

Cannabis 'makes the grade'

Exploring cannabis content in accredited AOD training

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National Cannabis Prevention and Information Centre²



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Forum Outline

- * Introductions
- * Cannabis - the essentials
- * Its only boring if... engaging students
- * Making it work - developing a curriculum framework
- * Hitting the target – different student sub-groups
- * Contextualising training for specific groups
- * Incorporating new evidence
- * “Cannabis competency”
- * Assessing cannabis competency
- * Assessment and RPL strategies
- * Moderation and continuous improvement
- * Review, questions, feedback and close



NCETA's Roles

Research
Generation

Research
synthesis

Facilitating
research-
policy/
practice
transition

Research
translation

Implementing
What We
Know Works

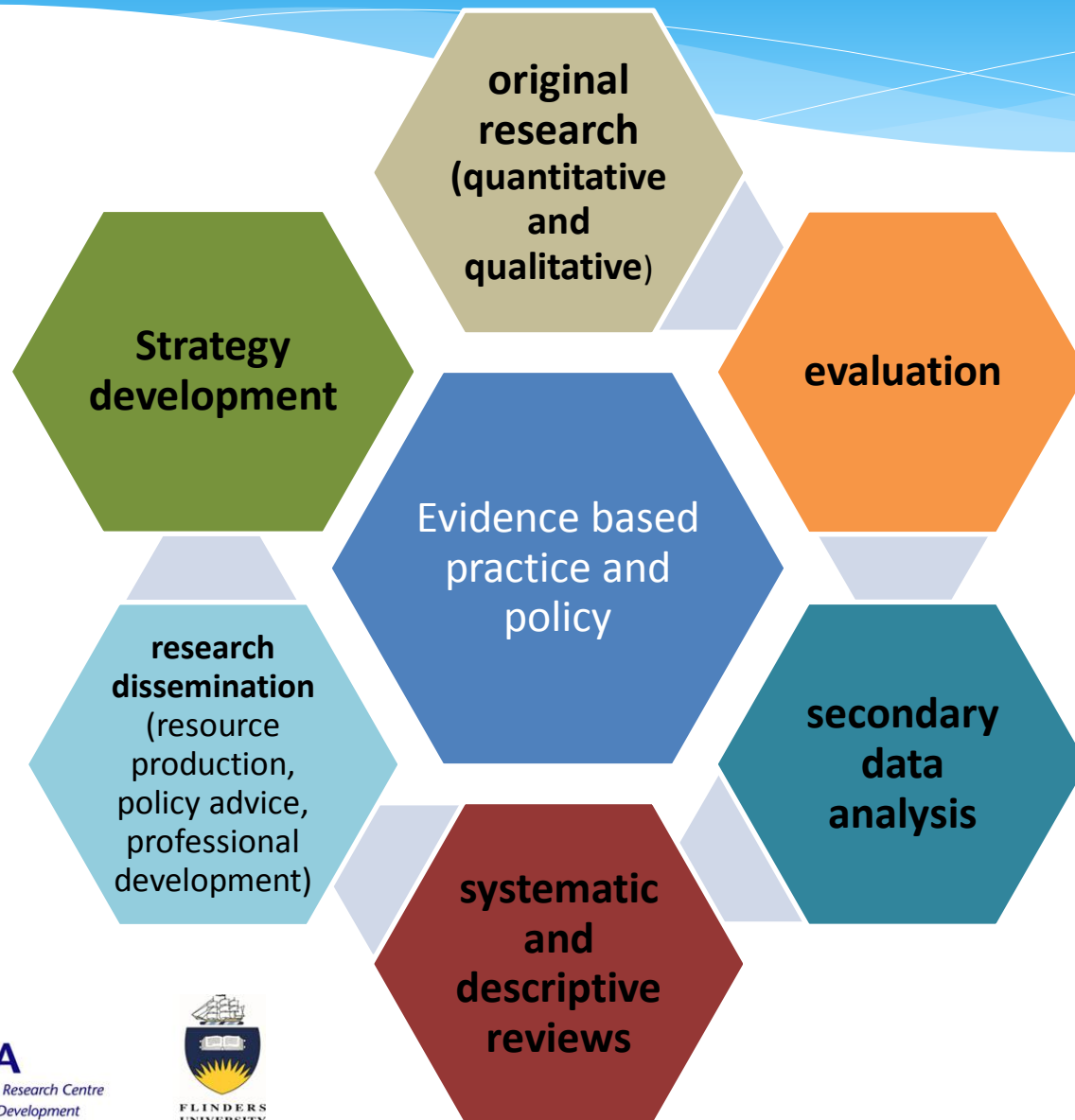


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NCETA's Activities



NCPIC's Key Goals

NCPIC's key goals are:

- * to provide the Australian community with access to evidence-based information on cannabis and related harms
- * to provide community access to, and awareness of, evidence-based information to prevent uptake, and continuation, of cannabis use
- * to supply service providers with evidence-based interventions to respond to people experiencing cannabis-related problems



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Icebreaker - 3 things - 1 lie

- * Work in pairs. Introduce yourself to each other by sharing three things about yourself. One of the things should be a lie.
- * A bit of detail helps. You each have 2-3 minutes for your introduction.
- * Introduce your partner to the whole group.
- * We then have to guess what things were lies.



Workshop purpose

- * To provide a forum for exploring the delivery of cannabis related content in the three core AOD units of competency (CHCAOD402, CHCAOD406, CHCAOD408).
- * Recent research by NCETA identified that:
 - * many providers do not give sufficient attention to cannabis
 - * some of the messages given to students (both those pre-employment and in the workforce) underplay cannabis as a drug of concern
 - * students are leaving training unprepared to deal with clients cannabis issues[1]



Why is cannabis content an issue?

- * In 2012 NCETA undertook research resulting in a report, 'Trainers Talking Training: An examination of vocational education and Training for the Alcohol and other Drug sector in Australia' [1]
- * This report identified, along with a number of other issues, that whilst cannabis was the most popularly used illicit drug, and after alcohol and tobacco, the most common drug of concern for clients presenting at AOD services few training providers specifically:
 - * focused on cannabis in training
 - * addressed cannabis in assessment strategies
 - * addressed cannabis in recognition of prior learning



Why cannabis 'fails to make the grade'

(findings from Trainers Talking Training)

Whilst the majority (96%) of respondents believed that it was very important that cannabis was addressed in training, they identified a number of significant barriers:

- * Limited student interest
- * Myths and misperceptions held by some students, trainers and AOD workers e.g., cannabis was a 'soft' or 'natural' drug
- * Community acceptance of cannabis use
- * Some students and trainers personal experience of use.



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Cannabis - the essentials

Pop quiz

* Rank the following drugs from 1 (high) -8 (low) in relation to:

	Prevalence of use in community	Most common PDOC	Student interest	% of course devoted to drug	students likely to have used
Cannabis					
Alcohol					
Tobacco					
Cocaine					
Heroin					
Meth/Amphet					
Pharma					
Ecstasy					



Pop quiz

* Results from 2010 National Drug Strategy Household Survey Report:

	Prevalence of use in community	% of clients with drug as PDOC	Most common PDOC	Student interest	% of course devoted to drug	students likely to have used
Alcohol	1 (80.5%)	45.6	1	?	?	?
Cannabis	3 (10.3%)	22.0	2	?	?	?
Meth/ Amphet	6 (2.1%)	11.2	3	?	?	?
Heroin	8 (0.02)	8.7	4	?	?	?
Pharmaceuts	4 (4.2%)	4.0	5	?	?	?
Tobacco	2 (16.6 d/w)	1.0	8*	?	?	?
Ecstasy	5 (3%)	0.05	6	?	?	?
Cocaine	7 (2.1%)	0.03	7	?	?	?



Cannabis: Properties

**Active ingredient:
THC or delta₉tetrahydrocannabinol**

- * Frequently, but erroneously, classified as a narcotic, sedative or hallucinogen. Sits alone within a unique class
- * Rapidly absorbed and metabolised when smoked, less so when ingested (1–3 hours for psychoactive effects)
- * Attaches to specific cannabinoid receptors in the brain.

NCETA, 2004, Resource Kit for GP Trainers



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Cannabis Forms

Forms include:

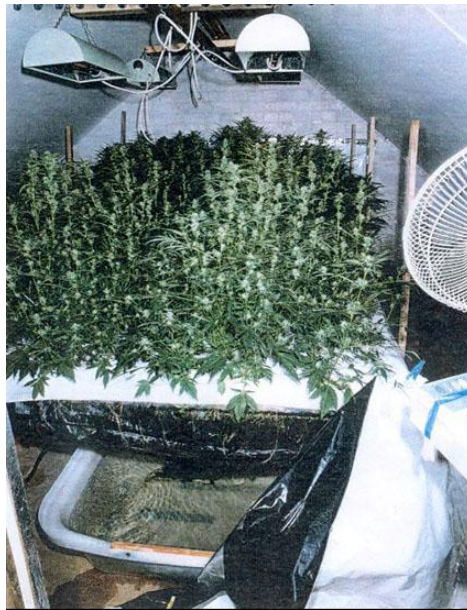
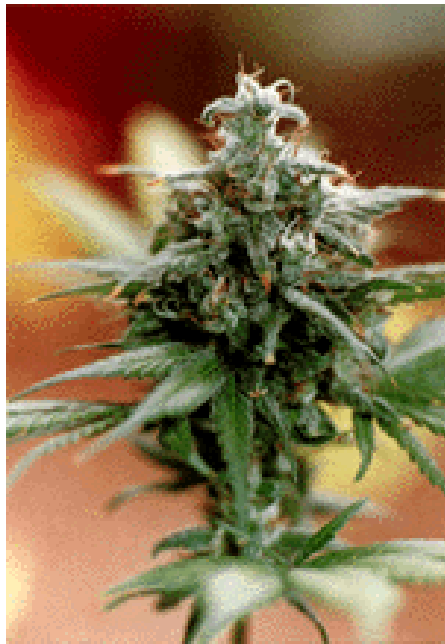
- * dried flowers/leaves/buds (*marijuana/ganja*)
 - * 1–15% THC (depending on genetic and environmental factors)
- * extracted dried resin, sometimes mixed with dried flowers and pressed into a cube (*hashish*)
 - * around 10%–20% THC
- * extracted oil using an organic solvent (*hashish oil*)
 - * 15–30% THC



