types of drug testing or screening for schools?**

   i. **Questionnaires (pen and pencil / online screening forms)** – Carefully worded surveys may be applicable in the context of a preliminary school drug education program in the classroom.

   ii. **Interviews and clinical observations (e.g. those used in a clinical interview assessment)** – appropriate for use only if a positive test result is obtained.

   iii. **Independent tests of body fluids (e.g. saliva, sweat, urine, breath or blood)**

   iv. **Independent tests of body tissue (e.g. hair, skin or nails)**

A guide to current practice is described in **Attachment 1, Case Study 1.**
To quote:

"Our testing protocol includes an immunoassay screening of a urine sample. Qualified personnel who have been trained to read the test results conduct this on-site screening process. We also test saliva for the presence of alcohol, although we are moving to a more rigorous test which is a urine test. This test is called the EtG

(ethyl glucuronide) test and this laboratory-based test that measures the biomarker ethyl glucuronide which results from consumption or absorption of alcohol. Ethyl glucuronide stays in the urine for up to eighty hours. In comparison, alcohol metabolises out of saliva in six to eight hours.

This more rigorous test seems to be a stronger deterrent for students considering alcohol use. We chose these tests over the alternatives (blood, sweat, breath, or hair) for a variety of reasons. The collection of a blood sample is much more invasive than collecting urine. A sweat sample would best be collected using a patch – not something that would be practical for a random testing program where we look for a speedy result. Hair samples carry long term information, but not short term recent use. Breath samples have the same limitation that a saliva sample would have.(Breathalyzers and Passive Alcohol Sensors are effective for school dances where you are making sure students have not been drinking prior to or during the school event.)"

v. **Non-invasive detection mechanisms (e.g. sniffer dogs, scanning equipment**) – Please note **Attachment 1, Case Study 1** – for a description of how sniffer dogs have been implemented within the wider drug policy of the school.

5. Which type(s) of drug testing or screening do you believe should be implemented in schools? Please provide reasons for your response.

Drug Free Australia favours the least invasive, but most effective screening method available. These are constantly being improved. For instance, the **IMVS in Adelaide SA**, have some current screening processes that would be beneficial to research. These include **'sweat tests'**.

In addition, pharmacological products are currently available 'over the counter' which test a range of drugs, including cannabis, opiates, cocaine and methamphetamines.

One such product 'Oraline' is a saliva screening device that is non-invasive. According to its manufacturer – *'it is designed to detect the presence of parent drug compounds that are present for a period following ingestion, before they are metabolized and would show up in urine .... is particularly sensitive with respect to most widely used, illicit substances such as marijuana/cannabis, which may be detected 4-6 hours after consumption ... enables timely screening for the presences of illicit drugs without the need for laboratory equipment and is designed to detect recent drug usage'.*

Drug testing in workplaces has been a catalyst for such pharmacological development and would current processes being utilised be worthy of further investigation.

6. In your opinion, should drug testing be randomly conducted or targeted at selected groups? Please provide reasons for your response.

There are two types of testing processes that Drug Free Australia would support:

- Voluntary Random tests for students in Years 8-12
- Mandatory tests, in consultation with parents, if a teacher believes a student exhibits symptoms of being under the influence of a substance. Please further information on the reasons for this in both the body of this submission, plus the case studies contained in the Attachments.

7. **If drug usage is detected, what do you think the next steps should be to address the problem?**

- Parents should be informed in a confidential interview
- Confidential arrangements should be made for an appropriate level of counselling and treatment for the student. The nature of the referral would be to ensure the student is able to stop using drugs and fully recover from their dependence on the substance.
- This may be out of school hours so that classes are not disrupted (unless the situation warrants more immediate assertive treatment).

Theme 2: Other Alternatives – Viability, Effectiveness, Impact and Implications (Social, Economical, Psychological, Ethical, Legal Perspectives)

8. **What alternatives to drug detection and screening programs do you believe would address drug use among school students?**

Drug Free Australia is concerned that we have reached a level of youth drug and alcohol use in Australia that leaves no alternative, but to introduce drug testing in schools. However, it is important to note that we recommend that drug detection and screening be part of an holistic and integrated school drug policy, NOT a stand alone mechanism for prevention and definitely NOT punitive.

Other areas that would work in conjunction with a drug testing process would be:

- Peer prevention (as illustrated in Attachment 1)
- Health Education and Life Skills
- Parent support
- Assessment, counselling, treatment and rehabilitation

To further illustrate the type of holistic approach that would be needed, please **refer to Attachment 3 – Voluntary Random Drug Testing Project for Schools– United Kingdom,** (Peter Walker, Consultant the UK Government's Department for Education & Skills)

9. **What would be the advantages of implementing these alternatives?**

A comprehensive, integrated policy that incorporates non punitive drug testing as a deterrent, together with items listed in No. 8 above, would demonstrate that a school community has done everything possible to achieve its Duty of Care for students.

The benefits to the school community, as described in Attachments 1 and 3 are summarised. Drug Free Australia would be pleased to provide further details on any of these items, should this be required by researchers.

10. **What would be the disadvantages of implementing these alternatives?**
N/A

11. **How viable, effective and appropriate are these alternatives**?
N/A – Unfortunately current statistics of youth drug use in Australia indicate that the alternatives are not viable in Australia, without the added deterrent of student drug testing, as described in this paper.

Additional Comments

12. Are there any other issues on drug detection and screening in schools that you would like to address?

Drug Free Australia would like to go on record as expressing that it is unfortunate that Australia has reached a stage where drug use is so prolific in our schools that we need to explore the concept of drug testing of our students as a deterrent to use. If Australia's drug policy had taken a more restrictive focus, as was done in Sweden, (as soon as escalating drug use became obvious) we may never have had to deal with this dilemma.

By way of explanation, our research shows that Sweden's drug prevention policy has succeeded in creating a culture intolerant to drug use. With the lowest illicit drug use rates in Europe and the OECD, this country finds itself, in 2007, being able to keep youth drug use levels down – without having to introduce drug testing in schools.

For over 20 years it has effectively used a balanced combination of intersectorial, bi-partisan strategies such as well orchestrated street policing and law enforcement, sensitively delivered early interventions, and in the last 7 years, a values-based school education program (the SET program).
For further information, go to the United Nation's Review of Swedish Drug Policy at:
http://www.unodc.org/pdf/research/Swedish_drug_control.pdf

Special note:
This submission includes evidence from formal studies, where available. We have found, however that, due to the only-recent adoption of this type of drug intervention, some of our evidence must necessarily be anecdotal, although we would insist that any anecdotal evidence cited must be as rigorous as possible, within the limitations of anecdotal evidence.

Recommendations:

1. That, given the level of drug use documented in Australian Secondary Schools, one clear way forward would be to recommend trials of voluntary random drug testing within the three main Australian school systems, (public, independent and catholic) and mandatory testing, based on a Duty of Care, if a student is deemed by school management to be demonstrating behaviours symptomatic of alcohol and/or illicit drug use.

2. That, benchmarks for such trial for planning, process and implementation could be based on the knowledge available from existing practices in Australia as well as those in the United Kingdom and the United States.

Attachment 1

Case Study 1 – Drug Testing at Pequannock Township Public Schools, Pompton Plains, NJ 07444 USA

The information in this case study is not confidential and may be used for the purpose of research by NCETA.

The problem of illicit drug and alcohol use by school students in the United States is a major concern. Looking at available national, state, and local survey data indicates that while there may be some positive trends over the past ten years, there is still considerable reason for concern. It is clear that school districts must look for means of prevention in order to deal with this problem because not one student is expendable. All it takes is one bad decision relative to the use of drugs and alcohol to change one's life forever. In our

small school district of approximately 2500 students in grades K-12, we have suffered several individual tragedies resulting from drug and alcohol use. These tragedies helped to put a face on the problem and cause us to look for means of prevention and deterrence.

After a period of researching alternatives, our school district implemented a program of Random Student Drug Testing in grades 6-12. I believe that Random Student Drug Testing is an effective deterrent when it comes to making a decision about using drugs and/or alcohol.

At this point, the distinction should be made between several different approaches to drug testing in schools. In New Jersey, all schools are **required** to send a student for medical assessment and drug testing if a staff member suspects that the student is under the influence of drugs or alcohol at school. We call this "suspicion testing" and it is required by law in order to protect the health and safety of that student. In random drug testing, there is no element of suspicion that triggers the testing process. Everything depends on the process of random selection. Students participating in the program are members of a testing pool and they could be selected for testing if their number is selected (We use a Microsoft Excel spreadsheet and random number function to make this selection). Students agree to be tested to confirm that they are drug and alcohol free if they are selected using this random process. Because there is no suspicion of use, there is also no punitive consequences for a positive test under the random testing program.

Within Random Drug Testing, there are two different forms of testing that may be adopted. These are voluntary and mandatory testing. A voluntary testing program only involves those students who volunteer to be part of the testing pool. This form of testing has been found to be lawful because it is voluntary and all members of the school population have equal access to the program. Mandatory testing has been adjudicated in the state and national court systems in the United States and has been upheld for the following groups of students: students participating in athletics, extra-curricular activities, students wishing to drive/park on campus, and any other students who wish to volunteer for the testing program. Some schools have discussed making testing mandatory for all students, but this has not yet been brought to the court system for a ruling. Our program in Pequannock uses both forms of testing; voluntary only for students in our middle school (Grades 6 through 8) and mandatory and voluntary at our high school (Grades 9 through 12).

Making the decision to implement a controversial program such as random student drug testing should not be taken lightly. The central issues, put simply, are student privacy and civil liberties versus student (and school) safety and the preservation of a sound educational environment. After researching these issues, our decision was clearly on the side of the latter. The advantages of random drug testing include giving students the opportunity to make a commitment to live their lives drug and alcohol free and to back that commitment with the willingness to take a urine test should they be randomly selected from the testing pool (the group of all students signed up for the testing program). Another advantage of the program is that it gives participating students a reason not to try drugs and alcohol if offered to them. They can simply say "I am a

member for the RSDT program at my school and I cannot take the risk that I will test positive." This simple statement may be adequate to help students make a good decision about drug and alcohol use. Research has shown that the longer students remain drug and alcohol free, the less likely it will be for them to have an addictive problem as an adult.

In the process of implementing Random Student Drug Testing in our schools, we have heard many arguments against testing. Compared to the potential that Random Drug Testing has for deterring students from drug/alcohol use, these arguments seem hollow. We have heard that drug testing programs erode trust between adults and students. We have not found this to be the case. In our schools, students have responded positively to the idea of improving the school environment through drug testing and testing has become a part of the school culture. We have found no evidence of the erosion of trust in speaking to students and parents in our school community. We have also heard that giving a urine sample in school would be unnecessarily traumatic for students (particularly at our middle school – Grades 6, 7 and 8). This should be no more traumatic than a visit to the doctor's office. We treat our students with dignity and protect their confidentiality throughout the testing process. Our students have not found the testing process to be traumatic; quite the reverse, they seem to have a positive attitude about testing. We have also heard that this is a job for parents. We absolutely agree that parents should take the lead in promoting good decision-making in regards to this issue; however, we feel the school also bears a responsibility to make this point clear. Schools also have the opportunity to take a proactive stance on the issue of Random Drug Testing and should do so, with the support of the community. Another argument we hear is that we are testing the wrong group of students. This presupposes that there is a stereotypical drug-using group in our schools. We have found that drugs and alcohol do not play favourites. Any student could be at risk. We can at least focus on those students in our testing pools and assist them in meeting their commitment not to use. It also continues to be our goal to increase the percentage of students participating in the program (our current number is approaching 80% of the school populations).

Screening methods

Our testing protocol includes an immunoassay screening of a urine sample. Qualified personnel who have been trained to read the test results conduct this on-site screening process. We also test saliva for the presence of alcohol, although we are moving to a more rigorous test which is a urine test. This test is called the EtG (ethyl glucuronide) test and this laboratory-based test that measures the biomarker ethyl glucuronide which results from consumption or absorption of alcohol. Ethyl glucuronide stays in the urine for up to eighty hours. In comparison, alcohol metabolises out of saliva in six to eight hours.

This more rigorous test seems to be a stronger deterrent for students considering alcohol use. We chose these tests over the alternatives (blood, sweat, breath, or hair) for a variety of reasons. The collection of a blood sample is much more invasive than collecting urine. A sweat sample would best be collected using a patch – not something that would be practical for a random testing program where we look for a speedy result. Hair samples carry long term information, but not short term recent use. Breath samples have the same

limitation that a saliva sample would have.(Breathalyzers and Passive Alcohol Sensors are effective for school dances where you are making sure students have not been drinking prior to or during the school event.)

Our school also collects data using the American Drug and Alcohol Survey. This instrument allows us to compare student reports of opinions, attitudes, and usage on a year-to-year basis. We use this data to inform us about changes in usage patterns that might be attributable to our drug and alcohol prevention programs. We are also working with a prevention organization, "The Partnership for a Drug Free New Jersey" to develop a research study which will be survey-based to ascertain the effectiveness of random drug testing over a seven-year period which would track student attitudes and use patterns from Grade Six through Grade Twelve and compare students who have participated in the Random Drug Testing Program and those that have not.

Results and outcomes

Through our two years of experience with Random Student Drug Testing, we have found it to be a successful deterrent to drug and alcohol use. We have conducted approximately 450 tests and have only two positive results. This small percentage of positives speaks to the fact that students are living up to their commitment to be drug and alcohol free. Those two students who tested positive faced the consequence of being removed from their athletic teams for a brief period and had to submit a negative test prior to continuing participation. They also participated in an early-intervention program with our school student assistance counsellor and received the help they needed to deal with this problem. Again, **the focus of this program is on deterrence from use and when/if a student tests positive, the focus is on student assistance.**

Testing in the context of the school's broader Drug Policy

Our Random Drug Testing Program is one facet of our overall approach to the problem of drugs and alcohol in our school. There is an educational component, a detection component, and a prevention component. The educational component consists of a drug and alcohol curriculum which is infused in our instructional program. This includes units of study in a variety of classes from health, to science, to social studies. We offer special programs which are linked with the Township Police Department. These programs utilize our Student Resource Officer who is a member of our police force specially qualified to work with students. We also offer parent and student programs on drug and alcohol-related topics. These programs are age-appropriate and cover many different aspects of the problem.

