PARLIAMENT OF VICTORIA

LEGISLATIVE COUNCIL
Legal and Social Issues Committee

Inquiry into the use of cannabis in Victoria

Parliament of Victoria
Legislative Council Legal and Social Issues Committee

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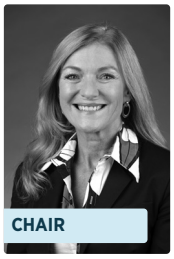

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About the Committee

Functions

The Legislative Council Legal and Social Issues Committee's functions are to inquire into and report on any proposal, matter or thing concerned with community services, education, gaming, health, and law and justice.

As a Standing Committee, it may inquire into, hold public hearings, consider and report on any Bills or draft Bills, annual reports, estimates of expenditure or other documents laid before the Legislative Council in accordance with an Act, provided these are relevant to its functions.

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This report is available on the Committee's website.

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Terms of reference

Inquiry into the use of cannabis in Victoria

On 29 May 2019, the Legislative Council agreed to the following motion:

That this house, requires the Legal and Social Issues Committee to inquire into, consider and report, by no later than 2 March 2020*, into the best means to—

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

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

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

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

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

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

* The Legislative Council agreed to extend the reporting date to 31 March 2021, and subsequently to 5 August 2021.

Chair's foreword

I am pleased to present this report on the Inquiry into the use of cannabis in Victoria.

Cannabis is the most commonly used illicit drug both in Victoria and Australia. This is despite decades of prohibition which has done little to minimise cannabis use or halt illegal growing and supply.

Over the last 20 years, rates of cannabis use have remained steady—around 36% (1.9 million) of Victorian adults have used cannabis in their lifetime and 11% in the past 12 months. Cannabis users are more likely to be young people, with those aged 20 to 29 reporting the highest use in the past 12 months (24%), followed by those in the 14 to 19 age group.

This is a foundational report and the culmination of a significant amount of work conducted by the Committee. The Committee received 1,475 written submissions, held 28 public hearings over 7 days and spoke specifically to young people under the age of 25 at the Committee's Youth Forum held at Parliament House. I am grateful to all stakeholders here in Australia and internationally who gave up their time to share their valuable knowledge with us.

The overwhelming majority of stakeholders supported the need for cannabis law reform. Time and time again the Committee heard that the current criminalisation approach to cannabis in Victoria is not addressing problematic use of cannabis and is in fact contributing to the harms experienced by vulnerable groups. There is every reason to believe that this view permeates the wider community.

Criminal convictions from minor cannabis offences cause lifelong impacts on a person's ability to seek meaningful employment and often impedes access to education and even housing.

Aboriginal and Torres Strait Islander Victorians, young people and other minority groups are disproportionately affected by current cannabis laws which are not achieving their intended goals of reducing use, supply and harm.

Criminalisation contributes to stigma that deters cannabis users from seeking help for problematic use. It also creates a significant financial and resourcing burden on the Victorian Government and Victoria Police to enforce minor cannabis offences. What we are doing now is just not working.

Victoria spends millions of dollars annually criminalising cannabis. But criminal organisations are still making millions of dollars cultivating and selling cannabis in Victoria. These funds are being funnelled into other criminal activity including the manufacture of far more dangerous substances.

It is time that we treat the harms associated with cannabis use as a health issue rather than a criminal justice issue.

Education and other tools that prevent the early onset of cannabis use or problematic use could be enhanced in a regulated environment where stigma is reduced and we allow for appropriate education that focuses on more than 'just saying no'. However, there is much we can do now to improve drug education and the resilience of our young people and these opportunities are explored in detail in the report.

Moving towards a regulated and legalised cannabis market in Victoria will help reduce criminal activity relating to the illegal cannabis trade, including access by children and young people. Regulation would help to reduce the harms associated with consuming a black market product by strictly regulating what is sold, where it is sold and who it is sold to.

It would also open opportunities for better community awareness of the mental health and other risks associated with the consumption of cannabis.

Several jurisdictions in Europe, the United States, Canada and even our neighbours in the Australian Capital Territory have recognised this and have introduced legislation to decriminalise or legalise cannabis to some degree. The lessons learnt from these jurisdictions shows that appropriate regulation of adult use of cannabis can be achieved whether that is through the decriminalisation of the use and possession of small quantities of cannabis or a scheme that strictly regulates its sale and cultivation.

The report and its findings reflect the evidence we received for the need for reform and outline the key considerations for the Victorian Government if it is to carefully move to a legislated framework for the use of cannabis in Victoria. I urge the Victorian Government to take a proactive stance in taking measures to address the harm caused by the current prohibition on cannabis use.

Many of the issues about resourcing the alcohol and other drugs sector raised in this Inquiry reflect the findings of the Mental Health Royal Commission's final report, which was tabled in 2021. This report echoes many of them and urges the government to properly resource desperately needed alcohol and drug services. I look forward to the Government's implementation of those recommendations.

I would like to express my gratitude to the secretariat staff who worked on the Inquiry and helped prepare this comprehensive report during these continually changing and difficult times. In particular, I would like to thank the research team of Kieran Crowe and Caitlin Connally who were also assisted by Justine Donohue, under the management of Lilian Topic and later Matt Newington.

I would also like to thank my colleagues on the Committee for their work on the Inquiry and in preparing the Committee's Final Report.

Fiona Patten
Chair

Findings and recommendations

1 Key considerations for reforming Victoria's cannabis laws

RECOMMENDATION 1: That the Victorian Government investigates the impacts of legalising cannabis for adult personal use in Victoria. This should include:

- possession of a small quantity of cannabis for people over the age of 18, when the drug is possessed in Victoria
- the use of cannabis for people over the age of 18 in private locations, when used in Victoria
- the cultivation of a small number of cannabis plants per person over the age of 18, at their principal place of residence, in Victoria. Plants should be grown in an area that is not accessible to the public or people under the age of 18
- the supply of cannabis in small quantities for persons over the age of 18 in Victoria to gift cannabis to each other without the transaction of money or any other goods or services taking place.

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FINDING 1: Any model for a legalised and regulated market for the supply and sale of cannabis should consider the following elements:

- an appropriate level of government regulation to ensure that cannabis supply and sale are subject to strict controls
- establishing a regulatory body to oversee the industry
- regulation on the potency of THC in legal cannabis products
- market controls to avoid the creation of a 'big cannabis' industry
- regulation of cannabis social clubs
- restrictions on advertising, marketing and promotion of products
- competitive pricing to undercut sales in the illicit market to ensure users access regulated products
- careful consideration should be given before further legalisation of other cannabis products (such as edibles)
- an appropriate tax framework should be put in place to help fund cannabis-related programs.

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FINDING 2: Any model for a legalised and regulated market for the supply and sale of cannabis should consider the following objectives in its establishment:

- prevent the access of children and young people to cannabis
- improve the health and wellbeing of Victorians and reduce the overall harms associated with cannabis use in Victoria through regulating the availability, potency and product standards of the drug
- improve awareness of the health and mental health risks associated with cannabis use and reduce stigma in seeking help
- reduce criminal activity in Victoria relating to the illegal cannabis trade
- reduce the impact of criminalisation of cannabis on Victorians. 11

RECOMMENDATION 2: That the Victorian Government considers referring an inquiry to the Victorian Law Reform Commission to investigate state and Commonwealth laws inhibiting the introduction of a legislated and regulated cannabis market, including social clubs. 46

3 Mental health and other health issues associated with the use of cannabis

RECOMMENDATION 3: That in implementing the recommendations of the Royal Commission into Mental Health relating to the alcohol and other drug sector, the Department of Health conducts an assessment of funding and workforce needs of the alcohol and other drug sector to ensure it meets the demand of Victorians seeking alcohol and other drug treatment, particularly in regional Victoria. 79

RECOMMENDATION 4: That the Victorian Government provides ongoing funding for alcohol and other drug sector organisations to provide programs that seek to build protective factors against problematic drug use. 79

FINDING 3: The causal link between cannabis use and some mental illnesses is unclear. Some people with existing mental health issues may be drawn to cannabis use to treat their symptoms and in doing so, exacerbate their mental illness further. For this group, cannabis use is a compounding factor rather than a cause. 83

FINDING 4: The population level risk for the development of psychosis and psychotic disorders as a result of cannabis use is very low. 88

FINDING 10: The current administration of the Victoria Police cannabis cautioning program is:

- too discretionary in how it is used by police, with cautions being unequally used between precincts and officers
- too inflexible, particularly the limit of two cautions per person
- unintentionally acting as a disincentive to use cautions or refer to diversion due to the administrative burden on police. 131

RECOMMENDATION 7: That the Victorian Government provides further funding to expand drug diversion programs, particularly in rural and regional Victoria. 131

RECOMMENDATION 8: That the Victorian Government establishes a legislated Youth Caution program to deal with low-level cannabis offences committed by young people under the age of 18. This program should incorporate specific provisions, including:

- shifting towards drug diversion programs as the default law enforcement response for minor cannabis offences committed by young people
- removing requirements for a young person to plead guilty before they are eligible for a caution notice
- not imposing fixed caps on the number of times a young person can participate in the program, where minor cannabis offences are the only or primary offence
- support and training for police officers aimed at reducing additional workload when issuing a youth caution. 134

FINDING 11: Both male and female offenders are more likely to receive an imprisonment sentence for possession-related offences compared to use-related offences:

- Over 25% of male offenders received an imprisonment sentence for cannabis possession offences between 2016 and 2019.
- Over 15% of female offenders received an imprisonment sentence for cannabis possession offences between 2016 and 2019. 137

FINDING 12: Aboriginal and Torres Strait Islander Victorians are significantly overrepresented in sentencing statistics for minor cannabis offences compared to other Victorians. From 2015 to 2020, they accounted for 6% of cannabis offenders, despite only making up 0.8% of Victoria's population. In addition, they are:

- less likely to receive a caution
- more likely to be required to attend Court proceedings for the offence
- more likely to receive a punitive sentence. 141

FINDING 13: The restrictive eligibility criteria of drug diversion programs have excluded some of those who are marginalised and vulnerable and in the most need of treatment and support services. 143

RECOMMENDATION 9: That the Victorian Government reviews the eligibility requirements of existing drug diversion programs to determine if they are too restrictive and excluding of vulnerable people in need of treatment of support. In particular, the Government should consider the need for requirements such as:

- requiring police to consent to offering an offender drug diversion
- pleading or admitting guilty to an offence, including alternatives to admitting the offence which do not result in a finding of guilt
- capping the number of diversions a person can receive where a minor drug/cannabis offence is the sole or primary offence. 143

RECOMMENDATION 10: That the Victorian Government provides funding to the Magistrates' Court and County Court (following the outcomes of its pilot program) to expand the Court Integrated Services Program, particularly into regional and rural Victoria. 150

FINDING 14: The current regulatory framework for medicinal cannabis has created barriers limiting patient access. As a result, some people are choosing to access the illicit cannabis market for themselves to self-medicate or on another person's behalf because they are unable to procure cannabis through licit channels. 154

RECOMMENDATION 11: That the Victorian Government advocates to the National Cabinet to remove unnecessary barriers for accessing medicinal cannabis and consider whether current pricing schemes are too high. 154

5 Cannabis and other drug education

RECOMMENDATION 15: That the Victorian Government reviews the effectiveness of school-based drug education and whether the existing curriculum is achieving its intended outcomes. This should also consider whether the curriculum structure is suitable for a harm minimisation approach to drug education as intended. The review should examine:

- if teachers and schools are receiving appropriate training and resources to deliver drug-education to students
- if it is being taught in the most appropriate subject areas
- its effectiveness on young peoples' understanding of the risks of cannabis/drug use
- what impact it has had on delaying the onset of cannabis use by young people. **191**

RECOMMENDATION 16: That the Victorian Government consults with the health sector, particularly the alcohol and other drug sector, on evidence-based strategies for better promoting harm minimisation in school-based drug education. **192**

RECOMMENDATION 17: That the Victorian Government's approach to drug education should:

- avoid stigmatising users
- promote help-seeking behaviours
- engage in open and non-judgemental dialogue with people using drugs
- have a greater emphasis on teaching about the risks to young people, and acknowledge that the risks of drug use exist on a continuum. **193**

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FINDING 20: The Victorian Government's approach to school-based drug education is not achieving its stated objectives of a harm minimisation approach. Drug education in Victorian schools would be improved with the involvement of frontline health workers in the development and delivery of the curriculum. **203**

FINDING 21: Public health and drug education campaigns should avoid harmful stereotypes of users and reinforcing stigma. These campaigns are ineffective in achieving better health outcomes for users or preventing drug use. 208

What happens next?

There are several stages to a parliamentary inquiry.

The Committee conducts the Inquiry

This report on the Inquiry into the use of cannabis in Victoria is the result of extensive research and community consultation by the Legislative Council Legal and Social Issues Committee at the Parliament of Victoria.

We received written submissions, spoke with people at public hearings and at a Youth Forum, reviewed research evidence and deliberated over a number of meetings. Experts, organisations and other stakeholders expressed their views directly to us as Members of Parliament.

A parliamentary committee is not part of the Government. Our Committee is a group of members of different political parties. Parliament has asked us to look closely at an issue and report back. This process helps Parliament do its work by encouraging public debate and involvement on issues. We also examine government policies and the actions of the public service.

This report is presented to Parliament

This report was presented to Parliament and can be found on the Committee's website at: https://parliament.vic.gov.au/lsic-lc/article/4264.

A response from the Government

The Government has six months to respond in writing to any recommendations we have made. The response is public and put on the inquiry page of Parliament's website when it is received at: https://parliament.vic.gov.au/lsic-lc/article/4265.

In its response, the Government indicates whether it supports the Committee's recommendations. It can also outline actions it may take.

1 Key considerations for reforming Victoria's cannabis laws

1.1 Summary and key findings and recommendations

This Inquiry was an examination into how Victorian cannabis policy can be improved. The evidence provided by stakeholders overwhelmingly supported cannabis reform in the form of introducing regulation rather than increasing penalties or retaining the status quo. This included the majority of submitters, witnesses at public hearings and participants at the Committee's Youth Forum. Appendix A details how the Committee conducted the Inquiry and gathered evidence.

Enforcing minor cannabis offences for a drug that is is widely used[1] creates significant costs for police and the justice system. The current approach of prohibition focuses on cannabis use as a criminal justice issue, where in the Committee's view it should be considered a health issue.

As a result of criminalisation, there is a considerable culture of stigmatisation that deters people who have problematic use from seeking help. In addition, the impact of criminal records for those convicted of cannabis offences can have lifelong negative consequences which significantly impedes their future prospects of employment, housing and education.

This report refers to two specific streams of cannabis policy reform:

- **Legalisation of cannabis for adult personal use, including small supply quantities and group cultivation:** which would allow adults to possess, use and supply small quantities of cannabis and cultivate a small number of plants at home. In addition, group cultivation would allow small groups of adults to grow cannabis collectively. This is the policy that the Committee has recommended the Victorian Government consider, although it would not allow for legal and regulated production or sale of cannabis.
- **A legalised and regulated cannabis market:** which would allow for the legalisation of cannabis and the licenced production and sale of cannabis in shops and regulated cannabis social clubs. There are considerable barriers to introducing a statewide legalised and regulated cannabis framework due to Commonwealth drug and tax legislation. This option would require cooperation from the Commonwealth Government, including possible amendments to Commonwealth legislation.

1 In 2019, Cannabis was used by 36.3% of adult Victorians in their lifetime and 11.7% of adult Victorians in the past year (Australian Institute of Health and Welfare, *Submission 209*, p. 7.)

On consideration of the evidence provided by stakeholders, the Committee believes that the Victorian Government should further investigate the impacts of legalising adult personal use of cannabis. This includes legalising use, possession and cultivation for adult personal use, as well as the gifting of cannabis and group cultivation for small groups of adults to grow plants collectively. The Committee notes that some Victorians can and do access cannabis legally through a prescription via the medicinal cannabis scheme.

The Committee is also not making specific recommendations for introducing a legalised and regulated market but has put forward significant issues for the Victorian Government to consider if such a model were introduced. However, the Committee does highlight issues for consideration by the Government.

The Committee is aware of the health impacts associated with cannabis use, particularly when that use becomes excessive or problematic. However, this type of cannabis use should be treated as a health issue rather than a criminal justice issue.

1.1.1 Terminology

As noted throughout this report, there are a variety of regulatory approaches to dealing with cannabis use. The Committee has examined several of these approaches, particularly regarding the experiences from other jurisdictions.

It is important that these regulatory models are clearly defined in the report. The key regulatory approaches considered in this Inquiry are:

- **Prohibition:** a regulatory approach where most, if not all, activities related to illicit drugs are criminal offences. This includes possession, use and supply. Under a prohibitionist framework these offences can attract criminal penalties, but civil penalties might also be available for lower level offending such as personal use.
- **Decriminalisation:** a regulatory approach where proscribed behaviours related to illicit drugs are dealt with using civil penalties as opposed to criminal penalties. Typically, the type of offences which are decriminalised are for activities such as personal use or possession. In comparison, supply-based offences (including cultivation and trafficking) generally are not decriminalised.
- **Legalisation:** a regulatory approach where activities related to a drug are not illegal. A legalisation regime can remove criminal offences for certain activities (e.g. adult personal use) or establish regulations for consumer and supplier markets. Approaches to legalisation can range from a tightly controlled and regulated market to a commercialised model with limited regulation.

Further information on various types of regulatory approaches to cannabis use is discussed in Chapter 6.

1.1.2 Key considerations for the legalisation of cannabis for adult personal use in Victoria

Legalisation of cannabis for adult personal use would allow adults to possess, use and supply small quantities of cannabis and cultivate a small number of plants at home. This framework is consistent with cannabis legislation in place in the Australian Capital Territory (ACT), which is discussed further in Section 1.5.3 and Chapter 6.

The ACT framework includes a limit of two plants per person, with a maximum of four plants per household. In addition, plants can only be grown outdoors. These issues should be considered by the Victorian Government and settled upon after adequate consultation with relevant stakeholders.

The Committee also recommends that the Victorian Government investigate the legalisation of the supply of small, non-commercial quantities of cannabis. This would allow people to 'gift' cannabis to each other without the transaction of money or any other goods or services. The legalisation of gifting cannabis and group cultivation would somewhat limit users' reliance on the black market to source cannabis.

In addition, the Committee believes the Victorian Government should investigate allowing for cannabis group cultivation. This would allow a small group of adults to cultivate plants collectively to allow those who cannot grow plants at their own home to avoid accessing the black market to purchase cannabis. This is discussed further in Section 1.1.4.

The Committee believes that the consumption of cannabis should be limited to private homes and not in general public places. This will limit the potential for second hand smoke to be ingested and will reduce the visibility of cannabis use in the community. The Committee recognises that in high-density or residential areas, other residents may have concerns about cannabis consumption. These issues may be considered by owners corporations in apartment complexes or local councils.

RECOMMENDATION 1: That the Victorian Government investigates the impacts of legalising cannabis for adult personal use in Victoria. This should include:

- possession of a small quantity of cannabis for people over the age of 18, when the drug is possessed in Victoria
- the use of cannabis for people over the age of 18 in private locations, when used in Victoria
- the cultivation of a small number of cannabis plants per person over the age of 18, at their principal place of residence, in Victoria. Plants should be grown in an area that is not accessible to the public or people under the age of 18
- the supply of cannabis in small quantities for persons over the age of 18 in Victoria to gift cannabis to each other without the transaction of money or any other goods or services taking place.

1.1.3 Cultivation for personal use

The Committee has recommended that the Victorian Government investigate the impact of legalising cultivation of a small number of cannabis plants per adult only, at their principal place of residence. This should also consider a maximum number of plants per household.

In considering the number of plants that adults should be able to cultivate, the Committee heard some evidence about the restrictions of the ACT legislation. Mr Sione Crawford, Chief Executive Officer at Harm Reduction Victoria said that the ACT model has its issues with allowing sufficient access to legally grown cannabis:

> the experience in the ACT included a restriction on private growers only being able to grow two outdoor plants at a time. This is all about learning as we go along, and what that has done effectively is actually continue the black market because, as you may or may not be aware, you cannot grow cannabis continually outdoors throughout the year. And so by making it illegal to grow it inside, it means that actually when people have grown their plants and have gone through the cannabis they get from that plant, which is limited again by the regulations, they are basically left with no other options if they are a regular cannabis user other than to go out and to continue to purchase their small amounts through the black market.[2]

The Committee maintains that prescribing a limit on the number of plants per adult allows for transparency and consistency in application of the law. Allowing a relatively small number of plants is also a conservative first step in legalising cannabis.

In relation to where cannabis should be grown, the Committee also notes the evidence from Mr Crawford that cannabis cannot be grown outdoors all year round. In addition, regular users who cultivate cannabis may have to continue accessing the black market because two plants grown outdoors does not produce enough cannabis for their ongoing use.[3]

The Committee received evidence from Mr Michael Pettersson MLA, Member for Yerrabi of the ACT Legislative Assembly who introduced the private members Bill to allow for adult personal use in the ACT. He said that the provision for outdoor cultivation only was an amendment to the Bill:

> The reasoning made by those who put forward that amendment was that they wanted to better enable police to identify commercial growers from people growing for their own personal consumption.[4]

While the model in the ACT only allows plants to be grown outdoors, the Committee notes the issues raised by stakeholders about the shortcomings of this policy. The Committee advises the Victorian Government to consider whether cannabis should be permitted to be grown indoors as well as outdoors.

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2 Mr Sione Crawford, Chief Executive Officer, Harm Reduction Victoria, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 21.

3 Ibid.

4 Mr Michael Pettersson MLA, ACT Legislative Assembly, public hearing, Melbourne, 19 May 2021, *Transcript of evidence*, p. 22.

In addition, the Victorian Government should consider regulations regarding where in the home cannabis can be grown so that the plants are not accessible to people under 18.

1.1.4 Cannabis group cultivation

The legalisation of cannabis for adult personal use would address issues related to the criminalisation of minor cannabis use. However, this would not address the issue of illicit supply. Professor Simon Lenton, Director and Program Leader of the National Drug Research Institute estimated that 80% of cannabis users would still access the black market to purchase cannabis.[5] In addition, not everyone is able to grow their own cannabis at their own property.

In the Committee's view, this would be addressed in part by allowing for group cultivation. Group cultivation would allow for additional plants to be grown at the residence of a member of the group. The groups should have a maximum number of members and a maximum number of plants that can be grown. Each plant should be owned by a member of the group and there should be a maximum number of plants per member. The cannabis must be cultivated on the premises of one of the members.

Group cultivation was considered by the ACT Standing Committee on Health, Ageing and Community Services in its consideration of the Drugs of Dependence (Personal Cannabis Use) Amendment Bill 2019 (ACT). This Bill was eventually passed and legalised adult personal use of cannabis in the ACT. The Bill is discussed further in Section 1.5.3 and Chapter 6 of this report.

The ACT Committee recommended amendments to the Bill to provide for group cultivation, specifically where:

- the number of people in the group is between 2 and 10
- the cannabis must be cultivated on the premises of one of the members
- every plant must be 'owned' by an individual ACT resident and the name and address of this individual must be made available to police if requested
- no one in the group can own more than the legal limit of plants for an individual
- cannabis product in the group is owned by the individual owner of the plant that produced it
- cannabis product cannot be traded or exchanged with other individuals.[6]

However, the amendments were ultimately not made as the ACT Government considered it outside the scope of the initial Bill.

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5 Professor Simon Lenton, Director and Program Leader, National Drug Research Institute, public hearing, Melbourne, 19 May 2021, *Transcript of evidence*, p. 30.

6 Australian Capital Territory Legislative Assembly, Standing Committee on Health, Ageing and Community Services, *Inquiry into Drugs of Dependence (Personal Cannabis Use) Amendment Bill 2018*, June 2019, p. 57.

Although the Committee acknowledges that group cultivation will not address all problems with illicit supply, it believes this is a moderate and achievable first step.

1.1.5 Age restrictions

Age restrictions on the use of cannabis are important to ensure that cannabis does not get into the hands of children and young people. As discussed in detail in Chapter 3, cannabis use while young can harm the developing brain and is a risk factor in the development of mental health harms.

The Committee's recommendation calls for the Victorian Government to investigate the impact of legalisation for adult personal use for people over the age of 18. This age is consistent with the accepted legal definition of a 'child' across the Victorian legislative framework. It also aligns with the legal age for alcohol and tobacco.

Dr Alex Wodak, President of the Australian Drug Law Reform Foundation considered 18 years was in line with legal access to many things nationwide:

> In terms of the age limit, I see a lot of sense in having a uniform age limit for all sorts of things. We have the age of 18 in Australia for many progressions into adulthood, including alcohol, including a driving licence, and I think there are good reasons to have the same kind of age limit and the same kind of age restrictions that we have for alcohol availability used for cannabis availability.[7]

Some stakeholders discussed the benefits of a higher legal age limit for accessing cannabis. In particular, several noted that the model proposed in the 2020 New Zealand Cannabis Referendum which proposed a legal age limit of 20.

Mr Stephen Blyth, Communications Manager for the New Zealand Drug Foundation explained that there are two competing issues when considering an age limit. They are:

- the need to reduce harm on the developing brain and the risk of mental health issues by delaying use for as long as possible
- the recognition that young people will seek to use cannabis and the need to ensure they do not turn to the black market. [8]

Mr Blyth also explained why the age of 20 was proposed in the referendum:

> there is a bit of a ballpark figure. Some say 23, 25. At the same time, in New Zealand, alcohol can be legally purchased at 18, and we know the people that are most vulnerable to the use of these substances are younger people and we need to do as much as possible to protect them. The idea of making the age analogous or the same as alcohol was considered probably a step too far, although why would you allow young people to access one type of psychoactive substance and not another? There is a sort of double

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7 Dr Alex Wodak, President, Australian Drug Law Reform Foundation, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 40.

8 Mr Stephen Blyth, Communcations Manager, New Zealand Drug Foundation, public hearing, Melbourne 21 April 2021, *Transcript of evidence*, p. 32.

> standard going on there, which I think brings into question whether 18 is the appropriate age for alcohol, although it is not really a live debate. So balancing those two sorts of considerations, 20 was settled on as both closer to the age where less harm would occur but also pragmatic based on who was actually accessing and using cannabis, because you have got to remember we do not want to exclude those who would most benefit from the legislation and its protections. They would essentially be turning once again to the black market, where they miss out on the health interventions that you can get from a regulated approach.[9]

The Committee is aware that cannabis can harm the developing brains of young people. It has kept the age of 18 for the Victorian Government to consider for inclusion in a possible adult personal use legalisation framework because it acknowledges that young people will seek to use cannabis. It does not want to exclude young adults from any legalisation scheme and drive them to continue to access the black market, with its associated harms of criminalisation and high tetrahydrocannabinol (THC) strength cannabis.

1.1.6 Criminal sanctions that should be kept and convictions that should be spent

Under a legalised cannabis framework in Victoria, penalties outlined in the *Drugs, Poisons and Controlled Substances Act 1981* (Vic) that do not interact with the framework should be retained. In particular, illegal cultivation and trafficking. In addition, offences for driving while impaired by cannabis should be retained. The issue of testing for cannabis impairment while driving is discussed further in Chapter 4.

However, prior convictions for offences that may become legal should be spent automatically under the *Spent Convictions Act 2021* (Vic). Criminalisation of cannabis delivers life-altering criminal records to Victorians for what the Committee believes should be considered a health issue. This creates significant barries to gaining employment, housing and education which are important protective factors to manage reintegration and prevent reoffending. In the Committee's view, in many cases a criminal record generates substantial social harms for cannabis users which is disproportionate to the harm of using cannabis.

In addition, Aboriginal and Torres Strait Islander Victorians, young people and other minority groups are disproportionately affected by cannabis laws which can add to the disadvantage some face.

1.1.7 Education campaigns

Currently, cannabis education is primarily provided through the school curriculum to primary and secondary students. However, at the time of writing there were no current cannabis-related health campaigns targeted at the wider public.

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9 Ibid.

The Committee received a considerable amount of evidence relating to cannabis and other drug education, which is discussed in detail in Chapter 5.

The Committee believes any legalisation of cannabis should be accompanied by targeted public education campaigns that inform the public about the risks of cannabis use. In particular:

- the risks to mental health such as the development of psychosis or schizophrenia, including the use of high-strength THC cannabis and genetic or other predispositions
- the dangers of early onset cannabis use to the developing brain
- the dangers of driving while impaired by cannabis.

The Committee received a considerable amount of evidence on current drug education in the school curriculum and the broader community. This highlighted issues with current and past education programs, particularly the lack of direct involvement from frontline health workers. This is discussed in detail in Chapter 5.

1.2 Considerations for a legalised and regulated market for production and sale of cannabis in Victoria

As noted previously, the Committee considers that the establishment of a legalised and regulated market is not possible without significant Commonwealth Government cooperation.

However, the Committee received a substantial amount of evidence about what any legalised and regulated market for the sale of cannabis should include. The Committee has reached conclusions to minimise harms from cannabis in the community if a legalised and regulated market were established. These considerations and conclusions are discussed in the sections below.

Any model for a legalised and regulated market should seek to remove the harmful elements of criminalisation, while treading a cautious path that does not encourage new uptake of cannabis use.

FINDING 1: Any model for a legalised and regulated market for the supply and sale of cannabis should consider the following elements:

- an appropriate level of government regulation to ensure that cannabis supply and sale are subject to strict controls
- establishing a regulatory body to oversee the industry
- regulation on the potency of THC in legal cannabis products
- market controls to avoid the creation of a 'big cannabis' industry
- regulation of cannabis social clubs
- restrictions on advertising, marketing and promotion of products
- competitive pricing to undercut sales in the illicit market to ensure users access regulated products
- careful consideration should be given before further legalisation of other cannabis products (such as edibles)
- an appropriate tax framework should be put in place to help fund cannabis-related programs.

In considering its position on the merits of a legalised model, the Committee was informed by the experience of other jurisdictions that have considered legalisation or have legalised cannabis. These are discussed in detail in Chapter 6.

The Committee also received evidence on New Zealand's unsuccessful referendum on cannabis legalisation in 2020 and has referred to the issues presented by stakeholders in the considerations below.

Many stakeholders suggested or recommended specific models of legislation and regulation from other countries. The Committee highlights that these jurisdictions have distinctly different social, political and historical factors that have influenced their frameworks. As such, the findings and recommendations of this report have adapted elements of these in what the Committee considers is the best fit for Victoria.

1.2.1 Objectives for the establishment of a legalised and regulated market

The Committee believes the objectives for the establishment of a legalised and regulated market should be clear so that regulation and policies are able to be guided by a number of core principles. These should be to:

- prevent the access of children and young people to cannabis
- improve the health and wellbeing of Victorians and reduce the overall harms associated with cannabis use in Victoria through regulating the availability, potency and product standards of the drug

- improve awareness of the health and mental health risks associated with cannabis use and to reduce stigma in seeking help
- reduce criminal activity in Victoria relating to the illegal cannabis trade
- reduce the impact of criminalisation of cannabis on Victorians.

In formulating these objectives, the Committee was informed by the harms associated with the black market in Victoria as well as the benefits of establishing a legalised and regulated market.

In addition, the Committee believes that any legislation for a regulated market should be informed by the purposes outlined in New Zealand's Draft Cannabis Legalisation and Control Bill, which were:

- exercising controls over the availability of cannabis in New Zealand and deterring the illegal supply of cannabis
- raising public awareness of the health risks associated with cannabis use
- protecting the health and wellbeing of New Zealanders, particularly young people, through restricting their access to cannabis and prohibiting incentives to use cannabis
- improving access to health and social services, and other whānau[10] supports, for those who require assistance to address issues associated with cannabis use
- providing access to a legal and quality-controlled supply of cannabis for adults who choose to use cannabis
- limiting the public visibility of, and exposure to, cannabis use in New Zealand
- placing controls on the potency and content of licensed cannabis
- providing for the limited growing of cannabis for personal use, within a regulated environment
- ensuring that responses to contraventions of the Act are proportionate, encourage compliance, and incorporate a focus on reducing overall harms.[11]

10 Whānau is a Māori-language word for extended family.

11 Cannabis Legalisation and Control Bill, Consultation Draft (NZ) cl 3.

FINDING 2: Any model for a legalised and regulated market for the supply and sale of cannabis should consider the following objectives in its establishment:

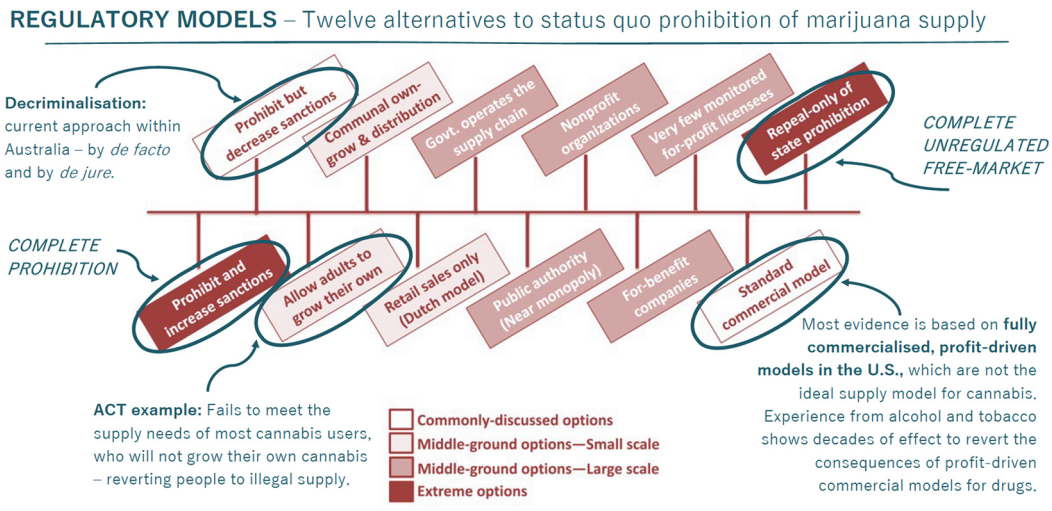
- prevent the access of children and young people to cannabis
- improve the health and wellbeing of Victorians and reduce the overall harms associated with cannabis use in Victoria through regulating the availability, potency and product standards of the drug
- improve awareness of the health and mental health risks associated with cannabis use and reduce stigma in seeking help
- reduce criminal activity in Victoria relating to the illegal cannabis trade
- reduce the impact of criminalisation of cannabis on Victorians.

1.2.2 The need for appropriate regulation

Witnesses continually told the Committee that Victoria should not follow some jurisdictions of the United States which have adopted a laissez faire approach to the legalisation of cannabis. This has resulted in very few regulations put in place on the supply and sale of cannabis. Rather, several submitters told the Committee that 'middle ground' policy options were preferable as a means of regulating the use of cannabis while avoiding the harms of criminalisation.

There is a broad spectrum of policy choices by which a government may choose to regulate cannabis. The Burnet Institute illustrated this spectrum in a presentation to the Committee at a public hearing. The spectrum ranges from the prohibition of cannabis at one end to the legalisation of cannabis with no regulation at the other. This is illustrated in Figure 1.1 below.

Figure 1.1 The spectrum of regulatory models for cannabis



Source: Burnet Institute, presentation at a public hearing, 25 March 2021, p. 5.

Ms Ashleigh Stewart, Research Assistant at the Burnet Institute said that most Australian jurisdictions, including Victoria, currently adopt a 'prohibit but decrease sanctions' approach. She stated that this fits toward the prohibition end of the spectrum.[12]

In contrast, other stakeholders noted that heavily commercialised policies with little regulation could have negative consequences. They believed that any model for legalisation and regulation of cannabis needs to avoid excessive commercialisation like that seen in some states in the United States.

Professor Simon Lenton from the National Drug Research Institute said that any regulatory approach must avoid the harms that have arisen from alcohol and tobacco industries:

> My reviews of the literature and those of my colleagues suggest that we should be cautious in terms of going forward and we should be taking gentle steps in terms of perhaps liberalising laws around cannabis—those that are less likely to result in the kinds of problems that we have seen with alcohol and tobacco—and we want to be taking those steps cautiously and looking at the benefits and the costs of those and be in a position where we can tweak and change those regulations going forward. So I think the evidence is pretty clear that criminalising people does not work, but we do not want a model that replicates the issues that we have had with alcohol and tobacco. So we think gentle, carefully considered, middle-ground steps are the way to go.[13]

The Committee was told that caution must be taken when legislating for private companies to produce and sell cannabis. Professor Tom Decorte, an academic from the University of Ghent, strongly warned that large companies may become involved. These companies have significant resources to lobby to change regulation to suit their commercial interests. He stated that such lobbying may not be in the interests of community health:

> But for me it is very important to stress that there are important historical lessons to be drawn from our regulatory approach to alcohol, tobacco and even pharmaceutical drugs. So we have been faced—with big tobacco, with big alcohol, with big pharma—with a commercial model, and there are important lessons to be drawn, because once you create these multibillion-dollar industries you will see aggressive marketing for the products. These multinationals ultimately have the same goal as the organised criminals behind illegal cannabis production, which is selling and promoting as much of the product as they can, and they will never stop looking for new target groups and for profitable ways of marketing and branding the product. They will continue to develop products particularly appealing to young people. They will always show great resistance to measures from the government to try to restrict supply, and we will see a lot of attempts from the industry to influence the regulatory development. They have huge budgets. They have huge resources for lobbying, for trying to influence scientific

12 Ms Ashleigh Stewart, Research Assistant, Burnet Institute, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p.40.

13 Professor Simon Lenton, *Transcript of evidence*, p. 29.

> research, for trying to minimise and to disguise the health risks of cannabis products that they try to sell. They may even engage in corrupt practices, as we have seen with big alcohol and big tobacco and big pharma.[14]

Professor Lenton also cautioned against the influence of large corporate interests. He noted that in Canada, where regulation is tighter than the United States, large companies have entered the market:

> The other thing that has been clear is that a lot of the regulators, particularly the Canadians, recognised early on that limiting the impact of industry was going to be important in terms of reducing harm—minimising the problems associated with criminality but reducing harm in the community—and what happened was immediately on the introduction of the laws in Canada in 2018 we had multinational liquor companies, tobacco companies, soft drink companies buying into the market. I think just in March this year apparently British American Tobacco bought a 20 per cent share—$175 million—in one of the biggest cannabis-producing companies. And in 2018 the brand that is responsible for Corona beer, Constellation Brands, bought a US$5 billion share in the biggest cannabis retail company in Canada—a 38 per cent share. That should be of concern to anyone who understands the impact of industry in terms of tobacco, alcohol and other drug-related harm. The Canadians thought they had the system set up to minimise that, and guess what? It got turned over pretty quickly.[15]

The Committee heard that there are middle ground policy options that seek to mitigate the harmful impacts of criminalisation while avoiding issues associated with heavy commercialisation. This is discussed further in Sections 1.3.1 to 1.3.4.

Professor Decorte discussed middle ground policy options, such as a non-commercial model involving cannabis social clubs:

> So the main point I would like to stress in my opening statement is that, yes, it is well worth thinking about regulating the market—probably much better than keeping it under a system of prohibition. But if you want to do so, it does make sense to look at these historical lessons and to choose a very conservative regulatory approach. And I have written some scenarios and worked on some scenarios with fellow academics in the field suggesting that it is way better to start with a very conservative regulatory approach. Maybe even choose a middle-ground option, such as legalising and regulating home cultivation and a non-commercial model—for example, involving cannabis social clubs.[16]

Associate Professor Chris Wilkins, Leader of the Drug Research Team at the SHORE & Whariki Research Centre believed production and sale of cannabis in retail outlets should be tightly regulated:

> we do not generally support the commercial markets that are being established in the United States. We would say, you know, if you are going to legalise, it seems to make

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14 Professor Tom Decorte, Director, Institute for Social Drug Research, University of Ghent, public hearing, Melbourne, 9 June 2021, *Transcript of evidence*, pp. 7–8.

15 Professor Simon Lenton, *Transcript of evidence*, p. 33.

16 Tom Decorte, *Transcript of evidence*, 9 June 2021, p. 8.

> sense to be very strict about the regulatory regime and strict about the retail just because you are worried about what might eventually come out at the end.[17]

The Committee heard that New Zealand's proposed model for legalisation of cannabis favoured community enterprises operating cannabis retail and production establishments. According to Ms Sarah Helm, Executive Director of the New Zealand Drug Foundation, this was intended help to prevent corporate interests becoming dominant in the supply or sale of cannabis:

> a phased approach would have been taken to prevent big alcohol and big tobacco by putting some steps in place to prevent the same kind of high commercialised model that we have seen in some of our other harmful substances. So that was the legislation itself.[18]

The Committee believes that care should be taken to avoid excessive concentration of corporate interests in any cannabis industry that is established in Victoria. To prevent this, the Victorian Government should explore options for the involvement of not-for-profit community or social enterprise licensees.

While regulation is important, the Committee heard that it must strike the right balance to encourage users to switch from the illegal market to purchasing legal products. Mr Sione Crawford from Harm Reduction Victoria warned that too many barriers to access cannabis could drive people away from the legal market:

> I think there is definitely a concern amongst people who use illicit drugs that with any new market that is brought in under the government's watch—and we may be able to tweak it and change it—unless there is commitment to a long-term market, I think that people will still be very dubious about engaging in a legal market. We want to make sure that people feel comfortable in engaging in the legal market so they do not continue accessing illicit drugs. We do not want to make it so hard to access the legal market or put up so many barriers to the legal market that people just continue to access the illicit market.[19]

The Committee acknowledges that caution should be taken to ensure that over-regulation does not disincentivise people accessing a legal market. However, the Committee believes that the harms of under-regulation require a middle ground approach. Such an approach would see appropriate regulations on the production and sale of cannabis to ensure community safety.

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17 Associate Professor Chris Wilkins, Leader, Drug Research Team, SHORE & Whariki Research Centre, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 30.

18 Ms Sarah Helm, Executive Director, New Zealand Drug Foundation, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 27.

19 Mr Sione Crawford, *Transcript of evidence*, p. 21.

1.2.3 Establishing a regulatory body

A regulatory body or bodies should oversee any proposed regulatory framework. Part of their role should include oversight of licencing arrangements and cannabis product and safety standards.

In his submission, Associate Professor Chris Wilkins provided an example of a regulatory body that would undertake such a role. He provided a paper which explained the regulatory body that was proposed to oversee the model of cannabis legalisation in New Zealand. This included extensive powers to licence production and sale of cannabis, with a role in monitoring product standards and safety:

> Under the CLCB [the proposed New Zealand Cannabis Legalisation and Control Bill], the newly established Cannabis Regulatory Authority is tasked with a wide range of functions, including setting the national cannabis production cap, issuing licenses, setting the criteria and conditions for licenses, setting the THC levels of products, monitoring and enforcing compliance of production standards and retail and consumption premises, administering and collecting excise taxes, implementing appeal decisions, monitoring and enforcing compliance of home grows, developing good practice guidelines for home grows, conducting public education campaigns, raising public awareness of the new law, collecting and analysing statistics on supply and demand, promoting and supporting research, regulation production and marketing, regulating cannabis accessories and facilitating a whole-government approach to non-compliance, in particular in relation to young people.[20]

The paper also explained that the proposed New Zealand regulatory body had three main objectives of:

- promoting the wellbeing of New Zealanders
- reducing the multiple harms associated with cannabis use
- reducing the overall use of cannabis over time.[21]

If cannabis was legalised in Victoria, the Committee believes that the Victorian Government should consider establishing a regulatory body. In addition, it should be guided by the model that was proposed in New Zealand.

1.2.4 Regulating THC potency

Cannabis contains chemical substances called cannabinoids. The two main cannabinoids in cannabis are THC and cannabidiol (CBD).[22] THC is the psychoactive substance which gives cannabis users an intoxicating sensation and is one of the key

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20 Associate Professor Chris Wilkins, *Submission 1297*, p. 16.

21 Ibid., p. 12.

22 Therapeutic Goods Administration, *Safety of low dose cannabidiol*, Department of Health, Commonwealth Government, 2020, pp. 4, 9.

harmful components of cannabis. This is because cannabis with a high THC potency is a risk factor for the onset of psychosis if used frequently. In addition, it can cause damage to the developing brains of young people.

Dr Karen Gelb, Senior Research and Policy Officer at the Penington Institute discussed options for a THC potency cap in a regulated market:

> What that actual limit should be—going back to Georgie's question—is very hard to know. In some jurisdictions there is a cap of 15 per cent, in others the maximum amount varies, so I think some expertise would need to be called on to identify what would work best there.[23]

Dr Alex Wodak from the Australian Drug Law Reform Foundation gave his view that a range of products with different THC levels should be available:

> We have to listen to people who have used a lot of cannabis over a long period of time and find out what they have to teach us on this. My instinct tells me that it would be good to have maybe two or three options—people who have mild, moderate and high concentrations—and they could self-select from that. I know in the medicinal cannabis literature that where different kinds of medicinal cannabis were provided, such as in the Netherlands, people with different medical conditions found that different kinds of cannabis helped their conditions more than other kinds of cannabis, so people with arthritis tended to use one kind of product and people with chronic pain used another kind of product. I think we will find the same sorts of things in this area.

He added that regulation on THC strength could be changed over time if authorities discovered it is too high or too low:

> One of the points I think we need to remind ourselves of is that we are starting cannabis regulation pretty well from scratch. There is not a big international experience on it, and we are going to make some mistakes. I wish that was not the case but it will be the case, and so it is very important that built into whatever systems we have there is a lot of evaluation and an ability to be flexible and change our mind if we find we have made a mistake. If we find that 7 per cent THC is too high or too low, we have to have enough flexibility to admit we have made a mistake and then modify the policy.

The Committee was also told that the harmful properties of THC can be moderated by the content of CBD. Dr Gelb explained that if a level of CBD is mandated in cannabis products in a legalised and regulated market, it can reduce the harmful impacts of THC:

> I think the evidence shows that CBD can dampen, counteract, the effects of THC. The argument there is that if you require some level of CBD—or approaching some kind of balance between the CBD and the THC—then you can potentially reduce harm, allowing you to avoid products that have no CBD in them at all.

The Committee believes that a THC cap should be considered in a legalised and regulated market. If a cap is introduced, it should be flexible. The Victorian Government

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23 Dr Karen Gelb, Senior Research and Policy Officer, Penington Institute, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*.

should seek to increase the cap if it finds that consumers are not sufficiently encouraged to move from the illicit market, or users are consuming more cannabis. The Government should also explore options to ensure an appropriate CBD level in cannabis products sold in a legalised and regulated market.

1.2.5 Cannabis social clubs

Cannabis social clubs are a model which can regulate the use of cannabis. This model was considered in detail by the Committee. Cannabis social clubs are generally not-for-profit associations which cultivate plants on behalf of members.

The Committee recognises there is merit in the cannabis social club model to address cannabis supply issues. However, there are significant barries to introducing a regulated social club market in Victoria due to the restrictions of Commonwealth legislation. This is discussed in detail in Section 1.5.

Many Inquiry stakeholders believed that cannabis social clubs could reduce public health risks associated with cannabis consumption and promote better health and social outcomes amongst users. They noted that closed membership, imposed quantity limits and the emphasis on immediate consumption are seen to encourage planned and responsible use by adult users. This also intends to restrict availability and limits promotion of cannabis to the wider public, particularly to young people.[24]

Professor Simon Lenton from the National Drug Research Institute gave an overview of how many people could benefit from cannabis social clubs, and the kinds of regulation that may be beneficial:

> Probably 80 per cent or more of people that consume cannabis do not grow their own, so you have got to find some way for them to get cannabis that does not involve going to the illegal market. We believe cannabis social clubs, with their ability to tightly control—government control, regulation, limited, no advertising, no promotion, lose their licence to grow if they provide it to others and all that kind of thing—provide a model that could meet the needs of at least a significant proportion of that 80 per cent of people that do not grow their own cannabis.[25]

In its submission, the Penington Institute believed that cannabis social clubs could be an appropriate way to regulate cannabis in Victoria. It supported adopting an approach similar to Spain:

> This aligns with the existing approach to medicinal cannabis, whereby a limited number of licensed growers are involved in the scheme. Home-grown cannabis for personal use could follow the cannabis club model in Spain but needs to be tightly regulated to prevent criminal infiltration.[26]

Spain's cannabis social clubs model is discussed further in Chapter 6.

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24 Drug Policy Modelling Program, *Submission 1347*, p. 4.

25 Professor Simon Lenton, *Transcript of evidence*, p. 30.

26 Penington Institute, *Submission 1468*, p. 17.

The Drug Policy Modelling Program asserted that the cooperative structure of cannabis social clubs supports harm reduction, as members are actively involved in choosing varieties and cultivation methods. It stated:

> The literature shows that people who use drugs try to obtain the least harmful substances for themselves and their peers, so models that afford members a degree of choice and control over the product will likely have greater harm reduction effects than those that do not.[27]

Some stakeholders highlighted the benefits of the not-for-profit model of cannabis social clubs, as it ensures that clubs are not driven by commercial interests. The Drug Policy Modelling Program noted this in its submission:

> As a closed, non-profit system of cannabis supply and consumption Cannabis Social Clubs lack commercial incentives to increase consumption and so avoid the excesses of profit-driven systems seen elsewhere.[28]

Professor Tom Decorte noted that legal cannabis markets have the potential to 'attract substantial demand away from the black market' but not entirely. In evidence to the Committee he advocated for social clubs as a middle ground to address these issues. However, he noted that any social club model needs to be tailored to a jurisdiction's local context:

> Any experiment with regulated Cannabis Social Clubs should also be tailored to the local context. This implies a discussion about the location and density of clubs per area (a point taken up in Uruguayan legislation), about whether or not it is good practice to allow consumption of cannabis (and/or alcohol) at the venue of the clubs, and about the distribution procedures (during opening hours, by order only, through frequent 'distribution fairs', etc.).
>
> [Cannabis social clubs] too have an interest in such a regulation as it will ensure legal availability of cannabis to their members, their right to freedom of peaceful assembly and association, and the legal status of their organisation and activities. [29]

As noted in Section 1.5, the Victorian Government is unable to introduce legislation to create a regulatory framework for cannabis social clubs due to restrictions of Commonwealth legislation. However, the Committee believes a tightly-regulated framework for cannabis social clubs would also address issues regarding illicit supply.

The Committee believes this would also act as a complementary measure in a legalised cannabis market to help regulate use and reduce the risks of cannabis consumption.

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27 Drug Policy Modelling Program, *Submission 1347*, p. 6.

28 Ibid., p. 4.

29 Professor Tom Decorte, *Submission 1288*, p. 137.

1.2.6 Advertising, marketing and packaging

The Committee believes a key principle of a legalised market is that it should not seek to increase cannabis use overall. On this basis, all advertising and promotion of cannabis should be strictly regulated. Particular care should be taken to ensure cannabis is not promoted to young people. Cannabis should also be sold with product information and health warnings.

Mr Michael Pettersson MLA, Member for Yerrabi at the ACT Legislative Assembly said that advertising would allow for the cannabis industry to seek to entice more consumers, which is not in the interests of public health:

> Now, I believe that when you set up a commercial market—I think the best examples are in America—when you allow advertising, when you create this commercial imperative for people to try and increase their profits, people generally try to push this substance on people, and I suppose on people that due to circumstance might develop an interest in it. If we can stop people developing an interest in using drugs, that is a good thing.[30]

Similarly, Mr John Ryan, Chief Executive Officer of the Penington Institute warned against any advertising that would make cannabis products more desirable:

> I would absolutely dread seeing cannabis advertising to young people or adult people. I do not think we need billboards promoting cannabis use
>
> ...
>
> I do not think we should be creating products that generate a mystique or are informed by marketing.[31]

Professor Simon Lenton from the National Drug Research Institute expressed his concern about advertising of cannabis on social media and the difficulty in regulating it:

> The other thing that has happened is that while many of those markets are purported to have controls on advertising and promotion—great stuff from a public health point of view; we know that advertising works and so we want to make sure that is well controlled—what has happened of course is that the companies have moved into social media. So we get YouTube videos, we get strain reviews, we get stuff on Facebook and Instagram and all that kind of stuff. And there has been some new research that was just published this year which looked at young people under the age of 18 and their exposure to cannabis-related media and promotion, and it looks like both in the states that have recreational markets and some of the longstanding medical markets that young people are getting access to promotion of cannabis through social media—really difficult to regulate, and that is a problem.[32]

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30 Mr Michael Pettersson MLA, *Transcript of evidence*, p. 25.

31 Mr John Ryan, Chief Executive Officer, Penington Institute, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 44.

32 Professor Simon Lenton, *Transcript of evidence*, p. 33.

In Canada, which has a legalised and regulated cannabis market, advertising is tightly regulated while still allowing licenced premises and suppliers to inform adults about the products they provide. Canada's *Cannabis Act 2018* includes provisions which regulate the advertising and marketing of cannabis products. These include:

- A prohibition on the promotion of cannabis or associated products. Exceptions include the following:
  - A person who is authorised to produce, sell or distribute cannabis may produce informational or brand-preference promotional material.[33] Measures are in place to prevent this information being displayed to young people, including:
    - the promotion should not be displayed in a place that is accessible by young people
    - reasonable steps should be taken to ensure the promotion cannot be accessed by young people, including online.[34]
  - A person who is authorised to sell cannabis may promote it at the point of sale if the promotion indicates only its availability and/or price.
- A prohibition on displaying branding which could be considered appealing, particularly to young people and in places accessible to young people.[35]

The Canadian model strikes a balance between informing adults who are accessing cannabis about the product and ensuring that young people are not exposed to cannabis branding or advertising. The Committee believes that the Victorian Government should consider this model of advertising prohibition when considering regulations for any future legalised and regulated market.

In relation to packaging, the Committee was told about the value for consumers in having product information on the package, including THC strength. This would allow cannabis users to make decisions about the kind of product they wish to purchase. Ms Tamar Todd, a lecturer at the University of California, Berkeley, put forward her views on product information and health warnings:

> let us say it is a completely illicit market, and I am going to go out and I am going to buy on the illicit market cannabis for myself to consume later. I go out and buy the product. I have no idea what the THC concentration is. I might have no idea what the cannabinoid concentration is. I do not know any of that information—how it was produced or what is in it or how potent it is—versus I go into a regulated retail outlet in California and I purchase a product. First of all, I have a range of choices, like I can choose to get a 20 per cent THC product or I can choose to get a 5 per cent THC product. I can choose what I want the potency to be. I know it has been standardised and tested to meet that potency. I know what a serving is—when I ingest a piece of it I know how much

33 Health Canada (Government of Canada), *The Cannabis Act and Cannabis Regulation: Promotion prohibitions*, <https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/laws-regulations/promotion-prohibitions.html> accessed 15 July 2021.

34 Ibid.

35 Ibid.

> THC is ingested. So as the consumer, you are being provided access to a product that is tested and properly labelled and also has proper warnings attached to it, like, as you mentioned, about pregnancy or impairment or any other health effects that we want the consumer to know. It can come with that in addition to the requirement that I am given information or education about how to most safely consume it, how much to take at one time. So to me it is like equipping the consumer with a product that has an assurance of what it is, a range of choice in products to me as a consumer, and accurate labelling and a warning about what the product is.[36]

The Committee agrees that health warnings should be included on cannabis packaging. In addition, product information should also be a feature, particularly about the strain and strength of THC and CBD contained in the product.

1.2.7 Pricing

Any price of legal cannabis must be competitive with the black market so that users are encouraged to consume regulated products. High prices caused by unnecessary costs for retailers will diminish the demand for legal products and incentivise users to continue purchasing cannabis from illegal sources.

As discussed in Chapter 2, the Committee received evidence that the price of cannabis has remained stable at about $20 per gram for the last decade.[37]

In considering policy settings for the price of cannabis, Associate Professor Peter Higgs, Burnet Senior Fellow at the Burnet Institute said that the structure of alcohol pricing could offer a guide:

> Part of that is going to be about: well, what are you charging? If it is cheaper on the black market to be able to buy cannabis, then they are not going to go to legal markets to do it. Where do people most buy their alcohol? Lots of people have grandparents or others who brew their own and all of those sorts of things, but most people still buy their alcohol through legal regulatory kinds of frameworks where we know how much we are getting when we buy a bottle of Jack Daniel's. But it can be titrated as well, so we see a number of participants who will buy 4 per cent Bundies and Cokes through to 8 per cent through to 12 per cent, but at least we know that we are getting the 12 per cent when we buy the 12 per cent. I think the ways in which you can kind of try and control for the black market are by having a system where the price is tight enough to ensure that people are not using it outside of that. Obviously you need to police it at some level as well, where there are some kinds of crackdowns on people who are still doing it through the illicit way, in the same way that we do for tobacco.[38]

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36 Ms Tamar Todd, Lecturer, Berkeley Law and Former Legal Director, Drug Policy Alliance, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 7.

37 Mr Sam Biondo, Executive Director, Victorian Alcohol and Drug Association, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 19.

38 Associate Professor Peter Higgs, Burnet Senior Fellow, Burnet Institute, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 42.

Professor Simon Lenton from the National Drug Research Institute told the Committee that price could be used as an important factor in dissuading use. He noted that it has been successful with tobacco:

> Well, what we know from alcohol and tobacco is that price is the number one lever in terms of effectiveness for reducing use and harm. The reason why a packet of cigarettes costs whatever they cost now—is it $30?—is because it works: it stops people from buying tobacco. It is much more effective than telling them that tobacco will harm their health—much more effective. It is the same with alcohol as well. We have lots of evidence with alcohol that as the price of a unit of alcohol goes down, consumption and harm goes up—and it also goes up in the most marginalised communities who also experience all sorts of catastrophic levels of harm as a result. So price is an extremely important lever, and when price drops by 50 per cent that is a real worry. That is an indication that we are heading for public health problems.[39]

However, Ms Tamar Todd cautioned that to supress the illegal market, the price of cannabis should not be excessive. Only once the illegal market has been diminished over time should the price be raised to discourage use:

> You should try to bring in and allow legal opportunity to as many as you can, capture as many people as you can under the umbrella of legal regulation and taxation, make it initially a very easy entry, and then as the illicit market becomes less viable and goes away, at that point then you can increase regulation and increase taxation. We can effectively do that here with tobacco because it has long been a legal industry and there is not a thriving illicit industry—or there is actually still some illicit industry to evade taxes; we have very high taxes—but if we start out with cannabis with very high taxes and make it pretty difficult for people to enter, they will just stay in the illicit market and that will thrive. But it is a challenge; I think it is figuring out the right balance.[40]

1.2.8 Other cannabis products

Cannabis can be incorporated into a number of consumable products such as foods, oils and vaporisers. The Committee heard that these products can include highly concentrated amounts of cannabis with high THC concentrations. However, these products do not require the cannabis to be smoked which can prevent harms associated with smoking, particularly if tobacco is also involved.

Professor Simon Lenton discussed the prevalence of other cannabis product use in the United States markets where cannabis has been legalised. He said that:

> in the marketplace there is a range of products you probably would have heard about. There is obviously cannabis flower, heads, cannabis that we are familiar with, but there are also edibles—so chocolate, sweets and so on—that are infused with cannabis. There are vape cartridges that contain THC, there are oils and a whole range of products. What we have seen in those states, particularly the ones that have been doing it for a

39 Professor Simon Lenton, *Transcript of evidence*, p. 33.

40 Ms Tamar Todd, *Transcript of evidence*, pp. 6–7.

> while, is that the proportion of consumption—and we know it now because we have got the market data—that comprises those high-potency products has rapidly increased. There has been a move away from flower, if you like—from heads—to the more potent products. And while some people would say from a harm reduction perspective that is good because they are not smoked and so on, it would be as if we all of a sudden shifted our alcohol market away from beer and wine and had 50 or 70 per cent of people consuming spirits all the time. We can anticipate what those problems will be.[41]

The Committee believes there should be caution about introducing other cannabis products due to the potential for them to incorporate high amounts of THC. In any legalised and regulated market, the suitability of allowing the sale these products should be reviewed once the market has sufficiently matured. A THC cap should also be applied to these cannabis products.

1.2.9 Taxes

Many stakeholders proposed the introduction of taxes on the sale of cannabis products which could be put towards public health and education programs. However as discussed in Section 1.5, this is likely not possible at a state level. This is due to the Commonwealth Government's exclusive power to 'impose duties of customs and of excise' under the *Commonwealth of Australia Constitution Act*.[42]

Regardless, the Committee agrees that appropriate taxes should be introduced in a legalised and regulated cannabis market. This would help address some of the harms associated with cannabis consumption by providing revenue to fund health and support services.

In addition, there may be scope for the Victorian Government to introduce 'licence fees' for outlets that sell cannabis that would operate in a similar fashion to liquor licences. This is discussed further in Section 1.5.2.[43]

At a public hearing, Ms Ashleigh Stewart from the Burnet Institute said:

> Any revenue that might be raised—even including through taxation, if that is something that we go down—should be re-invested into treatment, health and education campaigns.[44]

Dr Karen Gelb from the Penington Institute discussed how other jurisdictions had ringfenced taxation from the cannabis industry so that it funded health and justice programs:

> Certainly it is an opportunity for revenue raising and for that revenue to be allocated appropriately, as you talk about the hypothecating or the ring fencing of the licensing fees. Again, it has been used in other jurisdictions. Canada has identified the use of

41 Professor Simon Lenton, *Transcript of evidence*, p. 33.

42 *Commonwealth of Australia Constitution Act* (Cth) s 90.

43 Ms Ashleigh Stewart, *Transcript of evidence*, p. 41.

44 Ibid.

> funds raised—to be used towards prevention. I know earlier today there was mention of the New York model that has just been proposed, which has been proposed as a form of justice reinvestment, which is where the money that is either saved or raised through criminal justice reforms is put back into those communities that have been most affected by the criminal justice policies. We know justice reinvestment generally is very effective. It is a very good way of reducing offending. So I think that is a fabulous opportunity for Victoria to make a really good use of its funds.[45]

In deciding what component of cannabis should be taxed, Caulkins et al. in a report for the Rand Corporation outlined several options, including taxes based on:

- weight
- value (price)
- THC strength.[46]

The report noted that taxing cannabis by weight or price would be an easier option to implement. A tax based on the THC strength would have the advantage of disincentivising users from purchasing stronger THC products and reduce the harms associated with them. However, such a tax could be difficult to implement as the Victorian Government would have to implement product testing to verify THC strength.[47]

The Committee supports using tax collected from a legalised and regulated market to be used for public health and education measures. This would help to limit any harms that may arise from the legalisation of cannabis. Such measures would seek to limit the financial impact of any increase in alcohol and other drug services and health costs.

1.3 Arguments for legalising cannabis

The Committee heard evidence throughout the Inquiry about the serious harms that arise from the prohibition of cannabis. These harms relate to two key areas:

- the harms associated with the sale of cannabis on the illicit market, including:
  - the sale of cannabis with high THC potency
  - access to cannabis by children and young people
  - organised crime profiting from the sale of cannabis and introducing cannabis users to other more dangerous illicit substances
- the impact of criminalisation of cannabis, which delivers life-altering criminal records.

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45 Dr Karen Gelb, *Transcript of evidence*, p. 48.

46 Jonathan P. Caulkins et al., *Considering Marijuana Legalization: insights from Vermont and other jurisdictions*, RAND Corporation, 2015, pp. 76–82.

47 Ibid., pp. 80–82.

It is for these key reasons, that the Committee is recommending that the Victorian Government investigates the impacts of legalising cannabis for adult personal use. Some of these harms can be alleviated by legalising cannabis for adult personal use, others can be solved through a legalised and regulated market.

The evidence received about the harms associated with the sale of cannabis on the illicit market and the impacts of criminalisation are discussed in depth in Chapters 3 and 4. However, two examples from key stakeholders are included below to illustrate their serious nature.

Mr Sam Biondo, Executive Director of the Victorian Alcohol and Drug Association, discussed the failure of prohibition and the harmful outcomes of the black market:

> There is a pressing need to accept that the current approach to cannabis amounts to decades of failure and lost opportunities. It has been destructive for many otherwise normal people, yet facilitated billions of dollars of profit for powerful drug cartels dwelling in the depths of the dark economy. For decades we have pursued a litany of failed policies with a range of perverse outcomes, yet at great human cost ...
>
> In cannabis, you have all sorts of adulterants that may go onto the plants. You may have insecticides, you may have quality issues. You have it being inappropriately targeted to young people who should not have access, technically. If there was a regulated market, maybe you could control some of that ...
>
> The frame for our presentation was around the harms with the criminal justice approach to dealing with what essentially is a health harm or health issue, and that creates a whole range of repercussions throughout the individual's life, because of those sorts of interventions. With the harm for young people, obviously the younger you start the greater the potential for damaging lungs, brain, all that sort of thing. With the THC levels, what is available in Australia in terms of cannabis can be high in THC one day, low in another; this has got more propensity to have this sort of mental health outcome ... [48]

In its submission, Victoria Legal Aid outlined the impact of criminalisation on those who use cannabis and encounter the criminal justice system:

> in summary we recommend decriminalisation of possession and personal use of marijuana, because we would rather see those cases out of the criminal justice system, because our experience is that the criminal justice system causes harm to our clients who actually need a health response, sometimes to deal with addiction and often to deal with mental health issues
>
> ...
>
> Any criminal justice involvement can be harmful. It can hurt your education and housing. For people who are likely to be our clients, who have things like mental health issues, it can compound their dependence on cannabis or other drugs that they use to manage the impacts of those conditions. But actually what we found when we were preparing the submission was that we had clients who were being remanded in custody after

48 Mr Sam Biondo, *Transcript of evidence*, p. 19.

> being charged with possession of cannabis, and that shocked me. Often these clients—and I think you will see it in the case studies of people like Katie and Anthony in our submission—were people who have had criminal justice involvement in the past, who were actually doing pretty well and recovering and turning their lives around, but then they were getting arrested for possession of cannabis and they ended up remanded in custody even though clearly they did not belong in prison. Even short periods of imprisonment can be pretty harmful. They can be traumatic, particularly at a time when we are understandably imposing a lot of restrictions on people in custody because of COVID, but also disruptive of supports that they have in the community, like housing, work and mental health treatment.[49]

The two key issues identified are not an exhaustive list of the problems caused by prohibition. There are others, particularly in relation to government spending on cannabis prohibition and stigma associated with use which prevents cannabis users seeking help. These are discussed further in Chapters 4 and 5.

The Committee heard that regulating the sale of cannabis can also create opportunities to address issues with the illicit market cannabis, including:

- regulating the THC potency of cannabis so it is less harmful to the mental health of users
- removing profits from organised crime and creating a taxation scheme, the proceeds of which can be spent on public health measures.

1.3.1 How the legalisation of cannabis addresses issues raised in the Inquiry

The Committee's Inquiry focused on how to improve health outcomes associated with cannabis use in Victoria. This included public education campaigns on the dangers of use and wider effects of cannabis on users and the people around them. It also considered ways to protect young people from accessing and using cannabis and how to prevent criminal activity associated with the drug.

The Committee concluded that the best means to address these considerations is under a legalised and regulated cannabis market. Under a properly regulated market:

- young people could be better prevented from accessing and using cannabis
- the public health and safety of Victorians who use cannabis could be improved through regulation of the potency and quality of the drug
- proper public education campaigns can inform people of the risks associated with use and reduce the stigma felt by users who wish to seek help for problematic use
- criminal activity relating to the illegal cannabis trade would be reduced.

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49 Mr Dan Nicholson, Executive Director, Criminal Law Services, Victoria Legal Aid, public hearing, Melbourne, 19 May 2021, *Transcript of evidence*, p. 2.

Mr Sione Crawford from Harm Reduction Victoria agreed with this view, stating:

> We do recommend that the Victorian government develop a legal and socially equitable commercial cannabis market as a means to achieve all of the inquiry's terms of reference. In the Victorian Inquiry into Drug Law Reform in 2018 it was recognised that internationally discussion regarding the legal regulation of cannabis for adult use is becoming more common, and we are doing it now to a degree. A regulated cannabis market for Victoria can reduce the criminal activities associated with an illegal market. A regulated commercial market might provide a service interface for the public and an opportunity to integrate health promotion and harm reduction education and interventions into that. If Victoria introduced a regulated and taxed commercialised cannabis market, citizens might enjoy multiple financial, health and social benefits. This could be a significant revenue source for Victoria too, and such revenue could be reinvested into health and community services to benefit all Victorians.[50]

These outcomes, as well as other associated benefits, can be broadly categorised into the themes of access, health and justice. These are summarised below and discussed in detail in Chapters 3 and 4 of this report.

It is important to note that some of these outcomes can be realised through legalising adult personal use, while others would only be possible through a legalised and regulated market.

1.3.2 Access to cannabis by children and young people

One of the key harms associated with the sale of cannabis on the black market is that there are no barriers to the sale of cannabis to children and young people. The Committee heard that cannabis use is particularly damaging to children and young people. This includes neurological damage to their developing brains as well as an increased likelihood of mental health harms.[51]

A legalised and regulated market for cannabis could address this through mandating a minimum age limit on the sale of cannabis, similar to alcohol or tobacco. In conjunction with appropriate education campaigns on the risks of use, this will help to delay the onset of use by restricting the ways a young person can be exposed to cannabis.

Dr Shalini Arunogiri, Chair of the Faculty of Addiction Psychiatry at the Royal Australian and New Zealand College of Psychiatrists Victorian branch, explained that cannabis use is particularly harmful to the mental health of children and young people:

> I think we have really conclusive kind of evidence that delaying the age of onset of cannabis use is a positive thing. It actually reduces the risk of a whole range of harms but definitely the mental health harms. For instance, if people are initiating below the

50 Harm Reduction Victoria, *Submission 1385*.

51 Drug Free Australia, *Submission 1364*, p. 14.

> age of 12, we know that that is significantly high risk in terms of actually transitioning to becoming dependent on cannabis itself but also actually developing a whole range of other harms.[52]

Dr Erin Lalor, Chief Executive Officer at the Alcohol and Drug Foundation discussed how cannabis use in adolescence can harm their developing brain:

> We know that adolescents are at greater risk of harm because the adolescent brain is undergoing significant development, and the use of any psychoactive drug, including cannabis, risks interfering with those processes.[53]

Mr John Ryan from the Penington Institute believed a legalised and regulated market would also empower parents to encourage their children to delay their use of cannabis:

> I know one of the key terms of reference is around young people. We know that young people are using cannabis already. In a regulated cannabis market with a cut-off age, parents are supported to say, 'No, you can't use cannabis until you get to the legal age'—the same empowerment that they can have with alcohol. We do not have that at the moment. It is all an underworld business.[54]

The Committee is mindful that the legalisation of cannabis for adult personal use and the introduction of a legalised regulated market would not entirely displace the illicit market. This was reflected in a range of evidence received from key stakeholders. However, Ms Tamar Todd from the University of California, Berkeley said that in the United States the rates of use amongst young people has not increased:

> Then finally one of the big fears with legalisation before it started was that legalisation would increase use by youth, and we are now 10 years into it and it has not increased youth use at all. Actually the data from all the states shows no increase, and some of it shows a slight decline. The states that have legalised cannabis for adults have not seen sort of that feared increased in youth use.[55]

1.3.3 Health

The Committee heard that a regulated market can help ensure that safer products are made available to consumers. In its submission, Students for Sensible Drug Policy Australia gave an example of the potentially harmful high THC cannabis that is currently available on the illegal market in Australia:

> A NSW study that analysed the alkaloid content of key cannabinoids in seized samples indicates that cannabis sold in Australia is extremely high in THC (Tetrahydrocannabinol), but has a low quantity of other potentially therapeutic

52 Dr Shalini Arunogiri, Chair, Faculty of Addiction Psychiatry, Royal Australian and New Zealand College of Psychiatrists (Victorian branch), public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 29.

53 Dr Erin Lalor, Chief Executive Officer, Alcohol and Drug Foundation, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 62.

54 Mr John Ryan, *Transcript of evidence*, p. 43.

55 Ms Tamar Todd, *Transcript of evidence*, p. 3.

> cannabinoids such as CBD (Cannabidiol). Studies have linked high levels of THC and minimal CBD to increased risk of mental health issues such as schizophrenia and psychosis.[56]

Dr Alex Wodak from the Australian Drug Law Reform Foundation believed that if cannabis was sold legally the THC potency of the cannabis could be controlled. He also suggested that product information and health warnings could be included on packaging:

> Regulating cannabis gives us the opportunity to ensure that there are safeguards introduced into this market. The safeguards would include warnings on packaging about health risks, providing help-seeking information for people using cannabis and also advising consumers about the contents of the packet. That would allow consumers to know, most importantly, what the percentage of tetrahydrocannabinol—THC—is in the packet and to try and maintain consistency from batch to batch. This means we could attempt to reduce the harm from cannabis, and I hope we would take reducing the harm from cannabis as seriously as we take reducing the harm from other mood-altering drugs. So far all we have been concerned about is reducing the use of cannabis, but we should be trying particularly to reduce the harm. I will stop at that point because I am sure there are many points that all of us would like to discuss.[57]

Mr Ryan from the Penington Institute agreed with this sentiment. He also noted that a regulated market would encourage conversations between the purchaser and the vendor about the potency of the cannabis product:

> I think what we should be trying to do is to have transparency in terms of the product at the very minimum, including packaging that describes the THC content, for example. But I think it is interesting that in the regulated markets there is a conversation typically, as I understand it, between the vendor and the purchaser around the different sorts of psychoactive consequences of that use, so if you want a more up, gregarious experience, then it is this particular strain and if you want a product that is good for creativity or deep thought, then this is a better product. So I think that sort of nuance is what you get provided in the regulated market, including stipulations around THC and CBD content.[58]

The Committee considers a key benefit of establishing a legalised, regulated market is the imposition of a cap on the amount of THC in cannabis products. This would reduce exposure to harmful high-potency cannabis and help to reduce the risk of mental illness and harm to developing brains. The Committee was told that a THC cap has been introduced in Vermont in the United States.[59] Such a limit should be considered by the Victorian Government in the event it resolves the legal barriers with the Commonwealth Government to allow for a legalised and regulated market.

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56 Students for Sensible Drug Policy Australia, *Submission 1392*, p. 17.

57 Dr Alex Wodak, *Transcript of evidence*, pp. 35–36.

58 Mr John Ryan, *Transcript of evidence*, p. 46.

59 Dr Kevin Sabet, President, Smart Approaches to Marijuana, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 11.

Under a regulated market, people with problematic cannabis use will be more likely to seek help for problematic use or health issues associated with consumption. The Committee was told that in Canada the legalisation of cannabis had removed the stigma of seeking information around harm reduction. In addition, the Canadian Government had dedicated funding to educate young people about the dangers of cannabis, with a view to delaying the onset of use. Mr Stephen Blyth from the New Zealand Drug Foundation said:

> Well, one of the things that we have noted with Canada—and we were observing very closely—is that by bringing cannabis into the open it is no longer taboo. It does open the way to public education in a way that we have not been doing up until this point. I note that the Canadian government has invested very heavily in this—$100 million over six years. That far exceeds the amount of funding that goes into education at this point under our prohibition model. Interestingly, a lot of it is about obviously concerned with delaying the onset of young people's use.[60]

1.3.4 Justice

A criminal justice system-based approach to cannabis use can generate substantial harms, many of which are disproportionate to the harms associated with using the drug.

Legalising adult use of cannabis will divert adult users away from the criminal justice system and prevents them experiencing the associated harms. This will allow law enforcement to refocus on organised criminal activity and illegal market suppliers rather than spending considerable resources on policing low-level offences.

At a public hearing, Assistant Commissioner Glenn Weir, Drug portfolio holder at Victoria Police explained that the harms of cannabis use extend beyond the health impacts of consumption to criminal activity associated with organised crime groups:

> The vast majority of plants and crops seized by Victoria Police have been cultivated hydroponically, largely in suburban residential properties and also increasingly in commercial and rural locations. These properties are sometimes referred to as crop houses, and we know that organised crime groups and syndicates such as outlaw motorcycle gangs establish crop houses due to the high profitability of cannabis crops. The income from cannabis is also used by these syndicates to fund other illegal activities such as the manufacture of other illicit drugs, including methamphetamine, and we know that crop houses are often targeted by other criminals and this can result in violent altercations, or run-throughs as they are commonly known.[61]

Some of the other key issues with a criminal justice-based approach that may be addressed with the legalisation of cannabis for adult personal use are:

- the social and economic barriers from having a criminal record

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60 Mr Stephen Blyth, *Transcript of evidence*, p. 29.

61 Assistant Commissioner Glenn Weir, Drug portfolio holder, Victoria Police, public hearing, Melbourne, 29 June 2021, *Transcript of evidence*, pp. 2–3.

- the overrepresentation and distinct harms experienced by vulnerable communities, such as Aboriginal and Torres Strait Islander Victorians
- the impacts on young people
- the significant costs of a law enforcement response to cannabis use.

In its submission, Turning Point explained that a criminal record can cause 'long-lasting and disproportionate' harms to cannabis users. It believed that the prohibition of cannabis has criminalised a health issue when many people would be better served by treatment or education. Turning Point stated that the choice to approach cannabis use as a criminal or health issue is 'often oversimplified' but this does not negate the need for an 'honest appraisal' of the harms associated with each.[62]

The Victorian Aboriginal Legal Service similarly believed that the prohibitionist approach to cannabis use has generated additional harms for users, in addition to the health harms associated with cannabis consumption.[63] It also noted that Aboriginal and Torres Strait Islander communities experience additional harms from the criminalisation of cannabis use, such as:

- challenges with kinship arrangements
- employment exclusion from government-funded organisations
- systemic discrimination and stigmatisation.[64]

The Victorian Aboriginal Legal Service also noted that the recent Closing the Gap report attributed 53% of the health gap between Aboriginal people and the general population in Australia to social determinants of health.[65]

Another issue raised by stakeholders related to the criminal justice-based approach to cannabis use was the impact it had on young people. In its submission, Liberty Victoria believed that children should not be exposed to the criminal justice system. In addition, it believed that use and possession offences should be dealt with through an approach that prioritises education and health.[66]

This was echoed by Springvale Monash Legal Service in its submission, which stated that prohibition has done little to deter youth use but that the criminalisation of young cannabis users is a 'serious concern'.[67] It advocated that the decriminalisation or legalisation of cannabis is a 'necessary' step to protect young people from criminal justice-related harms for cannabis use.[68]

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62 Turning Point, *Submission 1352*, p. 1352.

