T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into the use of cannabis in Victoria

Melbourne—Wednesday, 21 April 2021

(via videoconference)

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WITNESS

Dr Alex Wodak, President, Australian Drug Law Reform Foundation *(via teleconference)*.

The CHAIR: Welcome back, everyone. You are watching the Legal and Social Issues Committee public hearing into the Inquiry into the Use of Cannabis in Victoria. We are delighted to be able to welcome Dr Alex Wodak from the Australian Drug Law Reform Foundation. Unfortunately we will not be able to see his handsome face, he will be on the phone with us.

Alex, here with me I have Deputy Chair, Tien Kieu; Georgie Crozier; Kaushaliya Vaghela; Sheena Watt; and Tim Quilty. David Limbrick will be coming in and out.

If I could just let you know that—I know you have heard this before—all evidence taken at this hearing is protected by parliamentary privilege, and that is provided by our *Constitution Act 1975* but also the standing orders of the Legislative Council. This means that any information you provide during the hearing is protected by law; however, any comment that you may make outside the hearing may not be protected. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

Alex, we are live; we are also recording this for transcript purposes. We will provide you with a copy of that transcript, and I would encourage you to have a quick look at it to make sure that we have not made any errors. It will ultimately form part of the report and will go up on the committee's website.

Thank you again for being here today with us and for your submission, which all of the committee members have had a chance to look at. If you would like to make some opening comments, then I will open it up to a broader committee discussion.

Dr WODAK: Look, I will be very brief. I cannot tell you what a pleasure it is, how much it means to me, having been advocating for the regulation of recreational cannabis for several decades, that we are now at a point in Australia where this is within sight. Just yesterday in the US Senate Majority Leader Chuck Schumer made note of the fact that yesterday in the United States, 20 April, was an unofficial American holiday acknowledging the importance of this issue to so many people in the United States, and indeed that is true here in Australia.

I think the starting point of any discussion about the legalisation of cannabis has to be a recognition of the enormity of the failure of cannabis prohibition. These days that is a commonplace, mainstream kind of observation and is very obvious to many people, but for a long time that has been resisted. We have to keep reminding ourselves what a failure that was and also how the decision to prohibit cannabis in Australia was made on the slenderest of evidence, and that goes back to the League of Nations meeting—I will be brief—in Geneva 1925, where Australia was represented. This was the so-called second opium commission where the world decided to prohibit the three plant-based drugs: opium, cocaine and cannabis, with cannabis added to the agenda in the last minute without provision of information to the delegates. The commonwealth came back from that conference and wrote to the states, requesting the states to carry out what had been decided internationally in Geneva, and it was on that basis that cannabis was criminalised in Australia. The different states took action at different times, but that is really why we prohibited cannabis. Very few people know that. And at that meeting in Geneva it was decided that cannabis was as dangerous as opium, which was ridiculous then and is even more ridiculous in view of what we know now. I think it is very important to keep on coming back to that.

What happened since then was that we have been unable to suppress supply of cannabis in Australia as other countries have. We have been unable to suppress demand—not for lack of trying. And so that has left demand being supplied basically to some extent by self-supply, but a lot of it has been supplied by criminals, outlaw motorcycle gangs and to some extent also corrupt police. It has helped enrich the criminal groups and it has made supply easy to under-age kids.

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.

The CHAIR: Thank you, Alex. I appreciate that. I will turn to Deputy Chair Tien Kieu.

Dr KIEU: Thank you, Alex, for your submission and for appearing as a witness today. You have raised in your submission many interesting points about roadside testing, reviewing of current education and so on, but I would like to have you elucidate a little bit further on regulation versus decriminalisation. You said regulation may be useful and helpful in the sense that it would have warnings, it would control THC content and so on, but you also mentioned in your submission that criminal supply should be replaced where it can be by regulated supply or domestic cultivation. But that would go against regulation because domestic cultivation would not have that kind of control over the THC content, for example, and a few other things as well. So there are essentially two things: could you further elucidate on regulation versus decriminalisation and, secondly, where the domestic cultivation would come in here. Thank you.