Our detection component includes our suspicion-based testing program where faculty assist in identifying and referring any students suspected of being under the influence. Faculty members receive annual training in detection and drugs of choice in our area. Another aspect of detection includes working with Country Prosecutor's Office to use drug-sniffing dogs in our schools. Periodic sweeps of the school area alert students to the risk of bringing illicit substances to school.

Possession of illicit substances and the intent to distribute are always reported to the Township Police Department and students face charges for such activity. We work

closely with the Township Police and other agencies, maintaining positive communication about issues of mutual interest and concern.

Finally, the prevention component includes our Random Student Drug Testing Program and other programs which address the issue of demand reduction (reducing the number of drug and alcohol users). We are in the process of creating a Drug and Alcohol Task Force which will bring members of our educational community together with representatives from other sectors of our community to work toward a unified approach to prevention.

In today's society, drugs and alcohol continue to pose a significant problem. This problem is systemic in that no community is completely immune to the problems of the greater society. The best way to approach a systemic problem is with a systems-based solution. This solution requires a multi-faceted approach with investiture from all constituencies of the society. These include parents, schools, local government, law enforcement, health professionals, and the legal system. While Random Student Drug Testing is but a part of that system, we have seen the power that it has to keep students safe and free of drug and alcohol use. Our students themselves have been strong advocates for testing programs. In fact, student advocacy for random testing is one of the few examples of **positive** peer pressure relative to the question of the drug and alcohol problem. In sum, we believe that Random Student Drug Testing is perhaps the most effective tool in addressing drug and alcohol use among school students today. We urge you to consider this tool as you look to address this issue in Australia.

Respectfully submitted,
William H. Trusheim, Ed.D
Principal, Pequannock Valley School
493 Newark-Pompton Turnpike
Pompton Plains, NJ 07444 USA
william.trusheim@pequannock.org

Case Study 2 – Random School Drug Testing, Erie, Pennsylvania:

There are 13 school districts in the county, several of which have a Voluntary Random Drug Testing Program, the first one having been implemented in 1998.

The process:

- The signature of both the parent and the student is required to participate in the program, following their drug education program in 5th or 6th grade, in preparation for testing when they enter Middle School. The rationale is that students do not feel forced into a program, but see it as part of a drug use deterrent mechanism. The superintendents believe that it is better for the children to share in the responsibility to remain drug free.

- Testing is done by a medical vendor.

- They may request to withdraw at any time up until graduation from high school.

- Parent notification – if a child in the program, refuses to take a test the parent is notified. If a child tests positive, reports go to the parents and the school. Results are accompanied by information about services available to counseling and treatment within the local community.

- No positive results are recorded on the school record of the student in our program. School personnel have no knowledge of the individual records. The school receives a summary report from the medical vendor for the overall school program periodically, probably quarterly.

Uptake rates: indications are that voluntary participation has averaged 60% of the target school population.

Barriers to effective implementation:
The main drawback of this program is the lack of adequate promotion to parents. This has been largely overcome by the development of an information brochure for parents sponsored by a local Drug and Alcohol Coalition. This describes the program and is intended to encourage parents to encourage their children to sign up for it.

Nancy Starr
Erie, Pennsylvania

Case Study 3 – Random School Drug Testing, Californian Model:

NON-PUNITIVE RANDOM STUDENT DRUG TESTING

Californian Model

Illicit drugs are killing an estimated 129,000 Americans annually; one every 4 minutes. 9.4% of the adult population is dependent on alcohol and drugs, which cost the other 90.6% of the population roughly $500 billion per annum. Over 6.0 million children are being raised by their grandparents or foster parents. In 1998 States alone spent over $81 billion (2001 CASA study Shoveling Up) per annum on substance abuse, 99% on justice, health, welfare, education, child/family assistance and mental health … and only 1% on prevention. This is horrible economic policy, and cause for a taxpayer revolt.

Prevention of the problem of substance abuse requires that action be taken before the problem begins: with kids. Almost all those who die or destroy their lives from addiction start between age 11 and 17. Schools, with parental support, can prevent it from happening with the same

tool that stopped drug use in the military, transportation industry and work place: *random drug testing.* Fear of detection is the biggest reason adults and young people don't do drugs.

Protecting the people and managing tax dollars are two of the most important responsibilities of all elected officials, from the federal government to the school boards. It is time they assume that role and implement prevention policies that work. The lives of our children and the future of our country depend on it.

1/12/2007

CALIFORNIANS FOR DRUG-FREE SCHOOLS
rogermorgan339@sbcglobal.net or Carladlowe@aol.com

ADULTHOOD INTACT ...

Research has shown that if a young person reaches adulthood prior to first significant use of alcohol, tobacco and other illicit drugs they should never have a problem of addiction. It follows, and is also a fact, that almost all adults who contracted the disease of addiction did so as children or adolescents, aged 11 to 17, when their brains and vital organs were not fully developed and they were physiologically much more susceptible to addiction.

Schools are vital to the preventing this from happening, since almost all kids in the critical years are in the school domain a major portion of the time. While parents are considered the most important in keeping kids off drugs and alcohol, 56% of young people are considered at moderate to high risk because the home situation is what it is; and problems that originate at home will not get solved at home without outside intervention, which in all probability can only come from schools.

The most effective and least costly method to keep kids from using drugs is *non-punitive random student drug testing.* The model program contained herein shows that an on-site drug test kit for five drugs, which can be administered successfully by a lay person, costs only $2.50 to $2.75. Experience has shown that testing as few as 10% of the student population can achieve the desired deterrent effect. So depending on the ratio of tests per student during the school year ranging from 10% to 100%, 1000 students can be protected for a range of only $250 to $2500; really nothing compared to the average cost of education of roughly $7,400 per student, or the cost to the nation of substance abuse (alcohol and drugs) of almost $500 billion per annum.

Based on empirical evidence, schools and communities that implement a good non-punitive random drug testing program can expect the following:

- A drastic reduction in student drug use.
- A drastic reduction in juvenile behavioral problems.
- Higher levels of academic achievement.
- Higher graduation rates.
- A safer and healthier learning environment, with less bullying and peer pressure.
- No negative impacts on student participation in sports or extra curricular activities.
- Teachers are free to teach and not play drug cop.

- Trust between parents, teachers and children is preserved, while children learn to be accountable for their own actions.
- Parents and schools work more closely together to safe guard the kids.
- Parents learn to appreciate the extra layer of protection for their child's health and safety.
- Kids like it because it gives them a reason to say no to peer pressure.
- School boards and administration fulfill their responsibilities to protect the children and provide a safe and drug free learning environment by using the best science available.

To ensure the health and safety of all young people, and preserve and enhance our competitive standing as a nation, our goal is to see that the tool of *non-punitive random student drug testing* is available to all schools who want to implement the program. To that end, if a School Board is strapped for money and a local benefactor is not available, we are willing to underwrite the cost of our program to get it started. By following the guidelines to make test kits available to parents for home use for a donation, the program will become self sufficient, and the kids will have the best protection possible to get them to adulthood intact.

INDEX

DRUGS – THE NATION'S BIGGEST WEAPONS OF MASS DESTRUCTION

Alcohol, tobacco and other drugs (ATOD) are at the heart of almost all of this nation's social and economic problems. The cost to our country for substance abuse is horrendous, as indicated below:

HUMAN COST - Based on information from two federal agencies, ONDCP and CDC, an estimated 100,000 to 150,000 Americans die each year from illicit drug use: **one every 4 to 7 minutes**. Nothing since WWII, where 308,600 Americans lost their lives in six years, even comes close. American casualties in Afghanistan and Iraq pale in comparison. More Americans die every week than all those who died on the infamous 9/11. While we mourned the loss of 1,500 soldiers in Iraq in 24 months, we seemed to overlook the fact that potentially 2800 Americans die every week, just from drug abuse.

DRUG-INDUCED AND DRUG RELATED DEATHS IN U.S.

Death Rates in Bold are CDC Figures. The balance are projections.

Year Deaths	Drug Induced Deaths	% Of Total	Est Total Deaths	Average Annual Increase in Drug-Induced
1995	**14,218**	**27%**	**52,624**	
1996	**14,843**	27%	54,974	**104% of 1995 figure**
1997	**15,973**	27%	59,159	**108% of 1996 figure**
1998	**16,926**	27%	62,689	**106% of 1997 figure**
1999	**19,102**	27%	70,748	**113% of 1998 figure**
2000	**19,698**	27%	72,956	**103% of 1999 figure**
2001	**21,683**	27%	80,307	**110% of 2000 figure**
2002	**26,040**	27%	96,444	**120% of 2001 figure**
2003	**28,723**	27%	106,381	**110% of 2002 figure**
2004	31,681	27%	117,339	110% of 2003 figure
2005	34,945	27%	129,425	110% of 2004 figure

SOCIAL COST - 9.4% of all Americans over 12 years old are dependent on alcohol and drugs. Unable to hold a job, drug addicts commit 100 crimes per annum. They cause over 70% of the crime in America; challenge the capacity of law enforcement; overrun the capacity of our prisons to incarcerate them; fill our welfare rolls; continue to support the $500 to $600 billion drug trade, much of which goes to support terrorism; and they cause unimaginable pain and suffering not only for family members who love them, but for all of the victims of their actions. In the year 2000, over 5.2 million Americans were raising their... grandchildren because their children were incapacitated.

ECONOMIC COST - According to ONDCP, the cost to America for substance abuse was approximately $1,000 per annum for every man, woman and child in this country ($294 billion per annum) in 1998, and is probably over $500 billion today. The cost of illicit drugs alone was estimated at $180 billion by ONDCP, but even that figure is several years old, and is probably $200 billion today. 99% of that is spent on the painful aftermath that these drugs inflict on our society, and only 1% on prevention. This is horrible economic policy.

Almost all those who have died or are addicted have something in common: the vast majority got hooked in high school... 12 to 15 years old according to the experts. **If we want to stop the problem, we have to stop it before it starts, with school age children.**

Non-punitive random student drug testing, the most effective and least costly deterrent for youth (and adults), would cost very little but could literally save hundreds of billions of dollars. It is no longer a choice, but a necessity.

CALIFORNIANS FOR DRUG-FREE SCHOOLS
rogermorgan339@sbcglobal.net or Carladlowe@aol.com

A PRESIDENTIAL MANDATE FOR NON-PUNITIVE RANDOM STUDENT DRUG TESTING .....

Preventing the onset of alcohol, tobacco and other illicit drug (ATOD) use by children and adolescents is no longer an option; it is a necessity. The level of death, destruction and economic cost clearly categorizes this domestic tragedy as bigger than all other forms of terror, as indicated below:

Prevention is the key, and prevention must take place before the problem occurs: with kids. Thereafter it is not prevention, but treatment and/or wreckage to society. For years, science indicated that if children reach adulthood prior to first significant use of ATOD they should never have a problem of addiction. It is also a fact that almost all adult addicts contracted their disease as adolescents, between 11 and 17 years old. To prevent the horrible problem substance abuse inflicts on society, we must prevent it from starting with kids.

Non-punitive random student drug testing (NPRSDT) is the most effective and least costly way to deter drug use, and to identify problems early, so treatment can begin. The President of the United States and the Office of National Drug Control Policy support drug testing, but there is no plan for its implementation throughout the United States, leaving it up to local persuasion within school districts. This process **is too inefficient and will not yield significant near term results. A federal mandate is required, and justified.** Short of that, schools can help win the local war, one community at a time.

Using on-site drug test kits that cost $2.75 (costs range from $2.45 to $3.50, but could come down for volume purchases), every middle and high school kid in the nation could be tested once during a school year for $61.8 million. Testing even 10% for $6.2 million could produce the desired deterrent result.

COST OF NATIONWIDE NON-PUNITITIVE RANDOM DRUG TESTING
Figures exclude 850,000 home school students (1999) in all grades 9 through 12

# of Student 7 – 12 grades in U.S.	22,461,500	22,461,500	22,461,500
# of Middle/Junior/High Schools	58,682	58,682	58,682
Cost – On Site Test	$2.75	$2.75	$2.75
Percentage Tested	10%	50%	100%
# Kids Tested	2,246,150	11,230,750	22,461,500
Total Cost	**$6,176,913**	**$30,884,563**	**$61,769,125**
Ave cost/School	$ 105	$ 526	$ 1,053

A federal mandate to test all kids would save more lives, cost less and yield greater economic and social benefits than any war in modern history. Random student drug testing is the answer to winning the war on drugs.

In the event a mandate is not possible, we are encouraging Congress, the Administration and state governments to use financial incentives to encourage schools to implement non-punitive random student drug testing, including economic incentives through the Department of Education. The downstream savings from the wreckage to our society in law enforcement, health costs, welfare, education, mental health and child/family assistance would be measured in billions. If the savings were in part channeled back to schools, we would then be investing our future rather than paying for social destruction.

Roger Morgan

5771 Sweetwater Rd., Bonita, Ca. 91902 (619) 475 9941/475 9942 email rogermorgan339@sbcglobal.net

SCHOOLS – *VITAL TO THE SOLUTION!*

Schools are vital to the solution, by virtue of the fact they deal with almost all children. Parents are considered number one in terms of the problem of at-risk behavior, followed by school environment. **But schools are number one in terms of the solution,** since problems that originate in the family will not go unsolved without outside intervention. For all practical purposes, schools are the only safety net.