Cannabis: Forms



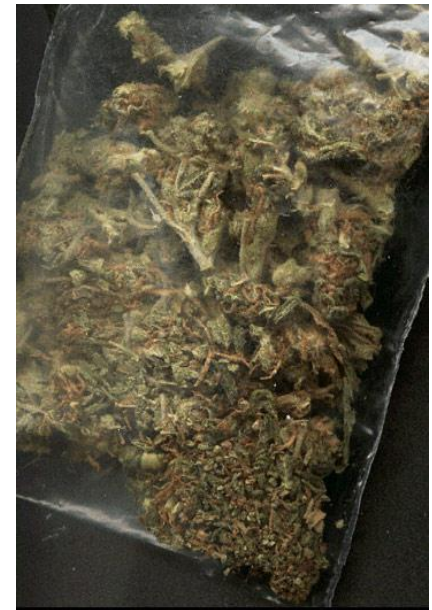
Cannabis plant
Photo by Wild Man, © 2000 Erowid.org



Hydroponic Cannabis Garden
Photo by FluffyWeed420. © Erowid



¼ Kilogram bar of Hashish
Photo by Carlito, © 2001 Erowid.org



Dried Cannabis Buds
photo by G4nj4M4th, © 2002 Erowid.org

Recent drug use 14+ (%) (NHDS, 2010)

Drug Behaviour	2010	Inc/Dec
Tobacco	16.6	↓
Alcohol	80.5	↓
Cannabis	10.3	↑
Pharmaceuticals	4.2	↑
Ecstasy	3.0	↓
Meth/Amphetamines	2.1	→
Cocaine	2.1	↑
Hallucinogens	1.4	↑
Inhalants	0.6	↑
Heroin	0.2	→



Cannabis prevalence (NHDS, 2010/2013)

- * Most commonly used illicit drug in Australia
- * One in three (34.8%) aged 14 + reported having used in their lifetime*
- * Mean age of initiation – 16.7 years, increased from 16.2 years in 2010*
- * Over one in ten (10.3%) used in the previous 12 months*
- * 18-19 and 20-29 yr olds most likely to have recently used (previous 12 months)#
- * 20-29 year old males most likely to report recent use (25%) compared to 17.5% of 20-29 yr females#
- * increase proportion had recently used in all age groups but only statistically significant for 50–59 yr olds (3.8% in 2007 to 5.5% in 2010)#
- * since 1998, recent cannabis use generally decreased in younger age groups, but either increased/remained stable for older age groups (40 yrs or older)#

(2013* preliminary data has been used where available, other data is from 2010#)



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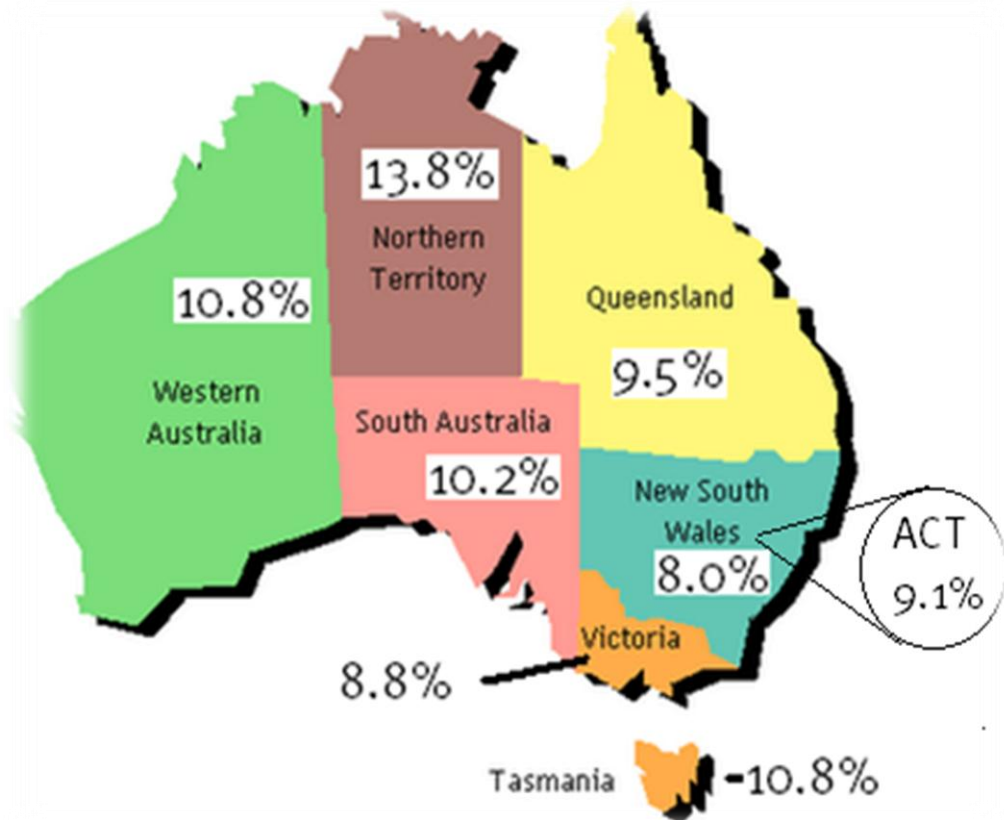
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Prevalence rates around the country (NHDS, 2010)

Frequency order

1. Northern Territory
2. Tasmania
3. Western Australia
4. South Australia
5. Queensland
6. ACT
7. Victoria
8. New South Wales



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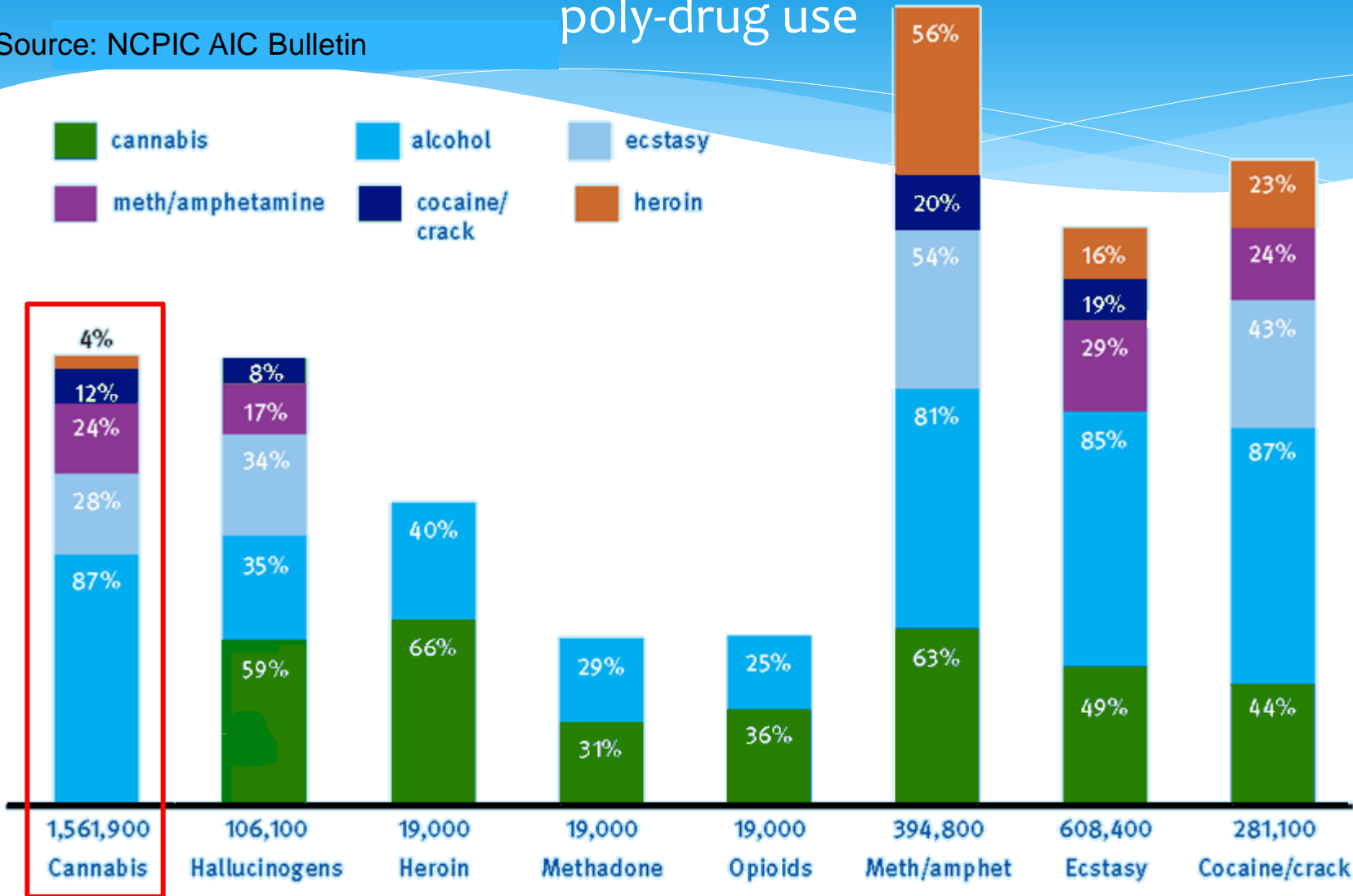


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Proportion (%) of general population reporting poly-drug use