63 Victorian Aboriginal Legal Service, *Submission 1398*, p. 7.

64 Ibid., p. 6.

65 Ibid.

66 Liberty Victoria, *Submission 1377*, p. 7.

67 Springvale Monash Legal Service, *Submission 1399*, p. 8.

68 Ibid.

Alongside the individual harms of a criminal justice approach, there are also substantial costs associated with a law enforcement response to cannabis use. In 2020, the National Drug Research Institute published a report assessing the national costs of cannabis, including justice system costs, for the 2015–16 financial year. The report found that the national costs incurred by the justice system totalled $2.4 billion.[69]

In its submission, Fitzroy Legal Service discussed the National Drug Research Institute's estimation of the costs of cannabis and noted that it does not include social costs for affected communities:

> We note that the costs associated with criminalisation processes to affected communities are not incorporated into the social cost analysis either as a formal or informal cost. We cite as two major interrelated streams criminal record discrimination and the structurally driven stigma attached to drug use. We submit that both of these streams of social harm require significant attention.[70]

The legalisation of cannabis for adult personal use may create some savings for the justice system, with the opportunity for funding to be redirected to other sectors such as health or education.

However, the legalisation and regulation of cannabis may result in government spending in other areas. Dr Kevin Sabet, President of Smart Approaches to Marijuana raised that in the United States where legalised has occurred there have been additional policing costs related to drug driving and subduing the black market.[71] In addition, there will be costs to regulate legal licenced premises that sell cannabis. The Committee also notes that Victoria already has an extensive roadside drug testing regime.

1.3.5 Stakeholder consensus for policy reform

The majority of submitters, both individuals and organisations, advocated for cannabis to be legalised in Victoria and for the Victorian Government to introduce a regulated market for the production and sale of cannabis.

Amongst those in favour of cannabis policy reform, the most widespread view was that cannabis should be legalised and that a regulated market for the production and sale of cannabis be introduced. Only a small number of individuals and organisations who gave evidence to the Inquiry were in favour of retaining or enhancing the current prohibition of cannabis.

The Committee conducted an optional survey for Inquiry submitters who lodged their submission through the website.

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69 Steve Whetton et al., *Quantifying the Social Costs of Cannabis Use to Australia in 2015/16*, National Drug Research Institute, Western Australia, 2020, p. vii.

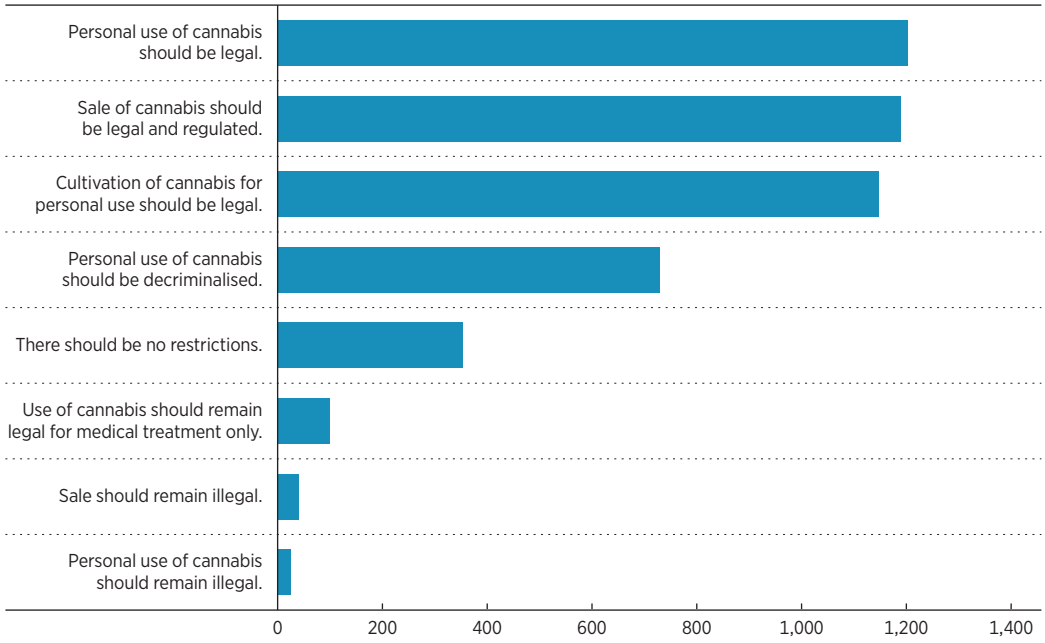
70 Fitzroy Legal Service, *Submission 1396*, p. 9.

71 Dr Kevin Sabet, *Transcript of evidence*, p. 14.

For the 1,348 submitters who completed the survey, an overwhelming majority were in favour of legalisation or decriminalisation of cannabis in some form. Figure 1.2 below shows the results of the survey.

It should be noted that respondents could tick more than one box and that not all submitters to the Inquiry filled out the survey.

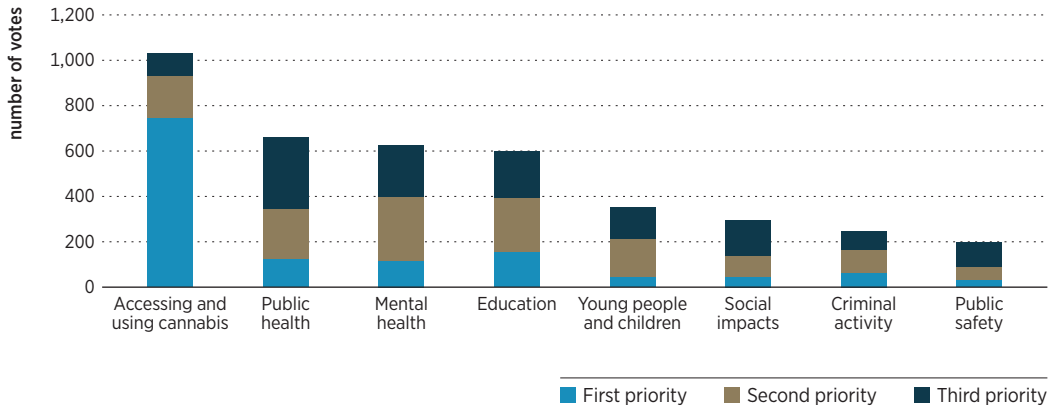
Figure 1.2 **Survey results from Inquiry e-submitters (individuals, organisations and academics)**



Source: Legislative Council Legal and Social Issues Committee.

When ranking their priorities for the Inquiry on the same survey, e-submitters rated access and use of cannabis as the number one priority. Figure 1.3 below shows the combined results of the top three priorities chosen by e-submitters.

Figure 1.3 **The combined top three priorities for Inquiry survey respondents, from most to least important**



Source: Legislative Council Legal and Social Issues Committee.

In addition, 66% of the 59 organisations and academics who made submissions were also in favour of either decriminalisation or introducing a legalised and regulated market. While only 13% of organisations were in favour of keeping the prohibition on cannabis.

A breakdown of these submissions shows:

- 31 were in favour of legalising cannabis and establishing a regulated market for its sale, including cannabis social clubs
- 8 were in favour of decriminalising cannabis
- 1 organisation advocated to enhance court diversion schemes
- 8 were in favour of keeping the prohibition on cannabis
- 11 did not express a view on the legal status of cannabis.

Amongst the organisations who advocated for a legalised and regulated market, a number were key drug and health policy organisations with a wealth of expertise in their field. They include:

- the Alcohol and Drug Foundation
- the Australian Nursing and Midwifery Association Victoria Branch
- the Burnet Institute
- the Drug Policy Modelling Program at the University of New South Wales
- Harm Reduction Victoria and Harm Reduction Australia
- the Health and Community Services Union Victoria
- the National Drug Research Institute
- Odyssey House Victoria
- the Penington Institute
- the Victorian Alcohol and Drug Association
- Windana Drug and Alcohol Recovery
- 360Edge.

The following important legal organisations advocated for decriminalisation:

- Fitzroy Legal Service
- Victoria Legal Aid
- Victorian Aboriginal Legal Service.

Other stakeholders who were in favour of maintaining the prohibition of cannabis and expressed this view either in their submission or at public hearings include:

- the Australian Christian Lobby
- the Dalgarno Institute
- Drug Free Australia (including the Queensland branch)
- Family Council of Australia
- Family Voice Australia
- the Self-Help Addiction Resource Centre
- Victoria Police.

The Committee is aware that submitters to the Inquiry are self-selecting and many would have an existing interest in cannabis policy reform. In its submission, the Australian Institute of Health and Welfare provided data from its *National Drug Strategy Household Survey 2019*. This collects information on alcohol and tobacco consumption, and illicit drug use among the general population in Australia.

In 2019, the survey collected the opinions of over 22,000 people.[72] They survey found that 39.7% of people supported the legalisation of cannabis. In contrast, only 23% believed that there should be criminal penalties for the use and possession of cannabis for personal use.[73]

This indicates that amongst the general public the support for the legalisation of cannabis is not as high as it was amongst Inquiry submitters. Nevertheless, the Committee notes that a large majority of those surveyed did not support the criminalisation of cannabis possession for personal use.

1.4 Arguments against legalising cannabis

Cannabis use can be harmful to a subset of users. The Committee does not wish to diminish these negative effects. It recognises that legalisation of cannabis for adult personal use or a legalised and regulated market may lead to adverse health and social consequences.

The Committee heard there were a number of possible negative outcomes that may accompany legalisation for adult personal use or a legalised and regulated market. They include:

- an increase in accessibility and use
- risks to mental health and other negative health impacts

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72 Australian Institute of Health and Welfare, *National Drug Household Survey 2019*, 2020, <https://www.aihw.gov.au/about-our-data/our-data-collections/national-drug-strategy-household-survey/2019-ndshs> accessed 1 July 2021.

73 Australian Institute of Health and Welfare, *Submission 209*, p. 19.

- drug driving
- the resilience of the illicit market.

1.4.1 Accessibility and use

The Committee was told that one of the most significant adverse consequences of ending the prohibition on cannabis is that it will become more accessible and that more people could use it. More use of cannabis increases the likelihood of mental health harms, physical health harms and drug driving. The Committee heard that under a legalised and regulated market, it is possible that overall use may increase slightly. However, this may not be a concern for occasional users. Frequent users are more likely to experience harm from cannabis and market regulation should be implemented to discourage their use.

Use trends under a legalised and regulated market

In its submission, Victoria Police was supportive of keeping the prohibition on cannabis. It cited studies which have found that drug prohibition inhibits use, thereby preventing the harms associated with drug use.[74] Victoria Police stated that prohibition is theorised to constrain consumption by:

- limiting the legitimate opportunities for drug use
- raising the non-monetary costs associated with drug use (that is, the effort and risk involved in obtaining drugs, such as risk of arrest)
- making drug use expensive.[75]

The Committee spoke to Dr Kevin Sabet from Smart Approaches to Marijuana, a cannabis policy organisation in the United States. Dr Sabet believed that by legalising cannabis, the state was acting permissively and encouraging use:

> I think what we are saying is that absolutely obviously there is a constituency of people who use. The question is: do we want to expand that by essentially having the state stamp on perhaps encouraging that use, especially if there are revenues involved or other interests involved? It is very difficult to eliminate the use. Again, the question is whether to encourage or discourage. I think of it as kind of like a speeding limit: we have a speeding limit, we know that many people will exceed the speeding limit, a lot of people will exceed the speeding limit—a lot of people can exceed the speeding limit safely, by the way—but do we want to get rid of the speeding limit and say that, 'Well, because people are speeding, let's get rid of the speeding limit'? Whereas I would say, 'The speeding limit probably has some value of discouraging'. It does not mean that if you are caught speeding you should have your life ruined, but it means that we should have some kind of societal disapproval even though there may be a good percentage of people violating it.[76]

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74 Victoria Police, *Submission 901*, p. 14.

75 Ibid.

76 Dr Kevin Sabet, *Transcript of evidence*, p. 16.

Other stakeholders accepted that it is possible that use amongst the general population may increase, but that it may not be problematic if people only use cannabis occasionally. As noted in Chapter 2, most Victorians only use cannabis occasionally.

The Committee heard from Professor Dan Lubman AM, Executive Clinical Director, Turning Point, and Director of Monash Addiction Research Centre. He said that cannabis could be considered among other legal drugs, which are used by most people sporadically:

> If we just looked at alcohol and we just looked at gambling, at addictive behaviours, there is no way in the world that if we just focused on those harms that we would in any way legalise those substances. Yet they are part of Australian culture, and we know that many people across government are very supportive of gambling and alcohol as important industries because many Australians enjoy them, and I think the same is true of cannabis. We know that cannabis, although it is not legal, is widely used across the community. Many people are using it in the way that they use alcohol or gamble. They use it in very low levels, and it is important to understand that we need to have—at the moment for those people who do develop problems, we do not have really great mechanisms in place to support them.[77]

This correlates with the data from the National Drug Strategy Household Survey which asked respondents if their cannabis use would increase if it were legalised. In 2019, 78.7% of adults said they would not use it, even if it were legalised. In contrast, only 2.9% of respondents said they would use it more often.[78]

Dr Marta Rychert, Senior Researcher at SHORE & Whariki Research Centre said that when considering patterns of increasing use that may come with legalisation, the most important cohort was frequent users. This is because they are the group that is far more likely to experience harm:

> Also some of the leading drug policy researchers and cannabis policy researchers I think agree that in terms of light markets, which the question was about, it is entirely feasible to expect that there will be an increase in use in the population. Chris mentioned that is per se a not a bad thing, because we are worried about patterns, not that more people are using. If they are using once a month, we do not care.
>
> But if we have such a large increase expected based on evidence from alcohol, in the using population, then it is likely that cannabis use disorder and these negative health effects may follow that. So that is based, I guess, on that inference from alcohol as well, and we are specifically talking about light market regulation here.[79]

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77 Professor Dan Lubman AM, Executive Clinical Director, Turning Point, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 7.

78 Australian Institute of Health and Welfare, *Submission 209*, p. 20.

79 Dr Marta Rychert, Senior Researcher, SHORE & Whariki Research Centre, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 31.

Professor Simon Lenton from the National Drug Research Institute told the Committee that the cannabis industry in the United States targets regular users. He said:

> the industry knows that most of their market is really the people who are regular, daily, heavy users, and they recognise that if they want to make a profit, they need to meet the needs of those consumers. So what have we seen is that 70 per cent of the consumption of cannabis in the legal markets, particularly in Colorado, is due to the top 22 per cent of the heaviest users of cannabis. That is a problem because we know that regular heavy use produces dependence, produces problems and so on. The industry knows that is where they make their money, and they target it. That is of concern.[80]

Ms Laura Bajurny, Information Officer for the Alcohol and Drug Foundation, commented on a survey regarding use rates in Canada following its legalisation of cannabis in 2018. Canada implemented a legalisation model that is far more tightly regulated than some states in the United States. She said that while there had been increases in use amongst occasional users, the use patterns of regular users had remained steady:

> Overall, when we are talking about adults—and they frame adults as 16-plus in the Canadian cannabis survey—the critical thing is that we are seeing daily use remain stable because those are people who are more likely to be experiencing a dependence on cannabis. We have seen increases in past- month use and past-year use, but because that is either monthly or yearly, not on a daily basis, those are people who are more likely to be using infrequently, possibly experimentally, less likely to be dependent.[81]

The evidence points to a complex picture of use trends that may emerge if cannabis were legalised in a regulated market. As legalisation and regulation of cannabis worldwide has only occurred recently, there is a distinct lack of empirical data about longer term trends and effects on cannabis use. Whilst overall use may increase, it is use amongst regular cannabis users that is of the most concern. In this case, the Committee was warned that any jurisdiction seeking to legalise cannabis must be sure to have sufficient regulation aimed at minimising harm for this cohort.

Use trends under decriminalisation or legalisation for adult personal use

The Committee received less evidence about the possible trends in use if cannabis were legalised for adult personal use. In contrast to a regulated market, legalisation for adult personal use would not legalise the sale of cannabis. As a result, cannabis users would still rely on the illicit market to access cannabis or grow their own plants at home.

In 2019, cannabis for personal use was legalised in the ACT. This allows adults in the ACT to grow two plants per person at home, with a maximum of four per household.

The Committee heard from Mr Michael Pettersson MLA, Member for Yerrabi in the ACT Legislative Assembly. Mr Pettersson was the Member who introduced the Drugs

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80 Professor Simon Lenton, *Transcript of evidence*, p. 33.

81 Ms Laura Bajurny, Information Officer, Alcohol and Drug Foundation, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, pp. 68–69.

of Dependence (Personal Cannabis Use) Amendment Bill 2018 that provided for the cannabis reforms. He said that since the Act came into force use trends have remained stable:

> To some people's surprise, the sky did not fall in. As time passed it became clear that the overall impact of legalisation was rather subtle and not as drastic as many had hoped. According to a wastewater analysis, cannabis usage rates remained the same upon the Bill's passing and consistent with trends in other jurisdictions over time.[82]

He added that 'These are of course early numbers and very blunt measures, but they do not spell the doom that many predicted'.[83]

Other witnesses believed that use would increase if cannabis were decriminalised. Mr Gary Christian, Research Director at Drug Free Australia pointed to examples from Portugal and other Australian jurisdictions who have taken measures to remove criminal penalties for drug use and possession:

> It is a harmful substance, so when you decriminalise drugs, as they did in Portugal—drug use has gone up 59 per cent in Portugal. Why would we want to increase it? Australians want less drug use; they do not want more drug use. And if you decriminalise, the drug use goes up. It happened in South Australia, it happened in the ACT, it happened in the Northern Territory
>
> ...
>
> So there is no point to increasing drug use. It harms so many people, and they are unacceptable harms. Psychosis—just take that as an example. A lot of the violence and aggression actually turns into homicide. This is a worldwide-known phenomenon about cannabis. They kill the people closest to them. This is not a drug that we want to decriminalise. We do not want it to be increasing; we want it to be decreasing. We want prevention, and that is important.[84]

1.4.2 Mental and other health risks of cannabis use

Cannabis use can cause harm for a subset of users. These harms are principally:

- development of mental illnesses, such psychosis or schizophrenia, amongst those who use cannabis in line with the following risk factors:
  - frequency of use
  - high THC potency in the cannabis consumed
  - predisposition to psychotic disorders, either from genetic predisposition or previous mental ill health or trauma
  - early onset of use

82 Mr Michael Pettersson MLA, *Transcript of evidence*, p. 18.

83 Ibid.

84 Mr Gary Christian, Research Director, Drug Free Australia, public hearing, Melbourne, 19 May 2021, *Transcript of evidence*, p. 38.

- damage to the developing brain for people who use cannabis in adolescence
- the development of cannabis use disorder (addiction)
- health-related consequences when cannabis is consumed via smoking.

Professor Simon Lenton summarised the evidence regarding the risk factors for psychosis and harm to the developing brain. He noted that while the risks exist, it relates to a small subsection of users:

> The evidence is that heavy, regular use beginning early is a risk factor for increasing a range of mental health problems. That is unsurprising. I mean, there are also problems when young people use alcohol at an early age and so on. We should not be surprised by that. You have probably heard from a range of experts who are more expert on this than me, but the evidence looks to be that heavy early use beginning in the early- to mid-teens and continuing raises the risk of things like psychosis—roughly doubles the rate of psychosis among people—and is a clear risk factor for problems. And if you have got a genetic susceptibility to that and so on, then it might unmask a psychotic illness that otherwise would go without manifesting itself.
>
> But the important thing to remember is that the rate of those illnesses in the community is particularly low; it is probably in the range of 1 to 2 per cent, I think, on the last data. So we are talking about doubling a very low number to another low number. Is it concerning? Absolutely. Should we be doing everything we can to prevent heavy, regular cannabis use by people in those early years of brain development? Absolutely. Is it the number one issue in terms of cannabis and health? I do not think so.

The Committee received evidence regarding risks to mental health from several expert witnesses. These included the Royal Australian and New Zealand College of Psychiatrists Victorian branch and Turning Point and Monash Addiction Research Centre. These issues are discussed in depth in Chapter 3.

The Committee received conflicting evidence on the prevalence of cannabis use disorder amongst users. At a public hearing, Dr Kevin Sabet from Smart Approaches to Marijuana cited a study from New York that showed 1 in 3 cannabis users will develop cannabis use disorder.[85]

In contrast, health consultancy firm 360Edge quoted a study which looked at rates of cannabis use disorder in jurisdictions in the United States which had legalised cannabis. The study found that the proportion of study participants reporting cannabis use disorder increased from 0.9% to 1.23%.[86]

Cannabis ingested via smoking can cause health risks. One of the most popular methods of ingesting cannabis is through smoking it with tobacco in a rolled cigarette.[87] This can expose a person to the health risks associated tobacco as well as cannabis.

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85 Dr Kevin Sabet, *Transcript of evidence*, pp. 11–12.

86 360Edge, *Submission 1350*, p. 8.

87 Dr Shalini Arunogiri, *Transcript of evidence*, p. 32.

The Victorian Department of Health notes that cannabis may have cancer causing properties similar to tobacco when smoked.[88] However, other sources say that more research about the long-term effects of smoking cannabis is needed to establish the link between cannabis use and cancer.[89]

The Committee does not seek to downplay the harms that cannabis can cause to users. The Committee also recognises that there is a cohort of people, including those suffering from mental health issues, who may seek to use cannabis more if it is decriminalised or legalised. Mr Andrew Hick, Manager of the Circuit Break program at Odyssey House outlined these concerns at a public hearing:

> I think there are some views that we can have — I do not know about anyone here, but I am talking of myself particularly — as nice, middle-class people, that we can help and we then signal our virtue to other people, one of which is quite popular is saying that we should legalise cannabis.
>
> It's a probably a view I hold myself, but the facts are though, that the people that I associate with outside of work and my family are unlikely to be adversely affected by that decision. However, my opinion is that there is a group of people, who you might want to call the disadvantaged or the people in society who do not have the same privileges I have, who may well be dramatically affected by that. Those would be by concerns.

Mr Gary Christian from Drug Free Australia highlighted that it is not just the user that suffers harm from cannabis but it can also harm the people around them:

> Cannabis affects a whole constellation of people around the user. There is the partner. There are the children, obviously. Often the children are affected the most. There are friends, there are siblings, there is the community at large, other drivers on the road. It is a harmful substance.[90]

The National Drug Research Institute led a study which estimated that the cost of cannabis to Australia in 2015–16 was $4.5 billion.[91] As noted in Section 1.3.4, the largest cost related to crime, which included costs for policing and the courts, which was estimated at $2.4 billion. These crime related costs are expected to reduce if cannabis were legalised. This is discussed in detail in Chapter 4.

Other costs associated with cannabis include the burden on the health care system and road traffic accidents. Some of the estimated costs include:

- healthcare costs ($714 million)
- workplace costs ($560 million)

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88 Alcohol and Drug Foundation, *Drug Facts: Medicinal Cannabis*, <https://adf.org.au/drug-facts/medicinal-cannabis> accessed 9 June 2021.

89 Centers for Disease Control and Prevention, *Marijuana and Public Health: Cancer Risk*, <https://www.cdc.gov/marijuana/nas/cancer-risk.html> accessed 11 June 2021.

90 Mr Gary Christian, *Transcript of evidence*, p. 38.

91 National Drug Research Institute, *Submission 1325*, p. 11.

- road traffic accidents ($194 million)
- other costs, including child protection ($470 million).[92]

While these costs are substantial, the harms of cannabis should also be considered in comparison to other legal and illegal drugs. When considering the impacts on the user and to society at large, the harms of cannabis rank behind legal drugs like alcohol and tobacco. It is also considered less harmful than illegal drugs such as methamphetamine, heroin and cocaine.[93]

The limited nature of cannabis harms in comparison to other legal and illegal drugs is another significant factor as to why the Committee recommends the Government investigate the impacts of legalising cannabis for adult personal use. These issues are explored further in Chapter 3.

1.4.3 Drug driving

Driving under the influence of cannabis impairs driving ability and puts the driver and other road users at risk of injury or death. In its submission, Victoria Police outlined how cannabis impairment can impact a driver:

> As both illicit and medicinal cannabis contain the psychoactive constituent, Delta-9-Tetrahydrocannabinol (THC), they are both known to reduce a driver's ability to have full control of a vehicle. Cannabis can slow down reaction times, distort perception of speed and distance, reduce concentration when driving, particularly in response to emergency situations. 18 This creates a risk for the driver, but also other occupants of the vehicle and other vehicles on the roads around the affected driver.

At a public hearing, Assistant Commissioner Glenn Weir from Victoria Police told the Committee that he was concerned that the incidence of drug driving would increase if cannabis were legalised. He pointed to emerging outcomes from states that have legalised cannabis in the United States and noted some of the consequences of legalisation, including increased traffic fatalities.[94]

These concerns were shared by Dr Kevin Sabet who told the Committee about a study in Washington State which found that people who died on the roads with cannabis in their system had doubled since legalisation.[95] The Committee notes that there was an increased from 8.8% in the 5-year average prior to legalisation in 2012 to a 5-year average of 18% after legalisation.[96]

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92 Ibid.

93 Professor David J. Nutt et al., 'Drugs harms in the UK: a multicriteria decision analysis', *The Lancet*, vol. 376, no. 9752, 2010, pp. 1558–1565.

94 Assistant Commissioner Glenn Weir, *Transcript of evidence*, p. 3.

95 Smart Approaches to Marijuana, *Submission 1194*, p. 5.

96 Brian Tefft and Lindsay Arnold, *Cannabis use among drivers in fatal crashes in Washington State before and after legalization*, American Automobile Association Foundation for Traffic Safety, 2020, p. 3.

However, the Committee heard that in other jurisdictions where cannabis had been legalised, the incidence of drug driving has not increased or decreased. For example, Mr Michael Pettersson MLA said that since the legalisation of cannabis for adult personal use in the ACT drug driving offences have remained steady. [97]

Ms Laura Bajurny from the Alcohol and Drug Foundation explained that in Canada drug driving may have even decreased since legalisation. She said the number of people reporting driving within two hours of using cannabis was 27% in 2018 but had decreased to 19% in 2020. She believed this may be attributable to strong public education campaigns and increased penalties for drug driving offences in Canada following its legalisation of cannabis in 2018.[98]

The Committee is aware that legalising cannabis has the potential to increase the number of drivers on the roads who are under the influence of cannabis. People who drive while impaired are a threat to themselves and other road users. However, the Committee also notes that drug driving already occurs under Victoria's current prohibition of cannabis. If cannabis were legalised for adult personal use, an appropriate drug driving education campaign should accompany its implementation. This is discussed further in Chapter 3.

The issue of testing for cannabis impairment while driving is discussed further in Chapter 4.

1.4.4 The resilience of the illicit market

The Committee was provided examples from other jurisdictions which have shown that the sale of cannabis on the illicit market does not disappear once cannabis is legalised. Organised crime may try to undercut the price of legal cannabis, offer different products or present more convenient ways to purchase cannabis illegally.

Professor Simon Lenton from the National Drug Research Institute told the Committee that where cannabis has been legalised in the United States, half of cannabis demand is still being met by the illegal market:

> The evidence is from the early markets, both in North America and also in Uruguay, that the shift from the black market to the legal market has probably been at this stage around about 50 per cent, and part of the reason for that is that there are certain controls, so some people are always excluded, and it is also about price and about the black market trying to survive and undercutting prices in the legal market.
>
> So it is complex and it is difficult. I think the reality is that there always is going to be a black market, if you like, for cannabis, even if a legal market occupies the greatest proportion it probably could. There are always people who are going to be excluded from that market. There is always going to be some illegal market happening. The question is: what is the best balance and have we got the balance right now?[99]

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97 Mr Michael Pettersson MLA, *Transcript of evidence*, p. 19.

98 Ms Laura Bajurny, *Transcript of evidence*, p. 69.

99 Professor Simon Lenton, *Transcript of evidence*, pp. 31–32.

The resilience of the illicit market illustrates that if cannabis were legalised in Victoria, policing and justice resources would not be fully shifted away from cannabis related crime. Mr Gary Christian from Drug Free Australia said that financial savings for the government from any reallocation of resources away from cannabis policing may not be significant:

> We were told that if drugs were going to be legalised, it would get rid of the criminals. No. That is not what happened. Los Angeles Times will tell you the black market is far bigger now that they have got legalised cannabis and it is more than double—down here—'more than double the amount of legal sales'.[100]

In its submission, the Dalgarno Institute also warned that the legalisation of cannabis could create a 'grey market'. This refers to companies that sell cannabis without a licence or in breach of their licence conditions. With fewer regulatory costs, these companies can sell cannabis at a cheaper rate than their licenced competitors.[101] This illustrates that any government regulatory agency overseeing the industry must be well resourced to ensure that that companies operating in a legalised market are compliant with regulations and licence conditions. This is discussed in detail in Chapter 4.

On balance, the Committee considers that if cannabis were legalised for adult personal use, or a legalised regulated market were created, it would result in some financial or resourcing gains for the Victorian Government. Police resources will be diverted away from policing cannabis use and possession to some degree. The courts will deal with fewer cannabis use and possession offences and profits made from the sale of cannabis by organised crime will also be disrupted to some degree. These are positive developments that the Committee believes should be pursued by the Government.

1.5 Issues with Commonwealth legislation

There are significant barriers to creating a legalised, regulated cannabis market due to the jurisdiction of the Commonwealth Government. These relate to sections of the *Constitution of the Commonwealth of Australia Act*, specifically:

- section 109 prescribes that Commonwealth legislation prevails over state legislation for any inconsistencies
- section 90 states that the Commonwealth Government has the exclusive power to 'impose duties of customs and of excise'.

The effect of s 109 is that the Commonwealth's existing drug laws that prohibit and criminalise cannabis use and sale would override any state-based legislation aiming to regulate or legalise cannabis use. This is discussed in detail in Section 1.5.1 below.

Legalisation of cannabis for adult personal use in the ACT was accomplished by relying on a provision in the *Criminal Code Act 1995* (Cth). This provides a defence for some

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100 Mr Gary Christian, *Transcript of evidence*, p. 38.

101 Dalgarno Institute, *Submission 215*, p. 16.

drug offences including use, possession and cultivation if 'the conduct is justified or excused by or under a law of that State or Territory'.[102]

The Committee notes publicly released correspondence from the Commonwealth Director of Public Prosecutions to the Acting Director General of the ACT's Justice and Community Safety Directorate. This confirmed that if a person in the ACT were charged with a relevant drug offence under the Commonwealth Criminal Code Act, then it would be open for them to rely on the exemption as a defence.[103] The Committee considers that legislation to permit cannabis for adult personal use in Victoria would be able to rely on the same provision, if the Victorian Government chose to pursue it.

1.5.1 Commonwealth jurisdictional issues that prevent a legalised regulated market for cannabis

Non-medicinal cannabis and cannabis products are prohibited or regulated in Australia under various Commonwealth Acts. These laws intersect across different areas of Commonwealth jurisdiction. This ranges from medicinal cannabis administration under the *Therapeutic Goods Act 1989* (Cth), to customs and border control laws that prohibit the importation of cannabis under the *Customs Act 1901* (Cth).

As a result, several regulatory changes to Commonwealth legislation are necessary for a legalised and regulated market to function. The same is true for cannabis social clubs which require a registration framework to be in place to be adequately regulated and monitored by authorities.

It is difficult for the Committee to predict the legislative changes that will be necessary for the particular model of legalisation the Committee has outlined. However, a private members Bill introduced into the Australian Senate by Senator David Leyonhjelm offers some guidance.[104] The Bill aimed to repeal all Commonwealth legislation that would prevent state or territory governments from legalising and regulating cannabis.

The Bill was scrutinised by the Senate's Legal and Constitutional Affairs Legislation Committee. The report of that Committee outlined the Acts with provisions that relate to the prohibition of cannabis under Commonwealth law as follows:

- The *Customs Act 1901* (Cth), which prohibits the import and export of cannabis through the Customs (Prohibited Imports) Regulations 1956 and the Customs (Prohibited Exports) Regulations 1958.[105]
- The *Criminal Code Act 1995* (Cth), which includes offences relating to the cultivation, import and export, and possession of controlled drugs, including cannabis.[106]

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102 *Criminal Code Act 1995* (Cth) pt 9.1 s313.1

103 Ms Sarah McNaughton QC, Commonwealth Director of Public Prosecutions, to Mr Richard Glenn, the Acting Director General of the ACT's Justice and Community Safety Directorate, correspondence, 16 September 2019.

104 Criminal Code and Other Legislation Amendment (Removing Commonwealth Restrictions in Cannabis) Bill 2018 (Cth).

105 *Customs (Prohibted Imports) Regulations 1956* (Cth) sch 4; *Customs (Prohibited Exports) Regulations 1958* (Cth) pt 2.

106 *Criminal Code Act 1995* (Cth) pt 9.1 s308.

In addition, the Criminal Code Regulations 2002 lists cannabis as a controlled and border-controlled drug.[107]

- The *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990* (Cth), which defines cannabis and THC as a narcotic drug and includes offences for their dealing.[108]
- The *Defence Force Discipline Act 1982* (Cth) which includes offences for defence force personnel who use cannabis. [109]
- The *Narcotic Drugs Act 1967* (Cth), which regulates the cultivation and manufacture of cannabis products for medicinal and other scientific purposes. It also includes penalties for licenced medicinal cannabis producers who deal with cannabis in a manner that is not in line with their licence conditions.[110] There may also be penalties associated with dealing with cannabis in a manner that is not in line with the Act.[111]
- The *Therapeutic Goods Act 1989* (Cth), which lists cannabis as a Prohibited Substance under the Poisons Standard.[112]

At a minimum, it is likely the provisions above would require amendments to allow for a legalised and regulated market, including social clubs, to operate in Victoria.

In addition, any regulatory framework for the legal sale of cannabis for recreational purposes may conflict with Commonwealth laws regulating medicinal cannabis. This is because a regulatory model for the legalisation of recreational cannabis by the Victorian Government would be inconsistent with the Commonwealth legislation for medicinal cannabis. As a result, this could leave any Victorian legislation introduced open to challenge under s 109 of the Australian Constitution.

The Committee believes that there would be benefit in the Law Reform Commission conducting a review of Commonwealth and state legislation regarding cannabis use. This is a complex area of law involving legal grey areas which the Committee believes would benefit from further examination.

RECOMMENDATION 2: That the Victorian Government considers referring an inquiry to the Victorian Law Reform Commission to investigate state and Commonwealth laws inhibiting the introduction of a legislated and regulated cannabis market, including social clubs.

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107 Parliament of Australia, Senate Standing Committee on Legal and Consitutional Affairs, *Criminal Code and Other Legislation Amendment (Removing Commonwealth Restrictions on Cannabis) Bill 2018*, September 2018, p. 2.

108 Senator David Leyonhjelm, Parliament of Australia, Senate, 9 May 2018, *Parliamentary debates*, p. 2748.

109 Senator David Leyonhjelm, ibid.

110 Parliament of Australia, Senate Standing Committee on Legal and Consitutional Affairs, *Criminal Code and Other Legislation Amendment (Removing Commonwealth Restrictions on Cannabis) Bill 2018*, p. 2; *Narcotic Drugs Act 1967* (Cth) ss 11B-E.

111 Senator David Leyonhjelm, Parliament of Australia, Senate, 15 October 2018, *Parliamentary debates*, p. 7035.

112 *Therapeutic Goods Act 1989* (Cth) s 52D.; The Poisons Standard October 2019, sch 9.

1.5.2 Commonwealth tax jurisdiction

Another area of Commonwealth jurisdiction which may inhibit efforts to establish a legalised and regulated market for the production and sale of cannabis is taxation. Under s 90 of the Australian Constitution, the Commonwealth Government has the exclusive power to 'impose duties of customs and of excise'.[113] This means that the Commonwealth Government would have the exclusive power to tax the sales of cannabis under a legalised and regulated market. As a result, the Victorian Government would not be able to collect tax on the sale of cannabis to fund public health measures.

The Committee received correspondence from Professor Patrick Keyzer from La Trobe Law School. This included a research paper that discussed issues relating to cannabis law reform resulting from the Commonwealth's taxing powers.[114]

The paper details how the Commonwealth Government has exclusive power to levy excise duties under s 90 of the Australian Constitution. These are taxes on goods produced or manufactured in Australia.[115] Section 90 is one of the few areas of the Constitution which expresses exclusivity, meaning that only the Commonwealth Government has power to tax in this area.

Over the years, the Commonwealth Government has acquired a near monopoly in the practice (although not the power) of levying taxes in Australia.[116] This includes income taxes and company tax, as well as goods and services tax (GST). The Commonwealth Government's exclusivity has also been reiterated by various interpretations of s 90 in the High Court of Australia. A paper from the Commonwealth Parliamentary Library highlighted how the states have few areas for which to levy taxes:

> with the Commonwealth taking over sole responsibility for income taxation since 1942, the States have reverted to very limited taxes, especially since High Court interpretation of section 90 [relating to excise] of the Constitution has prevented them from imposing any form of sales tax on goods.[117]

Professor Keyzer's paper raised doubts that the Victorian Government would have jurisdiction to raise taxes in any proposed legalised model:

> while the states and territories have legislative power to regulate cannabis production, supply, distribution and sale (as an incident of their very wide powers of legislation), the Commonwealth has exclusive power to levy duties of excise, including taxes on the production, supply, distribution and sale of goods (including cannabis). For these reasons, the states and the territories have no fiscal incentive to legalise cannabis,

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113 *Commonwealth of Australia Constitution Act* (Cth) s 90.

114 Patrick Keyzer, 'How section 90 of the Constitution makes cannabis law reform less likely in Australia', *Alternative Law Journal*, vol. 45, no. 4, 2020.

115 Ibid., p. 2.

116 Denis James, *Federal and State Taxation: A Comparison of the Australian, German and Canadian Systems*, Australian Parliamentary Library, 1997.

117 Ibid.

> because they cannot generate additional tax revenue by doing that. On the other hand, the Commonwealth could enter the field of cannabis taxation, but it does not have the power to regulate its production or use.[118]

Without the ability to raise taxes under a legalised model, the Victorian Government would require the support of the Commonwealth Government to share or return the funds it collects. This was noted by Professor Keyzer:

> it might be possible for the Commonwealth, the states and the territories to work cooperatively in relation to cannabis regulation, and share any revenue that could be raised from a cooperative approach.[119]

Despite this, the Committee notes there are other options whereby the Victorian Government could receive revenue in a legalised and regulated framework for cannabis. This includes a licencing scheme for retail outlets (similar to liquor licences). Dr Karen Gelb from the Burnet Institute noted these possibilities:

> As for licensing, there are issues around the constitution in Australia, but there are ways to deal with that. If this is not a tax-raising system, if it is a licensing-fee system, that would be viable under the constitution. So I think that that is certainly something that should be considered, and you could really make inroads into health promotion and community safety and wellbeing by using that sort of funding.[120]

The Committee notes that any efforts by the Victorian Government to introduce a taxation scheme in a legalised and regulated market would face significant barriers due to Commonwealth tax laws. For the Victorian Government, this would negate one of the advantages of a legalised and regulated market, collecting tax. Cooperation with the Commonwealth Government or an arrangement to share taxation revenue would be necessary.

1.5.3 The Australian Capital Territory model and Commonwealth law

The *Drugs of Dependence (Personal Cannabis Use) Amendment Act 2019* (ACT) came into force in January 2020.[121] The Act permits people over the age of 18 to use and possess up to 50g of cannabis. It also permits personal cultivation of up to two plants in a personal residence, or a maximum of four plants per household.[122]

The ACT scheme to legalise cannabis for adult personal use does not attempt to create a legalised market for the production or sale of cannabis, which may clash with other Commonwealth laws. It merely legalises possession, use and cultivation of small

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118 Patrick Keyzer, 'How section 90 of the Constitution makes cannabis law reform less likely in Australia', p. 4.

119 Ibid., p. 7.

120 Dr Karen Gelb, *Transcript of evidence*, p. 48.

121 ACT Legislation Register, *Drugs of Dependence (Personal Cannabis Use) Amendment Commencement Notice 2020*, 2020, <https://www.legislation.act.gov.au/View/cn/2020-1/20200124-73128/PDF/2020-1.PDF> accessed 19 July 2021.

122 *Drugs of Dependence Act 1989* (ACT) ss 162(2), 71AAA.

quantities for adults. As a result, it largely only conflicts with the Commonwealth Criminal Code Act, for which there is a defence if a state or territory exempts proscribed activities.

Before the ACT passed the Act, the Bill was considered by the Legislative Assembly Standing Committee on Health, Ageing and Community Services. In its report on the Bill, the Committee examined the conflict between the Bill's proposed legalisation of cannabis for adult personal use and div 308 of the Criminal Code Act that prohibits the possession of cannabis.[123]

Part 9.1 of the Criminal Code Act contains offences relating to the cultivation, import, export, and possession of controlled plants and drugs, including cannabis. Division 308 of pt 9.1 outlines possession offences, the penalty for which is 2 years imprisonment or 400 penalty units, or both.[124]

In examining the Bill, the ACT Committee highlighted that s 313.1 of the Criminal Code Act provides a defence for all of the drug offences listed in pt 9.1, except offences relating to importing and exporting.[125] Section 313.1 states that the drug offences do not apply if 'the conduct is justified or excused by or under a law of that State or Territory'.[126]

The ACT Committee concluded that if the Bill included a provision that expressly allowed the possession of cannabis then this could constitute a defence to a possession charge under the Commonwealth Criminal Code Act. Section 171AA(3) of the *Drugs of Dependence Act 1989* (ACT) includes a provision that says penalties for possession of less than 50g of cannabis do not apply if the person is over 18 and possesses the cannabis in the ACT.

At a public hearing, the Committee spoke to Mr Michael Pettersson MLA, the Member for Yerrabi in the ACT Legislative Assembly who introduced the private members Bill. In relation to any possible conflicts between the Act and the Commonwealth Criminal Code Act, Mr Pettersson stated that:

> The legal conflicts between the commonwealth and ACT laws have also proved unproblematic. No-one has been charged for unlawful possession under federal legislation, and ACT police report they have not faced any issues with implementing the new laws.[127]

Possession, use and cultivation of cannabis were the only drug offences that the ACT Committee determined conflicted with the Commonwealth Criminal Code Act.

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123 Parliament of Australian Capital Territory, Standing Committee on Health, Ageing and Community Services, *Inquiry into Drugs of Dependence (Personal Cannabis Use) Amendment Bill 2018*, pp. 40–44.

124 Ibid., p. 8.

125 All parts other than Division 307, (Division 7 of the Criminal Code Act 1995 relates to Import and Export Offences).

126 *Criminal Code Act 1995* (Cth) pt 9.1 s313.1.

127 Mr Michael Pettersson MLA, *Transcript of evidence*, p. 19.

1.6 Overview of the legislative framework for cannabis in Victoria

The principal legislation governing illicit or controlled substances in Victoria is the *Drugs, Poisons and Controlled Substances Act 1981* (Vic). The Act and its associated Regulations create a scheduling system for controlled substances, drugs of dependence and poisons. They also establish penalties for offences against the Act.

Under the Act, cannabis is scheduled as both a drug of dependence and a poison. A 'drug of dependence' is prescribed under sch 11 of the Act, and includes other substances such as methamphetamines, oxycodone and codeine. Cannabis is also scheduled as a sch 8 poison under the Act which adopts the same meaning as a sch 8 poison of the Commonwealth Poisons Standard:

> **Controlled Drug** – Substances which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.

Schedule 11 of the Act also establishes the four quantity categories which are used by the courts to determine types of offences against the Act and associated penalties. Part 2 of sch 11 describes the quantities of cannabis under each category. This is summarised in Table 1.1 below.

Table 1.1 Controlled drugs quantity categories for cannabis

Large commercial quantity	Commercial quantity	Trafficable quantity	Small quantity
250kg or 1,000 plants	25kg or 100 plants	250g or 10 plants	50g

Source: *Drugs, Poisons and Controlled Substances Act 1981* (Vic) sch 11.

Section 76 of the Act gives courts discretion to issue adjourned bonds (e.g. community corrections orders) in certain cases, particularly when cannabis is the primary substance. However, this applies to small quantities only and trafficking offences are not eligible regardless of quantity. To be eligible for an adjourned bond, offences for use, possession or cultivation must not involve trafficable quantities or more, or an intent to traffic. Table 1.2 below outlines penalties for offences under the Act.

Table 1.2 Penalties under the *Drugs, Poisons and Controlled Substances Act 1981* (Vic)

Offence	Maximum Penalty				Adjourned bonds to be given in certain cases? (section 76)
	Small Quantity	Traffickable Quantity	Commercial Quantity	Large Commercial Quantity	
Use of a drug of dependence	5 penalty units ($826.10).				Yes, small quantity only.
Cultivation of a drug of dependence	1-year imprisonment or 20 penalty units ($3,304.40) or both.	15 years imprisonment.	25 years imprisonment.	Life imprisonment and 5,000 penalty units ($826,100).	Yes, small quantity only.
Possession of a drug of dependence	Small quantity: 5 penalty units ($826.10). For trafficking purposes: 30 penalty units or 1-year imprisonment, or both.	Prima facie evidence of drug trafficking.	Prima facie evidence of drug trafficking.	Prima facie evidence of drug trafficking.	Yes, small quantity only.
Inciting or conspiring to commit an offence	Liable to the same pecuniary penalty as the conspired/incited offence (ie use, possession, trafficking or cultivation).				Yes, if the conspired/ incited offence is eligible.
Trafficking a drug of dependence	15 years imprisonment.	15 years imprisonment.	25 years imprisonment.	Life imprisonment and 5,000 penalty units ($826,100).	No.

Source: *Drugs, Poisons and Controlled Substances Act 1981* (Vic).

1.6.1 Medicinal cannabis

In 2016, the *Access to Medicinal Cannabis Act 2016* (Vic) came into operation.[128] The Act established a medicinal cannabis scheme and allowed for lawful manufacturing of medicinal cannabis products. The Act preserved existing prohibitions and penalties for trafficking, cultivation, supply and use of cannabis for non-medical purposes.

Under the scheme, any patient with any medical condition can be prescribed medicinal cannabis by a doctor if it is clinically appropriate.

The Act was repealed by the *Health Legislation Amendment and Repeal Act 2019* (Vic). This was uniform legislation introduced to avoid regulatory duplication following the passage of the *Narcotic Drugs Amendment Act 2016* (Cth). The Repeal Act also repealed some sections of the Victorian Drugs, Poisons and Controlled Substances Act to avoid duplication and contradiction.

128 Victoria, *Victoria Government Gazette*, No. 284, 13 September 2016.

The Commonwealth Act establishes a national medicinal cannabis scheme, including a licensing and permit system for accessing, prescribing and manufacturing medicinal cannabis products.

In addition, the Victorian Government has established the Office of Medicinal Cannabis under the Department of Health. This agency administers the Victorian Compassionate Access Scheme which provides medicinal cannabis access specifically to children suffering from severe intractable epilepsy.

There are a limited number of placements under this scheme with strict eligibility requirements. Children are the focus of this scheme because of the severity of the illness and the inability of existing medicines to adequately treat seizures.

Medicinal cannabis prescriptions in Victoria require authorisation by the Commonwealth and Victorian governments. Issue of licenses and permits for manufacturing, cultivation or production of cannabis for medical or research purposes is administered by the Commonwealth Government under the Narcotic Drugs Act.

2 Cannabis use in Victoria

2.1 Introduction

The Committee received evidence from the Australian Institute of Health and Welfare that, in conjunction with other sources, has helped to build a detailed picture of cannabis use in Victoria.

Cannabis is the most widely used illicit drug in Victoria. 36.3% of adult Victorians have used cannabis in their lifetime and 11.7% have used cannabis in the last 12 months. This rate of cannabis use has been relatively steady for almost 20 years.[1]

Young people are more likely to use cannabis than other age groups. Those aged 20–29 are the most likely to have used cannabis in the past 12 months, followed by those aged 14–19. Those least likely to have used cannabis in the past year are aged 50 and over, although those who do use cannabis at that age are more likely to be regular users.[2]

Regional Victoria has a higher rate of cannabis use than metropolitan Melbourne. Wastewater data from 2020 showed that twice as many people used cannabis in regional Victoria than in Melbourne.[3]

Cannabis use by socioeconomic factors shows a more complex picture. Recent cannabis use is highest in the most socioeconomically advantaged areas, while those who have used cannabis in the last 12 months are more likely to have lower educational attainment or be out of full-time work.[4]

Aboriginal and Torres Strait Islander Victorians have a slightly higher rate of use of cannabis than the general population and the rate of criminalisation as a result of this use is higher.[5]

Despite many decades of prohibition, cannabis remains widely available to purchase, tetrahydrocannabinol (THC) potency has not diminished, and its price has remained stable for the past decade.[6]

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1 Australian Institute of Health and Welfare, *Submission 209*, p. 3.

2 Ibid.

3 Australian Criminal Intelligence Commission, *National Wastewater Drug Monitoring Program: Additional longitudinal data figures, by state and territory and drug type*, <https://www.acic.gov.au/publications/national-wastewater-drug-monitoring-program-reports/report-12-national-wastewater-drug-monitoring-program> accessed 28 June 2021.

4 Australian Institute of Health and Welfare, *Submission 209*, pp. 5–6.

5 See: Victoria Legal Aid, *Submission 1373*, p. 8; Victorian Aboriginal Legal Service, *Submission 1398*, p. 5.

6 National Drug and Alcohol Research Centre, *Australian Drug Trends 2020: Key Findings from the National Illicit Drug Reporting System (IDRS) Interviews*, <https://ndarc.med.unsw.edu.au/resource/australian-drug-trends-2020-key-findings-national-illicit-drug-reporting-system-idrs> accessed 18 June 2021.

The Committee also examined whether there is evidence for cannabis being a 'gateway drug' to the use of more harmful illicit drugs. The information presented to the Committee suggests that while many people who go on to use hard drugs (such as heroin or methamphetamine) start with cannabis, not everyone who uses cannabis goes on to use hard drugs. The large proportion of the population who have used cannabis and did not progress to hard drugs suggest that the causal factors are more complex than cannabis use alone.

This Chapter addresses the use of non-medicinal cannabis only.

2.2 What is cannabis?

As noted in Chapter 1, cannabis is a plant which contains chemical substances called cannabinoids. The main two are THC, which is a psychoactive substance that gives users an intoxicating sensation. The second is cannabidiol (CBD), which is a non-psychoactive substance that can be used for medicinal purposes.[7]

The primary method of using cannabis is through smoking the dried leaves and flowers of the cannabis plant. However, there are other ways of preparing cannabis to be ingested. The Alcohol and Drug Foundation provides a list on its website:

- Hashish: the dried plant resin that is usually mixed with tobacco and smoked or added to foods and baked goods, such as cookies and brownies.
- Hash oil: liquid that is used sparingly (due to high potency) and added to the tip of a joint or cigarette and smoked.
- Concentrates: extracts (dabs, wax or shatter) typically using butane hash oil as a solvent, often vaporised in small quantities due to high THC content.[8]

Cannabis can also be prepared into various foods generally called 'edibles'.[9]

The method of ingestion has an impact on the time it takes users to feel the effects of intoxication. Users who smoke or vaporise cannabis will generally feel the effects almost instantly. In contrast, it may take 1–3 hours for people who ingest cannabis via edibles.[10]

According to the Alcohol and Drug Foundation, the effects of cannabis may include:

- feelings of relaxation and euphoria
- spontaneous laughter and excitement
- increased sociability

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7 Therapeutic Goods Administration, *Safety of low dose cannabidiol*, Department of Health, Commonwealth Government, 2020, pp. 4, 9.

8 Alcohol and Drug Foundation, *Drug Facts: Cannabis*, <https://adf.org.au/drug-facts/cannabis> accessed 16 June 2021.

9 Ibid.

10 Ibid.

- increased appetite
- dry mouth.[11]

When taken at high doses, or in batches with high potency THC, the effects of cannabis may include:

- memory impairment
- slower reflexes
- bloodshot eyes
- increased heart rate
- mild anxiety and paranoia.[12]

The Alcohol and Drug Foundation also noted that the effects of cannabis on an individual can be different from person-to person due to variables such as:

- size, weight and health
- whether the person is used to taking it
- whether other drugs are taken around the same time
- the amount taken
- the strength of the cannabis
- personal expectations of consuming cannabis
- the environment of the individual
- the individual's personality.[13]

The long-term effects of use can vary depending on a number of risk factors. Long-term use can result in cannabis dependency and reduced cognitive function.[14] Frequent use of cannabis with high THC potency has been associated with the onset of psychosis, which can lead to psychotic disorders such as schizophrenia.[15] This is particularly the case with people who have a genetic or other predisposition to psychosis.[16] Early onset of cannabis use is also a risk factor with those who begin in adolescence at risk of greater harms due to their still developing brains.

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11 Ibid.

12 Ibid.

13 Ibid.

14 Ibid.

15 Dr Shalini Arunogiri, Chair, Faculty of Addiction Psychiatry, Royal Australian and New Zealand College of Psychiatrists (Victorian branch), public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 28.

16 Professor Dan Lubman AM, Executive Clinical Director, Turning Point, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 6.

There are also physical health risks associated with cannabis. These include long term risks to health when smoked with tobacco, and a risk of road accident or death if used while driving under the influence of cannabis.

The physical and mental health risks of cannabis use are discussed in detail in Chapter 3.

2.3 Who uses cannabis in Victoria?

The Committee received evidence from the Australian Institute of Health and Welfare which contained data from its *National Drug Strategy Household Survey.* This large population survey has been conducted by the Institute every three years since 1983. The survey in 2019 included more than 22,000 participants.[17] Respondents are asked about their knowledge and attitudes around drugs and alcohol, as well as their history of consumption. Numerous stakeholders also referred to the survey in their evidence to the Committee.

The survey captured data on people who used cannabis for medicinal purposes as well as recreationally. The 2019 survey included questions for people who use medicinal cannabis prescribed by a doctor, solely for medical purposes.

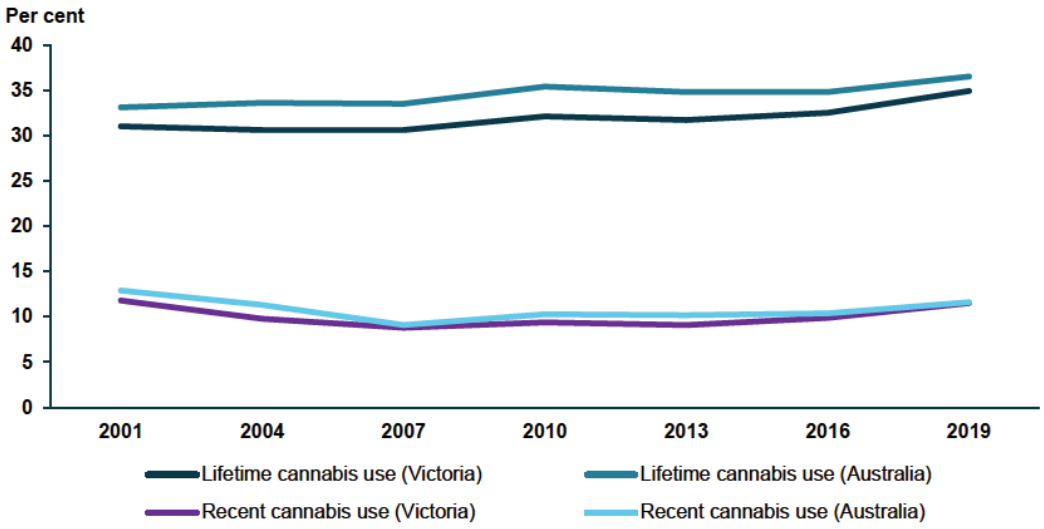
The 2019 survey identified cannabis as the most widely used illicit drug in Victoria, with an estimated 1.9 million (or 35%) Victorians having used cannabis in their lifetime. This figure is consistent with nationwide use, with 36% of respondents across Australia reporting they have used cannabis.

There was a slight increase in cannabis consumption in Victoria from 2016. However, the Australian Institute of Health and Welfare noted that this was not a statistically significant increase.[18] Figure 2.1 below shows cannabis use in Victoria has remained relatively stable since 2001, which is consistent with national trends.

17 Australian Institute of Health and Welfare, *National Drug Household Survey 2019*, 2020, <https://www.aihw.gov.au/about-our-data/our-data-collections/national-drug-strategy-household-survey/2019-ndshs> accessed 1 July 2021.

18 Australian Institute of Health and Welfare, *Submission 209*, p. 3.

Figure 2.1 Lifetime and recent use of cannabis, people aged 14 and over, Victoria and Australia, 2001 to 2019



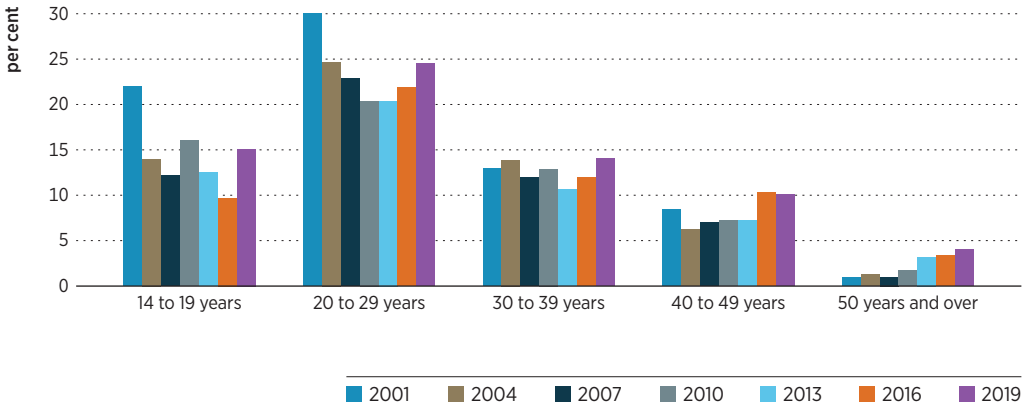
Source: Australian Institute of Health and Welfare, *Submission 109*, p.3.

2.3.1 Use of cannabis according to age

The National Drug Strategy Household Survey 2019 showed that the highest incidence of cannabis use was found among people in the 20–29 age bracket. Use among people aged 20–29 was 24%, with male users (32.8%) more than doubling female users (15.6%).[19]

Figure 2.2 below shows the use of cannabis by age group in Victoria from 2001 to 2019.

Figure 2.2 Frequency (percent) of people who have used cannabis in the past 12 months, by age in Victoria 2001 to 2019



Source: Australian Institute of Health and Welfare, *Submission 209*, p. 9.

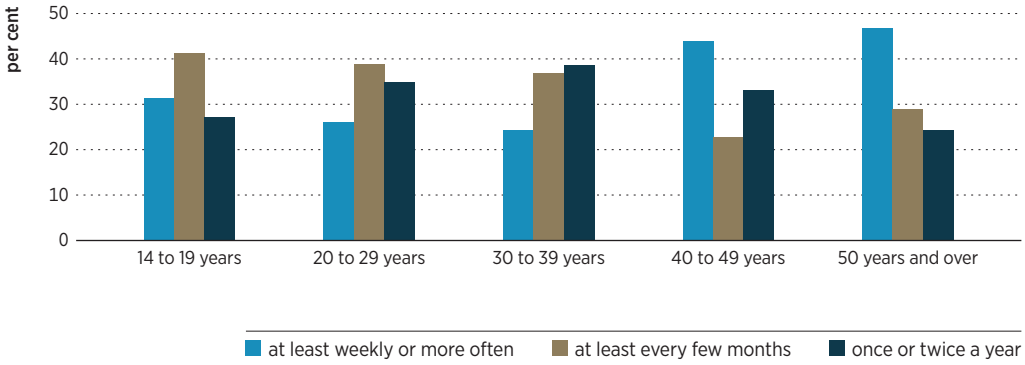
19 Ibid.

While the position of the different age groups has remained consistent since 2001, there have been variations within the groups. Among the 14–19 and 20–29 age groups, cannabis use has declined since 2001. Use amongst people in the 30–39 and 40–49 age groups showed a slight increase across the 18-year period. Use in the 50 years and over age group has steadily increased over this time.

The Australian Institute of Health and Welfare also provided information about how often each age group used cannabis in the preceding 12 months. Those in the 40–49 and 50+ categories were more likely to use cannabis at least weekly. While those in the 14–19, 20–29 and 30–39 age categories were more likely to use at least every few months or less. The cannabis consumption patterns by age group are shown in Figure 2.3 below.

However, as noted in Figure 2.2 above, there are fewer people who use cannabis in the 40–49 and 50+ age groups. Therefore, the high percentage of frequent users in those older age groups represent a lesser number of cannabis users compared to those in the 20–29 age group.

Figure 2.3 Frequency of people who have used cannabis in the past 12 months, by age, in Victoria in 2019



Source: Australian Institute of Health and Welfare, *Submission 209*, p. 11.

The National Drug Strategy Household Survey was the most widely referred to source of data in the evidence received by the Committee. However, some stakeholders acknowledged the difficulty in obtaining accurate data on young people who use cannabis. Some suggested there should be more consideration of ways to reach young people.[20]

The results of surveys more closely targeted at young people are quite different to those of the national survey. The Burnet Institute supplied data from its 'Sex, Drugs, and Rock'n'Roll' (Big Day Out Study), which surveys young people attending music festivals. In 2020 the survey was completed by 714 young people aged 16 to 29 years.

20 See for example: Students for Sensible Drug Policy Australia, *Submission 1392*; Associate Professor Peter Higgs, Burnet Senior Fellow, Burnet Institute, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 43; Ms Julia Daly, Operations Manager, Students for Sensible Drug Policy Australia, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 14.

The results showed that use among young people was significantly higher than indicated by the National Drug Strategy Household Survey. Around 50% of respondents reported having used cannabis in their lifetime. Of those 20%, stated they had used cannabis in the past month.[21]

In comparison, Students for Sensible Drug Policy Australia provided data from Triple J's 'What's up in your world?' survey.[22] In 2019, the survey was completed by 15,703 young people aged 18–29 years. The results found that 53% of respondents had used cannabis in the last 12 months.[23]

Ms Julia Daly, Operations Manager at Students for Sensible Drug Policy Australia believed the difference in results was most likely due to Triple J having greater engagement with young people. She also considered that cannabis users may be more willing to disclose information in comparison to the national survey:

> There is a bit of trust when Triple J rings and it is going to create a cool conversation and maybe spark a few interesting discussions. When you are doing the national direct household survey, what are you trusting? Is someone going to put a little tag on your phone number?[24]

Similarly, the Alcohol and Drug Foundation cited the 2017 Australian Secondary Students' Alcohol and Drug Survey in its submission to the Inquiry. According to this survey cannabis was the most used illicit substance among secondary school students. Of the respondents, 14% of students reported having used cannabis in the past year. Of those, 38% of males and 29% of females reported use on a regular basis.[25]

The Alcohol and Drug Foundation also ranked cannabis as the main drug of concern (58%) for clients aged 10–19 years who accessed treatment services in Victoria in 2018.[26]

2.3.2 Use of cannabis by geographic area

The National Drug Strategy Household Survey compared cannabis use across regions of Victoria. As shown in Figure 2.4 below, people in regional areas used cannabis far more than those in metropolitan areas. In inner regional areas, 13.3% of people had used cannabis recently and 11.8% of people in outer regional areas had used cannabis recently. This compares to 11.1% of people from metropolitan Melbourne.

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21 Ms Ashleigh Stewart, Research Assistant, Burnet Institute, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 38.

22 Students for Sensible Drug Policy Australia, *Submission 1392*, p. 29.

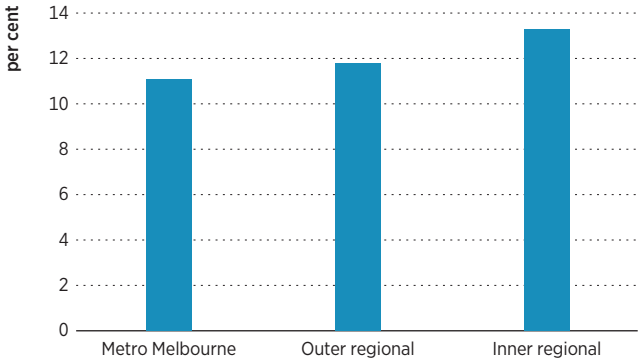
23 Mr Gulliver McLean, Research and Advocacy Officer, Students for Sensible Drug Policy Australia, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 8.

24 Ms Julia Daly, *Transcript of evidence*, p. 14.

25 Alcohol and Drug Foundation, *Submission 1386*, p. 3.

26 Ibid., p. 15.

Figure 2.4 Recent cannabis use, people aged 14 and over, by geographic area in 2019 (%)

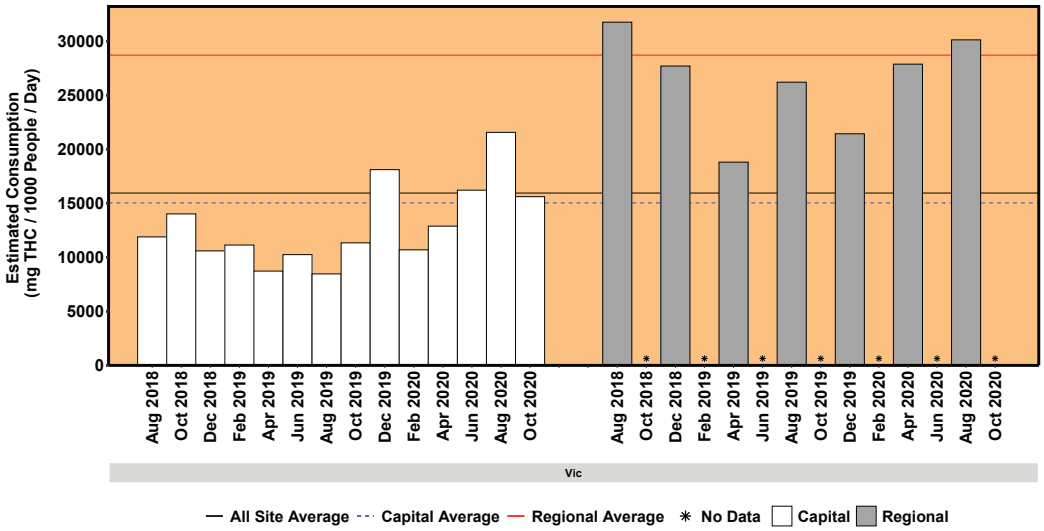


Source: Adapted from Australian Institute of Health and Welfare, *Submission 209*, p. 14.

These figures align with data from the Australian Criminal Intelligence Commission which conducts regular wastewater analysis to detect illicit drug consumption. Consumption of cannabis is estimated through measuring the amount of THC found in wastewater.[27]

Readings taken in August 2020 showed a much higher use of cannabis in regional areas compared with that of metropolitan areas. As shown in Figure 2.5 below, the regional average in October 2020 was close to 30,000 people, nearly double that in metropolitan Melbourne (approximately 15,000 people) and nearly twice the national average.[28]

Figure 2.5 Comparison of cannabis consumption in metropolitan Melbourne and regional Victoria in 2020



Source: Australian Criminal Intelligence Commission, Additional longitudinal data figures, by state and territory and drug type, *Victoria*, 2020, p. 2.

27 Australian Criminal Intelligence Commission, *National Wastewater Drug Monitoring Program: Additional longitudinal data figures, by state and territory and drug type*.

28 Ibid.

The Committee heard evidence that the increased consumption in rural and regional areas is not matched by alcohol and drug resources.[29]

The Victorian Alcohol and Drug Association provided data on cannabis-related ambulance attendances and hospital admissions. It showed that 6 of the top 10 most affected local government areas were in Gippsland, northern and western Victoria, indicating that regional Victoria experienced a greater rate of harm than metropolitan Melbourne.[30] The Association stated that despite the 'high level of regional harms', alcohol and other drug services for adults and young people in regional areas were under-resourced.[31]

The Public Health Association of Australia also noted that drug treatment services were mostly located in metropolitan areas, despite the higher drug use in rural and regional Victoria.[32]

Several stakeholders highlighted the growth of cannabis related offences in regional and rural Victoria compared to metropolitan Melbourne.[33] The Alcohol and Drug Foundation noted that this upward trend has persisted for most of the past decade.[34]

The issue of resourcing alcohol and other drug services in regional areas is discussed in detail in Chapter 3.

2.3.3 Use of cannabis by socioeconomic area, education status and employment status

A complex picture emerges when considering the use of cannabis by socioeconomic metrics such as area, education status and employment status.

Data from the National Drug Strategy Household Survey shows in 2019 those living in more advantaged socioeconomic areas of Victoria had the highest rate of use. Of these respondents, 14.7% reported recent cannabis use. In contrast, in the least advantaged areas only 12.2% of people reported recent use. This is illustrated in Figure 2.6 below.

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29 Mr Sam Biondo, Executive Director, Victorian Alcohol and Drug Association, public hearing, Melbourne, 25 March 2021. *Transcript of evidence*, p. 20; Dr Shalini Arunogiri, *Transcript of evidence*, p. 34.

30 Victorian Alcohol and Drug Association, *Submission 1390*, pp. 10–11.

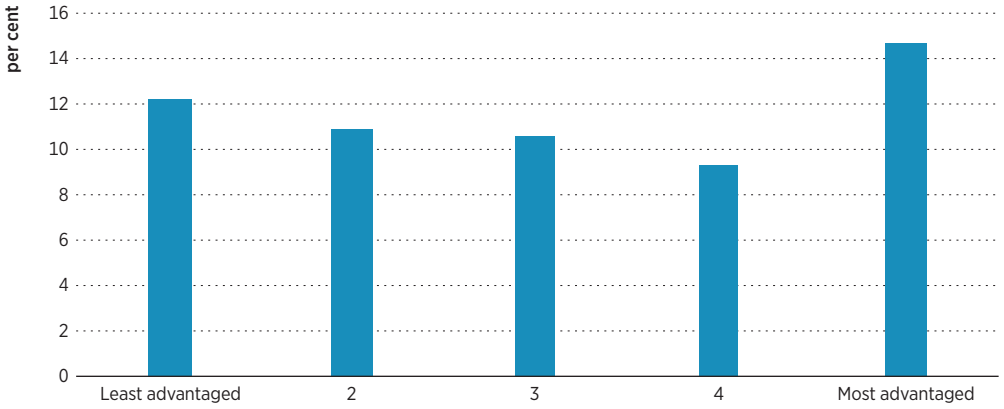
31 Ibid.

32 Public Health Association of Australia, *Submission 1391*, p. 6.

33 See for example: Victoria Legal Aid, *Submission 1373*; Victorian Alcohol and Drug Association, *Submission 1390*; Victorian Aboriginal Legal Service, *Submission 1398*.

34 Alcohol and Drug Foundation, *Submission 1386*, p. 15.

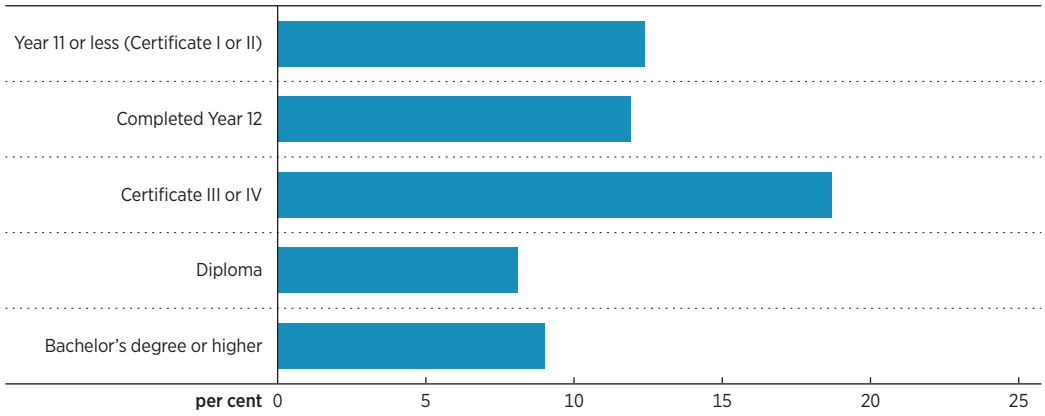
Figure 2.6 Recent cannabis use, people aged 14 and over, by socioeconomic area in Victoria, 2019 (%)



Source: Adapted from Australian Institute of Health and Welfare, *Submission 209*, p. 14.

When considering education status, cannabis use is generally higher amongst groups who have completed schooling or vocational training as their highest level of education. This is illustrated in Figure 2.7 below.

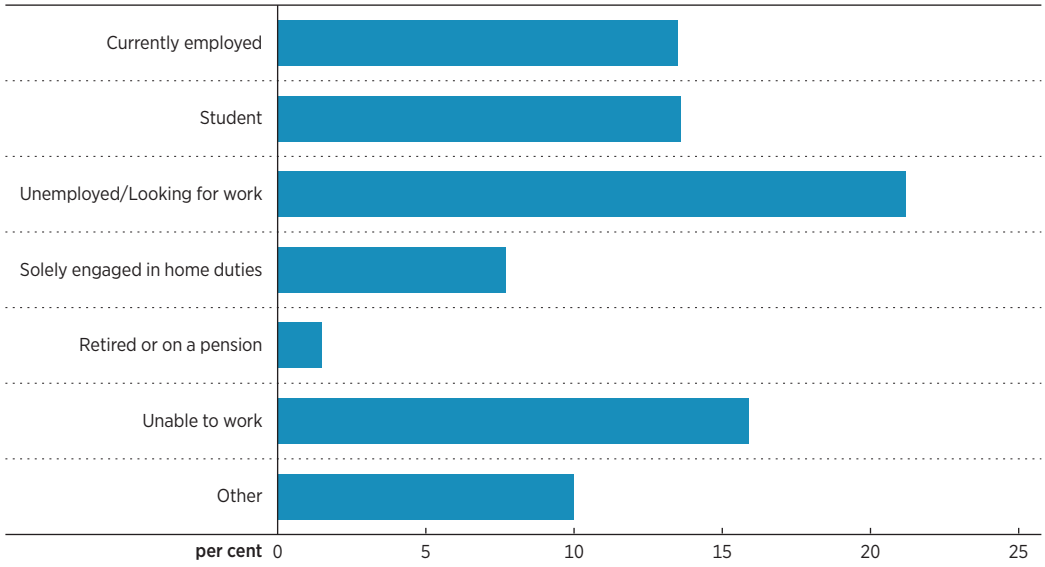
Figure 2.7 Cannabis use in the last 12 months by education status in 2019 (%)



Source: Adapted from Australian Institute of Health and Welfare, *Submission 209*, p. 13.

In relation to employment status, recent cannabis use in 2019 was highest amongst those looking for work or who are unable to work. Cannabis use amongst those who are employed was the fourth highest category, slightly behind students. This is shown in Figure 2.8 below.

Figure 2.8 Cannabis use in the last 12 months by employment status in 2019 (%)



Source: Adapted from Australian Institute of Health and Welfare, *Submission 209*, p. 15.

The evidence from the National Drug Strategy Household Survey illustrated that while socioeconomic factors are important, drug use can still occur in high socio-economic areas as well as disadvantaged areas. Nevertheless, the data points to a stronger correlation between indicators for lower socioeconomic statuses such as lower educational attainment and unemployment.

This is in line with evidence that suggested a link between disadvantage and drug use. For example, Professor Tom Decorte, an academic at the University of Ghent with a background in social drug research, told the Committee that it is important to focus on social policy as a means to prevent problematic drug use:

> To add to that, we can focus on drug policy, but what is often forgotten in these debates about which regulatory model would be the best is that … the most fundamental causes of drug problems in our society, need to be tackled by having a poverty policy and an education policy and by including people. So drug policy is a part of a much broader social policy in society. I do believe that a society which excludes more members—where there is a larger amount of social inequity, where there is a lot of discrimination, where there is a lot of pain, where there is a lot of unwellness or ill being—will have more drug problems. So if you want to have less drug problems, including cannabis abuse and cannabis-related problems, it is also important to invest enough in a much broader social policy—because it is often the people that are excluded from society, the people that have unfinished trauma and pain, that get into trouble with drugs, whether it is cannabis or alcohol or any other drug, or different drugs together.[35]

Chapter 3 discusses in detail how disadvantage affects drug use and discusses programs that enhance protective factors against problematic drug use.

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35 Professor Tom Decorte, Director, Institute for Social Drug Research, University of Ghent, public hearing, Melbourne, 9 June 2021, *Transcript of evidence*, p. 12.

2.3.4 Aboriginal and Torres Strait Islander users

The Australian Institute of Health and Welfare's National Aboriginal and Torres Strait Islander Health Survey shows that cannabis was the most commonly reported illicit drug used by Aboriginal and Torres Strait Islander people in the last 12 months (24%).[36] The most common age groups for people who had used cannabis were 15–29 (29%) and 30–44 (25%). Males were more likely to use cannabis than females at 31.4% compared to 17.7%. This indicates a slightly higher prevalence of use in these communities compared to the general population.

Nationally, a higher proportion of Aboriginal and Torres Strait Islander Australians had used cannabis in the last 12 months (15%) compared to the rest of the population (12%).[37]

Several stakeholders highlighted the proportion of Aboriginal and Torres Strait Islander Victorians charged with cannabis offences is higher than all other groups.[38] At a public hearing Mr Kin Leong, Principal Managing Lawyer, Criminal Law Practice with the Victorian Aboriginal Legal Service discussed this issue. He stated that, cases involving use and possession had risen by 55% in the past five years and 97.5% since 2011, substantially more than the general community at 25.8% in the last five years. He added that 'Aboriginal and Torres Strait Islander people are policed for minor drug offences five times higher than the non-Aboriginal and Torres Strait Islander community'.[39]

The distinct impacts of cannabis-related offences and interactions with the criminal justice system on Aboriginal and Torres Strait Islander peoples is discussed in detail in Chapter 4.

2.4 How often and what kind of cannabis do Victorians use?

In 2019, 11.7% of Victorians aged 18 and over had used cannabis in the past year, and 36.3% had used it at least once in their lifetime.[40]

Some stakeholders believed the Committee should consider policies that target frequent users of cannabis, because they are the heaviest consumers. Dr Kevin Sabet, President of Smart Approaches to Marijuana commented on the experience in the United States, where the majority of cannabis is consumed by frequent users:

> Another thing to remember is that, when we are talking about the marijuana market, we have to talk about what we mean by that, and really what we mean is the fact that

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36 Australian Bureau of Statistics, *National Aboriginal and Torres Strait Islander Health Survey*, <https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/national-aboriginal-and-torres-strait-islander-health-survey/latest-release#substance-use> accessed 30 June 2021.