Even if they don't cherish the task, schools are surrogate parents while children are in their domain. They have a responsibility to provide a safe and drug-free environment, and schools cannot optimize academic achievement when large percentages of students are using alcohol, tobacco and other illicit drugs .... all of which diminish one's capacity to learn. The other reality is that since almost all addiction starts with kids 11 to 17 years old, and schools house over 98% of kids in this age range, **schools are effectively the only place where prevention programs can be implemented to protect all kids.**

Parents are hugely important in the effort. But, given the state of the American family today, with 50% divorce rate, single parenting, two parents working, child abuse, substance abuse .... it seems to be a somewhat hostile environment for everyone rearing children, and parents need and deserve all the help they can get. Parents do not know that the average child uses drug for two years before their parents find out. And too often they find out from the school, police, or morgue. Then it is too late. **Protective school policy favoring prevention is the key.**

Schools can do many things to enhance the chances of getting kids to adulthood intact, but the following are of vital importance:

1) **Get alcohol, tobacco and other illegal drugs off campus** by use of the best known technologies. Currently, that may include sniff dogs. If drugs are kept, sold or used on campus, kids are four or five times more likely to use them.

2) Implement **non-punitive random student drug testing (NPRSDT)** for the maximum number of kids possible under existing Supreme Court rulings, to prevent drug use and for early identification of those who need help. Emphasize the non-punitive aspects of the program, designed to keep kids in the system, not flush them out under "zero tolerance" policies.

3) **Provide hard hitting factual education from grades 1 through 12 to heighten the perception of harm** from tobacco, alcohol and other drugs. Even *"just marijuana,"* because of its long staying power, is addictive, dangerous, and very detrimental to short term memory and the learning process. The brain is not fully developed until the late teens or early twenties. Whatever harm occurs during the teenager years from alcohol or drugs will in large part determine the quality of the rest of one's life.

4) Offer **Student/Parent Assistance Programs** that work closely with the students and parents.

This website is intended to provide a concise and complete package for schools to enable them to implement a random drug testing program quickly, easily and inexpensively, drawing on the experience of other schools in the nation that have working programs.

CALIFORNIANS FOR DRUG-FREE SCHOOLS
rogermorgan339@sbcglobal.net or Carladlowe@aol.com

SCIENCE – KEY TO THE SOLUTION

The ONDCP (Office of National Drug Control Policy) and President Bush have now recognized the potential for ***non-punitive drug screening to both deter drug use, and for early intervention*** for those kids who need help. The following facts from the best experts supports this position:

- **If children reach adulthood before first substantial use, chances are they will never have a problem.** We know this, and so do those who sell illicit drugs. Thus, kids are in the cross hairs by an evil force more dangerous than all other forms of terror combined. As parents, teachers and politicians, ***we have an inherent responsibility to protect children.*** (ONDCP; CASA)

- The vast majority of those dependent on alcohol and other drugs ***got hooked between ages 12 and 15,*** plus or minus. (Institute For Behavior and Health, Dr. Robert Dupont)

- **The single biggest reason kids don't do drugs is fear their parents will find out.** Random drug screening is how they will find out, and thus it gives them a valid reason to "just say no" to peer pressure. (CADCA; CASA)

- **Young people are much more susceptible to addiction than adults.** Some drugs are so strong that even one week is sufficient for them to become addicted, so early detection and help is a must. While the death rate because of substance abuse is unthinkable, scores more don't die, they just destroy their lives .... often times in eighth grade. Once addicted, there is only a 10% to 15% chance they will ever fully recover. (CASA)

- **According to CASA, 44% of kids are at low risk; 38% moderate risk; and 18% at high risk of substance abuse.** The family is considered number one as the source of the problem, followed by school environment. (CASA – Malignant Neglect Study)

- Given the state of families in America today, with a 49% divorce rate nationally, single parenting, two parents working, parents who use drugs themselves, abusive parents and good, normal parents who just need help, **schools are the safety net and the extended family.** All kids are at risk, but the 60% of kids that are at moderate to high risk need help. If they have a problem stemming from home, and don't get help from the schools, they probably won't get help period, until its too late.

- **A person coming from a family with a history of addiction is four times as susceptible to becoming addicted him/herself.** These kids are often the ones who need help, as early as age ten or eleven. And they need it fast. If they don't get constant monitoring and early intervention, they basically destroy their lives and become parasites on society. **Then everyone pays the price.** Some drugs are so strong a susceptible child can become addicted in a week. (ONDCP)

- **Availability of drugs increases the risk they will be used.** If drugs are kept, used or sold on campus, students are many times more likely to use. (CASA)

- **Perception of harm** from alcohol, tobacco and other drugs is an important factor as to why young people don't use alcohol, tobacco and other illicit drugs. (ONDCP)

If ever we, as a nation, are to make significant strides in reducing illicit drug use, we must stop the problem where it originates ... ***with school age children.*** Non- punitive drug testing is not the only tool to this multifaceted problem, but research shows it is the most effective and least expensive way to reduce illicit drug use and to intervene early in the lives of those who will otherwise ruin their lives through dependency.

CALIFORNIANS FOR DRUG-FREE SCHOOLS
rogermorgan339@sbcglobal.net or carladlowe@aol.com

CALIFORNIA MODEL SCHOOL DISTRICT POLICY
FOR NON-PUNITIVE RANDOM STUDENT DRUG TESTING

Following is the California Model District Policy for Non-Punitive Random Student Drug Testing (NPRSDT). It was adapted from policies of school districts throughout the nation who have active random drug testing programs. Rather than re-invent the wheel, schools considering implementation of a non-punitive random student drug testing program can hopefully use this as a basis for implementing their own program, duly modified to fit their own circumstances. Please note that there are three significant elements to this model:

1) It is available to all students;
2) Participation in the program is a requirement to participate in athletics and extra curricular activities, or to drive or park on campus;
3) Parents have a right to "opt out", if they desire.

Subject: **Non-Punitive Random Drug-Testing Available to All Students With Parents Right to "Opt Out" (Mandatory For Athletes and Those Engaged in Extra Curricular Activities and Driving/Parking On Campus.**

Because the Board recognizes that illicit drugs impair a young person's ability to retain information and learn, and because students who are under the influence of drugs may endanger themselves and others, the superintendent and/or his or her designee will establish a non-punitive random drug-testing program for all students in grades 6 through 12 (middle, junior, continuation and high school) in order to protect their health and safety and enhance the learning environment for all students. Parents will be required to sign the consent form at the beginning of the each school year and will have the right to determine that their child not be subjected to the random testing during the specific school year, however, participation in athletics or extra curricular activities will and driving/parking on campus require the student's participation.

LEGAL REFERENCES

LEGISLATION

- Vernonia School District 47J vs. Acton, 515 U.S. 646, 115 S Ct. 2386, 132 L. Ed. 2d 564 (1995)
- Board of Education of Independent t School District No. 92 of Pottawatomie County v. Earls, 536 U.S. 822, 122 S. Ct 2559, 153 L. Ed.2d 735 (2002);
- Joye v Hunterdon Central Regional High School, 176 N.J. 568, 826 A.2d 624 (NJ 2003);
- Linke v. Northwestern School Corp., 763 N.E. 2d 972, 162 Ed. Law Rep. 525 (Ind. 2002)
- Trinidad School Dist. No. 1 By and Through Lopez, 963 P.2d 1095, 129 Ed.Law Rep.812 (Colo. 1998)
- York v. Wahkiakum School dist. No. 200, 110 Wash. App. 383, 40 P.3d 1198, 161 Ed. Law Rep. 1023 (Div. 2 2002)
- Drug Testing Law, Technology, and Practice (West Group, Rochester, NY) Chapter 8

PROCEDURES

NON-PUNITIVE RANDOM DRUG-TESTING OF STUDENTS

Students who test positive under the policy and this accompanying procedure will be treated according to the terms of this procedure. Otherwise, students who are determined to be involved in criminal activities related to drugs will be disciplined in the same manner as any other student, according to the local school district policy.

POLICY OBJECTIVES

1. To create and maintain a healthy, safe, drug-free environment for all students.
2. To provide early detection and treatment of students exposed to illegal drugs use.
3. To encourage any student with a dependence on, or addiction to, tobacco, alcohol or other illicit drugs to seek help in overcoming the problem.
4. To reduce the likelihood of incidents of accidental personal injury and/or damage to students of property.
5. To minimize the likelihood that school property will be used for illicit drug activities.
6. To protect the reputation of the school system and its students.

NON-PUNITITVE NATURE OF POLICY

No student shall be penalized academically for testing positive for use of illegal drugs or alcohol, nor shall any student be denied any benefits or services other than the district sponsored athletic and/or other extra-curricular activities as outlined above. The results of drug tests pursuant to this policy will not be documented in any student's academic records. Information regarding the results of drug tests shall be kept confidential between the superintendent, the building principal, their designee, the student assistance program representative, the student's custodial parent or legal guardian, and the student. In the event that a student appears in front of the School District Board of Directors for an appeals hearing of any nature, information pertaining to non-punitive random drug testing of the student shall be made available to School Board Representatives.

In particular, test results will not be disclosed to law enforcement or juvenile authorities absent a valid and binding subpoena or other legal process issued by a court of competent jurisdiction. In the event of service of any such subpoena or legal process, the student's custodial parent or legal guardian will be notified in writing as soon as reasonably possible, but in no event more than seventy-two (72) hours after such subpoena is received. Verbal notification may be given, followed by written notification.

NOTIFICATION

1. Parents/guardians of all students will be notified of this procedure prior to the beginning of the drug testing program.
2. Written notification of the procedure will be included with orientation/registration materials that are provided to all students and their parents/guardians at the beginning of the school year.

CONSENT FORM

1. All students and their parents/guardians will need to sign consent forms to participate in the Non-Punitive Random Student Drug Testing Program as a requirement for participation in athletics and extra curricular activities and driving or parking on school property.

2. Consent forms will grant permission for non-punitive random drug testing of students and will include an acknowledgement that all illegal and non-prescription drugs will be subject to identification.

3. Students, with parental consent, will have an option to "opt out" of the program, subject to the parent and child signing a consent form (attached) on which they acknowledge they understand the intent of the program; the school's responsibility to protect the health and safety of all students; and the limitations on the child's participation in athletics and extra curricular activities by not participating in the non-punitive random student drug testing program.

EDUCATION

1. A program of drug education for students and their parents/guardians will be established at each school to present a clear "no use" of any illicit drug message.

2. Presenters will be knowledgeable in alcohol, tobacco and other drugs (ATOD) education, student needs, and drug testing procedures.

PARENT MEETINGS

1. Schools will schedule at least one meeting for students and their parents/guardians early in the school year to present and explain the student drug testing program and to answer questions. Principals will designate the appropriate people to conduct the presentations.

2. Parents/guardians will be notified of the meetings in letters as described in No. 2 of the Notification Section (above).

TESTING PROCEDURES

1. Testing will be conducted by trained personnel using on-site drug test kits. Parents/guardians and students will be advised of the result. In the case of a positive test, the parents/guardians and students may request a confirmation test by a qualified laboratory at their own expense, unless the laboratory finds the result should have been negative, in which case the School will pay.

2. Tests will be performed in a secure and private area, established by each school with the advice and counsel of qualified experts.

3. Parents/guardians and/or students may choose saliva, hair or other types of tests for an additional fee to cover the additional cost versus a urine test. The base cost of the program will be based on taking urine samples.

4. On-site test kits range in cost from $2.75 per device for a device to detect 5 drugs; $5 for 10 drugs; $6.90 per device for an on-site Oral test using saliva to detect 6 drugs. *(Redwood Biotech, P.O. Box 14327, Santa Rosa, Ca 95402. Phone 877 444 0049. Fax 707 577 8102).* Prices vary from manufacturer to manufacturer and the cost may come down based on volume.

5. The school will make on-site test kits available to parents for home use for an increased fee to cover handling costs.

6. Testing will consist of obtaining samples to be screened for, but not limited to, any of the following substances:

	Tobacco		
-	Alcohol	-	LSD
-	Marijuana	-	Phencyclidine (PCP)
-	Amphetamines	-	Steroids
-	Cocaine	-	Heroin
-	Ecstacy	-	Other controlled substance

7. Unless testing occurs in the course of a drug counseling/rehabilitation program , or as a requirement of an appeal for re-instatement, students will be identified for testing through a random, computer-driven process.

8. The principal's designee will be informed of the students to be tested by the testing program representative.

9. All test-related information will be kept confidential, except principals/designees will be notified by the testing facility of positive test results, after the facility has notified affected students and their parents/guardians. Principals/designees will the notify those employees who need to know.

9. Students taking drugs prescribed by their physicians must notify principals/designees prior to testing and provide written documentation upon request.

CONSEQUENCES

1. Students who refuse to be tested will be considered to have tested positive for each instance of refusal and will not be granted the option of appeal.

2. In the event of a FIRST positive test, students will be:

   - Ineligible to drive/park on campus for a period of 5 school days, but permitted to continue with athletics and/or extra curricular activities.

   - Required, with at least one parent/guardian, to participate in, and complete, an identified drug counseling program at the district's expense.

   - Required to be re-tested on a regular, non-random basis while participating in athletics for the remainder of the school year.

3. In the event of a SECOND positive test, students will be:

   - Ineligible to participate in athletic competition or extra curricular activities, including driving or parking on school premises, for a period of 45 calendar days, but permitted to practice.

- Required, with at least one parent/guardian, to participate in, and complete, an identified drug-counseling program at the student's expense.

- Required to be re-tested and receive a negative result before release from the counseling program and to be re-tested on a regular, non-random basis while participating in athletics or extra curricular activities, including driving or parking on school premises, for a period of one calendar year.

- Required, in the event of an interruption between seasons of athletic competition, to re-test with negative results before participating again.

4. In the event of a THIRD positive test, or any positive tests thereafter, students will be:

    - Ineligible to participate in athletic competition or extra curricular activities or driving/parking on campus for the balance of the school year.

    - Required, with at least one parent/guardian, to participate in, and complete, an identified drug counseling program at the students expense.

    - Required, to be re-tested and receive a negative result before released from the counseling program and to be re-tested on a regular, non-random basis while participating in athletics for the remainder of their enrollment in high school.

    - Required, in the event of an interruption between seasons of a athletic competition or other extra curricular activities, to re-test with negative results before participating again.

APPEALS

1. Appeals of positive drug tests may be initiated by students and their parents/guardians and students will remain eligible during the appeal process until and if a qualified laboratory confirms the positive result.