Source: NCPIC AIC Bulletin



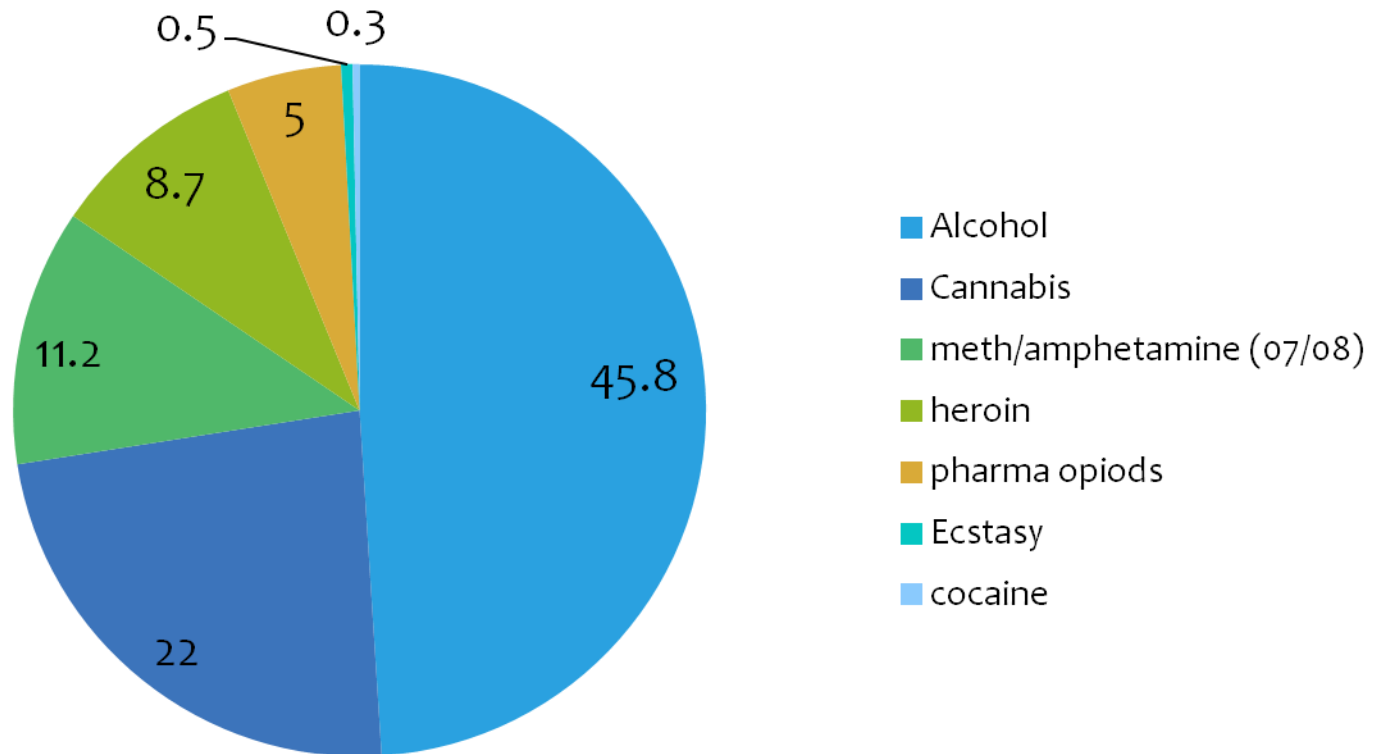
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Primary drug used

Treatment episodes (AIHW, 2012)

Presenting Drug of Concern 2010/2011



Route of administration

Can affect dose:

- * smoked

- * joint, pipe, bong, bucket bong

- * 50% absorbed, peak concentration 10–30 mins, lasts 2–4 hours.

- * ingested

- * cake, biscuits

- * 3–6% absorbed, peak concentration 2–3 hours, lasts up to 8 hours.



What it costs...

Average smoker

8 – 10 cones a day

56 - 70 cones per week

≈ \$125 - \$150

(≈ 2.25 each smoke)

1 oz = 28 grams

≈ 80 joints/280 cones

≈ \$300

**The more you buy the
cheaper it is**



¼ gram of cannabis
head/flowers
= 3 cones



1 gram of head/flowers
= 3 joints or 8 – 12 cones



1 gram packaged
\$20 – \$25

Source: IDRS, 2013 participant interviews



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Short Term, High-dose Effects

Cannabis also affects:

- short term memory
- ability to learn and retain new information
- task performance
- balance, stability, mental dexterity
- the cardiovascular and respiratory systems.

Short term, high-dose use may result in:

- synesthesia
- pseudo- or true hallucinations
- delusions, feelings of depersonalisation
- paranoia, agitation, panicky feelings, 'psychosis'.



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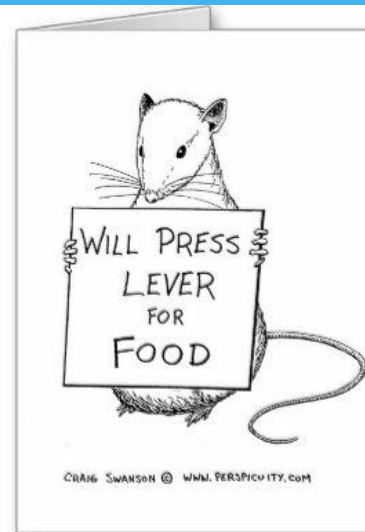
Cannabis: Acute Effects

- * Analgesia
- * Euphoria, altered concentration, relaxation, sense of calm or wellbeing, disinhibition, confusion
- * Increased appetite, thirst
- * Heightened visual, auditory and olfactory perceptions, resulting in inability to appropriately interpret surroundings
- * Reduced intra-ocular pressure (used for glaucoma treatment)
- * Nausea, headaches
- * With consistent use, upper respiratory tract infections
- * Problems associated with intoxication.



Cannabis: Heavy Use

- * Daily cannabis users are more likely to:
 - * have tried many illicit drugs
 - * use alcohol regularly
- * People with coexisting mental health problems often report high rates of regular cannabis use
- * Detox/withdrawal treatment mainly sought by men in their early 30's:
 - * who are using 30–50 cones per day
 - * who want to regain motivation
 - * whose relationships are at risk with continued use.



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Long-term Effects

- * Central nervous system
- * Respiratory system
- * Cardiovascular system
- * Immune system
- * Endocrine and reproductive systems
- * Adverse social outcomes
- * Mental health problems
- * Cognitive impairment
- * Dependence



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Risks associated with use

<p>Risks of acute intoxication</p>	<ul style="list-style-type: none">• impaired attention, memory, and psychomotor performance while intoxicated• cannabis-induced psychosis• increased risk of motor-vehicle accidents
<p>Most probable chronic effects</p>	<ul style="list-style-type: none">• subtle cognitive impairment in attention, memory, and the organisation and integration of complex information (of unknown reversibility, though not likely to be grossly debilitating)• increased risk of developing a dependence syndrome• adverse respiratory effects, such as chronic bronchitis (greater if cannabis is used with tobacco)



Risks associated with use

Possible chronic effects

- increased exposure to xerostomia (dry mouth) can lead to tooth decay, gum disease, and other oral-health issues
- some evidence cannabis may affect human female fertility
- found to reduce sperm count and testosterone levels in some male animals - not established in humans
- children exposed to cannabis in the womb may have more difficulties with problem-solving and attention, which may continue into adulthood and reduce education potential
- an increased likelihood of pre-cancerous changes
- increased rate of lung cancer
- increased possibility of heart attack in people who have risk factors for heart disease (e.g. obesity and/or cigarette smoking)



Risks associated with use

Probable risks amongst specific populations

- associations with adolescent cannabis use:
 - poorer school performance and outcomes
 - lower levels of degree attainment by age 25
 - higher unemployment
 - lower levels of life satisfaction
 - leaving the family home
 - early sexual activity and teenage pregnancy
 - other illicit drug use and dependence
- in women who continue to smoke cannabis during pregnancy, increased risk of having a low birthweight baby (can lead to mortality, morbidity, and disability)
- exacerbation of some mental health conditions such as depression , anxiety, and schizophrenia



Its only boring if...
(engaging students)

Discussion

In small groups and working with a unit choose one element of competency and identify where cannabis could fit:

- * Do you currently include content about cannabis at this point?
- * What could be the consequences of increasing the focus on cannabis?
- * Can cannabis content be blended with other content?