37 Ibid.

38 See: Victoria Legal Aid, *Submission 1373*, p. 8; Victorian Aboriginal Legal Service, *Submission 1398*, p. 5.

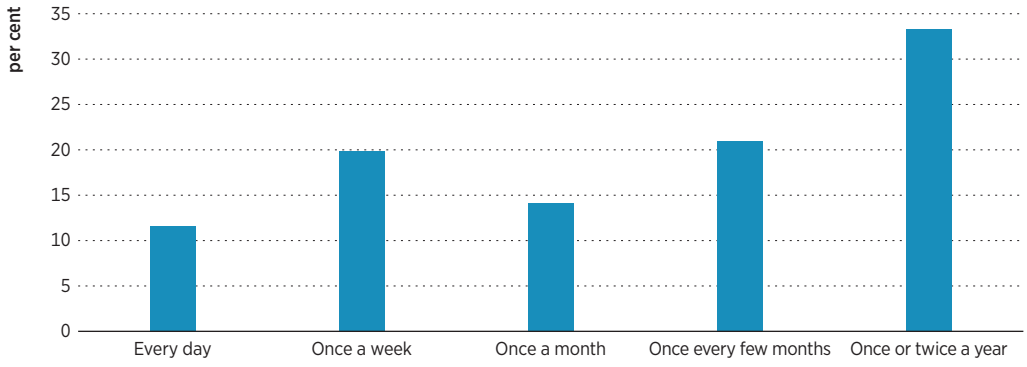
39 Mr Kin Leong, Principal Managing Lawyer, Criminal Law Practice, Victorian Aboriginal Legal Service, public hearing, Beechworth, 28 April 2021, *Transcript of evidence*, p. 13.

40 Australian Institute of Health and Welfare, *Submission 209*, pp. 7, 9.

> a very small proportion of overall users consume the vast majority of the product, and that falls very similarly with alcohol. In the Unites States 10 per cent of drinkers consume 80 per cent of the product. I think that number is very similar globally. It would be similar in Australia and it would be similar around the world. And that is also the case for cannabis—we are talking about 30 per cent of users consuming 87 per cent of the cannabis. This is a review done in Colorado, but the markets would be very similar in other states.[41]

An overview of the user profile of frequent cannabis users was provided to the Committee by the Australian Institute of Health and Welfare. The submission showed that in 2019, of the 11.7% who used cannabis in the past year the majority only use cannabis once or twice a year. The second highest reported frequency was once every few months, followed by once a week. Approximately 11.6% of this group use cannabis every day. This is shown in Figure 2.9 below.

Figure 2.9 Frequency (%) of cannabis use for those 14 and over who have used cannabis in the past 12 months, Victoria, 2019



Source: Australian Institute of Health and Welfare, *Submission 209*, p. 11.

Frequency of cannabis use is a key risk factor in the development of adverse health issues, particularly mental health issues such as psychosis. The Royal Australian and New Zealand College of Psychiatrists said that daily use along with early onset use could put users in a 'different stratosphere' in terms of the risk of development of mental health risks.[42]

2.4.1 THC potency of cannabis sold on the black market in Victoria

The THC potency of the cannabis sold on Victoria's illicit market varies from batch to batch. The Committee was told that over the years the potency of cannabis has increased due to consumer demand and prohibition measures that create incentives for organised crime to produce stronger products. This increase in potency has created a product that is a greater risk factor for psychosis.

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41 Dr Kevin Sabet, President, Smart Approaches to Marijuana, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 11.

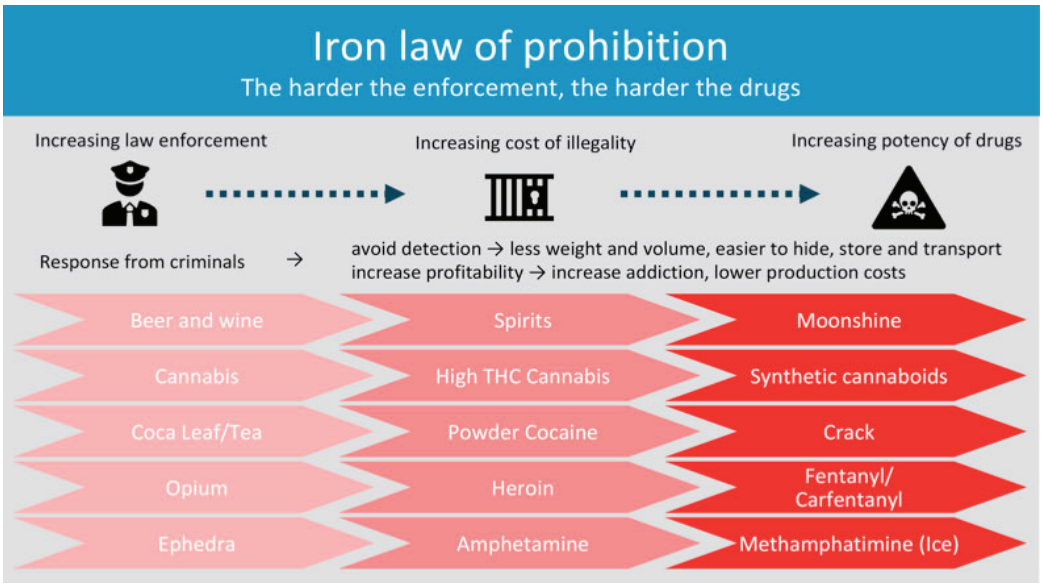
42 Dr Shalini Arunogiri, *Transcript of evidence*, p. 35.

Mr Shane Varcoe, Executive Director, Operations at the Dalgarno Institute told the Committee that cannabis sold on the black market has been manufactured to have higher levels of THC:

> The argument we have from a lot of people is: 'It is just a plant'. I say, 'Well, that plant does not exist anywhere on the planet anymore'. If you can find somewhere where no person, no human being, has ever traversed, you might find an original plant of cannabis. It will have about 2 to 3 per cent THC and the various cannabinoids involved, and of course CBD is an agonist to THC so you cannot really blow your brains out with a joint like that. But now all the cannabis is engineered—all of it is engineered—and CBD is engineered out of it for the purposes of: high.[43]

In its submission, the Penington Institute explained the theory of the 'Iron Law of Prohibition'. This asserts that if a drug is illegal, then market forces will result in it becoming stronger and more addictive to increase the customer base and profitability. In addition, stronger products can mean less volume and transport costs and less chance of detection.[44] Figure 2.10 below shows this process.

Figure 2.10 The iron law of prohibition



Source: Penington Institute, *Submission 1468*, p. 12 (original infographic sourced from the Queensland Productivity Commission).

The Penington Institute explained that this theory could account for the relatively high levels of THC currently found in cannabis in Australia and overseas:

> On the basis of this so-called 'iron law of prohibition' levels of tetrahydrocannabinol (THC) in cannabis products have increased dramatically. For example, the estimated potency of herbal cannabis in Europe doubled from 5% in 2006 to 10% a decade later, while the estimated potency of cannabis resin in Europe doubled from around 8% to

43 Mr Shane Varcoe, Executive Director, Operations, Dalgarno Institute, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 58.

44 Penington Institute, *Submission 1468*, p. 12.

> 17% in that period. The average THC content in confiscated cannabis samples in the US increased from less than 4% in the early 1990s to more than 15% in 2018. Similarly, analysis in Australia found cannabis with a high average potency: three-quarters of the samples contained at least 10% THC, while around half contained at least 15% THC. There is clear evidence that the risk of harms associated with cannabis use increase as the amount of THC increases.[45]

At a public hearing, Dr Shalini Arunogiri, Chair of the Royal Australian and New Zealand College of Psychiatrist's (Victorian Branch) Faculty of Addiction Psychiatry, expanded on this issue. She highlighted the need to map the potency available on the Australian black market:

> In terms of high potency, it is a really good point, because I think it certainly has changed in terms of the availability of different types of cannabis, and you will have seen several different types this morning. What we know is often drawn from international literature as well in terms of different types, and the climate here is a little different, but we have not as comprehensive kind of information on the different types and different potencies here in Australia. I think also the landscape is quite diverse, so there will be also low-potency THC and high CBD formulations in the community. There will also be other pockets with really high potency, high-THC formulations. And so we do not necessarily currently have comprehensive data to support what the prevalence of very high potency formulations here are. In Europe there are a number of studies actually starting to map this and tap the fact that there are very high potency pockets in particular countries, and so I think that is a definite risk that needs to be looked at.[46]

The Committee received evidence on the Illicit Drug Reporting System, which is an initiative that includes a study on the potency of cannabis in Victoria.[47] The initiative is conducted by the University of New South Wales' National Drug and Alcohol Research Centre. It is intended to identify emerging trends in illicit drug markets, including drug users' perceptions of the strength of cannabis over time.[48]

The Illicit Drug Reporting System reports noted that the results 'are not representative of all people who use illicit drugs, nor of use in the general population'. This is because the information in the reports is gained from interviews with 'drug users who were recruited via advertisements in needle syringe programs and other harm reduction services, as well as via peer referral'.[49]

Figure 2.11 from the Illicit Drug Reporting System's 2020 report outlined the perceived strength of cannabis in Victoria from 2006 to 2020.[50] The report differentiated between two types of cannabis. The first is 'hydroponic cannabis' which is grown indoors with

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45 Ibid.

46 Dr Shalini Arunogiri, *Transcript of evidence*, p. 33.

47 Ms Ashleigh Stewart, *Transcript of evidence*, p. 47.

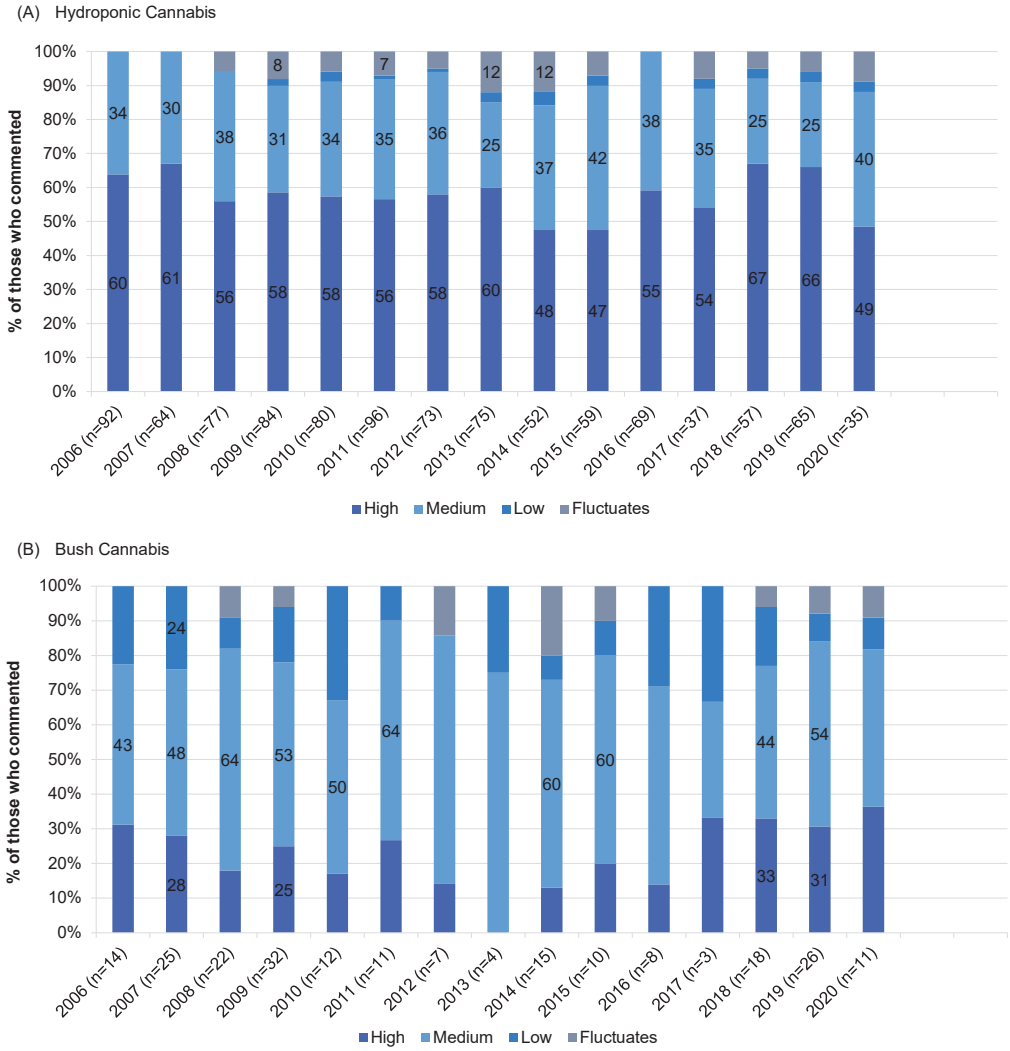
48 National Drug and Alcohol Research Centre, *Australian Drug Trends 2020: Key Findings from the National Illicit Drug Reporting System (IDRS) Interviews*.

49 Amy Peacock et al., *Australian Drug Trends 2020: Key Findings from the National Illicit Drug Reporting System (IDRS) Interviews*, National Drug and Alcohol Research Centre, UNSW, Sydney, 2021, p. 51.

50 Ibid., p. 48.

a hydroponic system and considered to be more potent. The second is 'bush cannabis' which is grown outdoors and may be less potent.[51] The graphs below indicate the number of people interviewed each year (n).

Figure 2.11 The perceived potency of cannabis in Victoria from 2006 to 2020 from interviewees to the Illicit Drug Reporting System



Note. The response 'Don't know' was excluded from analysis. Hydroponic and bush cannabis data collected separately from 2004 onwards. Data labels have been removed from figures with small cell size (i.e. n≤5 but not 0). **p*<0.050; ***p*<0.010; ****p*<0.001 for 2019 versus 2020.

Source: University of New South Wales, National Drug and Alcohol Research Centre, *Victorian Drug Trends 2020: Key Findings from the National Illicit Drug Reporting System (IDRS) Interviews*, 2020, p. 51.

Figure 2.11 above illustrates a relatively steady perception of the strength of cannabis over time. The Committee notes that the majority of users indicated that the strength of hydroponic cannabis available to them was high.

51 Ibid.

Due to the nature of black-market products such as cannabis, it is difficult to get a comprehensive picture of the potency of cannabis sold in Victoria. However, it is clear that some of the cannabis that is available has high THC potency, which is a risk factor for the development of psychosis. In addition, the potency of cannabis sold in Victoria may have increased over time.

2.4.2 Availability of cannabis on the black market in Victoria

The Committee heard that despite the efforts of law enforcement over many decades to halt the supply of cannabis, it is still widely available for purchase on the black market. There is also substantial demand for cannabis in Victoria with it remaining the most widely used illicit drug in the State. In addition, the price of cannabis has remained consistent over the past decade.[52]

The Australian Criminal Intelligence Commission's *Illicit Drug Data Report 2018–19,* showed that law enforcement operations nationally have succeeded in seizing large amounts of cannabis over the past decade:

> The number of national cannabis seizures increased 26 per cent over the last decade, from 44,736 in 2009–10 to 56,491 in 2018–19. The number of national cannabis seizures decreased 5 per cent this reporting period from 59,139 in 2017–18.
>
> The weight of cannabis seized nationally increased 29 per cent over the last decade, from 5,989.8 kilograms in 2009–10 to 7,740.8 kilograms in 2018–19. The weight of cannabis seized nationally decreased 11 per cent this reporting period from 8,655.9 kilograms in 2017–18.[53]

The amount of cannabis intercepted entering the country from overseas has increased exponentially. The report stated that it has increased 666% over the last decade:

> The number of cannabis detections at the Australian border increased 666 per cent over the last decade, from 1,454 in 2009–10 to 11,133 in 2018–19. The number of cannabis detections decreased 36 per cent this reporting period from 17,383 in 2017–18. The weight of cannabis detected increased 9,144 per cent over the last decade, from 19.6 kilograms in 2009–10 to 1,811.7 kilograms in 2018–19, the highest weight recorded in the last decade.[54]

For border detections of cannabis in 2018–19, by far the greatest number came from international mail which accounted for 97% of detections. However, sea cargo accounted for the greatest proportion by weight of cannabis detected.[55]

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52 Australian Criminal Intelligence Commission, *Illicit Drug Data Report 2018–19*, Australia, 2020, p. 55.

53 Ibid.

54 Ibid., p. 51.

55 Ibid.

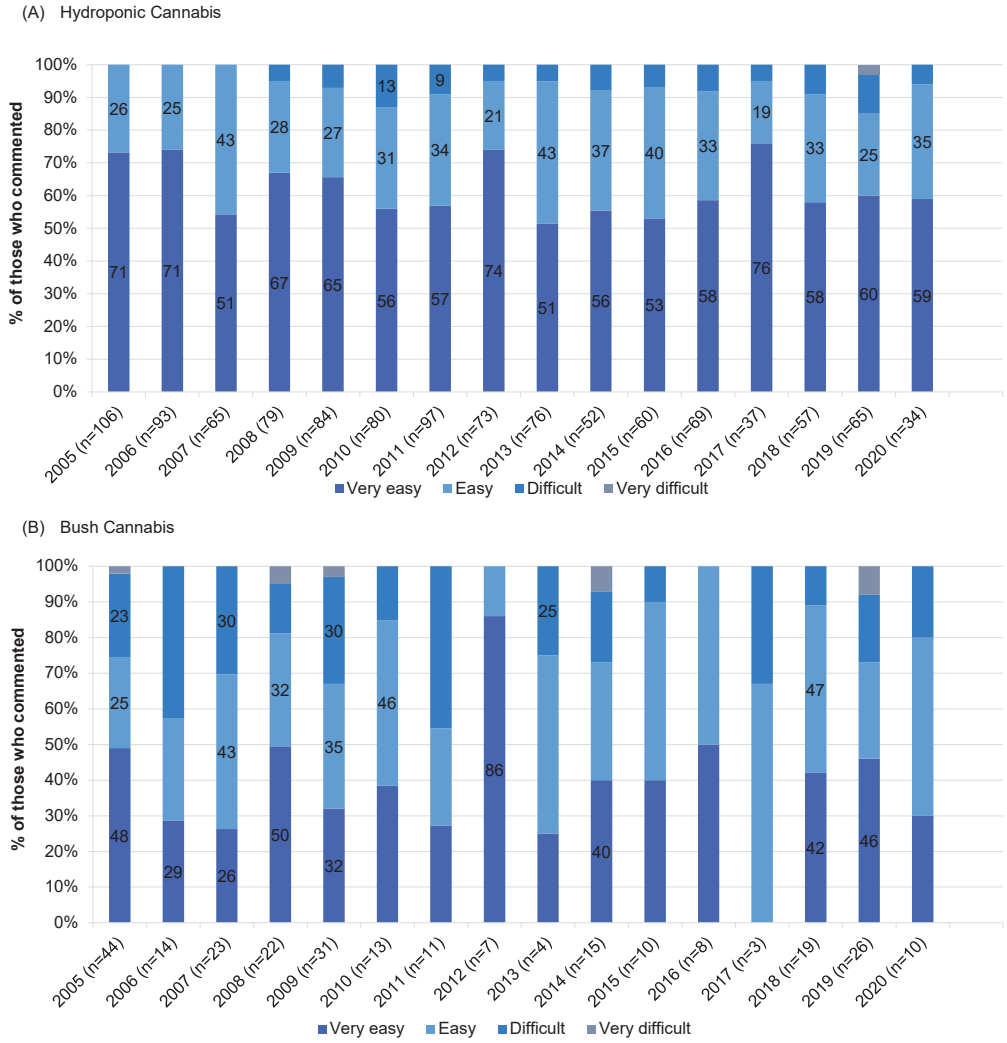
At a public hearing Mr Sam Biondo, Executive Officer of the Victorian Alcohol and Drug Association, provided data about the availability of cannabis and the number of Victorians who have used it:

> To date, significant and persistent policing endeavours have done little to curb the availability of cannabis, with 36 per cent, or 7.6 million, of Australians having ever consumed it. In Victoria 11.5 per cent or 625 000 people aged 14 and over have consumed it in the past 12 months. Furthermore, efforts to reduce supply have not been successful, with cannabis availability rated as 'very easy to obtain' by nine out of 10 cannabis users surveyed.[56]

These assertions align with information in the Illicit Drug Reporting System report on Victorian drug trends in 2020. The report provided data about drug users' perceived availability of cannabis each year from 2005 to 2020. Most responses from interviewees rated both hydroponic cannabis and bush cannabis as 'very easy' or 'easy' to obtain. This is summarised in Figure 2.12 below.

56 Mr Sam Biondo, *Transcript of evidence*, p. 19.

Figure 2.12 Perceived availability of cannabis in Victoria from 2005 to 2020 from interviewees to the Illicit Drug Reporting System



Note. The response 'Don't know' was excluded from analysis. Hydroponic and bush cannabis data collected separately from 2004 onwards. Data labels have been removed from figures with small cell size (i.e. n≤5 but not 0). **p*<0.050; ***p*<0.010; ****p*<0.001 for 2019 versus 2020.

Source: University of New South Wales, National Drug and Alcohol Research Centre, *Victorian drug trends 2020: key findings from the national Illicit Drug Reporting System interviews*, 2020, p. 52.

The price of cannabis is another key indicator of availability. At a public hearing, Mr Biondo noted that the price of cannabis has not increased in over a decade. He suggested this indicated the supply of cannabis is not decreasing which has led to higher prices:

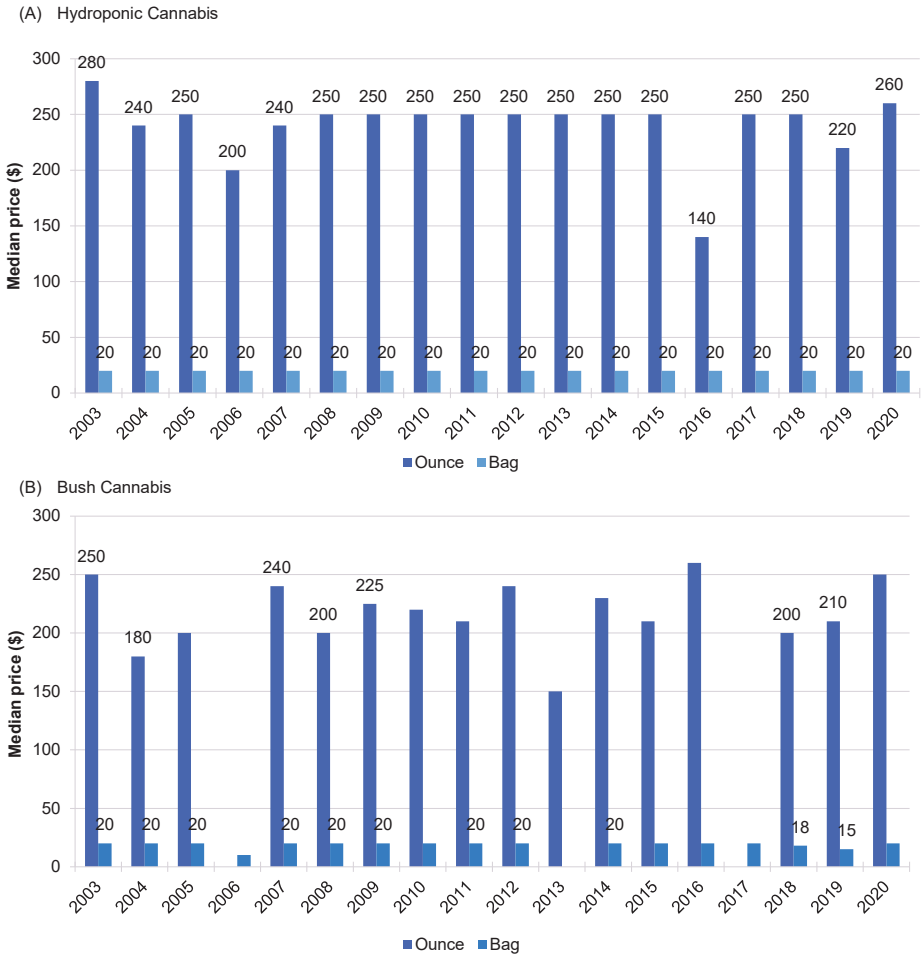
> It is erroneously assumed that successful law-enforcement interdiction would result in a reduced quantity of available product with a resultant increase in cost. However, the street price of cannabis has remained steady in the face of intense policing for the last decade from about 2009, at around $20 per gram. The durability of the market reflects the substantial limitations of policing attempts, especially given that over half of all national illicit drug seizures, about 52 per cent, and 48 per cent of those arrests, are

related to cannabis. Cannabis is clearly highly prioritised by policing efforts, but policing efforts have done little to shake the $3.9 billion market.[57]

The Australian Criminal Intelligence Commission's Illicit Drug Data Report also acknowledged that nationally, the price of cannabis has remained stable over the last decade.[58]

The stability of the price of cannabis is reflected in the interviews from the Illicit Drug Reporting System. This showed that in Victoria the price has remained relatively steady since 2003. The price for a 'bag' (1g) of cannabis did not change during the reporting period, while prices for an ounce (28g) of cannabis fluctuated. Figure 2.13 below illustrates this data.

Figure 2.13 Median price of cannabis in Victoria from 2003 to 2020 according to interviewees to the Illicit Drug Reporting System



Note. Among those who commented. From 2003 onwards hydroponic and bush cannabis data collected separately. Data labels have been removed from figures with small cell size (i.e. n≤5 but not 0). *p<0.050; **p<0.010; ***p<0.001 for 2019 versus 2020.

Source: University of New South Wales, National Drug and Alcohol Research Centre, *Victorian Drug Trends 2020: Key Findings from the National Illicit Drug Reporting System Interviews*, 2020, p. 50.

57 Ibid.

58 Australian Criminal Intelligence Commission, *Illicit Drug Data Report 2018–19*, p. 54.

2.5 Is cannabis a gateway drug?

One of the issues put forward to the Committee is that cannabis use acts as a 'gateway' to other illicit drugs. This is based on the assumption that once a person uses cannabis, they are more likely to go on to use other more harmful illicit drugs such as methamphetamine or heroin. Other stakeholders disagreed with this assessment, arguing that most people who use cannabis will not go on to use other illicit drugs and that there are more complex social causes for problematic drug use.

In its submission, Drug Free Australia provided an excerpt of a research paper titled *Cannabis: a general survey of its harmful effects*.[59] The paper argued that a large body of circumstantial evidence has 'found time and again that cannabis is a central component of the network of influencing factors that leads to the abuse of hard drugs'.[60] The author stated that support for the 'gateway drug' hypothesis is as follows:

a. Marijuana users are many times more likely than non-users to progress to hard drug use.

b. Almost all who have used marijuana and hard drugs have used marijuana first.

c. The greater the frequency of marijuana use, the greater the likelihood of using other drugs later.[61]

The gateway drug theory was supported by witnesses to the Committee who work with people experiencing problematic drug and alcohol issues. Mr Trent Jones, a Learning Support Officer from the Centre Wangaratta, an adult education service, said that in his experience cannabis can be a gateway drug:

> Often there is a pattern beginning with nicotine to alcohol and cannabis to other drugs. Although there has been research and opinion that doesn't support cannabis being a gateway drug, I can only speak from my experience. And in my experience I believe that it is for some people.[62]

In discussing the drug use of his clients, he said that cannabis is often the first illicit substance they use:

> Yes, we used a comprehensive drug and alcohol assessment—it was 32 pages big, and we went through the years 13 to whatever their age is, and what years they used drugs, and often, sadly, it was nicotine at around 13 and then alcohol at 15, and cannabis as 16, 17, and then for some, it went onto hard drugs—or to other drugs, like methamphetamine and heroin.[63]

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59 Drug Free Australia, *Submission 1364*, pp. 5–9.

60 Mary Brett, *Cannabis: a general survey of its harmful effects*, report for The Social Justice Policy Group, 2014 (revised version), p. 69.

61 Drug Free Australia, *Submission 1364*, p. 19.

62 Mr Trent Jones, Learner Engagement Officer, The Centre for Continuing Education (Wangaratta), public hearing, Beechworth, 28 April 2021, *Transcript of evidence*, p. 24.

63 Ibid., p. 28.

The Committee also heard evidence from Ms Kerri Barnes, Project Manager of the Finding Strengths program at The Centre for Continuing Education (Wangaratta), which provides education and training to individuals who have interacted with the criminal justice system. She told the Committee that most of her clients began their drug use with cannabis:

> We have of our offenders, 92 percent of them report illicit drug use. For 78 percent of those their preferred drug of choice is actually ice however, a majority of them do nominate cannabis as their gateway drug and a lot of that is normalised for them through their environment as they're growing up, so it is something that they've observed and it is inter-generational problem.[64]

While this narrow group of offenders and drug and alcohol service clients started out with cannabis, not all cannabis users go onto use other more harmful illicit drugs. Mr John Ryan, Chief Executive Officer of the Penington Institute, explained that a large majority of people who use cannabis do not go on to use harder drugs:

> Many, if not the vast majority of, hard drug users use cannabis. They also often smoke. Methamphetamine users often smoke tobacco; so do opioid users often smoke tobacco. The interesting thing to my mind in America in recent years with the overdose epidemic is that most people's first psychoactive substance was pharmaceutical drugs, so they moved from pharmaceutical drug misuse to street-based opioid drug misuse. That stepping-stone theory, I think, does not actually hold up because the numbers are so huge. The number of people who consume cannabis in Australia compared to the number of people who consume heroin is off the scale in terms of cannabis versus heroin.[65]

Health consultancy firm 360Edge also disagreed that cannabis is a gateway drug and pointed out that alcohol and tobacco use often precedes cannabis use:

> Claims that cannabis is a 'gateway drug' which leads to consumption of more harmful drugs, has been thoroughly debunked. While it is true that people who use other drugs later most often use cannabis first, the converse is not true - most people who use cannabis do not go on to use other drugs. In addition, alcohol and tobacco usually precede cannabis use, which if the theory were correct, would make those drugs the 'gateway' to cannabis and other drug use.[66]

Drug Free Australia cited a study which followed the illicit drug use of 2,000 Victorian secondary students over 13 years into adulthood.[67] The study found that the prevalence of cannabis use declines sharply as people grow older. However, it also found that many people who did continue using cannabis into their late 20s used cannabis on a weekly

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64 Ms Kerri Barnes, Project Manager, Finding Strengths, The Centre for Continuing Education (Wangaratta), public hearing, Beechworth, 28 April 2021, *Transcript of evidence*, p. 24.

65 Mr John Ryan, Chief Executive Officer, Penington Institute, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 46.

66 360Edge, *Submission 1350*, p. 5.

67 Wendy Swift et al., 'Cannabis and progression to other substance use in young adults: findings from a 13-year prospective population-based study', *Journal of Epidemiology and Community Health*, vol. 66, no. 7, 2012, e26.

or daily basis. This group were 2 to 3 times more likely to progress onto other illicit drug use compared with those who used cannabis on a less than weekly basis. Those who have never used cannabis were more likely not to use other drugs.[68]

While the results did find a correlation between regular cannabis use and progression onto other illicit drugs in comparison to occasional cannabis use, it acknowledged that other social factors may be involved:

> Our findings on increased uptake and persistence of other substance use in regular cannabis users may also reflect psychosocial processes. Various indices of social marginalisation, such as poorer educational outcomes, unemployment and welfare dependence, as well as greater exposure to availability of drugs and more permissive attitudes towards other drug use that may be associated with regular cannabis use, might provide a conducive context and lower the barriers for engaging in other substance use.[69]

Ms Ashleigh Stewart, Research Assistant at the Burnet Institute, agreed that other social factors could play a role in increasing drug use, particularly social disadvantage:

> To your point before, Georgie, as well I was going to say on that trajectory for people as a gateway drug, using cannabis and then going on a trajectory to consume heroin, I think that there is a lot in between that confounds that causal pathway as well in the sense of issues in housing stability, entrenched disadvantage, marginalisation and low educational attainment.[70]

The Committee was also told that drug dealers on the black market may play a role in leading people toward harder drugs. In its submission, Victoria Legal Aid provided a case study about a person who was led to the use of methamphetamine by his drug dealer:

> Alfi [not real name] is around 25 years old. He has ADHD and had been using cannabis for some years before he was introduced to ice through his cannabis dealer. It had a catastrophic impact on his life as he became addicted to it and began offending while under the influence of ice. Alfi has told his VLA lawyer that he would not have tried ice if his dealer hadn't provided it to him. Alfi was accepted into the Assessment and Referral Program at the Magistrates' Court and he is now receiving treatment and mental health management. He has not re-offended again and says that he will not take ice again due to the damaging impact it had on his life and his family.
>
> Victoria Legal Aid, *Submission 1373*, p. 4.

68 Ibid.

69 Ibid., p. e26.

70 Ms Ashleigh Stewart, *Transcript of evidence*, p. 44.

The Committee agrees that often those who go onto use more harmful illicit drugs, such as heroin or methamphetamine, may have started with cannabis. However, the reasons for their progression to more dangerous illicit drugs may be more complicated than simply using cannabis to begin with as a 'gateway drug'. The evidence received shows that adults who use cannabis regularly in their 20s have a higher risk of using other illicit drugs. The Committee believes the reasons that compel them to regularly use cannabis—such as entrenched disadvantage or marginalisation[71]—may contribute to the use of more harmful illicit drugs.

71 Ibid.

3 Mental health and other health issues associated with the use of cannabis

3.1 Introduction

Cannabis use can be associated with metal health issues, most significantly psychosis. It can also cause harm to the developing brains of adolescents and result in cannabis use disorder (addiction). These risks are generally confined to a subset of users who use cannabis where other risk factors exist, such as:

- frequent use
- use of high tetrahydrocannabinol (THC) potency cannabis
- early onset use.

In relation to psychosis, genetic predisposition and other factors such as previous mental health and trauma also play a role.

There is a complex relationship between cannabis use and mental health issues. Cannabis may be used by some people to treat the symptoms of mental health conditions, while for others it may contribute to the exacerbation of these issues.

While risks to mental health exist, it is important to note that for most cannabis users, the risks are low.[1]

There can also be long term dangers to physical health that arise from cannabis ingested by smoking, either by itself or with tobacco. In addition, people who drive while impaired by cannabis put themselves and others at risk of death or injury on the roads.

Victoria's alcohol and other drugs sector requires additional resourcing to meet demand for services, particularly in regional and rural Victoria. Training of clinicians in both mental health and alcohol and drug specialisations is important to ensure people face no wrong door when seeking help for drug and alcohol and mental health treatment.

The prevention of problematic drug use is important. The Committee was provided with commendable examples of programs already in place, as well as others such as the Planet Youth program which the Committee believes should be trialled in Victoria.

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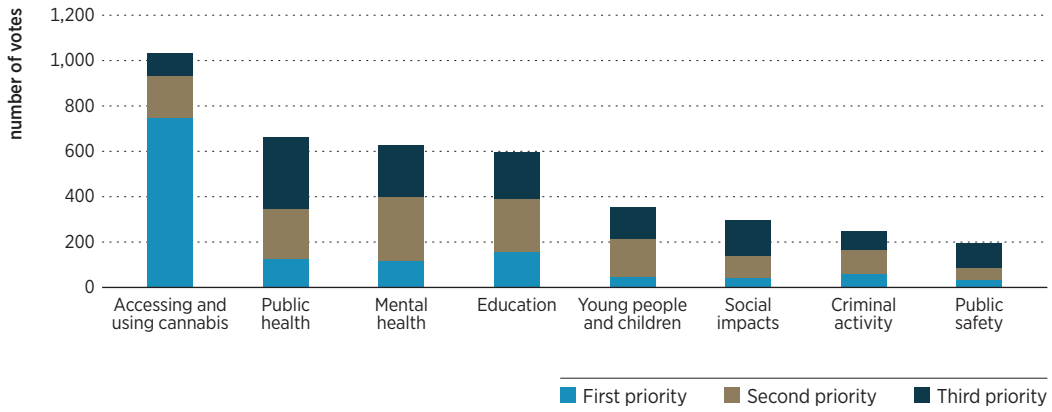
1 Professor Dan Lubman AM, Executive Clinical Director, Turning Point, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 6.

Public health and mental health were important considerations for submitters who answered the survey on the Committee's e-submissions page. When the top three priorities of survey respondents were combined, public health and mental health ranked as the second and third most important priorities. This is shown below in Figure 3.1.

Figure 3.1 Combined top three priorities for survey respondents from most to least important



Source: Legislative Council Legal and Social Issues Committee.

3.2 A new approach to mental health and alcohol and drug issues

Victoria's alcohol and other drugs sector provides treatment and support to those struggling with dependence on alcohol or other drugs. The treatment includes help with drug and alcohol use, rehabilitation and counselling.

Key stakeholders to the Inquiry explained how the alcohol and other drugs sector is underfunded and suffering significant workforce shortages, particularly in the field of addiction specialist doctors.[2] These issues are outlined in detail in Sections 3.6.1 and 3.6.2.

Despite the significant crossover between mental health and drug and alcohol issues, there is not enough cooperation between the mental health and alcohol and other drugs sectors to provide services for both issues. This is a problem for those seeking treatment and leads to people being turned away because of institutional barriers and a lack of clinical training. More information about the evidence the Committee received on these issues is detailed in Section 3.6.2.

Victoria's Royal Commission into Mental Health identified the crossover of mental health and alcohol and drug issues. Its recommendations included the establishment of a new state-wide service for mental health and alcohol and drug issues that would promote

2 See: Victorian Alcohol and Drug Association, *Submission 1390*, p. 12; Dr Shalini Arunogiri, Chair, Faculty of Addiction Psychiatry, Royal Australian and New Zealand College of Psychiatrists (Victorian branch), public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 34.

clinical cooperation and training in both disciplines. In addition, the Royal Commission recommended an urgent increase in the number of addiction specialists.[3]

The Committee welcomes these recommendations and notes that the Victorian Government has committed to their implementation. However, the Committee remains concerned that the level of funding directed to alcohol and other drugs services following the Royal Commission will not be sufficient to meet demand in the sector, particularly in regional Victoria. The Committee recommends that the needs of the alcohol and other drugs sector be included in reviews of funding and workforce needs.

The Committee also received evidence about programs aimed at the prevention of problematic drug use. These programs target social disadvantage and seek to foster engagement with family, community, education, and employment to strengthen protective factors against problematic drug use. They are important tools to prevent drug use amongst young people. Currently, funding for some of these programs is insufficient or inconsistent. The Committee recommends that the Government provide ongoing funding for Victorian alcohol and other drugs agencies to implement preventative programs that seek to build protective factors against drug use.

RECOMMENDATION 3: That in implementing the recommendations of the Royal Commission into Mental Health relating to the alcohol and other drug sector, the Department of Health conducts an assessment of funding and workforce needs of the alcohol and other drug sector to ensure it meets the demand of Victorians seeking alcohol and other drug treatment, particularly in regional Victoria.

RECOMMENDATION 4: That the Victorian Government provides ongoing funding for alcohol and other drug sector organisations to provide programs that seek to build protective factors against problematic drug use.

3.3 Mental health risks and cannabis use

Most people who use cannabis will not experience serious harms. However, there are a subset of cannabis users who may be at risk of developing psychosis, which in some cases can lead to long term psychotic disorders such as schizophrenia. This issue is discussed in detail in Section 3.3.2.

In addition to psychosis, the Committee was informed of additional mental health harms associated with cannabis use. They are cannabis use disorder (addiction) and harms to the developing brain when used in adolescence. Some evidence was also provided to suggest a very moderate association between cannabis use and depression, although not anxiety. This is discussed in detail in Sections 3.3.4 and 3.3.5.

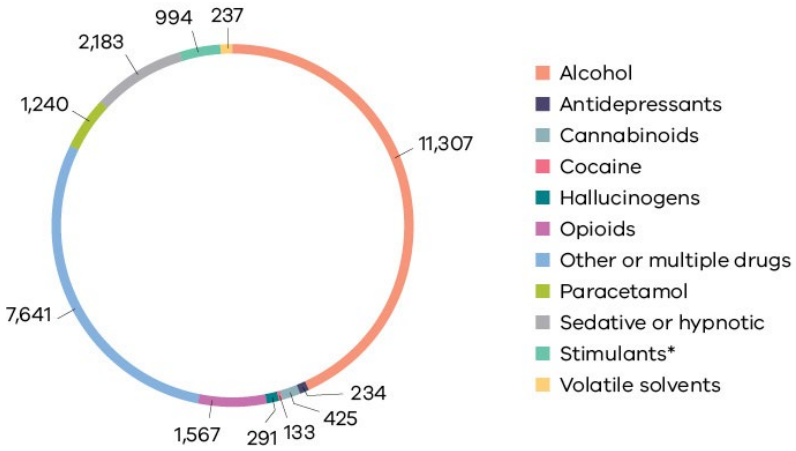
3 *Royal Commission into Victoria's Mental Health System*, (Final Report, February 2021) vol 3, p. 284.

The association between cannabis use and mental health is complex. It is unclear whether cannabis use causes mental health issues, or vice versa. The evidence presented to the Committee suggested that cannabis can be used as a treatment for or exacerbate the symptoms of certain mental health issues. Section 3.3.1 discusses the causal relationship between cannabis and mental illness further.

While the risk of psychosis and other harms exist, cannabis use is responsible for 'an extremely small proportion of the burden of disease and injury due to mental ill-health'.[4]

Data published in the Royal Commission into Mental Health's final report showed that cannabinoids[5] account for a relatively small number of mental health-related emergency presentations attributable to drugs and alcohol.

Figure 3.2 Mental health-related emergency department presentations attributable to drugs and alcohol in Victoria in 2019–20



Source: Department of Health and Human Services, Victorian Emergency Minimum Dataset 2019–20.

Notes: Mental health-related emergency department presentation defined as (a) the presentation resulted in an admission to a mental health bed (inpatient or residential), or (b) the presentation received a mental health related diagnosis ('F' codes, or selected 'R' & 'Z' codes R410, R418, R443, R455, R4581, Z046, Z590, Z609, Z630, Z658, Z765), or (c) the presentation was defined to be 'Intentional self-harm', or (d) the presentation involved interaction with a mental health practitioner.

*Stimulants category includes methamphetamine.

Source: *Royal Commission into Victoria's Mental Health System*, (Final Report, February 2021) vol 3, p. 296.

A legalised and regulated cannabis market may address the risk factors associated with cannabis use and mental health by regulating the aspects of cannabis use that cause harm. This includes prohibiting the sale of cannabis to young people, regulating the potency of THC and providing education campaigns for young people and those who have a predisposition to psychosis.

4 Penington Institute, *Submission 1468*, p. 3.

5 The data from the Emergency Minimum Dataset used in the Royal Commission into Mental Health's Final Report did not specify whether cannabinoids include synthetic cannabis or if it is herbal cannabis alone.

3.3.1 Does cannabis use cause mental illness?

The Committee heard there is uncertainty that cannabis use is the cause of some of the mental health harms associated with it. While there is a general acceptance that there is a causal link between risky cannabis use and psychosis, the link between cannabis use and other mental health conditions is less clear. Some stakeholders argued that people who already experience or are vulnerable to mental illness may use cannabis to treat their symptoms, and in doing so can exacerbate the symptoms further.

The Royal Commission into Mental Health gave an overview of the complicated relationship between illicit drug use and mental illness, noting that mental illness and drug use can contribute to one another:

> The relationship between mental illness and substance use or addiction is complex, and each can contribute to the other. Once mental illness and co-occurring substance use or addiction are established, they can be difficult to disentangle. While there appears to be insufficient evidence to conclude that substance use *causes* mental illness in a general sense, substance use appears to be a factor that can increase the risk of a person experiencing poor mental health, or exacerbate the symptoms of mental illness. Some studies indicate that a complex range of factors, including environmental stressors (such as violence in the home environment or encounters with the justice system) or even genetic factors, are likely to play a role in the onset of both substance use or addiction and poor mental health, but more research is needed to understand the links between these factors, particularly for developing brains in young people.[6]

The Committee spoke to Maryanne Donnellan, Program Manager, AOD services at Gateway Health in Wangaratta which is the largest alcohol and drug service provider in north-east Victoria. Ms Donnellan outlined her experience with clients who use cannabis to self-medicate for mental health issues and in doing so exacerbate the issues further:

> We see that daily cannabis is linked to underlying mental health concerns. So not the occasional user, but the consistent, using very regularly. We see it for self-medicating and masking symptoms of anxiety, depression, ADHD and PTSD and paradoxically increasing the very symptoms that they are trying to mask as well.[7]

In its submission, the Australian Institute of Health and Welfare noted data from the National Drug Strategy Household Survey. This showed that in 2019, 29.4% of people with a mental illness reported using cannabis in the past month.[8]

The Committee received evidence including papers from peer reviewed journals that have found an association between cannabis and mental illnesses such as psychosis and schizophrenia. However, some stakeholders cautioned that these studies have met research challenges relating to the scope and methodology of the studies.

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6 *Royal Commission into Victoria's Mental Health System*, p. 292.

7 Ms Maryanne Donnellan, Program Manager AOD, Gateway Health, public hearing, Beechworth, 28 April 2021, *Transcript of evidence*, p. 5.

8 Australian Institute of Health and Welfare, *Submission 209*, p. 12.

Dr Shalini Arunogiri, Chair of the Faculty of Addiction Psychiatry at the Royal Australian and New Zealand College of Psychiatrists Victorian branch discussed this at a public hearing. She told the Committee that some studies look at populations of people, their use of drugs and whether they experience mental health issues. Such studies may not consider other factors that can lead to mental ill health and fail to link cannabis use as the cause of mental health harms:

> What we know is, as we all have heard from several other people as well, the studies and research into the relationship between cannabis and then a whole range of mental health harms—that includes depression, anxiety and psychosis—is fraught with a whole range of research-related challenges. Many of these research studies have been conducted on population level statistics and epidemiological studies rather than necessarily being able to look at a prospective link between substance use and harms and also wanting to disaggregate the impacts of punitive measures such as criminalisation, for instance, on those harms as well as disaggregating polysubstance abuse from those harms—the challenges in being able to, for instance, draw out use of other substances which often go along with cannabis use, including tobacco and alcohol.[9]

Professor Dan Lubman AM, Executive Clinical Director, Turning Point and Director, Monash Addiction Research Centre, also discussed the role that other factors might play in the experience of mental health harms amongst cannabis users. He stated that the experience of trauma and mental health issues might lead to cannabis use, rather than the other way around:

> And there is more work now, and work that we have done as well, that has shown that many of the young people who develop problems with cannabis already are vulnerable in many other ways. They are choosing to start and have problems with cannabis because of other underlying issues that they have in terms of mental health, in terms of issues of underlying trauma and issues of social inequity. We had a paper many years ago now where we were following a longitudinal study following young people and looking at their brain development. It showed that the young people who are most likely to actually experiment with and then use cannabis regularly were those people who had already had impairments in parts of their brain in the frontal cortex related to other issues in their lives.[10]

Dr Arunogiri also identified trauma as a key factor linked to drug use, but similarity noted it was difficult to identify causation:

> This is fraught across the whole drug and alcohol space, being able to tease out use alone versus use correlating with a whole range of other confounding factors. I think trauma is a significant confounding factor. We know that regular use of drugs and alcohol is much higher in people who have had exposures to trauma in childhood or even later in life. And we know that rates of PTSD are very high in people who have regular use. So again, here is the chicken or egg.[11]

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9 Dr Shalini Arunogiri, *Transcript of evidence*, p. 29.

10 Professor Dan Lubman AM, *Transcript of evidence*, p. 5.

11 Dr Shalini Arunogiri, *Transcript of evidence*, p. 37.

A more personal example of how past experiences, trauma and mental health issues might lead to substance abuse problems was provided by Mr Andrew Hick, Manager of the Circuit Breaker program at Odyssey House Victoria:

> I am remembering a conversation I had with a chap years and years ago, and he was talking about—I won't talk about which drug it was, but he was talking about the drug he had, and he was saying, 'I took this for so and so amount of years,' and I interrupted him and I said, 'And it nearly killed you,' and he said, 'No, no, you've got it all wrong, you do not understand it; it saved me. That drug saved me. If I hadn't have taken that drug, I would have killed myself.' And I understand quite well from my own experience—although it wasn't as extreme as that—what he meant by that, which was that if you do live that life of abandonment and brutality and sexual assault and not getting the love that you want, then boy, why wouldn't you take something that makes you feel happy and gives you some relief from what's been happening in your life for the last however many years that that might be?[12]

The evidence presented to the Committee suggests it is too simplistic to conclude that cannabis use alone causes a person to develop a mental illness. Several factors relating to an individual's background and mental health need to be taken into consideration. Some cannabis use may be associated with mental health harms. However, key witnesses to the Inquiry believed the relationship is not always causal and that cannabis use and poor mental health can lead to one another.

FINDING 3: The causal link between cannabis use and some mental illnesses is unclear. Some people with existing mental health issues may be drawn to cannabis use to treat their symptoms and in doing so, exacerbate their mental illness further. For this group, cannabis use is a compounding factor rather than a cause.

3.3.2 Psychosis and schizophrenia

Psychosis is a group of symptoms that relate to how an individual thinks, feels and behaves. The onset of these symptoms may involve an individual seeing things that do not exist or believing things that are not true. Psychosis may be experienced as a one-off event, or it may form into an ongoing disorder, most commonly schizophrenia.[13]

The risks of developing psychosis are low for most people who use cannabis. However, those who use cannabis in line with certain risk factors face an increased risk. These risk factors are:

- frequency of use
- the potency of THC in the cannabis consumed

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12 Mr Andrew Hick, Circuit Breaker program, Odyssey House Victoria, public hearing, Beechworth, 28 April 2021, *Transcript of evidence*, p. 38.

13 Department of Health Commonwealth Government, *Schizophrenia and Psychotic Disorders*, <https://headtohealth.gov.au/mental-health-difficulties/mental-health-conditions/schizophrenia-and-psychotic-disorders> accessed 24 May 2021.

- predisposition to psychotic disorders, including from a genetic predisposition or previous mental ill health or trauma
- earlier onset of use.[14]

Frequency of use and high THC potency cannabis

In its submission, the Royal Australian and New Zealand College of Psychiatrists Victorian branch discussed the risks associated with high potency THC cannabis and frequent use. It noted that the risk of developing a psychotic disorder could be nearly five times higher in those who used cannabis daily with high potency THC:

> Daily cannabis use has been associated with increased odds of psychotic disorder, compared with no use, with these odds increasing to nearly five-times for daily use of high-potency types of cannabis. High-potency cannabis is where there is a greater concentration of THC.[15]

Dr Shalini Arunogiri from the Australian and New Zealand College of Psychiatrists Victorian branch added to this in her evidence, citing frequency of use and the THC potency as risk factors. However, she stated that this accounted for a small subset of users:

> For a small subset of cannabis users cannabis use itself may be a precipitating or maintaining factor for a range of mental health problems, specifically psychosis. Cannabis use has been linked to psychotic disorders, as you may have heard already today, with the frequency of use and the high-potency cannabis use elevating that risk.[16]

Mr Sione Crawford, Chief Executive Officer at Harm Reduction Victoria believed that the increase in mental health issues related to cannabis was likely related to the increased strength of cannabis available on the illicit market.[17]

The Penington Institute noted in its submission that high potency THC was a risk factor for psychosis, but explained that the harmful effects of THC could be offset by a high concentration of CBD:

> However, the effects of cannabis vary based on the levels of THC and CBD in different strains of the plant. Research has found a link between high-potency cannabis and the risk of psychosis, but only for cannabis with a high THC content; cannabis with CBD content similar to or greater than its THC content shows no increase in the risk of psychosis. This is because CBD dampens the effect of THC to a significant extent.[18]

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14 Royal Australian and New Zealand College of Psychiatrists, *Submission 1309*, p. 4.

15 Ibid.

16 Dr Shalini Arunogiri, *Transcript of evidence*, p. XXX.

17 Mr Sione Crawford, Chief Executive Officer, Harm Reduction Victoria, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, pp. 22–23.

18 Penington Institute, *Submission 1468*, p. 3.

Some stakeholders believed that a legalised and regulated cannabis market would allow for the regulation of some of the harmful aspects of the cannabis that is sold on the black market, including THC. Professor Alex Wodak, President of the Drug Law Reform Foundation outlined how a regulated cannabis market could provide safeguards in relation to THC content:

> Regulating cannabis gives us the opportunity to ensure that there are safeguards introduced into this market. The safeguards would include warnings on packaging about health risks, providing help-seeking information for people using cannabis and also advising consumers about the contents of the packet. That would allow consumers to know, most importantly, what the percentage of tetrahydrocannabinol—THC—is in the packet and to try and maintain consistency from batch to batch. This means we could attempt to reduce the harm from cannabis, and I hope we would take reducing the harm from cannabis as seriously as we take reducing the harm from other mood-altering drugs. So far all we have been concerned about is reducing the use of cannabis, but we should be trying particularly to reduce the harm.[19]

Mr John Ryan, Chief Executive Officer at the Penington Institute agreed that the use of psychoactive substances such as cannabis is potentially dangerous. However, he believed a regulated system would allow purchasers to know the THC content of the product and to make choices accordingly. In addition, he stated the CBD content of the plant could be regulated to offset the harmful qualities of THC:

> Well, I think all psychoactive substance use is potentially dangerous. I think what we should be trying to do is to have transparency in terms of the product at the very minimum, including packaging that describes the THC content, for example. But I think it is interesting that in the regulated markets there is a conversation typically, as I understand it, between the vendor and the purchaser around the different sorts of psychoactive consequences of that use, so if you want a more up, gregarious experience, then it is this particular strain and if you want a product that is good for creativity or deep thought, then this is a better product. So I think that sort of nuance is what you get provided in the regulated market, including stipulations around THC and CBD content. You do not get any of that in a decriminalised or illegal market as we have got at the moment.[20]

BOX 3.1: The difference between medicinal and recreational cannabis

Medicinal cannabis is generally different to recreational cannabis because the balance of the cannabinoids has been altered so that it may treat certain medical conditions. Medicinal cannabis can come in various forms such as oils or capsules. Medicinal cannabis products are produced to high clinical standards and prescribed by a doctor, with appropriate labelling. Medicinal cannabis is not the focus of this Chapter.

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19 Dr Alex Wodak, President, Australian Drug Law Reform Foundation, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, pp. 35–36.

20 Mr John Ryan, Chief Executive Officer, Penington Institute, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 46.

Predisposition to psychotic disorders and early onset of use

Another risk factor for the onset of psychosis is both predisposition to psychotic disorders and early onset of use. Dr Arunogiri said that people who have family or genetic factors that pre-dispose them to psychosis have a higher chance of developing psychosis from cannabis use:

> Psychosis is the one risk that we think that there is something there in terms of there being an association, particularly for individuals who are at high risk and here we mean there might be some familial or genetic factors that might be promoting that risk.[21]

Professor Dan Lubman from Turning Point agreed that there was an additional risk for those with an underlying vulnerability to psychosis, which could be compounded by early onset of cannabis use in young people:

> I think the evidence there is really clear around early onset use in young people. And the evidence really is, rather than the development of psychosis in people, in terms of what we know about those people who develop it, certainly much more about unmasking an underlying vulnerability to psychosis. We really need to pay attention to that, and we need to make sure, like we do with all our illicit drugs, that we have protections in place to make sure that young people who are vulnerable do not have access at that young age, as a teenager.[22]

In his submission, Professor Joe Boden from the University of Otago gave a summary of a study by Caspi et al. It suggested that the risk factors for developing psychosis were limited to a very small proportion of the population who both used cannabis heavily in adolescence as well as a genetic predisposition to psychosis:

> Caspi's study suggests that the vulnerability to psychotic illness exists only amongst those who have a particular variant (Val/Val) of the COMT gene, which is involved in dopamine regulation. This variant is found in 25% of the population, which shows that it is likely that to develop psychotic illness following cannabis use, a person must: a) be genetically predisposed; b) begin use at an early age (as dopamine regulation is "set" by early adulthood 6; and c): used heavily at an early age. This implies that the vulnerable group makes up a very small proportion of the population.[23]

Professor Lubman added that schizophrenia remains a rare condition and that there has not been an increase in psychosis and schizophrenia worldwide, despite an increase in cannabis use:

> At the moment I think one of the positives that we are seeing in what we have seen globally is there has not been an increase in the rate of psychosis and schizophrenia in the population, and that reinforces the idea that those people who smoke cannabis and develop schizophrenia are already people who are vulnerable in some way. So it is not

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21 Dr Shalini Arunogiri, *Transcript of evidence*, p. 28.

22 Professor Dan Lubman AM, *Transcript of evidence*, p. 5.

23 Professor Joe Boden, *Submission 1471*, p.1.

> creating schizophrenia in people who would not have that genetic predisposition. I think that speaks to the issue that schizophrenia is a very rare condition. It is a very damaging condition but it is a very rare condition. We know in Australia and around the world cannabis is heavily used by the population, and we have not seen, particularly with legalisation and decriminalisation, an increasing rate of psychosis globally.[24]

The view that the population level risk of schizophrenia due to cannabis use is low was also put forward in the submission from the Penington Institute. It noted that in Australia cannabis use only accounts for 2% of the burden of disease and injury due to mental ill health.[25]

The Penington Institute recommended that in light of these confined risks that harm reduction measures to educate people about the dangers of psychosis should be targeted at individuals with pre-existing vulnerabilities:

> These potential risks highlight the importance of a targeted cannabis education campaign around cannabis for people with pre-existing vulnerabilities. Such a campaign may be seen as analogous to approaches taken to other groups with specific vulnerabilities: rather than a ban on sugar, for example, people who have diabetes are educated around their sugar intake. The same approach can be taken with cannabis.[26]

This point was also raised by Ms Stephanie Tzanetis, DanceWize Program Director, Management Team at Harm Reduction Victoria. She suggested harm reduction measures should be targeted toward people who may be vulnerable to mental health harms:

> In regard to mental health, this is something where it is really important to tailor harm reduction education so people are really conscious of their individual risk profile and are aware of whether they are predisposed to a condition—say, schizophrenia—because there is some evidence that cannabis can exacerbate mental health conditions if someone is already predisposed.[27]

Finally, the Committee heard that not all who experience psychotic episodes because of cannabis use will develop long-term schizophrenia. Turning Point and Monash Addiction Research Centre's joint submission to the Inquiry discussed the risk of developing schizophrenia for those who do experience psychosis:

> An association between cannabis use and psychosis or schizophrenia has been recognized for over two decades. To date, the strongest evidence suggests that a link exists between cannabis use and the development of psychotic disorders in vulnerable individuals, due to underlying genetic and familial factors. Recent research suggests that the rate of conversion from cannabis-induced psychosis to schizophrenia could be as high as 50% of cases, almost double the rate associated with psychosis induced by

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24 Professor Dan Lubman AM, *Transcript of evidence*, p. 6.

25 Penington Institute, *Submission 1468*, p. 3.

26 Ibid.

27 Ms Stephanie Tzanetis, DanceWize Program Director and HRVic Management Team, Harm Reduction Victoria, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 20.

> other drugs. Evidence of a dose-response relationship points towards cannabis-induced psychosis being a specific risk factor for converting to schizophrenia, particularly amongst younger people (16–25 years) and males.[28]

The evidence presented to the Committee suggested that there is a risk of developing psychosis and schizophrenia amongst those who use cannabis in line with the risk factors discussed in this report. The likelihood of the development of these conditions in adults should be seen in the light of these narrow risk parameters.

FINDING 4: The population level risk for the development of psychosis and psychotic disorders as a result of cannabis use is very low.

FINDING 5: There is an increased risk of psychosis and psychotic disorders amongst those who use cannabis in line with the following risk factors:

- frequent use
- use of cannabis with a high THC potency
- a genetic or other predisposition to psychotic disorders
- early onset of use.

3.3.3 The impact on the developing brain

Cannabis use amongst young people and adolescents can cause neurological damage while the brain is still developing. This harm can alter cognitive and emotional functioning, including later in life and increase the risk of psychosis. Efforts should be made to prevent cannabis use or delay the onset of use.

The submission from the Royal Australian and New Zealand College of Psychiatrists Victorian branch gave an overview of the dangers to the developing brain from cannabis use. This includes poorer cognitive and emotional outcomes:

> Cannabis use during adolescence also impacts neurological development, and may lead to poorer cognitive and emotional outcomes later in life. Increasing cannabis use has also been associated with failure to obtain educational milestones, including high school completion, university enrolment and degree attainment.[29]

Dr Erin Lalor, Chief Executive Officer of the Alcohol and Drug Foundation stressed that as well as developmental harm, early use could increase the risk of mental illness:

> We know that adolescents are at greater risk of harm because the adolescent brain is undergoing significant development, and the use of any psychoactive drug, including cannabis, risks interfering with those processes. Some of the research suggests that

28 Turning Point, *Submission 1352*, p. 10.

29 Royal Australian and New Zealand College of Psychiatrists, *Submission 1309*, p. 8.

> cannabis use in adolescence is a risk factor for experiencing mental illness and that young people who have experienced trauma, have a family history of mental illness or possess other biological risk factors may be particularly susceptible to experiencing adverse effects from cannabis use.[30]

Mr Shane Varcoe, Executive Director, Operations at the Dalgarno Institute put forward his concerns about the risk of cannabis use amongst young people, noting that any level of use could be harmful:

> When it comes to the health of young people and their wellbeing it is really concerning because we know of their developing brain, and there is no credible voice in the marketplace in the scientific literature anywhere—anywhere—that says there is any such thing as any safe substance use of any kind for the developing brain'. There is no dissenting voice—'no safe substance use for the developing brain'. It is up to around 25 years of age. Sure, the damage might be minuscule, hardly detectable, but it is there. Again, in the literature no-one is saying , 'Yeah, you can smoke a bit of weed and it's going to be okay'. No, it will do some damage. How much damage and how early you start ramps it all up. The science is in on that.[31]

Given the harms associated with cannabis use amongst young people, delaying use for as long as possible, or preventing the use of cannabis altogether should be a key aim. Dr Arunogiri from Australian and New Zealand College of Psychiatrists Victorian branch argued that delaying onset of cannabis use could prevent mental health harms and cannabis dependence:

> I think we have really conclusive kind of evidence that delaying the age of onset of cannabis use is a positive thing. It actually reduces the risk of a whole range of harms but definitely the mental health harms. For instance, if people are initiating below the age of 12, we know that that is significantly high risk in terms of actually transitioning to becoming dependent on cannabis itself but also actually developing a whole range of other harms.[32]

An important measure to delaying and preventing cannabis use is education. Chapter 5 discusses drug education in Victorian schools and public health campaigns aimed at reducing cannabis use. It also notes education strategies from other Australian states and internationally.

An education campaign targeting young people could accompany the decriminalisation or legalisation of cannabis. Such a campaign could inform young people and the community about the dangers of cannabis and the developing brain.

Another tool for delaying the onset of cannabis use is legislation aimed at restricting the sale to young people. As discussed in Chapter 1, a legalised and regulated market for the sale of cannabis in Victoria could restrict access to cannabis by young people.

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30 Dr Erin Lalor, Chief Executive Officer, Alcohol and Drug Foundation, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 62.

31 Mr Shane Varcoe, Executive Director, Operations, Dalgarno Institute, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 58.

32 Dr Shalini Arunogiri, *Transcript of evidence*, p. 5.

FINDING 6: Cannabis use in adolescence can impact neurological development while the brain is still growing and maturing. This harm can alter cognitive and emotional functioning, including effects that occur later in life and increase the risk of mental illness.

FINDING 7: The risk of neurological damage caused by early onset cannabis use can be mitigated by measures such as education campaigns about the dangers of cannabis use for young people, and legalising cannabis and prohibiting its sale to young people.

3.3.4 Depression and anxiety

Some stakeholders to the Inquiry argued that cannabis use can cause depression and anxiety. However, the evidence presented to the Committee suggested the association is very mild. As well, it suggested that people with depression or anxiety may use cannabis to relieve their symptoms, making it difficult to determine the cause of the conditions.

For example, Dr Lalor from the Alcohol and Drug Foundation mentioned anxiety and depression as one of the mental health impacts of cannabis use:

> Regular or prolonged use can lead to dependence and withdrawal symptoms when ceasing use and is a risk factor for mental health impacts such as anxiety, depression and experience of psychosis.[33]

In its submission, Drug Free Australia provided a research paper which analysed association of cannabis use by adolescents and the risk of depression, anxiety and suicide.[34] The paper reviewed the results from 35 articles compromising 11 studies of a total of 23,317 individuals. It found that there is an odds ratio of 1.37 for developing depression and a 1.18 for developing anxiety due to cannabis use. An odds ratio of 1 indicates a neutral risk and a higher ratio indicates increased risk.

The study found that the odds ratio of 1.37 for depression 'indicate[s] that cannabis use during adolescence is associated with a moderately increased risk of depression in young adulthood'.[35] Conversely, it found that the odds ratio for anxiety was 'statistically insignificant'.[36] The authors cautioned that while the risk of depression was relatively low, 'the high prevalence of adolescents consuming cannabis generates a large number of young people who could develop depression and suicidality attributable to cannabis'.[37]

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33 Dr Erin Lalor, *Transcript of evidence*, p. 62.

34 The paper is titled *Association of Cannabis Use in Adolescence and Risk of Depression, Anxiety, and Suicidality in Young Adulthood, A Systematic Review and Meta-analysis.*

35 Gobbi et al., 'Association of Cannabis Use in Adolescence and Risk of Depression, Anxiety, and Suicidality in Young Adulthood, A Systematic Review and Meta-analysis', *JAMA Psychiatry*, 2019, E1.

36 Ibid.

37 Ibid., E6.

At a public hearing, Dr Arunogiri from the Royal Australian and New Zealand College of Psychiatrists Victorian branch noted the conflicting evidence relating to the risk of depression and cannabis use. She stated that the latest large-scale studies found a 'very modest, if any' association with cannabis use and depression:

> So what is necessary I think is to be able to look at specific studies and actually interpret them with the lens of what is applicable to, first of all, the Australian context, what is also applicable here and we think about specific harms. We have got some references in here, but we can also forward some other references in relation to depression and anxiety in particular which have highlighted depression on a population level. The most recent large-scale studies have actually found very modest, if any, association with depression and cannabis on a population level
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> ...
>
> In terms of anxiety, less so.[38]

Some submitters also noted that cannabis may be used to manage symptoms of depression and anxiety. For example, the Royal Australian and New Zealand College of Psychiatrists Victorian branch stated, 'For some young people struggling with symptoms of mental disorders, such as anxiety or depression, cannabis may be used to relieve symptoms'.[39]

The Penington Institute explained that jurisdictions with regulated cannabis markets could allow for a higher concentration of CBD in cannabis to help treat depression and anxiety. It noted that for some people CBD can help to medicate symptoms:

> In jurisdictions where cannabis production is regulated, the cannabis produced contains lower levels of THC and higher levels of CBD – a secondary psychoactive compound with numerous beneficial medicinal properties, including the treatment of mental health problems such as depression, anxiety and post-traumatic stress disorder.

The evidence provided to the Committee suggested that the association between cannabis use and depression and anxiety is very small. In addition, it is difficult to determine whether cannabis use causes depression and anxiety, or the other way around.

3.3.5 Cannabis use disorder

Cannabis use disorder (addiction) is a condition whereby an individual is dependent on cannabis. People with cannabis use disorder are at a higher risk of short-term memory impairment, mental health issues and respiratory diseases. Dependence may also impact an individual's finances, relationships, and employment.[40]

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38 Dr Shalini Arunogiri, *Transcript of evidence*, pp. 32–33.

39 Royal Australian and New Zealand College of Psychiatrists, *Submission 1309*.

40 Royal Australian College of General Practitioners, 'Cannabis use and its associated disorders: Clinical care', *Australian Family Physician*, vol. 45, no. 12, 2016, pp. 874–877.

Dr Arunogiri explained the risk factors for the development of cannabis use disorder. These are broadly in-line with the risk factors for the development of psychosis:

> So broadly speaking—I think we have got this in our submission—it is about one in five who have a risk of having a cannabis use disorder. But again, keeping in mind that high-potency risk that we talked about, with high-potency use that can go up. Risk is also associated with early use and high-frequency use, so when we are talking about that child of 12, certainly high frequencies of daily use as compared to, you know, past month use are in a completely different stratosphere in terms of that risk. And I think the other things that we have referenced there are people who have a history of trauma. Childhood trauma significantly increases that risk of a use disorder as well.[41]

Dr Erin Lalor from the Alcohol and Drug Foundation outlined the impact cannabis use disorder may have on individuals who develop it, including adverse mental health and social effects:

> Regular or prolonged use can lead to dependence and withdrawal symptoms when ceasing use and is a risk factor for mental health impacts such as anxiety, depression and experience of psychosis. People who are dependent on cannabis may experience negative impacts on their work, family and other social relationships. Additionally, the stigma associated with cannabis use and particularly with cannabis dependence can prevent people from asking for support, and this can lead to internalised feelings of shame and worthlessness.[42]

The Committee was provided with diverging estimates regarding the risk of developing cannabis use disorder for those who use cannabis. In its submission, the Victorian Alcohol and Drug Association stated that of 'Of those who use cannabis, 2.9% are deemed to be at high risk of harm, including dependency, amounting to 220,400 Australians aged 14 years and over'.[43] This figure was referenced from the Australian Institute of Health and Welfare's National Drug Strategy Household Survey, which collects population-level data. The Association also noted that overall, presentations to its member alcohol and other drugs services where cannabis was the primary drug of concern has fallen in the decade preceding 2018–19:

> Cannabis related treatment presentations have declined by 25% over the decade leading to 2018/19, from 25,365 to 19,196.[44]

However, Dr Arunogiri told the Committee that approximately 1 in 5 people who use cannabis will develop cannabis use disorder. She explained that the discrepancy with the 2.9% figure related to the population-level data collected by the National Drug Strategy Household Survey. Dr Arunogiri further noted that the Survey included those who have used in their lifetime or in the past 12 months in their data:

> I think first of all the national household survey is done on a population level and is done on a specific and much broader subset of individuals. I think the statistic that we will

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41 Dr Shalini Arunogiri, *Transcript of evidence*, p. 35.

42 Dr Erin Lalor, *Transcript of evidence*, p. 62.

43 Victorian Alcohol and Drug Association, *Submission 1390*, p. 5.

44 Ibid.

> draw back from—and again, I am happy to provide the original study and references—specifically looked at, once you have initiated, the likelihood to transition. That transition factor is really interesting. But the transition from recreational use to disorder, that is quite different from, say, any use or use in the past 12 months in comparison to using in a fashion that is actually problematic and regular, particularly in terms of frequency. We know that that high frequency has a significantly higher risk of a whole range of harms, and again drawing back to that idea of, for instance, any use in the past 12 months versus using every day—it is quite a different ballpark in terms of risk. So I think, again, that 2.9 per cent on a population level includes every harm. It includes the likelihood of dependence but also other mental health harms as well. And then here when we look at this statistic, this is about the likelihood of transition across if someone uses.[45]

The Committee also heard conflicting evidence about what the impact might be if cannabis were legalised in Victoria. Dr Kevin Sabet, President of Smart Approaches to Marijuana, an organisation based in the United States, believed that cannabis use disorder had increased in states where cannabis has been legalised due to its increased accessibility:

> The other side of this that I am very concerned about in the United States, that we have been witnessing, is really a marked rise, increase, in cannabis use disorder—otherwise known as addiction but really the clinical term is CUD, cannabis use disorder. We are seeing that, according to Deb Hasin's research from New York, one in three past year users will have achieved a cannabis use disorder, which is a remarkable number—30 per cent, because we used to say 10 per cent, 15 per cent. This is probably due to a number of factors, I think one being the availability and access and number two being the potency and strength of cannabis, and the normalisation of it as well.[46]

Health consultancy firm 360Edge highlighted in its submission results from a study in the United States which found that states that had legalised cannabis had only seen a small increase in cannabis use disorder:

> One study, found small increases in cannabis disorder in legalised jurisdictions in the United States. The proportion of respondents aged 12 to 17 years reporting cannabis use disorder increased from 2.18% to 2.72% after legalisation. The proportion of respondents 26 years or older reporting frequent cannabis use increased from 2.13% to 2.62% and those with cannabis use disorder, from 0.90% to 1.23%.[47]

A possible increase in the occurrence of cannabis use disorder if cannabis were legalised in Victoria is a concern to the Committee. The prevalence of cannabis use disorder in legalised jurisdictions such as the United States suggests a cautious approach is necessary, particularly when considering a legalised and regulated market for the sale of cannabis.

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45 Dr Shalini Arunogiri, *Transcript of evidence*, pp. 36–37.

46 Dr Kevin Sabet, President, Smart Approaches to Marijuana, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 11.

47 360Edge, *Submission 1350*, p. 8.

3.4 Risks to physical health from cannabis use

> We do the overdose report. I am very concerned that overdoses in Australia exceed the road toll, but we looked at cannabis in terms of contribution to overdose, and there is not a single overdose from single drug use cannabis.
>
> Mr John Ryan, Chief Executive Officer, Penington Institute, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 44.

As well as mental health risks, cannabis use can be harmful to physical health. However, it is important to note that there have been no overdose deaths in Australia from cannabis toxicity on its own.

The physical risks from cannabis use relate primarily to adverse health effects from smoking it, including with tobacco. In addition, cannabis use can impair drivers and cause injury and death on the roads.

According to the Penington Institute's *Annual Overdose Report*, there have been no deaths from cannabis use by itself. Mr John Ryan from the Penington Institute told the Committee:

> We do the overdose report. I am very concerned that overdoses in Australia exceed the road toll, but we looked at cannabis in terms of contribution to overdose, and there is not a single overdose from single drug use cannabis.[48]

However, the Committee heard that the prohibition of cannabis has resulted in alternatives such as synthetic cannabis becoming more attractive.[49] Synthetic cannabis is plant matter that has been sprayed with a psychoactive substance that mimics the intoxicating effects of cannabis. However, it does not contain cannabis itself. Like cannabis, it is usually smoked.[50]

Mr Matthew Hercus, Executive Director, Mental Health and AOD System Operations and Commissioning, Mental Health Division at the Department of Health, discussed the issue of synthetic cannabis. He noted that between 2017 and 2019 the Victorian Coroner found that synthetic cannabis contributed to up to 12 fatal overdoses.[51]

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48 Mr John Ryan, *Transcript of evidence*, p. 44.

49 Synthetic cannabis is illegal in Victoria following the introduction of *the Drugs, Poisons and Controlled Substances Amendment Act 2014*.

50 Youth Support and Advocacy Service, *Synthetic Cannabis*, <https://ysas.org.au/drugs-facts/synthetic-cannabis> accessed 9 June 2021.

51 Mr Matthew Hercus, Executive Director, Mental Health and AOD System Operations and Commissioning, Mental Health Division, Department of Health, public hearing, Melbourne, 1 June 2021, *Transcript of evidence*, p. 5.

Ms Sarah Helm, Executive Director of the New Zealand Drug Foundation, also told the Committee that synthetic cannabis contributed to drug overdose deaths in New Zealand:

> For example, we do not have many illicit drug related overdose deaths in New Zealand. In 2018 we had 40 to 45, and we have just had one in the last 48 hours to do with synthetic cannabinoids—all of them related to synthetic cannabinoids. We know, especially before synthetic cannabinoids came about, that even now some of those synthetic cannabinoid users would actually use cannabis if it was readily available.[52]

3.4.1 Smoking cannabis and co-use with tobacco

The dangers of smoking tobacco are very well documented. Australia has been a world leader in reducing tobacco use and preventing harms from smoking. Witnesses expressed concern that smoking cannabis on its own or mixed with tobacco could cause harms including increased risk of cancers and other illnesses.[53]

In Australia, one the most popular methods of ingesting cannabis is smoking it with tobacco in a rolled cigarette.[54] The National Drug and Alcohol Research Centre's Illicit Drug Reporting System reported that 97% of people who use cannabis consume it through smoking.[55]

A book extract submitted to the Inquiry by Professor Tom Decorte an academic from the University of Ghent gave an overview of why smoking is the preferred method of ingestion:

> The most common means of consumption is smoking cannabis, either in a sort of pipe, in a joint that only contains cannabis, or in which marijuana or hash is mixed with tobacco. Smoking cannabis is a popular method of use, because it's easy and not expensive. The effect of the product is quickly felt and allows the user to easily control the dose. Preparing and sharing a joint is also a social, shared experience to many.[56]

Ms Julia Daly, Operations Manager for Students for Sensible Drug Policy Australia suggested that cannabis is co-used with tobacco so the cannabis can be diluted, due to its high cost.[57]

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52 Ms Sarah Helm, Executive Director, New Zealand Drug Foundation, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 30.

53 Better Health Channel, *Cannabis (marijuana)*, <https://www.betterhealth.vic.gov.au/health/healthyliving/cannabis-marijuana> accessed 1 June 2021.

54 Dr Shalini Arunogiri, *Transcript of evidence*, p. 32.

55 Amy Peacock et al., *Australian Drug Trends 2020: Key Findings from the National Illicit Drug Reporting System (IDRS) Interviews*, National Drug and Alcohol Research Centre, UNSW, Sydney, 2021, p. 13.

56 Professor Tom Decorte, *Submission 1288*, p. 80.

57 Ms Julia Daly, Operations Manager, Students for Sensible Drug Policy Australia, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 12.

When cannabis is ingested via smoking, harms arise from both the cannabis and the tobacco. Less is known about the long-term physical harms from smoking cannabis alone. However, the Victorian Department of Health noted that it may have cancer causing properties similar to tobacco.[58]

Mr Gary Christian, Research Director at Drug Free Australia told the Committee that a study in the United States linked cannabis use to increased risk of cancer:

> In terms of genotoxic and mutagenic, what cannabis does is it actually shatters chromosomes, and when the body's DNA repair mechanisms try and put that together in a process called chromothripsis the DNA does not always get that right and so you have got your DNA in the wrong order. Of course that is going to spell harm to the body and usually manifests in cancers
>
> ...
>
> I have seen the charts for adult cancers in America, using CDC data tracking every cancer in America and looking at that as compared state by state—those states that have low cannabis use, those that have rising cannabis use—and this is just one cannabinoid only that was being tracked in this study: it is actually causing as many cancers as tobacco. Now, you know what we are trying to do with tobacco here in Australia. This is what we need to be doing with cannabis. These are very clear things.[59]

Mr Christian also noted another study from the United States which showed an increase in paediatric cancers in states that have legalised cannabis.[60]

The Committee acknowledges that smoking cannabis is harmful for the lungs and involves inhalation of carcinogenic substances.[61] It notes the stance from the American Centers for Disease Control and Prevention, which states that more evidence is needed to establish the link between smoking cannabis and cancer.[62] The Committee does not condone smoking cannabis and believes caution should be taken by individuals who do use cannabis in this regard.