2. Students will be permitted to include any relevant information at the time of submitting their appeals, such as prescription drugs being taken which could affect the test.

3. Appeals must be submitted in writing to principals/designees within 48 hours of notification of positive drug-tests, using District "Appeal of Drug-Test" forms obtained at school sites. (See Exhibit B)

4. Confirmation tests will then be conducted at an alternate laboratory.

5. If test results of the second portion of the original urine sample are positive, the appeal will be denied.

6. If test results of the laboratory test are negative, students will remain eligible to participate in athletics and extra curricular activities and the District will bear the cost of the confirmation test. If the lab test confirms the initial result, the student/parents will pay for the test.

INTERVENTION

1. Coaches, teachers, counselors, administrators, and/or other students, who suspect illegal

drug use by students, should immediately notify their principals/designees.

2. Principals/designees will contact parents/guardians and encourage them to conduct suspicion based on-site drug testing, and/or seek professional substance-abuse evaluation and counseling for their child.

SELF REFERRALS

1. Students who refer themselves, or are referred by their parents/guardians, to their coaches, teachers, counselors, or administrators before being selected for random testing, will be exempt from the next series of random drug tests.

2. Students who use this exemption may do so only once.

3. In order to use this exemption, students will be required, with at least one parent/guardian, to participate in, and complete, an identified drug counseling program.

4. Students who use this exemption will also be required to be re-tested on a regular, non-random basis while participating in athletics and other extra curricular activities driving/parking on campus for the remainder of the school year.

CALIFORNIANS FOR DRUG-FREE SCHOOLS
rogermorgan339@sbcglobal.net or carladlower@aol.com

MANDATORY NON-PUNITIVE RANDOM DRUG-TESTING FOR STUDENTS TO BE ENGAGED IN ATHLETICS AND EXTRA CURRICULAR ACTIVITIES INCLUDING DRIVING AND PARKING ON CAMPUS

CONSENT FORM

In order for students to participate in athletics, extra curricular activities and/or park or drive on school property, parents/guardians and students must sign this consent form at the beginning of each school year.

Board Policy _____ states that:
Because the Board recognizes that illicit drugs impair a young person's ability to retain information and learn, and because students who are under the influence of drugs may endanger themselves and others, the Superintendent and/or his or her designee will establish a non-punitive mandatory random drug-testing program for all students engaged in athletics or extra extra-curricular activities in Grades 6 (middle schools) through 12 in order to protect their health and safety and enhance the learning environment for all students.

We fully understand that the student identified below may be randomly selected, or required in certain circumstances, to be tested for the presence of all illegal and non-prescription drugs and/or alcohol, and we give consent for the student to participate in the non-punitive random drug testing program, which is described on the reverse side of this form.

The student shall have a right and obligation to explain any medical condition for which drugs have been prescribed which could alter the test result.

We authorize the school's designated testing person to disclose the results of the testing to us and to the school principal's designee, who will share that information only with other employees who need to know.

Street Address	City	Zip Code	Phone

Parent/Guardian Name (Print)	Parent/Guardian (Signature)	Date

Student Names (Print)	Student Signature	Date

CALIFORNIANS FOR DRUG-FREE SCHOOLS
rogermorgan339@sbcglobal.net or carladlowe@aol.com

MANDATORY NON PUNITIVE RANDOM DRUG-TESTING OF STUDENT ATHLETES AND THOSE ENGAGED IN EXTRA CURRICULAR ACTIVITIES

APPEAL FORM

School Board policy reads that "appeals of positive drug tests may be initiated by student athletes and/or their parents/guardians as follows:

- Students will remain eligible during appeal and laboratory confirmation of test results.
- Students will be permitted to submit any relevant information at the time of requesting appeals.
- Appeals must be submitted in writing to principals/designees within 48 hours of notification of positive drug test results.
- Confirmation tests will be conducted at an alternative laboratory on a second portion of the original urine sample.
- If test results of the second portion of the original urine sample are negative, the student will remain eligible to participate in athletics and extra curricular activities and the District will pay the cost of the confirmation test. If positive, the student and/or parents will pay the cost of the confirmation test which will be approximately $30, and subject to change."

We appeal the positive test results of the student identified below. In addition, we authorize the confirming laboratory to disclose the results of the testing to us and to the school Principal/designee.

Street Address	City	Zip Code	Phone

Parent/Guardian Name (Print)	Parent/Guardian Signature	Date

Student Name (Print)	Student Signature	Date

Print in the space below any comments/information you have regarding the appeal. You may attach additional items.

CALIFORNIANS FOR DRUG-FREE SCHOOLS
rogermorgan339@sbcglobal.net or carladlowe@aol.com

"OPT OUT" AGREEMENT REMOVING STUDENT FROM NON-PUNITIVE RANDOM STUDENT DRUG TESTING PROGRAM

THIS OPTION MUST BE SIGNED AT THE BEGINNING OF EACH SCHOOL YEAR

We elect to "opt out" of the random student drug testing program, and acknowledge our understanding of the following:

- The disease of addiction can be acquired easily and quickly by a child or adolescent and lead to addiction to alcohol, tobacco and other drug; and if there is a history of addiction in the family, the chances of a child having a genetic predisposition to addictions is 4 to 5 times greater.

- Children are much more susceptible to harm and addiction than adults because their brains and vital organs are not fully developed until the late teens or early twenties.

- Research shows if a child reaches maturity prior to first significant use of alcohol and drugs they should virtually never have a problem with ATOD; and that almost all addiction originates with children between 11 and 17 years old.

- The school has a "no use" policy for ATOD by students, and we agree to comply with this policy.

- The school program of random student drug testing is:
    1) Non-punitive, intended to deter use of alcohol, tobacco and other drugs (ATOD), and detect problems early in children so they can get treatment before addiction reaches a level that addiction makes treatment difficult, expensive, and too often ineffective;
    2) The results are confidential between designated school personnel and the parents; the records are sealed and destroyed upon graduation, and have no impact on a child's ability to seek higher education or scholarships;
    3) The intent of the program is to keep kids in the school system until they arrive at adulthood free of dependency on ATOD, when science says they should never have a problem.

- The school recognizes that the majority of students do not use ATOD, but that random drug testing is the best deterrent to keep the majority of students healthy and in a safe learning environment.

- Schools function as surrogate parents while children are in their domain, and as such, have a responsibility to protect the health and safety of all students and preserve a good learning environment.

- The school reserves the right to do "suspicion-based testing" for ATOD, and in the event of a "positive" test result will communicate the results to the parent. The school will have the right to order additional alcohol and drug testing as required by school district policy to protect the student and other students who may be affected by his or her behavior.

- We are fully informed of any the Student Assistance Program offered at school, and should the need arise, these resources are still available to us.

- Enrollment in the non-punitive random student drug testing program is a requirement to participate in school athletics or extra curricular activities or to drive or park on school property.

Street Address	City	Zip Code	Phone
Parent/Guardian Name (Print)	Parent/Guardian (Signature)		Date
Student Name (Print)	Student Signature		Date

WHAT DO YOU TELL THE PARENTS

ABOUT RANDOM DRUG TESTING FOR STUDENTS .....

Don't Gamble! Your child only has one shot at life. Make it a good one.

There is a very active, evil and incredibly well financed illicit drug trade focused on destroying your child. The *druggies* know that if a child reaches adulthood prior to first significant use of alcohol, tobacco and illicit drugs, they should virtually never have a problem. So they do everything possible to hook them early. Almost all of the estimated 150,000 who die annually due to substance abuse; and the 22 million Americans who are dependent on drugs and alcohol, have something in common. ***They got hooked between 12 and 15 years old***, plus or minus. If we want to stop abuse of alcohol and drugs, that's where we must start.

What many adults and young people fail to understand is that ***physiologically, children are much more susceptible to harm and addiction than adults***, since the brain and vital organs are not fully developed until adulthood. Therefore it is incumbent on all of us adults to do whatever it takes to safeguard their health and safety, and to educate young people on the harm that they can inflict on themselves by using drugs.

Schools and parents are fortunate today to have a prevention tool that was not available until recently: on-site drug test kits. These test kits have made random drug testing in the work place, military and schools easy and inexpensive. Concurrently, many parents just keep a test kit on top of the refrigerator, as a constant reminder that if for any reason a child gives cause for suspicion, the child will give a sample to allay their parents' fears.

According to ONDCP and other credible sources, random drug testing reduced drug use in the work place, transportation industry, private schools, public schools and military from 67% to 90%. In 2002 the US Supreme Court allowed its use for all athletes and those engaged in extra curricular activities. Private schools can make it a criteria for admission.

With on-site drug test kits, the process is quick and inexpensive. It can be administered for as little as $2.45 to $2.75 per test. So it costs the state and schools almost nothing. If all schools were to implement non-punitive random student drug testing programs and achieve even half the results of the military, we could reduce expenditures on the wreckage to our society in crime, health and welfare costs by billions of dollars. Then we would have more money for schools, health care, etc.

The results of the drug tests are confidential, shared only with parents and those who in the school system who need to know. Law enforcement is kept out of the process, and the records are sealed on graduation so they have no impact on a child's future. Unlike zero tolerance policies where a kid is expelled and taken out of the system, the endeavor here is to keep them in the system until the arrive at adulthood intact, well educated and prepared for a productive, wholesome adulthood.

The specific intent of non-punitive random student drug testing is: 1) ***To prevent drug use;*** and **2)** ***To identify problems early, so a child can get help.*** The single biggest reason kids don't use drugs is fear their parents will find out. Random drug testing implants enough fear that most kids don't use. If they know they are going to be tested and they use anyway, then chances are they have a problem and need help. Some drugs are so strong, like crystal meth and crack cocaine, that a kid can become addicted in a matter of days. So the window of opportunity to get help is very short. Often too short.

Other advantages of non-punitive random drug testing by schools is that it takes the onus off teachers and parent to play drug cop, and teaches children to be responsible for their own actions. It also gives kids a reason to just say no to peer pressure. 54% of kids and 70% of parents surveyed like the idea of random drug testing.

CALIFORNIANS FOR DRUG-FREE SCHOOLS
rogermorgan339@sbcglobal.net or carladlowe@aol.com

WHAT DO YOU TELL THE Kids

ABOUT DRUGS AND DRUG TESTING FOR STUDENTS .....

Alcohol, tobacco and other drugs kill and destroy people, particularly young people. You see, physiologically, the vital organs and brain are not fully developed until adulthood..... around age 21 according to the experts. Until the brain is fully developed, you are much more susceptible to harm and addiction than an adult.

Science has proven that if you get to adulthood before first significant use of tobacco, alcohol or other illicit drugs, you should virtually never have a problem of dependency. If you can accept one good piece of

advice for life, it would be to always have the chips in your corner, so you are in control. If you have seen an addict or two, or lost a friend, no doubt you have seen through their misery that drugs and/or alcohol control them.

Look at it another way. Let's just look at your total expected life cycle, keeping in mind that people today can live longer. How long, and particularly how well you live, will depend in large part to how well you maintain your bodily machine, particularly in the formative years while you are building a foundation. Some old people joke, "...if I knew I'd live this long I would have taken better care of myself." The problem is, it is often not a joke.

Years of Age	10	20*	30	40	50	60	70	80	90	100

Adolescents are already pretty close to the safe zone .... about 21. If you get that far without alcohol, tobacco and other drugs controlling you, in all probability ***the quality of your life***, which could be another 80 years, will be enhanced considerably. A long life without quality, incapacitated with a stroke, heart attacks, brain damage, mental illness, hardening of the arteries, liver or lung damage which could mean you are just trapped in a body that doesn't function. At that point, sitting in a wheel chair, you may wish you were dead.

2,500 to 3000 people die each month because of drug overdose. But that appears to be an accident. Just a casualty of war. Dead people can't buy drugs. The real mission of the *druggies,* including the tobacco industry, is simply to get you hooked early, so you will be a captive market for their insidious products until death does you in ... which will usually be at an early age. Approximately 150,000 people die annually due to drugs alone, and almost one of ten people over 12 years old are dependent on alcohol and drugs. They all have something in common. ***They got hooked between 11 and 17 years old.***

A lot of young people don't see the harm in drugs. They see adults drink, smoke ... even use illegal drugs. As mentioned earlier, ***your brain is much more susceptible to harm and addiction.*** Further, if you have any history of addiction in your family, your chances of becoming addicted are four times greater than someone who doesn't. Observe those in your family or that you know who have died because of alcohol or other drugs, then ask yourself if you want to be like them.

Think hard also about smoking tobacco and marijuana. Neither is harmless. They adversely affect short-term memory, concentration, attention span, motivation, problem solving and clearly interferes with your ability to learn. Pot also retards the maturation process. Almost all users of hard drugs started with a little puff of marijuana. Over 60% of those in treatment for addiction are there because of marijuana. You need to maintain your competitive edge in life. While some people smoke marijuana religiously and still manage to function, the vast majority function at a fraction of their true potential as a human being. Decide carefully which side of the fence you want to be on.

The simple wisdom is just wait until you are in the safe zone, after 21 to use legal drugs. Then you will have all the cards in your corner, and be in control of the quality and probably the longevity of your life.

CALIFORNIANS FOR DRUG-FREE SCHOOLS
rogermorgan339@sbcglobal.net or carladlowe@aol.com

HOW SCHOOLS CAN COVER THE COST

Given the cost to educate a child ranges from $7,000 to $12,000 a year, allocating another $2.45 to $3.50 to ensure their health, safety and ability to acquire and retain knowledge is negligible.

Thanks to the technological advancements of *on-site drug test kits*, the process of drug testing is easy and the cost is a fraction of what it once was for laboratory services. For example, a kit to test urine for up to five drugs can cost as little as $2.50 to $3.50, and for up to 10 drugs for $4.50 to $5.00. A urine sample is

taken, the test card placed in the urine, and the result is known within 5 to 10 minutes. If the test is negative, which happens about 97% of the time, that's the end of it. If the test is positive for drugs, the sample is sent to a laboratory for a confirmation test and review by a Medical Review Officer (MRO). This can cost $10 to $30.