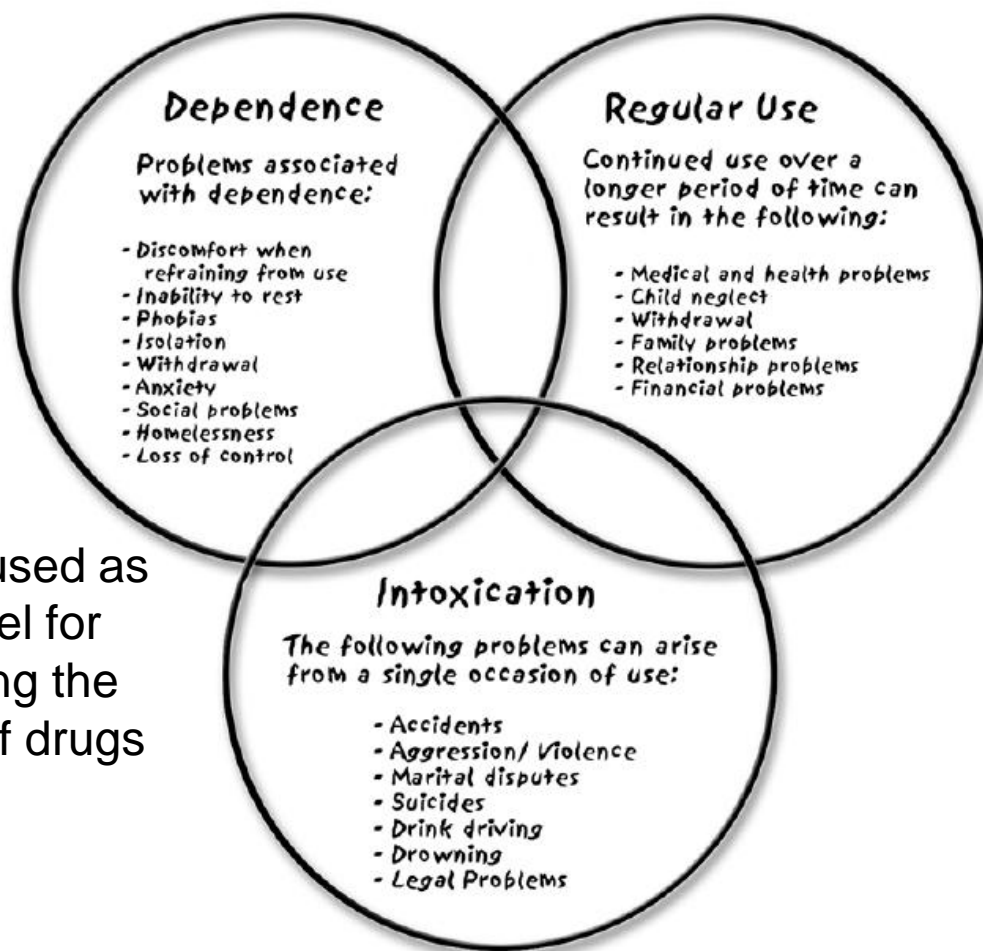


Finding cannabis in the competencies

ELEMENT	PERFORMANCE CRITERIA	CANNABIS RELATED CONTENT	SAMPLE ASSESSMENT ACTIVITIES/QUESTIONS
1. Work within the context of the AOD sector	1.1 Reflect consideration in all work in the sector of the historical context of the sector		
	1.2 Reflect consideration in all work of the changing social, political and economic context		
	1.3 Reflect consideration of the interrelationship of issues affecting clients in all work in the AOD sector		



Thorley's Model of Harm



Can be used as a model for exploring the impact of drugs

ACTIVITY

- Identify harms for different drugs, include alcohol and cannabis in your response.
- What are key similarities/differences in harms associated with the drugs you have chosen?



Engaging student's interest (NHDS 2010)

Students are often unaware of the importance of cannabis in clinical and community work:

- * Primary drug of concern in 22% of treatment episodes
- * Responsible for 66% of drug related arrests
- * Use increasing again after a number of years of decline
- * 13% of users are daily users
- * 72% of people who inject drugs (PWID) regularly use cannabis
- * 46% of PWID use cannabis daily
- * 85% of regular ecstasy users use cannabis (18% daily basis)
- * responsible for 5.5 ambulance call outs a day in Victoria



The Framework

Critical questions:

- * Is some of the content too basic?
- * Is some too difficult to deliver in the time you have available?
- * What other content do you have to deliver that may be lost?
- * Are there ways to blend cannabis and other content effectively?



Triaging the training

Hitting the target –
different student sub-groups

Discussion

- * What are the challenges of training different student cohorts e.g.:
 - * Pre-service workers
 - * In-service workers
 - * Peer support workers
 - * Nurses
 - * Students with pre-existing higher education qualifications



Aboriginal and Torres Strait Islander cannabis use

National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) 2004/5

- * 19.1% lifetime use
- * 9.1% previous year

2004 survey rural community (Arnhem Land, NT)

- * 69% of the males, 26% of the females had ever used
- * 67% of the males, 22% of the females had used it in the last month (among 336 13-36-year-olds)

2007 National Drug Household Survey

- * almost one in four Indigenous Australians used cannabis in last year

<http://ncpic.org.au/ncpic/publications/bulletins/article/bulletin-14-raising-awareness-about-cannabis-its-use-and-impact-on-health-and-wellbeing-among-indigenous-australians>



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Aboriginal and Torres Strait Islander peoples' cannabis use

Limited available data suggests:

- * Higher rates of use and dependence (especially rural communities)
- * Indigenous secondary students significantly more likely to use, more susceptible to initiating use and use more frequently
- * More harmful ways of using cannabis (e.g., 'bucket bong')
- * Indigenous communities have expressed concerns about:
 - * high proportion of income spent on cannabis
 - * community violence related to supply
 - * child neglect, sexual exploitation
 - * declining participation in community life
 - * reduced participation in education and training

<http://ncpic.org.au/ncpic/publications/bulletins/article/bulletin-14-raising-awareness-about-cannabis-its-use-and-impact-on-health-and-wellbeing-among-indigenous-australians>



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Aboriginal and Torres Strait Islander Students

- * *Feeling Deadly, Working Deadly* is a new NCETA resource, builds on the *Indigenous Worker Wellbeing* resource
- * It is designed to provide organisations and workers with support and information on working with Aboriginal and Torres Strait Islander colleagues
- * It can be used in training to explore the issues facing Indigenous AOD workers
- * It identifies and provides guidance on many of the issues facing Indigenous AOD workers
- * Cannabis is a significant problem in many Indigenous communities



Video

- * Watch the video 'A day in the life...' which is part of the NCETA *Feeling Deadly, Working Deadly* resource kit
- * Imagine Keith is a student in your course undertaking his Certificate IV in CS (AOD).
 - * What might be some of the issues he faces as a student based on the depiction of his life as a worker?
 - * What strengths might he bring to his studies?
 - * What might you need to adjust to make his assessments flexible and fair?



Sources of Indigenous Worker Stress

Includes but is not limited to:

- * Workloads – numbers and complexities
- * Expectations on workers
- * Boundaries
- * Lack of recognition, respect and support
- * Working conditions
- * Racism and stigma
- * Complex personal circumstances
- * Loss, grief and Sorry Business
- * Culturally safe ways of working
- * Funding, job security and salaries.

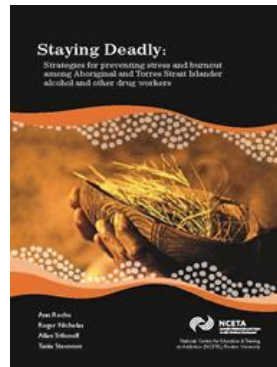
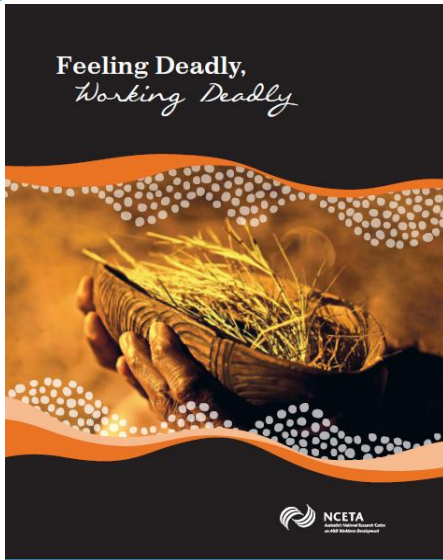
Feeling Deadly, Working Deadly, NCETA, 2013



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What's in the Kit?

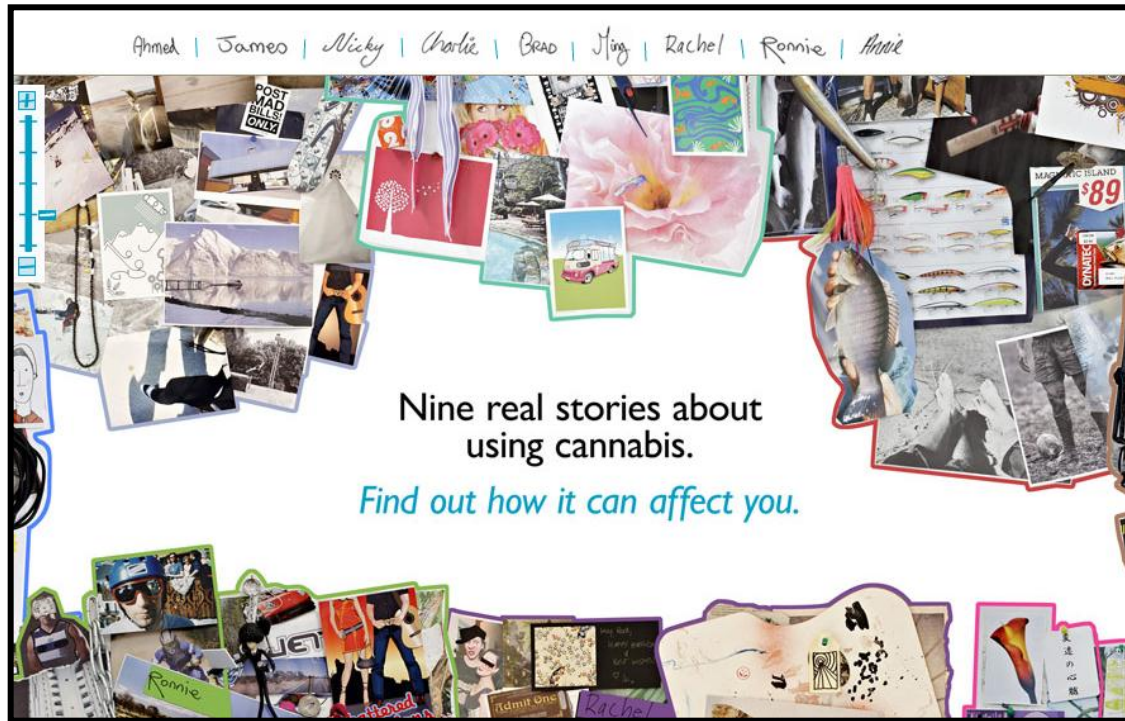


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NCPIC website: Young people



The NCPIC website has also developed a young people's section – providing information from a prevention perspective. Some of the topics covered include psychosis, dependence, sniffer dogs, cannabis and driving, joints vs bong, etc

9 young people and their experiences with cannabis – real-life stories and a series of questions that relate