Co-use of cannabis with tobacco can increase the risk of long-term nicotine addiction, and with it the risk of cancer related to tobacco smoking.[63]

Ms Daly from Students for Sensible Drug Policy Australia put forward the view that if there were a regulated market for cannabis, different methods for ingesting cannabis that do not involved smoking could be explored. This may include inhaling cannabis-infused vaping products and cannabis edibles. Ms Daly also believed that the

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58 Better Health Channel, *Cannabis (marijuana)*.

59 Mr Gary Christian, Research Director, Drug Free Australia, public hearing, Melbourne, 19 May 2021, *Transcript of evidence*, p. 37.

60 Ibid.

61 Alcohol and Drug Foundation, *Drug Facts: Medicinal Cannabis*, <https://adf.org.au/drug-facts/medicinal-cannabis> accessed 9 June 2021.

62 Centers for Disease Control and Prevention, *Marijuana and Public Health: Cancer Risk*, <https://www.cdc.gov/marijuana/nas/cancer-risk.html> accessed 11 June 2021.

63 Professor Tom Decorte, *Submission 1288*, p. 80.

tax income from cannabis sales could be directed into education programs about the dangers of co-use with tobacco. Although, as noted in Chapter 1, a taxation scheme would require cooperation from the Commonwealth Government.[64]

Dr Arunogiri from the Royal Australian and New Zealand College of Psychiatrists Victorian branch also believed that more education was needed for people who use cannabis regularly to be informed about the dangers of co-use of cannabis and tobacco. She noted that this was an 'underappreciated' aspect of cannabis use:

> Many people in Australia smoking cannabis would spin it with tobacco. I think that the harms associated with that are underappreciated in the sense that individuals seeking tobacco cessation are often a different group than individuals who are seeking cannabis cessation. When we actually look at cannabis cessation, there is not a whole lot of emphasis on helping that person also quit smoking tobacco as part of that process. I am aware of studies that have looked at, say for instance, pregnancy or neonatal outcomes as well. We know that again with tobacco mixed in with cannabis there are potential risks associated with the cannabis itself, but in fact the risks associated with the tobacco in that environment are significant as well and underappreciated. In terms of thinking of all the different options in terms of legislation, I think thinking about ways to minimise the use of tobacco and educate again about the risks of tobacco are important.[65]

The evidence presented regarding the harmful effects of smoking cannabis and tobacco, including the risks of cancer are concerning to the Committee. Although it is preferable from a public health perspective that people do not smoke cannabis, the Committee believes the harms from criminalisation are greater. These considerations are discussed in Chapter 4.

When considering options for the legalisation and regulation of cannabis, harm reduction measures including education about the dangers of cannabis co-use with tobacco should be considered.

3.4.2 Accidental injury and death on the roads

Accidental injury is the most common cause of death related to cannabis consumption. Of accidental deaths, the most common type is road traffic accidents. Driving while impaired by cannabis is a concern for the Committee and measures to prevent it should be explored.

In its submission, Victoria Police highlighted the risks of driving while under the influence of cannabis. It stated that 'Cannabis can slow down reaction times, distort perception of speed and distance, reduce concentration when driving, particularly in response to emergency situations'.[66] Victoria Police added that 'since 2015, collision

64 Ms Julia Daly, *Transcript of evidence*, p. 12.

65 Dr Shalini Arunogiri, *Transcript of evidence*, pp. 31–32.

66 Victoria Police, *Submission 901*, p. 4.

statistics indicate that the crash risk associated with cannabis use is double that of driving without drugs'.[67] It further outlined the proportion of crash deaths that involved cannabis use:

> Rolling 12-month collision data indicates that five per cent of lives lost on our roads involved the use of cannabis. Further, cannabis is the second most common drug identified through toxicology testing in transport accident deaths.[68]

However, Dr Erin Lalor from the Alcohol and Drug Foundation cautioned that while toxicology tests show whether a drug is present in a driver's system, they do not show the level of impairment and whether drug use was the cause of the crash:

> We know that drugs are present in I think around 13 per cent of serious crashes in Victoria. What we do not know is how many of those crashes were caused by the presence of drugs. We have to assume that it is a harm related to drug use, because we know that you do get impairment from drug use; we just do not know the level. So I think we are all interested in and committed to reducing drug-related harm. In this particular instance there is not enough evidence for us to know categorically how we should do that in the best possible way.[69]

The issue of cannabis impairment and driving is discussed in detail in Chapter 4.

Some submitters suggested that if cannabis were legalised there would be a corresponding increase in drug driving. In its submission, Smart Approaches to Marijuana noted that in the United States, states which had legalised cannabis saw an increase in driving under the influence of cannabis:

> One of the greatest concerns that comes with marijuana legalization is the increase in driving under the influence of marijuana. Marijuana-related traffic fatalities have been shown to increase in American states that legalized the drugs. A study conducted by AAA found a doubling in marijuana-impaired driving deaths in Washington State since legalization.[70]

However conflicting evidence was presented about other jurisdictions where cannabis has been legalised. For example, the Committee heard from Mr Michael Pettersson MLA, Member for Yerrabi in the Australian Capital Territory (ACT) Legislative Assembly who introduced a private members Bill to legalise adult personal use in the ACT in 2019. He noted that neither drug driving nor cannabis-related hospital presentations had increased:

> According to ACT police, drug driving offences have remained steady. And according to ACT Health, legalisation has not increased the number of cannabis-related hospital presentations. These are of course early numbers and very blunt measures, but they do not spell the doom that many predicted.[71]

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67 Ibid.

68 Ibid.

69 Dr Erin Lalor, *Transcript of evidence*, p. 70.

70 Smart Approaches to Marijuana, *Submission 1194*, p. 5.

71 Mr Michael Pettersson MLA, ACT Legislative Assembly, public hearing, Melbourne, 19 May 2021, *Transcript of evidence*, p. 19.

Ms Laura Bajurny, Information Office at the Alcohol and Drug Foundation explained that in Canada drug driving has slightly decreased since legalisation, due partly to a strong public education campaign:

> So since legalisation, from 2018, they have seen the number of people reporting driving within 2 hours of smoking or vaporising cannabis, which is when someone is more likely to be intoxicated, come down. In 2018 it was 27 per cent and in 2020 it is 19 per cent—still far too many people, but clearly something is working there. There have been major changes to drug-driving laws and there have been big awareness programs, some of which were quite humorous, which can be a good way to cut through the noise and get your message across. But yes, they are seeing positive shifts in people driving after using cannabis.[72]

The Committee believes there are risks associated with driving under the influence of cannabis. The assessment of the risks provided by Victoria Police suggested that the danger of crashing and road fatalities is increased when driving while impaired by cannabis.[73] These risks extend not just to impaired drivers but to other road users.

If cannabis were legalised in Victoria, it could be accompanied by a campaign regarding cannabis use and road safety. The evidence provided by the Alcohol and Drug Foundation showed that the approach taken in Canada to raise awareness of the risks of driving has had some preliminary success.[74]

In addition, measures to detect drivers who are impaired by cannabis use and appropriate penalties are another important tool to keep dangerous drivers off the roads. This issue, including the adequacy of current impairment tests, is discussed in Chapter 4.

RECOMMENDATION 5: That the Victorian Government implements a road safety awareness campaign to highlight the dangers of driving while intoxicated by cannabis.

3.5 The harms of cannabis use in comparison to other drugs

As has been outlined in this Chapter, cannabis use can be harmful in certain situations and for certain groups of people. It is useful to put these harms in perspective to those caused by other drugs, both legal and illegal, when deciding on the overall harm that can be caused by cannabis.

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72 Ms Laura Bajurny, Information Officer, Alcohol and Drug Foundation, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 69.

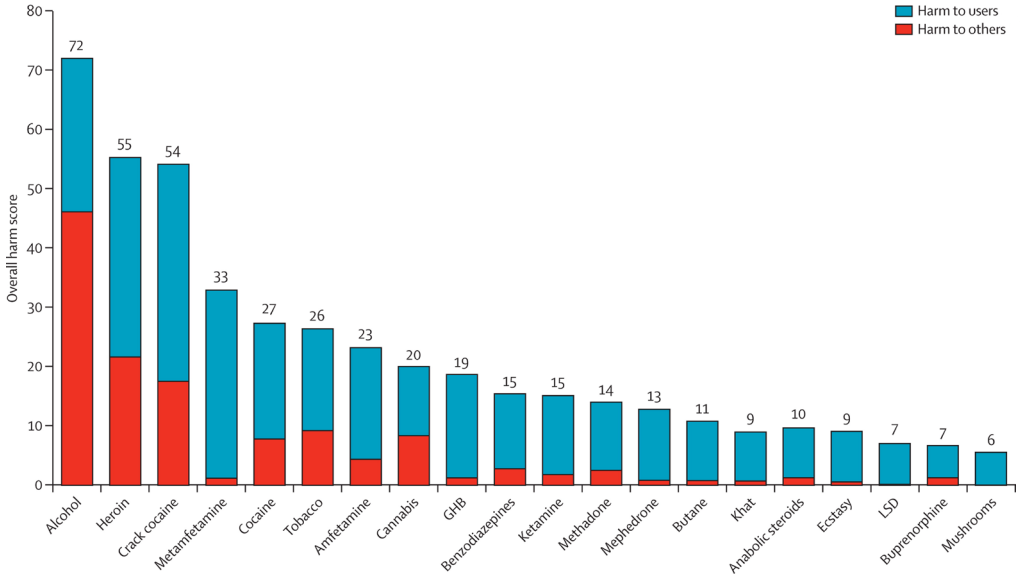
73 Victoria Police, Submission 901, p. 4.

74 Ms Laura Bajurny, Transcript, p.69.

The Committee was provided a research paper by Professor David Nutt et al. from the United Kingdom's Independent Scientific Committee on Drugs.[75] The paper ranked the harms of legal and illegal drugs in the United Kingdom based on the harm caused to users and the harm caused to others. The paper used several criteria points to assess the harms including physical, psychological and social harms.

The results of the study shown in Figure 3.3 below found that alcohol ranks as the most harmful drug, followed by heroin and crack cocaine. Of the 20 drugs shown, cannabis was rated as the 8th most harmful drug.

Figure 3.3 Ranking of the most harmful legal and illegal drugs in the United Kingdom in 2010



Source: Professor David J. Nutt et al., 'Drugs harms in the UK: a multicriteria decision analysis', *The Lancet*, vol. 376, no. 9752, 2010.

A similar exercise to rank the drug harms in Australia was carried out in 2019 by Yvonne Bonomo et al.[76] The study found the most harmful substances to users was fentanyl followed by heroin and methamphetamine. The most harmful substances to others were alcohol, followed by methamphetamine and tobacco. However, a supplementary analysis taking into account the prevalence of certain drugs ranked cannabis behind alcohol, tobacco and methamphetamine.[77]

Dr Shalini Arunogiri from the Royal Australian and New Zealand College of Psychiatrists Victorian branch cited the United Kingdom study and noted its findings regarding the relative low levels of harm for cannabis:

> This is certainly not a new drug. It has been around for a very long time and used very widely in Australia for a very long time, so we certainly have lots of population-level data in terms of levels of use, in terms of population-level harms and also of population-level appreciation of lack of harm too. So, for instance, to draw back to a number of

75 Professor David J. Nutt et al., 'Drugs harms in the UK: a multicriteria decision analysis', *The Lancet*, vol. 376, no. 9752, 2010.

76 Yvonne Bonomo et al., 'The Australian drug harms ranking study', *Journal of Psychopharmacology*, vol. 33, no. 7, 2019.

77 Ibid.

> consensus and priority statements both in the UK and Australia recently that have looked at addiction professionals and mental health professionals and ranking drugs in terms of ranking drugs in relation to harm, cannabis here rates very low among the risks of harms. Usually alcohol and tobacco are rated the highest in terms of actual risk of harms in terms of physical and mental health harms.[78]

Professor Tom Decorte said that alcohol was far more harmful and noted the possibility for cannabis use to replace alcohol use amongst some people in a legalised and regulated market:

> as you know, we can rank all the drugs that we know in our society according to the harm they can cause to the individual who consumes them and the harm they can bring to society and people around the consumer, and we know that alcohol is always on the top of the list. It is one of the hardest, one of the most risky drugs. It has more risks than cannabis, and it is also associated with more harm to the environment of the user in terms of violence, sexual violence, domestic violence et cetera. So if it is true that people, when cannabis is legalised, in global consume less alcohol, this is a public health benefit I would say.[79]

The harms associated with cannabis, while serious, should be considered in comparison to those that accompany other legal and illegal drugs. For this reason, the Committee recommends that the Victorian Government consider the impacts of legalising cannabis for personal adult use, but not for other illicit drugs.

3.5.1 A comparison of harms relating to health and the criminal justice system

This Chapter has focused on the mental health and other health harms associated with cannabis use. While the use of cannabis is not condoned by the Committee, it must acknowledge that the majority of stakeholders noted the most harmful aspect of cannabis use—both to individuals and society—occurs when individuals come into contact with the criminal justice system. Harms associated with encountering the criminal justice system include loss of employment and housing, and restrictions around international travel.[80]

In her submission Dr Kate Seear, an Associate Professor at Latrobe University and a leading expert on drug law and policy, stated that criminalising drug use could lead to disadvantage and exacerbate social problems which drug laws aim to address:

> This is a subject about which much has been written, including work I have published examining the role that drug laws can play in producing the very problems it hopes to address, by exacerbating social disadvantage, and generating problems as a consequence of criminalisation, such as the persistent effect of criminal records on employment, housing, welfare and so on

78 Dr Shalini Arunogiri, *Transcript of evidence*, p. 32.

79 Professor Tom Decorte, Director, Institute for Social Drug Research, University of Ghent, public hearing, Melbourne, 9 June 2021, *Transcript of evidence*, p. 13.

80 Dr Erin Lalor, *Transcript of evidence*, p. 63.

> ...
>
> In short, the impacts of cannabis use are inherently tied up with, inseparable from and shaped by law and policy itself. As such, I encourage the Committee to think broadly about cannabis 'impacts' and related issues (such as health and safety), since these matters cannot be investigated without also reflecting on the way that legal and policy frameworks shape how we come to understand cannabis and what it does to people and to communities.[81]

Similarly, the Alcohol and Drug Foundation noted that a criminal record could cause long-term damage to an individual's future and their integration with society.[82]

The Public Health Association of Australia said that criminal records may lead to longer lasting harms for users. It suggested programs that support protective factors against problematic drug use such as engagement with family, community and education can lead to better outcomes:

> Responses which result in a criminal record and incarceration may lead to more lasting harm to the user than may be cause by the use of the drug. In contrast, strengthening and supporting personal and social protective factors reduces the likelihood that young people will engage in problematic drug use, and promotes mental and physical health and wellbeing. This includes many social determinants of health including family relationships, education, employment and housing.[83]

The Committee believes it is important to put the individual mental health and other health impacts of cannabis use in perspective against the more harmful impacts arising from criminalisation. The foremost amongst these is a criminal record which can have ongoing implications for an individual's employment and other prospects. This can entrench social disadvantage and in turn lead to more drug use. The Committee has previously explored and reported on this issue in detail in its Inquiry into a legislated spent convictions scheme.

The impact of the criminalisation of cannabis is discussed in detail in Chapter 4.

Programs to address social disadvantage and promote protective factors to prevent drug use are discussed in Section 3.7.

FINDING 8: The harms that arise from the criminalisation of cannabis affect a larger number of people and have a greater negative impact than the mental health and other health harms associated with cannabis use.

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81 Dr Kate Seear, *Submission 1384*, p. 3.

82 Alcohol and Drug Foundation, *Submission 1386*, p. 4.

83 Public Health Association of Australia, *Submission 1391*, p. 5.

3.6 Victoria's alcohol and other drugs sector

Victoria's alcohol and other drugs sector provides treatment and support to Victorians experiencing dependence on alcohol or other drugs, including cannabis. The services are largely provided by non-government organisations, community health organisations and hospitals. Funding is primarily provided by the Department of Health.

The treatment options provided by the alcohol and other drugs sector include:

- counselling
- alcohol and drug withdrawal programs, both non-residential and residential
- rehabilitation programs, both non-residential and residential
- care and recovery coordination
- pharmacotherapy
- specialist harm reduction services.[84]

There are also population-specific services for young people, Aboriginal and Torres Strait Islander Victorians, and forensic services for people engaged with the criminal justice system.

Mr Matthew Hercus from the Department of Health explained the treatment pathway for a person entering the alcohol and other drugs sector from entry to assessment through to treatment:

> With regard to the treatment system, the Victorian government has a statewide intake model and area-based entry points into the alcohol and other drugs system. DirectLine, via telephone or via a website, provides 24-hour, seven-day counselling, information and referral support. Across the state service access can be facilitated by individuals directly contacting a local intake provider. People seeking treatment may also be referred to intake services from a range of other health and human services providers, including general practitioners. Following intake, a person is referred for a comprehensive biopsychosocial assessment, after which referrals then occur to the services that meet their needs as identified in the core services previously referenced. Individuals can also be referred to services that they may need outside the drug and alcohol system; for example, mental health and family violence support services. Access to targeted youth and Aboriginal drug and alcohol services is available through direct self-referral to those providers.[85]

Mr Hercus said that cannabis is the third most common drug of concern for people seeking treatment in Victoria, noting that 19% of clients in the Victorian system were admitted with cannabis as the principal drug of concern.[86]

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84 Mr Matthew Hercus, *Transcript of evidence*, p. 4.

85 Ibid.

86 Ibid.

The Royal Commission into Mental Health tabled its Final Report in the Legislative Assembly on 2 March 2021, part way through this Inquiry.[87] Given the intersections between the mental health and alcohol and other drugs sectors, the Royal Commission gave in-depth consideration to Victoria's alcohol and other drugs sector and its capabilities. It noted that Victoria's current alcohol and other drugs sector has strengths, including that it:

- puts consumers at the heart of decision making, with the tools, approaches and models of care in the alcohol and other drug sector, based on staff walking alongside people, hearing what their issues are, and developing interventions that work for them
- has a peer workforce that includes many people with a lived experience of substance use or addiction and recovery
- recognises the need to respond to the needs of consumers in a holistic way that understands the complexities of their support needs and their life circumstances
- acknowledges the relationship of trauma and distress and substance use or addiction
- offers therapeutic alternatives to medication and care and recovery coordination
- offers treatment, care and support that is compassionate and non-judgemental
- is proficient in partnerships with other systems and organisations.[88]

The recommendations of the Royal Commission into Mental Health regarding alcohol and other drugs services are discussed in detail in the following sections.

Along with the considerations of the Royal Commission, the Committee was provided evidence that Victoria's alcohol and other drugs sector has significant issues regarding lack of resources. This is particularly true in regional and rural Victoria, which as noted in Chapter 2 has a higher per-capita rate of use than metropolitan Melbourne. This lack of resources extends to workforce shortages, with a lack of addiction specialists being the primary concern.

In addition, there is a lack of integration between the alcohol and other drugs sector and the mental health sector, which means people in need of treatment for both issues have difficulty accessing services.

3.6.1 Resourcing and workforce needs

Key stakeholders in Victoria's alcohol and other drugs sector including the Victorian Alcohol and Drug Association, the Royal Australian and New Zealand College of

87 Victoria, Legislative Assembly, 2 March 2021, *Parliamentary debates*, p. 651.

88 *Royal Commission into Victoria's Mental Health System*, p. 308.

Psychiatrists Victorian Branch, and Gateway Health told the Committee that Victoria's alcohol and other drugs sector is under-resourced, particularly in relation to:

- services statewide, but particularly in regional and rural Victoria
- workforce needs.

Mr Sam Biondo, Executive Officer of the Victorian Alcohol and Drug Association spoke about the need for additional funding to the alcohol and other drugs sector. He noted that there is an unmet demand for services:

> I think that definitely we need to balance up the harm created. If you are looking at a multibillion dollar—and I am talking big, big, lots of billions of dollars—industry that is creating the harm, and then you have an alcohol and drug system that is supposed to run on the smell of an oily rag, be it several hundred million dollars, and you know that nationally half a million people who could and want to get access to alcohol and drug treatment but cannot, then really we need to balance it up.[89]

Mr David Taylor, Policy and Media Officer at the Victorian Alcohol and Drug Association added that the ratio of alcohol and other drugs treatment beds per 10,000 people in Victoria is well below that of New South Wales and Queensland:

> Victoria has, building in the welcome uplift in residential rehabilitation in the past few years, 0.71 beds per 10 000 head of population. This sits well below New South Wales and Queensland, which both float around 1 to 1.1. Now, they may have had more beds since we did this data, so it may actually be a greater difference still. I think our position has generally been at least to put us on par with those other jurisdictions, that we should seek to lift it to 1, so we probably need something similar to the uplift which was put in a couple of years ago. We would need something similar to that again to lift us to that figure.[90]

This shortage of alcohol and other drugs services is most acute in regional and rural Victoria. Yet as noted in Chapter 2, cannabis and other illicit drug use per person is higher in regional areas. Mr Biondo outlined the lack of funding for alcohol and other drugs services in regional and rural Victoria and the difficulties in the recruitment and retention of qualified staff:

> in many parts of regional Victoria the rate per capita of cannabis-related hospitalisation surpasses that in the metro area, yet health service capacity, including AOD [alcohol and other drugs] treatment in those areas, is far lower in regional areas. For too long alcohol and drug treatment in rural and regional Victoria has been hobbled by the tyranny of distance, limitations in resources as well as a significant issue with the recruitment and retention of staff. This has to come into play as one of the factors used to mitigate the harms of cannabis in Victoria.[91]

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89 Mr Sam Biondo, Executive Director, Victorian Alcohol and Drug Association, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 24.

90 Mr David Taylor, Policy and Media, Victorian Alcohol and Drug Association, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 24.

91 Mr Sam Biondo, *Transcript of evidence*, p. 20.

The issues regarding resourcing to the alcohol and other drugs sector are known by the Victorian Government. The Victorian Alcohol and Drug Association's State Budget submission from 2020–21 noted increased wait times to access services, leading to a growing number of unregulated private rehabilitation facilities that may exploit vulnerable Victorians:

> As a result of the inadequate resourcing of the sector, voluntary clients in particular are incurring increased waiting times for treatment. Such issues and waiting times are further compounded when considering trends such as the burgeoning prison population and their complex AOD [alcohol and other drugs] needs on release.
>
> One perverse result of the AOD [alcohol and other drugs] system's lack of capacity is the creation of fertile ground for unregulated 'for profit' treatment facilities. Some of these private operators exploit desperate and vulnerable Victorians by promising fast and significant results, while providing high-cost programs often with little evidentiary basis.[92]

Another area where the alcohol and other drugs sector is underfunded is in its ability to treat co-occurring mental health conditions. The Royal Commission into Mental Health reported on this lack of resources, particularly a lack of access to mental health or medical addiction specialists.[93]

At a public hearing, Dr Arunogiri from the Royal Australian and New Zealand College of Psychiatrists (Victorian Branch) spoke about workforce shortages for addiction specialist doctors.[94] She explained that Victoria has only 25 Equivalent Full Time (EFT) roles for addiction specialists. This comparatively low number of specialists means that even in central Melbourne it is difficult to access the services of an addiction specialist doctor:

> for Victoria, in comparison, say, to New South Wales, we really lag behind in terms of numbers of professionals. In total across the state I think we have about 25 EFT, so that is 25 full-time specialty positions. That is not 25 specialists. Half of those are people in training, so trainee registrars and doctors. If we actually look at somewhere in the realm of about 15 EFT in total, across the whole of the state, and again there is a rural, regional and metropolitan divide there. Even if you are square in the middle of East Melbourne, you would still struggle to be able to find an addiction specialist. Succession planning is another issue that has been brought up with addiction specialty, with a significant proportion planning to retire in the next five to 10 years, and then not increasing kind of space for new professionals coming in.
>
> So based on those modelling statistics I think the thinking is that we would need somewhere in the region of about 70 more specialty physicians to be able to be actually funded and have capacity to have that, and in the initial estimate that I told you in terms

92 Victorian Alcohol and Drug Association, *State Budget Submission 2020/21*, p. 5.

93 *Royal Commission into Victoria's Mental Health System*, p. 319.

94 Addiction specialists are medical doctors (both physicians and psychiatrists) who have advanced training in addiction, including drug and alcohol addiction. (ibid., p. 335.)

> of 25, that includes the private mental health sector too. So that actually did not include just the public mental health sector, so it is quite woeful in comparison to many of the other specialties.[95]

In its 2021–22 budget, the Victorian Government announced support for the recommendations of the Royal Commission into Mental Health. Several of the initiatives that received funding relate to the alcohol and other drugs sector, recognising the close relationship between mental health and drugs and alcohol. The Government announced that new addiction medicine specialist hubs will be established and that funding has been provided for workforce training to treat both alcohol and other drug and mental health issues.[96]

Mr Matthew Hercus from the Department of Health expanded on how the Government intended to implement the recommendations of the Royal Commission:

> In the implementation of the royal commission's recommendations and looking at long-term sustainability of the specialist drug and alcohol treatment system, the department will be reviewing and undertaking statewide and regional planning, assessing demand and reviewing key enablers of both systems, such as funding models. In this way, the department is looking to improve access and support for both substance use, addiction and mental health concerns, including ensuring appropriate access to integrated care.[97]

He also informed the Committee that a review of the workforce needs of the mental health sector and alcohol and other drugs sector will take place by the end of 2021.[98]

The Committee welcomes the Government's review of the alcohol and other drugs and mental health sectors, including funding and workforce needs. The information received regarding the adequacy of funding for the alcohol and other drugs sector showed that it is not sufficient to meet the demand for services, particularly in regional and rural Victoria.

Crucially, the Royal Commission into Mental Health recommended the creation of a new statewide mental health and drug and alcohol specialist service to ensure the two sectors are better integrated. This will be discussed in Section 3.6.2 below.

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95 Dr Shalini Arunogiri, *Transcript of evidence*, p. 34.

96 Department of Treasury and Finance, *Victorian Budget 2021/22 Paper No. 3: Service Delivery*, 2021, p. 11.

97 Mr Matthew Hercus, *Transcript of evidence*, p. 6.

98 Ibid.

3.6.2 Mental health and alcohol and other drug sector integration

As noted by the Royal Commission into Mental Health and highlighted by stakeholders to the Inquiry, mental health and alcohol and other drugs issues are closely related. Currently, Victoria's alcohol and other drugs sector is not equipped to deal with these co-occurring problems due to inadequate resourcing and a lack of staff trained in both disciplines.

According to the Royal Commission into Mental Health, the alcohol and other drugs sector was separated out from the mental health sector in the 1990s. This was a result of the move towards a community-based services model for mental health and drugs and alcohol.[99]

While the community-based services model has led to better outcomes for clients of mental health and alcohol and other drugs services,[100] the separation has led to people with more complex support needs facing barriers to access services concurrently.[101]

Mr Andrew Hick from Odyssey House Victoria described the high percentage of his clients who experience mental ill-health as well as drug and alcohol issues:

> What I can say with our beds is that around about 60 to 65 per cent of the people who come to us will have a co-occurring mental disorder; usually depression and/or anxiety, but around 5 per cent have a serious mental illness, and that is usually schizophrenia. We do not exclude anyone on those grounds. It might take a little bit longer if you're a schizophrenic to come to Circuit Breaker because we've only got 15 beds and we want to limit the amount of people who are there with serious mental problems at any one time, so we can give them the best possible treatment.[102]

Dr Shalini Arunogiri from Royal Australian and New Zealand College of Psychiatrists Victorian branch believed that there needs to be more integration between the mental health and alcohol and other drugs sectors. She noted that significant investment is required to ensure appropriate treatment:

> People who have problematic cannabis use may also have a whole range of other complex psychosocial comorbidities and mental health comorbidities, including, for instance, psychosis, which is a severe mental illness that requires tertiary mental health capacity to address it. So within that specialty there is really a lack of capacity to be able to address that at the moment. In order to skill up and be able to train enough professionals, I think it really requires quite a significant kind of commitment and capacity to invest in this space.[103]

The Committee is aware of efforts undertaken by clinicians to promote training and cooperative working arrangements between the alcohol and other drugs and mental

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99 *Royal Commission into Victoria's Mental Health System*, p. 320.

100 Valerie Gerrand et al., 'Reforming mental health care in Victoria: a decade later', *Australas Psychiatry*, vol. 15, no. 3, 2007, pp. 181–4.

101 *Royal Commission into Victoria's Mental Health System*, p. 310.

102 Mr Andrew Hick, *Transcript of evidence*, p. 34.

103 Dr Shalini Arunogiri, *Transcript of evidence*, p. 34.

health sectors. One of the key initiatives is the Victorian Dual Diagnosis Initiative which is a network that supports the development of better treatment practices and collaboration across the two sectors. The initiative is funded by the Department of Health.[104]

Box 3.2 outlines the functions of the dual diagnosis initiative.

BOX 3.2: The Victorian Dual Diagnosis Initiative role description

The Victorian Dual Diagnosis Initiative's target group is mental health and alcohol and other drug treatment workers who require support to respond to clients with concurrent alcohol and other drug and mental health issues. The initiative includes the following functions:

- Develop co-operative working relationships between mental health and alcohol and other drug treatment services within the relevant service area. This should particularly address areas of access, assessment and the development of effective treatment planning.
- Provide training and consultation to all community mental health and alcohol and other drug treatment services within the catchment with a strong focus on building capacity within the services to respond more effectively to people with a dual diagnosis.
- Provide direct service to clients with a serious mental illness and substance use problems with a focus on developing and modelling good practice. This may be by providing a limited direct service and intensive support/consultation to case managers on specific cases.

Source: Victorian Dual Diagnosis Initiative, *Available Services / Contact Details / Policy Context*, <https://www.dualdiagnosis.org.au/home/images/VDDI/VDDI-Role-Contacts-Policy-Context-May-2021.pdf> accessed 7 June 2021.

The Royal Commission into Mental Health commended the work of the Victorian Dual Diagnosis Initiative. It recommended the creation of a new statewide service for mental health and drug use or addiction to improve the treatment of people requiring both mental health and alcohol and other drugs support:

> The Royal Commission recommends that the Victorian Government:
>
> 1. establish a new statewide specialist service, built on the foundations established by the Victorian dual diagnosis Initiative, to:
>
>   a. undertake dedicated research into mental illness and substance use or addiction;
>
>   b. support education and training initiatives for a broad range of mental health and alcohol and other drug practitioners and clinicians;

104 Victorian Dual Diagnosis Initiative, *Available Services / Contact Details / Policy Context*, <https://www.dualdiagnosis.org.au/home/images/VDDI/VDDI-Role-Contacts-Policy-Context-May-2021.pdf> accessed 7 June 2021.

c. provide primary consultation to people living with mental illness and substance use or addiction who have complex support needs; and

d. provide secondary consultation to mental health and wellbeing and alcohol and other drug practitioners and clinicians across both sectors.

2. as a matter of priority, increase the number of addiction specialists (addiction medicine physicians and addiction psychiatrists) in Victoria.

3. work with the Commonwealth Government to explore opportunities for funded addiction specialist trainee positions in Victoria.[105]

The Committee supports the recommendation and notes that the functions of the statewide service will include training for clinicians in both disciplines and care for people with mental health and drug and alcohol issues. The Committee also supports the recommended increase in the number of addiction specialists.

Mr Matthew Hercus from the Department of Health noted that Victorian Government is currently establishing the statewide service for mental health and drug and alcohol issues as part of implementing the recommendations of the Royal Commission.[106]

The recommendations of the Royal Commission were largely welcomed by Inquiry stakeholders. However, Professor Lubman from Turning Point highlighted the need for better resourcing of the alcohol and other drugs sector to ensure the new service meets the needs of Victorians:

> We really welcome the recommendations around integration. I think one of the things to say, though, is that the purview of the royal commission was wholly on the mental health system, and while it has made some recommendations around integration, its remit was not to look at the alcohol and drug system. I suppose our concerns remain. This is the opportunity I think for the royal commission, but while we all look at the redesign of the mental health system I suppose one of our concerns is that that will not see an increase in the necessary support and functioning around the alcohol and drug system and the necessary investment in terms of providing specialist support in that system.[107]

The Committee welcomes the creation of the specialist service for mental health and drug and alcohol issues. This aligns with the evidence provided by stakeholders to this Inquiry that more needs to be done to ensure the two sectors work together. The Committee agrees however, that in reforming the mental health system that the alcohol and other drugs sector should not be left behind.

The alcohol and other drugs sector should be included in the workforce and funding reviews arising from the Royal Commission into Mental Health which the Department of Health is conducting. This should include an assessment of the demand for alcohol and other drugs services statewide to cater to the demand of Victorians seeking treatment for problematic alcohol and drug use, particularly in regional and rural Victoria.

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105 *Royal Commission into Victoria's Mental Health System*, p. 284.

106 Mr Matthew Hercus, *Transcript of evidence*, p. 5.

107 Professor Dan Lubman AM, *Transcript of evidence*, p. 6.

3.7 Protective factors and prevention of harmful illicit drug use

Some of the issues that lead to problematic illicit drug use, including cannabis, stem from social and economic disadvantage. Prevention programs can identify vulnerable or disadvantaged young people. They can also promote protective factors against drug use, such as engagement with family, community, education and employment.

In its submission, the Alcohol and Drug Foundation highlighted the social determinants that can lead to problematic drug use:

> the drivers of drug use are the confluence of the personal characteristics and attributes of the individual, the nature and properties of the substances consumed, and the environment and culture which creates norms and expectations of substance use. These include family conflict, peer influence, mental health problems, early and excessive alcohol and other drug use.[108]

This view was also put forward by Professor Tom Decorte an academic from the University of Ghent:

> To add to that, we can focus on drug policy, but what is often forgotten in these debates about which regulatory model would be the best is that … the breeding ground for drug problems, the most fundamental causes of drug problems in our society, need to be tackled by having a poverty policy and an education policy and by including people. So drug policy is a part of a much broader social policy in society. I do believe that a society which excludes more members—where there is a larger amount of social inequity, where there is a lot of discrimination, where there is a lot of pain, where there is a lot of unwellness or ill being—will have more drug problems. So if you want to have less drug problems, including cannabis abuse and cannabis-related problems, it is also important to invest enough in a much broader social policy—because it is often the people that are excluded from society, the people that have unfinished trauma and pain, that get into trouble with drugs, whether it is cannabis or alcohol or any other drug, or different drugs together.[109]

The Alcohol and Drug Foundation also highlighted the importance of prevention programs that seek to address social and economic disadvantage:

> Prevention plays a critical role in reducing the risk factors associated with problematic cannabis use. Prevention also plays a key role in targeting and strengthening personal and community protective factors to keep people healthy and well. These approaches focus on promoting and improving positive mental, social and physical health outcomes. The evidence base highlights a range of factors that prevent AOD [alcohol and other drugs] harms in young people including: I) assisting young people maintaining positive relations with parents and other family members; ii) enjoying school, completing school or leaving to take up employment pathways; iii) having firm attachment to adult role

108 Alcohol and Drug Foundation, *Submission 1386*, p. 4.

109 Professor Tom Decorte, *Submission 1288*, p. 12.

> models outside the home such as teachers, sporting coaches and/or youth leaders; iv) developing future-oriented recreational pursuits; and v) living in communities with lower levels of drug use.[110]

The Public Health Association of Australia agreed that programs that target protective factors can minimise the harms of cannabis use. It noted there may be evidence to indicate the kinds of programs that are effective include:

- education and skills
- training interventions
- family interventions
- brief intervention
- motivational interviewing strategies.[111]

The Committee was provided examples of preventative programs that seek to strengthen engagement in education, employment, family and the community for at-risk young people. These programs have been successful in preventing and reducing drug use.

Some drug prevention programs are aimed at educating students in schools about drug harms. There are also broader public health education campaigns targeting specific types of drug use. These education programs are discussed in Chapter 5.

3.7.1 The Planet Youth program ('Iceland model')

The Planet Youth program is a drug prevention program which operates within schools. It has operated in Iceland for over 20 years and has since been replicated in other countries. It aims to prevent drug use amongst young people by strengthening protective factors that will lead to less drug use. This includes promotion of involvement in sport, the school community and family relationships.[112]

At a public hearing, Dr Erin Lalor from the Alcohol and Drug Foundation gave an overview of the program and its beginnings in Iceland:

> Planet Youth is a program that has been running in Iceland for more than 20 years. They started it when they were recognising that the youth in Iceland were amongst the highest users of cannabis, alcohol and tobacco in Europe. They had attempted an approach of 'Just say no' and it was not working. It was not shifting use amongst young people. They looked closely at the research that they were doing that considered what were the characteristics of the young people in Iceland who were more likely or less likely to use alcohol, cannabis and tobacco. What they found is that those who were less likely to use substances had very strong relationships with parents, they were connected into a positive school environment, they had peers that were unlikely to be using alcohol

110 Alcohol and Drug Foundation, *Submission 1386*, p. 4.

111 Public Health Association of Australia, *Submission 1391*, p. 8.

112 Dr Erin Lalor, *Transcript of evidence*, p. 64.

and drugs and they were protected through the larger regulatory environment in which they lived—the community environment in which they lived.[113]

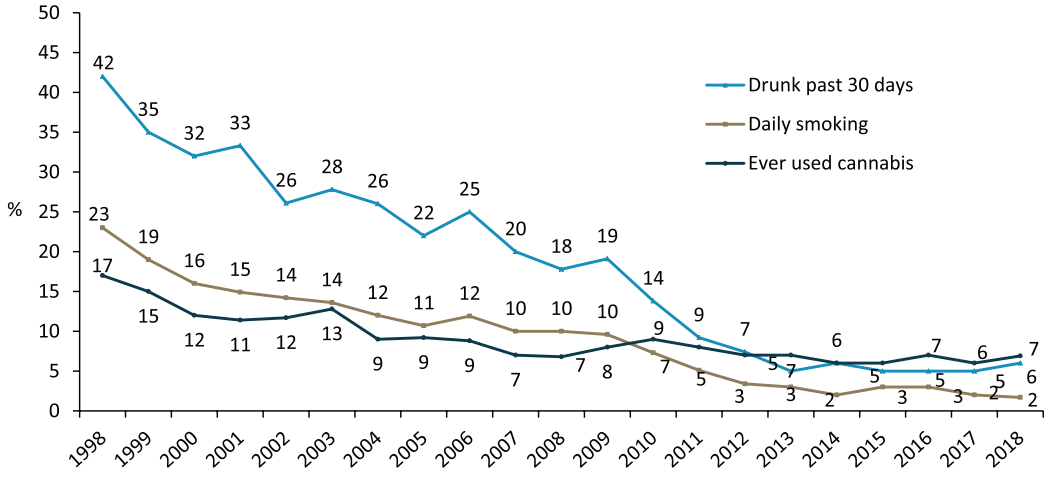
So what Iceland started to do was to introduce activities that really strengthened those protective factors. So they worked with parents to get them to understand the importance of positive role modelling, of understanding where the kids were late at night, of knowing the parents of their children's friends. They worked with peer groups and they worked with schools, and they took a whole-of-community approach to prevention. They found enormous differences. Over the last 20 years they have shifted from the highest users of substances in Europe to amongst the lowest, and they have now started trialling that program in other parts of the world; they have introduced it to into South American countries, into parts of the US, and into many other European countries, and they are seeing similar declines over time.[114]

A paper by Alfgeir Kristjansson et al. gave an overview of the success of Planet Youth.[115] It stated:

Since the original development of the model, Iceland has led the decline in substance use in all of Europe. In 2015, the rate of ever smoking tobacco was 46% among 10th-grade adolescents in Europe but had plunged to 16% in Iceland; average rates of current alcohol use were 48% in Europe but 9% in Iceland; and average rates of lifetime use of cannabis substances remained at 16% in Europe, similar to 1999, but declined to 5% in Iceland.[116]

Figure 3.4 below illustrates the decline in alcohol, tobacco and cannabis use amongst adolescents in Iceland between 1998 and 2018.

Figure 3.4 Substance use among Icelandic adolescents between 1998 and 2018



Source: Alfgeir Kristjansson et.al, 'Development and Guiding Principles of the Icelandic Model for Preventing Adolescence Substance Use', *Health Promotion Practice*, vol. 21, no.1, 2020, p. 65.

113 Ibid.

114 Ibid.

115 Alfgeir L. Kristjansson et. al., 'Development and Guiding Principles of the Icelandic Model for Preventing Adolescence Substance Use', *Health Promotion Practice*, vol. 21, no. 1, 2020.

116 Ibid., p. 64.

The Committee heard that the Planet Youth program had been piloted in other Australian states and similar programs have been established. At a public hearing, Mr Gary Christian from Drug Free Australia described the implementation of a protective factors and resilience-based program at a school in Kellyville in Sydney's north west:

> Kellyville school in New South Wales was the first that I know of—maybe Concord West as well—but Kellyville actually had a whole-of-school and community approach to resilience, very similar to the Iceland program but not with the resourcing in the community of all the sports activities. What it tended to do was bring community people into the school and be a part of the school on a regular basis, and so people who were retired and so on became part of that school and were linked to the community for those young people and got to know the young people in the school. They had fantastic outcomes, and that became a program back in 2007 called Getting Connected, which is available on our Drug Free Australia website for schools. They can still access that resilience program. So it is very much there, and it can be done. I would love to see governments take it up to the level of the Iceland model, which involves the community at that infrastructure level.[117]

It is clear that the protective factors promoted by Planet Youth play a role in preventing young people from taking up illicit drugs. This prevents not only the harms to developing brains that come with cannabis use but also other individual and societal harms.

Dr Lalor said that the Planet Youth program has been trialled in other Australian jurisdictions. However, a pilot was not established in Victoria as the Department of Education and Training did not give consent. This is because the program requires mandatory participation by students unless they choose to opt out. Dr Lalor explained that students in New South Wales and South Australia had undertaken surveys[118] about the prevalence of substance use in the school community as well as protective factors in the students social environment:

> The Australian trial: we, through our local drug action team program, are now piloting it in sites in New South Wales and in South Australia. The surveys were done there in October 2019, and this year we will do the second lot of surveys. The South Australian government has committed to extending the pilot in South Australia for five years. The pilot in Australia, or the process, requires opt-out consent. So it means that all young people in a school complete the survey, and if they do not want to do it or their parent does not want them to, they opt out. Most requirements for education departments in Australia require opt-in, where parents are required to say, yes, their children can participate in that particular survey, and that means that we can sometimes miss out on information from kids who are most in need.

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117 Mr Gary Christian, *Transcript of evidence*, pp. 39–40.

118 Alfgeir L. Kristjansson et. al., 'Development and Guiding Principles of the Icelandic Model for Preventing Adolescence Substance Use', p. 73.

> It is a requirement of the Planet Youth approach. We were not able to do the pilot in Victoria because we were not able to get approval for an opt-out approach to consent. It has been run in South Australia and New South Wales only at this point in time.[119]

The Committee believes that the Department of Education and Training should review its approach in this case to allow for a trial of the Planet Youth program to proceed in Victoria.

RECOMMENDATION 6: That the Department of Education and Training facilitates a trial of the Planet Youth program in Victoria.

3.7.2 Social and community engagement

The Committee was informed of two other services provided by the Alcohol and Drug Foundation that seek to enhance social and community engagement and prevent drug use.

The first is the Good Sports Program which supports community sport clubs to promote healthy approaches to alcohol and to cut tobacco and illicit drug use. Dr Lalor from the Alcohol and Drug Foundation described the program as follows:

> It had a focus on alcohol and tobacco in the early years, and in recent years we have introduced components that are looking at helping clubs support people who may be using illicit drugs and direct people to appropriate support and information. But the other thing about the Good Sports program is we know that participation in community sport is a really strong protective factor, and the more we can engage kids in positive club culture, the less likely they are to use illicit drugs. And Good Sports clubs have greater participation than non-Good Sports clubs, particularly amongst young people and amongst women. So Good Sports not only changes club culture around alcohol and drugs but it also encourages people in community to participate in sports, which is a great outcome.[120]

The second type of service is the Foundation's Local Drug Action Teams. These are community groups situated throughout Victoria and Australia. They are formed by local community members who identify areas of need and develop an action plan to strengthen the protective factors for people who might use drugs.

Ms Jill Karena, State Manager, Victoria and Tasmania at the Alcohol and Drug Foundation described some of the work of Local Drug Action Teams in Victoria. This included:

- encouraging young people to stay engaged in education and find employment opportunities in their local communities
- developing leadership skills and positive role models

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119 Dr Erin Lalor, *Transcript of evidence*, p. 64.

120 Ibid., pp. 66–67.

- increasing employability
- deepening connections with culture for Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities
- increasing family and community connectedness
- reducing social isolation and loneliness
- increasing positive leisure activities
- building knowledge around the harms of alcohol and other drugs.[121]

The Committee received evidence from The Centre for Continuing Education in Wangaratta, an adult education provider and founding member of the Local Drug Action Team in Wangaratta. The Local Drug Action Team raised community support to target methamphetamine use in northern Victoria. It was successful in obtaining funding to open a residential drug rehabilitation facility in Wangaratta.[122] Ms Felicity Williams, Chief Executive Officer of The Centre for Continuing Education Wangaratta explained its achievements:

> the success of the [local drug action team] was very much grounded in its joined up agency and community approach crossing the sectors of health, justice, education and community. We also recognised that it is absolutely critical that people recovering from addiction are supported to stay within their own community, and that is why we advocated so heavily for the residential rehab that is currently being built in Wangaratta, which we are extremely excited about, and the centre will actually be participating in providing in-reach education programs.[123]

The Committee commends the work of the Alcohol and Drug Foundation in developing these programs and its ongoing efforts to ensure success.

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121 Ms Jill Karena, State Manager, Victoria and Tasmania, Alcohol and Drug Foundation, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 67.

122 Ms Felicity Williams, Chief Executive Officer, The Centre for Continuing Education (Wangaratta), public hearing, Beechworth, 28 April 2021, *Transcript of evidence*, p. 22.

123 Ibid.

3.7.3 Education and employment

> We have one guy who has taken the attention off our high level management in Corrections who, he was what they would call a revolving door. A 20 year history of in and out of prison and had actually articulated that this was the first time he actually felt some hope. The bottom line is for us we realise that the things that we sometimes overlook with offenders and where they're at and potentially maybe why people are turning to substances because they feel things are hopeless, worthless, useless and there is no hope for them. So to give them something to hang onto and that little glimmer of hope which then actually makes their future look brighter is something that we see has been a bit of a game changer for them.
>
> Ms Felicity Williams, Chief Executive Officer, The Centre for Continuing Education (Wangaratta), public hearing, Beechworth, 28 April 2021, *Transcript of evidence*, p. 24.

Education and employment are key determinants in keeping people housed and leading stable, productive lives free from problematic drug use.

The Centre for Continuing Education (Wangaratta) described its core work in providing adult education courses. This includes providing accredited and industry-specific training, VCAL and adult literacy education.[124] Ms Felicity Williams from The Centre for Continuing Education said that students come from a variety of backgrounds, but that education leads to employment and a stable future:

> Adults come into our community adult education environments with multiple issues, challenges and barriers. A life that is much wider than just education and employment. While our learners come to learn skills, improve their literacy, numeracy and digital skills as well as develop core skills for work, they must also engage in programs that build their self-awareness, goals for life and employment as well as confidence, aspiration and hope. Providing hope and opportunity to aspire to achieving meaningful employment. Reducing mental ill health by increasing people's resilience, community and social connection and also dealing with learning difficulties in adults which may have been misdiagnosed as mental health issues.[125]

She said that the skills learnt and the structure provided by the education and training offered by the Centre could provide opportunity for people with problematic drug use.[126]

The Centre offers a program called Finding Strengths that works with people who have learning difficulties that have come into contact with the criminal justice system. The program assists participants to gain education and develop employment-based skills.

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124 The Centre Wangaratta, *Course Guide*, <https://www.thecentre.vic.edu.au/course-guide> accessed 19 June 2021.

125 Ms Felicity Williams, *Transcript of evidence*, p. 23.

126 Ibid.

Ms Kerri Barnes, Program Manager for Finding Strengths said that the vast majority of participants reported using illicit drugs:

> We have of our offenders, 92 per cent of them report illicit drug use. For 78 per cent of those their preferred drug of choice is actually ice however, a majority of them do nominate cannabis as their gateway drug and a lot of that is normalised for them through their environment as they're growing up, so it is something that they've observed and it is inter-generational problem. 85 per cent of those offenders also report mental health or have mental health concerns or issues and so it is probably likely that one and the other are very closely linked.[127]

Ms Barnes said that despite the co-occurring mental health and drug and alcohol issues experienced by participants, through close support, some gain employment skills and see a path towards employment:

> Along the way with that we identify that it is not easy for them to make changes because they have such complex issues and barriers so we have the support of a case manager who worked very closely alongside them and sometimes mentors the person into the change. That is where we are working with them and we are seeing some really good results. We have one guy who has taken the attention off our high level management in Corrections who, he was what they would call a revolving door. A 20 year history of in and out of prison and had actually articulated that this was the first time he actually felt some hope. The bottom line is for us we realise that the things that we sometimes overlook with offenders and where they're at and potentially maybe why people are turning to substances because they feel things are hopeless, worthless, useless and there is no hope for them. So to give them something to hang onto and that little glimmer of hope which then actually makes their future look brighter is something that we see has been a bit of a game changer for them.[128]

The evidence provided by The Centre for Continuing Education (Wangaratta) is an example of how education and ultimately employment can play an important role in removing the motivation for problematic drug use.

The Committee acknowledges the valuable work of the Centre and the dedication of its staff in providing participants access to education and a chance to gain meaningful employment.

3.7.4 Funding for drug prevention programs

The Committee heard that insufficient funding was a primary reason as to why there are not enough programs that focus on preventing problematic drug use.

The Public Health Association of Australia noted that in 2009–10, funding allocated to drug harm overall was imbalanced heavily toward law enforcement, with 66% ($1.1 billion) of expenditure. Only $156.8 million was spent on prevention services.[129]

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127 Ms Kerri Barnes, Project Manager, Finding Strengths, The Centre for Continuing Education (Wangaratta), public hearing, Beechworth, 28 April 2021, *Transcript of evidence*, p. 24.

128 Ibid.

129 Public Health Association of Australia, *Submission 1391*, p. 8.

The Victorian Department of Health provides resources to fund some alcohol and other drugs prevention programs. The funding is provided in two streams:

1. Information and support: this includes funding for programs such as the Alcohol and Drug Foundation's Drug Facts.
2. Family Support: counselling, support and education for families of those affected by drug use.[130]

These programs are aimed at providing information about drug use or supporting the families of problematic drug users. However, they do not enhance the protective factors that can prevent problematic drug use, such as those provided by the Alcohol and Drug Foundation.

In its submission, the Victorian Alcohol and Drug Association addressed the lack of prevention programs funded by the Victorian Government. It noted there was some funding provided by the Commonwealth Government for prevention programs:

> [Alcohol and other drugs] treatment providers have had minimal involvement in prevention activities relating to cannabis. Prevention remains an unfunded activity leaving the space open to a range of bodies with varying experience and evidence.
>
> Prior to the implementation of the Drug and Alcohol Fund which is commissioned by the Primary Healthcare Networks (PHN), there was scope for prevention activities to be funded through the Commonwealth. There is no allowance for funded prevention based activities within the state system.[131]

The Victorian Alcohol and Drug Association also noted that the lack of alcohol and other drugs sector involvement in developing prevention programs had created a gap in services. It noted that in the absence of these programs, organisations with varying levels of expertise in drug and alcohol policy had stepped into offer their own:

> This gap is currently filled by a range of organisations and individuals, with varying bases, priorities and approaches. While some reflect on evidence based practice in delivering prevention activities, others may use a faith based approach or reflect on prior experience in policing or other associated fields.
>
> AOD [alcohol and other drugs] agencies are best placed to consider the evidence and reflect on lived experience in the delivery of evidence informed prevention based activities.[132]

It recommended that 'a funding stream should be developed to allow for [alcohol and other drugs] agencies to deliver prevention based activity'.[133]

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130 Department of Health, *Alcohol and other drugs program guidelines Part 2: program and service specifications*, <https://www2.health.vic.gov.au/Api/downloadmedia/%7BD87E-AF08-4580-8A75-BD8DA95%7D> accessed 7 July 2021.

131 Victorian Alcohol and Drug Association, *Submission 1390*, p. 8.

132 Ibid.

133 Ibid.

The Committee agrees that ongoing funding should be provided to alcohol and other drugs sector organisations to develop and provide prevention programs on an ongoing basis. These programs should be aimed at strengthening the protective factors that prevent drug use.

4 Issues identified with the criminal justice-based approach to cannabis use in Victoria

4.1 Introduction

A criminal justice-based approach to regulating cannabis use generates additional harms, many of which outweigh the harms associated with using cannabis. By criminalising the use of cannabis, significant resources are spent on policing, prosecuting and punishing low-level cannabis offenders instead of being redirected towards organised criminal activity and large-scale illegal market suppliers.

There are a myriad of harms associated with encountering the criminal justice system, many of which can have disproportionate impacts on individuals whose only offending relates to cannabis use. An individual's social, economic and health wellbeing can be undermined through a criminalisation response, which can weaken any efforts for rehabilitation and reintegration.

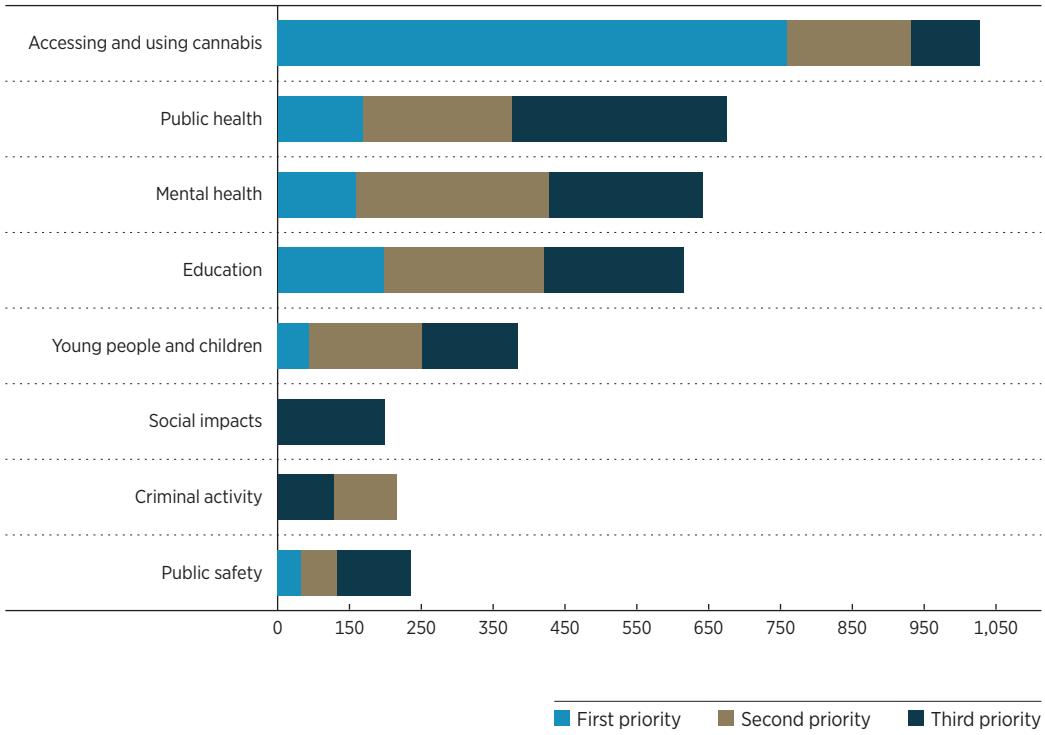
The Committee identified several significant harms associated with the criminal-justice based response towards the use of cannabis:

- the social and economic barriers from having a criminal record
- the overrepresentation and distinct harms experienced by vulnerable communities, such as Aboriginal and Torres Strait Islander people
- the impacts on young people
- the significant costs of a law enforcement response to cannabis use.

The Committee's view is that adult users should be shifted away from the criminal justice system and that young users are diverted through a reprioritisation towards drug diversion. By doing this, considerable resources are freed up which can be better allocated to policing more serious crime, including the trafficking and commercial supply of cannabis. The Committee acknowledges that current drug diversion programs are under-resourced.

As part of the survey included on the Inquiry's e-submission form, the Committee asked submitters to rank their priority areas for this Inquiry, including whether they prioritised issues such as 'criminal activity' and 'public safety'. Figure 4.1 below shows each time a priority category was ranked in the top three for a submitter.

Figure 4.1 Combined top three priorities for survey respondents from most to least important



Source: Legislative Council Legal and Social Issues Committee.

As discussed throughout this report, cannabis is a controlled substance in Victoria and except for approved medical use is prohibited. Chapter 1 provides an overview of the current legislative framework for cannabis prohibition in Victoria, including associated penalties for minor cannabis offences.

The criminalisation of cannabis use is dealt with using a variety of law enforcement responses from both the Victoria Police and the court system including caution notices, diversion, and imprisonment.

4.2 Cannabis offences in Victoria: offender statistics and arrests

The Australian Criminal Intelligence Commission produces an annual *Illicit Drug Data Report* from information provided by all states and territories. The 2020 report includes data on the number of jurisdictional arrests by drug type for the last two reporting periods.

According to the Commission, between 2017–18 and 2018–19 there was an 8.4% increase in cannabis-related arrests in Victoria, despite a -1.7% drop in arrests nationally. This is shown in Table 4.1 below.

Table 4.1 Cannabis arrests in Victoria, 2017–18 and 2018–19

	Number of cannabis arrests		Change
	2017–18	2018–19	(%)
Victoria	9,675	10,485	8.4
National	72,381	71,151	-1.7

Source: Australian Criminal Intelligence Commission, *Illicit Drug Data Report 2018–19*, Australia, 2020, p. 57.

The *Illicit Drug Data Report* also published information on the number of arrests for cannabis consumers (users) versus providers (suppliers or traffickers). The data is further separated by gender. The report defines a 'consumer' as offenders charged with 'user-type' offences such as administering or possessing a drug for their personal use.[1] A 'provider' refers to an offender charged with a 'supply-type' offence such as importation, trafficking, cultivating, manufacturing and selling.[2]

The report also provided figures on the number of arrests for people caught consuming (using) or providing (supplying) cannabis. In 2018–19, the total number of cannabis consumer arrests in Victoria was 9,867 versus 618 provider arrests. Table 4.2 below shows these arrests by gender.

Table 4.2 Cannabis: consumer versus provider arrests, Victoria, by gender, 2018–19

	Male	Female	Not known	Total
Consumer	7,930	1,936	1	**9,867**
Provider	502	116	0	**618**
Total	**8,432**	**2,052**	**1**	**10,485**

Source: Australian Criminal Intelligence Commission, *Illicit Drug Data Report 2018–19*, Australia, 2020, p. 152.

Some stakeholders noted in their submission that cannabis arrests account for most illicit drug arrests in Australia and that most cannabis arrests are consumer-based arrests.[3]

For example, the Burnet Institute highlighted that a significant proportion of drug enforcement is focused on cannabis:

> Despite the fact that cannabis is regarded as less harmful than other illicit drugs, the enforcement of cannabis control laws occupies a disproportionate share of overall drug enforcement activities. The Australian Criminal Intelligence Commission (ACIC) reported that over 2017–2018 cannabis accounted for the greatest number of drug related arrests

1 Australian Criminal Intelligence Commission, *Illicit Drug Data Report 2018–19*, Australia, 2020, p. 143.

2 Ibid.

3 See: Rationalist Society of Australia, *Submission 1343*; Labor for Drug Law Reform - Victorian Branch, *Submission 1346*; Burnet Institute, *Submission 1358*.

(72,381 arrests) nationally, being approximately half of all drug related arrests. Over 9,760 cannabis arrests took place in Victoria. Of all arrests, over 90% were of cannabis consumers, as opposed to cannabis providers[4]

Drug Policy Australia stated that the average quantity of cannabis for consumer only offences was approximately 54 g of cannabis.[5]

FINDING 9: Despite a reduction in the number of cannabis offences nationally, in Victoria:

- between 2017–18 and 2018–19, there was an 8.4% increase
- in 2018–19, over 94% of cannabis-related arrests in Victoria were for offences related to consumption.

4.3 Victoria Police's approach to cannabis offences

The *Victoria Police Drug Strategy 2020–25* outlines the direction of current and future drug policing. According to the Strategy, Victoria Police's approach to drug policing is based around four key pillars:

- prevention
- disruption and supply reduction
- treatment and support
- harm reduction.[6]

Box 4.1 below summarises the Drug Strategy.

4 Burnet Institute, *Submission 1358*, p. 4.

5 Drug Policy Australia, *Submission 1372*, p. 6.

6 Victoria Police, *Victoria Police Drug Strategy 2020–25*, Victoria, 2020, p. 11.

BOX 4.1: *Victoria Police Drug Strategy 2020–25*

The *Victoria Police Drug Strategy 2020–25* outlines the law enforcement approach to drug use in the Victorian community. The key objective of the strategy is to improve the health and safety of the community. The strategy acknowledges that drugs create significant social and economic harms across the community, including to:

- the individual who uses drugs
- the families of drug users
- the broader community.

According to the strategy, the cost of drug use to society (at a national level) is approximately $8.2 billion annually. These societal costs come from:

- spending on law enforcement and justice responses
- health costs associated with managing illnesses, mental health issues, injury and disease related to drug use and offending
- social rehabilitation costs
- lost income and production from drug addiction treatment, and drug related death.

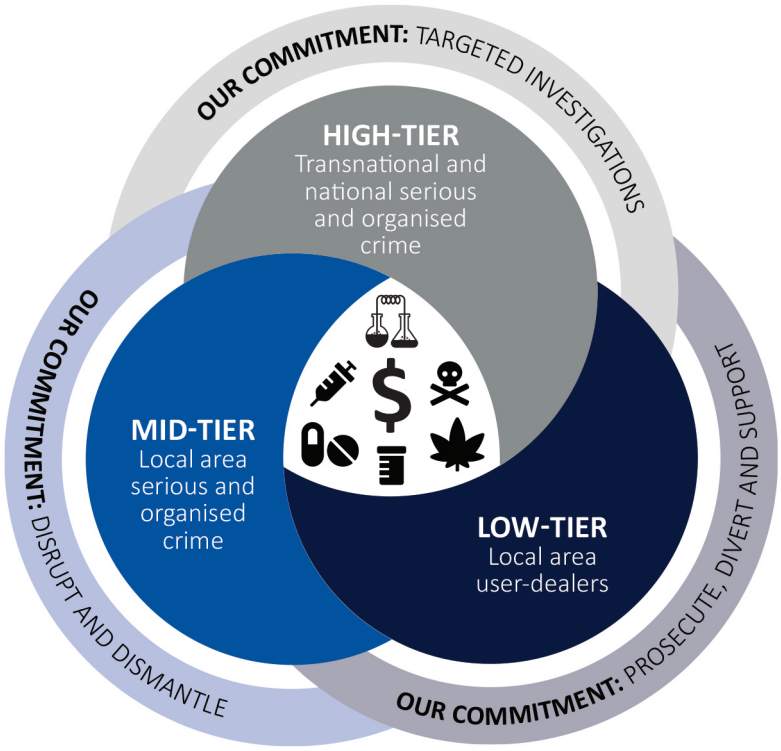
The strategy is based on four key pillars which together establish an integrated response to drug use in Victoria:

1. **Prevention:** participating in a whole of government response aimed at preventing drug use before it occurs by participating in, and delivering educational and social programs aimed at building awareness of the risks of drug use and where individuals can access support.
2. **Disruption and supply reduction:** policing the illicit drug market from trafficking, to manufacturing and sale. Victoria Police has established a three-pronged approach to policing the illicit market based on three-overlapping tiers that cover organised crime, local drug dealers and users. Figure 4.2 below shows the three tiers of the illicit drug market and the approach Victoria Police takes to each.
3. **Treatment and support:** using Victoria Police's drug diversion programs to divert individuals into treatment programs and support services when they have been found with a small quantity of illicit drugs. This is based on the view that treatment may be more beneficial in reducing drug use and recidivism than the criminal justice system.
4. **Harm reduction:** implement government initiatives aimed at reducing the health harms an individual may face when they use drugs, such as the needle and syringe program or supervised injecting rooms.

Source: Victoria Police, *Victoria Police Drug Strategy 2020–25*, Victoria, 2020.

As discussed in Box 4.1 above, Victoria Police approaches disruption and supply reduction through policing the entire illicit market through a three-tiered approach. This encompasses organised crime, local drug markets and users and is illustrated Figure 4.2 below.

Figure 4.2 Tiered approach to policing the illicit drug market, Victoria Police Drug Strategy 2020–25



Source: Victoria Police, *Victoria Police Drug Strategy 2020–25*, Victoria, 2020, p. 17.

4.3.1 The cannabis cautioning program

In 1998, Victoria Police introduced the 'Cannabis Cautioning Program' to divert adults[7] charged with use and possession of cannabis offences away from the criminal justice system. The program is an internal, discretionary policy of Victoria Police.

Under the program, if an adult is found with no more than 50g in their possession and no other offences have occurred, Victoria Police may issue a caution notice rather than pursuing criminal charges. An individual can receive a maximum of two cannabis cautions before being ineligible for the program for future offences.

Cannabis cautions have conditions attached to them which must be complied with, often within a set timeframe. If conditions are not complied with Victoria Police will proceed to formal charges. For example, a person may be required to complete a drug

7 Aged 18 and over.

education program (e.g., the Cautious With Cannabis program (see Box 4.2)), seek drug treatment or undergo counselling.

The following pre-conditions must be met for an individual to receive a cannabis caution:

- they must admit to the offence
- the cannabis possessed must be for personal use only
- they have not been involved or detected in any other offence
- they have not received more than one previous drug cautioning notice for other drugs (if they have more than two, they will be formally charged).[8]

Box 4.2 below provides a summary of the Cautious With Cannabis program.

BOX 4.2: Cautious With Cannabis program

The Cautious With Cannabis program is a government funded drug education program which aims to teach people about the risks of cannabis use. It was established by Uniting Vic.Tas following the introduction of Victoria Police's cannabis cautioning program in the 1990s.

Cautious With Cannabis is a 2.5 hour training session for people with a cannabis caution or for anyone wanting to understand the risks of cannabis use.

In its submission, Uniting Vic.Tas which developed the program explained that it aims to improve participants understanding of:

- the effects of cannabis
- potential harms of use
- harm reduction strategies
- behavioural change strategies
- available supports and services.

Uniting stated that a wide range of people have accessed the program, not just individuals who have to because of the requirements of their cannabis caution.

Source: Uniting Vic.Tas, *Submission 1388*, p. 13.

The cannabis cautioning program is specifically designed for offences relating to cannabis use and possession. Victoria Police also established the Drug Diversion Program in 2000 which deals with other illicit substances. This program operates in a very similar fashion to the cannabis cautioning program and has the same eligibility criteria.

8 Victoria Police, *Submission 901*, p. 8.

In its submission, Victoria Police provided information about the use of cannabis cautions:

- The number of cannabis cautions issued by Victoria Police have risen each year since 2016:
  - 2017: 2,953
  - 2018: 3,096
  - 2019: 3,388.
- Between 2010 and 2016, 21,668 (53% of all offences) offences for use and possession of cannabis were eligible for a cannabis caution.
- A cannabis caution was issued for 70% (15,090) of eligible cases. This averages to around 2,515 cautions issued each year for the period captured (2010 to 2016).
- The main reason for ineligibility was concurrent offending (77%).[9]

In its 2020–25 Drug Strategy, Victoria Police stated that offenders who are diverted into a drug diversion program are 10% less likely to reoffend.[10]

Dr Kate Seear, Associate Professor and Principal Research Fellow, DruGS Research Program at Latrobe University compared the use of drug diversion in Victoria to comparable programs in other jurisdictions. She stated that in Victoria only around 65.4% of people with a principal offence for use and possession were diverted. She also noted that Tasmania, the Australian Capital Territory and South Australia were achieving better outcomes because there is no limit in the number of diversions a person can have for cannabis offences.[11]

Dr Seear believed that Victoria's cannabis cautioning program is 'inconsistent and incoherent', stating:

> In many instances the logic is that a person might have a problem that requires some support or guidance or education, and to say to that person, 'You are able to receive support and guidance, education and help if you need it twice but then on the third occasion we are going to treat you as a criminal' to me does not really make much logical sense, and it is something that I think could be readily and easily fixed and would see a lot more people in Victoria have the opportunity to take up diversion.[12]

This was echoed by the Victorian Aboriginal Legal Service which similarly believed that the limit of two cautions per person is too inflexible and does not reflect the complexity of drug use and addiction:

> It is important to recognise that drug use is a complex and nuanced issue that cannot be addressed either with a 'one-size fits all' sentencing outcome in court or a conviction.

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9 Ibid.

10 Victoria Police, *Victoria Police Drug Strategy 2020–25*, p. 17.

11 Dr Kate Seear, Associate Professor & Principal Research Fellow, DruGS Research Program, Australian Research Centre in Sex, Health and Society, Latrobe University, public hearing, Melbourne, 19 May 2021, *Transcript of evidence*, p. 54.

12 Ibid.

> The benefits of the cannabis cautioning scheme, deriving from its flexible approach and avoiding the lifelong stigma of a recordable court outcome, are limited by the fact that this option is available only once or twice to people. People's journeys to address their drug issues is likely to take time, with potential relapses along the way.[13]

Some stakeholders expressed concern that the cannabis cautioning program in Victoria was not accessible for everyone. They also highlighted that this is potentially compounded by the lack of legislation supporting the program. There was a perception that because it is a discretionary policy it was being used in an ad-hoc way, meaning not all people eligible for the program were referred to it, and instead criminal charges were being pursued.

In its submission, Students for Sensible Drug Policy Australia noted research into the program that summarised the barriers to access experienced by research stakeholders:

> Among the listed barriers to access were: narrow criteria for the schemes, and cultural factors, where different police area commands may have had a higher reluctance to use diversion schemes. One stakeholder noted that "there is more diversion in affluent suburbs than in poorer suburbs".[14]

Springvale Monash Legal Service described diversion programs such as the cannabis cautioning program as 'therapeutic justice'. It asserted that evidence indicates these are often 'more cost effective, pragmatic and consistent with a harm minimisation approach'.[15] However, it believed that the cannabis cautioning program may not be achieving the aims of therapeutic justice because:

- the current program is subject to police discretion
- strict limits on the number of times a person can access diversion
- it may be limited by perception that diversion is a 'soft option'.[16]

Springvale Monash Legal Service recommended the introduction of a legislative scheme for drug diversion to prevent discretionary application and broaden eligibility requirements.

Victoria Legal Aid also supported the introduction of a legislated cannabis diversion scheme. In its submission, it discussed the decreasing use of cannabis cautions or diversion in Victoria and that police are increasingly referring cannabis possession charges to court:

> The use of diversions in Victoria has halved over the last 10 years. Data shows that police are increasingly likely to commence court proceedings rather than utilise non-court action including referrals, diversions and cautions. Our practice experience reflects

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13 Victorian Aboriginal Legal Service, *Submission 1398*, p. 12.

14 Students for Sensible Drug Policy Australia, *Submission 1392*, p. 16.

15 Springvale Monash Legal Service, *Submission 1399*, p. 16.

16 Ibid.

> this data, finding that police officers often default to charging people for cannabis possession when a caution would be appropriate, and continue to prosecute where a diversion would be appropriate.[17]

Victoria Legal Aid suggested that the decreasing use of cautioning or diversion programs is because it is more time consuming and has additional administrative burdens:

> Recent qualitative research with police officers found that heavy workloads and a lack of time were cited as barriers to offering diversion and referral options, as pursuing these options is more time-consuming than simply charging. Furthermore, police officers in the study acknowledged that they were more likely to invest this extra time if they thought a person demonstrated remorse, was not aggressive, or was perceived to have good prospects of rehabilitation. These findings underscore the likely impact of implicit bias on decisions to grant cautions and diversion.[18]

In its submission, the Australian Institute of Health and Welfare provided data from the 2019 *National Drug Strategy Household Survey*. This included respondents' perceptions of what actions should be taken against people found in possession of cannabis, shown in Table 4.3 below.

Table 4.3 Choice of action that should be taken against people found in possession of cannabis, percentage, Victoria, 2010 to 2019

Preferred Action	2010 (%)	2013 (%)	2016 (%)	2019 (%)
A caution/warning or no action	38.3	42.9	45.2	53.3
Referral to treatment or education program	30.1	29.1	28.1	23.9
Fine	17.6	16.2	15.7	14.0
Community service or weekend detention	5.9	5.6	5.0	4.4
Prison sentence	6.9	5.0	4.5	3.7
Some other arrangement	1.1	1.2	1.4	0.8

Source: Australian Institute of Health and Welfare, *Submission 209*, p. 19.

The results of the survey showed that caution/no warning or action has increasingly become the preferred option of respondents, up from 38.3% in 2010 to 53.3% in 2019. Referral to treatment and education programs was the second highest preference in 2019, which fell from 30.1% in 2016 to 23.9% in 2019 partly due to the increased preference for caution/warning.

17 Victoria Legal Aid, *Submission 1373*, p. 9.

18 Ibid. Research referred to in quotation is Rachel Green et. al., 'Police decision-making with young offenders: Examining barriers to the use of diversion options', *ANZ Journal of Criminology*, vol. 53, no. 1, 2020.

The Committee believes it is important to acknowledge that there are significant issues with the current administration of the cannabis cautioning program. This includes the discretionary use by police officers due to a lack of legislative basis.

FINDING 10: The current administration of the Victoria Police cannabis cautioning program is:

- too discretionary in how it is used by police, with cautions being unequally used between precincts and officers
- too inflexible, particularly the limit of two cautions per person
- unintentionally acting as a disincentive to use cautions or refer to diversion due to the administrative burden on police.

RECOMMENDATION 7: That the Victorian Government provides further funding to expand drug diversion programs, particularly in rural and regional Victoria.

In addition, the Committee believes that a youth cannabis cautioning program should be introduced as a legislated requirement rather than a discretionary policy of Victoria Police. Currently, the Victoria Police Manual excludes young people from the cannabis cautioning program. However, there are youth specific diversion options available.[19]

4.3.2 Youth diversion

Young people aged under 18 are not eligible to receive a cannabis caution. Instead, young people who are charged with use or possession offences may be diverted away from the criminal justice system by way of a Child Caution.[20]

In its submission, Victoria Police described the process for dealing with youth offenders who receive a Child Caution:

- the illegality and risks of cannabis use are explained to the offender and their accompanying guardian
- the young person may be referred to an alcohol and other drug service or other relevant youth service via the Victoria Police eReferral system.[21]

Whether a young person is eligible to receive a caution from Victoria Police depends on several factors:

- the seriousness of the crime
- circumstances of the offender or any victims

19 Victoria Police, *Submission 901*, p. 8.

20 Ibid.

21 Ibid.

- extent of damage or injury caused
- potential deterrence effect of a caution
- the number of people affected
- whether the young person has previously received a caution.[22]

At a public hearing, Assistant Commissioner Glenn Weir, Drug Portfolio holder at Victoria Police explained why cannabis offenders aged under 18 are dealt with through the Child Caution program as opposed through a cannabis caution:

> We see that as less of a stigma, for a child to not receive a drug caution—'Oh, you've got a drug caution', as a child that can be quite limiting—and just to receive a general caution which includes drugs. So we see that as quite a good way of trying to protect the child, if you like. So people need to be over 18 …[23]

The Committee supports the separation of a youth focused diversion program from general drug diversion programs due to the additional harm that can be generated. As noted by Victoria Police, dealing with a young person's cannabis use under the umbrella of a 'Child Caution' helps limit the stigma associated with drug use that may further limit their opportunities.

Like other drug diversion or cannabis caution programs, a young offender must admit to the offence in order to received a Child Caution. At a public hearing for the Victorian Public Accounts and Estimates Committee's Inquiry into the 2021–22 Budget Estimates, Chief Commissioner Shane Patton explained that Victoria Police are looking to change requirements for issuing a Child Caution:

> [Victoria Police are] implementing a policy change in respect to that so that we can say, 'Well, no, let's assess the overall circumstances here of that child's behaviour, that child's conduct'. For instance, they might have had in the past a prior history for smashing a letterbox or something—a minor offence. They might have, when we interviewed them, quite appropriately taken legal advice and made no comment. Under the guidelines we had they would be restrictive, if you like, and they probably would not get that caution for a small amount of drugs or something like that, whereas I am changing that so that we can be more flexible and we can take into account the whole circumstances and not limit just by strict criteria that are not going to be conducive to the approach we want to get, and that is: let us not try and criminalise people for very small amounts of cannabis itself used. Let us focus on the drug traffickers who are really causing the problem.[24]

22 Caitlin Grover, *Youth justice in Victoria: Research paper*, Parliamentary & Information Services, Victoria, 2017, pp. 8–9.

23 Assistant Commissioner Glenn Weir, Drug portfolio holder, Victoria Police, public hearing, Melbourne, 29 June 2021, *Transcript of evidence*, p. 8.

24 Mr Shane Patton, Chief Commissioner, Victoria Police, Public Accounts and Estimates Committee, public hearing, Melbourne, 21 June 2021, *Transcript of evidence*, p. 5.

In 2017, the Victorian Parliamentary Library Research Service published a research paper on *Youth justice in Victoria*. This noted that youth cautioning has been effective in deterring reoffending, with Victoria Police reporting that 80% had not reoffended after a year and 65% after three years.[25]

However, the paper also noted concerns about the discretionary applications of youth cautions in Victoria, which has been compounded by the lack of a legislative scheme. The authors observed:

- there were significant variations in the use of cautions for young offenders between local government areas
- marginalised and vulnerable groups are less likely to receive cautions, particularly Aboriginal and Torres Strait Islander youth.[26]

In its submission, Youthlaw believed that police discretion in the use of youth cautions for cannabis offences means that diversion may not always be offered even in eligible cases. It also argued that this could lead to discrimination, citing evidence that young Indigenous people are less likely to be granted diversion than those from other communities.[27]

Victoria Legal Aid advocated for a youth cannabis cautioning scheme, noting that cautioning and diversion has shown to reduce reoffending in young people.[28]

Similarly, Ms Ashleigh Newnham, Manager, Strategic and Community Development at Springvale Monash Legal Service stated that although cautioning would 'not necessarily … solve all of the issues', it was a 'step in the right direction'.[29]

In response to a question on notice, Ms Newnham explained the use of incentives for law enforcement to use a caution where an offender is eligible:

> My understanding is that in some jurisdictions, drug diversions have been added to performance monitoring systems, including the use of Key Performance Measures – setting targets for each officer that are monitored by supervisors/ managers. Studies have shown that this has increased the numbers of diversions offered. In addition are targets for specific geographic regions (apparently there is some competition in various regions regarding the number of diversions). This is not limited to NSW. Another method of incentivising diversion is to require reports from each region on diversion numbers, and having these reports published.[30]

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25 Caitlin Grover, *Youth justice in Victoria*, p. 9.