To keep the costs down, the school can use the nurse, or perhaps a coach or volunteer to administer the tests, instead of paying for an outside service. The computer randomly selects those to be tested, and they are directed to report immediately to the school nurse's office. Once the sample is taken, they can go back to class, cycle time about 15 minutes. The results from ten tests can probably be determined in thirty minutes. Not a big deal.

History has shown that the desired deterrent affect can be achieved by testing as few as 10% of the students in the program, however, testing all students at least once in a school year seems reasonable. Assuming a school has 1,000 students in middle and high school, the costs are projected below, assuming the school tests 10%, 50% and 100% of the students.

SAMPLE: COST OF NON-PUNITIVE RANDOM DRUG TESTING

Assumptions			
# of Students 7 – 12 grades	1,000	1,000	1,000
Cost – On Site Test	$2.75	$2.75	$2.75
Percentage Tested	10%	50%	100%
# Kids Tested	100	500	1,000
Total Cost	$ 275	$ 1,375	$ 2,750

The cost of testing all middle and high school kids in California would range from $758,000 to $7,600,000, depending on what percent of students are tested during a school year. The figures, which were obtained from the internet follow, and similar figures can probably be accessed for every state. According to Governor Schwarzenegger, California is spending over $50 million on education. An additional investment of about 10% of that amount would enhance the academic environment and better ensure the health and safety of all students.

COST FOR CALIFORNIA TO PROTECT ALL STUDENTS WITH NON-PUNITIVE RANDOM DRUG TESTING

# of Student 7 – 12 grades in Calif.	2,756,117	2,756,117	2,756,117
# of Middle/Junior/High Schools	2,394	2,394	2,394
Ave # of Kids/School	1,151	1,151	1,151
Cost – On Site Test	$2.75	$2.75	$2.75
Percentage Tested	10%	50%	100%
# Kids Tested	275,612	1,3780,585	2,756,117
Total Cost	$ 757,933	$ 3,769,108	$ 7,579,321
Ave cost/School	$ 658	$ 3,292	$ 6,585

If a student tests positive, and the student and/or parents dispute the result and want a confirmation test, a policy could be established that the cost of the confirmation test be paid by the parents or student if the result is confirmed. If the confirmation test shows the initial result was wrong, then the school could pay, with a *"better safe than sorry"* apology to the parents and student.

Another way schools could help offset the cost would be to buy on-site test kits at wholesale, as suggested above, and provide them to parents for suspicion based home use for a donation at two to three times the cost. This is a very valid service and a good price, given the fact that the same drug test sells for $15 to

$25 retail. The best combination to keep a child safe is random testing at school backed by an on-site test kit on the refrigerator at home, just as a reminder ..... if ever there is cause for concern.

Schools can ask a local service club such as the Elks, The Rotary Club, Optimists, Kiwanis, Lions Club, Soroptimist, large corporations, or other local benefactor for help. All are community minded, and there is probably no cause greater than ensuring the health and safety of young people.

The city or county council or local governing board is another source. They share the responsibility to *protect the people* and *manage tax dollars responsibly.* Given the fact that over 70% of crime is associated with people under the influence, the best way to curtail crime in the community and reduce downstream law enforcement and judicial costs is to prevent alcohol and drug use and abuse before it begins: *with kids.*

This Is An Investment. Not an Expense.

CALIFORNIANS FOR DRUG-FREE SCHOOLS
(619) 475 9941/(916) 965 4825 email: rogermorgan339@sbcglobal.net or Carladlowe@aol.com

SOURCES FOR ON-SITE DRUG KITS

There are numerous sources for on-site drug test kits, many of which can be found at www.DATIA.com, an industry association representing drug testing companies. Californians For Drug-Free Schools does not advocate the use of any one manufacturer, or guarantee that their products conform to industry standards. Following are three sources that we have identified.

REDWOOD BIOTECH, 3700 Westwind Blvd., Santa Rosa, Ca. 95403. (877) 444 0049. Fax (707) 577 8102. Contact: Suzanne Bertolucci. They offer various products and have their own laboratory for confirmation testing. They do not have an in house Medical Review Officer (MRO) but will fax the test results to any MRO, as directed by a parent or school. The products they have offered are as follows:

- 5 Drug Panel/Dip - $2.75 each. Urine test for 5 drugs. Results known within 10 minutes. Confirmation tests are available. The company does not have an in-house Medical Review Officer but can refer one. Tests for Meth, Amphetamine, Cocaine, Opiates, and THC.

- 5 Drug RediCup - $5.00 each. Urine test for 5 drugs. Results known within 10 minutes. Container is sealed on top with readout shown on the lid and cut with sample is inverted. Serves as a mailer in case a confirmation test . Same 5 drugs as above.

- 6 Drug On-Site Oral Test. $6.90 each. Confirmation tests are available. Tests for Meth, Amphetamine, Cocaine, Opiates, PCP and THC.

- Alcohol test strip - $1.50 each.

INSTANT TECHNOLOGIES, Inc., 883 Norfolk Square, Norfolk, Va. 23502-3209. (800) 340 4029. Fax (888) 340 4029. (757) 318 4810 Local. Contact Gerald Ramsey, Ph.D. For order of 500 or more drug screens, they have offered the following prices:

- 5 Drug Panel w/adulteration - $4.25 each. No in-house confirmation capability or MRO, but can refer qualified labs for confirmation testing. Tests for Meth, Amphetamine, Cocaine, Opiates, and THC.

- IScreen – 5 panel dip or pipette - $2.45 each. Tests for Meth, Amphetamine, Cocaine, Opiates, and THC.

- IScreen – 6 panel oral fluid - $6.00 each. Tests for Meth, Amphetamine, Cocaine, Opiates, PCP and THC.

MEDTOX LABORATORIES, INC., 354 West County Road D, Saint Paul, Minnesota 55112. (800) 832 3244. Local (651) 636.7466. Fax (651) 636 7466. email jstores@medtox.com. www.medtox.com

- 5 Panel - $3.50. Tests for THC, Cocaine, Opiates, Amphetamines, Benzodiaszepines Company can configure tests for different mixes of drugs. Cut off levels of drug detection appear to be superior. They have a 1 and 2 day drug detection training course as well (free) for schools and parents.

- Alcohol test devices - $1.75 each

A school could carry urine and oral drug test kits, and maybe offer a source for hair analysis, which has a 90 day window. Alcohol test strips are also a good idea. Many parents also like to have the tools at home. The combination of random drug testing at school and suspicion or random drug testing at home provides the best protection a young person can have.

CALIFORNIANS FOR DRUG-FREE SCHOOLS
rogermorgan339@sbcglobal.net or carladlowe@aol.com

EFFECTIVENESS OF RANDOM STUDENT DRUG TESTING

Critics say there is a lack of empirical evidence that random student drug testing works. We would like to have more data, but there is consistent evidence to show that it works, just as it has in the military, transportation work place and elsewhere where it reduced drug use by 67% to 90%.

There is overwhelming evidence to show that our collective failure to stem the level of death, destruction and economic cost to the nation without using this tool is at the heart of the nation's problem of substance abuse. A non-punitive random student drug testing program is the best way to ensure the health and safety of young people, and its use as a prevention tool may no longer be an option, but more of a necessity.

Legal challenges by the ACLU slowed the momentum, and caused some schools to suspend programs that were showing considerable success. The 2002 Supreme Court rulings cleared the use of RSDT for athletes and those engaged in extra curricular activities, and now many schools are getting on board. Schools who have properly administered programs have almost unanimously achieved success. Following are some examples that support that contention:

De La Salle High School, New Orleans A Catholic school, had been nicknamed "De La Drugs" by the students before the Principal took action around 1998 and implemented a non-punitive random student drug testing policy using hair analysis, which gives a 90 day detection window. Kids testing positive are referred to parents, and there are practically no repeat offenses. School administration reports today there are practically no problems. Private schools have the luxury of mandating NPRSDT as a criteria for admission.

2003 Research by Dr. Joseph McKinney of 65 Indiana High Schools that were using random student drug testing before 2000 when ACLU legal challenges caused the cessation of the programs. After the 2002 Supreme Court Decisions, Dr. McKinney surveyed the schools and reported the following. A more complete disclosure is available at www.studentdrugtesting.org.

98% of the Principals said they would re-implement a rsdt program.
91% of the Principals said they believed rsdt helped students reject peer pressure to use drugs.
In 2005, 95% tested athletes, 78% Extra Curricular activities, 51% both, and 71% included drivers.
Formal written surveys of students indicated 58% said drug use had decreased, 0% increased, and 42% remained the same.
Regarding what impact RSDT had on student participation:
- Athletics - 0% decrease, 46% increase and 54% remained the same.
- Extra Curricular Activities – 0% decrease, 45% increase and 55% remained the same.

100% of principals said there was no negative impact in the classroom.
80% of high schools with RSDT programs in 2002/03 and 79% in 2003/04 scored higher that the State average on the State mandated graduation test (grades 10-12)
71% to 75% of high schools had graduation rates higher than the average.
In 2003/04, 80% of high schools with RSDT programs had 10th graders passing both graduation exam standards higher than the state average.
The consequences of a first positive drug test for students – 100% were referred to parents; 63% were given follow up tests; 43% were referred to drug education; 85% lost playing time; 79% loss participation in extra-curricular activities.

The conclusions reached by Dr. McKinney's research indicated: 1) The intent was not to "catch and punish"; 2) RSDT is effective in reducing temptation; 3) Formal written surveys provided hard evidence that RSDT programs are effective as a deterrent to prevent drug use; 4) Per student drug testing costs are reasonable; and 5) RSDT programs do not cause reductions in student participation in sports and extra curricular activities.

CALIFORNIANS FOR DRUG-FREE SCHOOLS
rogermorgan339@sbcglobal.net or carladlowe@aol.com

The Institute For Behavior and Health (Dr. Robert Dupont) surveyed 7 public and 2 private schools that had RSDT programs for 2001/02 school years. Results are available at www.studentdrugtesting.org. In general, schools reported improved behavior; increased productivity; significant reductions in behavioral problems, noticeable reduction in student arrests and student referrals. The only opposition to RSDT came from students and the media. When RSDT programs were suspended due to legal challenges, drug use increased.

The SATURN Study, Oregon. 1999-2000 pilot study of two public high schools, Wahtonka H.S. which had an RSDT program for student athletes and Warrenton H.S. who did not have a program. Wahtonka had 5.3% of student athletes said they were using illegal drugs as compared to 19.4% of Warrenton students, less than 1/3rd the usage. In a 2000/01 study of 13 schools, preliminary finds showed: 1) No decrease in sports activity, in fact there was an 11% increase; 2) testing 50% of students was adequate to deter drug use; 3) Heavier alcohol users decreased their alcohol use due to RSDT; 4) Drug testing appears to deter frequent drug users rather than "experimenters". The full report is at www.studentdrugtesting.org.

Hunterdon Central Regional High School, New Jersey. Had a RSDT program for student athletes from 1997 to 2000, then suspended for two years due to legal challenges, and re-implemented program in late 2002. They experienced an overall decrease during 1997 to 2000, then drug use skyrocketed when the program was cancelled (316% for 9th graders to 209% for seniors), then a decrease again when program was re-instituted. They experienced a reduction in 20 of 28 categories of drug use by testing only 10% of the student athletes. Details are available at www.studentdrugtesting.org.

San Clemente High School, California. They have a voluntary program, which has grown every year to now include over 50% of student population. According the Principal, a student survey showed over 50% of the students in the program had used the excuse of RSDT to reject peer pressure to use drugs.

Oceanside Unified School District, California. Implemented a RSDT program for athletes in 1997 at the request of students and then dropped the program in 2002 due to budget constraints. Drug use declined when the program was in effect, and increased again when they stopped. They will implement a program again in 2005 using on-site drug test kits rather than an off-site laboratory service, which will reduce the cost of their program by roughly 85%. During years when they had a program, they got no complaints. When a positive test resulted, they called in parents and never had a repeat problem.

There is enough evidence to suggest that every school district in the nation should at least try non-punitive random student drug testing, because it is the most effective and least costly way to ensure the health, safety and learning environment of young people.

We are also available to help explain the program and benefits to any school board of local community group. Just contact Roger Morgan at (619) 475 9941, email rogermorgan339@sbcglobal.net; or Carla Lowe, at (916) 965 4825, email carladlowe@aol.com.

CALIFORNIANS FOR DRUG-FREE SCHOOLS

rogermorgan339@sbcglobal.net **or** carladlowe@aol.com

Attachment 2

STUDIES SHOW THAT RANDOM TESTING WORKS

DUPONT STUDY - NINE SCHOOLS

With funding from the United States Department of Education, researchers surveyed nine geographically diverse schools that employed student drug testing programs during the 2001-02 school year. Robert L. DuPont, Teresa G. Campbell & Jacqueline J. Mazza, Report of a Preliminary Study: Elements of a Successful School-Based Student Drug Testing Program, July 22, 2002, at ii available at www.datia.org/ pdf_resources/prelim_study.pdf (DuPont Study). The schools assessed effectiveness through a variety of methods, including tracking students who previously had tested positive for drug use, anecdotal evidence, measurable decreases in discipline problems, and student surveys. Id. at 14. The DuPont Study reports that "all of the school officials surveyed strongly supported their entire [student drug testing] programs and all were convinced that their [student drug testing] programs benefitted their entire school communities, including the students." Id. at 18.

BALL STATE UNIVERSITY STUDY - MCKINNEY

A study surveyed seventy-one high school principals, whose schools had conducted random drug testing. Joseph R. McKinney, The Effectiveness and Legality of Random Drug Testing Policies, at 3 available at www.studentdrugtesting.org/ Effectiveness.htm) (McKinney Study). Researchers asked the principals "to compare drug and alcohol activity during the 1999-2000 school year when drug testing policies were in effect with the 2000-01 school year when schools were not allowed to continue with their random drug testing policies." The reason for the hiatus is that an intermediate appellate court in Indiana had ruled that such policies were unconstitutional, a ruling ultimately reversed by that state's highest court. Linke v. Northwestern Sch. Corp., 763 N.E.2d 972 (Ind.2002).After reviewing the collected statistics, the author of the McKinney Study concluded that

[r]andom drug testing policies appear to provide a strong tool for schools to use in the battle to reduce alcohol and drug usage among teens .... While the legal debate will continue over drug testing in schools, this study does show that random drug testing policies are effective in reducing the temptation to use drugs and alcohol. [McKinney Study, supra, at 4.]