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Older adults

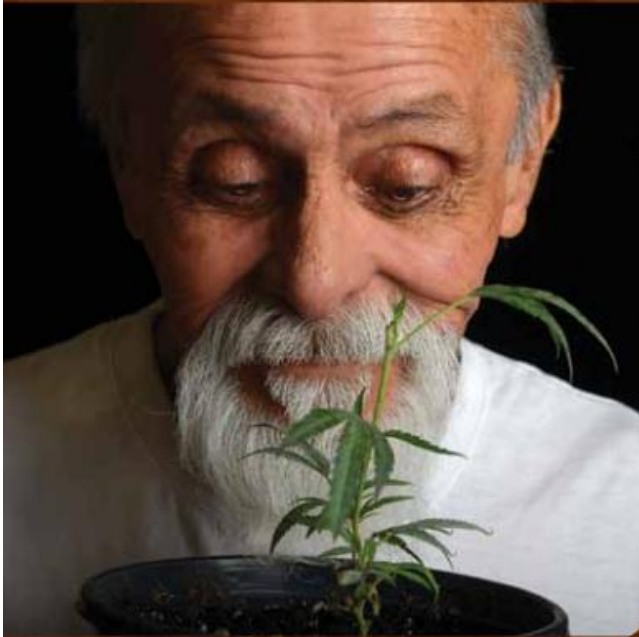
- * Of illicit substances, **cannabis** was the most commonly used in a study of adults aged 55 and older with a mental illness. (Ryan, 2012)
- * “marijuana use was more common than non-medical use of prescription-type drugs among males aged 55 or older... and rates were similar with women.” (NSDUH, 2001)



Still inhaling:

The rising tide of
older cannabis
consumers

Gideon Warhaft



- * The 2010 NDSHS report showed that while there was a marginal increase in the overall population that had used cannabis recently, a more significant increase was found in those aged 50-59 years, up from 3.8 per cent in 2007 to 5.5 per cent in 2010.



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Incorporating new evidence

Legalisation debate

The Sydney Morning Herald
Federal Politics

Legalisation of cannabis could be key issue in Western Australia Senate election

March 24, 2014

Comments 64



1 May 2014, 11.45pm AEST

THE CONVERSATION
Academic rigour, journalistic flair

Legalising cannabis is more than just a yes or no decision

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Legalise cannabis, says report backed by Clegg: Deputy PM endorses paper which condemns war on drugs as costly failure and recommends smarter laws

- Report: 'countries should conduct experiments in legalising cannabis'
- Clegg among 21 academics and campaigners who signed the foreword
- The report has been produced by the London School of Economics
- His repeated calls for drug law reforms rejected by Tory Coalition partners

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'Legalise cannabis and ecstasy now'

Panel of distinguished world figures calls for an end to the 50-year war on drugs



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Evidence

Drug and Alcohol Dependence
Volume 123, Issues 1–3, 1 June 2012, Pages 141–147

Diagnostic criteria for cannabis withdrawal syndrome

J. A. Gorelick^a, Kenneth H. Levin^{a,1},
Douglas L. Boggess^a, Deanna L. Kelly^a

Show more

<http://dx.doi.org/10.1016/j.drugalcdep.2011.11.007>

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Drug and Alcohol Dependence
Volume 119, Issues 1–2, 1 December 2011, Pages 123–129

The Cannabis Withdrawal Scale development: Patterns and predictors of cannabis withdrawal and distress ☆

David J. Allsop^a, Melissa M. Norberg^a, Jan Copeland^a,
Shanlin Fu^b, Alan J. Budney^c

Show more

<http://dx.doi.org/10.1016/j.drugalcdep.2011.06.003>

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Reviews and Overviews

Review of the Validity and Significance of Cannabis Withdrawal Syndrome

Alan J. Budney, Ph.D.
John R. Hughes, M.D.
Brent A. Moore, Ph.D.
Ryan Vandrey, M.A.

The authors review the literature examining the validity and significance of cannabis withdrawal syndrome. Findings from animal laboratory research are briefly reviewed, and human laboratory and clinical studies are surveyed in more detail. Converging evidence from basic laboratory and clinical studies indicates that a withdrawal syndrome reliably follows discontinuation of chronic heavy use of cannabis or tetrahydrocannabinol. Common symptoms are primarily emo-

tional and behavioral, although appetite change, weight loss, and physical discomfort are also frequently reported. The onset and time course of these symptoms appear similar to those of other substance withdrawal syndromes. The magnitude and severity of these symptoms appear substantial, and these findings suggest that the syndrome has clinical importance. Diagnostic criteria for cannabis withdrawal syndrome are proposed.

(Am J Psychiatry 2004; 161:1967–1977)

Psychological Medicine (2012), 42, 1321–1328. © Cambridge University Press 2011
doi:10.1017/S0033291711002078

Cannabis, schizophrenia and other non-affective psychoses: 35 years of follow-up of a population-based cohort

E. Manrique-Garcia^{1*}, S. Zammit², C. Dalman³, T. Hemmingsson⁴, S. Andreasson⁵ and P. Allebeck⁶

¹Department of Public Health Sciences, Division of Social Medicine, Karolinska Institutet, Stockholm, Sweden
²Department of Psychological Medicine and Neurology, MRC Centre for Neuropsychiatric Genetics and Genomics, Cardiff University, Cardiff, UK
³Department of Public Health Sciences, Division of Public Health Epidemiology, Karolinska Institutet, Stockholm, Sweden
⁴Department of Public Health Sciences, Division of Occupational and Environmental Medicine, Karolinska Institutet, Stockholm, Sweden
⁵Swedish National Institute of Public Health, Sweden

Background. There is now strong evidence that cannabis use increases the risk of psychoses including schizophrenia, but the relationship between cannabis and different psychotic disorders, as well as the mechanisms, are poorly known. We aimed to assess types of psychotic outcomes after use of cannabis in adolescence and variation in risk over time.

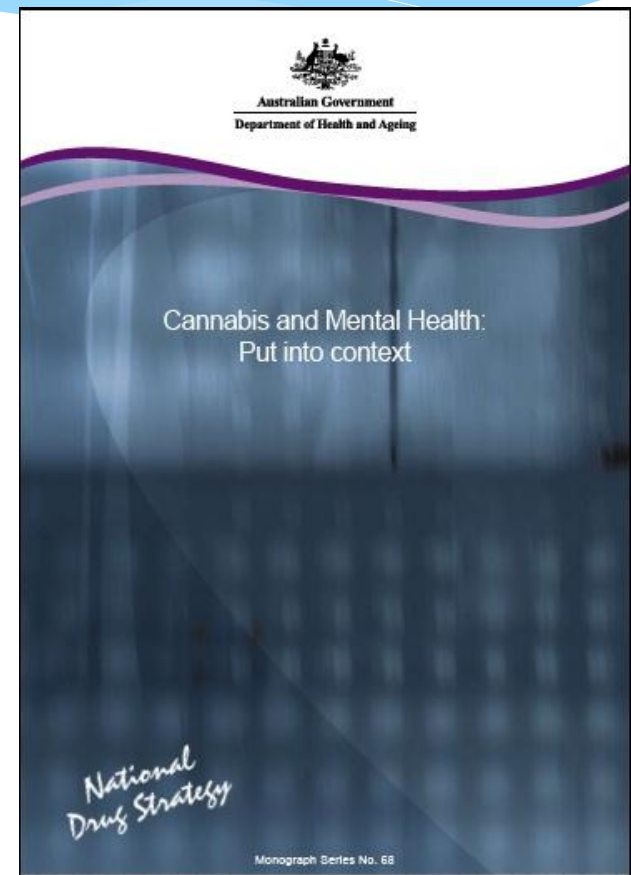


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Finding evidence informed training and assessment materials

There are significant underpinning resources available:

- * www.nicpic.com.au
- * <http://oyh.org.au/>
- * <http://www.turningpoint.org.au/>
- * www.youthbeyondblue.com.au
- * www.sane.org.au
- * <http://www.ysas.org.au/articles/youth-aod-toolbox>



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NCPIC's Key Activities

NCPIC's mission is to reduce the use of cannabis in Australia by preventing uptake and providing evidence-based information and interventions.

It achieves this by offering services that include:

- * website providing cannabis information to the community, users, their families and [workforces](#)
- * a free [Cannabis Information and Helpline](#)
- * regular [e-Zines](#) and a [Bulletin Series](#) on the latest cannabis research by NCPIC and its partners
- * [free training](#) on motivational and brief interventions for cannabis-related problems
- * projects to inform service delivery e.g., studies on [cannabis treatment seeking](#)
- * development of new models of delivering interventions (e.g., via [telephone](#), [web](#) and post)
- * the development of course materials for cannabis and mental health assessment and intervention at Certificate 4 level, available as course units and on-line
- * community activities to increase awareness of the harms associated with cannabis use e.g.:
 - * school [poster competitions](#),
 - * [short film competitions](#),
 - * [Aboriginal and Torres Strait Islander music competition](#),
 - * [road safety messages](#), and partnerships with key organisations
 - * [dedicated website section](#) for those working with Aboriginal and Torres Strait Islander peoples

NCPIC is a [Department of Health](#) initiative.



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Evidence based interventions

- * Randomised controlled trials (RCTs) for cannabis use disorder only reported in literature in last 15 years.
- * Many clinicians conclude the relatively mild cannabis withdrawal syndrome indicates that dependence unlikely and treatment unnecessary
- * However research suggests that a substantial proportion of cannabis users develop cannabis-related problems, including abuse and dependence.
- * Whilst only a minority seek assistance from a health professional, demand for treatment for cannabis use disorder is increasing internationally.

<http://ncpic.org.au/ncpic/publications/research-briefs/article/evidence-based-interventions-for-cannabis-use-disorder>



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NCPIC website

www.ncpic.org.au

Prevention and Helpline 1800 30 40 50

The screenshot shows a Mozilla Firefox browser window displaying the NCPIC website. The address bar shows the URL <http://stage.doubleloop.com.au/ncpic/>. The website header includes the NCPIC logo and navigation tabs for WORKFORCE, CANNABIS USERS, FAMILY & FRIENDS OF USERS, YOUNG PEOPLE, INDIGENOUS COMMUNITIES, and GENERAL COMMUNITY. The main content area features a large image of cannabis leaves with the text "Cannabis Information" and "Evidence-based information on cannabis and related harms". Below this is a section for "News articles & publications from NCPIC" with images of a "short film competition" poster and a "poster competition" poster. On the right side, there is a sidebar with links for "About Us", "Media", "News", "Links", and "Partners", a search box, and a "Member Log-in" section with fields for "Username" and "Password".