26 Ibid.

27 Youthlaw, *Submission 1389*, p. 4.

28 Victoria Legal Aid, *Submission 1373*, p. 8; Mr Dan Nicholson, Executive Director, Criminal Law Services, Victoria Legal Aid, public hearing, Melbourne, 19 May 2021, *Transcript of evidence*, p. 5.

29 Ms Ashleigh Newnham, Manager, Strategic and Community Development, Springvale Monash Legal Service, public hearing, Melbourne, 19 May 2021, *Transcript of evidence*, p. 47.

30 Ms Ashleigh Newnham, Manager, Strategic and Community Development, Springvale Monash Legal Service, Inquiry into the use of cannabis in Victoria hearing, response to questions on notice received 14 June 2021, p. 1.

However, she noted that if a legislated scheme was introduced, incentives would not be necessary.[31]

There are life-long impacts associated with young people entering the criminal justice system, which can deepen depending on the seriousness of their interaction. Furthermore, there are considerable issues with Victoria Police's discretionary use of Child Cautions. The Committee found this has led to inconsistent application across different geographical regions as well as different communities.[32]

In the Committee's view, a youth caution program should be legislated in Victoria to allow for uniform application and increase transparency. This will ensure that minor cannabis offences committed by young people are treated the same. Furthermore, the Committee believes that a caution notice should be the default law enforcement response for minor cannabis offences where no other offending has occurred.

RECOMMENDATION 8: That the Victorian Government establishes a legislated Youth Caution program to deal with low-level cannabis offences committed by young people under the age of 18. This program should incorporate specific provisions, including:

- shifting towards drug diversion programs as the default law enforcement response for minor cannabis offences committed by young people
- removing requirements for a young person to plead guilty before they are eligible for a caution notice
- not imposing fixed caps on the number of times a young person can participate in the program, where minor cannabis offences are the only or primary offence
- support and training for police officers aimed at reducing additional workload when issuing a youth caution.

4.4 Cannabis offending and the Victorian criminal justice system

In 2018, the Sentencing Advisory Council produced a report which examined trends in minor drug offence sentencing over a 10-year period from1 July 2007 to 30 June 2017.[33]

A minor drug offence is defined as 'the possession or use of an illicit drug of dependence.'[34]

31 Ibid.

32 Caitlin Grover, *Youth justice in Victoria*.

33 Sentencing Advisory Council, *Trends in Minor Drug Offences Sentenced in the Magistrates' Court of Victoria*, Victoria, 2018.

34 Ibid., p. xi.

The report analysed data on 118,101 proven charges of a minor drug offence, including cannabis-related offences.[35] It also provided general demographic profiles of minor drug offenders in Victoria, including specific profiles for cannabis-related offences.

Table 4.4 below shows the number of proven charges of minor cannabis offences sentenced in the Magistrate's Court from 2007–08 to 2016–17.

Table 4.4 Proven cannabis related charges sentenced in Magistrates Court from 2007–08 to 2016–17

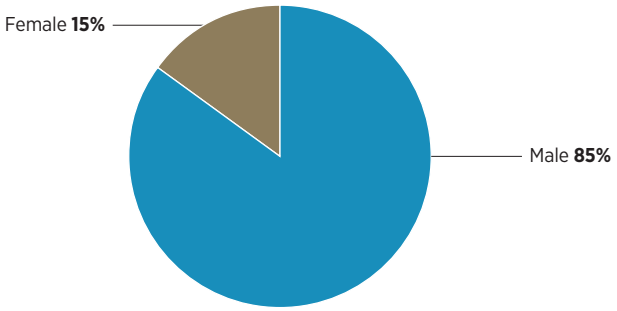
Charge	Number of proven charges
Possession of cannabis	33,966
Use of cannabis	14,506
Total	**48,472**
Proportion of all minor drug offence charges (%)	**41**

Source: Sentencing Advisory Council, *Trends in minor drug offences sentenced in the Magistrates' Court of Victoria*, Victoria, 2018, p. 32.

4.4.1 By gender

The report provided specific data on minor cannabis offences by gender. From 2007–08 to 2016–17, there were 23,340 minor drug offence cases involving only cannabis. Of these, 85% of cases were male. This is illustrated in Figure 4.3 below.

Figure 4.3 Percentage of minor cannabis offence cases, by gender, 2007–08 to 2016–17



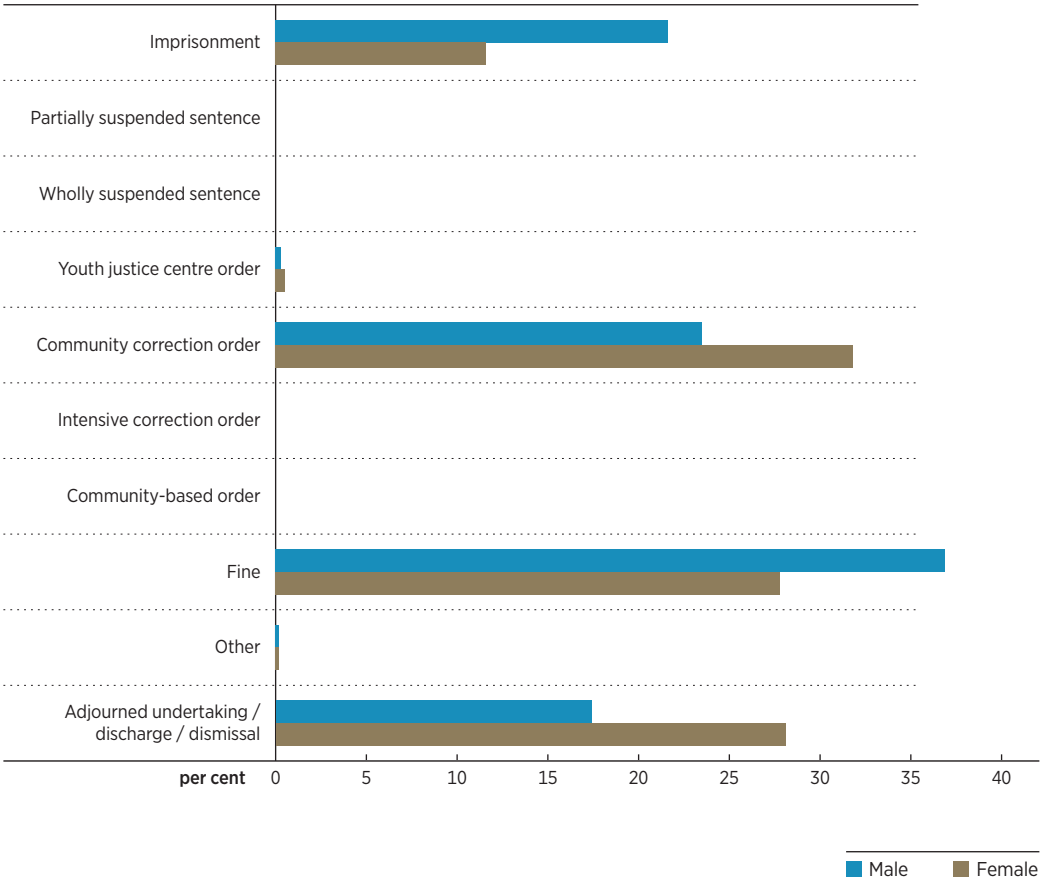
Source: Adapted from Sentencing Advisory Council, *Trends in minor drug offences sentenced in the Magistrates' Court of Victoria*, Victoria, 2018, p. 15.

The Sentencing Advisory Council also publishes data on sentencing outcomes for cannabis use and possession cases dealt with in the Magistrates' Court of Victoria.

35 Ibid.

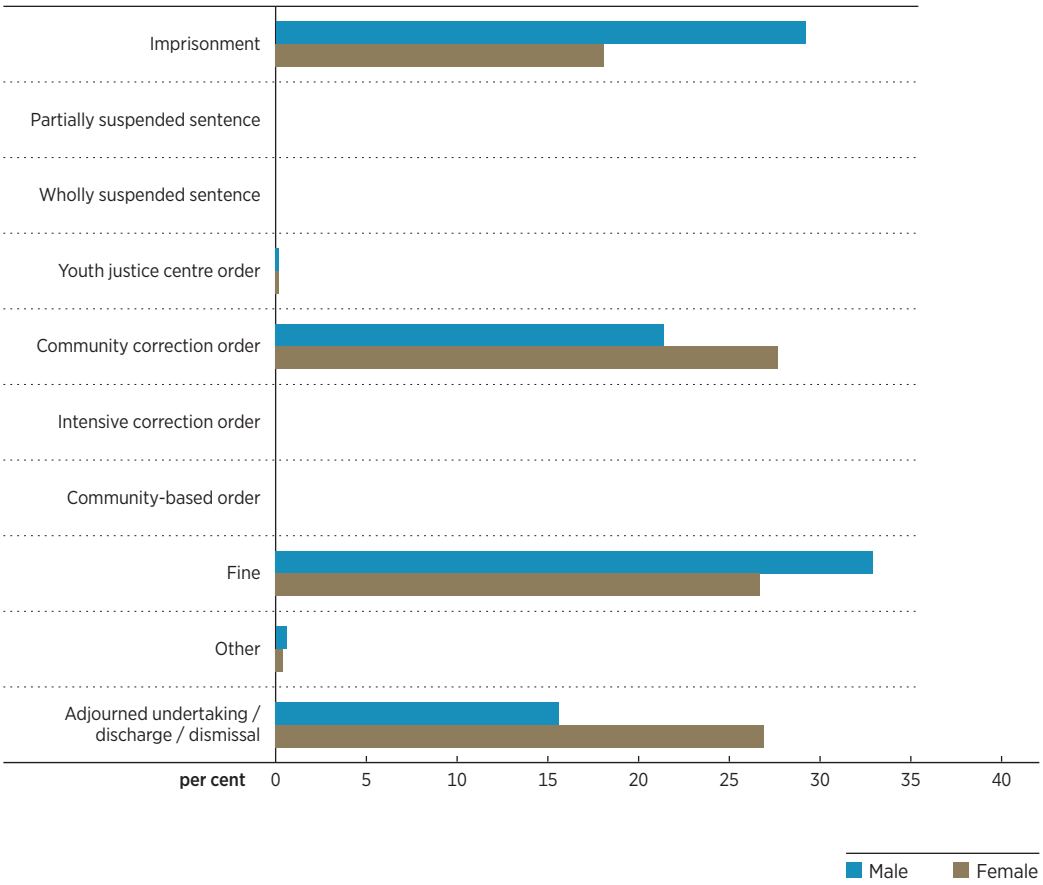
For both use and possession of cannabis, male offenders were more likely to receive a fine or prison sentence. In contrast, female offenders were more likely to be receive a community corrections order or an adjourned undertaking/discharge or dismissal. This is illustrated in Figure 4.4 and Figure 4.5 below.

Figure 4.4 Sentencing outcomes, use of cannabis, by gender, 1 July 2016 to 30 June 2019



Source: Sentencing Advisory Council, *SACStat Magistrates' Court: Use Cannabis*, 2019, <https://www.sentencingcouncil.vic.gov.au/sacstat/magistrates_court/9719_75.3.html> accessed 20 April 2021.

Figure 4.5 Sentencing outcomes, possession of cannabis, by gender, 1 July 2016 to 30 June 2019



Source: Sentencing Advisory Council, *SACStat Magistrates' Court: Possess Cannabis*, 2019, <https://www.sentencingcouncil.vic.gov.au/sacstat/magistrates_court/9719_73_1.7.html> accessed 20 April 2021.

FINDING 11: Both male and female offenders are more likely to receive an imprisonment sentence for possession-related offences compared to use-related offences:

- Over 25% of male offenders received an imprisonment sentence for cannabis possession offences between 2016 and 2019.
- Over 15% of female offenders received an imprisonment sentence for cannabis possession offences between 2016 and 2019.

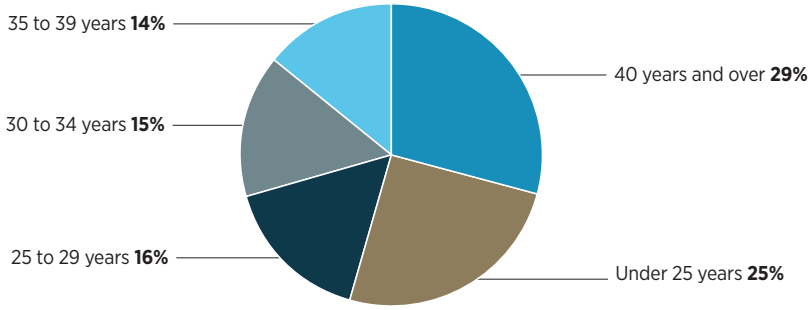
4.4.2 By age

Young people are slightly overrepresented in minor cannabis offences. From 2007–08 to 2016–17, most cannabis offenders (29%) were 40 years and over at the time of sentencing. However, 25% of cannabis offenders were under 25 years of age at the

time of sentencing. According to the Australian Bureau of Statistics, 22% of Victoria's population was aged between 10 (the age of criminal responsibility) and 25 years old between 2007 and 2017.[36]

Figure 4.6 below shows the percentage of minor cannabis offences by age bracket at the time of sentencing.

Figure 4.6 Percentage of minor cannabis offence cases, by age, 2007–08 to 2016–17



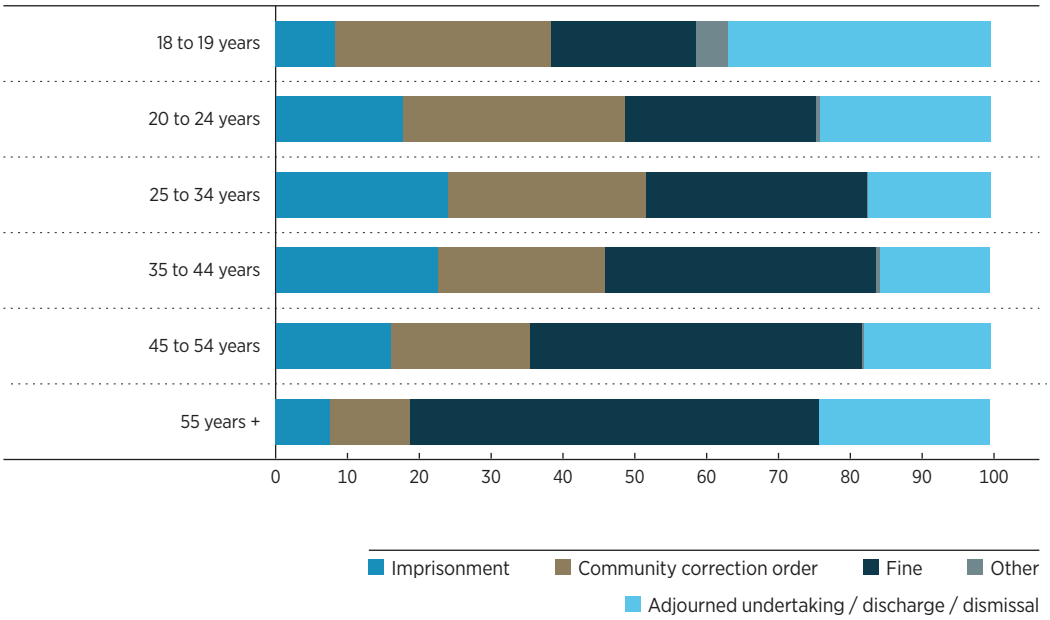
Note: the data does not add up to 100% due to rounding error.

Source: Adapted from Sentencing Advisory Council, *Trends in Minor Drug Offences Sentenced in the Magistrates' Court of Victoria*, Victoria, 2018, p. 16.

In contrast, data from the Sentencing Advisory Council suggests that young adults are more likely to receive an adjourned undertaking/discharge/dismissal for use and possession offences, particularly those aged 18 to 19. Figure 4.7 and Figure 4.8 below show the sentencing outcomes by age group for use and possession of cannabis offences dealt with in the Magistrates' Court of Victoria between 1 July 2016 and 30 June 2019.

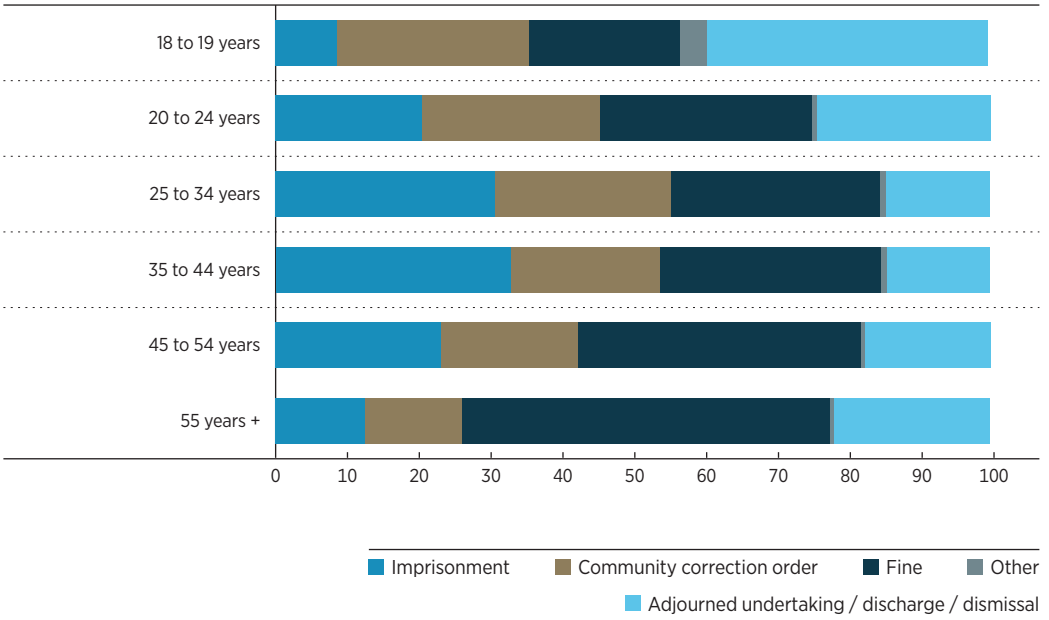
36 Resident Population by Single Year of Age Australian Bureau of Statistics, Victoria,, *National, state and territory population*, 2021, <https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/sep-2020#data-downloads-data-cubes> accessed 6 May 2021.

Figure 4.7 Sentencing outcomes for use of cannabis, by age, 1 July 2016 to 30 June 2019



Source: Sentencing Advisory Council, *SACStat Magistrates' Court: Use Cannabis*, 2019, <https://www.sentencingcouncil.vic.gov.au/sacstat/magistrates_court/9719_75.3.html> accessed 20 April 2021.

Figure 4.8 Sentencing outcomes for possession of cannabis, by age, 1 July 2016 to 30 June 2019



Source: Sentencing Advisory Council, *SACStat Magistrates' Court: Possess Cannabis*, 2019, <https://www.sentencingcouncil.vic.gov.au/sacstat/magistrates_court/9719_73_1.7.html> accessed 20 April 2021.

4.4.3 Aboriginal and Torres Strait Islander Victorians

Victoria's Aboriginal and Torres Strait Islander communities are significantly overrepresented in the criminal justice system, including in sentencing statistics for cases of cannabis use and possession.

According to the Crime Statistics Agency, from January 2015 to December 2020, 2,811 people who committed a minor cannabis offences identified as Aboriginal, Torres Strait Islander or both. Indigenous offenders accounted for approximately 6% of minor cannabis offences (47,598) committed throughout the period while comprising only 0.8% of Victoria's total population.[37]

Table 4.5 below shows the number of cannabis use and possession offences by Indigenous status from January 2015 to December 2020.

Table 4.5 Cannabis use and possession offences by Indigenous status, January 2015 to December 2020.

Indigenous Status	Number of cannabis use and possession offences					
	2015	2016	2017	2018	2019	2020
Aboriginal and/or Torres Strait Islander	409	450	404	428	474	646
Non-Indigenous	6,942	6,908	6,509	6,884	7,331	8,928
Total	**7,508**	**7,526**	**7,180**	**7,546**	**8,045**	**9,793**

Source: Legislative Council Legal and Social Issues Committee. Data provided by the Crime Statistics Agency.

The overrepresentation of Aboriginal and Torres Strait Islander Victorians is compounded by the fact they are less likely to receive a caution for a minor cannabis offence.[38] Whilst no comparable research exists in Victoria, several stakeholders noted the findings of research from New South Wales which showed that Aboriginal people are:

- less likely to receive a caution for possessing cannabis
- more likely to be brought to court for possession of cannabis offences
- once in court, more likely to receive punitive sentences compared to non-Aboriginal people.[39]

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37 Victorian Public Sector Commission, *Victorian Aboriginal Demographics*, 2019, <https://vpsc.vic.gov.au/html-resources/aboriginal-cultural-capability-toolkit/aboriginal-victoria-today/#:~:text=As%20of%20the%202016%20Census,to%2037%20for%20other%20Victorians> accessed 26 April 2021.

38 See: Victoria Legal Aid, *Submission 1373*; Students for Sensible Drug Policy Australia, *Submission 1392*; Victorian Aboriginal Legal Service, *Submission 1398*.

39 See: Victoria Legal Aid, *Submission 1373*; Students for Sensible Drug Policy Australia, *Submission 1392*; Victorian Aboriginal Legal Service, *Submission 1398*. The research referred to is Michael McGowan and Christopher Knaus, 'NSW police pursue 80% of Indigenous people caught with cannabis through courts', *The Guardian*, 10 June 2020, <https://www.theguardian.com/australia-news/2020/jun/10/nsw-police-pursue-80-of-indigenous-people-caughtwith-cannabis-through-courts> accessed 2 July 2021.

Despite the lack of specific research in Victoria, the Victorian Aboriginal Legal Service argued that it is 'accepted evidence' that Aboriginal and Torres Strait Islander people are more likely to have matters heard through the court than be recommended for diversion or caution programs.[40]

In its submission, Fitzroy Legal Service discussed the growing overrepresentation of Aboriginal and Torres Strait Islander people in Victoria's prison population. It noted that from 2009 to 2019:

- the number of Aboriginal prisoners in Victoria tripled
- number of receptions[41] of Aboriginal prisoners had quadrupled, increasing from 7% to 13%.[42]

The unique harms faced by the Aboriginal and Torres Strait Islander community because of the criminalisation of cannabis use is discussed further in Section 4.6.2.

The Committee is disappointed that there is no publicly available data on the number of cannabis cautions issued to Aboriginal and Torres Strait Islander Victorians. The overrepresentation of these communities in the criminal justice system is an ongoing concern that requires immediate redress. It is important that there is enough publicly available data to better understand the extent of the issue and to help develop solutions.

FINDING 12: Aboriginal and Torres Strait Islander Victorians are significantly overrepresented in sentencing statistics for minor cannabis offences compared to other Victorians. From 2015 to 2020, they accounted for 6% of cannabis offenders, despite only making up 0.8% of Victoria's population. In addition, they are:

- less likely to receive a caution
- more likely to be required to attend Court proceedings for the offence
- more likely to receive a punitive sentence.

4.4.4 Court diversion

Similar to Victoria Police's diversion programs discussed previously in Section 4.3.1, people charged with minor cannabis offences may also be eligible for court diversion programs. However, there is no specific cannabis diversion program offered by the courts. Rather, a diversion program can be offered for most minor drug offences which are heard in the Magistrates' Court.[43]

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40 Victorian Aboriginal Legal Service, *Submission 1398*, p. 12.

41 All prisoners undergo reception and assessment before being placed in a prison unit appropriate for the prison and the prisoner's needs.

42 Fitzroy Legal Service, *Submission 1396*, p. 14.

43 Victoria Legal Aid, *Diversion programs*, 2019, <https://www.legalaid.vic.gov.au/find-legal-answers/going-to-court-for-criminal-charge/possible-outcomes-for-criminal-offences/diversion-programs> accessed 1 July 2021.

Like the Victoria Police programs, a person charged with a drug offence must admit to the charges to be eligible to participate in a program. In addition, it must be recommended for diversion by the police officer responsible for the case.[44]

An offender may be eligible for diversion if:

- the offence can be heard in a Magistrates' Court
- the offence does not have a minimum fixed sentence or penalty
- the offender agrees to take responsibility for the offence.[45]

Ms Ashleigh Stewart, Research Assistant at the Burnet Institute, considered that eligibility requirements for drug diversion were 'strict'. She discussed the impact this can have on marginalised or vulnerable people:

> We know that these [diversion] programs have quite a lot of eligibility requirements, and the schemes often involve people who admit to the offence, have not been detected by police more than once or twice and carry a particular quantity, so up to a certain amount. Anyone who does not meet these strict requirements is processed through the usual court mechanism, and such eligibility requirements often exclude those who are most marginalised and most in need of diversion programs and treatment.[46]

This was echoed by Mr Sione Crawford, Chief Executive Officer of Harm Reduction Victoria. He believed that the purpose of drug diversion should be to help problematic users get the help they need to address their problems with drug use:

> Our current diversion scheme is useful but it does not go far enough to ensure that young people's lives are not ruined by using drugs. It may seem counterintuitive to people who have never been involved in a criminalised activity like illicit drug use and dependence, but really it is not simple to reach out for help, and it is important we do anything we can to make it easier for the minority of users who have problematic use to reach out.[47]

Mr Kin Leong, Principal Managing Lawyer, Criminal Law Practice at the Victorian Aboriginal Legal Service, believed that access to diversion programs should not rely on police consent or recommendation as this may unduly exclude people who need support:

> Access to cautions and diversions should be available, regardless of a person's criminal history and it should be made without the need for police consent and recommendation for diversion. At the moment if an adult in the criminal jurisdiction is seeking diversion,

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44 Ibid.

45 Ibid.

46 Ms Ashleigh Stewart, Research Assistant, Burnet Institute, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 39.

47 Mr Sione Crawford, Chief Executive Officer, Harm Reduction Victoria, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 17.

> for any kind of offence, the police need to consent to it. And so, that is often a bar to people receiving the benefit of diversion. We also need to broaden the scope of drug courts in Victoria.[48]

In the Committee's view, the current eligibility requirements for drug diversion programs are too restrictive. This includes the requirement for a guilty plea, which may dissuade some offenders based on legal advice they receive, or the possibility they may receive a lesser sentence.

This excludes some people who would benefit from the programs, particularly the ability to access treatment for problematic use. This has been particularly harmful for more vulnerable communities such as Aboriginal and Torres Strait Islander people. This issue is discussed further in Section 4.6.2.

The Committee recommends that existing drug diversion programs be reviewed to determine if they are too restrictive and excluding of vulnerable communities.

FINDING 13: The restrictive eligibility criteria of drug diversion programs have excluded some of those who are marginalised and vulnerable and in the most need of treatment and support services.

RECOMMENDATION 9: That the Victorian Government reviews the eligibility requirements of existing drug diversion programs to determine if they are too restrictive and excluding of vulnerable people in need of treatment of support. In particular, the Government should consider the need for requirements such as:

- requiring police to consent to offering an offender drug diversion
- pleading or admitting guilty to an offence, including alternatives to admitting the offence which do not result in a finding of guilt
- capping the number of diversions a person can receive where a minor drug/cannabis offence is the sole or primary offence.

Children's Court Youth Diversion Service

Diversion through the courts is also available for young people charged with cannabis use or possession offences in the Children's Court. This is a specialist court that presides over cases involving criminal offending committed by children and young people, as well as cases dealing with care and protection of children. The Children's Court also includes a Children's Koori Court, which deals with certain cases involving Aboriginal and Torres Strait Islander children.

48 Mr Kin Leong, Principal Managing Lawyer, Criminal Law Practice, Victorian Aboriginal Legal Service, public hearing, Beechworth, 28 April 2021, *Transcript of evidence*, p. 13.

The Children's Court of Victoria has a pre-plea program called the Youth Diversion Service which aims to prevent reoffending by:

- building protective factors and addressing the underlying factors contributing to offending
- prevent the stigma of a criminal record affecting a young person's life by giving them an opportunity to have their charges discharged.[49]

Box 4.3 below outlines the Children's Court Youth Diversion Service.

BOX 4.3: Children's Court Youth Diversion Service

The Children's Court Youth Diversion Service commenced state-wide in January 2017. The service provides a pre-plea option for young people appearing at the Court accused of criminal offences. It provides a young person the opportunity to undertake a diversion plan aimed reducing the likelihood of reoffending and for their charges to be discharged following the successful completion of the plan.

The Youth Diversion Service targets young people with no or limited criminal history whose likely sentence otherwise would not have required supervision from youth justice. The circumstances of the young person and their offending are also considered when assessing their suitability for the program. There are no automatically excluded sentences from the program, other than those which carry a mandatory penalty.

Under the *Children, Youth and Families Act 2005* (Vic) the prosecution and the accused both need to consent to diversion.

Some of the benefits of participating in the Youth Diversion Service program are:

- accepting responsibility for offending behaviour
- completing a diversion plan which intends to strengthen individual protective factors and increase understanding of the harm of a young person's offending
- upon the successful completion of a plan, have all charges discharged
- avoid the stigma associated with a criminal record.

Source: Children's Court of Victoria, *Youth Diversion Service*, <https://www.childrenscourt.vic.gov.au/criminal-division/youth-diversion-service> accessed 1 July 2021.

4.4.5 Drug Court

The Drug Court is a post-sentence program focused on rehabilitation and treatment of offenders with a drug and/or alcohol dependency. The purpose of the Drug Court is to impose a Drug and Alcohol Treatment Order. A Drug and Alcohol Treatment Order consists of two parts:

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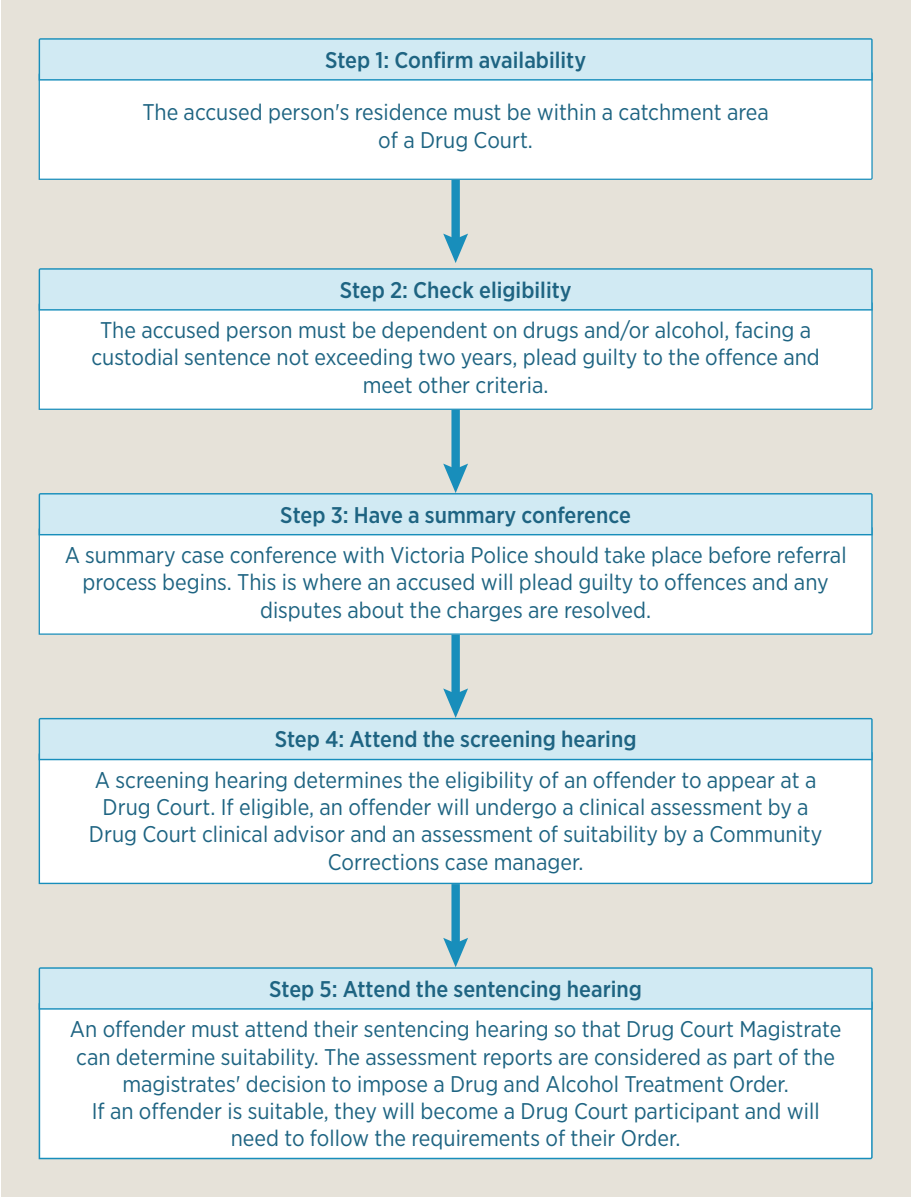
49 Children's Court of Victoria, *Youth Diversion Service*, <https://www.childrenscourt.vic.gov.au/criminal-division/youth-diversion-service> accessed 1 July 2021.

- **Custodial:** a custodial sentence—no more than two years—served in the community so that the offender can receive drug and/or alcohol treatment.
- **Treatment and supervision:** to address the drug and/or alcohol dependence.[50]

A referral to Drug Court to receive a Drug and Alcohol Treatment Order is a complex process. Figure 4.9 below outlines the steps required to receive a referral to a Drug Court.

Figure 4.9 Referral process for attending a Drug Court



Source: Magistrates' Court of Victoria, Drug Court, 2021, <https://www.mcv.vic.gov.au/about_us/drug-court> accessed 1 July 2021.

50 Magistrates' Court of Victoria, *Drug Court*, 2021, <https://www.mcv.vic.gov.au/about_us/drug-court> accessed 1 July 2021.

A participant of the Drug Court under the terms of their Drug and Alcohol Treatment Order are required to:

- attend regular appointments at the Court, including a weekly appearance at the Court
- submit to routine alcohol and drug testing
- engage in assessment and treatment
- attend education, employment, or other development programs
- comply with other conditions of their Order, such as a curfew condition.[51]

The Alcohol and Drug Foundation explained the rationale of the Drug Court is to target offenders at high risk of re-offending because of alcohol and/or drug misuse and address their substance abuse issues. It believed that the Drug Court model acknowledged that substance dependence was a health issue rather than a behavioural issue and aimed to improve the health and wellbeing of an offender to prevent reoffending.[52]

The Alcohol and Drug Foundation further outlined the outcomes of drug courts in Victoria and New South Wales and considered them an effective alternative to imprisonment:

> that Drug Courts are meeting their aims of reducing recidivism, reducing AOD use, increasing full-time employment, and reducing unemployment among participants. A report by KPMG found a 31 per cent lower rate of reoffending in the first 12 months, and a 34 per cent lower rate of reoffending within 24 months for offenders. Another study found participants were significantly less likely to commit any further offence. A review in 2006 found that full-time employment among participants doubled upon the completion of the program and unemployment lessened by 32 per cent. The structure of the program means that offenders are not separated from society and the period of readjustment upon completion is less onerous than the consequent readjustment necessitated by imprisonment.[53]

Victoria Legal Aid, which houses a specialist Drug Court team, noted that cannabis use alone typically does not result in a person participating in the Drug Court.[54]

The exclusion of cannabis use or possession offences from the Drug Court program was also discussed by the Victorian Aboriginal Legal Service which believed that the program's criteria were too narrow and restrictive. It recommended expanding the criteria to allow low level drug offences such as cannabis use and possession to be dealt with using a Drug and Alcohol Treatment Order.[55]

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51 Ibid.

52 Alcohol and Drug Foundation, *Submission 1386*, p. 12.

53 Ibid.

54 Victoria Legal Aid, *Submission 1373*, p. 6.

55 Victorian Aboriginal Legal Service, *Submission 1398*, p. 13.

In contrast, the Dalgarno Institute noted that if cannabis prohibition was removed, cannabis users would no longer have access to the program unless they committed another crime. This is despite the fact the program offers rehabilitation services.[56]

4.4.6 Court Integrated Services Program

The Court Integrated Services Program is a pre-sentence program established in 2006 to coordinate the assessment and treatment of accused persons appearing before a Victorian Magistrates' Court. It focuses on ways to address underlying causes of offending behaviour by providing case management support and referrals to support services such as:

- drug and alcohol treatment services
- crisis and supported accommodation
- disability services
- mental health services
- and other support services.[57]

As well as meeting the eligibility requirements, a person is required to undergo a formal risk assessment and screening process to enter the program. Entrants are assigned a case manager who is responsible for coordinating their treatment.[58]

To be eligible for the Magistrates' Court Integrated Services Program, the accused must:

- be charged with an offence
- consent to being involved in the program
- be experiencing:
  - drug and alcohol dependency and misuse issues
  - physical or mental disabilities or illnesses
  - inadequate social, family and economic support which has contributed to the frequency and severity of their offending
  - homelessness.[59]

56 Dalgarno Institute, *Submission 215*, p. 6.

57 Magistrates' Court of Victoria, *Bail support (CISP)*, 2019, <https://www.mcv.vic.gov.au/find-support/bail-support-cisp> accessed 25 June 2021.

58 Ibid.

59 Ibid.

Figure 4.10 below shows the client process for the program. At the conclusion of the program (once the bail period has ended), the offender returns to the court and enters the plea. Their participation in the Court Integrated Services Program may be considered when sentencing.[60]

Figure 4.10 The client process for the Court Integrated Services Program

Source: Magistrates' Court of Victoria, *Court Integrated Services Program: Tackling the causes of crime*, 2010, <https://aija.org.au/wp-content/uploads/2017/08/CISP.pdf> accessed 25 June 2021.

60 Magistrates' Court of Victoria, *Court Integrated Services Program: tackling the causes of crime*, 2010, <https://aija.org.au/wp-content/uploads/2017/08/CISP.pdf> accessed 25 June 2021.

In November 2020, the Court Integrated Services Program was expanded to the County Court through the Court Integrated Services Program Pilot. Under the pilot program, individuals accused of indictable criminal offences are eligible to participate in the program if they meet the eligibility requirements.[61]

In January 2021, the County Court pilot was expanded to include individuals seeking bail or deferral of sentencing. The County Court program includes offenders who have matters before the Koori Court.[62]

At a public hearing, Mr Diab Harb, Executive Director, Justice System Reform at the Department of Justice and Community Safety explained the aim of services like the Court Integrated Services Program. He stated these are intended to address the 'underlying causes of offending, leading to a reduction in reoffending and increased community safety'.[63]

The Victorian Aboriginal Legal Service considered the Court Integrated Services Program an opportunity for people to engage in support that will assist recovery and rehabilitation. However, it noted that being a court program it means that a person can only access the support and referral programs once they have interacted with the criminal justice system. In its submission, it described the issues its clients face in accessing the program:

> Unfortunately [the Court Integrated Services Program] is over-subscribed, under-resourced and not available at all courts, with many rural and regional courts unable to provide this service. With 50.7% of Aboriginal Victorians residing in regional and rural areas, and comparatively higher drug use in regional and rural areas, a great number of Aboriginal people fall on the wrong side of what could be viewed as postcode justice.[64]

In its submission, Victoria Legal Aid believed the program could be 'transformative' for a person experiencing disadvantage who is before a court, as it seeks to address underlying factors to offending. However, Victoria Legal Aid stated that the program is not available equally across all regions, with some rural and regional areas unable to offer the program because of resource and funding constraints.[65]

The Court Integrated Services Program is an effective response for offenders with alcohol and other drug issues, providing them an opportunity to get support to address underlying factors for their offending including drug misuse. Access to support that focuses on building protective factors is an effective way of reducing reoffending and assists offender reintegration and rehabilitation.

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61 The County Court pilot program includes additional eligibility requirements, such as residing in the Greater Melbourne catchment, not current be sentenced or on a community corrections order, have substantive matters committed to the Melbourne Country Court. The program also excludes people charged with sexual offences.

62 County Court of Victoria, *Court Integrated Services Program*, 2021, <https://www.countycourt.vic.gov.au/going-court/criminal-division/court-integrated-services-program> accessed 25 June 2021.

63 Mr Diab Harb, Executive Director, Justice System Reform, Department of Justice and Community Safety, public hearing, Melbourne, 1 June 2021, *Transcript of evidence*, p. 6.

64 Victorian Aboriginal Legal Service, *Submission 1398*, p. 14.

65 Victoria Legal Aid, *Submission 1373*, pp. 9–10.

In the Committee's view, the Court Integrated Services Program should be expanded to ensure as many eligible Victorians as possible have access to the program. The Committee also notes that many rural and regional courts are unable to provide this service with their current resources. To address this, the Victorian Government should provide adequate funding to ensure these courts have the capacity to offer it to eligible offenders.

RECOMMENDATION 10: That the Victorian Government provides funding to the Magistrates' Court and County Court (following the outcomes of its pilot program) to expand the Court Integrated Services Program, particularly into regional and rural Victoria.

4.4.7 Assessment and Referral Court

The Assessment and Referral Court is a court list of the Magistrates' Court of Victoria for accused persons who have a mental illness and/or cognitive impairment. It aims to help offenders address underlying factors which may contribute to their offending.

For a matter to be heard in the Assessment and Referral Court, it must be referred and the accused person is assessed to ensure they meet the following eligibility criteria:

- the accused person has been diagnosed with a mental illness and/or cognitive impairment
- their diagnosis substantially reduces their capacity to:
  - self-care
  - self-manage
  - socially interact
  - communicate
- the accused person would benefit from receiving coordinated services developed as part of an individual support plan, such as:
  - drug and alcohol treatment services
  - psychological services
  - welfare services
  - health and mental health services
  - disability services
  - housing support.[66]

66 Magistrates' Court of Victoria, *Assessment and Referral Court (ARC)*, 2018, <https://www.mcv.vic.gov.au/about-us/assessment-and-referral-court-arc> accessed 1 July 2021.

In its submission, Victoria Legal Aid discussed the importance of therapeutic court programs such as the Assessment and Referral Court:

> Therapeutic Court programs such as the Assessment and Referral Court are proven to deal more effectively with factors contributing to offending behaviour, such as mental health issues and substance dependence. The opportunity to access therapeutic and other court-based support services should be made available to all Victorians, regardless of where they live.[67]

Victoria Legal Aid also discussed that access to therapeutic diversion programs are often limited:

> Successful diversionary responses are reliant on funded services which can help people address underlying issues. Access to diversion schemes is often limited, as many jurisdictions only authorise access to programs to offenders without a lengthy criminal history, limiting access by repeat offenders who are affected by relapses of drug dependence.[68]

4.5 Medicinal cannabis

Medicinal cannabis is regulated under the *Narcotic Drugs Amendment Act 2016* (Cth) which established a national medical cannabis scheme. This includes a licensing system for patients, prescribers, and manufacturers. Chapter 2 explained the regulatory framework for medicinal cannabis in more detail.

Several stakeholders stated that there could be barriers limiting people's access to medicinal cannabis in Australia. Three common barriers discussed were:

- affordability of medicinal cannabis
- a confusing regulatory framework
- reluctance from medical professionals in prescribing medicinal cannabis.[69]

The Australian Lawyers Alliance believed that the current regulatory model for medicinal cannabis makes it difficult for people to access it. As a result, this drives some people to purchase black market cannabis for themselves or others when they are unable to get a prescription:

> Families are desperate to provide the best possible medical treatment and pain relief for their loved ones. The cost, the regulatory burdens and the outdated approaches of some medical practitioners means that these families are often forced to source illegal, black market cannabis, which puts them at risk of serious criminal charges.

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67 Victoria Legal Aid, *Submission 1373*, p. 10.

68 Ibid.

69 See: Australian Lawyers Alliance, *Submission 212*; Medicinal Cannabis Industry Australia, *Submission 1351*; Burnet Institute, *Submission 1358*.

> Black market cannabis is considerably more inexpensive than lawfully manufactured medicinal cannabis, which continues to deter patients from accessing medicinal cannabis lawfully. This will continue if the issue of cost is not addressed.[70]

The Australian Lawyers Alliance also discussed the findings of the Senate Community Affairs Committee's 2020 inquiry into the *Current barriers to patient access to medicinal cannabis in Australia.* The Committee found that there was inequitable access to medicinal cannabis across different jurisdictions:

> with patients in rural and remote communities finding it difficult to access medicinal cannabis if their local health professional is unwilling to consider prescribing medicinal cannabis or does not have sufficient knowledge of it. In situations described as 'postcode lottery', the Committee received reports of patients unable to meet the costs of travelling into cities to access health services, or having to relocate to other regions in order to access medicinal cannabis.[71]

In its submission, the Australian Lawyers Alliance recommended that prescription rights for medicinal cannabis be extended to nursing practitioners, particularly in rural and remote communities.[72]

The Medicinal Cannabis Industry Australia acknowledged barriers limiting patient access to medicinal cannabis caused by the current regulatory framework.[73] In its submission, it outlined several recommendations that could be implemented to redress these barriers:

- Facilitating access to Australian product through streamlining and operationalising the regulatory system
- Building confidence through supporting evidence and transparency i.e. facilitation of research and clinical trials to provide patients and medical practitioners with an evidence base regarding safety, efficacy, pharmacokinetics and pharmacodynamics of the products, target conditions, dosages, drug-drug interactions, the appropriate rescheduling of cannabis, etc
- Improving affordability and specifically subsidised pricing to deliver more affordable product for patients
- Supporting and funding healthcare practitioner education (doctors, nurse practitioners, pharmacists and others)
- Clarification of issues such as driving regulations and medicinal cannabis use[74]

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70 Australian Lawyers Alliance, *Submission 212*, p. 7.

71 Ibid., pp. 7–8.

72 Ibid., p. 8.

73 Medicinal Cannabis Industry Australia, *Submission 1351*, p. 4.

74 Ibid.

Numerous stakeholders shared personal stories about using cannabis for medical purposes, they noted they were unable or struggled to access legal medicinal cannabis. The following excerpts are taken from these submissions:

> 'I am a pensioner with a debilitating tremor that can be reduced substantially with the use of medicinal cannabis. Its current cost prevents me accessing it.'
>
> John Blanchfield, *Submission 483*, p. 1.
>
> 'It's time that people who can benefit from the mental and physical properties of marijuana are allowed to access that without going to the black market or jumping through a ridiculous set of hoops.'
>
> Brodie Evans, *Submission 690*, p. 1.
>
> 'I am extremely grateful of having access, though the cost is extremely prohibitive as it is not currently subsidised.'
>
> David Eddy, *Submission 1137*, p. 1.

In its submission, Budherd an advocacy group for the health benefits of cannabis stated that most people identifying as using cannabis for medicinal reasons are accessing it through the illicit market.[75] It noted the findings of a 2019 study undertaken by the University of New South Wales which examined medicinal cannabis use following medical legalisation. The study found that 2.4% of study respondents reported accessing legal medical cannabis prescribed by a doctor.[76]

Another issue considered by stakeholders who discussed medicinal cannabis was drug-driving. Stakeholders noted that in Victoria the drug-driving test is a detection-based test rather than an impairment-based test. This means that individuals using cannabis for legitimate medicinal purposes, even with a prescription, are unable to drive if they have any level of tetrahydrocannabinol (THC) in their system.

The issue of drug driving and medicinal cannabis is discussed further in Section 4.7.2.

It is important that people who may genuinely require medicinal cannabis should experience as little unnecessary barriers to accessing it as possible. The Committee found that pricing and the attitudes of general practitioners in prescribing medicinal cannabis has caused some people to purchase illicit cannabis and self-medicate. Purchasing illicit cannabis for self-medication is high-risk as most people will not have the medical knowledge to regulate their use in a safe way or the insight into how the product has been manufactured. In addition, as discussed in Chapter 2 modern black-market cannabis is often manufactured to have high potency.

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75 Budherd, *Submission 217*, p. 7.

76 Nicholas Lintzeris et al., 'Medical cannabis use in the community following introduction of legal access: the 2018-19 Online Cross-Section Cannabis as Medicine Survey (CAMS-18)', *Harm Reduction Journal*, vol. 17, no. 37, 2020, <https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-020-00377-0> accessed 1 July 2021.

Legal medicinal cannabis comes with the assurance that the product is safe, regulated and has been prescribed by a medical professional. In the Committee's view, a review should be undertaken of the existing medical cannabis framework to ensure it is not creating unnecessary barriers to access which could incentivise people to instead access illegal cannabis.

FINDING 14: The current regulatory framework for medicinal cannabis has created barriers limiting patient access. As a result, some people are choosing to access the illicit cannabis market for themselves to self-medicate or on another person's behalf because they are unable to procure cannabis through licit channels.

RECOMMENDATION 11: That the Victorian Government advocates to the National Cabinet to remove unnecessary barriers for accessing medicinal cannabis and consider whether current pricing schemes are too high.

4.6 Effects of a criminalisation approach to cannabis use

A key consideration for this Inquiry is how to best prevent the harms associated with the criminalisation of cannabis use. The Committee is particularly concerned about:

- the ramifications of having a criminal record for a conviction relating to minor use and possession and the stigma associated with a criminal record
- the distinct impact of criminalisation on vulnerable communities, such as Aboriginal and Torres Strait Islander Victorians and Victoria's culturally and linguistically diverse communities
- the impact of criminalisation on young people
- the substantial costs for the criminal justice system to police cannabis use.

At a public hearing, Ms Ashleigh Stewart from the Burnet Institute described some of the impacts the criminal justice system can have on an individual:

- increased risk of continued involvement and contact with the justice system (recidivism)
- poorer social outcomes, such as difficulty finding employment, housing, or education opportunities
- potentially poorer health outcomes or disrupted medical care
- challenges reintegrating back into society.[77]

77 Ms Ashleigh Stewart, *Transcript of evidence*, p. 39.

4.6.1 Criminal records

> Although the illegal status of drug use is an effective deterrent for many people, drug use does continue, and it is argued that imprisoning people for drug dependence has no effect on preventing further drug offences. The rate of offending is also higher among dependent drug users which is attributed to their drug use and people with criminal records as a result of drug offences [having] restricted employment opportunities.
>
> Victoria Police, *Submission 901*, p. 15.

A criminal record is an important public safety tool and can be used as a deterrent mechanism against reoffending. However, the Committee believes that for low-level cannabis offences it should not be used as an additional punitive measure against an individual. Victoria's current approach to cannabis prohibition has emphasised the criminalisation and policing of cannabis users alongside providers. Although many cannabis users are diverted away from the courts using cannabis cautions and diversion programs, a substantial number of users are not. As a result, these users may receive a conviction that is recorded on their criminal record.

The longevity and effects of a criminal record can sometimes be overly punitive. It can seriously impact an individual's opportunities to access education, employment or housing, which are important to manage their reintegration and prevent reoffending. The Committee found that in many cases, a criminal record generates substantial social harms for cannabis users which is disproportionate to the harm of using cannabis.

The Committee previously considered information disclosed on criminal records in its *Inquiry into a legislated spent convictions scheme*. The Committee found that a criminal record can:

- adversely impact a person's progress towards rehabilitation and reintegration
- cause widespread discrimination from employers, peers and the community
- lead to exclusionary practices, affecting a person's opportunities for employment, education and housing
- cause a sense of stigma or shame that is out of proportion to the offending.[78]

This was acknowledged by Victoria Police in its submission to this Inquiry. Victoria Police noted that a criminal record may be counterproductive in preventing reoffending and restricts employment opportunities:

> Although the illegal status of drug use is an effective deterrent for many people, drug use does continue, and it is argued that imprisoning people for drug dependence has no effect on preventing further drug offences. The rate of offending is also higher among

78 Parliament of Victoria, Legislative Council Legal and Social Issues Committee, *Inquiry into a legislated spent convictions scheme*, August 2019, pp. 12–16.

> dependent drug users which is attributed to their drug use and people with criminal records as a result of drug offences [having] restricted employment opportunities.[79]

The Public Health Association of Australia discussed that a criminalisation response to cannabis use generates greater harms to the user than those caused by the use of cannabis. It advocated for a response which focused on strengthening protective factors:

> Responses which result in a criminal record and incarceration may lead to more lasting harm to the user than may be cause by the use of the drug. In contrast, strengthening and supporting personal and social protective factors reduces the likelihood that young people will engage in problematic drug use, and promotes mental and physical health and wellbeing. This includes many social determinants of health including family relationships, education, employment and housing.[80]

A criminal record can cause significant social harms for an individual, which may be disproportionate to the harms of their offending. Some stakeholders suggested this was the case when the offending was related to cannabis use and possession.

A criminal record can impact a person's opportunities for employment or education which are important protective factors against recidivism.[81] For example, barriers to employment are created because of the stigma associated with a criminal record which can cause an employer to discriminate against a person with a criminal history. In the case of low-level cannabis use or possession, this is a significant social harm to experience for a relatively low harm offending.[82]

The Committee notes that the *Spent Convictions Act 2021* (Vic) amended the *Equal Opportunity Act 2010* (Vic) to make a spent conviction a protected attribute, prohibiting discrimination.

In its submission, Youthlaw advocated that the decriminalisation of cannabis use would consequentially remove the possibility of a criminal record for cannabis possession and move cannabis use from a criminal issue to a health one:

> Decriminalisation will help define drug use as a health and social issue, and thereby reduce the damaging stigma attached to people who use drugs. Reducing stigma, while expanding access to treatment services, could significantly improve health outcomes for young people who use drugs.
>
> The young person would not have a criminal record for personal use or possession of small quantities of illegal substances, which would improve their ability to gain employment or participate in other community activities.[83]

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79 Victoria Police, *Submission 901*, p. 15.

80 Public Health Association of Australia, *Submission 1391*, p. 5.

81 For example see: Professor Simon Lenton, Director and Program Leader, National Drug Research Institute, public hearing, Melbourne, 19 May 2021, *Transcript of evidence*; Students for Sensible Drug Policy Australia, *Submission 1392*; Fitzroy Legal Service, *Submission 1396*.

82 Fitzroy Legal Service, *Submission 1396*.

83 Youthlaw, *Submission 1389*, p. 4.

Education, employment and housing

The Committee heard how a criminal record can also negatively affect an individual's opportunities for education, employment and housing. This can increase the chances of recidivism and diminish the success of any rehabilitation or reintegration development an offender has undertaken. For minor drug offences such as cannabis possession this can also have negative consequences for the health and wellbeing of an individual. This includes:

- a reduced willingness to address problematic use
- hesitance to engage health professionals for support
- a higher likelihood of experiencing discrimination from the housing and employment sectors.

Springvale Monash Legal Service noted that a criminal record can increase a person's likelihood of periods of unemployment, housing insecurity or homelessness:

> Criminal records can exacerbate risk of unemployment, homelessness and poverty. The stigma of a criminal record is carried through life; even long after someone may have sought treatment for problematic drug use and reduced their consumption. Criminalisation significantly contributes to the stigma of cannabis use, which increases people's suffering and isolation and impacts the way they engage with services in their community. Experiences of exclusion, marginalisation and discrimination impacted on participants' access to health care (including treatment) and other services such as welfare services, AOD treatment providers, and housing, fair treatment in the justice system, employment opportunities, and relationships with family, friends and community. Criminalisation reinforces stigmatisation of drug dependency, addictions and use, and decriminalisation can be an intervention to stigmatisation.[84]

In its submission, Fitzroy Legal Service explained how the effects of a criminal record can have a life-long impact on an individual:

> The stigma of a criminal record is a major barrier to social opportunities – employment, study, kinship care. There are many work forces that are subject to specialised criminal record checks under policy or legislative schemes, wherein boards are empowered and guided to make judgements relevant to risk assessment (teaching, aged care, lawyers, doctors, nurses, real estate agents, police, working with children). Standard criminal record checks are handled by ordinary employers with extremely variable experience in making assessments of risk. The protections against unfair discrimination on the basis of what would legally be deemed an 'irrelevant criminal record' are extremely limited. Given the breadth of use of cannabis, this particular type of low-level offence is a clear example of the way in which a criminal record may not be an accurate indicator of risk, but rather, an indicator of bad luck, or peripheral circumstances likely to drive police attention (for example, visibility, youth, race, reliance on public spaces, poverty).[85]

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84 Springvale Monash Legal Service, *Submission 1399*, p. 11.

85 Fitzroy Legal Service, *Submission 1396*.

At a public hearing, Ms Felicity Williams, Chief Executive Officer, from The Centre for Continuing Education Wangaratta stated that there are some industries that will employ a person with a criminal record, such as the civil construction or hospitality industry. However, in other industries it is more difficult for a person to gain employment if they have a criminal record.[86]

A criminal record can create barriers to education, employment, and housing for offenders, even if the offending is relatively minor such as cannabis use and possession. The Committee believes that the harm caused by these barriers experienced by people with a criminal record for minor cannabis offences outweighs the harms generated from cannabis use. Barriers to employment and education can seriously affect an individual's rehabilitation and social reintegration, potentially increasing the likelihood of recidivism.

FINDING 15: A criminal record for a minor cannabis use or possession offence creates barriers to housing, education, and employment for individuals. These barriers are counterproductive to rehabilitation and reintegration, potentially increasing the likelihood of reoffending.

4.6.2 Overrepresentation and impacts on vulnerable communities

> We do not want half the population to be in a lottery where there are no winners and losers get a criminal record. This is especially true when there are no health benefits to the criminalisation and if the arrests are unevenly applied.
>
> Dr Devin Bowles, Chief Executive Officer, Alcohol Tobacoo and Other Drug Association.

The Committee found that minority communities face distinct harms from the criminalisation of cannabis use.

As discussed previously in Section 4.4.3, some minority groups are overrepresented in minor cannabis offences compared to the general population and more likely to face harsher penalties. The inequity of law enforcement responses to cannabis use has created unique harms for these communities and further entrench disadvantage experienced by community members.

Dr Devin Bowles, Chief Executive Officer at the Alcohol Tobacco and Other Drug Association ACT believed that the policing of cannabis use is not equitable, with more disadvantaged people experiencing greater harm:

> legislation that criminalises an activity that anywhere between a third and half of Australians have engaged in clearly needs rethinking from a human rights perspective.

86 Ms Felicity Williams, Chief Executive Officer, The Centre for Continuing Education (Wangaratta), public hearing, Beechworth, 28 April 2021, *Transcript of evidence*, p. 25.

> We do not want half the population to be in a lottery where there are no winners and losers get a criminal record. This is especially true when there are no health benefits to the criminalisation and if the arrests are unevenly applied. Most of my friends who used drugs did not get arrested because their families had the social status and money to insulate them from frequent police contact. Those of you who have a natural focus on equity have a lot to run with here, because disadvantaged people are arrested at much higher rates for the same activity that about a third to a half of Australians undertake.[87]

The Committee notes that culturally and linguistically diverse communities are particularly at risk of experiencing the myriad of personal and social harms generated from criminalising cannabis use. It is particularly concerned that minor cannabis offences could jeopardise someone's visa or result in visa cancellation and deportation.[88] In the Committee's view, the potential criminalisation harms faced by Victoria's culturally and linguistically diverse communities outweighs the harms of their cannabis use.

In its submission, Victoria Legal Aid noted the 'cascading harms' experienced by culturally and linguistically diverse communities because of their overrepresentation in the criminal justice system:

> For Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse communities, who are overrepresented in the justice system, contact with the criminal justice system for even minor offending can cause cascading harms, increasing the likelihood of ongoing interaction with the criminal justice system and deaths in custody.[89]

At a public hearing, Ms Ashleigh Newnham from Springvale Monash Legal Service discussed the issue of visa cancellations resulting from cannabis use and possession offences. She explained that a person's visa can be cancelled if they are 'deemed to be of bad character' and it could be automatically cancelled if they accumulate a sentence of imprisonment exceeding one year, even if it is a suspended sentence. Ms Newnham further noted:

> I know of young people that have been charged with, you know—sometimes it is a combination of charges. It is not necessarily only the possession of drugs; it can be maybe property damage or some other things that have led to an accumulative one-year sentence. So it might have been short sentences and then they add to up to 12 months and then your visa is automatically cancelled and you get a letter in the mail basically saying you have two weeks to leave the country. It is absolutely devastating, and sometimes these people—especially young people—do not actually know that they are not citizens. They are not aware of their own visa status, because—why is that something that is important to them at that young age?[90]

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87 Dr Devin Bowles, Chief Executive Officer, Alcohol Tobacco and Other Drugs Association ACT, public hearing, Melbourne, 19 May 2021, *Transcript of evidence*, p. 20.

88 Ms Ashleigh Newnham, *Transcript of evidence*, p. 49.

89 Victoria Legal Aid, *Submission 1373*, p. 3.

90 Ms Ashleigh Newnham, *Transcript of evidence*, p. 49.

The Public Health Association of Australia also discussed the vulnerability of some communities to the harms associated with cannabis use, including their underrepresentation in the alcohol and drug treatment system:

> There are culturally and linguistically diverse communities in Victoria who are particularly vulnerable to experiencing harms related to drugs – including low levels of health literacy and pre- and post- migration stressors making it harder to adjust to a new cultural environment. It is well documented that culturally and linguistically diverse communities are significantly underrepresented in the alcohol and drug treatment system, and that this lack of representation is illustrative of an under-utilisation of services rather than a lower need. Protecting public health and safety demands understanding the barriers and enablers of access to services for vulnerable groups such as culturally and linguistically diverse communities.[91]

Aboriginal and Torres Strait Islander communities

> So if you were to remove that requirement from the diversion program in Victoria and there was no longer a requirement to admit the offence, I think you would find Indigenous people would be more readily eligible for diversion programs and diverted of course out of the criminal justice system and all of the implications that flow on.
>
> Dr Kate Seear, Associate Professor & Principal Research Fellow, DruGS Research Program, Australian Research Centre in Sex, Health and Society, Latrobe University, public hearing, Melbourne, 19 May 2021, *Transcript of evidence*, p. 53.

As discussed in Section 4.4.3, Aboriginal and Torres Strait Islander Victorians are significantly overrepresented in offender statistics for cannabis use and possession. They are more likely to receive harsher penalties for use and possession offences compared to non-Aboriginal Victorians. Furthermore, they are less likely to be offered a cannabis caution or recommended into a diversion program.

At a public hearing, Mr Kin Leong, Principal Managing Lawyer, Criminal Law Practice, Victorian Aboriginal Legal Service, provided further data on cannabis users from the Aboriginal and Torres Strait Islander communities:

- Cannabis use is slightly higher amongst the Aboriginal and Torres Strait Islander population compared to the rest of the population, but it is declining.
- The number of incidents of cannabis use and possession involving Aboriginal and Torres Strait Islander people has risen by 55.5% in the last years and 97.5% since 2011. This is greater than the wider population where incidents involving cannabis use and possession has risen by 25.8% in the last five years.
- Aboriginal and Torres Strait Islander people are policed for minor drug offences five times higher than other communities.[92]

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91 Public Health Association of Australia, *Submission 1391*, p. 6.

92 Mr Kin Leong, *Transcript of evidence*, pp. 13–14.

Mr Leong discussed some of the distinct harms generated by Aboriginal and Torres Strait Islander people's overrepresentation as a result of minor cannabis offences:

> the correlation between ongoing trauma resulting from colonisation and substance use and death in custody, highlighting a system-wide failure to address the complex contributing factors of substance misuse in the Aboriginal communities. Rehabilitation from drug disorders is an individual journey that commonly includes a relapse as part of the recovery process. Addressing public health and safety concerns through the criminal justice system only contributes to the underlying causes and perpetuates disadvantage and further contact with the criminal justice system.[93]

Several stakeholders highlighted that Aboriginal and Torres Strait Islander people charged with minor cannabis offences are more likely to have their matter dealt with in court rather than be offered a cannabis caution or diversion program, even where they meet the eligibility requirements.[94]

Dr Kate Seear, Associate Professor at Latrobe University, described some of the unique barriers Aboriginal and Torres Strait Islander people face to accessing drug caution and diversion options:

> [a] serious problem for people from Aboriginal and Torres Strait Islander backgrounds is that in order to access diversion you are required under the cannabis caution program to admit the offence and to consent to participating in whatever it might be that you have been offered—usually to undergo a cannabis education session or the like. And we of course know that Indigenous people are often reluctant for cultural reasons and for reasons of history, including colonisation, to admit offences to police because of reasons which I am sure you are all well aware of, including concern about the implications for child protection, other systems and so on.[95]

She advocated that the program be reformed so that it removes requirements to admit the offence:

> So if you were to remove that requirement from the diversion program in Victoria and there was no longer a requirement to admit the offence, I think you would find Indigenous people would be more readily eligible for diversion programs and diverted of course out of the criminal justice system and all of the implications that flow on. I think that would be, for mine, the number one thing that you could do to ensure that the scheme essentially does not discriminate against or prohibit Indigenous people from taking up that opportunity.[96]

Mr Kin Leong from the Victorian Aboriginal Legal Service told the Committee that the Koori Court is unable to issue a drug treatment order and that Aboriginal and Torres Strait Islander people must appear before a Drug Court to receive an order. He noted

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93 Ibid., p. 13.

94 For example, see: Victorian Aboriginal Legal Service, *Submission 1398*; Victoria Legal Aid, *Submission 1373*.

95 Dr Kate Seear, *Transcript of evidence*, p. 53.

96 Ibid.

that in some cases this may not be appropriate as Drug Court is not always a culturally safe or appropriate venue. Mr Leong recommended that drug treatment orders be made a sentencing option available to the Koori Court.[97]

Another distinct harm stemming from the criminalisation of cannabis to the Aboriginal and Torres Strait Islander community is it impacts on kinship arrangements for young people.[98] An Aboriginal kinship arrangement involves relatives or other members of the young person's network taking over caring responsibilities when a parent or other primary caregivers are unable. Fitzroy Legal Service noted that the stigma of a criminal record creates barriers to kinship and causes distinct challenges to kinship arrangements.[99]

A criminal record for a minor cannabis offence can also cause practical barriers to kinship arrangements. In 2017, the *Working with Children Act 2005* was amended to include kinship arrangements under the definition of 'child-related work' making it necessary for carers to apply for a Working With Children Check. The application process for these checks requires a person to consent to a criminal record check and an application may be denied if a person has committed:

- serious, violent or drug offences
- offences that pose an 'unjustifiable' risk to a child
- offences against the Working with Children Act.[100]

In addition, Working With Children Checks are exempt from the requirements of the Spent Convictions Act.

The impacts of a criminal record on kinship arrangements were also discussed in the Committee's report for the *Inquiry into a legislated spent convictions scheme*. The Committee found that a minor conviction can be a barrier to kinship caring and deter aboriginal community members from undertaking kinship arrangements.[101]

At a public hearing, Dr Shalini Arunogiri, Chair, Faculty of Addiction Psychiatry at the Royal Australian and New Zealand College of Psychiatrists (Victorian Branch) discussed the 'disproportionate harms' faced by Aboriginal and Torres Strait Islander people with convictions relating to cannabis use:

> I think in terms of Indigenous and Torres Strait Islander communities, what we are thinking about there is really that there are pockets where there are disproportionate harms associated with a whole range of things. That includes cannabis use, but I think it also significantly includes all of the harms that can come from cannabis punishments.

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97 Mr Kin Leong, *Transcript of evidence*, p. 19.

98 See: Fitzroy Legal Service, *Submission 1396*.; Victorian Aboriginal Legal Service, *Submission 1398*.

99 Fitzroy Legal Service, *Submission 1396*, p. 9.

100 *Working with Children Act 2005* (Vic) s 33.

101 Parliament of Victoria, Legislative Council Legal and Social Issues Committee, *Inquiry into a legislated spent convictions scheme*, p. 25.

> So here I am talking about incarceration or repeated incarceration and also the child protection framework that comes along with that. I think that is a really important framework to keep in mind as well when engaging with people from particular backgrounds that may have been disproportionately affected by those harms too.[102]

The Committee acknowledges that Aboriginal and Torres Strait Islander people experience compounded harms for encountering the criminal justice system, both in general and for minor cannabis offences. These people also experience poorer outcomes consequently compared to non-Aboriginal and Torres Strait Island people.

FINDING 16: Aboriginal and Torres Strait Islander people experience distinct trauma from interactions with the criminal justice system.

RECOMMENDATION 12: That Victorian Government considers drug treatment orders for use in the Koori Court.

4.6.3 Impacts on young people

The impacts of criminalisation of cannabis use on young people have been addressed throughout this Report. However, the Committee believes that young people are best placed to explain the impacts the criminalisation has on them. The Committee was encouraged by the significant engagement young people had with this Inquiry, particularly through the submission process and participation in the Inquiry's Youth Forum.

The harms of criminalisation as discussed by young people generally focused on:

- a perception of being unfairly targeted by law enforcement in policing cannabis use
- that police responses and treatment of cannabis users generates a general distrust of the justice system
- a belief that cannabis use is a 'victimless crime' and therefore a criminalisation response is too heavy handed
- prohibition does not affect rates of cannabis use, but it does force young people to access an unregulated illicit market where products may be unsafe.

102 Dr Shalini Arunogiri, Chair, Faculty of Addiction Psychiatry, Royal Australian and New Zealand College of Psychiatrists (Victorian branch), public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 36.

Participants at the Youth Forum were specifically asked to comment on how cannabis prohibition affects young people. The following excerpts are taken from responses from Forum participants.

'Young people often feel very targeted by police when it comes to drug use. Places where young people are, tend to end up having high police presence such as music festivals'

Dana, *Youth Forum worksheet*, Number 4.

'creates a black market that's unregulated – prohibition does not work to prevent people from use'

Name Withheld, *Youth Forum worksheet*, Number 5

'the [il]legal status makes people apprehensive to seek help where/ when it is needed … can't be destigmatized when criminalised.'

Julia Daly, *Youth Forum worksheet*, Number 7.

'creates unneeded stress and anxiety'

Name Withheld, *Youth Forum worksheet*, Number 8.

'prohibition doesn't help young people – doesn't prevent use, increases harm. In the case of problematic use, trouble with law causes unnecessary life challenges'

Quinn Jones, *Youth Forum worksheet*, Number 9.

There was a perception amongst some forum participants that cannabis use is a 'victimless crime' and that the criminalisation of use infringed on a person's choices:

'cannabis consumption is a victimless crime – it is an expression of a person's life choices and the criminal aspect of it is due to its criminalisation'

Name withheld, *Youth Forum worksheet,* Number 5.

'cannabis consumption is a victimless crime – disproportionately affects lower socioeconomic people'

Julia Daly, *Youth Forum Worksheet*, Number 7.

'It is a victimless crime to consume or possess cannabis, so it should be legal'.

Name Withheld, *Youth Forum worksheet*, Number 8.

Mr Liam Flaherty, a Youth Forum participant, noted that the current prohibition of cannabis means young people are accessing cannabis through the black market, potentially exposing them to other illicit substances. He believed that the prohibition of cannabis has unintentionally established it as a 'gateway drug' to more harmful substances.[103]

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103 Liam Flaherty, *Youth Forum worksheet*, Number 1.

A young submitter similarly noted the dangers of young people accessing other illicit drugs on the black market:

> As a young person growing up and attending events in Victoria for several years, I have witnessed first hand the negative effects of drug criminalisation. It is clear that drug culture is still very much a part of most young people's lives and the impacts of the black nature of the market is clear, with many people I know and others that I have just seen out at events forced to rely on unregulated and dangerous suppliers.
>
> Because of this connection to a black market, access to other more dangerous drugs is pretty easy to come by, with everything from dangerous prescription drugs to the usual suspects of 'hard' drugs like heroin and ice also … available and connected to the black distribution market.[104]

Another submitter believed that cannabis legalisation would improve the safety of cannabis users and better protect children from accessing cannabis:

> I think legalising cannabis usage will do wonders to improve the safety of existing users. Personally, I have decided to abstain from consuming alcohol due to the health risks and see cannabis as a great alternative without any of the downsides of alcohol use. If I was able to access a safe, regulated supply, I would be able to use the drug recreationally in a way that is safer than buying it on the street. Regulation could and should also protect children and young people from accessing it until a suitable age, and would free up police resources to deal with issues that are of much more importance when considering public safety.[105]

Another issue raised by young people was drug driving and the current approach to roadside drug testing. Dana believed that the current detection-based method for roadside drug testing is unfair and that many young people inadvertently break drug driving laws even though they are not actually impaired:

> A lot of illicit substances stay in a person far longer than the impairment caused by them, not many people know that fact. They may think that they have done the right thing by waiting in some cases days before driving but on a roadside test they may still test positive despite having zero impact on their driving. It is not fair on these people that they did the right thing by waiting but may end up losing their license due to inadequate testing whereas someone that has been binge drinking the night before will most likely ok to drive at some point the next day and even able to have some alcohol in their system despite the fact that the same blood alcohol level may cause different levels of impairment depending on the person.[106]

Other participants at the Youth Forum also discussed the issue of drug driving. The following excerpts are taken from participant responses at the forum.

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104 Name Withheld, *Submission 1256*, p. 1.

105 Name Withheld, *Submission 1311*, p. 1.

106 Dana, *Youth Forum worksheet*, Number 4.

> 'drug driving tests are antiquated and do not test impaired-state of the driver – this needs reform'
>
> Name Withheld, *Youth Forum worksheet*, Number 5.
>
> '[Roadside Drug Tests] are not effective'
>
> Julia Daly, *Youth Forum worksheet*, Number 7.
>
> 'drug driving needs to be changed to check for impairment not presence – law is ruining people's lives'
>
> Name Withheld, *Youth Forum worksheet*, Number 8.

The issue of drug driving and cannabis, including the appropriateness of detection-based methods for roadside drug testing for cannabis is discussed further in Section 4.7.2.

4.6.4 Costs of policing cannabis use

Another issue associated with the criminalisation of cannabis use is the high costs for the justice system for police to enforce prohibition. The Committee heard that there are substantial costs for policing cannabis use across the criminal justice sector, including costs generated by the:

- police
- courts
- corrections system.

Mr Diab Harb from the Department of Justice and Community Safety explained that the Department does not record specific data on the costs to the justice system due to policing cannabis use. He did note some statistics around cannabis use offending which highlighted the proportion of drug offences related to cannabis:

> Unfortunately we do not have any information on what it does cost the justice system, and we have not modelled that ourselves. We do have statistics that talk to the proportion of drug offences that are related to cannabis: 30 per cent of drug-dealing and trafficking offences are cannabis related, and 45 per cent of drug use and possession offences are cannabis related. So we are talking for drug use and possession about 11,789 out of 32,926. Cannabis offending made up about 2.3 per cent of all offences recorded in the year ending December 2020.[107]

In 2020, the National Drug Research Institute published a report which provides some insight into economic costs of policing cannabis at a national level during the 2015–16 financial year.[108] The report found that in 2015–16, approximately $2.4 billion was spent on policing cannabis in Australia, with nearly half spent on imprisonment.

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107 Mr Diab Harb, *Transcript of evidence*, p. 8.

108 Steve Whetton et al., *Quantifying the Social Costs of Cannabis Use to Australia in 2015/16*, National Drug Research Institute, Western Australia, 2020.

The report assessed the justice system costs associated with cannabis for 2015–16 and found:

- $475 million is spent on policing
- $62 million on courts
- $1.1 billion on imprisonment
- $25 million on community correction
- $52 million on legal aid and prosecution
- $664 million incurred by personal crime and household crime victims.[109]

At a public hearing, Mr Sam Biondo, Executive Director at the Victorian Alcohol and Drug Association discussed the high costs of imprisonment related to cannabis offences in Victoria:

> This was the largest sole expenditure and relates to 3,400 prison sentences over that reporting period. This is a bad investment, particularly with an overall Victorian recidivism rate currently at around 43.3 per cent for male prisoners and 63 per cent for women who are returning to prison within a two-year release period. It perpetuates growing harm and growing costs, takes police away from more pressing police matters and unnecessarily expands the correctional system.[110]

In her submission, Dr Kate Seear discussed research on the financial savings associated with decriminalising cannabis:

> Research suggests a number of benefits associated with decriminalisation. These include financial savings from reduced law enforcement activities and improved social outcomes, although the specifics of such benefits would obviously differ depending on which models were to be implemented. There is evidence, for example, that charging an offender for cannabis use/possession is six to 15 times more expensive than offering them diversion.[111]

In contrast Mr Shane Varcoe, Executive Director, Operations at the Dalgarno Institute believed that the legalisation of cannabis would generate additional costs. He explained this was because law enforcement would need to police three markets: the legal market, illicit market and 'grey' market.[112] Mr Varcoe further explained that the assertion that legalisation would generate finances that could be redirected to the health system through revenue such as taxes was untrue:

> So there is a real aggression to try and get these things across the line, and we are now creating a public persona around this as, 'Look, this is where we're going. Come on!

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109 Ibid., p. vii.

110 Mr Sam Biondo, Executive Director, Victorian Alcohol and Drug Association, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 18.

111 Dr Kate Seear, *Submission 1384*, p. 10.

112 Mr Shane Varcoe, Executive Director, Operations, Dalgarno Institute, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 56.