Dr WODAK: Well, the problem with decriminalisation, which is better than just prohibiting the drug outright, is that decriminalisation is less bad than prohibition but it still leaves the market in the hands of criminals essentially—criminals and to some extent self-supply. And both of those, in my view, are problematic. We cannot eliminate self-supply. We have tried for over half a century, and if there is one thing we have learned from that experience, it is that it is just not possible to eliminate self-supply. So rather than trying to eliminate it, I think we should try and put some sensible boundaries around it and allow a certain amount of self-supply but within explicit boundaries. What I mean by that is that if someone is growing two or four or six plants for themselves and their immediate family or their immediate close relationships, that can be defended on the grounds of self-supply. But when they are growing 600 or 800 or 1000 plants, obviously that is ridiculous. It is more than self-supply, and I think it is reasonable for the state to intervene at that point.

Now, where the line is drawn between self-supply and supply of others is to some extent always going to be arbitrary, and I have learned from experience talking to experts in this area how difficult it is to draw boundaries. There are so many variables, and frankly I do not know enough about those details to be able to help your committee on that. But I think it is important to do that, remembering that there are inherent problems with self-supply. Self-supply does have the benefit that the person who is cultivating their own cannabis can avoid toxic chemicals and reduce risks down to a minimum, but when they are supplying for others you can no longer have any quality assurance. That is my reservation about self-supply.

I think we should look at other common commodities that people sometimes cultivate for themselves, like tomatoes or other vegetables, but most of us prefer to purchase. We cannot be bothered with self-supply, and we purchase those commodities very happily from suppliers. Those suppliers are regulated, and there is some assurance that the supply will meet quality standards. Therefore it comes back to some kind of regulated market, where there would be cultivation, presumably wholesale and retail, and all those things in the market can be regulated—should be regulated—to make sure that there is consistency over time and safety. We can try and avoid dangerous chemicals being introduced into those markets. There have been times when cannabis supply has been tainted by chemicals or heavy metals.

I think that deals with the first question. Now, whether the market is decriminalised or regulated, the problem for me with decriminalisation is that we still have the black market, and black markets are, in my view, inherently pernicious. It involves criminals. It involves the risk of corruption. And if we can avoid those risks, so much the better. That is why I prefer a regulated or a legalised market. But the term 'legalised' is too loose because regulation implies to me a higher degree of scrutiny of the market than simply legalisation. After all, things like soap and coffee are legal but they are not very carefully regulated, not closely regulated. Something like cannabis—I hope that market would have a greater degree of scrutiny. So I hope that answers the first question about decriminalisation versus regulation. I have forgotten what your second question was.

The CHAIR: I think you answered them both, Alex. I think you went to the second question first, so—

Dr WODAK: Okay—

The CHAIR: No, thank you for that.

Dr WODAK: It is a pleasure.

The CHAIR: Kaushaliya Vaghela.

Ms VAGHELA: Thanks, Chair. Thanks, Dr Wodak, for your submission, for your time today and for your ongoing work in the alcohol and drug related space. My question is regarding recommendation 4 in your submission. It says:

> No additional drug education of young people be conducted in Victoria unless a review of current drug education programs demonstrates clear gaps or weaknesses

What is the current state of play regarding drug education, and how effective are programs in schools and community awareness campaigns? More specifically, what changes need to be made to drug education to reduce harm and use in young people and adolescents?

Dr WODAK: Well, there has been a lot of evaluation of drug education, and I think, to sum it all up, the benefits of drug education are fairly modest. They are not always positive—some drug education actually increases drug use. And the other conclusion of a lot of evaluation of drug education is that what benefits there are are usually only very temporary, very transient. 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. We want to, I think, also be clear about the fact that we want to have minimal impact on the benefits that people using the drug perceive that they are getting from that drug. In the case of people using cannabis, many people say that it is pleasurable, and we should make sure we are not interfering with that pleasure. That is the side of harm reduction that tends to get overlooked. It is important. It is even more important, in my view, to try and reduce harm, deaths and disease and the cost—social and financial cost. Harm reduction has a role in that, and 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. Overall, drug education has modest benefits, and we should very much, in my view, bear that in mind.

The CHAIR: Thank you. David Limbrick.

Mr LIMBRICK: Thank you, Chair. And thank you, Dr Wodak, for appearing today and for your submission. I have got a couple of questions about your submission. Firstly, we have heard some things about levels of regulation and the spectrum of possible regulation ranging from prohibition through to very light regulation. There was sort of some talk around, 'Well, there might be more health harms with light regulation', but one of the things that you brought up in your submission was the black market in the US and the EVALI incident that happened. Could you expand a bit more on that and the interaction between prohibition and that health incident that happened in the US?