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Pharmacological interventions

- * There are no randomised control trials (RCTs) of pharmacological interventions for cannabis withdrawal or craving.
- * The results of less methodologically rigorous studies suggest that oral THC,^{9,10} and possibly mirtazapine¹¹ and lithium ¹², are promising for cannabis withdrawal, and that rimonobant¹³ and perhaps buspiron¹⁴ show potential in the management of cannabis craving.
- * Bupropion,¹⁵ nefazodone,¹⁶ divalproex ,^{11,17} naltrexone ¹⁸ and atomoxetine ¹⁹ appear less promising for cannabis withdrawal or craving.
- * Also, early indications suggest that oral THC is ineffective in the management of cannabis craving. ⁹

<http://ncpic.org.au/ncpic/publications/research-briefs/article/evidence-based-interventions-for-cannabis-use-disorder>



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Psychological interventions

RCTs of psychotherapeutic approaches to managing cannabis dependence suggest:

- * Cognitive behavioural therapy (CBT) and motivational enhancement therapy (MET) are the most effective in reducing cannabis use, dependence and related problems.²⁰⁻²²
- * one study showed social support psychotherapy equivalent to CBT.²³
- * Although brief interventions (usually MET) appear effective, recent studies suggest that extended, combined therapies are associated with slightly better outcomes.^{21,22}
- * In addition, recent research suggests that adding voucher based incentives to MET and CBT improves treatment compliance and long term outcome in both voluntary²⁴⁻²⁶ and coerced adult clients²⁷⁻²⁹
- * voucher-based incentives alone show improvements in compliance and outcome that diminish over time.²⁵

<http://ncpic.org.au/ncpic/publications/research-briefs/article/evidence-based-interventions-for-cannabis-use-disorder>



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Adolescent and psychiatric populations

Several RCTs suggest:

- * Brief interventions—which may involve the provision of information (including to parents), motivational enhancement therapy (MET), and cognitive behavioural skills training—are effective in reducing cannabis use and dependence in adolescents.^{30,31}
- * It appears extended therapies, which often incorporate significant family involvement (such as multidimensional family therapy) are effective in reducing cannabis use and dependence in adolescents but no more so than are brief interventions.³²
- * Contingency management also shows promise in enhancing treatment engagement in adolescents.³³

<http://ncpic.org.au/ncpic/publications/research-briefs/article/evidence-based-interventions-for-cannabis-use-disorder>



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Psychiatric populations

Clinicians' recommendations for the management of substance use in the context of severe and persistent mental illness rests with integrated shared care or dual diagnosis services, in which the critical components are:

- * staffed interventions
- * assertive outreach
- * motivational interventions
- * Counselling
- * social support interventions
- * a comprehensive and long-term perspective
- * and cultural sensitivity and competence.^{35,36}

<http://ncpic.org.au/ncpic/publications/research-briefs/article/evidence-based-interventions-for-cannabis-use-disorder>



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Evidence based interventions – key messages

Pharmacological interventions

- * no RCTs of pharmacological interventions for cannabis withdrawal or craving

Most effective psychological interventions

- * cognitive behavioural therapy (CBT)
- * motivational enhancement therapy (MET) ²⁰⁻²²

Strongest evidence in the management of cannabis dependence

- * MET and CBT in adults
- * brief interventions in adolescents

<http://ncpic.org.au/ncpic/publications/research-briefs/article/evidence-based-interventions-for-cannabis-use-disorder>



“Cannabis competency”

“Cannabis Competency”

- * Historically the CHC qualifications have not specified drugs by name (other than alcohol and tobacco).
- * This has led to a lack of clarity about which drugs should be taught and assessed.
- * Exacerbated by limited student interest and student self direction.
- * Feedback from industry (Pidd et al, 2010) indicates that many students entering the workforce do not know enough about specific drugs and their treatment.
- * It is critical that students leave training are able to work with client cannabis issues competently.



What constitutes ‘cannabis competence’?

CANNABIS ISSUES FOR THE SPECIALIST AOD NURSE

- * The specialist nurse in the ATOD field requires evidence-based guidelines, tools and intervention strategies to facilitate effective screening, assessment and interventions for clients experiencing cannabis-related problems, including dependence, withdrawal, co-morbidity with mental health disorders, and polydrug use.

Submission to the National Cannabis Strategy Drug and Alcohol Nurses of Australasia (DANA) 2005



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Cannabis competency

CANNABIS ISSUES FOR THE SPECIALIST AOD NURSE

- * While further research is still needed to better enable nurses to provide effective and evidence-based interventions for those affected by their use of cannabis, specialist nurses also need to acquire advanced competencies to assist them to apply specific skills, knowledge and abilities to deliver such interventions.

Submission to the National Cannabis Strategy Drug and Alcohol Nurses of Australasia (DANA) 2005



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Cannabis competencies

CANNABIS ISSUES FOR THE SPECIALIST AOD NURSE

- * require the organisational policies, protocols and support to deliver interventions in a way that improves client outcomes through ensuring that individuals (including those from high risk groups such as young people, pregnant women and Indigenous Australians) can readily access relevant information and treatment.

Submission to the National Cannabis Strategy Drug and Alcohol Nurses of Australasia (DANA) 2005



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Discussion

Specialist nurses are one group of AOD workers. What would you identify are cannabis competencies for a range of other workers:

- * AOD workers
- * Social workers
- * Doctors
- * Peer workers
- * Needle and syringe program workers
- * Prevention workers
- * Addiction medicine specialists and specialist
- * Psychologists and psychiatrists.



Assessing cannabis competency

Assessment Activity

- * Review an element of competency in the Framework
- * Considering the activities described and those in the underpinning skills and knowledge discuss whether it meets the requirements for assessment.
- * Do they meet the requirements for:
 - * validity
 - * reliability
 - * flexibility
 - * fairness
 - * sufficiency

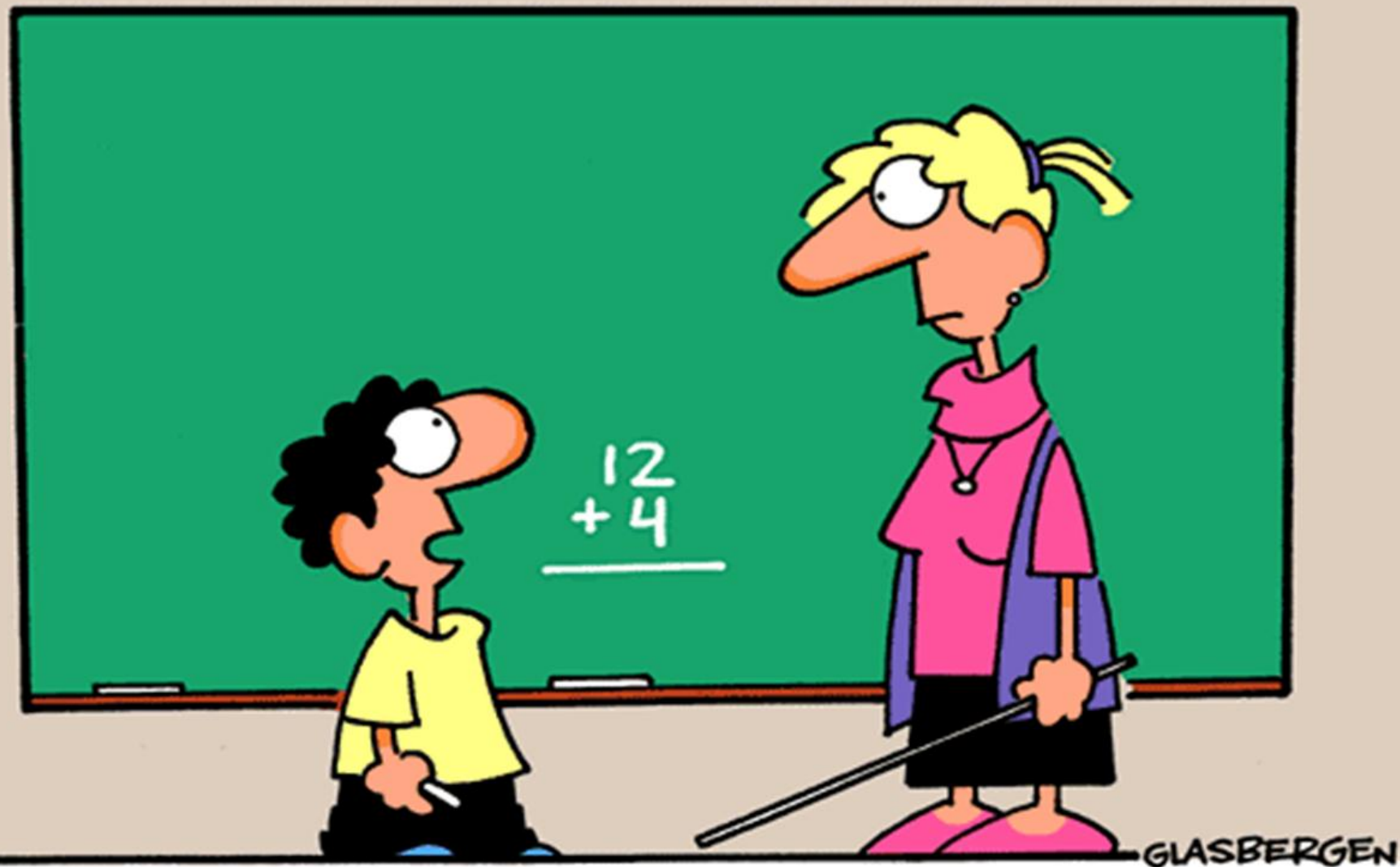


RPL strategies

RPL issues in AOD

- * Like most sectors AOD has issues with RPL
- * Number of students RPLed is low
- * Concerns about the quality of RPL
 - * Most providers developed their own system
 - * Subject to highly variable interpretation and application
 - * No common system
- * Most students not assessed on cannabis
(Trainers Talking Training)





“Do I get partial credit for simply having the courage to get out of bed and face the world again today?”