> Let's just get on board and move forward. Let's make some money out of this, and we'll flood our health budgets with the wonderful revenue we're going to get'. You will see if you look at Colorado and what is happening there, that is not the case; if you look at the data … you will see that this is not a cost-neutral arrangement. It is actually a deficit arrangement, and even if it is a cost-neutral arrangement, you have still got the public health issues, which we have not even begun to go into right now.[113]

In 2019, the Drug Policy Modelling Program published a report on criminal justice responses relating to personal use and possession of illicit drugs.[114] This examined the cost savings for New South Wales Police caused by diverting minor cannabis offenders away from the courts:

> the NSW Cannabis Cautioning Program led to 2658 fewer persons convicted with a principal offence of cannabis by the Local Courts in the three years since the introduction of the scheme, compared with the three years prior to the scheme. The burden on the criminal justice system also reduced, as evidenced by 5,241 fewer sole cannabis charges dealt with by the Local Courts and it was estimated that over the first three years of the scheme the police saved over 18,000 hours, or over $400k. A more recent evaluation by the NSW Auditor-General (2011) concluded that from 2000–01 and 2009–10 the NSW Police Force had used cautioning to divert over 39,000 minor cannabis offenders from the courts and saved at least $20 million in court costs.[115]

Policing cannabis has also generated significant costs in other jurisdictions. On the ACT's experience, Dr Devin Bowles from the Alcohol Tobacco and Other Drug Association ACT discussed that not only does the policing of cannabis generate significant costs it also limits the 'life chances' of an individual:

> All we need to know is that we are spending over a billion dollars a year imprisoning people because of cannabis, with many other associated costs, like almost half a billion dollars on policing … At the same time we are at best arbitrarily limiting the life chances of some Australians and limiting their ability to contribute to the economy with these arrest records. So it is costing a lot, and we are curtailing economic inputs—what a waste.[116]

Mr Kin Leong from the Victorian Aboriginal Legal Service believed that a health-based response to cannabis use would likely be less expensive compared to the current criminalisation approach:

> I am not across the figures that would be required for a health response but what I can say is my experience is the high cost of running it through the criminal justice system so the cost, from the very start, of say putting police on the street to employing like me to defend people; to create court rooms; to employ magistrates and all the support staff that go with that; building court houses and then building prisons. I think that cost is

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113 Ibid.

114 Caitlin Hughes et al., *Criminal Justice Responses relating to Personal Use and Possession of Illicit Drugs: the reach of Australian drug diversion programs and barriers and facilitators to expansion*, Drug Policy Modelling Program, Sydney, 2019.

115 Ibid., p. 12.

116 Dr Devin Bowles, *Transcript of evidence*, p. 20.

> quite high. I could only guess but a coordinated health response is probably going to be cheaper to the community under the current regime under the criminal justice system.[117]

The Committee found that there are significant costs associated with policing cannabis use. These could be redirected to fund health and education initiatives aimed at treating people with problematic use behaviours or warning about the risks of cannabis use. There also significant social costs caused by criminalisation of minor cannabis offences, like use and possession, such as:

- barriers to employment, education and housing experienced by cannabis use offenders because of their criminal record
- experiences of isolation and shame from the stigma associated with cannabis use and criminal records
- compounded social harms experienced by vulnerable communities, such as Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities.

FINDING 17: There are substantial costs involved in policing cannabis use through the criminal justice system, including in:

- police resources
- court expenses
- costs of imprisonment
- community corrections
- legal aid and prosecution.

4.7 Drug driving

In Victoria, there are three principal drug driving offences prescribed in the *Road Safety Act 1986* (Vic):

- driving a motor vehicle under the influence of a drug to such an extent that a person is incapable of having proper control of the vehicle[118]
- driving a motor vehicle with more than the prescribed concentration of a drug present in a person's blood or oral fluid[119]
- driving a motor vehicle while impaired by a drug.[120]

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117 Mr Kin Leong, *Transcript of evidence*, p. 17.

118 *Road Safety Act 1986* (Vic) s 49(1)(a). This offence also includes driving under the influence of alcohol.

119 Ibid., s. 49(1)(bb).

120 Ibid., s. 49(1)(ba).

For cannabis (or any prescribed illicit drug), the prescribed concentration refers to the presence of any concentration of cannabis in a person's blood or oral fluid.[121]

In 2004, Victoria was the first Australian jurisdiction to introduce roadside drug saliva testing for cannabis and methylamphetamines.[122] Roadside drug saliva testing is used to detect the presence of illicit drugs in a driver's system. A positive roadside drug test for cannabis occurs when THC is detected, which is the main psychoactive component in cannabis.

Table 4.6 taken from the VicRoads website outlines the penalties for a person who fails a roadside drug test in Victoria.

Table 4.6 Penalties for failing a roadside drug test

Offence	Penalties
First drug-driving offence and you received a Traffic Infringement Notice	You will: • receive a fine to the value of three penalty units • have your licence or learner permit suspended for six months • need to complete a Drug Driver Program in the first three months of your suspension period or your licence/learner permit will be cancelled.
First drug-driving offence and you are required to go to court	You will: • receive a fine of up to the value of 12 penalty units • need to complete a Drug Driver Behaviour Change Program • have your licence or learner permit cancelled for at least six months • have a zero Blood Alcohol Content (BAC) condition for three years. The court may also record a conviction.
Second drug-driving offence	You will go to court and will: • receive a fine of up to 60 penalty units • have your licence or learner permit cancelled for at least 12 months • need to complete an Intensive Drink and Drug Driver Behaviour Change Program • have a zero BAC condition for three years. The court may also record a conviction.
More than two drug-driving offences	You will go to court and will: • receive a fine of up to 120 penalty units • have your licence or learner permit cancelled for at least 12 months • need to complete an Intensive Drink and Drug Driver Behaviour Change Program • have a zero BAC condition for three years. The court may also record a conviction.

Source: VicRoads, *Drug-driving penalties*, 2020, <https://www.vicroads.vic.gov.au/safety-and-road-rules/road-rules/penalties/drug-driving-penalties> accessed 2 July 2021.

121 Ibid., s. 3(1).

122 *Research Note: Road Safety Amendment Bill 2015 - Drug Driving*, report prepared by Parliamentary Library & Information Services, Parliament of Victoria, Victoria, 2015, p. 4.

Roadside drug saliva testing is different from an impairment test as it only seeks to prove the presence of an illicit drug. A drug impairment test seeks to determine if a driver is under the influence of a drug by assessing functions such as balance, coordination and behaviour.[123] If a police officer determines a driver may be impaired, that person will be required to give a blood or urine sample to detect the presence of THC or any other illicit substance.

Table 4.7 below taken from the VicRoads website outlines the penalties for a person determined to be driving while impaired.

Table 4.7 Penalties for driving while impaired by drugs

Offence	Penalties
First drug-driving offence	You will: • go to court • receive a fine of up to 12 penalty units • have your licence or learner permit cancelled for at least 12 months • need to complete an Intensive Drink and Drug Driver Behaviour Change Program • have a zero BAC condition for three years. The court may also record a conviction.
Second drug-driving offence	You will go to court and: • receive a fine of up to 120 penalty units, or 12 months imprisonment • have your licence or learner permit cancelled for at least two years • need to complete an Intensive Drink and Drug Driver Behaviour Change Program • have a zero BAC condition for three years. The court may also record a conviction.
More than two drug-driving offences	You will go to court and will: • receive a fine of up to 180 penalty units, or 18 months imprisonment • have your licence or learner permit cancelled for at least two years • need to complete an Intensive Drink and Drug Driver Behaviour Change Program • have a zero BAC condition for three years. The court may also record a conviction.

Source: VicRoads, *Drug-driving penalties*, 2020, <https://www.vicroads.vic.gov.au/safety-and-road-rules/road-rules/penalties/drug-driving-penalties> accessed 2 July 2021.

In 2020, new licence suspension laws were introduced to allow Victoria Police to immediately suspend a person's licence if they have committed a drug driving offence, such as driving under the influence of drugs or refusing to undertake a drug test.[124]

123 Alcohol and Drug Foundation, *Roadside drug testing*, 2021, <https://adf.org.au/insights/roadside-drug-testing> accessed 2 July 2021.

124 VicRoads, *Immediate driver licence and/ or learner permit suspensions*, 2021, <https://www.vicroads.vic.gov.au/licences/demerit-points-and-offences/immediate-licence-suspension> accessed 2 July 2021.

In its submission, the Family Council of Victoria discussed the dangers of driving under the influence of cannabis and the impact this has had on Victoria's road toll. It stated that cannabis has:

> caused numerous accidents and death on our roads, often involving innocent people. One such individual who had been using cannabis for 24 hours, drove on the wrong side of a highway and killed a family of 7 in another vehicle during a psychotic state of altered perception. It appears that our roads are becoming more treacherous with drug affected people driving under such dangerous circumstances. Police are well aware of the outcomes of drug-affected driving, however, this information seems to be dismissed by users and promoters of legalising cannabis.[125]

Victoria Police's submission provided some data on the link between road trauma and cannabis use. The submission noted that:

- since 2015, crash risk associated with cannabis use is double compared to driving without drugs
- 5% of live lost on Victorian roads involved the use of cannabis (based on rolling 12-month collision data)
- cannabis is the second most detected drug in toxicology testing of transport accident death
- younger drivers appear to be generally unaware of the dangers of driving under the influence of cannabis.[126]

Several stakeholders raised concerns that roadside drug tests can detect cannabis in a person's system even after the effects have worn off and they are no longer experiencing impairments. This is because cannabis is fat soluble, which allows THC to stay in the system for days or possibly weeks after use. This differs to alcohol which is water soluble and leaves the body in a fairly consistent rate considering factors such as a person's weight, metabolism and the amount consumed.

Harm Reduction Victoria believed this makes cannabis users 'particularly vulnerable' to drug driving offences even when a person is not actually impaired.[127]

In its submission, Windana Drug and Alcohol Recovery highlighted that cannabis can remain in the system even after impairment has waned:

> Roadside saliva-based drug testing can detect THC (active ingredient in cannabis) for up to 30 hours in active users and a month in urine samples. For most of that period while there is a risk of a positive drug test, impairment will not be evident. This creates uncertainty where people may determine, where 24 hours have passed since they last consumed cannabis, that they are not impaired and would be safe to drive. However,

125 Family Council of Victoria, *Submission 211*, p. 2.

126 Victoria Police, *Submission 901*, pp. 4–5.

127 Harm Reduction Victoria, *Submission 1385*, p. 15.

> despite not being impaired they may provide a positive test and subsequently lose their licence and possibly their livelihood.[128]

The Alcohol and Drug Foundation stated that the presence of THC in a person's system can also be influenced by the frequency of their use, with more frequent users likely to have cannabis in their system for longer periods:

> Random roadside saliva tests can detect THC (the active ingredient in cannabis) for around twelve hours after use for people who use cannabis infrequently or 'recreationally'. However, for people who frequently use cannabis THC can be detectable for around 30 hours. It is important for people who use cannabis frequently to know that THC can be detected in urine samples for around a month after cannabis was last used – this is because the body stores THC in fat cells for a period of time.[129]

The Foundation also discussed the impacts of a detection-based test for drug driving:

> A contentious aspect of drug driving laws vis-à-vis drink driving laws is that the former is based on "any concentration of the drug present in the blood or oral fluid of that person", while drink driving laws are based on an impairment threshold. A Victorian parliamentary inquiry noted "insufficient evidence to support a causal relationship between specific concentration levels, particularly low levels, of illicit substances and driving impairment" and recommended investigation of "the current drug driving laws and procedures to determine their effect on road crashes and as a deterrent strategy".[130]

In its submission, Fitzroy Legal Service believed that the current roadside drug testing cannot differentiate between drivers who are impaired and those who have consumed cannabis days before.[131]

This was echoed in Springvale Monash Legal Service's submission which similarly stated that approach to drug driving in Victoria does not properly consider someone's actual ability to drive:

> the purpose of the Road Safety Act is 'to provide for safe, efficient and equitable road use', and not to regulate the use of illegal substances. Certain drugs have the potential to impair a person's ability to drive safely, however Victoria's zero-tolerance approach to drug-driving leaves no requirement of a person's driving being actually affected by a drug. Rather, such offences are established on driving with any concentration of an illicit drug in their saliva or blood, irrespective of impairment. These provisions are problematic when they fail to consider how the drug affects actual driving capacity.[132]

The current drug driving test was also discussed by several individual stakeholders to the inquiry who generally believed that the detection-based model was flawed.

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128 Windana Drug and Alcohol Recovery, *Submission 1367*, p. 5.

129 Alcohol and Drug Foundation, *Submission 1386*, pp. 8–9.

130 Ibid., p. 9. The parliamentary inquiry referred to is the Law Reform, Road and Community Safety Committee's 2018 *Inquiry into drug law reform*.

131 Fitzroy Legal Service, *Submission 1396*, p. 15.

132 Springvale Monash Legal Service, *Submission 1399*, p. 11.

'Road side drug tests are flawed. A trace amount in your system from 5 days ago isn't driving under the influence. There needs to be more accurate testing to catch those that think it's okay to smoke and drive and those that want to do the right thing.'

Name Withheld, *Submission 2*, p. 1.

'I would also like to see a sensible approach to policing cannabis use and driving vehicles. This should only be illegal if your driving ability is impaired while you are driving. You should not be punished for residual traces of cannabis that may have been from previous days or weeks.'

Name Withheld, *Submission 186*, p. 2.

'One thing that surprised me after moving here was how strict the drug driving laws are. I think that they miss the point entirely and don't help with safety at all. I've read online that people can test positive for cannabis 24 hours later and get a DUI while being perfectly clear headed.'

Jeffrey Knitter, *Submission 363*, p. 1.

'I would especially like the laws around driving with trace cannabis in your blood changed to consider impairment. The current law is destroying lives, especially in low socioeconomic communities.'

Name Withheld, *Submission 471*, p. 1.

The Committee acknowledges the risks of cannabis impaired driving and strongly supports initiatives aimed at making Victoria's roads safe. However, it is concerned that the current detection-based approach to roadside drug testing does not provide a clear depiction of the actual risk of driving. This is primarily because THC can be detected in a person's system long after last consumption and after impairment has waned. Therefore, the Committee believes it is important to consider the need to review current roadside drug testing methods and whether an impairment-based test is more appropriate.

4.7.1 Testing for impairment

Numerous stakeholders believed that the current approach to cannabis impaired driving is inappropriate because it does not consider the level of impairment. They argued that a detection-based test was not sufficient considering that THC can be present in a driver's system for long periods of time, even after impairment has diminished.

In its submission, Harm Reduction Victoria advocated for an evaluation of roadside drug testing:

> Roadside drug testing needs to be evaluated thoroughly to see if it reduces drug driving, road incidents, and whether it is delivered at acceptable social and economic costs. Further, since the roadside drug tests used by Victoria Police do not have the capacity nor is it the regime's intention to test for driving impairment, thousands of

> Victorians with THC in their system are being criminally charged and experience the immediate negative social and financial impacts of being criminalized. Which in the longer-term has a detrimental impact on health and wellbeing.[133]

Fitzroy Legal Service discussed that roadside drug testing needs to prove impairment and that THC should be treated similarly to alcohol with prescribed impairment limits (like Blood Alcohol Concentration). It noted the drug limit testing model introduced in Norway in 2012 as an example of where impaired-based testing has been implemented:

> We submit the test of impairment should be adequate to work to minimise harm by testing drivers for levels of THC scientifically proven to cause impairment for driving. That is, a similar approach for drink driving should be taken for driving and drugs. This approach has been used in Norway since 2012. The limits for THC and other drugs were based on a series of scientific studies compared with alcohol impairment. These limits are regularly updating in response to research to ensure the limits represent actual risks of impairment. Currently, the THC level considered equal to 0.05% BAC is at 3ng/ml.[134]

Box 4.4 below outlines Norway's drug driving impairment model.

BOX 4.4: Norway's drug driving impairment test model

In 2012, Norway introduced legislated impairment limits for drug driving offences for over 20 types of drugs, including cannabis. These are referred to as 'per se limits' which represent drug concentrations in a person's blood likely to be equivalent to a degree of impairment similarly to a Blood Alcohol Concentration (BAC) of 0.02%.

As well as establishing per se limits for cannabis impaired driving, Norway also introduced graded penalties for impairment levels comparable to a BAC of 0.05 and 0.12.

The following table outlines the per se limits for cannabis impaired driving in Norway:

Impairment limits comparable to 0.02 % BAC (ng/ml in whole blood)	Limit for graded sanctions comparable to 0.05 % BAC (ng/ml in whole blood)	Limit for graded sanctions comparable to 0.12 % BAC (ng/ml in whole blood)
1.3	3.0	9.0

To establish the per se limits, the Norwegian Ministry of Transport and Communications established an advisory group of medical experts who undertook experimental studies to determine impairment limits for each drug type included in the new regulations.

The per se limits do not apply to drivers who have a prescription for the drugs detected in their system, so long as they are not impaired.

Source: Norwegian Ministry of Transport and Communications, *Driving under the influence of non-alcohol drugs: legal limits implemented in Norway*, 2014.

133 Harm Reduction Victoria, *Submission 1385*, p. 16.

134 Fitzroy Legal Service, *Submission 1396*, pp. 15–16.

In a 2021 research paper, Daniel Perkins et al. compared international drug-driving enforcement and THC detection approaches, including whether the jurisdiction included an exemption for prescribed medicinal cannabis users. Table 4.8 below summarises the approach taken by the several jurisdictions considered in the paper.

Table 4.8 Summary of THC detection approaches for drug-driving in international jurisidictions

Country	THC presence offence?	THC detection method	Situation for medicinal cannabis patients
United Kingdom	Yes	Oral fluid taken at roadside. Blood at police station or hospital and sent to laboratory.	Medical defence—if not impaired, and using a prescribed product as directed
Norway	Yes	Oral fluid taken at roadside. Blood at police station or hospital and sent to laboratory.	Medical defence—if not impaired, and using a prescribed, registered product as directed
Germany	Yes	Oral fluid taken at roadside. Blood at police station or hospital and sent to laboratory.	Medical defence —if not impaired, and using a prescribed product as directed
Ireland	Yes	Oral fluid taken at roadside. Blood at police station or hospital and sent to laboratory.	Statutory medical exemption certificate—does not apply if the person is found to be impaired.
New Zealand	No	Field impairment assessment at roadside. Blood at police station or hospital and sent to laboratory.	Medical defence—if using a prescribed product as directed

Source: Daniel Perkins et al., 'Medicinal cannabis and driving: the intersection of health and road safety policy,' *International Journal of Drug Policy*, 2021, p. 7.

In 2020, the New Zealand Government introduced the Land Transport (Drug Driving) Amendment Bill 2020 which seeks to establish a roadside oral fluid drug testing regime. The Bill proposed the introduction of tolerance limits to measure impairment levels for illicit substances detected during a roadside drug test. For cannabis, the Bill prescribed for THC:

- a tolerance limit of 1ng/ml
- a 'high risk' limit of 3ng/ml.

At the time of writing, the Bill was still before the New Zealand Parliament for debate.

However, several stakeholders believed that it would be difficult to implement an impairment-based roadside drug test because there is a lack of good empirical evidence on the level of THC concentration which results in impairment.[135]

135 For example, see: Dr Erin Lalor, Chief Executive Officer, Alcohol and Drug Foundation, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 69; Assistant Commissioner Glenn Weir, *Transcript of evidence*; Professor Dan Lubman AM, Executive Clinical Director, Turning Point, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*.

At a public hearing, Dr Erin Lalor, Chief Executive Officer at the Alcohol and Drug Foundation, explained:

> I think part of the challenge that we have around drug driving is that unlike drunk driving there is no good evidence of the level of concentration that results in impairment, and until we have better research that really informs that, it is very difficult for us to be clear about the correlation between the concentration versus the impairment. So there is more work to be done in that space. We have seen some changes in the Canadian response to drug driving as they have learned more as they have rolled out their program … But I think until we have got good research around that relationship between concentration and impairment we really are a bit stuck.[136]

However, Dr Lalor believed that just because there is no solid evidence on assessing impairment does not mean that a detection-based roadside drug test is the appropriate solution. Rather, she considered research should be undertaken to look for an appropriate impairment test so that roadside drug testing can move away from a presence test.[137]

This was echoed by Ms Ashleigh Newnham from Springvale Monash Legal Service, who believed that a detection-based test is 'unjust'. She discussed that the drug driving provisions in the Road Safety Act were being used to police people's cannabis use which is not the intention of the Road Safety Act:

> If the purpose of the legislation is to improve road safety, and if someone's consumption of cannabis is not impairing their driving, then I am not sure why we are policing that, if it is not to police their drug use. I think that to lose your licence for a year or two years is an incredibly significant penalty
>
> …
>
> It stops people from being able to pick up their kids from school, it stops people from being able to keep their employment, it stops people from being able to seek help. Often they are told, 'Okay, well, stop driving. You can't drive for a year', or two years or something, and yet we fail to consider, as you say: was that justice? Is that just to police their drug use through our Road Safety Act? I think if we are going to police drug use, police it, but we should not be doing it through our other legislation which is designed to keep people on the road safe, not necessarily to police people's consumption of cannabis.[138]

Assistant Commissioner Glenn Weir, Drug Portfolio holder at Victoria Police stated that a metric-based test for cannabis impairment is difficult to achieve because it needs to be able to assess the level of harm or risk of impairment.[139] In his view, due to the risk cannabis poses to road safety the limit of THC detected in a driver's system should be zero.[140]

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136 Dr Erin Lalor, *Transcript of evidence*, p. 69.

137 Ibid., p. 70.

138 Ms Ashleigh Newnham, *Transcript of evidence*, p. 46.

139 Assistant Commissioner Glenn Weir, *Transcript of evidence*, p. 5.

140 Ibid., p. 6.

Assistant Commissioner Weir explained that under the Road Safety Act there is no requirement for police to show a level of impairment to determine if a person has committed an offence and that the presence of cannabis is an offence itself:

> We constantly hear that argument from people who are detected at what we would call the low to mid range, who say, 'Well, I'm not drunk, but I'm driving', and we will say, 'Well, the offence is not being drunk; it is driving with a limit over .05', and that is the accepted standard. There is no need for us to show a level of impairment associated with that; it just shows that the level of alcohol in your blood is over that prescribed limit, so I suppose the same argument could be made with cannabis. The mere fact that people are detected with cannabis in their system when they are driving means that the offence is complete. There is no requirement to show that they are impaired.[141]

In the Committee's view, current roadside drug testing does not allow for an adequate assessment of the actual or likely risk a driver poses on the road. Detection-based testing is being used to police cannabis presence rather than impairment which is not the intention of the Road Safety Act, which to improve road safety outcomes. The Committee understands that the Act does not establish a legislative requirement for impairment, but it is concerned that it could be used as a drug enforcement tool when its intended purpose is to ensure road safety.

However, the Committee acknowledges that while an impairment-based drug driving test is preferable, there is a lack of empirical evidence on what a best practice impairment test looks like. Therefore, the Committee believes that more assessment needs to be undertaken before an alternative drug driving test is implemented in Victoria. The Committee recommends that existing drug driving offences be reviewed to ensure they are being used appropriately, and that this review also consider alternative drug driving testing methods.

RECOMMENDATION 13: That the Victorian Government reviews existing drug driving offences relating to cannabis. This should include a consideration of alternative methods that could be used for detection and measuring impairment, noting that current tests do not adequately measure impairment and that THC can be detected in a person's system long after they are no longer affected by the drug.

4.7.2 Drug driving and medicinal cannabis

Currently, there is no exemption to drug driving offences for people who use prescribed medicinal cannabis. In October 2020, the Victorian Government established a working group to investigate law reform options to allow medicinal cannabis users the right to drive. However, the working group is yet to provide a report on its considerations.[142]

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141 Ibid.

142 Noel Towell and Michael Fowler, 'Drivers using medicinal cannabis could get green light', *The Age*, 14 October 2020, <https://www.theage.com.au/national/victoria/drivers-using-medicinal-cannabis-to-get-green-light-20201014-p564z0.html> accessed 7 July 2021.

At the time of writing, Tasmania was the only jurisdiction in Australia that had a legislated defence to protect medicinal cannabis patients from drug driving offences. Section 6A(2) of the *Road Safety (Alcohol and Drugs) Act 1970* (Tas) prescribes that a person is not committing a drug driving offence if the 'prescribed illicit drug was obtained and administered in accordance with the Poisons Act 1971.'[143]

In its submission, Cann Group Limited, a licenced supplier of cannabis for medicinal purposes in Australia, outlined key issues with current Victorian legislation:

> The [Road Safety Act] and corresponding regulations do not clearly prescribe whether patients who use prescribed medicinal cannabis are able to lawfully drive. Further, government guidance on this matter is lacking as it is not clear whether Cannabidiol ('CBD') is treated any differently to the psychoactive component of cannabis, Tetrahydrocannabinol ('THC'). Although it is noted in guidance from VicRoads, that it is an offence for someone to drive with THC in their system, irrespective of the concentration level in the person or whether the product is prescribed by a doctor. The critical element being that a medicinal cannabis patient will be deemed to have committed an offence based on presence of THC without consideration of whether impairment or influence can be shown.[144]

It recommended that:

- the treatment of Cannabidiol in drug driving offences be clarified
- impairment testing methods and standards, like roadside alcohol testing, be introduced.[145]

Cann Group also believed the introduction of these recommendations would be an important step in ensuring medicinal cannabis patients are not unduly impacted by the current drug driving approach:

> this will enable medicinal cannabis patients to have a guide as to whether and when they are able to drive based on the instructions of the product. Medicinal cannabis products improve the quality of life of many Australians for various indications, yet it is a concern that medicinal cannabis patients in Victoria are unable to establish whether they can lawfully drive a vehicle which in effect offsets a portion of improved quality of life brought by the medication.[146]

Dana, a participant at the Youth Forum, discussed the impact current drug driving laws have had on her as a medicinal cannabis user:

> A massive issue with the drug laws is driving. As I am a medicinal user I cannot drive at all even though I do not have any side effects from my medications but because of this and living in an area without the best public transport I have to rely on my family to get me to places. Thankfully with university this year I have not had to go in many days so it has reduced how much I need to rely on my family to get me around but

143 *Road Safety (Alcohol and Drugs) Act 1970* (Tas) s 6A(2).

144 Cann Group Limited, *Submission 1360*, p. 5.

145 Ibid.

146 Ibid.

> I fear what happens when I finish and properly enter the workforce it is going to be almost impossible for me to have a fulltime job if I cannot drive. I have been prescribed medications which would have definitely impacted my driving ability, I never drove because I want to do the right thing even though it has been hugely restrictive to my life. Other people could easily break the laws around not driving when impacted by medications as they do not show up in roadside testing.[147]

In its submission, the Medicinal Cannabis Industry Australia believed resolving current issues would reduce barriers impacting patient access to the medicinal cannabis scheme.[148]

At a public hearing, Professor Dan Lubman AM, Executive Clinical Director at Turning Point and Director of the Monash Addiction Research Centre, at Monash University discussed that other prescription medications such as opioids, are considered differently than cannabis for drug driving:

> But we certainly have that issue currently with a whole range of other prescribed medications. We know that acute opiate use impacts on driving, but we know there are many people in our community who are on long-term opioids for a whole range of medical conditions and who become tolerant of those effects and are able to successfully drive with those medications in their system. So we need to be very careful around the difference between detecting a substance in our system and recognising the level of impairment, and I think that is something that we need to think about carefully in terms of how we approach that issue.[149]

In a research article examining medicinal cannabis and driving, Daniel Perkins et al. found that:

> the crash risk for prescribed medicinal cannabis is substantially lower due to a range of factors, with this outcome supported by available international epidemiological data that suggests a null road safety impact in jurisdictions introducing 'medical only' access models.[150]

In the Committee's view, lack of appropriate exemptions for medicinal cannabis users from drug driving offences adversely affects their quality of life and mobility. As many medicinal cannabis users are frequent users of cannabis products it is difficult for them to assess when they can drive without fear of being charged with a drug driving test, even if there is minimal chance of impairment.

However, the safety of the driver and other road users must be a key priority when deciding to allow exemptions to drug driving laws. These changes must balance road safety with the need of an individual to be mobile and the benefits that affords. Therefore, the Committee believes that further exploration is needed to determine if medicinal cannabis patients should be made exempt from drug driving laws.

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147 Dana, *Youth Forum worksheet*, Number 4.

148 Medicinal Cannabis Industry Australia, *Submission 1351*, p. 4.

149 Professor Dan Lubman AM, *Transcript of evidence*, p. 3.

150 Daniel Perkins et al., 'Medicinal cannabis and driving: the intersection of health and road safety policy', *International Journal of Drug Policy*, vol. 97, 2021, p. 7.

RECOMMENDATION 14: That the Victorian Government explores ways to exempt medicinal cannabis patients from section 49(1)(bb) of the *Road Safety Act 1986* (Vic), and inquire into ways to modify impairment-based drug driving offences so that medicinal cannabis patients are exempted from prescribed criminal penalties.

4.8 The illicit cannabis market and organised crime

4.8.1 Victoria

According to the Australian Criminal Intelligence Commission, Victoria accounted for the greatest proportion of cannabis seized by weight nationally, increasing by 6.4% between 2017–18 and 2018–19.[151] Table 4.9 below shows the number of cannabis seizures by number and weight by state and territory during this period.

Table 4.9 Weight and percentage change of national cannabis seizures, 2017–18 and 2018–19

State/Territory	Number of seizures			Weight (g)		
	2017–18	2018–19	change (%)	2017–18	2018–19	change (%)
Victoria	3,312	3,524	6.4	1,434,393	3,184,656	122.0
New South Wales	17,720	17,261	-2.6	2,373,144	2,197,338	-7.4
Queensland	16,543	16,955	2.5	2,558,050	1,105,706	-56.8
South Australia	366	116	-68.3	506,229	223,684	-55.8
Western Australia	16,771	14,240	-15.1	1,254,008	392,922	-68.7
Tasmania	1,897	1,799	-5.2	213,959	220,887	3.2
Northern Territory	1,922	1,941	1.0	163,708	71,331	-56.4
Australian Capital Territory	608	655	7.7	152,507	344,362	125.8
Total	**59,139**	**56,491**	**-4.5**	**8,655,998**	**7,740,886**	**10.6**

Source: Australian Criminal Intelligence Commission, *Illicit Drug Data Report 2018–19,* Australia, 2020, p. 56.

In its submission, Victoria Police provided information about illicit cannabis cultivation and trafficking in Victoria, particularly around the prevalence of cannabis crop houses. The submission noted that:

- most cannabis crop houses detected by Victoria Police are in metropolitan Melbourne, although the number of crop houses detected in rural and regional Victoria is increasing
- organised crimes groups often establish cannabis crop houses because of the high profitability of cannabis

151 Australian Criminal Intelligence Commission, *Illicit Drug Data Report 2018–19*, p. 56.

- the income generated from cannabis is used by organised crime groups to fund other illegal activities
- cannabis crop houses are a significant community safety concern, particularly for neighbouring properties and residents.[152]

Victoria Police also described the nature of offending associated with cannabis cultivation and trafficking:

> There are a range of offences that occur in conjunction with cannabis cultivation or trafficking that impact on public safety. These include associated thefts, as well as crimes against the person including associated violence such as stand over tactics or intimidation, or kidnappings associated with drug related debt recovery and can also lead to homicides. Traffickers generally traffick multiple illicit drugs, not just cannabis. Profits from trafficking and cultivation of cannabis are usually conducted in cash. This also results in money laundering which causes residual damage to the Australian economy.[153]

Several stakeholders discussed that a consequence of the illicit cannabis market is that it risks exposing consumers to other illicit substances which are more dangerous. In its submission, the Australian Drug Law Reform Foundation believed that:

> If the only supply is from the black market, some young people seeking cannabis are inevitably going to make contact with suppliers who under current arrangements also provide heroin, cocaine and methamphetamine. How can that be a good thing for young Victorians? If the only supply is the black market, some young Victorians will be sanctioned in ways that risk damaging their education, employment prospects, relationships, accommodation, relationship with their parents and right to travel.[154]

Drug Policy Australia also believed that the illicit cannabis market gives Victorians 'easy access' to more dangerous drugs.[155]

The Australian Drug Law Reform Foundation noted that users have no way of knowing how the cannabis is produced and if other harmful substances have been used in the production of it.[156]

In its submission 360Edge, a health consultancy, discussed that the prohibition of cannabis has allowed the illicit market to flourish. As a result it is unregulated with no quality control on the type of products sold to users and limited prevention of young people purchasing cannabis.[157]

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152 Victoria Police, *Submission 901*, pp. 6–7.

153 Ibid., p. 7.

154 Australian Drug Law Reform Foundation, *Submission 210*, p. 2.

155 Drug Policy Australia, *Submission 1372*, p. 5.

156 Australian Drug Law Reform Foundation, *Submission 210*, p. 3.

157 360Edge, *Submission 1350*, p. 6.

The Penington Institute explained the prohibitionist approach to cannabis use has not significantly impacted the levels of use in the Victorian community and has generally proven to be ineffective:

> Enforcement-based approaches that focus on criminalisation cost around $1.7 billion each year and have proven ineffective at reducing the availability of cannabis and levels of cannabis use in Australia. The ABS estimated that $7.1 billion was spent on illicit drugs in Australia in 2010, more than half of which (3.8 billion) was spent on cannabis. The margins made by cannabis distributors in 2010 were estimated at $3.7 billion. Enforcement of cannabis laws diverts valuable police and other criminal justice system resources away from more serious and harmful crimes such as family violence and sexual offending.[158]

The Penington Institute further explained that prohibition has a minimal impact on the unregulated illicit cannabis market allowing organised crime groups to 'thrive'.[159] Furthermore, the criminalisation approach has exacerbated the overrepresentation of minority groups in the criminal justice system. The harms generated by a criminalisation approach to cannabis use has been discussed previously in Section 4.6.

FINDING 18: The prohibition of cannabis has had a limited impact on the illicit cannabis market and the use of cannabis generally.

4.8.2 Legal versus illicit cannabis markets in legalised jurisdictions

There was considerable debate amongst stakeholders about the impact legalisation of cannabis use would have on the illicit cannabis market. Most stakeholders believed that legalisation would shift demand away from the illicit market and undercut the illegal supply of cannabis by providing regulated products for adult users. In contrast, other stakeholders were not convinced that legalisation could significantly affect the illicit market and that policing illegal cannabis production would be made more difficult due to the creation of a new grey-market.[160]

In its submission, the National Drug Research Institute discussed that early indications from jurisdictions which legalised cannabis was that it has significantly undercut demand from the illicit market:

> Early experience of cannabis legalisation suggests that legal cannabis markets can attract substantial demand away from the black market, but some level of black market activity persists possibly related to regulatory controls such as purchase age restrictions, bans on particularly high risk product types, absence of legal retail outlets, and shortfalls in legal supply.[161]

158 Penington Institute, *Submission 1468*, p. 4.

159 Ibid.

160 For example, see: Dr Kevin Sabet, President, Smart Approaches to Marijuana, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*; Mr Shane Varcoe, *Transcript of evidence*.

161 National Drug Research Institute, *Submission 1325*, p. 14.

Although, Professor Simon Lenton, Director and Program Leader at the National Drug Research Institute, acknowledged that it has proven difficult to completely undercut the illicit cannabis market because the regulatory controls exclude some users:

> The evidence is from the early markets, both in North America and also in Uruguay, that the shift from the black market to the legal market has probably been at this stage around about 50 per cent, and part of the reason for that is that there are certain controls, so some people are always excluded, and it is also about price and about the black market trying to survive and undercutting prices in the legal market.
>
> So it is complex and it is difficult. I think the reality is that there always is going to be a black market, if you like, for cannabis, even if a legal market occupies the greatest proportion it probably could. There are always people who are going to be excluded from that market. There is always going to be some illegal market happening. The question is: what is the best balance and have we got the balance right now? Is there another model that brings more people into a legal system where they do get education at the point of sale—they get education in terms of the products—and the products are of known potency, purity and availability.[162]

Mr Shane Varcoe from the Dalgarno Institute believed that if cannabis was legalised three consumer markets would be established – the legal, the grey and the illicit – which would be difficult for law enforcement to police. He stated:

> Now you have got three markets. So basically you are still policing an illicit market, which is a real problem. So that still requires a supply reduction dynamic there, policing as well. You have of course the legal market, which has to be monitored, managed and administrated. That is another set of bureaucracy in play and the finances that go with that. And then of course you have got the grey market. That is the area where a lot of these things are slipping through the cracks. So there is a whole other sector that is operating in a grey space, which that particular document outlines, which creates another level of issues, another level of costing.[163]

At a public hearing, Mr Gary Christian, Research Director from Drug Free Australia discussed the limitations of the legal market in completely undercutting the illicit market:

> We were told that if drugs were going to be legalised, it would get rid of the criminals. No. That is not what happened. Los Angeles Times will tell you the black market is far bigger now that they have got legalised cannabis and it is more than double—down here— 'more than double the amount of legal sales'. Of course there are costs incurred by regulation, and that is the problem—as with tobacco here in Australia, where we will use chop-chop and we have got to control that illegal tobacco market because of high prices. The same problem is in the USA.

Several stakeholders discussed the impact of legalisation on the illicit cannabis market in Canada and the United States. The Committee has considered these in Inquiry deliberations and believes there are important trends and lessons that can be

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162 Professor Simon Lenton, *Transcript of evidence*, pp. 31–32.

163 Mr Shane Varcoe, *Transcript of evidence*, p. 56.

determined from their experiences. However, the Committee emphasises that these jurisdictions have significant legal, social and cultural differences to Victoria and Australia as whole.

Canada

According to Statistics Canada in the 10 months following legalisation approximately 42% of cannabis users were still purchasing from the illegal market.[164] Several media articles suggested that the reason the illegal cannabis market has a significant presence in Canada is because of the difficulty in legal supply meeting demand.[165]

At a public hearing, Ms Laura Bajurny, Information Officer, Alcohol and Drug Foundation discussed what emerging trends indicate about the impact on the illicit market in Canada post-legalisation:

> There has been a really positive shift between 2019 and 2020, where 41 per cent of respondents in 2020 were saying that they purchased from a legal storefront and 13 per cent were saying they buy from an online source. They also asked how often people buy either legally or illegally. We are seeing that people reporting that they never make illegal purchases is sitting at 55 per cent of respondents. So it is not there yet, but they have seen big improvements. COVID might have had an impact on people's behaviour because cannabis stores were deemed an essential service, so people could still get cannabis—much like alcohol was in Australia.
>
> ...
>
> People are changing their habits. Also the market is starting to catch up. The way that it was rolled out between all the different provinces—because Canada, like Australia, is a lot bigger than people tend to think; there is a lot of regional variation and a lot of provincial control over things like licensing and density regulations—was done very differently in different places, and some places like British Columbia were very slow to open legal storefronts. They had all kinds of product supply issues. It seems as if that is starting to iron itself out, but definitely there are lessons to be taken away from how that has been managed.[166]

Studies on the effectiveness of cannabis legalisation interrupting the illicit market have found that pricing differences play an important role in legal markets' success in taking over illegal sales. A 2019 study on cannabis demand in Canada in the licit and illicit markets found that legalising cannabis did have a positive effect on reducing the illicit market:

> results suggest that the introduction of legal cannabis into the market may disrupt and reduce illegal purchases, but specific pricing will determine the extent of this disruption.

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164 *National Cannabis Survey, second quarter 2019*, report prepared by Statistics Canada, Canada, 2019, <https://www150.statcan.gc.ca/n1/daily-quotidien/190815/dqa-eng.htm> accessed 2 July 2021.

165 Sahar Esfandiari, 'One year after Canada legalised weed, figures suggest a large number of Canadians still buy their cannabis on the black market', *Business Insider Australia*, 18 October 2019, <https://www.businessinsider.com.au/canada-weed-black-market-boom-despite-legalization-2019-10> accessed 2 July 2021.

166 Ms Laura Bajurny, Information Officer, Alcohol and Drug Foundation, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 68.

> When priced the same or slightly higher (i.e., $10 – 12/g), the legal cannabis was clearly preferred and suppressed illegal purchasing, but above these prices, preferences switched to the illegal option.[167]

After the first year of legalisation it was estimated that sales from the legal market totalled US$1 billion compared to the estimated US$7 billion total sales from the illegal market.[168]

Ms Bajurny believed that developing a regulated market for cannabis needs to be carefully designed to ensure that it finds the right balance between regulatory safeguard and meeting the demands of consumers:

> I could easily point out to you all of the missteps that happened in Canada, especially in Canada trying to find that balance between meeting the demands of buyers, right, in a commercial sense but also having the public health lens and trying to find that balance between enough tax but not too much tax and regulating things like THC content while still meeting the needs and demands of consumers. It is a really tricky and delicate balance, and they are still hammering out the details.[169]

United States

Some stakeholders also discussed the United States' experience with curtailing the illicit cannabis market in states where cannabis has been legalised. Stakeholders noted issues stemming from:

- consumer demand outpacing supply allowing illicit suppliers to fill the gaps
- trafficking or cannabis tourism from border states where cannabis is still illegal
- the maturity of the illicit cannabis market makes it more difficult to dismantle.

At a public hearing, Dr Kevin Sabet, President of Smart Approaches to Marijuana, noted that expectations that cannabis legalisation would dismantle illicit markets in the United States have not been met:

> we would think that the illegal market would simply fade away into the legal one. That is not happening with cannabis. Cannabis and alcohol are very, very different substances … they are different because it is much easier to produce illegal cannabis than it is illegal alcohol, just from a resource point of view and from the space it takes and the knowledge it takes, given that marijuana is after all a plant … You can undercut the legal price pretty easily, especially when you start adding taxes, which of course most jurisdictions have done. Obviously the drug cartels and the major international,

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167 Michael Amlung and James MacKillop, 'Availability of legalized cannabis reduces demand for illegal cannabis among Canadian cannabis users: evidence from a behavioural economic substitution paradigm', *Canadian Journal of Public Health*, vol. 110, no. 2, 2019, <https://pubmed.ncbi.nlm.nih.gov/30523535> accessed 2 July 2021

168 Sahar Esfandiari, 'One year after Canada legalised weed, figures suggest a large number of Canadians still buy their cannabis on the black market'; Elaine Thompson and Rob Gillies Gene Johnson, 'Frustration and pride in Canada after a year of legal pot', *AP News*, 17 October 2019, <https://apnews.com/article/health-marijuana-us-news-international-news-wa-state-wire-f9fc0e821e464e4d9ebd5d1dc1277912> accessed 2 July 2021.

169 Ms Laura Bajurny, *Transcript of evidence*, p. 65.

> transnational criminal organisations have not diminished as a result, and there is evidence that they have moved to other drugs like opioids, which is not necessarily a net gain[170]

Dr Sabet noted that a reason the illicit cannabis market has been difficult to erode is because cannabis has been an illegal drug in the United States for a significant period of time. As a result, the illicit market has been allowed to mature and develop.[171]

Drug Free Australia discussed the illicit cannabis market in California which it contended was still making substantial profits despite legalisation:

> 2019 data from California, the home of the world's largest cannabis market, (totalling approximately $12 billion in estimated sales) shows at least $8.7 billion is changing hands in the black market. Members of California's cannabis industry are sending an S.O.S. to the state capitol, saying they're struggling to compete against black market operators who don't have to meet stringent regulations or pay taxes and fees. California cannabis businesses that have cut their workforces or scaled back growth plans. Their challenges, they say, are homegrown: California has too few licensed cannabis businesses, too much taxation and overly onerous regulation.[172]

In the United States there is also a concern with cannabis trafficking into the neighbouring borders of states where it has been legalised. For example, following regulation of cannabis in Oregon there have been issues with illegal trafficking into bordering states.

As part of its move to a legal market, Oregon attempted to move illegal cultivators into the legal industry to curtail illicit cannabis trade in the state through a public campaign. However, this has resulted in a significant surplus of supply which outpaces demand for recreational cannabis.[173] This in turn caused:

- growing rates of illegal exportation of Oregon's cannabis into bordering states where it is still illegal
- the emergence of 'cannabis tourism' where residents in neighbouring states travel into Oregon to purchase cannabis.[174]

In response, the Oregon Government passed Senate Bill 582 in June 2019 to empower the Governor authority to enter into cannabis import and export agreements with other states.[175]

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170 Dr Kevin Sabet, *Transcript of evidence*, p. 11.

171 Ibid.

172 Drug Free Australia, *Submission 1364*, p. 7.

173 Suhauna Hussain, 'Oregon has too much cannabis. Two laws may help the state manage its surplus', *Los Angeles Times*, 24 June 2019, <https://www.latimes.com/nation/la-na-oregon-legislature-tackles-supply-marijuana-20190624-story.html> accessed 2 July 2021.

174 Natalie Fertig, 'Border weed: How the hometown of tater tots became a cannabis capital', *Politico*, 18 April 2021, <https://www.politico.com/news/2021/04/18/ontario-oregon-marijuana-481211> accessed 2 July 2021.

175 Suhauna Hussain, 'Oregon has too much cannabis. Two laws may help the state manage its surplus'.

Ms Tamar Todd, Lecturer, Berkeley Law discussed that there are continued harms from the legal market but these are likely a consequence of gaps in regulations:

> some of the harms that existed I think from the lack of regulation still continue to exist where there is a lack of regulation because there is still that illicit market. That is from a variety of factors. I mentioned the lack of federal change, the lack of states not yet legalising. Some states have very strong local control provisions, so there are localities within the state that do not allow for the legal sale, and then that drives the illicit market. Then I think just with a big transition to where there are taxes and regulations and it is still competing with an illicit market, there is a balance that needs to be worked out there in terms of how robust the tax and regulations are, at least during this period of time where it is a transition from the illicit market to the legal market.[176]

The influence of regulation on undercutting the illicit market in the United States was also raised by Professor Simon Lenton from the National Drug Research Institute. At a public hearing, he noted that:

> The evidence is from the early markets, both in North America and also in Uruguay, that the shift from the black market to the legal market has probably been at this stage around about 50 per cent, and part of the reason for that is that there are certain controls, so some people are always excluded, and it is also about price and about the black market trying to survive and undercutting prices in the legal market.[177]

Ms Todd further explained that any difficulties in dismantling the illicit cannabis market are exacerbated because the United States does not have a federally legalised market, but instead states are 'isolated':

> it is difficult to combat if you are an isolated jurisdiction within a larger sea of prohibition. One of the challenges that our states have is that there is still an illicit market out of the state—that is, a market that products can be diverted and distributed to—so that can help the illicit market thrive. Then we have pockets within the states, as I mentioned, where there will be local control provisions that do not allow for the legal sale within that jurisdiction, so then that creates an opportunity for the illicit market. So that piece is challenging if you do not have the ability to legalise throughout the jurisdiction.[178]

The tension between federal prohibition and state-based legalisation in the United States is discussed in Chapter 6.

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176 Ms Tamar Todd, Lecturer, Berkeley Law and Former Legal Director, Drug Policy Alliance, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 3.

177 Professor Simon Lenton, *Transcript of evidence*, p. 31.

178 Ms Tamar Todd, *Transcript of evidence*, p. 6.

5 Cannabis and other drug education

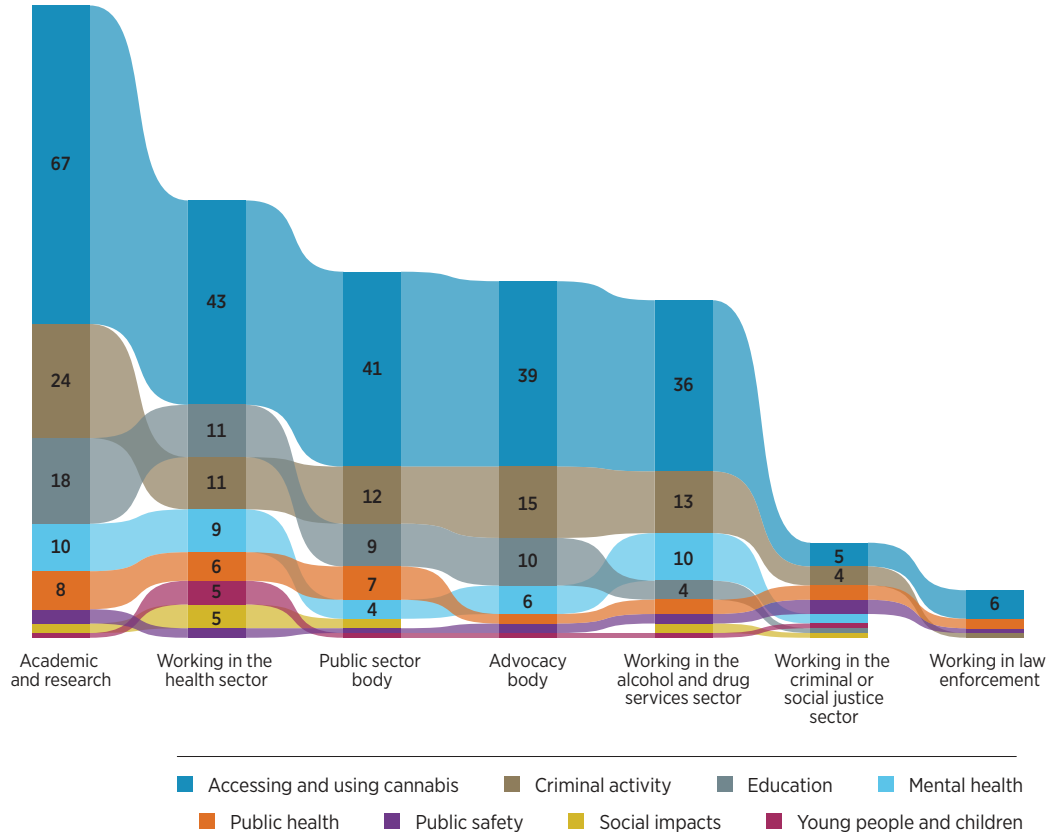
5.1 Introduction

Effective drug education is important to prevent or delay the onset of drug use. However, the Committee acknowledges it is not the solution for these issues, rather it should be combined with mental health and health responses.

Education was a key priority for Inquiry stakeholders. It ranked as the second most important priority for most categories of submitters in response to the Committee's survey on e-submissions, as illustrated in Figure 5.1 below. For submissions received from individuals, 141 out of 1,206 chose education as their top priority for this Inquiry. This was the second highest category for this respondent group.

Similarly, education ranked as the second most important priority for sector-based respondent groups, aside from those who identified as working in law enforcement. This is illustrated in Figure 5.1 below.

Figure 5.1 Top priority by sector-based respondent group



Notes: This graph excludes e-submitters who selected the 'individual' respondent category. It only reflects priority choices of e-submitters who selected a sector-based respondent category.

Respondents were able to select more than identity category, so one submission may be reflected across one or more sector-based respondent categories.

Source: Legislative Council Legal and Social Issues Committee.

5.2 Reforming drug education in Victoria

5.2.1 School-based drug education

Drug education in Victorian schools is delivered as part of the Health and Physical Education curriculum. Victoria's school-based drug education approach is built around the principle of harm minimisation, which is translated into school settings through programs focusing on:

- prevention, abstinence and early intervention
- demand reduction
- supply control
- specialist treatment and harm reduction.[1]

1 Department of Education and Training, *Get Ready: The A–Z Teacher Guide on Licit and Illicit Drugs*, Victorian Government, Victoria, 2013, p. 13.

The Committee heard that the prevention and demand reduction messages are prioritised in classroom-based drug education, whereas supply control and specialist treatment is managed through whole-of-school responses and policies to drug use at school.

An overview of Victoria's approach to school-based drug education is provided in Section 5.3.1.

The Committee acknowledges that the core principle of school-based drug education is harm minimisation, however, it is concerned that this message is not effectively reaching students. Some stakeholders considered that drug education in schools reinforces an abstinence-only message which can be counterproductive to preventing drug use and may impede student understanding of the health risks of cannabis.[2] Further, abstinence-based drug education can be perceived as stigmatising to students who are using cannabis, making them hesitant to seek support. The impacts of stigma in drug education is discussed in Section 5.4.

In the Committee's view, reforms are needed to school-based drug education so that it better delivers its intended harm minimisation message to students and improves their overall drug literacy. Improved drug literacy can be a protective factor against drug use. This may prevent or delay the onset of cannabis use amongst young people who are at greater risk of experiencing cannabis-related health issues. The health sector, including front-line alcohol and other drug workers, needs to be consulted on how to reform school-based drug education. The need for better involvement of the health sector in developing effective drug education is discussed in Section 5.3.

An evaluation of Victoria's current approach needs to be undertaken to better understand where gaps exist. This evaluation should consider school resources, subject placement, assessment of drug literacy and its impact on preventing cannabis use by young people.

RECOMMENDATION 15: That the Victorian Government reviews the effectiveness of school-based drug education and whether the existing curriculum is achieving its intended outcomes. This should also consider whether the curriculum structure is suitable for a harm minimisation approach to drug education as intended. The review should examine:

- if teachers and schools are receiving appropriate training and resources to deliver drug-education to students
- if it is being taught in the most appropriate subject areas
- its effectiveness on young peoples' understanding of the risks of cannabis/drug use
- what impact it has had on delaying the onset of cannabis use by young people.

2 For example: Mr Michael Pettersson MLA, ACT Legislative Assembly, public hearing, Melbourne, 19 May 2021, *Transcript of evidence*; Mr Gulliver McLean, Research and Advocacy Officer, Students for Sensible Drug Policy Australia, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*.

RECOMMENDATION 16: That the Victorian Government consults with the health sector, particularly the alcohol and other drug sector, on evidence-based strategies for better promoting harm minimisation in school-based drug education.

5.2.2 Public health education

Community-wide drug education campaigns are mostly delivered at a national level, through campaigns such as the National Drugs Campaign (see Section 5.6.1). At a state level, recent public health campaigns addressing drug use in Victoria have focused on ice, however, there have been specific campaigns focusing on driving under the influence of cannabis.[3]

The Committee believes there is merit in a public health campaign focused on the health and social risks of cannabis use. It looked to other jurisdictions where cannabis-specific campaigns have been implemented to understand what a Victorian campaign could look like. Examples of public drug campaigns, both cannabis specific and general, are provided in Section 5.6.

The Committee found that campaigns which promote negative stereotypes of cannabis users are stigmatising which can lead to counterproductive outcomes. If public education stigmatises those at most risk or already experiencing cannabis-related harms they are less likely to seek treatment. Therefore, it is important that a cannabis public education campaign does not reinforce harmful stereotypes. Instead, a cannabis education campaign should promote evidence-based information about the risks of cannabis use. The impact of stigma-based drug education is discussed further in Section 5.4.

Furthermore, a cannabis public education campaign needs to acknowledge that people use cannabis despite its prohibition. Therefore, community-wide education should incorporate harm reduction messaging so that the health risks of cannabis use are minimised. Harm reduction focuses on those already using drugs and provides evidence-based advice on minimising the risks of use. The alcohol and other drug sector is best placed to develop this campaign and should be consulted on the types of messaging promoted. A harm reduction approach to public drug education is discussed in Section 5.5.

In the Committee's view, the Victorian Government, based on consultation with the alcohol and other drug sector, should implement a state-wide campaign educating people about the risks of cannabis use. This campaign needs to avoid stigmatising users and adopt the principles of harm reduction. It should also promote help-seeking behaviour and foster an environment where people are encouraged to get treatment for cannabis-related issues.

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3 For example, the Transport Accident Commission Victoria's media campaign on cannabis-impaired driving. See Box 5.3.

RECOMMENDATION 17: That the Victorian Government's approach to drug education should:

- avoid stigmatising users
- promote help-seeking behaviours
- engage in open and non-judgemental dialogue with people using drugs
- have a greater emphasis on teaching about the risks to young people, and acknowledge that the risks of drug use exist on a continuum.

5.3 The current approach to drug education in Victoria

Public drug education in Victoria is based on the principles of harm minimisation.[4] Education aims to equip people with the knowledge about the risks of substance use on their health and wellbeing. Drug education generally focuses on promoting resilience and interpersonal skills to prevent or delay the onset of drug use. However, substance-specific campaigns and programs have also been developed.

There are two main target audiences for drug education:

- school-aged children
- the wider community (public health education).

The majority of drug education in Victoria is provided through the school curriculum.

5.3.1 Drug education in Victorian schools

The Victorian Department of Education and Training states that Victoria's drug education strategy for schools is based on the principle of harm minimisation.[5] This aims to:

- reduce the adverse health, social and economic consequences of drugs by minimising or limiting the harms and hazards of drug use for the individual, family or community
- teach young people the skills and knowledge they need to make sound and healthy choices, while acknowledging drug use is still likely to occur.[6]

4 Department of Education and Training Victoria, *Drug education*, May 2020, <https://www.education.vic.gov.au/school/teachers/teachingresources/discipline/physed/Pages/drugeducation.aspx> accessed 18 May 2021.

5 Ibid.

6 Ibid.

Drug education is a focus area of Victoria's Health and Physical Education curriculum. This is established under the Australian Curriculum developed by the Australian Curriculum, Assessment and Reporting Authority, which is an independent statutory body responsible for developing the national curriculum.[7] The Victorian Government is responsible for delivering the Australian Curriculum in Victorian schools.

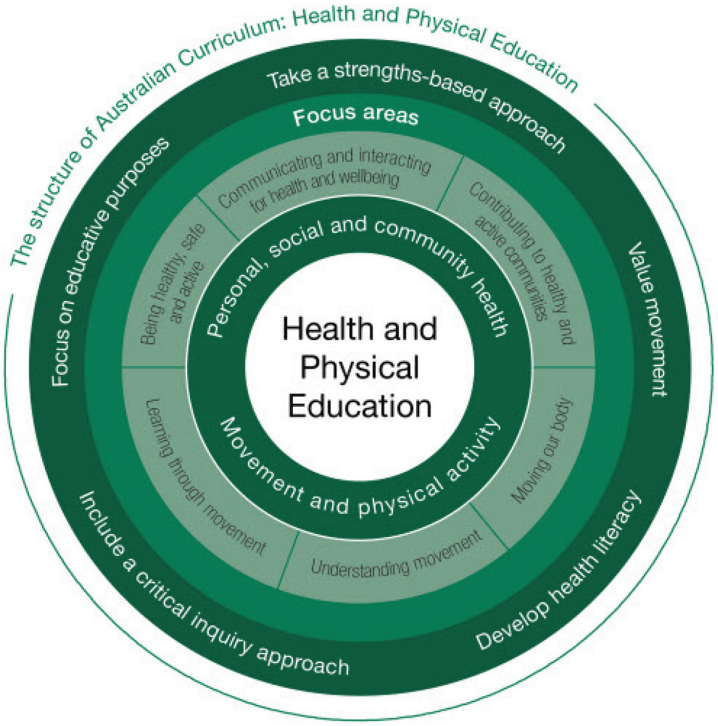
The current approach to drug education presupposes that teachers are best placed to provide young people with the skills and knowledge to make sound choices and decisions. Therefore, youth drug education is integrated into the school curriculum at both the primary and secondary school levels.[8]

The model for drug education promoted by the Department of Education and Training is based on a whole-of-school approach utilising evidence-based practice, positive school climates, and effective teaching. Figure 5.2 shows the curriculum structure of Health and Physical Education, and includes drug education as a specific focus area.

7 *Australian Curriculum, Assessment and Reporting Authority Act 2008* (Cth) s 6(a).

8 Department of Education and Training Victoria, *Drug education*.

Figure 5.2 The curriculum structure for Health and Physical Education



Focus areas
Alcohol and other drugs (AD)
Food and nutrition (FN)
Health benefits of physical activity (HBPA)
Mental health and wellbeing (MH)
Relationships and sexuality (RS)
Safety (S)
Active play and minor games (AP)
Challenge and adventure activities (CA)

Source: Australian Curriculum, Assessment and Reporting Authority, *The Australian Curriculum: Health and Physical Education*, 2016.

At a public hearing, Mr Justin McDonnell, Executive Director, Student Wellbeing, Health and Engagement Division, School Education Programs and Support, Department of Education and Training, described the focus of Victoria's drug education curriculum:

> The curriculum focuses on supporting students to understand drugs in terms of the health impacts, also the legal impacts and status of drugs, but also to grapple with the social pressures that can wrap around drug use, particularly at the younger ages, and also very much focuses on how students can seek help and build the social and emotional learning so that they can navigate those social pressures.

> We define as a department and put advice out to schools what are some of the key features of good practice drug education. They include that it includes content that is relevant to young people's lives and experiences and in doing that that it contains activities that really engage students in problem-solving and critical thinking. We ask that it has content that is tailored for age and commences in primary school. So the curriculum about alcohol and drugs starts at primary school, obviously with content that is tailored for younger ages and then builds and becomes more explicit about illegal drug use in later primary years and senior school.[9]

Mr McDonnell explained that drug education in schools is supported through a tiered approach that:

- builds social and emotional learning
- develops a positive understanding of health and health promotion
- grounds drug education in classrooms so that students understand the health and social impacts of drug use and are supported to make healthy life choices.[10]

He stated the intended effect of this tiered approach is to enhance student wellbeing, resilience skills and health literacy:

> So there is a real relationship at that tier of—in order to be able to navigate in life students grappling with drugs and all the social issues around that—having a really good grounding of social and emotional literacy so they can kind of understand what they are thinking and feeling and particularly they can put their hand up and ask for help if they are feeling uncomfortable. They know how to do that, and they can have that resilience to resist that social pressure or work with their friends. So it is very much at that prevention tier. All of these things come together, and good prevention can be making good choices about anything, whether it is drugs, whether it is cannabis, whether it is other choices.[11]

The Department of Education and Training has produced a range of material to assist teachers in providing drug education. A key teaching resource is *Get Ready: The A – Z teacher guide on licit and illicit drugs*. Box 5.1 below summarises the 'Get Ready' guide, including its advice on cannabis.

9 Mr Justin McDonnell, Executive Director, Student Wellbeing, Health and Engagement Division, School Education Programs and Support, Department of Education and Training, public hearing, Melbourne, 1 June 2021, *Transcript of evidence*, p. 2.

10 Ibid.

11 Ibid., p. 10.

BOX 5.1: *Get Ready: The A – Z teacher guide on licit and illicit Drugs*

Get Ready: The A – Z teacher guide on licit and illicit Drugs is a drug education teaching resource developed by the Department of Education and Training. It provides information on specific substances, drug-related laws, appropriate terminology, and drug education guidelines for the classroom.

The 'Get Ready' guide promotes a harm-minimisation approach to drug education in the classroom. According to the guide harm minimisation in schools can be promoted through:

- **Prevention, abstinence and early intervention:** providing drug-related information and fostering a school environment that allows students to develop social and personal skills that could enable them to refuse or delay the onset of drug use.
- **Demand reduction:** promotion of personal development and other relevant protective factors that can contribute to demand reduction.
- **Supply control:** enforcing an abstinence-only policy and enforcing clear consequences for drug use in schools.
- **Specialist treatment:** respond to the wellbeing of students, particularly those at risk.

While, harm minimisation is the core focus for schools the guide does outline some general harm reduction responsibilities, such as:

- ensuring student safety
- providing referral options
- monitoring and supporting student wellbeing.

The 'Get Ready' guide provides advice on specific substances, including cannabis. The guide states:

> Some young people will choose to use cannabis and may need to be referred for support and treatment. While abstinence is the desired outcome, some young people will continue to use and engage in practices that are harmful and sometimes life threatening. These young people need to be aware of strategies to avoid possible harmful effects. Schools must be clear in understanding their role in helping young people to access such information.

Source: Department of Education and Training, *Get Ready: The A–Z Teacher Guide on Licit and Illicit Drugs*, Victorian Government, Victoria, 2013.

Mr McDonnell outlined several key approaches to school-based drug education encouraged by the Department:

- Drug education should be linked to social and emotional learning to support students in coping with peer pressure and promote help-seeking behaviour.
- A whole-of-school-community approach which proactively engages parents so that they understand what their children are learning in the classroom in order to reinforce the same messages at home.
- Drug education should be responsive to the cultural and social context of the school community.
- Schools should engage with the alcohol and other drugs sector to build teacher's knowledge, and the curriculum should recognise the sector-based knowledge existing outside schools.[12]

Some stakeholders contended that school-based drug education is not based on harm minimisation, as stated by the Victorian Government, but instead reinforces an abstinence-based 'just say no to drugs' message.

Mr Michael Pettersson MLA, Member for Yerrabi in the ACT Legislative Assembly argued that drug education does not encourage an 'honest and frank conversation' because 'we kind of shroud everything with a 'just say no' approach.'[13] At a public hearing, he told the Committee that he believed that this was 'dishonest':

> The remark that I would make is that our drug discourse for the most part is dishonest. We do not actually talk about the real dangers and the real issues behind these substances. We hide behind the veil of 'Just say no' and we do not talk about what the problems at hand actually are, and I would say that probably starts in school. I went to public schools and I reflect on the education I received and the health information that I received, and I would not describe it as fulsome. It was for the most part grounded in the 'Just say no' approach[14]

Stakeholders views of an abstinence-based approach to drug education are discussed further in Section 5.4.

In its submission, the National Drug Research Institute contended that the 'quality of drug education programs implemented in the school setting are also influenced by the subject area in which content usually resides.'[15] The Institute believed that the current placement of drug education, in subjects associated with Physical and Health Education, causes 'inherent problems' because it is not prioritised by schools and often does not have adequate resources to be taught to students properly:

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12 Ibid.

13 Mr Michael Pettersson MLA, *Transcript of evidence*, p. 21.

14 Ibid., p. 23.

15 National Drug Research Institute, *Submission 1325*, p. 10.

> Traditionally, illicit drug education programs are delivered as part of the Physical/Health Education subject area and there are inherent problems associated with this placement. As a subject area, the status of Physical/Health Education is traditionally low. This is reinforced in the Australian National Curriculum where Physical and/or Health Education are allocated one hour per week and illicit drug education may not be allocated any time. The low status is also commonly reinforced at the school level where room allocation, teacher allocation and teachers' skill base are given low priority when administrative structuring and timetabling occurs. This means illicit drug education may be taught by untrained teachers who have been allocated that task to fill their teaching load.[16]

However, the Institute acknowledged that schools are a 'valuable setting for [drug education] … as they have existing staff, structures and supports that enable programs to be effectively delivered.'[17] It recommended that illicit drug education remains in schools but is instead taught through higher-level subjects such as English which have higher contact hours for students.[18]

In 2003 the Victorian Auditor-General's Office (VAGO) audited the Turning the Tide in Schools initiative, which was a harm-minimisation-based drug education approach introduced into government schools. Box 5.2 below summarises the findings of VAGO's audit.

16 Ibid.

17 Ibid.

18 Ibid.

BOX 5.2: VAGO report on *Drug education in government schools* (2003)

In 2003, VAGO conducted an audit of drug education in government schools, assessing the effectiveness and outcomes of the Turning the Tide in Schools initiative.

'Turning the Tide' introduced harm minimisation-based drug education into the core curriculum of Victorian Government schools and participating independent schools. The central strategy of the initiative was to assist schools in developing an Individual School Drug Education Strategy which would outline a school's approach to drug education based on Department of Education and Training guidance. The initiative outlined the goal of enhancing and sustaining drug education in schools.

VAGO's audit found that:

- Turning the Tide was successful in increasing the amount and quality of drug education in Victorian schools.
- Further work was needed to improve and expand drug education in VCE and early secondary school (Years 7 and 8).
- The goal to sustain drug education, needs to be improved by ensuring skills learnt in early school years are being maintained and refreshed, including in VCE years.
- Strategies are needed to better involve parents in their children's drug education.
- The drug education curriculum mainly comprised of training in social competencies and skills; with some time dedicated to drug-specific education.
- Drug education in schools tended to lack specific or ongoing involvement of parents, the wider community, or other external stakeholders.

Source: Victorian Auditor General's Office, *Drug education in government schools*, Victorian Government, Victoria, 2003.

Turning Point, an addiction treatment and research organisation, expressed concern that while the drug education curriculum is effective at promoting opportunities for students to develop drug and cannabis literacy, little is known if this is translated into practice.[19]

This was echoed by Ms Stephanie Tzanetis from Harm Reduction Victoria, who told the Committee that there has not been enough evaluation of drug education:

> evaluation of the quality and impacts of current alcohol and other drug education that is being delivered, for example, in secondary schools, and there is a difference between educating people about the potential harms and educating people in a more comprehensive way …[20]

19 Turning Point, *Submission 1352*, p. 6.

20 Ms Stephanie Tzanetis, DanceWize Program Director and HRVic Management Team, Harm Reduction Victoria, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 19.

In contrast, Dr Alex Wodak, President, Australian Drug Law Reform Foundation contended that there has been 'a lot of evaluation of drug education' which have found that the 'benefits of drug education are fairly modest.'[21] Dr Wodak believed it was important to recognise that drug education is only one tool to address drug use and its risks. He argued that reform should only take place if education initiatives are demonstrating clear gaps or weaknesses.[22] At a public hearing, Dr Wodak told the Committee:

> The expectations of drug education that most people have, especially if they are not well acquainted with the literature, is that drug education is enormously effective. It is not. It is modestly effective at best. We should by all means use drug education both within schools and in mass education, but we should be realistic about the fact that it is not a panacea. It is at best a marginal benefit.
>
> What is much more important is actually aiming very clearly to make sure that we are clear about where we want to end up. We want to minimise deaths and disease. We want to minimise unintended negative consequences of drug policy.[23]

Some stakeholders criticised the lack of involvement of frontline agencies in developing and providing drug education in schools. Mr David Taylor, Policy and Media at the Victorian Alcohol and Drug Association discussed the lack of funding for drug treatment agencies to be involved in school-based drug education:

> I was surprised that drug treatment agencies were not being funded to provide education and prevention activities at schools—that was absent. That was surprising. I would have thought that people who are working directly at the coalface and have a very clear understanding of the substances would be in a prime position to be able to deliver some of those programs. I know there are varying arrangements between schools and so forth, and a lot of our members that are not-for-profit drug treatment agencies provide some of this support off the bat at their own expense.[24]

Mr Gulliver McLean, Research and Advocacy Officer of the Students for Sensible Drug Policy Australia argued that drug education in schools needs a 'complete overhaul'. He believed the current approach stigmatises young people and needs to focus more on teaching harm reduction skills:

> It is like, 'Don't do drugs', and it is also stigmatising, which then means that young people are going to be less likely to feel comfortable talking to their friends, their teachers and their family about what they are actually doing. Nearly 40 per cent of people who are school aged have a stigmatising attitude towards other young people that use cannabis. That means that, you know, if you are going around as a young person using cannabis, you have a hunch that every second person you meet is going to be stigmatising towards you if you say something about the fact that you use cannabis ...

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21 Dr Alex Wodak, President, Australian Drug Law Reform Foundation, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 37.

22 Ibid.; Australian Drug Law Reform Foundation, *Submission 210*, p. 3.

23 Dr Alex Wodak, *Transcript of evidence*, p. 37.

24 Mr David Taylor, Policy and Media, Victorian Alcohol and Drug Association, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 23.

> I also think that any other education needs to be tailored to the young people that are going to be at risk of the most harm, so talking about how regular use can be really dangerous if you then fall into that really small percentage of young people that end up using regularly—it is a small amount, but that I think is where the resources need to be focused—and making sure that if they do end up in that small category, they actually still feel comfortable talking to someone about it, because otherwise they are just going to continue to feel isolated.[25]

Mr Liam Flaherty, a participant at the Youth Forum, believed that school-based drug education needs to be honest and teaching resources should be developed in collaboration with the health sector. He noted the 'positive relationships' Victorian schools have with organisations such as Headspace could be a potential opportunity to utilise sector expertise to redevelop drug education.[26]

The Australian Nursing & Midwifery Federation (Vic branch) recommended that drug health education programs in secondary schools should:

- deliver information in a positive learning environment
- engage students using interactive drug curricula
- adopt peer-led social competence approaches.[27]

It advocated that these measures could facilitate a harm minimisation approach by ensuring students receive important information on the reduction and prevention of drug use.[28]

Mr Liam Head, a Youth Forum participant, advocated for a better harm minimisation approach in school-based drug education. He also believed this should support young people to make informed decisions based on information from appropriate sources.[29]

In the Committee's view, a harm-minimisation approach to drug education is more effective than abstinence-based messaging. Drug education in schools needs to better focused on harm minimisation. The Committee acknowledges this is the stated approach of existing drug education in Victorian schools. However, the Victorian Government's approach is not currently achieving the intended outcomes of harm minimisation.

Teachers need to be equipped with appropriate and up-to-date knowledge on the personal risks of drug use by substance type. This information, including any teaching materials developed as part of the Australian Curriculum, should have input from the health sector, including front-line health workers. The involvement of the health sector in reforming drug education in schools is discussed in Section 5.2.

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25 Mr Gulliver McLean, *Transcript of evidence*, p. 13.

26 Liam Flaherty, *Youth Forum worksheet,* Number 1.

27 Australian Nursing & Midwifery Federation (Vic Branch), *Submission 1365*, p. 6.

28 Ibid.

29 Liam Head, *Youth Forum worksheet,* Number 2.

FINDING 19: School-based drug education is more effective when it is based on a harm-minimisation approach and not abstinence-based messaging. It should be based on a harm-minimisation approach and include honest discussions about the health risks of use.

FINDING 20: The Victorian Government's approach to school-based drug education is not achieving its stated objectives of a harm minimisation approach. Drug education in Victorian schools would be improved with the involvement of frontline health workers in the development and delivery of the curriculum.

5.3.2 Community-wide drug education

Community-wide public education campaigns are generally provided by the Commonwealth Government, such as the National Drugs Campaign (discussed in Section 5.6.1).

However, the Victorian Government has developed targeted drug campaigns usually focused on specific issues related to drug use. For example, the Transport Accident Commission has developed several drug-impaired driving campaigns which highlight the driving risks associated with specific drug-types. In 2009 the Commission produced an impaired driving campaign that focussed on the risks of driving while intoxicated by cannabis. This is described in Box 5.3 below.

BOX 5.3: Transport Accident Commission Victoria: Cannabis-impaired driving campaign (2009):

In July 2009, the Transport Accident Commission Victoria launched a public education campaign targeting cannabis users which emphasised the dangers of cannabis-impaired driving. The education campaign was part of the Victorian Government's broader 'Arrive Alive' road safety strategy.

The message of the campaign was, 'If you drive on drugs, you're out of your mind'.

A media release from the Transport Accident Commission Victoria described the campaign as a 'graphic highlight of the impairments caused by cannabis and reinforced why driving and drugs was a dangerous mix'.

The campaign's advertisements depict a driver high on cannabis who is 'experiencing impaired mental function that leads to waiting longer than necessary at a stop sign, driving over the kerb and into the middle of the road and stepping into traffic'.

The campaign ran for three weeks and was broadcast across television, radio, and digital media, as well as featuring on outdoor billboards.

Source: Transport Accident Commission Victoria, *New TAC shock campaign targets cannabis users*, media release, Victoria, 14 July 2009.

As cannabis is the most used illicit drug in the state, some stakeholders contended there should be a general public education campaign warning about the risks of cannabis use.[30] Drug Free Australia advocated for cannabis-focused campaigns similar to the Quit Smoking Tobacco campaigns of current and past decades.[31]

At a public hearing, Mr Matthew Hercus, Executive Director, Mental Health and AOD [Alcohol and Other Drugs] System Operations and Commissioning, Mental Health Division, Department of Health, explained that:

> the Department resources the Alcohol and Drug Foundation to provide information services about drugs such as cannabis. Information is available to help young people, schools and parents prevent and delay alcohol and drug uptake.[32]

In its submission, the Australian Nursing & Midwifery Federation (Vic Branch) recommended that frontline health workers, including nurses and other health practitioners, should be involved in delivering education programs aimed at minimising the harms of cannabis, particularly for young people and cannabis users.[33] It suggested that cannabis education initiatives should target:

- secondary schools
- cannabis users
- caregivers
- health and other related sectors.[34]

The Federation also outlined some strategies for ensuring that cannabis education is engaging and effective:

- programs should encourage 'open discussion, questions and opportunity for clarification'
- programs should employ various education models, including 'online education, group workshops, opportunistic discussion and one-on-one training.'[35]

Australian Capital Territory—cannabis education after adult personal use legalisation

In 2019 the Australian Capital Territory (ACT) Legislative Assembly passed a Bill that legalised the personal use, possession, and cultivation of cannabis for adults. This was the first time an Australia jurisdiction had legalised the use of cannabis, however, supply remains prohibited. Before the Act came into effect in January 2020, the ACT

30 Drug Free Australia, *Submission 1364*, p. 4.

31 Ibid.

32 Mr Matthew Hercus, Executive Director, Mental Health and AOD System Operations and Commissioning, Mental Health Division, Department of Health, public hearing, Melbourne, 1 June 2021, *Transcript of evidence*, p. 5.

33 Australian Nursing & Midwifery Federation (Vic Branch), *Submission 1365*, p. 6.

34 Ibid.

35 Ibid.

Government launched a public information campaign to educate people about the new laws coming into effect, the health impacts of cannabis use and where to access alcohol and other drug support services.[36]

The ACT's legalisation framework is discussed in detail in Chapter 6.

5.4 Stigma in public health drug education campaigns

Many stakeholders criticised the abstinence-based approach to public health drug education campaigns targeted at the wider community, due to the stigmatising effects on users. As a consequence, many people who use cannabis avoid seeking help or engage in riskier drug taking because of a sense of shame or discrimination.[37] Education campaigns that stigmatise use can also prevent help-seeking behaviours and the access of treatment.[38]

Participants at the Youth Forum also discussed the issue of abstinence-based drug education and how this generates stigma around cannabis use which could deter young people from seeking help:

'The classes were heavily clouded by any bias a teacher had towards certain drugs it was made out that there were zero positives to any drugs at all. If you were to even look at a drug your life would be over. We did not receive any education on what to do if we or someone we knew was suffering from addiction or what to do in the event of an overdose.'

Dana, *Youth Forum worksheet,* Number 4.

'stop sensationalizing negative effects of cannabis – this builds a distrust between students and the education system'

Name Withheld, Y*outh Forum worksheet*, Number 8.

'Uneducation and stigmas make young people feel like they don't have a safe space to seek genuine help [sic]'

Name Withheld, *Youth Forum worksheet*, Number 3.

'less stigmatising, less scare tactics, honesty about harm reduction-based substance use'

Julia Daly, Y*outh Forum worksheet*, Number 7.

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36 Daniella White, 'Health campaign as laws to legalise cannabis possession in ACT edge closer', *The Canberra Times*, 16 January 2021, <https://www.canberratimes.com.au/story/6582150/health-campaign-to-begin-as-cannabis-legalisation-edges-closer> accessed 18 May 2021.; Michael Inman, 'What has changed in the year since cannabis possession was legalised in the ACT?', *ABC News*, 31 January 2021, <https://www.abc.net.au/news/2021-01-31/what-has-changed-since-cannabis-was-legalised-in-the-act/13105636> accessed 18 May 2021.

37 See: Professor Dan Lubman AM, Executive Clinical Director, Turning Point, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*; Mr Sam Biondo, Executive Director, Victorian Alcohol and Drug Association, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*; Ms Ashleigh Newnham, Manager, Strategic and Community Development, Springvale Monash Legal Service, public hearing, Melbourne, 19 May 2021, *Transcript of evidence*.