Dr WODAK: In 2019 in the United States, and only in the United States and only in that year, an epidemic occurred which involved about 60 people dying and about 2000 people being admitted to hospital with serious illness. The epidemic involved a lung injury, so called. 'Lung injury' did not mean that someone had whacked these people on the chest with some hard object; it meant that there was a clinical injury to the lungs of some kind. It did not take long before it was traced to vaping, which is contentious in Australia and also in the United States. Then the suspicion grew that the cause of the epidemic was in fact people vaping with a particular kind of cartridge, and these were cartridges which were bought from the black market—manufactured illegally, unregulated. And these were cartridges filled with liquid cannabis of a kind, and the cannabis was THC, the main psychoactive ingredient of cannabis—tetrahydrocannabinol—and the THC was dissolved in vitamin E acetate, which is an oil. And that was done presumably to cut the cost for the supplier to bulk up the product that they were selling. You could not tell from the outside whether the liquid contained vitamin E acetate or not, and people vaped that.

The vitamin E acetate, as it passed through the vaping device, evaporated, but then when it got into the lungs of the person vaping and the temperature went down from 300 degrees centigrade or so back to body temperature,

the vitamin E acetate liquefied again and liquefied in the lungs of the person who had been vaping. The presence of that vitamin E acetate liquid in the lungs of the person who had been vaping caused a reaction which has been described as a lung injury, and that is what caused the disease, the hospital admissions and unfortunately the 60 deaths. It took a few months to sort all that out, and the main US government agencies, the Food and Drug Administration and the CDC, were involved in this. CDC in the United States, the Centers for Disease Control and Prevention, is quite anti harm reduction, FDA not quite so much. FDA accepted the analysis that I have just presented to you within two months or so of this epidemic breaking out. It took CDC a lot longer to acknowledge exactly what was happening. Because vaping is so controversial in the United States and also in Australia—I am now talking about vaping nicotine, as in people who smoke e-cigarettes—people opposed to nicotine vaping use EVALI as a device to strengthen their opposition to nicotine vaping. EVALI stands for e-cigarette- or vaping-associated lung injury. That is what EVALI stands for. It is a terrible name. It should have been changed, but because of the contentious nature of this argument it has not been changed.

What happened was when word got out that vaping these cartridges was highly dangerous people stopped buying them, and so the problem sort of sorted itself out. But it was very obvious to me very quickly that as this epidemic had never occurred before 2019 and it only occurred in one country, it was not a problem due to nicotine vaping, it was something else. And I think what that whole experience reminds us of is the dangers of unregulated black markets. If you have unregulated black markets, sooner or later you will have health problems in addition to the criminalisation and corruption that I mentioned before.

Mr LIMBRICK: Thank you, Dr Wodak. And yes, it certainly does sound like prohibition is dangerous. I wonder if I have time for one more quick question, Chair.

The CHAIR: You do, David, but only, Alex, if you can answer it really quickly.

Mr LIMBRICK: Okay.

Dr WODAK: Okay.

Mr LIMBRICK: One of the things you said in your submission, Dr Wodak, was that if there is going to be a legalised market, advertising should be banned. Now, this seems to go against the idea that if we are going to have a legal market, there will be product diversity—they are going to have products of different strengths or different levels of CBD to THC or different varieties and things like this. How would producers be able to tell consumers about their particular product if advertising was banned?

Dr WODAK: Look, I accept that there are wins and losses. And if advertising was allowed, it would have to be controlled so that advertising to health consumers to keep on lowering their risk is permitted but advertising to push the product is not. There are two things that worry me about legalisation. One is based on what we have seen with the tobacco and alcohol, the other legal drugs that we have got already, and that is I do not really want to see a powerful cannabis industry. And so I would like to, if possible, avoid donations from the cannabis industry to political parties or individual politicians. But also I want to see any advertising that is permitted to be carefully controlled so that we do not have products pushed to young people.

Mr LIMBRICK: Okay. Understood.

The CHAIR: Thank you. Georgie Crozier.