RPL Skills

- * We use these skills in teaching
 - * The guide on the side
 - * Learner centred practice
 - * Collaborative teams
 - * Experiential learning
 - * Mentoring
 - * Industry partnerships
- * We use these skills in industry
 - * Client centered practice
 - * Customer focus
 - * Action learning
 - * Behavioural Interviewing
 - * Mentoring
 - * 360 degree feedback
 - * Appreciative inquiry



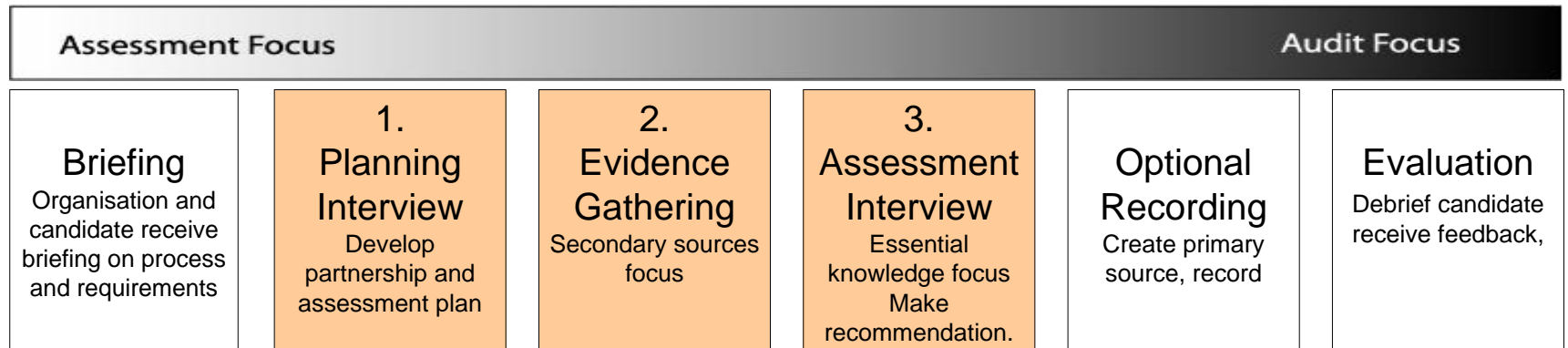
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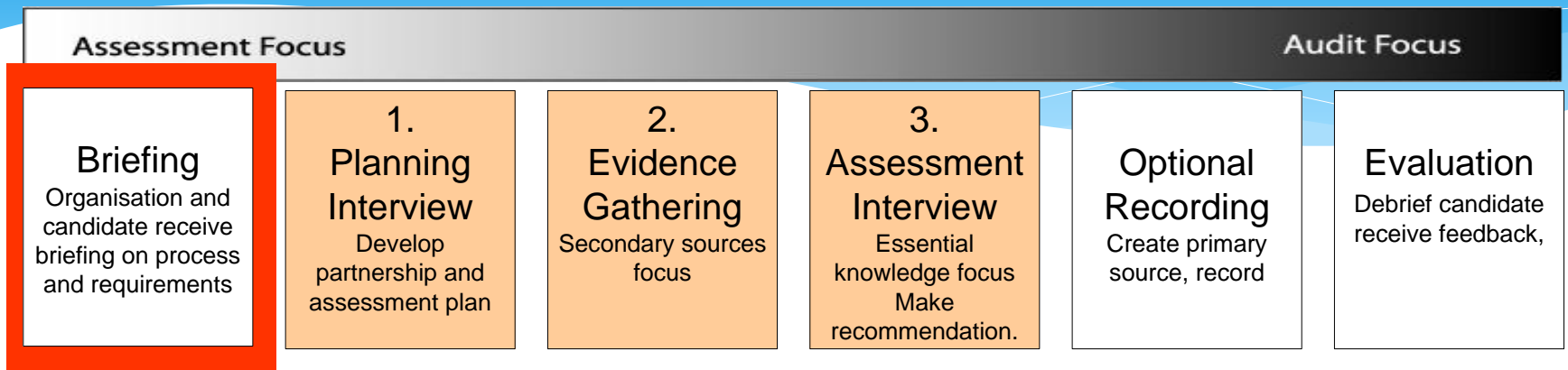
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Six Steps to Recognition (CSHITB)



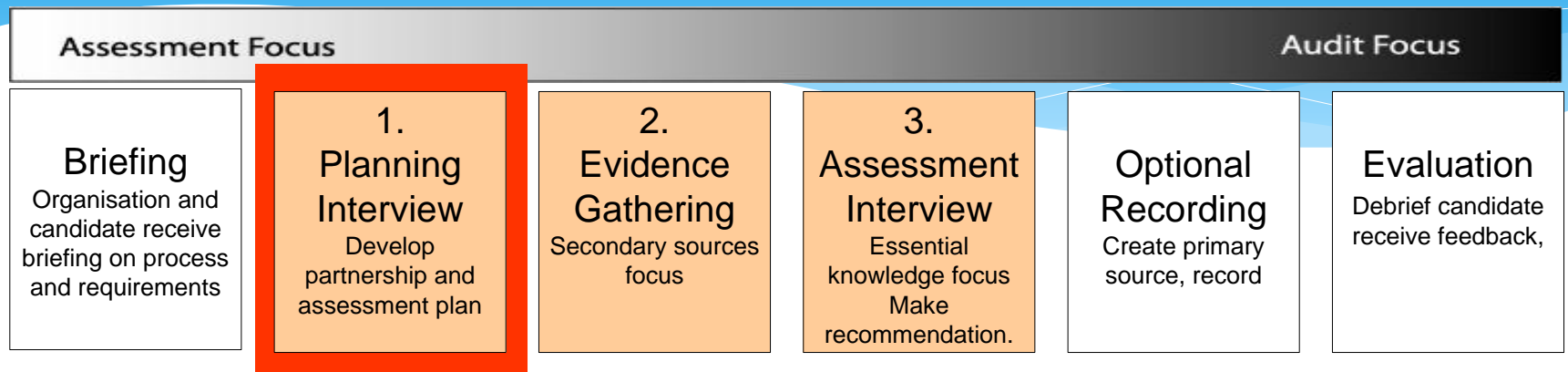
- * Supported process
- * Paper work minimised
- * Interview and observation driven
- * Empowering
- * Generates evidence
- * Developmental & validation pathways





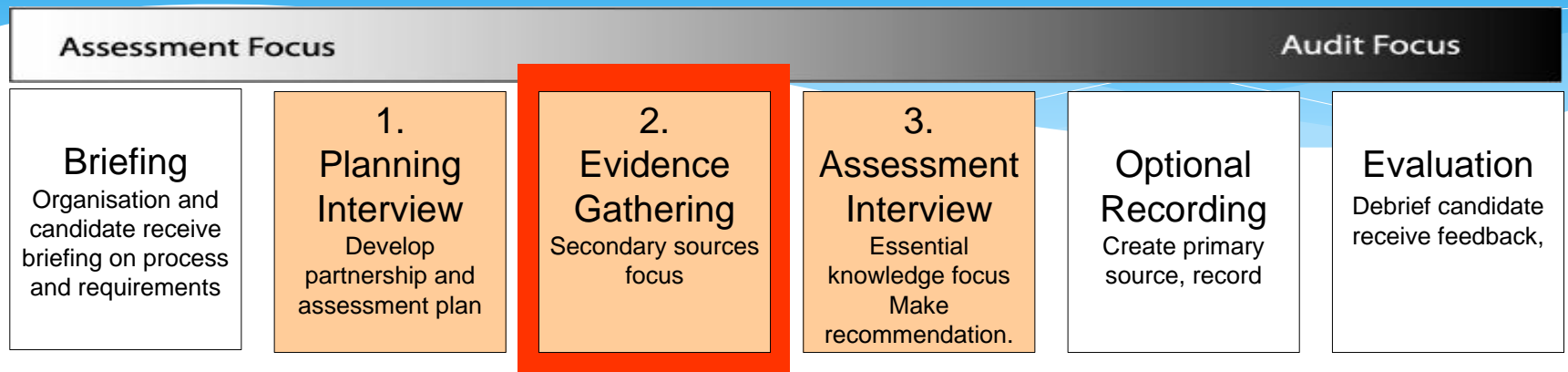
- * Key step
 - * Organisation and candidate receive briefing on process and requirements
- * Candidate receives kit:
 - ✓ RPL Brochure
 - ✓ Nomination form
 - ✓ Self assessment form
 - ✓ 3rd Party assessment
 - ✓ Competency list
 - ✓ Process overview
 - ✓ Contact numbers





- * Develop partnership with candidate
- * Review congruence of preliminary evidence
- * Benchmark candidates' responses
- * Explore depth of skill
- * Plan assessment pathway