38 See: Professor Dan Lubman AM, *Transcript of evidence*; Mr Sam Biondo, *Transcript of evidence*; Ms Ashleigh Newnham, *Transcript of evidence*.

In its submission, Turning Point emphasised the importance of not perpetuating harmful stereotypes or stigmatising cannabis users, as it may deter them from seeking help:

> In raising awareness of cannabis and other drug-related harms, it is essential that campaigns avoid perpetuating harmful stereotypes of users. Stigma and discrimination are powerful barriers to help-seeking, particularly among adolescents, and can lead to substantial delays in accessing treatment. Focussing on social inclusion and emphasising that people experiencing harms are not to blame for their problems may reduce prejudice and facilitate helping behaviour. Campaigns should also avoid fear-based strategies that highlight the negative effects of drug use in an anxiety provoking way, as they can be counter-productive if dangers are perceived as unrealistic or exaggerated.[39]

The Committee received a significant number of submissions from people who use cannabis. Many of the submitters discussed the stigma associated with cannabis use and the effects this has had on them. The following are excerpts taken from these submissions:

'I use cannabis recreationally. I don't want to lose my job, family/friends and have a criminal record just because I enjoy growing and consuming it.'

Name Withheld, *Submission 1428*, p. 1.

'By criminalising cannabis, all it does is isolate a person who needs help. Productive conversations often can't be had in normal life because of the stigma associated.'

Patrick Smith, *Submission 154*, p. 1.

'[there is] a taboo on its users who can't seek medical advice or personal help without fear of being demonised as a drug user, instead of someone who needs mental health assistance'

Name Withheld, *Submission 1119*, p. 2.

'People should not feel stigma for wanting to access this for personal reasons (for myself this is pain and nausea due to stomach cancer).'

Name Withheld, *Submission 272*, p. 1.

At a public hearing, Professor Dan Lubman AM, Executive Clinical Director at Turning Point and Director of the Monash Addiction Research Centre (Monash University) further explained that perceptions of stigma and discrimination can cause 'tremendous' delays in help-seeking behaviours from cannabis users.[40]

This was echoed by Mr Sam Biondo, Executive Director at the Victorian Alcohol and Drug Association, who told the Committee that stigma impedes 'sensible' policy development:

> On stigma, which deters help-seeking behaviour, AOD remains decades behind other areas, and that includes mental health, with needless denial of service, discriminating language and behaviour, media reporting and political statements driving adverse

39 Turning Point, *Submission 1352*, p. 9.

40 Professor Dan Lubman AM, *Transcript of evidence*, p. 6.

> community and even health worker perceptions of people who use drugs. Stigma impairs the development of sensible policy, where measures to prevent AOD use include nonsensical and harmful campaigns, such as the Stoner Sloth campaign, rather than progressing sensible drug law reform and treatment endeavours.[41]

Ms Ashleigh Newnham, Manager, Strategic and Community Development ath thee Springvale Monash Legal Service, discussed the impact stigma-based approaches can have on public health and the legal system:

> I think any messaging strategy through a public health campaign, through an advertising campaign, needs to take into account the harm that that type of association can create. We have just had the mental health royal commission results, and I would hate to see public health campaigns or messaging programs that had that kind of way of making people feel like they are bad people for certain behaviours that have not really a moral value assigned to them.
>
> In addition, stigma can impact the legal system. It impacts the way that people make decisions, it impacts the way that police undertake their duties, it impacts the way lawyers interact with their clients and it impacts the way that families interact with one another.[42]

Mr Sione Crawford, Chief Executive Officer of Harm Reduction Victoria, believed that destigmatised and non-discriminatory public messaging is an important part of successfully addressing cannabis use:

> Well, in a nutshell, we believe that bringing cannabis use out of the shadows and destigmatising it will allow for a far better understanding of its impact on public health and safety and allow us to engage in education and conversations both with young people and with wider society that are honest and trusting and free from discrimination, or as free as we can get. As a lived experience organisation, as people who have used and use illicit drugs, we know from our own experience that when one's own drug use is illegal and demonised, as it is now, we are focused primarily on avoiding criminal sanctions and not on engaging with health professionals or with health promotion or to better understand the health impacts of drug use.[43]

Harm Reduction Australia considered that public education campaigns should aim to 'inspire open dialogue about drug use' and that campaigns which reinforce 'abstinence based rhetoric, [achieve] little in terms of protecting young people and their families from problems that come from heavy cannabis use.'[44] It noted Norway's Rusopplysningen campaign as a strong example of effective harm reduction education (discussed in Section 5.6.4).

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41 Mr Sam Biondo, *Transcript of evidence*, p. 20.

42 Ms Ashleigh Newnham, *Transcript of evidence*, p. 45.

43 Mr Sione Crawford, Chief Executive Officer, Harm Reduction Victoria, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 17.

44 Harm Reduction Australia, *Submission 208*, p. 9.

Dr Christine Grove, Senior Lecturer, Educational Psychology and Inclusive Education at Monash University, advocated that the 'traditional risk approach' to drug education needs to be reformed and instead focus on health literacy:

> We need to change that conversation to develop health literacy around these conversations, and having accurate, correct information about this use is much more beneficial. Saying things like 'Don't smoke cannabis, you'll be a criminal and get a mental illness' is not helpful and is not in line with best evidence-based practices and education for young people. Even unpacking young people's risks and how that is different is on a continuum. It is not black or white, yes or no. The impact that it has definitely depends on the young person, their community and their experience as well.[45]

Public health drug education campaigns are vitally important to ensure that people understand the risks associated with drug use. Public health messaging should be evidence-based and honest about the potential risks of use, provide information on the potential harms to users, their families and the wider community.

However, health messaging needs to ensure its capable of reaching its target audience and does not generate additional social or health harms. Stigmatised drug education is counterproductive in achieving public health outcomes and deters users from seeking help. This can be particularly harmful for people with problematic drug use as they may delay or avoid accessing health services to address their substance abuse issues.

FINDING 21: Public health and drug education campaigns should avoid harmful stereotypes of users and reinforcing stigma. These campaigns are ineffective in achieving better health outcomes for users or preventing drug use.

5.5 Approaches to drug education: harm reduction versus demand reduction

Australia's National Drug Strategy is based on three pillars of harm minimisation: demand reduction, supply reduction and harm reduction (see Figure 5.3 below). These outcomes are largely measured through assessing interactions with the criminal justice system or the health sector.

As a specific strategy of harm minimisation, harm reduction is a type of public health strategy which aims to reduce the negative impacts of ongoing drug use. This strategy is specifically targeted at people who are likely to, or do use drugs and promotes evidence-based approaches for safer use that minimises the negative impacts of substance use.[46] An example of a harm reduction initiative is the establishment of a Medically Supervised Injecting Centre.

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45 Dr Christine Grove, Senior Lecturer, Educational Psychology and Inclusive Education, Monash University, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 7.

46 Better Health Channel, *Reducing harm from alcohol and other drug use*, May 2019, <https://www.betterhealth.vic.gov.au/health/ServicesAndSupport/reducing-harm-from-alcohol-and-drug-use> accessed 31 May 2021.

The National Drug Strategy outlines five core indicators used to measure the success of the strategy's goals:

- average age of uptake of drugs, by drug type
- recent use of any drug
- drug use of people recently arrested
- experiences of victims of drug-related incidents
- drug-related burden of disease.[47]

Figure 5.3 The three pillars of harm minimisation, National Drug Strategy 2017–2026

Source: Department of Health, *National Drug Strategy 2017–2026*, Commonwealth of Australia, Australia, 2017.

47 Department of Health, *National Drug Strategy 2017–2026*, Commonwealth of Australia, Australia, 2017, p. 2.

The Committee supports the harm minimisation approach outlined in the National Drug Strategy. However, it is concerned that the emphasis on promoting harm minimisation once problematic use has occurred could be better served by improving Victoria's approach to drug education.

Whilst primary prevention should remain a key focus of public health and safety, harm reduction should be a key priority of drug education. Acknowledging that people use illicit substances, even when prohibition is emphasised, allows education to focus on preventing more dangerous behaviour or problematic use occurring.

Several stakeholders discussed why Victoria's public drug education, including cannabis-specific education, should focus on harm reduction.

In its submission, Cann Group Limited, a medicinal cannabis product producer, argued that harm minimisation is essential for any approach to cannabis regulation. However, it contended that current approaches often have an 'overly simplistic and narrow view' which is focused on the 'dangers and adverse effects of cannabis use.'[48]

Harm Reduction Victoria described harm reduction as 'policies and programs that primarily seek to decrease immediate negative health outcomes and other detrimental effects associated with substance use, rather than to decrease drug use overall.'[49]

Mr Sam Biondo (Victorian Alcohol and Drug Association) believed that drug education in Victoria should focus on harm reduction, explaining that:

> Young people do not accept messaging which is on anyone's account wrong. It might look good to an advertising agency or to a government, but kids—young people—can sort out the chalk from the cheese in this, and they will do what they believe and what they understand. If they do not see harm being created for their friends, well, they do not believe the advertising that says it is going to be harmful. So harm reduction has to be a significant feature of anything that occurs in the future, and that is the reality bite we need to be led by.[50]

The Australian Nursing & Midwifery Federation (Vic branch) emphasised that education is essential to a harm-reduction approach to drug use. Its submission discussed that people need to be able to make informed decisions about cannabis use. The organisation believed that this can only be achieved through a comprehensive information campaign about the risks of cannabis use, including the varying risks associated with specific products.[51]

Harm Reduction Victoria argued that the negative health impacts of cannabis use could be reduced or controlled through harm reduction education. It contended that people who use cannabis are willing to 'receive education about harm reduction measures.'[52]

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48 Cann Group Limited, *Submission 1360*, p. 5.

49 Harm Reduction Victoria, *Submission 1385*, p. 6.

50 Mr Sam Biondo, *Transcript of evidence*, p. 21.

51 Australian Nursing & Midwifery Federation (Vic Branch), *Submission 1365*, p. 10.

52 Harm Reduction Victoria, *Submission 1385*, p. 8.

In its submission, the Alcohol and Drug Foundation recommended that harm reduction measures for heavy and riskier cannabis use be implemented and that harm reduction interventions should target higher use areas. It stated that it is:

> important to develop harm reduction measures that seek to reduce heavy and risky use of cannabis among young people. This is particularly pertinent noting that cannabis was the most common principle drug of concern (58%) for clients aged 10 – 19 years accessing treatment in Victoria in 2018–19. A further consideration relates to regionality. Victoria Crime data has consistently seen a higher rate of cannabis offences in both regional and rural Victoria compared to metropolitan Melbourne for much of the past ten years. Understanding trends such as this is essential when looking to reduce harm and understand where to focus research and policy interventions.[53]

Uniting Vic. Tas suggested that harm reduction education is an important part of micro-level alcohol and other drug intervention because it includes information about the ways to reduce harm from using cannabis.[54] Furthermore, Uniting argued that harm reduction education should also be extended to support people to understand the relationship between cannabis use and mental health issues.[55]

In its submission, Students for Sensible Drug Policy Australia recommended that current drug education and harm reduction programs should be reviewed and be:

- culturally relevant and relatable
- tailored and accessible from multiple platforms
- co-designed with the target communities.

Dr Shalini Arunogiri, Chair, Faculty of Addiction Psychiatry, Royal Australian and New Zealand College of Psychiatrists (Victorian branch), discussed the effectiveness of harm reduction education in engaging young people:

> thinking about how we introduce effective education and prevention strategies, I think it is about keeping that in mind, that that is the context which we are introducing that into, and being able to have accurate, factually based harm reduction strategies as well—for instance, individuals being able to understand, if they use, what they can do if these particular things happen. How do you seek help if you have any problems with use? How do you look after your friends if they are using? We know that overall young people are able to engage with this information very effectively.[56]

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53 Alcohol and Drug Foundation, *Submission 1386*, p. 15.

54 Uniting Vic. Tas, *Submission 1388*, p. 12.

55 Ibid.

56 Dr Shalini Arunogiri, Chair, Faculty of Addiction Psychiatry, Royal Australian and New Zealand College of Psychiatrists (Victorian branch), public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 31.

Not all stakeholders agreed that drug education reform should shift towards an emphasis on harm reduction. In its submission, the Dalgarno Institute argued that drug education needs to emphasise 'primary prevention, demand reduction and resiliency building'.[57] The Institute believed that:

> Building the capacity of the young to understand all the facts, consequences and cultural expectations and equip their agency to choose the best-practice is the best way for individuals, families, and the broader community.[58]

Demand reduction is an intervention strategy which seeks to prevent or delay the onset of drug use, reduce use, including harmful use, and support people to recover from substance abuse issues.[59]

Drug Free Australia believed public education needs to focus on demand reduction and could help to address issues with problematic cannabis use:

> Preventing the uptake of cannabis use (and associated harms) by pregnant women, children and teens could be achieved by prioritising a culture of 'demand reduction'. That is, changing the drug culture and narrative from one of 'acceptability, availability, accessibility' to that of 'informed awareness, personal responsibility and health promoting life choices'. As with tobacco, the mindset of cannabis as a 'harmless or soft' drug can change, and so too, the demand, especially amongst the youth. Without demand, there is no market.[60]

In contrast, Dr Alex Wodak, President of the Australian Drug Law Reform Foundation, believed that demand reduction interventions may not be effective for cannabis:

> usually we divide demand reduction into education and also treatment, and the reason for that is that treatment, we believe, reduces consumption. In the case of cannabis, that may be less effective than drug treatment for, say, other drugs such as heroin where it is clear that drug treatment is very effective, particularly with methadone and so on.[61]

Dr Wodak also stated that in his view drug education has moderate effects in reducing consumption and emphasised that it is only one part of the response.[62]

The Committee emphasises that although it supports the use of harm reduction strategies in Victoria's public health response to cannabis use, it neither supports nor condones the use of cannabis.

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57 Dalgarno Institute, *Submission 215*, p. 7.

58 Ibid.

59 Department of Health, *National Drug Strategy 2017–2026*, p. 7.

60 Drug Free Australia, *Submission 1364*, p. 2.

61 Dr Alex Wodak, *Transcript of evidence*, p. 37.

62 Ibid.

Rather, by adopting a harm reduction approach people will have access to an appropriate health care treatment and the response they need. Harm reduction establishes a 'community of care' around users which can promote better social inclusion and minimise drug-related harm.

5.5.1 Harm reduction in school-based drug education

Some stakeholders believed that harm reduction should also be embedded into school-based drug education. In its submission, Uniting Vic.Tas considered that harm reduction should be embedded into drug education in schools and that schools should work collaboratively with the alcohol and other drug sector on properly providing this to students:

> In relation to AOD education in schools, we believe this education must be embedded in the curriculum and situated within a broader health context, are resilience based, and occur over a period of time. One-off sessions do little to improve knowledge or reduce harm. They must be evidence-based and incorporate treatment and harm reduction expertise. There are a number of positive examples of AOD services working collaboratively and effectively with schools to develop relationships, support staff to increase knowledge and understanding of AOD issues and develop referral pathways for young people experiencing AOD-related harm.[63]

The Public Health Association of Australia noted that according to the results of the National Drug Strategy Household Survey young people are interested in engaging in harm reduction education and dialogue:

> Young people have demonstrated an eagerness to be involved in conversations about minimising the harms attributable to drug use in society. Young people surveyed generally:
>
> - Support harm reduction measures
> - Support government intervention only when a person's drug use is causing harm to someone else, with a preference for education and treatment being the first line of response by governments.[64]

63 Uniting Vic. Tas, *Submission 1388*, p. 14.

64 Public Health Association of Australia, *Submission 1391*, p. 7.

Some submissions supported harm reduction messaging for school-based drug education:

> 'From my experience with drug education at high school, it was mainly focused on the harmful side of the substance and it did not explore harm reduction. In reality, approx 35% of all Australians have tried cannabis, so it is clear that it is unrealistic to simply tell children that they should never use cannabis. I believe that the focus of these programs should shift from zero tolerance to harm reduction so that if people do choose to use cannabis (which many undoubtedly will), they are making an informed decision and are able to recognise the potential risks and aim to mitigate them.'
>
> Name Withheld, *Submission 156*, p. 1.

> 'Educating young Australians about Cannabis use should focus on harm reduction. The focus should be on the history of Cannabis use, its immediate effects, its longer term effects and learning to identify compulsive behaviour in relation to Cannabis use.'
>
> Nick Marks, *Submission 988*, p. 1.

> 'School based programs that adopt a harm reduction goal rather than a narrow focus on decreasing demand have been shown to prevent and reduce alcohol and other drug use.'
>
> 360Edge, *Submission* 1350, p. 9.

In its submission, the National Drug Research Institute discussed some findings of a 2021 review of harm reduction focused on alcohol and other drug programs in schools:

> a 2012 review of the efficacy of alcohol and other drug programs (harm reduction focussed) trialled in Australian schools reported two programs that included cannabis and both are combined with alcohol. One of these programs published in 2009/10 reported an impact on frequency of cannabis use at 6 and 12 months using an internet-based program. The other was published in 2004 and reported effect on any use in a year and any weekly use. Both programs were complex with multi-lessons, and both studies reported low effect size (impact).[65]

The Institute noted that more research needs to be done to determine whether schools are the appropriate setting for 'universal harm reduction' education:

> If universal illicit programs are implemented in the school setting, it is less likely that a statistically significant effect (less use, less risky use) will be attained in a group where only a small proportion of the cohort is currently displaying a behaviour or will engage in the behaviour in the future. When effect size is taken into account, there is limited evidence for applying universal harm reduction education to illicit drugs in the school setting at the current time. Further formative research needs to be conducted to refine how and when illicit drug education is provided and whether schools are the most appropriate setting for illicit drug education with young people.[66]

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65 National Drug Research Institute, *Submission 1325*, p. 7.

66 Ibid., p. 8.

As discussed in Section 5.3.1, school-based drug education should continue to focus on harm minimisation and primary prevention, with a view to including some harm reduction messaging without making this the focus. The goal of drug education in schools is to prevent, or at least delay the onset, of cannabis use and to help young people understand the risks of cannabis/ other drug use. However, it is important to acknowledge that even when utilising best practice primary prevention education, some young people will still use cannabis. Therefore, harm reduction should target students most at risk of substance use or more significant consequences from using cannabis. In the Committee's view, harm reduction should not be the focus for school-based drug education but a complementary component which ultimately supports primary prevention and harm minimisation.

Rather, harm reduction should be emphasised in public health education, as discussed in Section 5.5. The Committee's recommendations on improving drug education, both community-wide and in schools, is detailed in Section 5.2.

5.6 Drug education in other jurisdictions

The Terms of Reference for the inquiry asked the Committee to consider examples from other jurisdictions that have an impact on the issues raised in the Terms of Reference, including drug education. The following section provides examples of drug education initiatives that either wholly or partially focused on cannabis from various domestic and international jurisdictions. These initiatives were noted by the Committee when considering the approaches the Victorian Government should take in relation to school-based drug education and public health drug education campaigns.

The Committee conducted a review of the following Australian and international drug education campaigns:

- the Commonwealth Government's National Drugs Campaign
- the New South Wales 'Stoner Sloth' campaign
- the Canadian 'Pursue Your Passion' campaign
- the Norwegian Rusopplysningen (drug education) campaign
- the Oregon (United States) 'Stay True to You' campaign.

The key findings of the Committee were that successful drug education campaigns should avoid stigmatising users, provide evidence-based information about the risks of cannabis use, and foster help-seeking behaviours.

5.6.1 Commonwealth Government: National Drugs Campaign

The Commonwealth Government's National Drugs Campaign, established in 2001, focuses on specific drugs, based on emerging use trends at the time. The current focus of the campaign is on the use of ice (crystal methamphetamine).[67] According to the Commonwealth Department of Health's website the campaign was developed to:

- raise awareness of the harms associated with illicit drug use
- highlight the range of support and treatment services available
- highlight the resources for parents and guardians to empower them to talk about illegal drugs, such as ice, with their children.[68]

The campaign is part of the National Drug Strategy and aims to to reduce young people's desire to use illicit drugs but increasing their understanding of the risks.[69]

From 2004 to 2010, the National Drugs Campaign focused on cannabis use.[70] In 2010, the campaign released a series of advertisements with the tagline 'Smoking Marijuana wastes …' that were intended to deter cannabis use. According to its submission to the Commonwealth Parliament's Joint Committee on Law Enforcement's Inquiry into Public Communication Campaigns Targeting drug and Substance Abuse, the Commonwealth Department of Health's anti-cannabis campaigns specifically targeted young people aged 13 to 25 years and their parents.[71]

Figure 5.4 below is an example poster produced in 2010 reinforcing the personal consequences of cannabis use.

67 Department of Health, *Drug Help: About this campaign*, September 2017, <https://campaigns.health.gov.au/drughelp/about-this-campaign> accessed 12 May 2021.

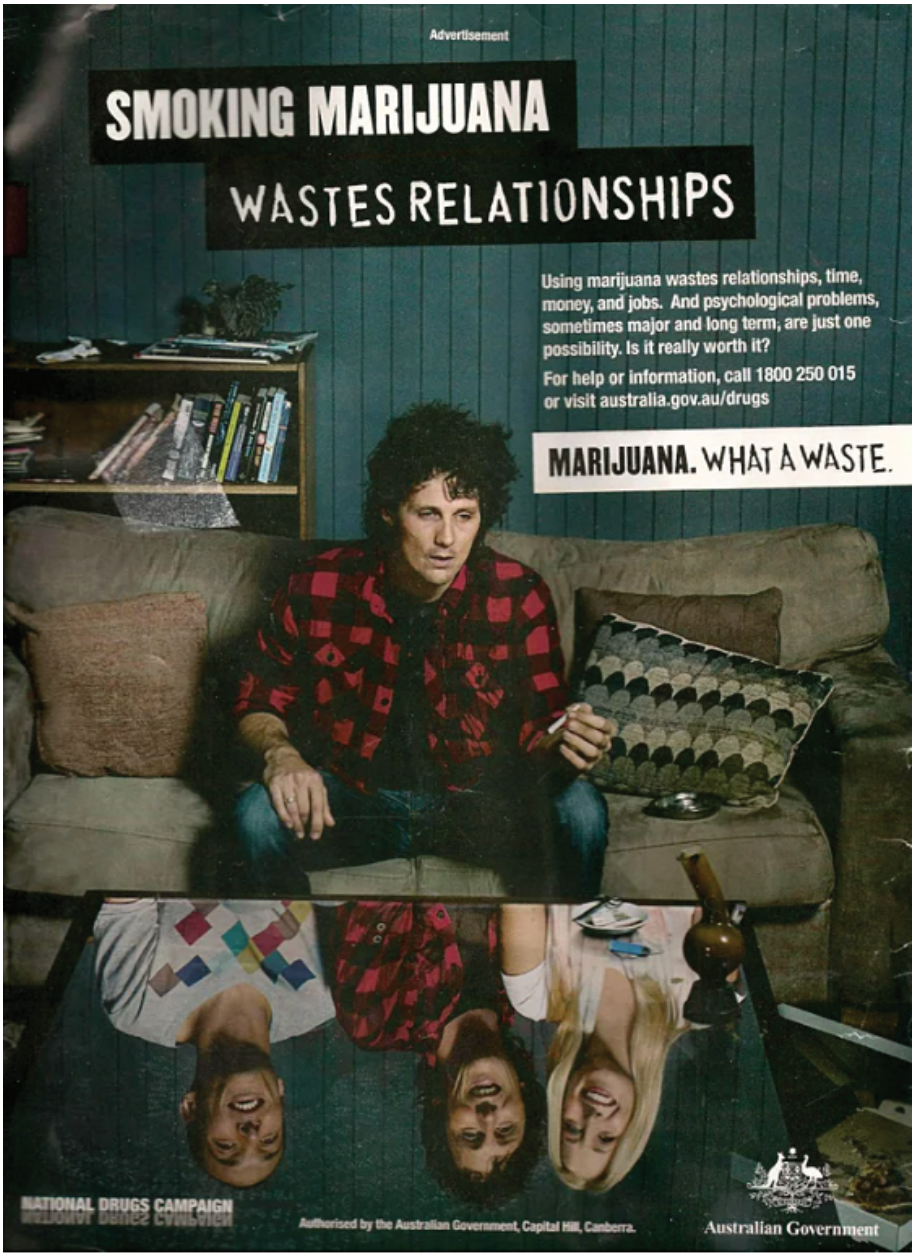
68 Ibid.

69 Ibid.

70 Department of Health, submission to Parliament of Australia, Joint Committee on Law Enforcement, Inquiry into public communications campaign targeting drug and substance abuse, 2020, p. 4.

71 Ibid.

Figure 5.4 Smoking marijuana wastes relationships, National Drugs Campaign, 2010



Source: Alamy, *Smoking Marijuana wastes relationships*, <https://www.alamy.com/stock-photo-smoking-marijuana-wastes-relationships-print-advert-part-of-the-australian-71803581.html> accessed 12 May 2021.

The Department of Health evaluated the effectiveness of the National Drugs Campaign from 2001 to 2018. The evaluation of the 2010 phase, which focused on cannabis, ecstasy and ice, determined that the campaign's impact was 'moderate' and mostly impacted people's perceptions of ecstasy specifically. Table 5.1 below summarises the Department's evaluation of the campaign phases which included cannabis (2004 to 2010) and includes information about materials developed and funding.

Table 5.1 Evaluation of National Drugs Campaign, phases involving cannabis, Department of Health

	2004 to 2007 (Phase 2—Youth)	2007 to 2008 (Phase 3)	2008 to 2009 (Phase 4—Stage I)	2009 to 2010 (Phase 4—Stage II)
Drugs	Marijuana, ecstasy, speed	Marijuana, ecstasy, speed, ice	Marijuana, ecstasy, ice	Marijuana, ecstasy, ice
Objective	Youth prevention campaign to reduce number of young people using illicit drugs	Contribute to reduction in number of young people using illicit drugs	Increase young people's awareness about the harms and risks of drug use	Reduce the uptake of drugs by raising awareness of the potential harms and encouraging decisions not to use
Target Audience	Primary: 13–24 year olds Secondary: Parents of 8–17 year olds	Primary: 13–24 year olds Secondary: Parents of 8–17 year olds	Primary: 15–24 year olds	Primary: 15–25 year olds
Total expenditure (approxiomate)	$15.7 million	$13.1 million	$1.7 million	$4.1 million
Resource sources	• TV • Print media • Online • Hotline • Website	• TV • Cinema • Print • Hotline • Website	• TV • Cinema • Print • Outdoor • Online • Hotline • Website • Nightclubs/ other venues	• Radio • Print • Postcards • Outdoor • Other venues • Online • website
Impact on target audience	• 41% of parents took 'some action' • 65% of young people influenced – 55% avoided drug use – 29% considered consequences	• 55% of parents took 'some action' • 78% of young people influenced – 26% avoided drugs – 41% considered consequences	• 74% of young people influenced – 31% avoided drug use – 41% considered consequences	• 46% of young people were influenced – 24% avoided drug use – 50% considered consequences • 26% saw drugs as harmful
Campaign impact	Increased awareness of health risks, young people rejecting drugs and parents engaging their children about drugs.	Continued positive impact on young people and parental engagement.	Maintained impact.	Moderate effects, mostly impacted perceptions of ecstasy.

Source: Department of Health, submission to Parliament of Australia, Joint Committee on Law Enforcement, Inquiry into public communications campaign targeting drug and substance abuse, 2020.

5.6.2 New South Wales: the 'Stoner Sloth' campaign (2015)

In November 2015, the New South Wales Department of Premier and Cabinet released a digital campaign targeted at young people to deter recreational use of cannabis by showing the harms it can cause. Advertisements were published on social media,

television, and a dedicated campaign website. Following criticism from the media and the health sector for the stereotypes of cannabis users that were portrayed, the campaign ended in January 2016.

The campaign aimed to warn teenagers about the cognitive and social effects of cannabis use, targeting them with the theme 'You're worse on weed.' The campaign depicted a human-sized 'stoner sloth' that moved slowly, struggled to speak or interact with peers and had difficulty learning in a classroom. The advertisements also showed friends and family becoming annoyed and disappointed at the 'stoner sloth.'[72] Figure 5.5 below shows a still from the advertisement.

Figure 5.5 A still image from the 'Stoner Sloth' campaign

Source: Still image from the NSW Department of Premier and Cabinet's 'Stoner Sloth' campaign. Image taken from Kim Arlington, 'NSW Government's Stoner Sloth anti-marijuana campaign cost taxpayers $350,000', *The Sydney Morning Herald*, 19 February 2016, <https://www.smh.com.au/national/nsw/nsw-governments-stoner-sloth-antimarijuana-campaign-cost-taxpayers-350000-20160218-gmxd8p.html> accessed 14 May 2021.

The key messages of the 'Stoner Sloth' campaign were:

- Cannabis is harmful to an individual's health, associated with issues such as brain impairment, anxiety or schizophrenia.
- Cannabis is harmful to others, such as passive smoking or cannabis-impaired driving.
- Cannabis is harmful to your daily cognitive ability, affecting your attention or ability to perform effectively in day-to-day situations such as school, peer socialisation or with family.[73]

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72 *Stoner Sloth Compilation*, video, 15 December 2015, <https://www.youtube.com/watch?v=7rHm8GbTHyE> accessed 12 May 2021.

73 Jim Macnamara and Gail Kenning, '"Stoner Sloth": Lessons from Evaluation of Social Media and Virality', in Judy VanSlyke Turk and Jean Valin (ed.), *Public Relations Case Studies from Around the World*, Peter Lang Publishing, New York, 2017.

The New South Wales Department of Premier and Cabinet identified three target audiences for the campaign (primary, secondary and other influencers). These are summarised in Table 5.2 below.

Table 5.2 Target audiences of the 'Stoner Sloth' campaign

Primary audience	Secondary audience	Other influences
Young people 14–18 years old in NSW, who are: • contemplating trying cannabis • have tried cannabis (but not frequent users) • more influenced or surrounded by peers/ family who are avid users	Young people 14–18 years old in NSW who are: • not contemplating trying cannabis (never users)	Peer groups of the primary target audience. Key influences of the primary target audience including teachers and older peers.

Source: Department of Premier and Cabinet, *Brief evaluation of anti-Cannabis campaign*, NSW Government, Sydney, 2015 cited in Jim Macnamara and Gail Kenning, '"Stoner Sloth": Lessons from Evaluation of Social Media and Virality', in Judy VanSlyke Turk and Jean Valin (ed.), *Public Relations Case Studies from Around the World*, Peter Lang Publishing, New York, 2017.

The Department also identified five specific communication objectives of the campaign:

- Raise awareness of the risks and consequences of recreational use of cannabis.
- Challenge the belief that cannabis is a safe and acceptable first drug.
- Dispel the curiosity and excitement associated with trying cannabis for the first time.
- Empower teens to reject use of cannabis for recreational purposes.
- Empower young people to look after their mates and discourage use of cannabis.[74]

Several stakeholders criticised the 'Stoner Sloth' campaign's portrayal of cannabis users and contended this approach was counterproductive in preventing cannabis use and deterred people from accessing health services.

In its submission, Students for Sensible Drug Policy Australia described the campaign as 'fear-driven' and is largely viewed by young people as humorous. It also believed that the campaign demonstrated that authority figures or policy makers are out of touch with the issues impacting young people.[75]

It stated that the 'advertisement was slammed by critics nationally and also mocked by international journalists because it lack[ed] any concrete educational information on the impacts of cannabis.'[76]

74 Ibid.

75 Students for Sensible Drug Policy Australia, *Submission 1392*, pp. 40–41.

76 Ibid., p. 40.

Harm Reduction Australia also criticised the 'Stoner Sloth' campaign, stating it was 'out of touch with the realities of cannabis use'.[77] It further explained why potentially patronising health campaigns are ineffective:

> It should be recognised that patronising messages based on shame and personal faults are not just ineffective, but directly undermine genuine attempts to engage younger audiences and people exposed to the illegal cannabis industry.[78]

The Victorian Alcohol and Drug Association contended that 'simplistic advertising campaigns' need to be avoided as they reinforce stereotypes and do not resonate with target audiences, stating that:

> relying on uninformed popular stereotypes, such as the 'stoner sloth' campaign should be avoided as they are not aligned with how young people perceive the impacts of cannabis use and seek to enforce damaging stereotypes. Such campaigns will likely generate greater harm.[79]

The Association recommended that public health campaigns should be evidence-based and aim to reduce cannabis-related harm.[80]

As discussed previously in Sections 5.2 and 5.4, the Committee believes that public health campaigns focusing on cannabis use need to avoid being stigmatising or discriminatory towards users. These types of campaigns are counterproductive as they often deter people from help-seeking behaviours and isolate them from support.

5.6.3 Canada: 'Pursue Your Passion' campaign (2018)

Canada's public health initiatives on cannabis use focus on educating people on the risks and demonstrating protective strategies to ensure safe use, including through provision of harm reduction information. However, youth initiatives still focus on prevention and strengthening preventative behaviours.

Following legalisation of cannabis in 2018, the Canadian Government implemented several ongoing public education campaigns aiming to inform people—particularly young people aged 13 to 24—about the health and safety risks of cannabis use. The focus of Canada's cannabis public education has been through digital and social-media campaigns, such as the 'Don't Drive High' (November 2017) campaign to raise awareness around the risks of drug-impaired driving.[81]

The Canadian Government, through Health Canada, also established the 'Pursue Your Passion' interactive engagement tour which targeted young people aged 13 to 24.

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77 Harm Reduction Australia, *Submission 208*, p. 6.

78 Ibid.

79 Victorian Alcohol and Drug Association, *Submission 1390*, p. 7.

80 Ibid.

81 Peak Processing Solutions, *Submission 1356*, p. 6.

The aim of the tour was to educate young people and their parents about the risks of cannabis use and to encourage positive lifestyle choices.[82]

'Pursue Your Passion' was a travelling tour promoting exhibits on the health and safety risks of cannabis use at youth-centred events, such as music festivals. The use of physical and digital stations allowed young people to engage with information on healthy lifestyle choices and cannabis use.[83]

As part of the campaign, between October 2018 and March 2019 Health Canada conducted a national school tour to teach young people about the effects of cannabis use. Campaign teams visited schools showcasing information about cannabis using a variety of digital methods, such as virtual reality, reaction tests, digital art and music.[84]

The Committee did not receive any specific evidence on Canada's 'Pursue Your Passion' campaign but stakeholders did broadly discuss Canada's approach to cannabis education since legalisation.

Mr Stephen Blyth, Communications Manager, SHORE & Whariki Research Centre, argued that legalisation of cannabis has improved drug education in Canada:

> with Canada—and we were observing very closely—is that by bringing cannabis into the open it is no longer taboo. It does open the way to public education in a way that we have not been doing up until this point. I note that the Canadian government has invested very heavily in this—$100 million over six years. That far exceeds the amount of funding that goes into education at this point under our prohibition model. Interestingly, a lot of it is about obviously concerned with delaying the onset of young people's use. That is the primary concern.[85]

Ms Laura Bajurny, Information Officer at the Alcohol and Drug Foundation discussed the outcomes of Canada's cannabis education strategies:

> especially since legalisation, there have been broad awareness programs, especially running in schools, to make sure that people understand that cannabis use is not without risks and especially for adolescents. There is a growing consensus that cannabis use can be very harmful to adolescents. That might be part of it, but again it is such an incremental increase [in use] I would be hesitant to say that the awareness campaigns have made that massive of a difference. But I do believe that evidence-based drug education in schools can have a significant impact …in hopefully preventing and delaying the uptake of alcohol and other drugs by young people.[86]

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82 Ibid.

83 Government of Canada, *Health Canada launches the Pursue Your Passion interactive engagement tour*, July 2018, <https://www.canada.ca/en/health-canada/news/2018/07/health-canada-launches-the-pursue-your-passion-interactive-engagement-tour.html> accessed 12 May 2021.

84 Pursue Your Passion, *Pursue Your Passion School Tour*, <https://pursueyourpassion.ca> accessed 12 May 2021.

85 Mr Stephen Blyth, Communcations Manager, New Zealand Drug Foundation, Melbourne hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 29.

86 Ms Laura Bajurny, Information Officer, Alcohol and Drug Foundation, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 65.

She went on to explain that following legalisation public education was an important protective factor for preventing cannabis use by young people and promoting safe use more broadly:

> My understanding was that [education] was embedded. I would want to fact check myself, but my understanding is that a component of changing the laws was saying, 'Okay, we need to have widescale health education campaigns so that people understand things like that cannabis impairs your driving', and now in 2020 we have 83 per cent of Canadians who participated in the survey who understand cannabis makes you impaired to drive. I do think that the protective factors element is the critical piece and that whether it is Canada or Australia we are seeing young people at least experiment with drugs like cannabis, with drugs like alcohol, which is still our number one concern, and the great thing about primary prevention is it addresses all of those harms. What I would really like to see is that while some people might experiment with cannabis, I want to see them not be harmed by that experimentation …[87]

5.6.4 Norway: Rusopplysningen campaign (2019)

In 2019, the Norwegian Association for Safer Drug Policies launched a public harm reduction campaign focused on providing evidence-based advice on safe use strategies to minimise the harms of drug use. As part of the campaign, the Association released a series of public posters centred on harm reduction advice for specific narcotic substances. Figure 5.6 are two example posters from the campaign.

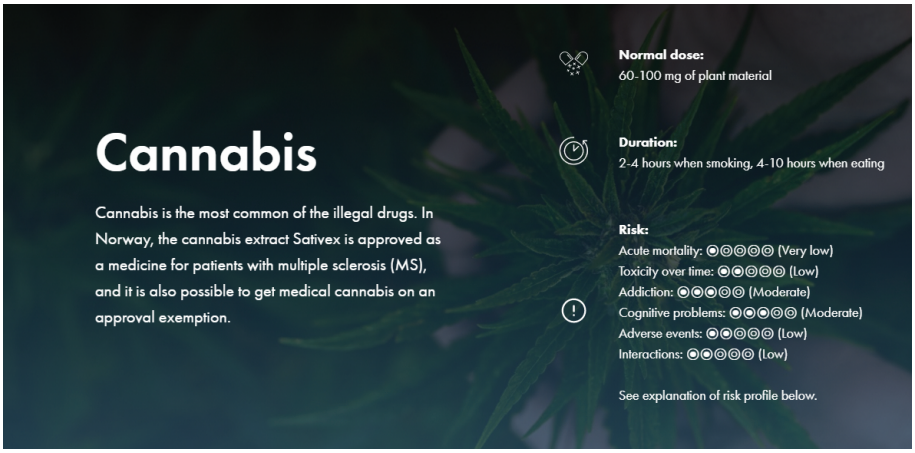
Figure 5.6 Rusopplysningen harm reduction posters (in English)

Source: Association for Safer Drug Policies, *New harm reduction campaign launched in Norway*, <https://saferdrugpolicies.com/harmreductioncampaign> accessed 11 May 2021.

87 Ibid., p. 69.

The Rusopplysningen website includes a risk profile and safe use advice for several harmful substances, including cannabis. Figure 5.7 below is a summary of Rusopplysningen's risk profile for cannabis.

Figure 5.7 Rusopplysningen's risk profile for cannabis



Source: Rusopplysningen, *Cannabis*, <https://rusopplysningen.no/cannabis> accessed 11 May 2021.

Harm Reduction Australia considered the Rusopplysningen campaign as an example of a 'mainstream public health campaign that directly addresses drug use' in a 'non-judgemental' way and that was 'informed by common lived experiences' of drug users. Its submission described the effects of the campaign:

> It communicates to people who use drugs and their families, it is acceptable to have conversations about the prevention of potentially dangerous substance use, including cannabis use. Those targeted in the Norwegian campaign - younger drug users - may be more likely to take active measures of minimising risks, if local communities and broader societal institutions are willing to listen to the motivations of young people.[88]

5.6.5 Oregon, USA: 'Stay True to You' campaign (2016)

In 2016, the Oregon Health Authority implemented a youth-focused media campaign aimed at preventing cannabis use and to educate about the dangers of cannabis for young people. The campaign initially introduced as a pilot program and was launched post-legalisation to counter cannabis product advertisements and the growing accessibility of cannabis through the retail market. The initial pilot program launched awareness campaigns in the counties of Jackson, Josephine, Clackamas, Washington, and Multnomah before it was expanded state-wide in 2017.[89]

88 Harm Reduction Australia, *Submission 208*, p. 8.

89 Stay True to You, *About Staying True*, <http://www.staytruetoyou.org/about> accessed 12 May 2021.

The social media campaign focused on the risks of cannabis use on young people to promote prevention. The campaign included the hashtag #StayTrueOregon which promoted a series of motivational posts to inspire young people to avoid cannabis use and understand its risks. This is shown in Figure 5.8 below.

Figure 5.8 Social media posts from the 'Stay True to You' campaign

Source: Stay True to You (@staytrueoregon), 'Retail marijuana ads are everywhere. One thing to remember: using pot as a teen could get in the way of reaching your full potential. #staytrueoregon', tweet, 14 April 2017, <https://www.instagram.com/p/BS1YdqCAv_Z> accessed 13 May 2021; Stay True to You (@staytrueoregon), 'Regular pot use is associated with lower math and reading score. #staytrueoregon', tweet, 18 November 2017, <https://www.instagram.com/p/Bbm38xYASJd> accessed 13 May 2021.

The goals of the 'Stay True to You' campaign were to 'influence attitudes toward and perceptions around youth marijuana use' and to prevent or delay the initiation of cannabis use by young people.[90]

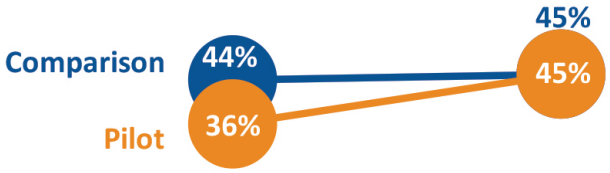
The Oregon Health Authority evaluated the effectiveness of the 12-month pilot program and released its report in June 2017. The evaluation compared perceptions of and intent to use cannabis by young people living in the pilot counties with counties where a pilot campaign was not conducted (Coos, Douglas and Lane). The report found that whilst the campaign had limited impact on youth cannabis use, there was a positive impact on attitudes towards drug use and increased understanding of risks related to cannabis.[91]

Figure 5.9 below is taken from the Oregon Health Authority's report. It shows that there were similar proportions for intent to use cannabis between the pilot and non-pilot counties. Furthermore, that by the end of the pilot there was a slight increase in the number of young people who indicated an intent to use cannabis.

90 Oregon Health Authority, *Oregon Youth Marijuana Prevention Pilot Campaign: Stay True to You 12-Month Pilot Campaign Evaluation Results*, State of Oregon, Oregon, 2017, p. 2.

91 Ibid., pp. 2–3.

Figure 5.9 **Proportion of youth and young adults who reported an intent to use cannabis, pilot (orange) versus non-pilot counties (blue), from beginning to end of evaluation period.**



Source: Oregon Health Authority, *Oregon Youth Marijuana Prevention Pilot Campaign: Stay True to You 12-Month Pilot Campaign Evaluation Results*, State of Oregon, Oregon, 2017.

The evaluation report also examined youth perceptions of the risks associated with cannabis use, the Oregon Health Authority found:

> Significantly more pilot than comparison youth and young adult survey respondents perceived moderate to great risk of harm from regular marijuana use and agreed with the statement "using marijuana limits a person's ability to have memorable experiences" (39% vs. 33%, respectively, for both attitudes). In addition, significantly more pilot than comparison respondents believed that using marijuana might encourage those who look up to them to use marijuana (44% and 38%, respectively). These results suggest a favorable campaign effect but should be interpreted with caution because change between baseline and evaluation end was not statistically significant for the pilot group.[92]

In response to the findings of the evaluation, the Oregon Health Authority made several recommendations to improve youth cannabis prevention:

1. Implement the campaign state-wide to provide support in every community for youth cannabis prevention.
2. Require cannabis businesses to disclose their expenditure on marketing and promotion.
3. Establish a maximum size and number for signs at retail cannabis stores.
4. Prohibit the sale of flavoured cannabis products, as they are more appealing to young people.
5. Protect local control of retail cannabis markets and businesses.[93]

92 Ibid., p. 3.

93 Ibid., p. 7.

6 Regulating cannabis use: experiences from other jurisdictions

6.1 Introduction

This Chapter profiles and compares various cannabis regulatory models that exist around the world, from prohibition to commercial legalisation. It provides an overview of the regulatory approach to personal use, possession and in some cases cultivation. The Committee acknowledges that not all regulatory models are canvassed in this Report and provides the information here that has assisted Inquiry deliberations.

The models and jurisdictions discussed in this Chapter are:

- prohibition (United Kingdom)
- de jure[1] decriminalisation (Portugal)
- cannabis social clubs (Spain)
- adult personal use legalisation (Australian Capital Territory)
- regulated legalisation (Ontario, Canada)
- commercial legalisation (California, United States).

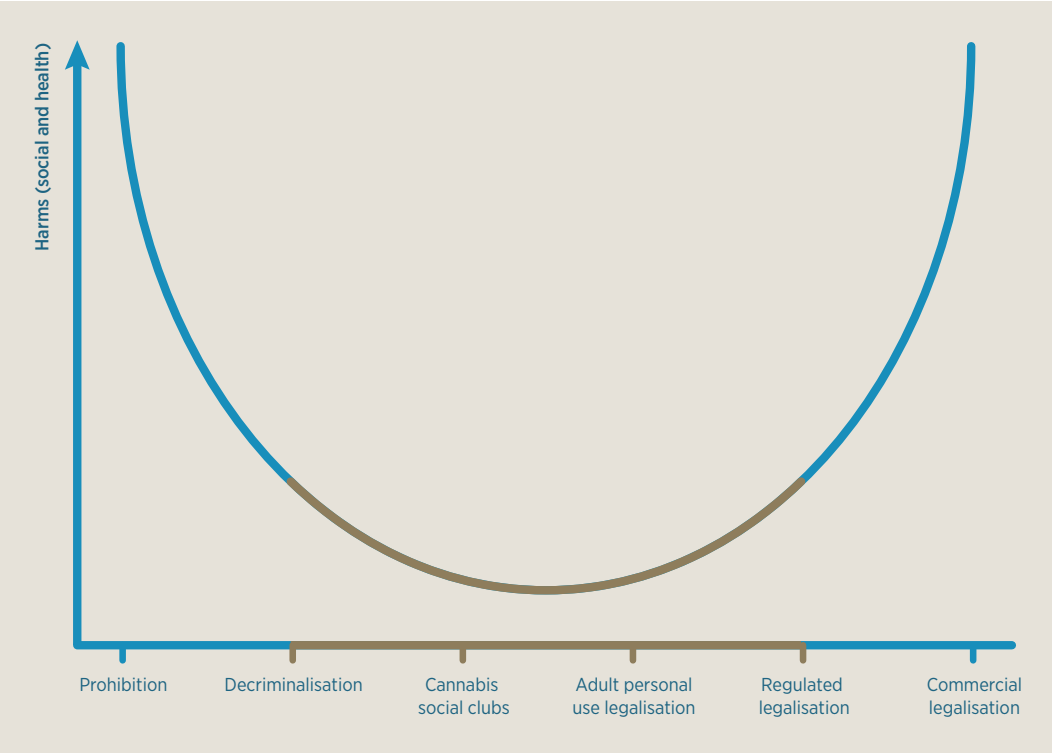
It is important to keep in mind that the effectiveness of drug control is influenced by a variety of factors. Therefore, the approach taken in one jurisdiction might not be suitable for another. Local factors such as political structures, health care systems, and the demographics of a community all need to be considered when reforming drug laws.

6.2 Overview of cannabis regulatory frameworks

It is a misconception that the only drug policy options available to lawmakers are either prohibition or commercialisation. As discussed in Chapter 1, a variety of policy options are available. Figure 6.1 below shows the spectrum of cannabis regulatory models and the predicted degree of social and health harms associated with each. It demonstrates that there are a variety of regulatory models that can be used to reform responses to cannabis use between prohibition and commercialisation.

1 Decriminalisation through legislative change, as a opposed to de facto decriminalisation where certain actions remain criminal offences but are rarely or selectively enforced.

Figure 6.1 The drug policy spectrum



Source: Legislative Council Legal and Social Issues Committee. Adapted from Global Commission on Drug Policy, *Regulation: the Responsible Control of Drugs*, 2018, p. 12.

Professor Dan Lubman AM, Executive Clinical Director at Turning Point, emphasised the importance of understanding that cannabis reform is not a binary choice between prohibition and commercial legalisation:

> It is not about having it available or not available … there are a whole range of different issues that need to be thought through … I think one of the great things that is happening worldwide is that there is a natural experiment going on in other people's countries that we should be really paying attention to and learning from, because I think there are all these different natural experiments going on around legalisation that can tell us a lot around what is and what is not working.[2]

Throughout the Inquiry, the Committee has consulted with stakeholders to develop a better understanding of various cannabis regulatory models that exist around the world. In this Chapter and throughout the Report, the Committee has presented examples of other models and considered the strengths, weaknesses and risks of each.

2 Professor Dan Lubman AM, Executive Clinical Director, Turning Point, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 4.

6.3 United Kingdom: prohibition

Prohibition of cannabis means most, if not all, related activities are criminal offences. This includes use, possession, supply and trafficking of cannabis. The actions usually attract a criminal penalty, including a term of imprisonment.[3]

The United Kingdom is an example of a prohibitionist model to cannabis use. Cannabis is considered a Class B drug under the *Misuse of Drugs Act 1971* (UK) (Misuse of Drugs Act) and is illegal for recreational purposes. However, some local law enforcement precincts have adopted a *de facto* decriminalisation policy where personal use or possession are not pursued through criminal charges.[4] A definition of *de facto* decriminalisation is provided in Section 6.4.

The Misuse of Drugs Act is the primary legislation dealing with preventing the misuse of controlled drugs. It sets out three categories of drugs: Class A, Class B and Class C. Class A represents substances considered to be the most harmful and likely for abuse. Class C represents substances with the least capacity for harm or abuse. Under the Misuse of Drugs Act cannabis is listed as a Class B drug.

There are no regulated quantities for cannabis under the Misuse of Drugs Act. However, the police will typically issue a caution in place of a fine if the amount is less than 1 ounce (28 g) for a first-time offence.[5] The use of cautions for cannabis offences is a policy of the police and not a legislated scheme.

Table 6.1 shows the penalties for Class B drug offences under the Misuse of Drugs Act. Penalties are divided into two categories: on indictment and summary.

Table 6.1 Maximum penalties under the Misuse of Drugs Act 1971 (UK)

Offence	Maximum penalty	
Possession	On indictment	Up to 3 months imprisonment or a £2,500 fine, or both
	Summary	Up to 5 years imprisonment or an unlimited fine, or both.
	Police can also issue an on-the-spot fine of £90.[6]	
Production/supply/ cultivation	On indictment	Up to 12 months imprisonment or a prescribed fine under s 32(2) of the *Magistrates' Court Act 1980* (UK), or both.
	Summary	Up to 14 years imprisonment or an unlimited fine, or both.

Source: *Misuse of Drugs Act 1971* (UK) sch 4.

3 Parliament of Victoria, Law Reform, Road and Community Safety Committee, *Inquiry into drug law reform*, 2018, p. 14.

4 Victoria Ward, 'Three more police forces signal that they will turn blind eye to cannabis use', *The Telegraph*, 28 July 2015, <https://www.telegraph.co.uk/news/uknews/law-and-order/11767001/Three-more-police-forces-signal-that-they-will-turn-blind-eye-to-cannabis-use.html> accessed 4 May 2021.

5 *Cannabis Laws: What is the law on cannabis in the UK?*, <https://www.politics.co.uk/reference/cannabis> accessed 4 May 2021; Tariq Tahir, 'Up in Smoke: Cannabis 'being unofficially legalised' as up to nine out of 10 people caught no longer charged for possession', *The Sun*, 16 June 2019, <https://www.thesun.co.uk/news/9309351/cannabis-unofficially-legalised-nine-out-of-10-caught-no-longer-charged> accessed 4 May 2021; European Monitoring Centre for Drugs and Drug Addiction, *Cannabis legislation in Europe: an overview*, Publications Office of the European Union, Luxembourg, 2018, p. 13.

6 *Criminal Justice and Police Act 2001* (UK) s 1.

There have been attempts in the United Kingdom to reform its approach to cannabis use, particularly how it is dealt with by the criminal justice system. From 2004 to 2009, cannabis was reclassified as a Class C drug under the Misuse of Drugs Act.[7] This meant personal use and possession was treated less harshly by law enforcement and attracted lesser criminal penalties. As a result, it gave law enforcement more discretion to not pursue criminal charges for minor cannabis offences. However, in 2009 cannabis was reinstated as a Class B drug.[8]

At a public hearing, Mr Brendan Hughes, Principal Scientist on Drug Legislation, Support to Policy Sector at the European Monitoring Centre for Drugs and Drug Addiction, discussed the United Kingdom's current approach to cannabis prohibition. He explained that despite the reclassification of cannabis as a Class B drug law enforcement maintained an informal policy to not arrest cannabis users.[9]

In 2019, the United Kingdom Government commissioned a two-part *Independent review of drugs* to examine drug harms in the community and consider strategies for treatment, recovery and prevention. Part One of the review was published in September 2020 and it assessed:

- the demographics of drug use, including demand, user profiles and motivations for use
- the United Kingdom drug market.

Regarding cannabis use, the phase one report made the following findings:

- Cannabis was the most frequently used illicit substance for people aged 16–59, with approximately 2.6 million reported users in 2018–19.[10]
- Between 2016–17 and 2018–19 there was a 16% increase in the number of people reporting to have used cannabis.[11]
- Amongst people aged 25–29, there was a 60% increase in reported use between 2016–17 and 2018–19.[12]
- The 'normalisation of drugs' in the media, such as coverage of cannabis legalisation efforts overseas, is a potential contributing factor to the increased use of cannabis.[13]
- Between 2009–10 and 2018–19, cannabis was the most cited problematic substance for non-opiate users in drug treatment.[14]

7 European Monitoring Centre for Drugs and Drug Addiction, *Cannabis legislation in Europe*, p. 21.

8 Ibid.

9 Mr Brendan Hughes, Principal Scientist on Drug Legislation, Support to Policy sector, European Monitoring Centre for Drugs and Drug Addiction, public hearing, Melbourne, 9 June 2021, *Transcript of evidence*, p. 3.

10 Dame Carol Black, *Review of drugs: phase one report*, report for Government of the United Kingdom, 2020, p. 72.

11 Ibid., p. 79.

12 Ibid.

13 Ibid., p. 81.

14 Ibid., p. 87.

Part One of the report also examined the prevalence of United Kingdom organised crime groups in the production of cannabis. The report found that 21% (364) of known organised crime groups in the UK were involved in cannabis cultivation in 2018.[15] Furthermore, there were significant overlaps (63%) between cannabis cultivation and production and the supply of other illicit drugs amongst organised crime groups, particularly powder cocaine.[16]

The report concluded that there is an increasing trend towards domestic production of cannabis.[17] This may be supported by the fluctuating quantity of cannabis seized at the UK border despite the number of seizures increasing.[18]

6.4 Portugal: de jure decriminalisation

In Portugal, the personal use (consumption and possession) of any drug—including cannabis—is decriminalised and dealt with through the country's legislated drug strategy, which emphasises a health-based response.

Illicit drugs have been decriminalised in Portugal since 1999 following the introduction of *Law No. 30/2000*. To further support redirection of drug offences away from the criminal justice system, the Portuguese Government enacted *Decree Law No. 183* in 2001 which established its national drug strategy. This introduced a 'general system of prevention policies, risk reduction, and minimization of harm that created programs and public health structures for increasing awareness' and referral processes to assist those with problematic use to get treatment.[19]

Decriminalisation is a regulatory approach to illicit drugs which specifies that proscribed behaviours, such as personal use and possession, remain offences but are dealt with using civil penalties rather than criminal penalties. Decriminalisation can occur in two ways, as a *de jure* or a *de facto* scheme.[20] *De jure* decriminalisation is when penalties for certain offences are removed from criminal law through legislation and replaced with civil penalties, such as fines.[21] *De facto* decriminalisation is when legislation is not formally changed but the practices or internal policies of law enforcement or the justice system change so that certain offences are generally not dealt with using criminal penalties.[22]

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15 Ibid., p. 34.

16 Ibid.

17 Ibid., p. 38.

18 Ibid., p. 37.

19 Library of Congress, *Decriminalization of Narcotics: Portugal*, December 2020, <https://www.loc.gov/law/help/decriminalization-of-narcotics/portugal.php#:~:text=To%20further%20implement%20the%20strategy,of%20drug%20addicts%20for%20treatment> accessed 26 May 2021.

20 Parliament of Victoria, Law Reform, Road and Community Safety Committee, *Inquiry into drug law reform*, p. 14.

21 Ibid.

22 Ibid.

Victoria Police's cannabis cautioning program (discussed in Chapter 4) is an example of *de facto* decriminalisation for personal cannabis use and possession. However, the program is limited to no more than two cautions per person, after which Victoria Police pursues criminal charges.

Portugal's decriminalised approach to cannabis and drug use is managed through the Commission for the Dissuasion of Drug Abuse. The Commission is responsible for dealing with people who have been caught in possession of an illicit drug where the amount is no more than the equivalent of 10 daily doses (known as the personal use threshold).[23]

The Commission has a presence in each of Portugal's 18 districts, with each team composed of:

- three members appointed by the Ministries of Justice and Health, who are typically:
  - a legal expert
  - a health professional
  - a social worker
- a small group of practitioners—with a similar background to the members—to support the Commission members.[24]

The European Monitoring Centre for Drugs and Drug Addiction described the process of addressing drug use offences through the Commission as follows:

> The Commission meets the person charged with illegal drug use/possession, in order to evaluate his/her situation with the aim of treating eventual addictions and rehabilitating the person; sanctioning, even if possible, is not the main objective in this phase.[25]

Portugal's decriminalisation model also distinguishes between 'addicted' and 'non-addicted' consumers. The Commission can administer different types of penalties depending on which type of consumer they are dealing with.

A non-dependent user can receive a fine between approximately €25 to €150 for consumption, acquisition, and possession of an illicit drug. Non-dependent users can also be referred to an education program instead of paying a fine. In contrast, dependent users may have their penalties suspended if the person voluntarily agrees to undergo drug rehabilitation and treatment.[26] If a dependent user refuses to comply with a treatment order during the suspension period, penalties may be reinstated.[27]

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23 *Law No. 30/2000, of 29 November* (Portugal) Art 2.

24 European Monitoring Centre for Drugs and Drug Addiction, *Drug Policy Profiles: Portugal*, Publications Office of the European Union, Luxembourg, 2011.

25 European Monitoring Centre for Drugs and Drug Addiction, *Country legal profiles: Portugal*, March 2012, <https://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=PT> accessed 26 May 2021.

26 *Law No. 30/2000, of 29 November* (Portugal) Art 14(1).

27 Ibid., Art 24(3).

For non-minor drug offences (such as trafficking, production, or other commercial activities) the penalty is an imprisonment sentence from 5 to 15 years.[28] This sentence can be increased by a quarter if the offence involves supply to minors or persons with a cognitive, behavioural, or intellectual disability.[29]

Several stakeholders contended that Portugal's approach to drug decriminalisation—including cannabis—had successfully achieved a number of positive public health outcomes.[30]

In its submission, the Alcohol and Drug Foundation described the purpose of Portugal's decriminalisation approach to drug use as follows:

> The Portugal system aims to divert people who use drugs from that path and to provide those whose use is problematic with an early pathway to treatment. Individuals found in possession of a small volume or 'personal supply' of an illicit drug or found to have consumed a drug, are referred to a tribunal known as the Commission for the Dissuasion of Drug Addiction. The Commission's role is to make an assessment of the meaning of the drug use for each individual who is referred to it: drug dependent people can be referred to drug treatment services, while those who are unimpaired by drug use are offered other options: these include having the proceedings suspended, being required to attend a police station, being referred for psychological or educational intervention, or paying a fine. The intent of this system is to emphasise the therapeutic response to a drug problem rather than punishment and to avoid stigmatising the individual.[31]

The Australian Lawyers Alliance discussed some of the 'positive health outcomes' that have occurred in Portugal post-decriminalisation:

> [there has been a] decline in illicit substance use in Portugal over the last decade, a decreasing trend in the total number of notifications of HIV infection and AIDS cases since the early 2000s, and … the drug-induced mortality rate among adults (ages 15–64) is lower than the most recent European average. Since 2001, in addition to trends consistent with regional trends, there has been a reduction in problematic drug users and a reduction in the burden of drug offenders on Portugal's criminal justice system.[32]

The Alcohol and Drug Foundation noted this led to a reduced number of criminal offences, in turn leading to savings to the Portuguese criminal justice system.[33]

According to the Victorian Alcohol and Drug Association, following decriminalisation substance-related incarceration rates reduced by 40%.[34] This point was also raised by

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28 *Decree Law No. 15 of 1993* (Portugal) Art 21 (2).

29 Ibid., Art 24(a).

30 See: Name Withheld, *Submission 169*, p. 2; Victorian Aboriginal Legal Service, *Submission 1398*, p. 9; Springvale Monash Legal Service, *Submission 1399*; Name Withheld, *Submission 938*.

31 Alcohol and Drug Foundation, *Submission 1386*, p. 13.

32 Australian Lawyers Alliance, *Submission 212*, p. 12.

33 Alcohol and Drug Foundation, *Submission 1386*, p. 13.

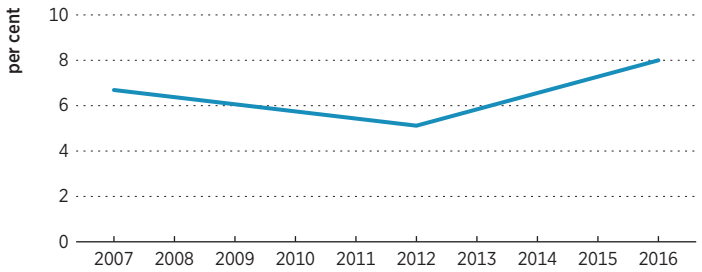
34 Victorian Alcohol and Drug Association, *Submission 1390*, p. 9.

the Victorian Aboriginal Legal Service, which also asserted that drug-related harm and problematic use had declined in Portugal following decriminalisation.[35]

However, some stakeholders disagreed with the assertion that decriminalisation had reduced drug use in Portugal. In its submission, Drug Free Australia argued that drug use in Portugal has increased, noting that drug use was 59% higher in 2017 than in 2001.[36] It also believed that downtrends in the few years following decriminalisation were a reflection of a period of decreased use preceding decriminalisation and not a consequence of decriminalisation.[37] However, the Committee notes that the increase in cannabis use in Portugal has also been attributed to a general upwards trend in cannabis use in Europe.[38]

In 2019, the European Monitoring Centre for Drugs and Drug Addiction released a drug report profile on Portugal. This provided an overview of the country's drug use statistics, including data specific to cannabis use and young people. According to the Centre, in 2016 approximately 8% of people aged 15–34 in Portugal reported using cannabis in the last months, a 50% increase from 2012. This is illustrated in Figure 6.2 below.

Figure 6.2 People aged 15–34 reporting cannabis use in the last year, Portugal, 2007 to 2016



Source: European Monitoring Centre for Drugs and Drug Addiction, *Portugal Country Drug Report 2019*, 2019, <https://www.emcdda.europa.eu/system/files/publications/11331/portugal-cdr-2019_0.pdf> accessed 27 May 2021.

The European Monitoring Centre for Drugs and Drug Addiction provided further figures on the prevalence of cannabis use by age group, which showed that people aged 15–24 years old had similar use rates as those aged 25–44. Significantly, Figure 6.3 shows that rates of reported use dropped to less than 1.5% for people aged 45 and over.

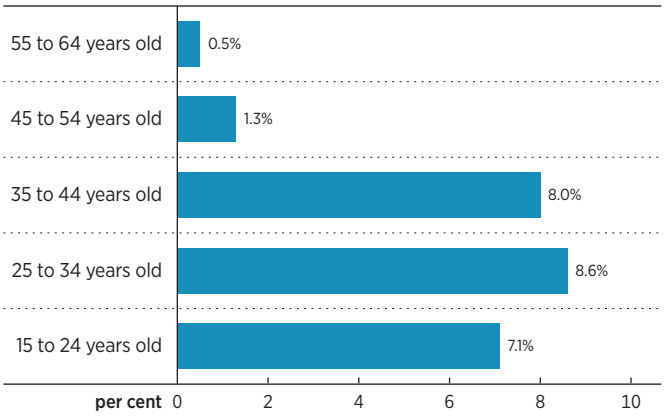
35 Victorian Aboriginal Legal Service, *Submission 1398*, p. 9.

36 No reference was provided so the Committee is unable to verify the source of these figures.

37 Drug Free Australia, *Submission 1364*, p. 3.

38 Statista, *Prevalence of cannabis use in the last year in Europe as of 2019, by country*, 2020, <https://www.statista.com/statistics/597692/cannabis-use-europe-by-country> accessed 19 July 2021.

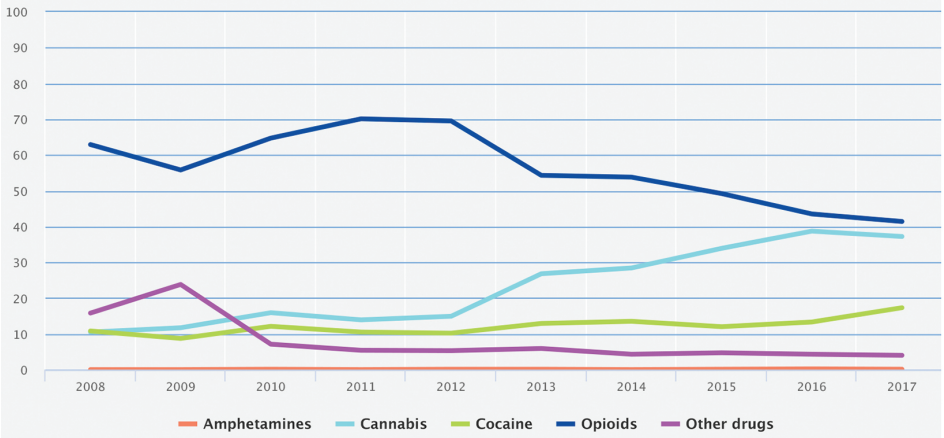
Figure 6.3 Prevalence of cannabis use by age, Portugal



Source: European Monitoring Centre for Drugs and Drug Addiction, *Portugal Country Drug Report 2019*, 2019, <https://www.emcdda.europa.eu/system/files/publications/11331/portugal-cdr-2019_0.pdf> accessed 27 May 2021.

The increased rates of reported cannabis use in Portugal is accompanied by increasing rates of people entering specialised drug treatment where cannabis is the primary drug. Figure 6.4 below shows the percentage of clients entering specialised drug treatment in Portugal, by primary drug from 2008 to 2017. Specialised cannabis treatment has increased from approximately 10% of clients in 2008 to around 40% in 2016–17.

Figure 6.4 Trends in percentage of clients entering specialised drug treatment by primary drug, Portugal



Source: European Monitoring Centre for Drugs and Drug Addiction, *Portugal Country Drug Report 2019*, 2019, <https://www.emcdda.europa.eu/system/files/publications/11331/portugal-cdr-2019_0.pdf> accessed 27 May 2021.

6.5 Spain: cannabis social clubs

Sections of the Spanish Criminal Code criminalise cultivation and trafficking of toxic drugs, narcotics or psychotropic substances for commercial purposes.[39] There are also administrative penalties for the possession and consumption of drugs in public spaces.[40]

However, possession and use of small amounts of an illicit drug—including cannabis—is not a criminal offence so long as:

- it does not disturb public order
- there are no aggravating circumstances such as supplying drugs to minors.[41]

While it is illegal to cultivate cannabis, people are unlikely to be charged if it is grown privately for personal use. Privately sharing of cannabis for personal use is also generally tolerated.[42]

As part of its decriminalised approach to cannabis, Spanish law allows for the establishment of cannabis social clubs, where cannabis is grown collectively and distributed to members for personal use. Plants are cultivated collectively by the clubs on the member's behalf. Cannabis social clubs also retain control over the potency and quality of the cannabis.

Membership of cannabis social clubs in Spain has steadily grown since the first club was founded in 2001.[43] There are now approximately 400 clubs in operation throughout Spain, mostly in Catalonia and the Basque country. They also operate in Belgium, the UK, Italy, Slovenia and the Netherlands, as well as Uruguay, Argentina, Colombia, Chile and Mexico.[44]

Cannabis social clubs are private associations which are governed by the Spanish *Organic Law 1/2002 of 22 March, Regulating the Right of Association*.[45] An association is defined as a group of people who enter into an agreement to achieve common purposes.[46] The clubs must be listed in their local regional registry of associations.

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39 *Ley Orgánica 1/2002, de 22 de marzo, reguladora del Derecho de Asociación* [Organic Law 1/2002 Of 22 March, Regulating the Right of Association] (Spain) ss 301, 368–372 [tr Translation Department of the Subdirectorate-General for Associations, Archives and Documents].

40 *Ley Orgánica 10/1995, de 23 de noviembre, del Código Penal* [Organic Law 10/1995, of 23 November, of the Criminal Code] (Spain) art 368 [tr Clinter].

41 Piñera del Olmo SLP, *Sentences for Drug Crimes*, 2021, <https://www.pineradelolmo.com/sentences-drug-crimes> accessed 18 May 2021.

42 Mr Brendan Hughes, Principal Scientist, Drug Legislation, Support to Policy Sector, European Monitoring Centre for Drugs and Drug Addiction, public hearing, via teleconference, 9 June 2021, *Transcript of evidence*, p, 2.

43 Laurent Jansseune et al., 'Revisiting the Birthplace of the Cannabis Social Club Model and the Role Played by Cannabis Social Club Federations', *Journal of Drug Issues*, vol. 49, no. 2, 2019, p. 2.

44 George Murkin, 'Cannabis social clubs in Spain: legalisation without commercialisation', *Transform Drugs*, 2018, <https://transformdrugs.org/blog/cannabis-social-clubs-in-spain-legalisation-without-commercialisation> accessed 16 May 2021.

45 Organic Law 1/2002, of 22 March, Regulating the Right of Association, art 1.

46 Ibid.

Like other registered associations, cannabis social clubs can be established with a minimum of three members, with founding members subject to background checks. The associations are also protected by the Constitution and can only be suspended or dissolved by a court order if they are considered to be illegal.

Cannabis social clubs, like other associations are generally not subject to federal government regulation. Local municipalities regulate the licensing and operation of the association's premises and deal with issues to do with health and safety, noise and noxious emissions.[47]

Most cannabis social clubs are self-regulating. Due to a lack of clear regulation, clubs create their own codes of practice or use existing templates developed by regional federations of clubs or the Europe-wide code of practice created by the European Coalition for Just and Effective Drug Policies.[48] Some regions have introduced specific legislation to regulate cannabis social clubs.

Criteria for establishing a cannabis social club in Spain include the following:

- Clubs must seek to reduce harms associated with the supply and use of cannabis.
- Club membership is restricted, with new memberships only being granted to those who have been invited by an existing member or with a doctor's certificate.
- Club members are able to obtain a limited quantity at any one time.
- Cannabis is for immediate consumption on the premises.
- Cannabis social clubs as registered associations must be not-for-profit.
- Clubs use membership fees to cover production and management costs, including rent and salaries. [49]

Under Spanish law, cannabis social clubs are unable to advertise. This is intended to reduce the risk of cannabis being promoted to non-users, particularly young people.[50]

In a research paper provided to the Committee by Professor Tom Decorte, Director of the Institute for Social Drug Research at the University of Ghent, Professor Decorte explained:

> Advertisement or promotion of cannabis consumption is explicitly prohibited by the Spanish Criminal Code. Most [cannabis social clubs] do not have a dedicated website, and in the cases where they do, the contents of such webpages tend to be limited to information about the name, location and contact details of the club.[51]

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47 Ibid., art 22, 38.

48 Martín Barriuso Alonso, *Cannabis social clubs in Spain: A normalising alternative underway*, Legislative Reform of Drug Policies series, No. 9, Transnational Institute, The Netherlands, 2011, p. 4.

49 Martín Barriuso Alonso, *Cannabis social clubs in Spain: A normalising alternative underway*, Legislative Reform of Drug Policies series, No. 9, Transnational Institute, The Netherlands, 2011, p.4; Xabier Arana, *Cannabis Regulation in Europe: Country Report Spain*, report for Transnational Institute, The Netherlands, 2019, p. 5; Spanish Ground Rules of Association (Spain) [tr Translation Department of the Subdirectorate-General for Associations, Archives and Documents, Ministerio del Interior, Gobierno de Espana, ed 2020] Madrid, art 7, 11.

50 Professor Tom Decorte, *Submission 1288*, p. 3.

51 Ibid., p. 130.

Some stakeholders considered the social club model as an effective way to regulate cannabis use and support people to have access to regulated products. At a public hearing, Ms Ashleigh Stewart, Research Assistant at the Burnet Institute explained to the Committee:

> The communal 'grow your own' distribution or cannabis social clubs which operate in Spain, Belgium, the UK, Italy, Slovenia, the Netherlands and Uruguay provide a relatively low-risk and self-sustaining model of regulated cannabis supply and are a viable way of meeting some supply needs for the vast majority of cannabis users. Cannabis social club members pool their plants and trade within the club but not to outsiders. … and clubs can provide a legal supply for people who lack the time, space or skill to grow themselves.[52]

Professor Decorte suggested that home cultivation would only address around 10% of the demand for cannabis in a society.[53] He recommended that decriminalisation options consider cannabis social clubs as an alternative means of supply to the illicit market.[54]

Some inquiry stakeholders considered the cannabis social club model to be an effective way of regulating cannabis supply and a halfway point between prohibition and full legalisation. The Drug Policy Modelling Program considered social clubs as a potential 'middle ground option' arguing that 'neither full prohibition nor full legalisation seem fit for purpose', and do not address the 'concerns around public health'.[55]

Similarly, the National Drug Research Institute stated in its submission:

> [Cannabis social clubs] have been shown to be viable low-risk and self-sustaining models of regulated cannabis supply that address the cannabis needs of regular users whom, because of their lack of knowledge, time, suitable physical space or interest, are unwilling or unable to cultivate their own cannabis for personal use.[56]

The Drug Policy Modelling Program believed that cannabis social clubs are an effective tool in diverting people away from the illicit cannabis market which can be more dangerous for users and supports organised crime activity. It stated that cannabis social clubs divert users away from the illicit market by providing an alternative supply which 'challenge[s] the dominance of organised crime in cannabis supply'.[57]

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52 Ms Ashleigh Stewart, Research Assistant, Burnet Institute, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 40.

53 Professor Tom Decorte, Director, Institute for Social Drug Research, University of Ghent, public hearing, Melbourne, 9 June 2021, *Transcript of evidence*, p. 7.

54 Professor Tom Decorte, *Submission 1288*, p. 3.

55 Drug Policy Modelling Program, *Submission 1347*.

56 National Drug Research Institute, *Submission 1325*, p. 17.

57 Drug Policy Modelling Program, *Submission 1347*.

6.5.1 Regulation of cannabis social clubs in Spain

There have been calls for more formal regulation of Spanish cannabis social clubs beyond self-regulated codes of conduct. Independent regions, operators and other stakeholders have advocated for general regulation of the clubs to reduce harm and provide legal security for cannabis associations and their members.[58]

Despite being tolerated by the law, in Spain cannabis social clubs still exist in a legal grey area because of lack of an overarching legal framework to regulate them. This has been attributed to the fact that Spain has not specifically legislated to allow cannabis social clubs to operate, but the clubs were able to take advantage of legal 'loopholes' to continue to operate.[59]

This has caused legal uncertainty for operators of cannabis social clubs, as well as regional authorities. The Drug Policy Modelling Program noted that this left Spanish cannabis social clubs in a precarious position:

> [cannabis social clubs are] located on the margins of the law where their existence is threatened by attempts to criminalise the model. The clubs can be therefore vulnerable to, and constantly adapting to, changing responses from the authorities.[60]

The Parliament of Catalonia has also drafted recommendations for the regulation of cannabis social clubs, aimed at harm reduction and providing legal security for cannabis associations.[61]

Professor Tom Decorte told the Committee that one of the outcomes of the lack of regulation was the existence of 'facade clubs'. This is where supposedly not-for-profit clubs actually produce and distribute large quantities of cannabis:

> So it is a facade for a commercial enterprise, and often these commercial cannabis social clubs are supplied by criminal networks or are even cannabis social clubs that buy the bulk of the cannabis that they are distributing among their members on the black market.[62]

Some clubs have also seen a rapid increase in membership numbers, with some having thousands of members.[63] This has led to concerns that clubs are moving from their original purpose as cooperative, not-for-profit, community-based centres aimed at reducing harm and promoting better health outcomes.

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58 'Navarra Approves a Law Regulating Cannabis Clubs: "Now We Can Look to the Future with Greater Optimism"', *Dinafem Seeds*, 4 December 2014, <https://www.dinafem.org/en/blog/navarra-approves-law-regulating-cannabis-clubs> accessed 16 May 2021.

59 Martín Barriuso Alonso, *Between collective organisation and commercialisation: The Cannabis Social Clubs at the cross-roads*, <https://www.tni.org/en/weblog/item/3775-between-collective-organisation-and-commercialisation> accessed 18 May 2021; Amber Marks, *The Legal and Socio-Political Landscape of Cannabis Social Clubs in Spain*, Observatorio Civil De Drogas, Spain, 2015, p. 4.

60 Drug Policy Modelling Program, *Submission 1347*, p. 6.

61 Amber Marks, *The Legal and Socio-Political Landscape of Cannabis Social Clubs in Spain*, p. 5.

62 Professor Tom Decorte, *Transcript of evidence*, p. 9.

63 Professor Simon Lenton, Director and Program Leader, National Drug Research Institute, public hearing, Melbourne, 19 May 2021, *Transcript of evidence*, p. 36.