SATURN STUDY - OREGON

Researchers in a study looked at two Oregon high schools during the 1999-2000 school year, one with mandatory drug testing as a condition of sports participation, and a control school without drug testing. Lynn Goldberg, Diane Elliot, David P. MacKinnon, Esther Moe, Kerry S. Kuehl, Liva Nohre & Chondra M. Lockwood, Drug Testing Athletes to Prevent Substance Abuse: Background and Pilot Study Results of the SATURN (Student Athlete Testing Using Random Notification) Study, Journal of Adolescent Health, at 16- 17 (Jan.2003). The school that drug-tested student athletes had a rate of

illicit drug use that was about one-fourth that of the control school. Id. at 24. The authors concluded that "[a] policy of random drug testing surveillance appears to have significantly reduced recent drug use among adolescent athletes." Ibid.

HUNTERDON CENTRAL HIGH SCHOOL STUDY - NEW JERSEY

Consider the results of random drug testing of athletes at Hunterdon Central Regional High School in Flemington, NJ. After two years of testing they experienced a decline in 20 of 28 categories of drug use in the whole student population. Prior to implementing random drug testing in 1997, the school conducted a survey of student drug use. 1 The survey, created by the Rocky Mountain Behavioral Sciences Institute, took students about 35 minutes to complete and covered their history of drug and alcohol use and the frequency and intensity of their current substance use. The survey has built in controls to detect erroneous or exaggerated responses with approximately 40 different consistency checks.

After conducting the 1997 survey, Hunterdon Central implemented mandatory random drug testing for all student athletes. Approximately half of the student body participated in athletics. Prior to implementing random testing, the school had in place a student counseling and education program and conducted drug searches. In 1999, the survey was conducted again. There had been no changes in the school anti-drug program except the introduction of random testing.

The 1999 survey showed that of the 28 categories of drug use evaluated by the survey, drug use went down in 20 categories. For example, in the highest risk drug use category of "Multi-Drug Users" the rates went down as follows:

9th grade - 57% decrease
10th grade - 100% decrease
11th grade - 14% decrease
12th grade - 52% decrease

THE MICHIGAN STUDY - THE ONLY STUDY USED AGAINST TESTING

A study suggests a contrary result, namely, "that drug testing in schools may not provide a panacea for reducing student drug use that some ... had hoped." Ryoko Yamaguchi, Lloyd D. Johnston & Patrick M. O'Malley, Relationship Between Student Illicit Drug Use and School

Drug-Testing Policies, Journal of School Health, at 164 (Apr.2003) (Michigan Study). In that study researchers found that "drug testing (of any kind) was not a significant predictor of student marijuana use in the past 12 months. Neither was drug testing for cause or suspicion." Id. at 163. However, the New Jersey Supreme Court states that the Michigan Study has limitations.

[The Michigan Study] does not differentiate between schools that do intensive, regular random screening and those that test only occasionally. As a result, it does not rule out the possibility that the most vigilant schools do a better job of curbing drug use. Joye v. Hunterdon Cent. Regional High School Bd. of Educ., 176 N.J. 568, 606, 826 A.2d 624, 647 (2003)

1. The American Drug and Alcohol Survey is available from RMBSI, Inc., 419 Canyon, Suite 316, Fort Collins, CO 80521, telephone 800-447-6354: the Hunterdon Central study is available from the Drug-Free Schools Coalition at 203 Main St, PMB 327, Flemington, NJ 08822, 908-284-5080, fax 908-284-5081.

Attachment 3

Voluntary Random Drug Testing Project for Schools– United Kingdom
Peter Walker, Consultant the UK Governments Department for Education & Skills.

1. Project Description

The Voluntary Random Drug Testing (VRDT) Project for schools, is being conducted in the United Kingdom to inform the government as to how:

- levels of prevention could be improved
- to improve the quality of life of those who choose not to take drugs.

The primary aim is to discourage drug use among young people. The secondary aim is to identify young people with a drug problem and then help them with that problem.

It has been made clear from the outset that the VRDT project is not:

- a stand alone strategy
- a replacement drug policy
- a replacement for drug education

2. Timeframe

2004 – Planning phase
2004 - Consultation phase
2005 – First trial commenced in Abbey School
2006 – Subsequent trials - two other schools commenced the project

3. Methodology

3.1 Planning phase:

The planning phase incorporated research into the following areas

- The Children's Acts
- Child Protection Acts
- Human Right Issues
- Methods of testing
- The testing process
- Who should be tested?
- The consultation process

3.2 Consultation phase

Consultation included the following stakeholders

- Students
- Parents
- Staff
- Community
- Local education authority
- Government

The following matters were considered to determine the testing process:

- Should there be a particular age group or should it be open to all students?
- Should staff also be tested?
- Should it be a full sample or random sample?
- Should some students be targeted?
- Who should test students?
- Who should analyse the samples?
- What types of screening should be used? (Urine, Saliva, Blood, Hair, DNA)
- How is the process financed – who pays?

The key factors in determining the process were that testing must be done:

- Sensitively
- Confidentially
- Voluntarily
- With parent/carer permission
- With student agreement

Process included the following:

- No punitive measures for positive results
- No punitive measure for students refusing to take the test
- Support program to be put in place, with mutual agreement of student/parent and school.
- Action to be taken where dealers are identified

4. Outcomes (Abbey School)

86% parents responded to give permission to testing their child.
600 students tested by 20 September 2005
4 refusals
1 positive test.

Student feedback:
Most students agreed that this is a good reason to say 'No' to drugs
Peer group pressure is the main reason why young people take drugs in the first place.

Documented Benefits:

- School performance increased
- Morale rose

- Student behaviour improved
- Public perception of school changed for the better
- Increased intake of student enrolments
- Students feel safer
- Increased parent support
- Immense public interest
- Reduced crime

For more information, please contact Peter Walker: wvorks@msn.com

END

Herschel M Baker
Director
Drug Free Australia
c/-Mr. Craig Thompson
PO Box 497
Elizabeth SA 5112

21 April 2010

Ms Lindy Nelson Carr MP
Chair
c/-The Research Director
Social Development Committee
George Street
Brisbane QLD 4000
Or by facsimile to 07 3406 7500
Or by email to sdc@parliament.qld.gov.au

Dear Madam

4. **What public health campaign strategies should be adopted to reduce cannabis use?**

Raising global awareness of the magnitude and nature of public health problems caused by harmful use of cannabis and fostering commitment by governments to act to prevent and reduce harmful use of cannabis.

Successful implementation of the strategy will require concerted action by governance and appropriate engagement of all relevant stakeholders.

Consideration should be given to developing a more detailed action plan with specific time-bound actions and appropriate resourcing.

They should also ensure that planning and provision of prevention and treatment strategies and interventions are coordinated with those for other related health conditions with high public health priority such as illicit drug use, mental illness, violence and injuries

a.Any public health campaign strategies should include the following objectives. programme design has to be comprehensive and repeated over consecutive years.

b.The interventions need to be practical and relevant to the target audiences. The messages should be very positive and delivered via multiple media with specific actions to reduce or quit cannabis use.

c. What we learned during programme design and implementation about cannabis use by the community and the acceptance of the cannabis messages must be applied in each subsequent rollout.

d.The consumer initiatives should be implemented in synergy with a complex and sophisticated array of interventions for health professionals that encompassed both users and abusers who are quitting cannabis or who want to quit.

e.We must address patient's attitudes and beliefs and provide them with the knowledge and skills to appropriately manage quitting cannabis use.

SAMHAS's research shows that the cost of substance abuse could be offset by a nationwide implementation of effective prevention policies and programs. SAMHSA's Strategic Prevention Framework should include a planning step that considers cost-benefit ratios. Communities should consider a comprehensive prevention strategy based on their unique needs and characteristics and use cost-benefit ratios to help guide their decisions. Model programs should include data on costs and estimated cost-benefit ratios to help guide prevention planning.

It is the view of Drug Free Australia that we should follow the media strategies that have been running here in Australia e.g. the Quit program and the "Bloody Idiot" program in regards to both tobacco and alcohol. The long term failure of these programs have been caused by not following the simple rules that require public health campaign strategies to include objectives, programme design has to be comprehensive and repeated over consecutive years.

It is not necessary for Queensland to spend large amounts of money in regards to a public health campaign in regards to cannabis/marijuana. The internet already has a number of credible web sites. We list a few below and a very good starting point for the committee in regards to its recommendations is to research these web sites. Drug Free Australia would be willing to assist the Committee in regards to these and other strategies

SAMHSA's
http://download.ncadi.samhsa.gov/prevline/pdfs/SMA07-4298.pdf

National Drug Campaign
http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/Content/home-1

"NCPIC" http://ncpic.org.au/

DFA" http://www.drugfree.org.au/

"Drug Advisory Council of Australia Inc." http://www.daca.org.au/cannabis.htm

"Just Think Twice" web site at .http://www.justthinktwice.com/

"ONCDP" http://www.whitehousedrugpolicy.gov/

NIDA" http://www.nida.nih.gov/

Cannabis Information and Helpline Study

NCPIC is conducting a free telephone-based cannabis treatment study. The treatment is based on cognitive behavioural and motivational interviewing strategies and is complimented by a self-help 'quitting cannabis workbook'. The treatment involves four sessions, or calls, over four weeks made by counselors from the Cannabis Information and Helpline. Anybody interested in participating

must live in Australia, be over 16, be English literate, and want to quit or reduce their cannabis use. Participants will be reimbursed for costs incurred at the end of a three month follow-up study on the treatment outcomes. To take part in this treatment, please phone the Cannabis Information and Helpline service on 1800 30 40 50 or email p.gates@unsw.edu.au.

Web-intervention Study: Reduce Your Use

NCPIC has recently launched a free, web-based treatment for cannabis use and related problems and is conducting a study that will test the effectiveness of the new treatment. The confidential*, online delivery attempts to make assistance more accessible for those in need and uses established counseling practices. It is available world-wide to participants who are 18 years or older, want to quit or reduce their cannabis use and have regular access to the internet. For more information, please email reduceyouruse@med.unsw.edu.au.
***Except where any information provided involves significant harm to self or others or suggested child abuse.**

Cannabis Check-Up+ for Young Adults

NCPIC, in conjunction with the Brain & Mind Research Institute, is evaluating the Cannabis Check-Up+ for Young Adults. This is a brief Intervention for young people who smoke cannabis and have mental health difficulties who might want a chance to talk about their cannabis use without worrying about feeling any pressure to change. Cannabis use will be discussed in an informative and educational way that will allow individuals to make their own decisions about whether they want to make any changes. Each person is also provided with some strategies for managing use, should they wish to do so. Regardless of whether they want to change their cannabis use or not, the principle focus of the intervention is to help identify values and improve quality of life. Participation involves 6-9 hours of time spread over several weeks and reimbursement in vouchers (books/music/DVD) are provided for completing assessments. To find out more information, please phone Rob on (02) 9351 0662 or email rbattisti@med.usyd.edu.au.

National Drug Campaign

The National Drugs Campaign (NDC) is part of the *National Drug Strategy 2004-2009* and specifically aims to reduce young Australians' motivation to use illicit drugs by increasing their knowledge about the potential negative consequences of drug use. This phase of the Campaign is designed to contribute to a reduction in the uptake of ecstasy, marijuana, methamphetamine (ice or speed) and other illicit drugs among young Australians, by raising awareness of the harms associated with drug use and encouraging and supporting decisions not to use.

The Campaign also encourages young people using illicit drugs to re-consider their use and direct them to relevant support, counseling and treatment services. The Campaign will also build upon the impact of earlier National Drugs Campaign prevention activities to reinforce negative perceptions of illicit drugs utilising advertising, public relations, online activities and information resources. The

National Drug Strategy 2004-2009 is the overarching policy framework across Australia for addressing licit and illicit drug issues. The National Drugs Campaign is designed to support education around illicit drug issues.

National Drug Campaign
http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/Content/home-1

SAMHSA's
http://download.ncadi.samhsa.gov/prevline/pdfs/SMA07-4298.pdf

Drug Information Marijuana
http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/Content/marijuana

Drug Information Schools
http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/Content/info-schools

Public Campaigns to Improve Outpatient Antibiotic Use in Europe Paris, 6 - 7 November 2008
http://www.sante-sports.gouv.fr/dossiers/antibiotiques/Pres_Harbarth.pdf

Antibiotic Wise Campaign Launch
http://www.beehive.govt.nz/node/33188

END

Herschel M Baker
Director
Drug Free Australia
c/- Mr Craig Thompson
PO Box 497
Elizabeth SA 5112

20 April 2010

Ms Lindy Nelson-Carr MP
Chair
c/-The Research Director
Social Development Committee
Parliament House
George Street
Brisbane QLD 4000
Or by facsimile to 07 3406 7500
Or by email to sdc@parliament.qld.gov.au

Dear Madam

What law enforcement methods and penalties

(1)In regards to the paper called *Cannabis-suicide, schizophrenia and other ill-effects* that Recommendation number 4 be implemented in all States and Territories-it's important for the Committee to note in regards to this important strategy. The *"Evaluation of Operation NOAH 1992: a quantitative and qualitative study"* by Karen Beck Operation NOAH will bring together Citizen participation, Drugs and the mass media, Drug Traffic control, Drug labs Investigation, NOAH will complement the present reporting program called Crime Stoppers, but without the need for a reward system this will give the ordinary citizen a chance to provide information for the right reasons. NOAH will send a strong message that the government is serious about Drug control of Narcotics, Opiates, Amphetamines, Hashish.

(2) Cannabis use across the Torres Strait, NPA and Cape York could be as high as 19-20 per cent, according to the Queensland Crime and Misconduct Commission (CMC), and not the 60 per cent level reported extensively across Australia.