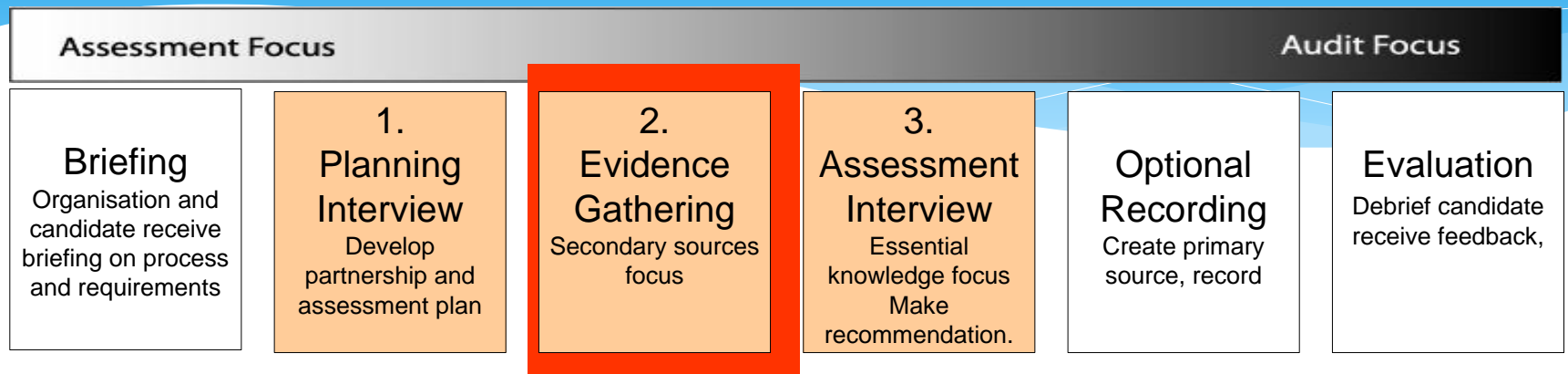




* Generating Evidence

- * Employer nomination
- * Candidate's CV
- * Evidence of relevant qualifications
- * Job description
- * 3rd party assessment
- * Self-assessment of Competency
- * Assessors record of discussion of critical aspects of assessment





- * On site visit

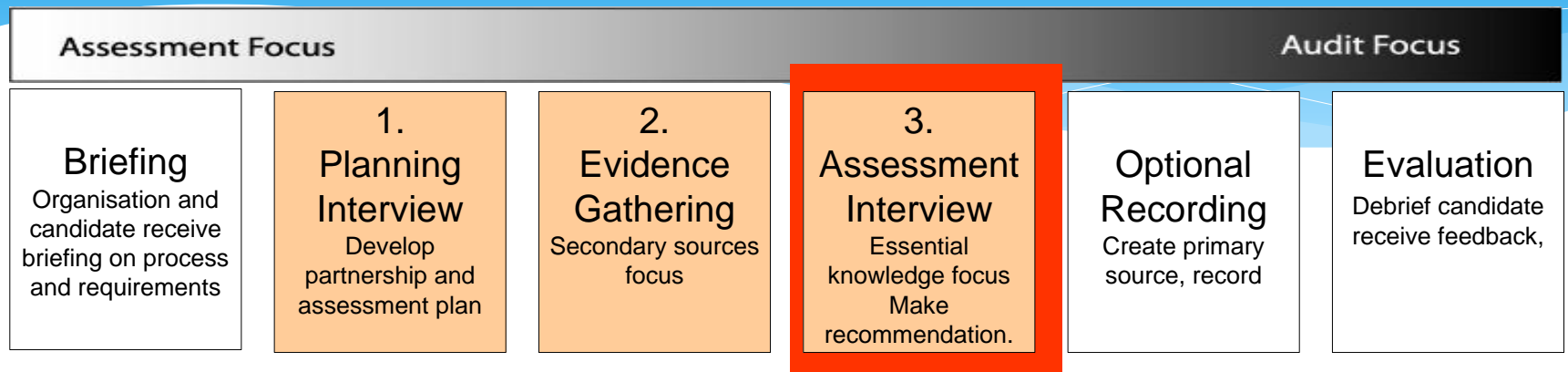
- * Assessor observes and questions

- * makes checks of the evidence against the competency units
 - * elements, performance criteria
 - * essential knowledge and underpinning skills.

- * Secondary sources focus

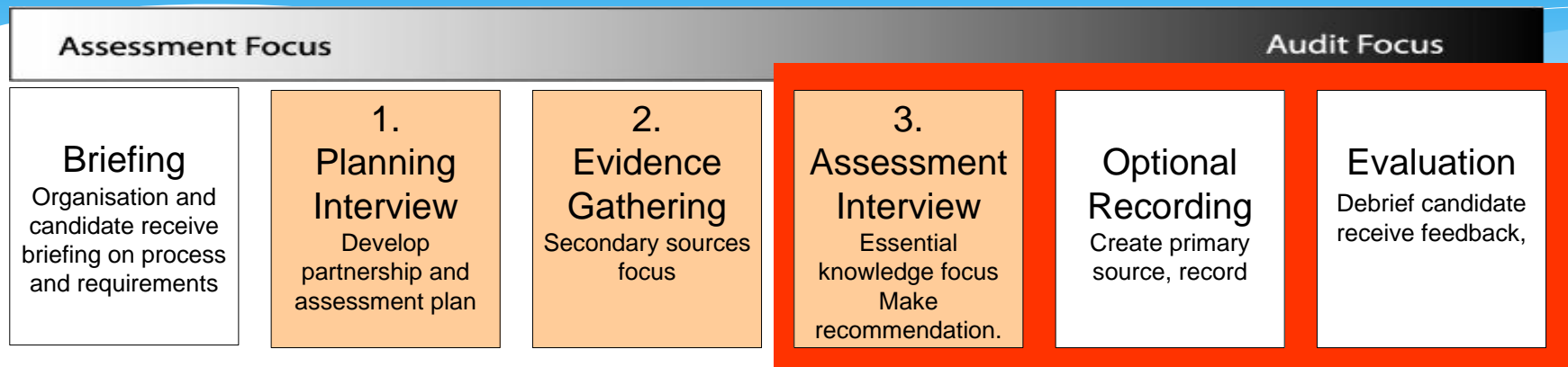
- * Gathering relevant workplace evidence
- * Documents and photographs (where appropriate)





- * Focus moves to explore essential knowledge
- * Make recommendation
- * Prepare the candidate for the digital video recording, if required





- * Audit requirements focus
- * Demonstrate essential knowledge, skills and attitudes
- * Assessor completes documentation in line with AQTF
- * Evaluation (what worked, what would you change)



Electronic portfolio

Section Nine - Assessment Matrix - Unit of Competency and evidence collection table BSB 51107 Diploma of Management Student: Michael White

Unit 1: BSBWOR501A Manage Personal Work Priorities and Professional Development

	Elements of Competency	Performance Criteria	Screenings	Student Comments	Evidence provided	Assessors comments	Signed & dated:
1.1	Establish personal work goals	<p>1.1 Serve as a positive role model in the workplace through personal work planning and organisation</p> <p>1.2 Ensure personal work goals, plans and activities reflect the organisation's plans, and own responsibilities and accountabilities</p> <p>1.3 Measure and maintain personal performance in varying work conditions, work contexts and contingencies</p>		<ul style="list-style-type: none"> work plan as used in previous job CV Position description developed for Training Team Stress Man Training program I delivered Personal reference Team work plans developed at CECFW CSHITB Operational Plan 	<ul style="list-style-type: none"> Business plan MW CV MWhite 2008 FLM RPL 2008 resources\position descriptions FLM RPL 2008 resources\Stress Management.pdf _Personal reference.pdf team work plans CECFW FLM RPL 2008 resources\Final OPPlan with \$08-09.doc 		



Moderation and continuous improvement

Moderation

- * Moderation refers to a process of comparing assessment judgments in relation to the same learning outcomes of different assessors in a variety of different contexts.
- * The purpose of moderation is to ensure comparability of assessment.
- * Actively addresses important issue of consistency of interpretation and implementation of competency standards (both content and assessment) in VET.



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Discussion

- * What is your current process for moderating materials/assessments?
- * Do you undertake internal and/or external moderation?
- * What would help with external moderation?
- * What strategies have you implemented in relation to ongoing improvement of you content and assessments?



Review, questions and feedback


Google Group for Trainers

Google+ Search for people, pages or posts +Michael

Communities All communities Recommended for you

NCETA AOD VET Enhancement project

Notifications on



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Private 20 members

Share what's new...

Text Photos Link Video Event

Michael White OWNER
General Training Resources and Research - 14:57

IDRS Data on drug use 2013
Great source of info on drug use and change over time, including costs of drugs, where they are bought etc

ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/National_IDRS_2013.pdf
ndarc.med.unsw.edu.au

+1 Add a comment...


Michael White OWNER
General Training Resources and Research - Yesterday 14:06

Roche A; Trifonoff A; White M; et al. (2014) From policy to implementation: Child and family sensitive practice in the alcohol and other drugs sector, Canberra: Australian National Council on Drugs (ANCD). This report examines the current policy environment in relation to child and family sensitive practice in alcohol and other drugs settings in Australia.

Pinned by moderator

Michael White OWNER
Community Guidelines - 20 Jun 2014

This website has been developed by the National Centre for Education and Training on Addiction (NCETA) with funding from the Australian Government Department of Health and part funding from the National Centre National Cannabis Prevention and Information Centre (NCPIC). NCPIC is funded by the Australian Government.



+2 Add a comment...

Kathryn Elkins
Announcements - Yesterday 14:11

Understanding the Dangers of Synthetic Cannabinoids. Interesting paper on the new cannabinoid consumables.

Wolters Kluwer Health
journals.lww.com

+1 Add a comment...

About this community

Invite people Share this community

This online community of practice (COP) was developed by the National Centre for Education and Training on Addiction (NCETA) to support vocational education and training (VET) educators in the alcohol and other drugs (AOD) field and enhance delivery of VET AOD qualifications. This project is designed to support the delivery of VET AOD qualifications through the development of new, evidence based resources and the dissemination of existing resources.

The project builds upon previous research undertaken by NCETA which examined the qualifications and skill sets offered in the:

- Certificate IV (AOD)
- Diploma in Community Services (AOD), and
- Diploma of Community Services (AOD and Mental Health).

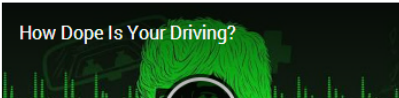
Developed with funding from NCPIC

[Link to old VET AOD Google Forum](#)

[Link to old site](#)

Michael White OWNER
Cannabis Clinical Content - 10:26

Smoke Signals originally shared:



<https://plus.google.com/u/0/communities/109081727783576106446>

Thank you

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