For example, in the Catalan region there has been a substantial increase in the number of cannabis social clubs, many of them opening in tourist areas. These clubs have removed many of their membership restrictions, and members do not have to be residents of the local area or even live in Spain. Membership applications can be made online.[64]

Researcher Martín Barriuso Alonso discussed the commercialisation of these clubs:

> Two kinds of cannabis clubs are developing in this community and it is here that the difference between them can most clearly be seen. At least on paper, both models adopt the same legal structure and maintain that they have similar aims. But such similarities in form cannot conceal profound differences in function, to the extent that they are now described as Cannabis Commercial Clubs, as against Cannabis Social Clubs.[65]

In its submission, the Drug Policy Modelling Program highlighted the risk of potential commercialisation of cannabis social clubs:

> A final caveat of Cannabis Social Clubs seems to be the risk of disguised entrepreneurial practices … These can compromise the private nature of Cannabis Social Clubs and take advantage from cannabis tourism. [66]

Some advocates have argued that the clubs generate thousands of jobs for locals as well as potential tax revenue for the state.[67] However, growing commercialisation raises concerns about the potential for criminal activity within the social club system. For example, research provided to the Committee by Professor Decorte noted that where cannabis demand exceeds supply, clubs have sought to fill the gap with drugs obtained illicitly:

> It should be noted that not all the CSCs grow their own cannabis at all times, as the CSCs base their activities on the 'shared consumption doctrine' … which leaves the users unpunished under certain circumstances, regardless of the way the substance (cannabis, in this case) is obtained. In some cases the clubs buy the cannabis in the black market.[68]

A comparison of the number of cannabis plants seized across European Union member states from 2013 to 2017 indicates that the illegal cultivation of cannabis has not decreased significantly since the establishment of cannabis social clubs in Spain. A report by the European Monitoring Centre for Drugs and Drug Addiction and Europol noted that:

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64 Professor Tom Decorte, *Submission 1288*, pp. 29–30.

65 Martín Barriuso Alonso, *Between collective organisation and commercialisation: The Cannabis Social Clubs at the cross-roads*.

66 Drug Policy Modelling Program, *Submission 1347*, p. 6.

67 Xabier Arana, *Cannabis regulation in Europe: country report Spain*, Transnational Institute, Netherlands, 2019, p. 11.

68 Professor Tom Decorte, *Submission 1288*, p. 132.

Both the clubs and the shops are vulnerable to the penetration of criminals seeking to develop large plantations and profitable businesses. These groups are interested in trading and profiting from their crops, often by exporting their products.[69]

6.6 Australian Capital Territory: adult personal use legalisation

As discussed previously in Chapters 1 and 4, in 2019 the Australian Capital Territory (ACT) Legislative Assembly passed the Drugs of Dependence (Personal Cannabis Use) Amendment Bill 2018. The Bill legalised adult personal use of cannabis through amendments to the *Drugs of Dependence Act 1989* (ACT), which came into effect on 31 January 2020.

Adults are permitted to use and possess up to 50g of cannabis,[70] as well as cultivate up to 2 plants in a personal residence (or a maximum of 4 plants per household).[71] However, it remains an offence to cultivate cannabis plants at a non-personal residence.

Adults aged 18 years or older who possess cannabis in the ACT within prescribed limits are exempted from the simple cannabis offence (personal possession, use or cultivation), including its associated penalties.[72] For those not exempted under the Act, personal use of cannabis is decriminalised so long as it falls within the prescribed amounts of a simple cannabis offence.[73]

Table 6.2 below shows the penalties under the *Drugs of Dependence Act 1989* (ACT) for cannabis-related offences.

Table 6.2 Maximum penalties under the *Drugs of Dependence Act 1989* (ACT)

Offence	Maximum penalty
Simple Cannabis Offence (personal possession, use or cultivation)	1 penalty unit People 18 years or older who possess cannabis in the ACT are exempt
Possession exceeding 50g	2 years imprisonment or 50 penalty units, or both
Cultivation exceeding 4 cannabis plants	2 years imprisonment or 50 penalty units, or both
Cultivation (place other than personal residence)	2 years imprisonment or 50 penalty units, or both
Sale or supply of a drug of dependence	5 years imprisonment or 500 penalty units, or both
Storage of cannabis within reach of a child	2 years imprisonment or 50 penalty units, or both

Source: *Drugs of Dependence Act 1989* (ACT) ss 162–171AAC.

69 European Monitoring Centre for Drugs and Drug Addiction, *EU Drug Markets Report 2019*, Publications Office of the European Union, Luxembourg, 2019, p. 91.

70 *Drugs of Dependence Act 1989* (ACT) s 171AA(3).

71 Ibid., s 171AAA(3).

72 Ibid., s 171AA(3).

73 Ibid., s 171AA(1).

At a public hearing Ashleigh Stewart explained that the ACT's decision to legalise adult personal use of cannabis. She stated it was 'in part driven by the need to encourage people to get the support that they need through health systems and not be forced through the criminal justice system'.[74]

Ms Stewart also stated the ACT was hoping to 'undercut the black market and separate people who use cannabis from criminal elements'.[75] However, she warned that for this goal to be successful there needs to be a mechanism to address the gap in supply created from new demands associated with legalisation. This is in part due to the limits imposed on plants for personal cultivation:

> there are a lot of people who use cannabis who will not grow their own or cannot access the means to do that, so that could potentially cause some problems. Allowing home production can sometimes perhaps seem a bit symbolic, and black market products are so readily available that few people do bother to grow their own potentially, so it is also very difficult to grow your own...[76]

Dr Erin Lalor, Chief Executive Officer at the Alcohol and Drug Foundation told the Committee that since the legalisation passed:

- there has been no increase in emergency department presentations
- the police report the new laws have been not any more difficult to enforce
- there was no increase in use.[77]

Similarly, the Penington Institute's submission noted some of the preliminary data around cannabis use and law enforcement post-reform:

- ACT police data showed 'no meaningful increase in drug arrests or drug-driving charges'
- the number of drug tests detecting the presence of tetrahydrocannabinol (THC) has not changed
- simple cannabis offences dropped by 90% in first 12 months after reform
- 12 young people were directed to drug support programs, which is the same number as previous years
- cannabis usage rates in the ACT have remained steady and there has been no increase in cannabis-related hospital presentations.[78]

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74 Ms Ashleigh Stewart, *Transcript of evidence*, p. 40.

75 Ibid.

76 Ibid.

77 Dr Erin Lalor, Chief Executive Officer, Alcohol and Drug Foundation, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 65.

78 Penington Institute, *Submission 1468*, p. 14.

The Penington Institute contended that following reform, more people have presented for treatment for cannabis use and associated mental health concerns due to the reduced stigma associated with cannabis.[79]

The Committee received evidence from Mr Michael Pettersson MLA, Member for Yerrabi in the ACT Legislative Assembly. Mr Pettersson introduced the Drugs of Dependence (Personal Cannabis Use) Amendment Bill as a private members' Bill. He discussed some of the impacts the reform has had on cannabis use and offending in the ACT:

> As time passed it became clear that the overall impact of legalisation was rather subtle and not as drastic as many had hoped. According to a wastewater analysis, cannabis usage rates remained the same upon the Bill's passing and consistent with trends in other jurisdictions over time. According to ACT police, drug driving offences have remained steady. And according to ACT Health, legalisation has not increased the number of cannabis-related hospital presentations. These are of course early numbers and very blunt measures, but they do not spell the doom that many predicted.[80]

This was echoed by Dr Devin Bowles, Chief Executive Officer at the Alcohol Tobacco and Other Drugs Association ACT. He stated that available data on cannabis usage rates in the ACT showed 'no change' following reform:

> The data shows that in 2020, the first year of the legalisation, 85 per cent of respondents used cannabis in the preceding six months. Now, this was slightly higher than the year before but slightly lower than the two years before that. In fact in the preceding 10 years only three had a lower rate of cannabis use than in 2020. Again, the evidence is that the legislation had no effect on the number of people using cannabis. Importantly, this other data source also lets us look at how frequently people were using cannabis—how many days—and there actually was a drop in 2020 compared to the previous year, but looking at the data overall, I think an intellectually honest interpretation would say 'No change'.[81]

However, the Committee notes that the ACT's legislation has only been in place since early 2020. Accordingly, it is difficult to draw any conclusions on the impacts the reforms have had on cannabis use and law enforcement. The Committee believes it is important to continue monitoring the experiences of the ACT.

Some stakeholders expressed concern that the ACT's model neither addresses nor could adequately reduce the supply of drugs from the illicit market. Witnesses from the ACT acknowledged that the aim of the reforms were to focus on personal use and to minimise the social and health harms for users. However, supplying cannabis remains an offence in the ACT so many adults wishing to use cannabis need to purchase it through the illicit market, even to buy seeds or plants for personal cultivation.

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79 Ibid.

80 Mr Michael Pettersson MLA, ACT Legislative Assembly, public hearing, Melbourne, 19 May 2021, *Transcript of evidence*, pp. 18–19.

81 Dr Devin Bowles, Chief Executive Officer, Alcohol Tobacco and Other Drugs Association ACT, public hearing, Melbourne, 19 May 2021, *Transcript of evidence*, p. 20.

Mr Pettersson explained that law enforcement has continued to focus on drug supply but believed that as consumption rates had not reduced it was unlikely that supply rates decreased.[82] Furthermore, he stated that people cultivating their own cannabis are likely to be the 'minority of cannabis users, so most people are still acquiring their cannabis through the black market'.[83]

6.6.1 Public education campaign

Before legislation came into effect, the ACT Government implemented a public health campaign explaining the changes to the law and to educate the general public about the dangers of cannabis use.

At a public hearing, Mr Pettersson described the information provided to the public as a 'general government communications campaign' involving advertising on television, radio and online.[84] He discussed that the purpose of the campaign was to educate the general public about the health risks of cannabis use:

> we spoke to the wider population about some of the dangers of cannabis use. Those are well documented and well studied. We reiterated to the community, with this change, that there are dangers to cannabis consumption.[85]

The Committee believes the implementation of a community wide health campaign following any cannabis use regulatory reform is an important step.

6.7 Canada and Ontario: regulated legal market

Canada's regulatory approach to cannabis is an example of a regulated legal market.

Under a regulated legal market, a government introduces regulatory framework which permits the use, supply and sale of previously illicit substances such as cannabis. However, these are carefully controlled through government regulation and oversight.[86] This is similar to the markets established for pharmaceutical products, tobacco and alcohol. The level of government regulation can vary depending on the jurisdiction.[87]

In 2018, the Parliament of Canada passed the *Cannabis Act 2018*. This legalised the recreational use of cannabis and established a nationwide regulatory framework to control the availability and use of cannabis.

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82 Mr Michael Pettersson MLA, *Transcript of evidence*, p. 24.

83 Ibid.

84 Ibid., p. 21.

85 Ibid.

86 *Regulation: The Responsible Control of Drugs*, Global Commission on Drug Policy, online, 2018.

87 Parliament of Victoria, Law Reform, Road and Community Safety Committee, *Inquiry into drug law reform*, p. 14.

The Act makes cannabis a legal substance and provides general provisions for production, supply and possession. Provincial legislation can place further regulations on the sale, use and possession of cannabis. However, there are criminal penalties for failure to comply with the regulations including exceeding regulated limits of cannabis. The legalisation of recreational cannabis occurred nearly two decades after medical marijuana was legalised in 2001.

6.7.1 Federal framework

The Cannabis Act legalised the recreational use of cannabis nationwide. The Act provides general provisions for a regulated recreational market. It also empowers provinces to establish local retail markets and the ability to further restrict possession, sale and use.

Key features of Canada's federal cannabis legalisation framework include:

- a person must be over the age of 18 years to purchase and use cannabis for recreational purposes[88]
- a person cannot possess more than 30g of dried cannabis in a public place[89]
- promotion of cannabis or associated products is prohibited[90]
- prohibiting packaging or labelling which could be considered appealing, particularly to young people[91]
- cannabis and associated products cannot be displayed in places accessible by young persons[92]
- allowing provinces to introduce their own legislation regulating the possession, sale and distribution of cannabis within their jurisdiction.[93]

Dr Karen Gelb, Senior Research and Policy Officer at the Penington Institute contended that one of the key lessons from the legalisation of cannabis in Canada was ensuring that time and care was taken to implement the regime. She highlighted the Canadian Federal Government's decision to introduce cannabis product-types in phases:

> Canada, when it began with its legalisation regime, began only with inhaled cannabis and then as the next step, the following year, allowed the introduction of edible products as a way to start off with the more, I guess, traditional type of cannabis use and then move to a different kind of product, enabling it to really monitor what was happening and make sure it was taking those sort of slow, steady steps. One of the lessons from Canada is that a lot of work needs to go into preparation if we are going to have a

88 *Cannabis Act 2018* (Ca) s 8(1)(b).
89 Ibid., s 8(1)(a).
90 Ibid., s 17(1).
91 Ibid., s 26.
92 Ibid., ss 29–30.
93 Ibid., s 69.

> regulated system—clearly what you are doing right now is part of this— and time and care needs to be taken when implementing a new regime. It needs to be monitored to make sure that there are not any unintended consequences.[94]

Following legalisation, Canada has collected a wide variety of data tracking developments from the recreational market through its annual Canadian Cannabis Survey. The survey is conducted online and collects data on topics such as:

- patterns of recreational versus medicinal cannabis use
- the cannabis market, including sources and pricing
- cannabis-related public safety issues, such as impaired driving.[95]

Ms Laura Bajurny, Information Officer at the Alcohol and Drug Foundation, summarised the 2020 survey's findings about whether cannabis is being purchased through legal or illegal markets:

> There has been a really positive shift between 2019 and 2020, where 41 per cent of respondents in 2020 were saying that they purchased from a legal storefront and 13 per cent were saying they buy from an online source. They also asked how often people buy either legally or illegally. We are seeing that people reporting that they never make illegal purchases is sitting at 55 per cent of respondents. So it is not there yet, but they have seen big improvements.[96]

Ms Bajurny acknowledged that there is a lot of data variation between provinces, with some jurisdictions showing higher rates of illegal purchases compared to others.[97] She noted that this was attributed to the significant differences in licensing and density regulations across the provinces and that some jurisdictions lagged in establishing legal storefronts affecting product supply.[98] However, Ms Bajurny contended that this issue was 'starting to iron itself out'[99]

Section 6.7.2 below discusses the sources of recreational cannabis in Ontario.

Figure 6.5 below taken from the 2020 Canadian Cannabis Survey illustrates where people obtained cannabis between 2019 and 2020.

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94 Dr Karen Gelb, Senior Research and Policy Officer, Penington Institute, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 47.

95 Government of Canada, *Canadian Cannabis Survey 2020: Summary*, 2020, <https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/research-data/canadian-cannabis-survey-2020-summary.html> accessed 4 May 2021.

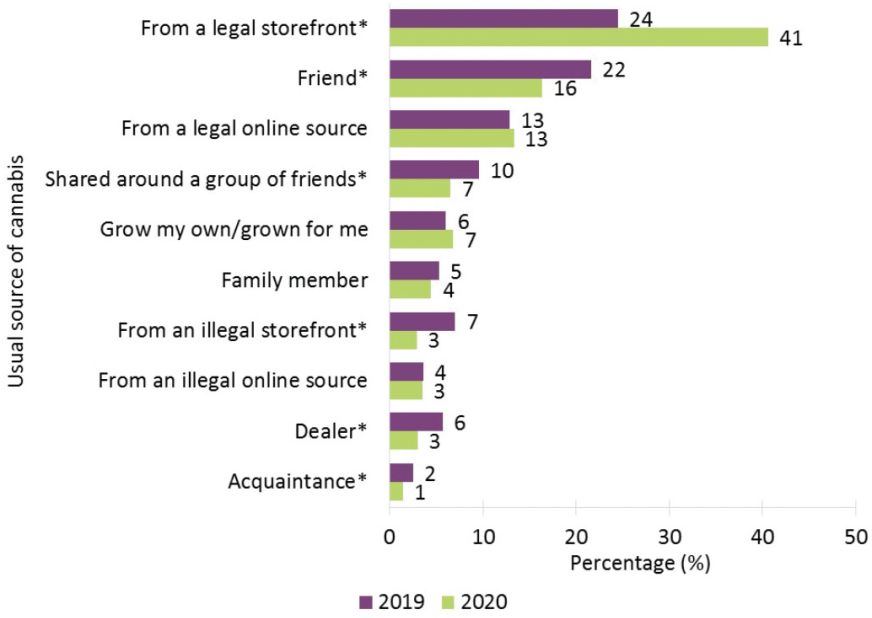
96 Ms Laura Bajurny, Information Officer, Alcohol and Drug Foundation, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 68.

97 Ibid.

98 Ibid.

99 Ibid.

Figure 6.5 Sources for obtaining cannabis, Canada (nationally) 2019 to 2020



* Significantly different compared to 2019.

Source: Government of Canada, *Canadian Cannabis Survey 2020: Summary*, 2020, <https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/research-data/canadian-cannabis-survey-2020-summary.html> accessed 4 May 2021.

The Committee acknowledges that a limitation of the Canadian Cannabis Survey is that it relies on participants to volunteer to complete the survey (following randomised phone recruitment) and to be honest about their responses.

Many Inquiry stakeholders expressed concern that any reform towards cannabis legalisation would need to consider how to prevent young people accessing and using cannabis. This was also a key consideration in Canada's decision to introduce a regulated legal market.[100] In response, provinces have introduced criminal penalties for sale or distribution of cannabis to a minor and use of cannabis by a minor to deter young people from using cannabis. Ontario's maximum criminal penalties for these offences is outlined in Section 6.7.2.

Whilst Canada's recreational cannabis sector is developing, some data trends are emerging about the use of cannabis by young people. Ms Bajurny from the Alcohol and Drug Foundation told the Committee that post-legalisation cannabis usage rates for people between 12 and 18 years' old have remained stable with pre-legalisation rates. However, she noted that data is emerging which shows 'incrementally the first instance of use is starting to go up.'[101]

100 Canada, House of Commons, 30 May 2017, *Parliamentary debates*, vol. 148.

101 Ms Laura Bajurny, *Transcript of evidence*, p. 64.

To further support efforts to prevent young people using cannabis, Canada also undertook 'broad awareness programs' targeted at school-age children about the risks of cannabis use.[102] Public and youth-focused drug education in Canada is discussed in more detail in Chapter 5.

6.7.2 Provincial framework: Ontario

As noted above, Canadian provinces can introduce their own legislation regulating the cannabis market in their jurisdiction. Therefore, there are some divergences in the way provinces have set up their recreational cannabis markets and regulations. The Committee has considered the Ontario model because of the breadth of evidence the Committee received about the approach taken in Ontario.

The recreational cannabis market in Ontario is managed through strict government regulations that control distribution, sale and possession limits for recreational cannabis. The Government of Ontario is directly involved in the province's retail market through the Ontario Cannabis Retail Corporation. This was established under the *Ontario Cannabis Retail Corporation Act 2017* (SO). It is a Crown Corporation which is the province's only:

- wholesale distributor of cannabis products[103]
- online cannabis retail store, trading as the Ontario Cannabis Store.[104]

A licensing system for 'brick and mortar' cannabis retail stores was established under the *Cannabis Licence Act 2018* (SO). Section 3 of the Act prescribes that anyone wanting to operate a retail cannabis store needs to have an approved Retail Operator Licence.[105] There are also additional licences for individuals that have managerial responsibilities.[106]

Cannabis retail stores are only permitted to sell cannabis products purchased from the Ontario Cannabis Retail Corporation[107] and a single sale transaction cannot exceed prescribed possession limits.[108]

The *Cannabis Control Act 2017* (SO) regulates the amount of cannabis a person can possess lawfully for recreational use. A person may possess no more than 1,000g of cannabis in a household and no more than 30g in a public place. The Act also prescribes penalties for unlawful sale, distribution and possession.

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102 Ibid., p. 65.

103 *Cannabis Licence Act 2018* (Ont) s 18(1).

104 *Ontario Cannabis Retail Corporation Act 2017* (Ont) s 2(1)(a).

105 *Cannabis Licence Act 2018* (Ont) s 3.

106 Ibid., s 5.

107 Ibid., s 18(1).

108 Ibid., s 21(4).

Table 6.3 below shows the maximum penalties for contravening the provisions of the Cannabis Control Act.

Table 6.3 Maximum penalties under the *Cannabis Control Act 2017* (SO)

Offence	Penalty
Unlawful sale/distribution (individual)	Up to 2 years imprisonment
Unlawful sale/distribution (corporations)	A fine up to $500,000 for each day the offence is committed
Sale or distribution to a minor	Up to 1-year imprisonment (individuals) or a fine of up to $500,000 (corporations)
Possession, consumption or cultivation by a minor	A fine up to $200

Source: *Cannabis Control Act 2017* (SO) s 23.

As noted previously, Canadian provinces—including Ontario—have had trouble in preventing people from accessing the illegal market following the legalisation of cannabis at a federal level. This is due to legal supply not keeping up with demand. Dr Kevin Sabet, President of Smart Approaches to Marijuana in the United States told the Committee that most recreational sales in Ontario are through the illegal market. He also acknowledged the illegal market's maturity makes it difficult to dismantle:

> it is very, very difficult to erode a mature underground market, because of course cannabis has been illegal for so long. Unlike alcohol, which was only illegal for less than 20 years, of course cannabis has been prohibited for much, much longer, so the illegal market has had time to mature, to adapt, to spread. It does not just fold up easily.[109]

In a 2020 audit of the Alcohol and Gaming Commission of Ontario the Auditor-General of Ontario found that approximately 80% of Ontario's recreational sales were made through the illegal market.[110] However, legal recreational sales increased between 2018 and 2020, accounting for 5% of sales in the fourth quarter of 2018 to 20% in the first quarter of 2020.[111]

The Auditor General also explained that a core objective of the Ontario Cannabis Store is to shift cannabis consumers away from the illicit market towards the legal market. To achieve this, the Ontario Cannabis Store will support the growth of private licensed retails to increase the number of sales occurring in the legal market.[112]

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109 Dr Kevin Sabet, President, Smart Approaches to Marijuana, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 11.

110 *Value-for-Money Audit: Alcohol and Gaming Commission of Ontario*, Office of the Auditor General of Ontario, Ontario, 2020, p. 4.

111 Ibid.

112 Ibid.

6.8 United States (California): commercial legal market

In the United States, cannabis is illegal for use, sale, cultivation and possession under federal law. Cannabis is a Schedule I drug under the *Controlled Substances Act* (USC) meaning it has high potential for abuse, no accepted medical use and poses significant risks.[113]

Despite ongoing federal prohibition, several states have enacted legislation permitting the use, sale and possession of cannabis for recreational purposes. Models of cannabis regulation range from decriminalisation to commercial legalisation. At the time of writing, 31 states in the United States had either legalised or decriminalised cannabis in some way. Cannabis decriminalisation first began in the United States in 1973 when Oregon decriminalised the personal use of cannabis.[114]

As noted previously, there are a range of regulatory models for cannabis use across the United States, ranging from prohibition to commercial legalisation. The Committee has focused on the California model because it is an example of commercial legalisation and the breadth of evidence the Committee received about the approach taken in California.

The following is a non-exhaustive list of other types of regulatory models that exist in the United States:

- **Oregon:** established a regulated market for recreational and medicinal cannabis, which capped the number of retail cannabis licenses available across the State so that only a limited number of businesses can dispense cannabis to adults for recreational and medicinal purposes. At the time of writing, the number of Conditional Adult Dispensing Organisation licenses was 75.
- **Washington (District of Columbia):** established a regulated market for medicinal cannabis and legalised the personal possession of cannabis. The supply of cannabis remains illegal in Washington (District of Columbia). Cannabis remains illegal for recreational purposes in the rest of the District of Columbia.
- **Florida:** cannabis is illegal for recreational use, but legal for medical use. Several counties and municipalities have approved plans to use civil citations (similar to a caution) if a person is found with less than a prescribed small quantity of cannabis (typically less than 20g). Other cities or counties have approved ordinances for decriminalising cannabis use. For example, Miami Beach passed an ordinance in July 2015 which resolved that the maximum penalty for a person found in possession of 20g or less of cannabis is a US$100 fine.

6.8.1 Federal prohibition

At times the United States' Federal prohibition of cannabis has made it difficult for states to enact cannabis legislation in practice. For example, in 1998 the District

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113 *Controlled Substances Act*, 21 USC § 812b (1970).

114 Lori Moore, 'Milestones in U.S. Marijuana Laws', *The New York Times*, 2013, <https://archive.nytimes.com/www.nytimes.com/interactive/2013/10/27/us/marijuana-legalization-timeline.html> accessed 6 May 2021.

of Columbia legalised the medical use of cannabis, but the implementation of the program was delayed until 2010 because of the Barr Amendment.[115] This blocked the implementation of medicinal cannabis programs and prohibited future state laws that contradicted federal penalties for cannabis or other Schedule I drugs. In 2009, the US House of Representatives and Senate lifted the ban against medicinal cannabis programs by removing the Barr Amendment.[116]

The tension between federal and state drug legislation still exists today. Even if a state has legalised cannabis use, a person can technically still be prosecuted by federal authorities under the federal Controlled Substances Act.

However, following state legalisation federal authorities have sought to clarify the approach of federal prosecutors in enforcing prohibitions in states that have legalised cannabis. The Cole Memorandum issued in 2013 by the Obama Administration indicated that federal prosecutors should not enforce cannabis prohibition on legalised states unless there were concerns for public safety and health. The Memorandum stated if there were 'strong and effective regulatory and enforcement systems that will address the threat those state laws could pose to public safety, public health, and other law enforcement interests' then federal prohibition would not be enforced.[117]

The Cole Memorandum was rescinded in January 2018 by the Trump Administration.[118] However, following the 2020 election the Biden Administration indicated it would reinstate a version of the Memorandum.[119]

Ms Tamar Todd, Lecturer at Berkeley Law and Former Legal Director of the Drug Policy Alliance (US) explained that the United States Federal Government relies on state cooperation in enforcing federal laws. She also noted that state governments are not 'obligated to assist the federal government in any way'.[120] Therefore, she believed that the federal government has 'some diminished power' in enforcing drug prohibition.[121]

Ms Todd also discussed the impact of the Cole Memorandum in guiding a federal approach to cannabis legalisation:

> we have had guidance by the federal department of justice that advises federal prosecutors and federal law enforcement to not interfere with the state regulatory programs. So even in the absence of a change in federal statute that would legalise

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115 'Congress Lifts Ban on Medical Marijuana in Nationa's Capital', *Americans for Safe Access*, 14 December 2009, <https://www.commondreams.org/newswire/2009/12/14/congress-lifts-ban-medical-marijuana-nations-capitol> accessed 6 May 2021.

116 Ibid.

117 James M Cole, *Memorandum for all United States Attorneys: Guidance Regarding Marijuana Enforcement*, Office of the Attorney General, U.S. Department of Justice, Washington D.C., 2013.

118 Jefferson B Sessions, *Memorandum for all United States Attorneys: Marijuana Enforcement*, Office of the Attorney General, U.S. Department of Justice, Washington D.C., 2018.

119 Judge Merrick Garland, Responses to Questions for the Record to Judge Merrick Garland, Nominee to be United States Attorney General hearing, response to questions on notice received 2021, p. 24.

120 Ms Tamar Todd, Lecturer, Berkeley Law and Former Legal Director, Drug Policy Alliance, public hearing, Melbourne, 25 March 2021, *Transcript of evidence*, p. 4.

121 Ibid.

> cannabis or align the law with state laws, they have taken a policy approach in enforcement to try and work cooperatively with states that are regulating rather than at cross purposes, and it has been fairly successful[122]

Despite the adoption of a 'no interference' policy approach to cannabis legalisation, one of the biggest challenges for legal markets in the United States is still federal prohibition. Ms Todd explained that ongoing federal prohibition causes a number of issues to the cannabis industry:

> The industry as a whole is very underserved in terms of banking because many banks do not want to provide services to cannabis businesses when it remains federally illegal. We also have no interstate commerce, so each state has had to set up a completely intrastate market, which means a lot is out of balance. Many states produce more than they can consume within the state and other states would need more production to come in, so it has created this real artificial barrier to the market that allows price manipulation and is not well balanced with production and demand, I would say.
>
> We do not have the same option that Canada has—Quebec—or Uruguay in that our state government cannot be a direct actor in the market, so we do not have the option of the state playing a direct role in selling because of the federal prohibitions, so that is a limitation. Then we continue to have an unregulated market, so some of the harms that existed I think from the lack of regulation still continue to exist where there is a lack of regulation because there is still that illicit market.[123]

6.8.2 California

The Californian Government's regulatory approach to cannabis is an example of a commercial retail market. California's cannabis market includes both recreational and medicinal use of cannabis under one regulatory system. It also allows for local discretion in setting up cannabis retailers with the state legislation only providing a broad regulatory framework.

In 2016, California introduced the *Adult Use of Marijuana Act* (Cal) which legalised recreational cannabis and established a broad framework for a cannabis retail market, including licensing, tax and other business regulations. In 2018 the *Medicinal and Adult-Use Cannabis Regulation and Safety Act* (Cal) combined California's recreational use framework with its medicinal use of cannabis framework, which was introduced in 1996.

Key features of California's cannabis regulatory framework are:

- a wholesale tax on cultivators, with a different tax rate for product types (e.g. flowers versus leaves)[124]

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122 Ibid., p. 5.

123 Ibid., p. 3.

124 California Department of Tax and Fee Administration, *Tax Guide for Cannabis Businesses: Cultivators*, <https://www.cdtfa.ca.gov/industry/cannabis.htm#Cultivators> accessed 6 May 2021.

- a 15% excise tax (at average market price) on recreational cannabis purchases, alongside additional local taxes (purchases for medicinal reasons are exempt)[125]
- plain and child-resistant packaging rules for cannabis products, including health warning information and a disclaimer that cannabis is a Schedule I controlled substance[126]
- restrictions on advertising and marketing, including prohibition against giving cannabis away as part of promotional or other commercial activities[127]
- establishment of local cannabis equity programs under the California Cannabis Equity Act (Cal), to facilitate greater equity in business ownership and employment in the cannabis market.[128]

Under the Medicinal and Adult-Use Cannabis Regulation and Safety Act, local jurisdictions are empowered to:

- completely prohibit the establishment or operation of any type of cannabis business
- enforce their own regulations around licensing, public health and other business requirements.[129]

Therefore, cannabis businesses are required to have both state and local licences to operate in California.

The discretionary powers given to local jurisdictions to establish recreational cannabis industries has resulted in significant inconsistencies across California. In August 2020, Applied Development Economics, a California-based economic consulting firm, released its *Analysis of the Cannabis Market in California and Case Study Cities* report. This examined the status of California's legal cannabis market. The firm found that across California there were wide-ranging inconsistencies in local cannabis markets:

> These inconsistencies range from land use regulations to tax rate and licensing procedures. While some jurisdictions have proactively sought to attract and develop local cannabis businesses, others have taken steps to block cannabis businesses from opening. Because retail cannabis licensing and sales still fall short of potential consumer demand, the illicit cannabis market continues to meet a large majority of this demand.[130]

Box 6.1 and Box 6.2 below outline different regulatory approaches taken by two cities in California. The City of Stockton decided to introduce a cannabis retail market and established an annual lottery system for business permits. In contrast, Sacramento County (unincorporated) decided against allowing any cannabis businesses to operate in the county.

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125 California Department of Tax and Fee Administration, *Tax Guide for Cannabis Businesses: Retailers*, <https://www.cdtfa.ca.gov/industry/cannabis.htm#Retailers> accessed 6 May 2021.

126 *Cannabis Regulation and Safety Act* 10 Cal § 12.2120 (2017).

127 Ibid., § 15.26151 (2017).

128 *California Cannabis Equity Act* 10 Cal § 23.26246 (2018).

129 *Cannabis Regulation and Safety Act* 10 Cal § 20.26200(a)(1) (2017).

130 Applied Development Economics Inc., *Analysis of Cannabis Market in California and Case Study Cities*, California, 2020, p. 4.

BOX 6.1: Stockton, California

In 2019, Stockton implemented a lottery system which issues two cannabis licenses annually for each of the four available cannabis business categories: cultivation, manufacturing, retail (storefront and non-storefront) and microbusinesses. A microbusiness is one that is approved for operating with at least 3 other cannabis business types.

Some business types do not have an annual permit limit and do not need to apply via the lottery. These include non-storefront retail (delivery), non-volatile manufacturer, distribution and testing labs.

In addition to state taxes, Stockton has introduced a local cannabis tax rate of 5%.

The City of Stockton also administers a cannabis equity program under the *Cannabis Equity Act* to promote greater equity in applicants applying to establish a cannabis business.

Source: City of Stockton, *Legal Cannabis Businesses*, April 2021, <http://www.stocktonca.gov/government/departments/communityDevelop/cdPlanCanBus.html> accessed 7 May 2021.

BOX 6.2: Sacramento County (unincorporated), California

Sacramento County (unincorporated) does not allow any cannabis-related businesses to operate within its boundaries. It has also not set up a local cannabis tax rate or begun establishing a framework for local cannabis businesses to operate.

In March 2019, Sacramento County (unincorporated) amended its cannabis regulations around personal cultivation so that it aligned more closely with state laws. Amendments included:

- Allowing up to six cannabis plants in a personal residence for personal cultivation (indoor only).
- Introduction of 'reasonable regulations' for personal cultivation, including requirements for rental properties.
- Increased penalties for cannabis related building and safety code violations.

In contrast, the City of Sacramento does allow cannabis dispensaries, cultivation, manufacturing, testing, and distribution within specific zones of the city. Therefore, residents and potential business owners need to be aware of specific zoning boundaries for cannabis businesses to ensure that they are operating legally.

Source: Sacramento County, *Cannabis in the Unincorporated County*, <https://www.saccounty.net/Business/Pages/Cannabis.aspx> accessed 7 May 2021.

The decision to not establish a retail cannabis market is not isolated to Sacramento County (unincorporated). Dr Sabet from Smart Approaches to Marijuana contended that many local jurisdictions have decided against allowing cannabis businesses to operate:

> the vast majority of cities and towns have actually banned the sales within their jurisdictions. I am not just talking about one or two members of sort of like city council or the mayor; I am talking about referenda, local referenda, where people essentially voted yes on sort of the broad state-level, 'We don't want to put people in prison' and that kind of thing, but a very hard no on whether or not a retail cannabis seller or establishment or even grower or cultivator, whatever, should be within their city limits.[131]

Proponents of legalisation contend that by establishing regulated commercial markets the illicit market would be disrupted and dismantled. As legal cannabis markets are all less than a decade old, data around the impact on illicit markets is still emerging.

However, several stakeholders expressed concern that even after legalisation a large portion of recreational sales in California were from the illicit market. In its submission, Drug Free Australia contended that $8.7 billion is 'changing hands' in California's illicit cannabis market. It also discussed the impact illicit market sales have on licenced cannabis businesses:

> Members of California's cannabis industry are sending an S.O.S. to the state capitol, saying they're struggling to compete against black market operators who don't have to meet stringent regulations or pay taxes and fees. California cannabis businesses that have cut their workforces or scaled back growth plans. Their challenges, they say, are homegrown: California has too few licensed cannabis businesses, too much taxation and overly onerous regulation.[132]

This was echoed by other stakeholders who shared similar concerns that legalisation was not effectively preventing recreational cannabis sales in California's illicit market.[133] The impact of legalisation on the illicit cannabis market has been discussed previously in Chapter 4.

As discussed in Chapter 1, an important consideration when evaluating the outcomes of legalising cannabis is its impact on rates of cannabis use, especially amongst young people. As stated previously, legalised cannabis markets are still quite young and trends around usage in these markets are still developing. However, some stakeholders argued that early data is suggesting that cannabis use is remaining steady in legalised countries and California may be an exception.[134]

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131 Dr Kevin Sabet, *Transcript of evidence*, p. 16.

132 Drug Free Australia, *Submission 1364*, p. 7.

133 For example: Smart Approaches to Marijuana, *Submission 1194*.

134 Ms Sarah Helm, Executive Director, New Zealand Drug Foundation, public hearing, Melbourne, 21 April 2021, *Transcript of evidence*, p. 30.

Adopted by the Legislative Council Legal and Social Issues Committee
Parliament of Victoria, East Melbourne
26 July 2021

Appendix A
About the Inquiry

A.1 The Inquiry process

This Appendix provides an overview of the evidence gathering process undertaken for this Inquiry. It includes the Inquiry's Terms of Reference and an overview of the evidence received by the Committee, which consisted of submissions, public hearings and a Youth Forum.

Terms of Reference

On 29 May 2019, the Legislative Council agreed to the following motion:

> That this house, requires the Legal and Social Issues Committee to inquire into, consider and report, by no later than 2 March 2020, into the best means to —
>
> a. prevent young people and children from accessing and using cannabis in Victoria;
>
> b. protect public health and public safety in relation to the use of cannabis in Victoria;
>
> c. implement health education campaigns and programs to ensure children and young people are aware of the dangers of drug use, in particular, cannabis use;
>
> d. prevent criminal activity relating to the illegal cannabis trade in Victoria;
>
> e. assess the health, mental health, and social impacts of cannabis use on people who use cannabis, their families and carers;
>
> and further requires the Committee to assess models from international jurisdictions that have been successful in achieving these outcomes and consider how they may be adapted for Victoria.

The Legislative Council agreed to extend the reporting date to 31 March 2021 and subsequently to 5 August 2021.

Submissions

The Committee advertised the Inquiry and called for submissions through its News Alert service, the Parliament of Victoria website, and print, online and social media. The Committee sent out over 100 letters to stakeholders inviting them to make a submission to the Inquiry. Stakeholders included:

- government departments
- cannabis advocacy organisations
- industry groups

- justice stakeholders
- policy advisers
- religious agencies
- academics
- international stakeholders
- community members
- current and past users of cannabis and others.

The Committee requested that submissions be received via an online submission portal. Submitters were able to supply demographic data and respond to survey questions relevant to the Committee's terms of reference.

The Committee received and accepted a total of 1,475 submissions, with 76 submissions granted confidentiality by the Committee. Confidential submissions inform the Committee's understanding but are not used substantively in this report. The Committee also resolved to grant 'name withheld' status to the many submissions it received in which the submitter discussed their use of cannabis. As use of cannabis is an offence in Victoria, submitters' names were redacted to protect their privacy.

All submissions, except for those accepted as confidential, were published on the Committee's website at https://www.parliament.vic.gov.au/lsic-lc/article/4260.

A list of submissions is included in Section A.2 of this Appendix.

Survey responses

The Committee obtained data from survey questions included in the Inquiry's submission form. Submitters were asked to rank the following themes in order of importance to the Inquiry:

- education
- young people and children
- criminal activity
- public health
- public safety
- social impacts
- mental health
- accessing and using cannabis.

Submitters were able to express their opinion on the legality of cannabis use by selecting one or more statements from the following:

- Sale should remain illegal.
- Personal use of cannabis should remain illegal.
- Personal use of cannabis should be decriminalised. (Decriminalised: there are no criminal or civil penalties instead a person is referred to a drug diversion program or other health/ treatment service).
- Personal use of cannabis should be legal.
- Sale of cannabis should be legal and regulated.
- Cultivation of cannabis for personal use should be legal.

Demographic data supplied through the submission form gave insight into the age range, sector and geographical region of submitters as well as their interest in the Inquiry. Where appropriate, the Committee used some of the data collected in its survey in formulating its recommendations throughout the Report.

Public hearings

Due to restrictions put in place in response to COVID-19 the Committee held several public hearings via videoconference.[1] Where it was able to, the Committee also held in-person hearings in metropolitan Melbourne and regional Victoria.

Public hearings were held on the following dates:

- 25 March 2021 (Melbourne)
- 21 April 2021 (via videoconference)
- 28 April 2021 (Beechworth)
- 19 May 2021 (Melbourne)
- 1 June 2021 (via videoconference)
- 9 June 2021 (via videoconference)
- 29 June 2021 (via videoconference).

The list of witnesses who attended public hearings can be found in Section A.3 of this Appendix.

Transcripts of evidence from public hearings were published on the Committee's website: https://www.parliament.vic.gov.au/lsic-lc/article/4263.

1 Videoconferences were undertaken via Zoom.

A

Youth Forum

As a key demographic for this Inquiry, the Committee wanted to hear from young people. The Committee received evidence that the highest rates of cannabis use by age were those in the 20–29 age group, followed by the 14–19 age group, and that young people are disproportionately impacted by the effects of cannabis policy.[2] There was also a high level of engagement by young people in this inquiry compared to other inquiries, with 45% (631 of 1,402) of submitters reporting their age as under 30.[3]

The Committee recruited participants for the Forum via a Facebook advertisement and through the Youth Affairs Council of Victoria's network. The majority of participants who attended the Forum applied after seeing the Facebook post.

The Youth Forum allowed the Committee to receive information from 11 young people about their experiences with drug education, mental or physical health impacts of cannabis use, drug and alcohol services, and the impacts of criminalisation. Participants completed worksheets which were received as evidence to the Inquiry. These worksheets and the discussions of the Youth Forum have helped shape the Committee's deliberations and are occasionally referred to throughout the Report.

2 See: Students for Sensible Drug Policy Australia, *Submission 1392*; Youthlaw, *Submission 1389*; Jesuit Social Services, *Submission 1471*; Victoria Police, *Submission 901;* Name Withheld, *Submission 1282.*

3 Data extracted from survey results from the Legislative Council Legal and Social Issues Committee online submission form.

A.2 Submissions

1	Name withheld
2	Name withheld
3	Name withheld
4	Thomas Gribben
5	Name withheld
6	Name withheld
7	Name withheld
8	Joshua Stewart
9	Name withheld
10	Nicholas Matkovic
11	Name withheld
12	Name withheld
13	Name withheld
14	Confidential
15	Name withheld
16	Stuart Allman
17	Name withheld
18	Name withheld
19	Confidential
20	Chris Sos
21	Name withheld
22	Name withheld
23	Kimberley Schollick
24	Name withheld
25	Confidential
26	Tobias Threadgold
27	Name withheld
28	Name withheld
29	Name withheld
30	Jeremy Bornstein
31	Name withheld
32	Dinch Kim
33	Name withheld
34	Myles Larkham-Pask
35	Name withheld
36	Name withheld
37	Name withheld
38	Feyza Koseler
39	Aaron Hird
40	Ronan Mellin
41	Confidential
42	Name withheld
43	Name withheld
44	Name withheld
45	Jeff Sqerado
46	Name withheld
47	Name withheld
48	Confidential
49	Name withheld
50	Name withheld
51	Name withheld
52	Name withheld
53	Name withheld
54	Name withheld
55	Confidential
56	Name withheld
57	Name withheld
58	Name withheld
59	Name withheld
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207	Damien Nicholls
208	Harm Reduction Australia
209	Australian Institute of Health and Welfare
210	Australian Drug Law Reform Foundation
211	Family Council of Victoria
212	Australian Lawyers Alliance
213	Green Planet
214	Eros Association
214A	Eros Association
215	Dalgarno Institute
216	Painaustralia
217	Budherd
218	Ainslee Webber

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1154	Laura Cininas
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1157	Name Withheld
1158	Name Withheld
1159	Renee Peterson
1160	Name Withheld
1161	Name Withheld
1162	Simon Keck
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1168	Simon Meagher
1169	Name Withheld
1170	William Furler
1171	Baljosh Dhaliwal
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1174	Thomas Morison
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1187	Name Withheld
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1189	Confidential
1190	Confidential
1191	Jamie Fitzgerald
1192	Confidential
1193	Confidential
1194	Smart Approaches to Marijuana (SAM)
1195	Name Withheld
1196	Name Withheld
1197	Name Withheld
1198	Name Withheld
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1207	Confidential
1208	Patricia Lisle
1209	Name Withheld
1210	Name Withheld
1211	Dr Michael White
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1213	Confidential
1214	Jessie Doolan
1215	Name Withheld
1216	Stefan Lodewychx
1217	Confidential
1218	Confidential
1219	Confidential
1220	Eduardo Teijeiro
1221	Yehuda Harmor
1222	Drug Free Australia (Queensland)
1223	Norah King
1224	Name Withheld
1225	Confidential
1226	Simon Longhurst
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1231	Michael Caminiti
1232	Name Withheld
1233	Darren Snijders
1234	Name Withheld
1235	Name Withheld
1236	Henry Kassay
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1241	Name Withheld
1242	George Dickson
1243	Name Withheld
1244	Matt Greaves
1245	Dominic Francis
1246	Hans Paas
1247	Christopher Huang-Leaver
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1251	Confidential
1252	Johathan Wilson
1253	Andrew Hale
1254	Name Withheld

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1255	Confidential
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1257	Name Withheld
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1259	Luke Beerling
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1263	Name Withheld
1264	Name Withheld
1265	Shea Synott
1266	Name Withheld
1267	Name Withheld
1268	Paul Ceccato
1269	Name Withheld
1270	Laura Barnard
1271	Name Withheld
1272	Keaghan Kennedy
1273	Wayne Taylor
1274	Confidential
1275	Ben Collins
1276	Dr John Paul Wilson
1277	James Warren
1278	FamilyVoice Australia
1279	Aaron Beecham
1280	Confidential
1281	Cannabis Association Organic Oz
1282	Name Withheld
1283	Luke Bryant
1284	Taylor Curtis
1285	Penelope Davison
1286	Name Withheld
1287	Name Withheld
1288	Professor Tom Decorte
1289	Heather Gladman
1290	Roger Foley
1291	Name Withheld
1292	Cynthia Kerr
1293	Name Withheld
1294	Name Withheld
1295	Name Withheld
1296	Shane Howes
1297	Associate Professor Chris Wilkins
1298	Name Withheld
1299	Dr Marta Rychert
1300	Name Withheld
1301	Confidential
1302	Name Withheld
1303	Name Withheld
1304	Matthew Grant
1305	Mutullah Can Yolbulan
1306	Kirill Smelov
1307	Tobias Nash
1308	Lisa Peterson
1309	Royal Australian and New Zealand College of Psychiatrists
1310	Name Withheld
1311	Name Withheld
1312	John Harland
1313	Dr Deanna Wang
1314	Miguel Cochofel
1315	Sharni Graham
1316	Joel Martin
1317	Name Withheld
1318	Lawrence Fatahie-Oliaie
1319	Name Withheld
1320	Confidential
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1322	Jackson Jefferson
1323	Robert Erwin
1324	Name Withheld
1325	National Drug Research Institute
1326	Name Withheld
1327	Name Withheld
1328	Name Withheld
1329	Name Withheld

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1332	Name Withheld
1333	Daniel Simpson
1334	Jacob Kovacevic
1335	Name Withheld
1336	Luc Nguyen
1337	Confidential
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1340	Name Withheld
1341	Name Withheld
1342	Name Withheld
1343	Rationalist Society of Australia
1344	Australia21 Limited
1345	Health and Community Services Union Vic No. 2 Branch
1346	Labor for Drug Law Reform – Victorian Branch
1347	Drug Policy Modelling Program
1348	Name Withheld
1349	Ruby Edwards
1350	360Edge
1351	Medicinal Cannabis Industry Australia
1352	Turning Point
1353	Name Withheld
1354	Confidential
1355	Aaron Lim
1356	Peak Processing Solutions
1357	Self Help Addiction Resource Centre
1358	Burnet Institute
1359	Name Withheld
1360	Cann Group Limited
1361	Name Withheld
1362	Name Withheld
1363	Mary Edwards
1364	Drug Free Australia
1365	Australian Nursing & Midwifery Federation (Victorian branch)
1366	Australian Christian Lobby
1367	Windana Drug and Alcohol Recovery
1368	Name Withheld
1369	Name Withheld
1370	Name Withheld
1371	Name Withheld
1372	Drug Policy Australia
1373	Victoria Legal Aid
1374	Timothy Gurowski
1375	Michael Balderstone
1376	Stuart Clark
1377	Liberty Victoria
1378	Jacob Wescombe
1379	Dr Julia Butt
1380	Name Withheld
1381	Loren Paul Wiener
1382	Zackary Finn
1383	HEMP Party
1384	Dr Kate Seear
1385	Harm Reduction Victoria
1386	Alcohol and Drug Foundation
1387	Taylor Dale
1388	Uniting Vic.Tas
1389	Youth Law
1390	Victorian Alcohol and Drug Association
1391	Public Health Association of Australia
1392	Students for Sensible Drug Policy Australia
1393	Name Withheld
1394	Finian Scallan
1395	Odyssey House Victoria
1396	Fitzroy Legal Service
1397	Living Positive Victoria
1398	Victorian Aboriginal Legal Service
1399	Springvale Monash Legal Service Inc.
1400	Adam Vincini
1401	Hosam Fikry

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1402	Sean McCauley
1403	Umar Farman Ali
1404	Benjamin Becirovic
1405	Piotr Dyjak
1406	Matthew Wilkinson
1407	Jarrod Karpala
1408	Richard Fraser
1409	Daniel Roa
1410	Name Withheld
1411	Henri Hohaus
1412	Number not used.
1413	Casey Scott
1414	James Maguire
1415	Artemis Pinferi
1416	James Algie
1417	Jake Russell
1418	Jamie Buono
1419	Tim Elliott
1420	Brenton Sword
1421	Narelle Maddison
1422	Name Withheld
1423	Dr Kris Sonek
1424	Name Withheld
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1433	Alexander Clarke
1434	Name Withheld
1435	Anthony O'Neill
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1454	Martin Treasure
1455	Chris Patajac
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1464	Name Withheld
1465	Name Withheld
1466	Rodney Savage
1467	Brad Summers
1468	Penington Institute
1469	Ambulance Victoria
1470	Hayden Telford
1471	Professor Joe Boden
1472	Roz Blades
1473	Name Withheld
1474	Jesuit Social Services
1475	Gary Croton

A.3 Public hearings

Thursday, 25 March 2021

Meeting Rooms G1 & G2, 55 St Andrews Place, East Melbourne

Name	Title	Organisation
Tamar Todd	Lecturer, Berkeley Law & Former Legal Director, Drug Policy Alliance	–
Dr Kevin Sabet	President	Smart Approaches to Marijuana
Sam Biondo	Executive Director	Victorian Alcohol and Drug Association
David Taylor	Policy and Media	Victorian Alcohol and Drug Association
Dr Shalini Arunogiri	Chair, RANZCP Faculty of Addiction Psychiatry	Royal Australian and New Zealand College of Psychiatrists (Victorian branch)
Associate Professor Peter Higgs	Burnet Senior Fellow	Burnet Institute
Ashleigh Stewart	Research Assistant	Burnet Institute
Shane Varcoe	Executive Director, Operations	Dalgarno Institute
Eleni Arapoglou	Researcher	Dalgarno Institute
Dr Erin Lalor	Chief Executive Officer	Alcohol and Drug Foundation
Jill Karena	State Manager, Victoria and Tasmania	Alcohol and Drug Foundation
Laura Bajurny	Information Officer	Alcohol and Drug Foundation

A

Wednesday, 21 April 2021

Via Zoom

Name	Title	Organisation
Professor Dan Lubman AM	Executive Clinical Director	Turning Point
Dr Christine Grove	Senior Lecturer, Educational Psychology and Inclusive Education	Monash University
Gulliver McLean	Research & Advocacy Officer	Students for Sensible Drug Policy Australia
Julia Daly	Operations Manager	Students for Sensible Drug Policy Australia
Jesse Colling	Victorian Campus Teams Manager	Students for Sensible Drug Policy Australia
Sione Crawford	Chief Executive Officer	Harm Reduction Victoria
Stephanie Tzanetis	DanceWize Program Director	Harm Reduction Victoria Management Team
Associate Professor Chris Wilkins	Leader, Drug Research Team	SHORE & Whariki Research Centre
Dr Marta Rychert	Senior Researcher	SHORE & Whariki Research Centre
Sarah Helm	Executive Director	New Zealand Drug Foundation
Stephen Blyth	Communications Manager	New Zealand Drug Foundation
Dr Alex Wodak	President	Australian Drug Law Reform Foundation
John Ryan	Chief Executive Officer	Penington Institute
Dr Karen Gelb	Senior Research and Policy Officer	Penington Institute

Wednesday, 28 April 2021

Howard Whittaker Conference Room, George Kerferd Hotel, Beechworth

Name	Title	Organisation
Leigh Rhode	Chief Executive Officer	Gateway Health
Maryanne Donnellan	Program Manager AOD	Gateway Health
Kin Leong	Principal Managing Lawyer, Criminal Law Practice	Victorian Aboriginal Legal Service
Felicity Williams	Chief Executive Officer	The Centre for Continuing Education (Wangaratta)
Trent Jones	Learner Engagement Officer	The Centre for Continuing Education (Wangaratta)
Kerri Barnes	Project Manager, Finding Strength	The Centre for Continuing Education (Wangaratta)
Andrew Hick	Manager, Circuit Breaker program	Odyssey House Victoria

Wednesday, 19 May 2021

Meeting Room G6, 55 St Andrews Place, East Melbourne

Name	Title	Organisation
Dan Nicholson	Executive Director, Criminal Law Services	Victoria Legal Aid
Sharon Keith	Managing Lawyer, Summary Crime	Victoria Legal Aid
Paul Healey	Victorian Secretary	Health and Community Services Union
Stephanie Thuesen	Area Organiser	Health and Community Services Union
Dr Devin Bowles	Chief Executive Officer	Alcohol Tobacco and Other Drugs Association ACT
Michael Pettersson MLA	–	Member for Yerrabi, Australian Capital Territory Legislative Assembly
Professor Simon Lenton	Director and Program Leader	National Drug Research Institute
Gary Christian	Research Director	Drug Free Australia
Ashleigh Newnham	Manager, Strategic and Community Development	Springvale Monash Legal Service
Korina Leoncio	Lawyer	Springvale Monash Legal Service
Dr Kate Seear	–	Private capacity

Tuesday, 1 June 2021

Via Zoom

Name	Title	Organisation
Justin McDonnell	Executive Director, Student Wellbeing, Health and Engagement Division, School Education Programs and Support	Department of Education and Training
Matthew Hercus	Executive Director, Mental Health and AOD System Operations and Commissioning, Mental Health Division	Department of Health
Diab Harb	Executive Director, Justice System Reform	Department of Justice and Community Safety

A

Wednesday, 9 June 2021

Via Zoom

Name	Title	Organisation
Brendan Hughes	Principal Scientist on Drug Legislation, Support to Policy sector	European Monitoring Centre for Drugs and Drug Addiction
Professor Tom Decorte	–	Private capacity

Tuesday, 29 June 2021

Via Zoom

Name	Title	Organisation
Assistant Commissioner Glenn Weir	Drug Portfolio Holder	Victoria Police

Extracts of proceedings

Legislative Council Standing Order 23.27(5) requires the Committee to include in its report all divisions on a question relating to the adoption of the draft report. All Members have a deliberative vote. In the event of an equality of votes, the Chair also has a casting vote.

The Committee divided on the following questions during consideration of this report. Questions agreed to without division are not recorded in these extracts.

Committee meeting—20 July 2021

Chapter 1

RECOMMENDATION 1: That the Victorian Government introduces a framework to legalise cannabis for personal adult use in Victoria. This should allow for:

- possession of a small quantity of cannabis for people over the age of 18, when the drug is possessed in Victoria
- the use of cannabis for people over the age of 18 in private locations, when used in Victoria
- the cultivation of a small number cannabis plants per person over the age of 18, at their principal place of residence, in Victoria. Plants should be grown in an area that is not accessible to the public or people under the age of 18.

Dr Kieu moved, in Recommendation 1 **omit** 'introduces a framework to legalise' and **insert** 'investigates the impacts of legalising' and **omit** 'allow for:' and **insert** 'include:'

The Committee divided.

Ayes	Noes
Dr Kieu	Ms Patten
Ms Vaghela	
Ms Watt	

Question agreed to.

RECOMMENDATION 2: That the Victorian Government introduces provisions for group cultivation of cannabis where:

- the group is comprised of only a small number of people
- the cannabis is cultivated on private property of an individual of the group
- every plant is owned by an individual of the group and their details must be made available to police or other relevant authorities if requested
- each member of the group complies with the maximum number of cannabis plants under the legalised adult use framework
- cannabis product produced in the group is owned by the individual who owns the plant.

RECOMMENDATION 3: That people who have been convicted of minor cannabis offences that are no longer illegal under the recommended framework for cannabis legalisation should have their convictions spent automatically under the *Spent Convictions Act 2021* (Vic).

RECOMMENDATION 4: To accompany the implementation of legalisation of cannabis for adult personal use, that the Victorian Government in consultation with the alcohol and other drugs sector, implements a public health campaign to educate the public on the following:

- the changes to the law, including what remains illegal
- the risk associated with cannabis use, particularly for mental health, use by young people and driving while impaired
- services that are available for those who wish to seek assistance about cannabis use.

RECOMMENDATION 5: That the Victorian Government includes a legislative review requirement to monitor the operation of the legalised adult personal use framework. This should include appropriate data collection mechanisms.

Dr Kieu moved, that Recommendations 2, 3, 4 and 5 be omitted.

The Committee divided.

Ayes	Noes
Dr Kieu	Ms Patten
Ms Vaghela	
Ms Watt	

Question agreed to.

RECOMMENDATION 6: That the Victorian Government refers an inquiry to the Victorian Law Reform Commission to investigate state and Commonwealth laws inhibiting the introduction of a legislated and regulated cannabis market, including social clubs.

Dr Kieu moved, in Recommendation 6 **omit** 'refers' and **insert** 'considers referring'.

The Committee divided.

Ayes	Noes
Dr Kieu	Ms Patten
Ms Vaghela	
Ms Watt	

Question agreed to.

RECOMMENDATION 7: That the Victorian Government work with the Commonwealth Government to change or exempt Victoria from Commonwealth legislation necessary for a model for a legalised and regulated market for the production and sale of cannabis in Victoria, including social clubs, to function.

Dr Kieu moved, that Recommendation 7 be omitted.

The Committee divided.

Ayes	Noes
Dr Kieu	Ms Patten
Ms Vaghela	
Ms Watt	

Question agreed to

Chapter 3

RECOMMENDATION 3: That the Victorian Government implements a road safety awareness campaign to highlight the dangers of driving while intoxicated by cannabis to accompany the legalisation of cannabis for personal adult use in Victoria.

Dr Kieu moved in Recommendation 3 **omit** 'to accompany the legalisation of cannabis for personal adult use in Victoria.'

The Committee divided.

Ayes	Noes
Dr Kieu	Ms Patten
Ms Vaghela	
Ms Watt	

Question agreed to.

Committee meeting—23 July 2021

Chapter 4

RECOMMENDATION 1: That the Victorian Government establishes a legislated Youth Caution program to deal with low-level cannabis offences committed by young people under the age of 18. This program should incorporate specific provisions, including:

- shifting towards drug diversion programs as the default law enforcement response for minor cannabis offences committed by young people
- removing requirements for a young person to plead guilty before they are eligible for a caution notice
- removing caps on the number of times a young person can participate in the program, where minor cannabis offences are the only or primary offence
- support and training for police officers aimed at reducing additional workload when issuing a youth caution.

Ms Crozier moved, in Recommendation 1 **omit** the third bullet point.

The Committee divided.

Ayes	Noes
Ms Crozier	Dr Kieu
Ms Maxwell	Ms Patten
	Ms Vaghela
	Ms Watt

Amendment negatived.

Dr Kieu moved, in Recommendation 1 **omit** 'removing caps' and **insert** 'not imposing fixed caps'

The Committee divided.

Ayes	Noes
Dr Kieu	Ms Crozier
Ms Maxwell	
Ms Patten	
Ms Vaghela	
Ms Watt	

Question agreed to.

RECOMMENDATION 2: That the Victorian Government reviews the eligibility requirements of existing drug diversion programs to determine if they are too restrictive and excluding vulnerable people in need of treatment or support. In particular, the Government should consider the need for requirements such as:

- requiring police to consent to offering an offender drug diversion
- pleading or admitting guilty to an offence, including alternatives to admitting the offence which do not result in a finding of guilt
- capping the number of diversions a person can receive where a minor drug/cannabis offence is the sole or primary offence.

Ms Crozier moved, in Recommendation 2 **omit** all words after 'vulnerable people in need of treatment of support.'

The Committee divided.

Ayes	Noes
Ms Crozier	Dr Kieu
	Ms Maxwell
	Ms Patten
	Ms Vaghela
	Ms Watt

Amendment negatived.

Committee meeting—26 July 2021

Dr Kieu moved, that Chapter 1 as amended stand part of the report.

The Committee divided.

Ayes	Noes
Dr Kieu	Ms Crozier
Ms Vaghela	Ms Maxwell
Ms Watt	Ms Patten

The ayes and noes being equal, the Chair gave her casting vote with the ayes.

Question agreed to.

Dr Kieu moved, that the Draft Final Report (Chapters 1 to 6 including Findings 1 to 21 and Recommendations 1 to 17, together with Appendix A), be adopted as the Report of the Committee, and that it be Tabled on 5 August 2021.

The Committee divided.

Ayes	Noes
Dr Kieu	Ms Crozier
Ms Patten	Ms Maxwell
Ms Vaghela	
Ms Watt	

Question agreed to.

Minority reports

Minority Report

Inquiry into the use of cannabis in Victoria

This inquiry garnered significant public interest with well over 1,000 submissions from individuals, organisations and institutions. The overwhelming majority supported some form of a legalised market.
The arguments put forward by many of these people were well supported by individuals and organisations with considerable knowledge and expertise in public health and drug policy who gave testimony to the inquiry. This minority report summarises many of the arguments presented for the benefits of legalising cannabis and focuses on the importance of addressing point D in the terms of reference:

(d) *prevent criminal activity relating to the illegal cannabis trade in Victoria;*

The Committee has done good work examining and presenting the data and evidence to address the terms of reference of this inquiry. I am broadly supportive of the recommendations, particularly around health, education and justice system reforms. I do not believe however that it goes far enough in presenting a strong recommendation for legalising cannabis to address organised crime.

A simple question asked in many of the submissions from individuals was, “why is cannabis illegal when the more dangerous substances, alcohol and tobacco are legal?”

While the Committee received submissions and heard from witnesses who did not support legalisation, none presented an adequate answer to this question that would justify maintaining cannabis prohibition in Victoria.

Data presented in the chapter 2 of the Committee’s report demonstrates that cannabis is widely used and easily available. Both individual submissions and expert testimony argued that for many young people it is easier to procure cannabis than legal intoxicants such as alcohol. Data presented in chapter 4 shows that despite police seizing over 3,000kg of cannabis in 2018/19, representing nearly half of all national seizures, this failed to make any significant impact on the market.

This failure not only supports the profits of organised crime but impacts on the health of consumers with cannabis products being unregulated for safety and potency. It can also put cannabis users in contact with dangerous criminals and expose them to more dangerous illicit drugs.

Many individuals highlighted that they access black market cannabis products for medicinal use because the legal market is either too restrictive or too expensive. Some pointed out that this makes cannabis significantly different to alcohol and particularly tobacco which do not have a comparable therapeutic use.

Possibly the most important factor raised in many submissions was that legalisation

is the only way to effectively reduce criminal activity associated with cannabis production and use. Although this was not highlighted as a priority for many of the individuals as shown by figure 1.3, for the state of Victoria, undermining organised crime has significant benefits.

As noted in the main report, the Victoria Police submission noted that:

- Organised crimes groups often establish cannabis crop houses because of the high profitability of cannabis
- The income generated from cannabis is used by organised crime groups to fund other illegal activities

Figure 1.1 in the main report highlights different options for regulatory models. Each of these will have a different ability to divert activity away from the illegal market. While consideration should be given to concerns around health impacts, education and treatment options, taking a cautious approach similar to the ACT will fail to have a significant impact on organised crime.

Cannabis that is not for medicinal use is a product for adults and the best way to restrict underage use is to establish a legal model where it is provided in age restricted venues.

Recommendation 1
Cannabis should be legalised for adult use in Victoria.

Recommendation 2
Any model of legalisation should not be overly restrictive to allow for the legal market to flourish and maximise the potential to undermine organised crime.

David Limbrick MP
Member for South Eastern Metropolitan Region

The Minority Report

Legislative Council Legal and Social Issues Committee
Inquiry into the Use of Cannabis in Victoria

Introduction

This minority report by the Liberal Party of Australia (Victorian Division) (the Liberals) and the National Party of Australia – Victoria (the Nationals) has been produced in response to concerns held about some of the findings and recommendations in the majority report on the Legislative Council Legal and Social Issues Committee's (the Committee) Inquiry into the Use of Cannabis in Victoria (the Inquiry).

Our report is informed by evidence provided to the Committee, primarily by Victoria Police and others who raised significant concerns around the legalisation of cannabis, lack of appropriate education to young people as to the effects of cannabis and the harms of drug use.

The Liberals and Nationals overarching concerns about the majority report are as follows:

- The report considers legislation to be the preferred option for cannabis reform and does not adequately assess or consider concerns raised by Victoria Police;
- Too much emphasis is placed on allowing recreational users to access cannabis instead of reducing drug use;
- Some of the recommendations contradict each other in a way that cannot be resolved;
- Characterising cannabis use as solely a health issue ignores the very real criminal justice issues that must be addressed when it comes to illicit drug use; and
- There is an overarching theme in the majority report that because cannabis use is perceived to be wide-spread, it should just be legalised.

The Harms of Cannabis

The Liberals and Nationals believe despite the majority report noting the dangers of cannabis on mental and physical health, its recommendations to legalise cannabis exacerbate the very real risk to public health from cannabis use.

Of particular note, are comments made by Victoria Police in their submission to the Inquiry. It was stated, "Victoria Police notes that cannabis use is particularly harmful for young people. Further, the most vulnerable young people in our community appear to be the most impacted by cannabis – these young people are more likely to use cannabis and to suffer consequential harms."[1]

Appearing before the Inquiry, Assistant Commissioner Glenn Weir, Drug Portfolio Holder, Victoria Police, provided evidence that, "Victorian crime stats, through the Crime Statistics Agency, indicate a link between cannabis use and other offending. Over the last five years approximately 40 percent of cannabis use or possession offences occurred in conjunction with another offence."[2]

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[1] Victoria Police's Submission to the Inquiry, p. 3
https://parliament.vic.gov.au/images/stories/committees/SCLSI/Inquiry_into_the_use_of_Cannabis_in_Victoria/Submissions/S901_-_Victoria_Police.pdf

[2] Assistant Commissioner Glenn Weir's Evidence to the Inquiry, p. 2
https://parliament.vic.gov.au/images/stories/committees/SCLSI/Inquiry_into_the_use_of_Cannabis_in_Victoria/Transcripts/20210629/FINAL-CANNABIS-VicPol.pdf

Assistant Commissioner Glenn Weir also noted that, "illicit drug use, and cannabis in particular [is] a common feature in family violence and sexual offending." However, it was clarified that whilst this "cannot be seen as the cause of family violence or violence against women and children", it "may reinforce or exacerbate factors that contribute to the frequency or severity of that violence."

The Liberals and Nationals do not believe recreational cannabis should be viewed as being a 'safe' drug when the impacts of use are leading to some very serious outcomes as was highlighted by numerous witnesses to the Committee including Victoria Police.

The Liberals and Nationals support Victoria Police's Cannabis Cautioning Program which, "functions to reduce these potential harms from prohibition by providing the option to caution a person for possession or use of cannabis, rather than charge the person with a criminal offence."[3]

Victoria Police were also able to provide the Committee with a breakdown of mental health transfers to Emergency Departments that had been recorded in Victoria between 1 July 2014 and 30 June 2020. These had increased by 17.1% from 9,365 to 18,096 [4] (though it should be noted that these statistics are prior to the extensive second lockdown and subsequent lockdowns which have been accompanied by more complex presentations to Emergency Departments as a result of mental health issues and substance abuse).

In addition to the comments made by Victoria Police, the Committee heard evidence from Dr Kevin Sabet of Smart Approaches to Marijuana (SAM). Dr Sabet is a former adviser on drugs to the Clinton, Bush and Obama administrations in the United States and provided extensive insight into cannabis policy development and the impact of legalisation in various states of the United States. He highlighted the high potency of tetrahydrocannabinol (THC) – the active ingredient of cannabis – in contemporary cannabis products that is far stronger than was found in cannabis products last century, even 10 years ago. He stated that cannabis comes in a variety of forms, including, "edibles – the candies, the cookies – the vaporisers, the blowtorches, all the different things that are out there."[5]

Dr Sabet commented that the rise in THC potency is threatening public health in a number of ways, including a rise in the prevalence of 'cannabis use disorder', also known as addiction. Dr Sabet made reference to research in New York that found, "one in three past-year users will have achieved cannabis use disorder," with several factors contributing to this, such as "availability and access" and "the potency and strength of cannabis and the normalisation of it as well."[6]

Victoria Police's submission also referenced the effects of legalisation in certain states within the United States. They stated, "The quantity of cannabis consumed by adults in Colorado has increased steeply since legalisation." They also said, "This is problematic as heavy and regular use of cannabis

[3] Victoria Police's Submission to the Inquiry, p. 15
https://parliament.vic.gov.au/images/stories/committees/SCLSI/Inquiry_into_the_use_of_Cannabis_in_Victoria/Submissions/S901_-_Victoria_Police.pdf
[4] Victoria Police's Response to Question on Notice, p. 3
https://parliament.vic.gov.au/images/stories/committees/SCLSI/Inquiry_into_the_use_of_Cannabis_in_Victoria/QONs/20211607_Response_to_QONs_web.pdf
[5] Dr Kevin Sabet's Evidence to the Inquiry, p. 11
https://parliament.vic.gov.au/images/stories/committees/SCLSI/Inquiry_into_the_use_of_Cannabis_in_Victoria/Transcripts/20210325/FINAL-USE_OF_CANNABIS-SMART.pdf
[6] Dr Kevin Sabet's Evidence to the Inquiry, p. 12
https://parliament.vic.gov.au/images/stories/committees/SCLSI/Inquiry_into_the_use_of_Cannabis_in_Victoria/Transcripts/20210325/FINAL-USE_OF_CANNABIS-SMART.pdf

is associated with much higher risks of dependence, mental health problems and other chronic adverse health outcomes." More concerningly, they stated, "Following legalisation in Colorado, cannabis-related hospitalisations have increased."[7]

The Liberals and Nationals are concerned that legalisation of cannabis would likely result in an increase in the number of regular users and a rise in associated mental and physical health issues. The aim of this Inquiry is to improve public health and it would be counterintuitive for more cannabis to be made available in a bid to reduce overall use, particularly as evidence from other jurisdictions shows a rise in cannabis use after legalisation.

Further to concerns about addiction, users of cannabis products in jurisdictions within the United States have been found to not store cannabis products in a safe manner. This has resulted in children being poisoned following ingestion of these products. Other issues such as second-hand smoke, which is widely recognised as being a health problem when it comes to cigarettes, require further study, but early indications are that second-hand smoke from cannabis products is unhealthy. [8]

The Liberals and Nationals fundamentally believe that young people should not be exposed to these products and despite the majority report aiming to restrict use of cannabis products to those aged over 18, it is likely such products will make their way into the hands of children who do not understand the consequences and dangers of consuming such products.

Whilst acknowledging that individuals will still access these products even if they are illegal, as they do already, the Liberals and Nationals still believe there must be some deterrent. Dr Sabet, in his evidence to the Inquiry, said the issue of cannabis is analogous to the speed limit, "[…] we know that many people will exceed the speeding limit, a lot of people will exceed the speeding limit—a lot of people can exceed the speeding limit safely, by the way—but do we want to get rid of the speeding limit and say that 'Well, because people are speeding, let's get rid of the speeding limit'? Whereas I would say, 'The speeding limit probably has some value of discouraging.' It does not mean that if you are caught speeding you should have your life ruined, but it means that we should have some kind of societal disapproval even though there may be a good percentage of people violating it."[9]

In protecting public health, the Liberals and Nationals believe legalising cannabis only seeks to provide ready access to cannabis products; it does not provide a deterrent to stop people using the products in the first instance. This is supported by the experience of jurisdictions who have legalised cannabis. Furthermore, long-term data on cannabis use in jurisdictions where it is legal is still some time off as legalisation of cannabis is still in its infancy. The Liberals and Nationals are of the view that it is in the interests of all Victorians to be able to see some more evidence from the data coming from those jurisdictions and longitudinal studies that are being conducted before any steps are taken towards legalisation.

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[7] Victoria Police's Submission to the Inquiry, p. 16
https://parliament.vic.gov.au/images/stories/committees/SCLSI/Inquiry_into_the_use_of_Cannabis_in_Victoria/Submissions/S901_-_Victoria_Police.pdf

[8] Dr Kevin Sabet's Evidence to the Inquiry, p. 12
https://parliament.vic.gov.au/images/stories/committees/SCLSI/Inquiry_into_the_use_of_Cannabis_in_Victoria/Transcripts/20210325/FINAL-USE_OF_CANNABIS-SMART.pdf

[9] Dr Kevin Sabet's Evidence to the Inquiry, p. 16
https://parliament.vic.gov.au/images/stories/committees/SCLSI/Inquiry_into_the_use_of_Cannabis_in_Victoria/Transcripts/20210325/FINAL-USE_OF_CANNABIS-SMART.pdf

Distinction between Medicinal and Recreational Use of Cannabis

It is important to avoid conflating medicinal use of cannabis with recreational use of cannabis. Whilst the majority report does make this difference known, it is important to reiterate this point. Medicinal cannabis products do have legitimate medical uses and medicinal cannabis products are regulated by the Therapeutics Goods Administration (the TGA) and use of medicinal cannabis products is regulated by the *Drugs, Poisons and Controlled Substances Act 1981* (Vic).

Many arguments for the legalisation of cannabis seem to refer to medicinal cannabis. That is a separate matter to this Inquiry and one which has already been legislated for. Legalising recreational use of cannabis, which the majority report seeks to do, is a very separate manner and goes beyond providing access for legitimate medical reasons.

It should be noted that the Liberals and Nationals are supportive of medicinal cannabis being used in the treatment of patients who may have complex health needs and may be suffering from intolerable and ongoing pain, where it is prescribed.

Driving whilst under the Influence of Cannabis

As discussed by Victoria Police at a hearing of the Inquiry, whilst it is acknowledged that cannabis use impairs one's driving ability, establishing a metric for the level of impairment is "really difficult", and unlike the 0.05 BAC limit for alcohol, establishing a limit for cannabis and other drugs is not as easy for a variety of reasons.[10]

The Liberals and Nationals are supportive of drug driving campaigns however we are concerned that whilst the majority report acknowledges the danger of people driving with recreational cannabis in their system, it is more focused on drug driving education campaigns than preventing people from driving with cannabis in their system in the first instance.

Victoria Police is also concerned by the dangers of driving whilst on cannabis. Assistant Commissioner Glenn Weir stated in his evidence that, "Collision stats indicate that the crash risk associated with cannabis is double that of driving without drugs."[11]

Victoria Police's submission also highlighted serious concerns about young drivers who use cannabis and their lack of awareness of the danger their cannabis use poses to their driving. Victoria Police referred to, "[a] study involving participants aged between 15 and 25 years of age who had used cannabis in the month prior, found that 57 per cent believed cannabis did not increase their crash risk. Alarmingly, 12 per cent believed cannabis improved their driving by 'increasing awareness and concentration.'"[12]

The risk of cannabis when it comes to impaired driving is clear and the Liberals and Nationals believe existing driving offences should remain.

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[10] Assistant Commissioner Glenn Weir's Evidence to the Inquiry, p. 5
https://parliament.vic.gov.au/images/stories/committees/SCLSI/Inquiry_into_the_use_of_Cannabis_in_Victoria/Transcripts/20210629/FINAL-CANNABIS-VicPol.pdf
[11] Assistant Commissioner Glenn Weir's Evidence to the Inquiry, p. 2
https://parliament.vic.gov.au/images/stories/committees/SCLSI/Inquiry_into_the_use_of_Cannabis_in_Victoria/Transcripts/20210629/FINAL-CANNABIS-VicPol.pdf
[12] Victoria Police's Submission to the Inquiry, p. 5
https://parliament.vic.gov.au/images/stories/committees/SCLSI/Inquiry_into_the_use_of_Cannabis_in_Victoria/Submissions/S901_-_Victoria_Police.pdf

Drug Education, Diversion Programs and Support for Drug Users

Reducing the number of young people using drugs and ensuring they are aware of the dangers of cannabis is important. The Liberals and Nationals support drug education programs in schools and elsewhere, as these have been demonstrated to reduce the incidence of young people using illicit substances, including cannabis.

If young people don't begin using illicit substances there is a lower likelihood of them progressing to 'harder' drugs of dependence in future, including heroin and methamphetamine. Evidence provided by Ms Kerri Barnes, Project Manager, Finding Strength, The Centre for Continuing Education (Wangaratta) stated that "a majority" of their offenders "nominate cannabis as their gateway drug and a lot of that is normalised for them through their environment as they're growing up."[13]

As acknowledged in the majority report, there are several contributing factors that go into why people use cannabis and other drugs, including intergenerational substance abuse, mental health issues, disadvantage, and others.

The Liberals and Nationals again reiterate the point that one of the purposes of this Inquiry is to stop young people accessing and using cannabis. We do not believe that legalising cannabis and therefore providing greater access to cannabis addresses this issue. Allowing individuals to grow their own cannabis does not prevent young people from accessing cannabis.

The majority report refers to the limit of warnings that can be provided by Victoria Police when it comes to minor cannabis offences. It argues that such limits ought to be removed, effectively allowing users to indefinitely use products without any incentive whatsoever to stop using drugs. The Liberals and Nationals find this concerning.

The Liberals and Nationals support drug education programs warning of the harms of illicit substances, we support diversion programs that help get people off drugs, and we support other support services for those addicted to drugs. However, we do not support legalising cannabis.

[13] Ms Barnes' Evidence to the Inquiry, p. 24
https://parliament.vic.gov.au/images/stories/committees/SCLSI/Inquiry_into_the_use_of_Cannabis_in_Victoria/Transcripts/20210428/3._FINAL-CAE-280421.pdf

Recommendation 1: That the Victorian Government does not legalise cannabis for recreational use.

Recommendation 2: That the Victorian Government supports Victoria Police's submission and evidence to the Inquiry noting the lack of evidence from international jurisdictions on any longitudinal studies conducted on the mental, physical and social impacts as a result of the legalisation of cannabis.

Recommendation 3: That the Victorian Government reviews current drug education programs in schools to determine if they are effective in preventing young people from using cannabis and in informing them of the dangers posed by cannabis and other illicit substances.

Recommendation 4: That the Victorian Government considers whether broader public health campaigns are required to inform Victorians of the dangers of drug driving, particularly the dangers of cannabis consumption.

Ms Georgie Crozier MLC

Member for Southern Metropolitan Region

Mr Craig Ondarchie MLC

Member for Northern Metropolitan Region

Dr Matthew Bach MLC

Member for Eastern Metropolitan Region