CMC Director (Intelligence) Chris Keen told the Torres News that Australia-wide media reports last week of up to 60 per cent cannabis use in the Torres Strait/NPA/Cape York were the result of the media misreading the Commission's report into Queensland's Illicit Drug Markets.

"The report does not say that – it has been misinterpreted. Cannabis use across the general public is 9.5 per cent, and we have information that the use is double that in most Indigenous communities."

The 60 per cent, Mr Keen said, was the finding in three remote Indigenous communities in the Northern Territory. "What the report said was that unless steps were taken to curb the use of cannabis in some communities (across Cape York and the Torres Strait), it has the potential to reach the 60 per cent level found in the Northern Territory. "There could be some areas approaching that, not so much in the Torres Strait, but on Cape York. "We're were simply warning that it could happen unless it was acted upon, and there is a real concern that it will approach the Northern Territory scale if not done so." Mr Keen said: "While the local supply networks for (cannabis in remote regions across

Cape York and the Torres Strait) don't function like traditional organised crime groups, they are nonetheless 'organised' and operate for profit.

It is very urgent that the Committee recommend to the Queensland Government to hire and to be trained at Townsville as a group of 12 to 25 local Torres Strait Islanders who are able to speak some of the Traditional languages, these officers should be hired with the understanding that these jobs are for positions in the Torres Strait once they have successfully completed there training. On a number of occasions in the Courier Mail e.g. April 10-11 2010 page 22 it has been brought to the Queensland communities attention the urgent need for trained officers to work in the Torres Straits, in regards to drug trafficking and diseases that can come in from Papua New Guinea, these officers should work a rotation basis in and out from Thursday Island to the following Islands e.g. Boigu, Dauan, Saibai, Stephen I (Ugar), Darnley I (Erub), Coconut I (Poruma) Sue I (Warraber), Yam I (Iama) and Mabuiag

The Australian Parliament Joint Committee on Australian Crime Commission conducted an inquiry http://www.aph.gov.au/senate/committee/acc_ctte/laoscg/report/c03.htm

The evidence received by the committee during this inquiry focused on three broad types of legislation designed to target serious and organised crime:

- Laws which aim to prevent members of organised crime groups from associating with one another.
- Proceeds of crime or asset confiscation laws which remove illegally acquired assets with the aim of removing the motivation for criminal activity and preventing those assets from being used to fund further organised criminal activities.
- Policing laws which confer additional powers on police to enable them to more easily investigate and prove organised crime offences, for example telecommunications, interception and surveillance powers, the ability to conduct controlled operations or assume false identities and coercive questioning powers.

The Inquiry reached the following conclusion regarding key pieces of legislation in each Australian jurisdiction aimed at combating serious and organised crime. Each jurisdiction currently has a different set of legislative tools, including different criminal laws, proceeds of crime laws and a variety of policing powers. The development of different legislation in each jurisdiction is in part a response to specific law enforcement issues and criminal milieu. The benefit of such targeted legislation is that it enables law enforcement to effectively respond to the problems confronting their particular jurisdiction.

However, with the increasing complexity of organised crime, including its reliance on national and transnational networks, having different laws in each jurisdiction can make the national fight against serious and organised crime in Australia complex. The committee heard that there are often **loopholes and weak points created by the variety of legislative** approaches in Australia, and that criminals will often move to, or store their assets in, jurisdictions with 'weaker' laws. These issues are examined in further detail in chapter 6.

While this chapter has provided an overview of legislative arrangements in each Australian jurisdiction, chapters 4 and 5 consider in detail the major legislative approaches in Australian jurisdictions and internationally, which aim to prevent serious and organised crime. It is very important that the Social Development Committee make recommendations to the Government departments responsible to report on the progress that has been made to meet these recommendations outlined by the inquiry, especially the legislation in regards to the proceeds of crime or asset confiscation laws which remove illegally acquired assets with the aim of removing the motivation for criminal activity and preventing those assets from being used to fund further organised criminal activities. They also need to identify loopholes and weak points created by the variety of legislative approaches in Australia.

It's important for the Committee to note that the ACT is the only jurisdiction in Australia without roadside random drug testing laws.

References

(1)NOAH The *"Evaluation of Operation NOAH 1992: a quantitative and qualitative study"* by Karen Beck available from National Library of Australia ABN 28346858075 ISBN:064219632X call number NLq 363.259770994 B393

(2) Crime and Misconduct Commission *"Illicit drug markets in Queensland"* Crime Bulletin Series Number 12, February 2010.

(3) The Australian Parliament Joint Committee on Australian Crime Commission inquiry http://www.aph.gov.au/senate/committee/acc_ctte/laoscg/report/c03.htm Chapter 3

END

Herschel M Baker
Director
Drug Free Australia
c/-Mr. Craig Thompson
PO Box 497
Elizabeth SA 5112

21 April 2010

Ms Lindy Nelson Carr MP
Chair
c/-The Research Director
Social Development Committee
George Street
Brisbane QLD 4000
Or by facsimile to 07 3406 7500
Or by email to sdc@parliament.qld.gov.au

Dear Madam

6. What treatment options should be available to cannabis users?

As identified in the paper "*Cannabis-suicide, schizophrenia and other ill-effects"* health professionals, including drug counselors, addiction specialists, psychiatrists, psychologists and general practitioners urgently need much better education in terms of the documented and agreed upon harms and have agreement to strongly discourage any cannabis use by those whom they counsel or to whom they provide treatment for drug related problems. What is actually happening in our community in diverse therapeutic settings is that patients are repeatedly given benign or nonchalant advice on cannabis e.g. The mother who was a nurse took her teenage son who was a heavy user of cannabis to a counselors who told her son, "I use cannabis and there's nothing wrong with me" the mother was beside herself because of the problems that cannabis was causing her son.

There is a need for effective treatment of cannabis misuse. Psychological therapies have been developed based on principles of motivational interviewing, cognitive-behavioural therapy and relapse prevention. The evidence base for these therapies is explored in a review by Maddock & Babbs (2006), and studies targeting both adult users and young people are considered. They also discuss new pharmacological treatments.

Increased recognition that marijuana can cause addiction and significant negative consequences in a subset of users has prompted the development of marijuana-specific interventions and treatment materials paralleling those for other substance use disorders. These advances have increased users' and caregivers' perceptions that it is acceptable to seek and provide treatment for cannabis use and have contributed to an increase in the number of individuals requesting help (Budney, 2007). In light of the recognition that people smoke cannabis mainly for pleasure (euphoria/"high") it is noted that none of the available treatments are highly effective.

The Substance Abuse and Mental Health Services Administration (SAMHSA) released a treatment manual titled "Brief Counselling for Marijuana Dependence – a Manual for Treating Adults" and outlined procedures for individuals who use cannabis as their primary drug. The manual suggested chronic cannabis users tended not to seek treatment in traditional drug treatment settings, but that when given the opportunity would respond positively. Increasing evidence suggests that counseling for cannabis dependence is effective (Steinberg et al, 2002; SAMHSA, 2005).

Clients in treatment require a sense of hope and positive expectations are especially critical when facing a protracted period of withdrawal (Zweben & O'Connell, 1992). Programs designed to aid cessation should focus on the negative effects of marijuana and should offer alternative ways to relieve negative physical and psychological conditions such as stress (Weiner, 1999).

Professionals working with cannabis dependent people often see them relapse repeatedly. Relapse may involve the length of detoxification; ease of access to the substance; social pressures in schools, work, entertainment, social and family settings; persistent denial; or the high level of functioning many addicts have when they enter recovery. Marijuana addicts who have not previously shown extensive drinking histories often believe they can consume alcohol and this can lead to a cannabis relapse (Chacin, 1996). Budney et al (2002) found clinical trials evaluating treatment for cannabis dependence suggest that the withdrawal syndrome, like other substance dependence disorders, is responsive to intervention but the majority have difficulty achieving and maintaining abstinence.

In Nagel, T. 2009 random effects regression analyses showed significant advantage for the treatment condition in terms of well-being with changes in health of the nation outcome scales ($P < 0.001$) and Kessler 10 ($P = 0.001$), which were sustained over time. There was also significant advantage for treatment for alcohol dependence ($P = 0.05$), with response also evident in cannabis dependence ($P = 0.064$) and with changes in substance dependence sustained over time. CONCLUSIONS: These results suggest that motivational care planning (MCP) is an effective treatment for Indigenous people with mental illness and provide insight into the experience of mental illness in remote communities.

In recent years, multiple sources have released suggested treatment programs, ranging from counseling treatments for adults (SAMHSA, 2005), intervention programs (Maddock & Babbs, 2006) and specific treatment programs developed for women (Chacin, 2006). The work of Roffman & Stephens (2006), Steinberg & Roffman (2002) and Budney et al (2007) also discuss treatment options and are recommended reading on the topic.

Reference

Budney AJ, Brent A, Moore. *"Development and Consequences of Cannabis Dependence"* J. Clin Pharmacol **42**:28S-33S 2002.

Budney, A., & Stanger, C. (2007). *Contingency management for Marijuana (Cannabis) Abuse and Dependence.* In S. Higgins, K. Silverman, & S. Heil (Eds). *Contingency Management in the treatment of Substance Use Disorders: A science-based treatment innovation.* New York: Guilford. Chapter 4 Marijuana pp 61-79.

Chacin S., *"Women's Marijuana Problems: An Overview with Implications for Outreach, Intervention, Treatment, and Research"* Journal of Chemical Dependency Treatment Vol. **6,** No. ½, pp, 129-167 1996.

Maddock Clementine & Babbs Michelle *"Intervention for cannabis misuse"* Advances in Psyhiatric Vol. **12,** 432-439 2006.

Nagel, T., Robinson, G., Condon, J., & Trauer, T. (2009). *Approach to treatment of mental illness and substance dependence in remote Indigenous communities: Results of a mixed methods study.* The Australian Journal of Rural Health *17*, 174-182.

Roffman R, Stephens R, Marlatt A *"Cannabis Dependence Its Nature, Consequences and Treatment"* Cambridge, UK: Cambridge University Press ISBN#0-521-81447-2. 2006. http://assets.cambridge.org/97805218/14478/frontmatter/9780521814478_frontmatter.pdf

SAMHSA's *"Brief Counselling for Marijuana Dependence A Manual for Treating Adults"166 pages* Substance Abuse and Mental Health Services Administration 2005. www.ncadi.samhsa.gov

Steinberg, K.L.; Roffman, R.A.; Carroll, K.M.; Kabela, E.; Kadden, R.; Miller, M.; Duresky, D.; and The Marijuana Treatment Project Research Group. *"Tailoring cannabis dependence treatment for a diverse population".* Addiction Vol. **97**(Suppl. 1):135–142, 2002.

Weiner Michelle D., Sussman Steve, McCuller William J., Lichtman Kara *"Factors in Marijuana Cessation among High-Risk Youth"* J Drug Education Vol **29**(4) 337-357, 1999.

Zweben Joan Ellen Ph.D., O'Connell Kathleen *"Strategies for Breaking Marijuana Dependence"* Journal of Psychoactive Drugs Vol **24**(2) pp 165-171 1992. http://members.optushome.com.au/~apfdfy/Strategy.html

END

Herschel M Baker
Director
Drug Free Australia
c/-Mr. Craig Thompson
PO Box 497
Elizabeth SA 5112

20 April 2010

Ms Lindy Nelson Carr MP
Chair
c/-The Research Director
Social Development Committee
George Street
Brisbane QLD 4000
Or by facsimile to 07 3406 7500
Or by email to sdc@parliament.qld.gov.au

Dear Madam

7. What approaches should be used to reduce cannabis use in Aboriginal and Torres Strait Islander communities?

That recommendation Number 70 of the report to the *Ampe Akelyernemane Meke Mekarle* "Little Children are Sacred" Inquiry be fully implemented. This recommends that government develop and implement a multi-faceted approach to address the abuse of illicit substances in Aboriginal communities, in particular cannabis. This approach should include strategies for prevention, intervention and enforcement strategies which:

a) Recognise the geographic context of substance abuse, which occurs in both urban and remote locations, and its implications; and

b) Are population-based, youth-focused and integrate substance abuse, mental health and other health and welfare concerns into youth programs.

(1)**Nagel, T.** 2009 Random effects regression analyses showed significant advantage for the treatment condition in terms of well-being with changes in health of the nation outcome scales ($P < 0.001$) and Kessler 10 ($P = 0.001$), which were sustained over time. There was also significant advantage for treatment for alcohol dependence ($P = 0.05$), with response also evident in cannabis dependence ($P = 0.064$) and with changes in substance dependence sustained over time. CONCLUSIONS: These results suggest that motivational care planning (MCP) is an effective treatment for Indigenous people with mental illness and provides insight into the experience of mental illness in remote communities.

(2)**NSW Health** 2009 has established 5 clinics for cannabis users, with a 6th due to open in the Hunter New England Area Health Service mid 2009. The clinics offer outpatient services for people 16 years or over seeking to stop or reduce their cannabis use. Cannabis users with mental health issues and parents and carers of cannabis users are also offered support. http://ncpic.org.au/ncpic/links/treatment/ It does appear that if these clinics have been independently evaluated and meet with best practice then it would be appropriate that this model could be used within our Queensland hospital grounds at Thursday Island 4875, Mt Isa 4825, Cairns 4870 in the first instance, in other words there is no sense in recreating the wheel. It should also be noted that the Queensland Indigenous Alcohol Diversion Program (QIQDP) has commenced a three-

year pilot program in July 2007 in three areas: Townsville and Palm Island, Cairns and Yarrabah, Rockhampton and Woorabinda hopefully, an independent evaluation has taken place and the results should give the Social Development committee evidence on which to base the overall data to make some important recommendations in this important strategy.