Ms CROZIER: Thank you very much, Chair, and thank you, Dr Wodak, for a most interesting discussion this afternoon. I am wondering if you could perhaps enlighten me a little bit more. We have heard evidence from some witnesses internationally to say that, for instance, in Oregon, where cannabis is legalised, or recreational cannabis is legalised, only 18 to 30 per cent is sold legally and there is still a huge black market, to go to your points around the black market and the damage that that can do and unregulated cannabis. But another question I have for you also is: in addition to that evidence, cannabis use disorder affects one in three in some parts of America, whereas it is my understanding that it is only around one in 10 here in Australia. So in those areas where cannabis use has been legalised there seems to be a greater prevalence of cannabis use disorder. Can you comment on any of that?

Dr WODAK: Yes. Look, regarding the first point, it will take a while for a legal cannabis industry to take up the full demand. And in Canada, where legalisation was introduced in 2018, the percentage of the market that is accounted for by legal sales is still low, but it is increasing. It is continuing to increase. Same in

Washington state and Colorado state, which passed their bills in 2012—the market started, I think, in around about 2014, so six or seven years ago. It takes a while for the market to organise itself, and we cannot expect that that is going to happen overnight. People have to develop the production and they have to develop the wholesale market and the retail market, and all of that has got to start more or less from scratch and will be competing, no doubt, with the black market. We know with the Australian tobacco market that about 20 per cent of the tobacco market in Australia—cigarettes and other tobacco products—is accounted for by a black market.

Ms CROZIER: It is quite a lot, isn't it, for a long-time regulated tobacco market—20 per cent still under the black market?

Dr WODAK: Yes. But you have to remember that we have the highest cigarette prices in the world in Australia and we have had nine rises in cigarette taxation in the last decade during a period of sluggish income growth. So it is not really surprising that that has stimulated the black market. And that 20 per cent estimate, which is a KPMG estimate commissioned by the tobacco industry every year, is very controversial, and the tobacco control people are very critical of that estimate. Estimating black markets is inherently problematic because you are estimating something that is very hard to measure, but there is no doubt that it is significant in Australia. So I think we are going to see a cannabis black market for some years. Despite everything that is attempted, it will take a while for the white market to replace the black market, and it will never replace it completely. Now, I am struggling to remember what your second question was.

Ms CROZIER: It was about the cannabis use disorder—one in three in the States, where it is legalised, compared to my reading here in Australia where it is one in 10.

Dr WODAK: Thank you. There has been a lot of work to try and make some sense of what has happened in jurisdictions where people have gone from very strict prohibition to more liberal regimes. To sum all that up—and this is not just my view; this is the general consensus in the research area—there is very little relationship between the legal regimes and consumption levels. There are very few studies that directly allow us to compare this, but one of the studies that was done, published in the *American Journal of Public Health*, compared cannabis use in San Francisco and Amsterdam: two cities with similar population size, both coastal, both much more liberal than the rest of the countries that they are in. What they found for five different drugs including cannabis—and of course San Francisco has a much more punitive approach than the more liberal approach adopted in Amsterdam—was that the age people started using cannabis was similar in both countries, the age people stopped using cannabis was similar in both countries. So length of career was very similar and there was very little difference in cannabis use between the two countries, despite the very different regimes that were adopted in those countries when the study was conducted. Overall that is typical of the research that is done in this area. So I am very sceptical about results that are contrary to that, and measures like cannabis use disorder deciding whether someone meets those criteria or does not are for me inherently problematic. I do not really trust that research.

Ms CROZIER: I would love to question you more, but unfortunately I am getting the look from the Chair.

The CHAIR: It was actually a look of great interest, Georgie. But I will move on to Tim Quilty. Thank you.

Mr QUILTY: You told us how we got to our current prohibition model. Why do you think that we have persisted with the cannabis prohibition for so long?

Dr WODAK: Well, the reason for that, I think, is that if you look at most social policy reform it is terribly, terribly slow. The first slaves to arrive in the United States were in 1619 and it was at another 150 years before the first organisation to abolish slavery in the United States. Just an organisation to abolish slavery took 150 years, and then every step since then has been very slow, very delayed.