(3)**NCPIC** 2010 is shortly launching its Indigenous community project, *"Cannabis: It's not our culture"*. NCPIC program will take the form of a dedicated section of our website, resources for Indigenous health services and an art exhibition which will be held in late March. Images of the artworks and their accompanying stories from the exhibition, will be available on our website. These were created by seven Indigenous communities around Australia on the theme of how cannabis impacts their communities and the solutions they see to cannabis-related issues. http://ncpic.org.au/indigenous/

(4/5) **NCPIC** CLIMATE SCHOOL 2009 The CLIMATE Schools drug prevention programs, which are based on a harm-minimisation approach, have been designed to overcome such concerns by being specifically developed to enhance high fidelity program implementation. In terms of improving implementation, the CLIMATE Schools programs http://ncpic.org.au/ncpic/publications/bulletins/article/bulletin-9-climatecrufad-schools-cannabis-prevention-programs have also been developed in collaboration with teachers, students and relevant health and legal professionals to ensure they address different issues which have been identified to compromise implementation (e.g., program complexity, teacher workload, teacher training and program adaptation). Specifically, each of the CLIMATE school's drug prevention programs is a curriculum-based program consisting of six lessons, each with two components; a 15-20 minute computer-based component and an array of prepared classroom activities for teachers and pupils.

The computer component involves students navigating their way through a cartoon-based teenage drama. Each lesson deliberately forms part of an ongoing teenage drama to encourage teachers to present all lessons and avoid the temptation to omit any one of them. The computer and internet delivery guarantees that the complete content is consistently delivered to each student overcoming the majority of the obstacles to effective program implementation. The classroom activities are included to allow students to interact with the content in relation to their own lives. They are provided in the manual to ensure that all the activities comply with the principles of evidence-based drug prevention, but also decrease the teacher's workload. These activities include role plays, small group discussions, decision making and problem solving activities and skill rehearsal, all of which have been identified as being central to program efficacy.

Conclusions

The innovative design of the CLIMATE Schools drug prevention program has been found to be effective in increasing cannabis-related knowledge, and decreasing the cannabis use up to twelve months following the interventions. In addition, the contemporary and novel design and delivery of the courses has been found to be acceptable to students and teachers as a means of delivering drug education. As such, the novel internet-based course, which adopts a specific harm-minimisation goal, provides a promising framework for the provision of school-based prevention programs in the future.

(6)Drug Free Australia supports online computer-based component for drug education along the lines of Lilibiggs URL http://www.lilibiggs.ch but it must be supported by an array of prepared classroom activities for teachers and pupils. If the Committee requires additional data in this regards please contact Ms Jo Baxter Mobil: 0403334002 Phone: 08 82441185.

(7)Drug Free Australia brings to the urgent attention of the committee a program called Drug Abuse Resistance Education (D.A.R.E.) It seems that this program has received some negative comments from Health Education Professionals, but when you have The President of the United States making the following statements you need to take notice. "I BARACK OBAMA, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim April 8, 2009, as National D.A.R.E. Day.

The D.A.R.E. program has worked to educate students about drugs, gangs, and violence for more than 25 years. Placing law-enforcement personnel in the classroom, D.A.R.E. provides students with important lessons from experts and seeks to prepare them for the difficult encounters and choices they may face.

Education efforts to help children avoid drugs and violence must begin in the home. Parents must be positive role models and take the lead in advising their children on the effects of drugs on their health and well-being.

Today we honor D.A.R.E. for its important work. The efforts of D.A.R.E.'s instructors and supporters benefit our Nation's children and are deserving of praise and appreciation. D.A.R.E.'s renewed efforts to implement science-based programs and to strengthen partnerships among law enforcement, families, and their communities are particularly worthy of commendation. Through effective teaching methods and broad participation, D.A.R.E. can help ensure that every child in America enjoys the opportunities he or she deserves".

(8) The committee should be aware of one of Queensland most exciting strategies in the view of Drug Free Australia called Coordinated Response to Young People at Risk (CRYPAR) run by the Child Protection and Investigation Unit, Queensland Police Service. In the first 12 months of operation in North Brisbane Police District, officers referred 293 young people/families, a quarter being under the age of 13 and with a 96 per cent successful engagement rate. The leading issues were "family conflict", "drug and alcohol misuse" it has been found that these children usually come to the attention of the police around a year before being noticed by other agency e.g. schools. The committee can obtain further information by contacting Inspector Shane Doyle, Officer in Charge of the Drug and Alcohol Coordination Unit Queensland Police Service.

(9)Lee, K.S. 2008 The high prevalence of cannabis use and emerging evidence of an association with mental disorders suggests a need for clinical interventions and preventive programs aimed at cannabis misuse in Indigenous communities, along with continued support for measures to reduce supply.

(10)QPS Far Northern Region, in partnership with James Cook University and the National Cannabis Prevention and Information Centre, is working with communities in Cape York and the Torres Strait to reduce cannabis use and availability and strategically

address the prospect of amphetamine-type stimulants being introduced to those communities

http://www.police.qld.gov.au/Resources/Internet/services/reportsPublications/bulletin/331/documents/28.pdf

In April 2007 Detective Senior Sergeant Mick Dowie, Officer-in-Charge of Far Northern Region Drug Squad, collaborated with Associate Professor Alan Clough of JCU's Cairns campus to find a way to address cannabis related harms in the region's remote Indigenous communities.

(11) James Cook University "(JCU) on the other hand is responsible for gathering accurate localised data from three Cape York Communities to expand on the research data available from the NT surveys. "The research team will also work with community members and stakeholder agencies to develop long-term demand reduction strategies and educational packages."
http://cms.jcu.edu.au/phtmr/abc/research/JCUPRD_055084

The research team will be using the following guide-lines.

1. Self- reported cannabis use will be measured in each community at the beginning and towards the end of the project

- Each person aged 16-34 & usually resident in the community will be invited to take part in a 10-15 minute interview. If the person uses cannabis they will be asked some questions about their cannabis use (eg how old when first started, how often they use, any attempts to quit or cut down).
- We will ask that people do NOT tell us about cannabis supply and distribution or other cannabis-related criminal activities
- Interview information will be confidential
- Interviews with the same questions will be repeated towards the end of the project

2. The research team will assist with development of community- based demand-reduction initiatives.

- These initiatives will commence following the baseline studies
- They will occur at the same time as police strategies to reduce cannabis supply
- The research team will work collaboratively with existing service providers and key community stakeholders
- Initiatives will include: public meetings; provision of further training for health workers; working closely with schools and workplaces; resource development; continued project feedback to communities

- These demand-reduction initiatives will be developed **with** each community

Anticipated outcomes

- Reduction in cannabis use.
- Reduction in adverse mental health effects.
- Fewer young people taking up cannabis use.
- Increased capacity of communities to address cannabis issues

REFERENCE

(1)Nagel, T., Robinson, G., Condon, J., & Trauer, T. (2009). Approach to treatment of mental illness and substance dependence in remote Indigenous communities: Results of a mixed methods study. *The Australian Journal of Rural Health 17*, 174-182.

(2) NSW Health. (2009) http://ncpic.org.au/ncpic/links/treatment/

(3)NCPIC (2010) http://ncpic.org.au/indigenous/

(4) NCPIC (2009) Climate School Bulletin Series 9 November 2009. http://ncpic.org.au/ncpic/publications/bulletins/article/bulletin-9-climatecrufad-schools-cannabis-prevention-programs

(5) NCPIC 2009 Cannabis use prevention methods in Australian schools Bulletin 6 30 June 2009.http://ncpic.org.au/ncpic/publications/bulletins/article/bulletin-6-cannabis-use-prevention-methods-in-australian-schools.

(6) Drug Free Australia Children Healthly Life Skills Website e.g. Lilibiggs http://www.lilibiggs.ch

(7)Drug Abuse Resistance Education (D.A.R.E.) http://www.dare.org/home/default.asp

(8)Coordinated Response to Young People at Risk (CRYPAR) run by the Child Protection and Investigation Unit, Queensland Police.

(9)Lee, KS, Conigrave, KM, Patton, GC & Clough, AR. (2009). Cannabis use in remote Indigenous communities in Australia: Endemic yet neglected. *Medical Journal of Australia, 190*(5), 228-229.

(10)QPS Far Northern Region, in partnership with James Cook University and the National Cannabis Prevention and Information Centre http://www.police.qld.gov.au/Resources/Internet/services/reportsPublications/bulletin/331/documents/28.pdf

(11) James Cook University 2009 develop long-term demand reduction strategies and educational packages." http://cms.jcu.edu.au/phtmr/abc/research/JCUPRD_055084

Australian Bureau of Statistics. (2006). National Aboriginal and Torres Strait Islander Health Survey. Australia 2004-2005. ABS: Canberra (Cat. No. 4715.0) (Table 20, page 47).

Australian Institute of Health and Welfare. (2005). Statistics on drug use in Australia 2004. AIHW: Canberra (Cat no. PHE 62).

Northern Territory Police, Fire and Emergency Services. 2007 annual report. Darwin: NTPFES, 2007. http://www.nt.gov.au/pfes/documents/File/police/publications/annrep/Annual_Report_2007_FINAL.pdf (accessed Apr 2008).

Delahunty B, Putt J. 2006 The policing implications of cannabis, amphetamine and other illicit drug use in Aboriginal and Torres Strait Islander communities. Canberra: Commonwealth of Australia. http://www.aic.gov.au/publications/other/2006-ndlerfmono15.html (accessed Feb 2008).

Queensland Indigenous Alcohol Diversion Program (QIQDP) has commence a three-year pilot program in July 2007 in three areas: Townsville and Palm Island, Cairns and Yarrabah, Rockhampton and Woorabinda

Herschel M Baker
Director
Drug Free Australia
c/-Mr. Craig Thompson
PO Box 497
Elizabeth SA 5112

20 April 2010

Ms Lindy Nelson Carr MP
Chair
c/-The Research Director
Social Development Committee
George Street
Brisbane QLD 4000
Or by facsimile to 07 3406 7500
Or by email to sdc@parliament.qld.gov.au

Dear Madam

(8) The committee invites comments about any of the strategies mentioned or any alternative strategies for reducing cannabis use.

The latest annual report from the International Narcotics Control Board(1) claims that during 2007/8 an amount of 5400 kgs of Cannabis was seized in Australia, widespread use of cannabis in Australia underpins demand here, and that most of the cannabis seized in Australia had been grown in Australia. Of the imported cannabis seized in Australia, the Netherlands, **Papua New Guinea**, Thailand and the USA were the places of embarkation. Organized crime syndicates are the beneficiaries of the high cannabis demand in Australia and the Board is concerned about a cannabis industry being established to satisfy Australian demand.

The experts(2) say there are almost 100 organised crime groups of national significance in Australia and the sector's annual turnover is more than $10 billion, most of it from sales of illegal drugs. In his book Smack Australia, the former NSW police assistant commissioner Clive Small notes that apparently big drug busts in recent years have made little or no difference to the availability or price of illegal drugs. This, he writes, indicates the scale of the problem and "throws into serious question the strategies now employed by government and law enforcement agencies for combating organised crime".

It has become widely acknowledged that organised crime was regularly breaking states' laws, as well as the Commonwealth's. Australia had no agency capable of tackling this. The Australian Federal Police was concerned largely with crimes against federal and territory laws. To fight national crime effectively, the AFP and the state police forces needed to co-operate and this had proved almost impossible due to jealousy and mistrust, the latter often based, quite rightly, on the suspicion that one's counterparts elsewhere were corrupt.

Jason Wood was a Victorian detective before he became a Liberal federal MP. He's now the shadow parliamentary secretary for justice and public security and a member of the ACC oversight committee. He says the recent idea that you can fight crime by having one agency collecting information and others conducting the investigation is wrong.

"I know from my own experience, it's very hard if you haven't been involved from the beginning," he says. "The changes in the ACC are just about budget cuts. This [reduction in investigations by a national agency] is a devastating blow to law enforcement in this country, and a huge win to those involved in national organised crime."

For some time, Bob Bottom has urged the joint committee to conduct a review of the ACC. The committee does not want to do this and its chairman, Steve Hutchins, refused to talk to the Herald about Bottom's criticisms. In his most recent submission to the committee, Bottom noted that it is 25 years since the NCA was founded as a standing royal commission, a concept that "evolved from an **Australian-wide citizen campaign**, a series of royal commissions and an historic national crime summit".

"Whichever way you look at it and whoever pulled the strings, the downgrading of the ACC represents a victory for Canberra's white shirt brigade, in contempt of state and territory governments, and a betrayal of the Australian people."

Drug free Australia believes that the committee needs to look at the successful policy being used in Sweden which has a National Action Plan (3) for mobilisation and coordination of the Swedish National drug Policy and has adopted a long-term approach to create the prerequisites for sustainable, durable work based on the shared attitude that illicit drugs can never be accepted, - create opinions and mobilise against drugs, mainly by helping to strengthen and coordinate work against drugs at local, regional and national level, - bring to life the vision of a drugs-free society, - contribute to strengthening the positive forces that we know protect against abuse and equip young people with social ability, self-confidence, knowledge, belief in the future, etc, - work for action against the factors and environments that expose children and young people to the dangers of drug abuse, poor health, social exclusion or criminality, - contribute to effective treatment being made available to everyone who needs it, by, for instance, supporting research and method development, - support the work against the illegal drugs trade, by, for instance, stimulating the development of new methods to combat drugs related criminality, contribute to building up functioning collaboration between preventative work and early measures, care and treatment and combating crime, - ensuring that measures against drugs are followed up and evaluated and that good examples are spread, To implement this national action plan, we will undertake extensive outreach work and initiate various projects.

Reference

(1)2009 Annual Report, International Narcotics Control Board released 24 February 2010.

(2)A reprieve for organised crime Aug 29, 2009 1:15am Article from: Sydney Morning Herald.

Michael Duffy reports on concerns that empire building and jealousies robbed Australia of a shot at our own **FBI.**

(3) *National Action Plan* for mobilisation and coordination of the Swedish National Drug Policy.

http://www.fhi.se/PageFiles/7547/MOB2004-national-action-plan-for-mobilisation-and-coordination-of-the-Swedish-national-drug-policy.pdf

END

Herschel M Baker
Director
Drug Free Australia
c/-Mr. Craig Thompson
PO Box 497
Elizabeth SA 5112