Homosexual law reform in Australia began really in 1973 in South Australia when Don Dunstan as Premier decriminalised homosexuality, and it was almost half a century before marriage equality in 2017. The female members of your committee would be well aware, even more aware than I am, of how slow it has been to try and reduce the inequality between men and women in Australia, and the intellectual case for inequality between men and women, if it ever existed, was destroyed long ago. It just takes a long time for these reforms to happen. And now looking back, say, at marriage equality, it seems hard to understand why that took as long as it did in Australia, and in other countries.

But one of the other lessons about social policy reforms is that they are slow to start, but once they have become established, they accelerate. So the first country to legalise marriage equality was the Netherlands in 2001; there are now 30 countries around the world that have legalised gay marriage, and there are a few countries every year around the world that are doing that. I think we are seeing the same pattern now with cannabis. Uruguay was the first country to legalise cannabis in 2013; Canada in 2018; Mexico, this month; and 15 of the 50 states in the United States have now legalised recreational cannabis—and that only started in 2012, and they are already up to 15, accounting for over a third of the American population. So I think we will see the same thing here. It is slow to start; once it starts, it accelerates.

So 68 per cent of Americans in the Gallup poll now say they support the legalisation of marijuana, as they call it in the US, and 20 per cent was added to that number in the last 10 years. So it went from 48 per cent to 68 per cent in the last 10 years. Only 12 per cent in 1969 were supporting the legalisation of marijuana. So it was slow to start; it will accelerate. In 2019 in the last national drug strategy household survey, for the first time ever, 41 per cent of Australians supported the legalisation of cannabis, and that was the first time that the supporters outnumbered opponents, and opponents were 37 per cent. And I am sure that we will see that gap increasing in coming years.

The CHAIR: Great. Thank you, Alex. Alex, we have heard from the New Zealand Drug Foundation. They were going through some of the aspects of the proposed Bill that went to the referendum. I was particularly interested in the age limits that they put in place. I would be interested in your thoughts about those age limits. But also more generally do you think that New Zealand was on the right track, and is that type of Bill, of regulation, something that would be suitable for Victoria?

Dr WODAK: Well, I think what was terrible in New Zealand was to have a referendum. I think we elect politicians for good reason—to make difficult judgements on important questions—and a referendum is not a good way to sort out these complicated questions. I felt the same about marriage equality and also the Brexit referendum in the United Kingdom. So I am not a great fan of referenda. Sometimes they are useful, but mostly they are not.

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. I have not mentioned this elsewhere, but I think this raises the important issue for me that one of the potential benefits of regulating cannabis is the possibility that it may reduce consumption of alcohol and particularly reduce alcohol-related problems. There are some cases where that has happened around the world—where relaxing restrictions on cannabis has reduced alcohol-related problems—and some cases where that has not happened. It is very important that we try and have a better understanding of how that happens, when that happens, and try and make use of that.

The CHAIR: Sorry, just on that, with the New Zealand Bill, I accept what you are saying about the age, and I think even Canada, when they were considering this, wanted to keep customers for the black market as few as possible, so by increasing the age of access you are possibly creating a market for the black market. The other point that goes to controlling the black market was also around potency limits. I am not aware of many jurisdictions that have introduced potency limits, but that was certainly something that was discussed for the New Zealand model. I wonder about your thoughts on that.

Dr WODAK: Look, I think we need to have some idea of potency and agree on that and have that—if I had my way—fairly uniform across the whole market. But I think a lot of nonsense is talked about in relation to THC concentrations in the sense that if people knew what they were getting they would adjust to whatever that concentration was. The lower the concentration of THC in smoked cannabis the more people are going to take into their lungs—to breathe in—particulate matter, and particulate matter is not something that lungs enjoy having. So I think there is an argument in terms of lung health for keeping the concentration high. Most people will self-titrate the amount of intoxication they want to have, and if they feel that they are getting too much they will stop. But it is hard to do that when they do not really know how much THC is in the cannabis that they have acquired or bought. So I think there should be a debate about this.

One of the people we should be listening to about this is the experienced user. Now, one of the big lessons in harm reduction is listening to people, particularly listening to people who have lived experience. We learned that in spades with the HIV epidemic, where we—'we' meaning the whole community and officials—had to

listen very seriously to men who had sex with men, men and women who sold sex and men and women who injected drugs. We had to listen to them, and we learned a lot from listening to them, and that got ploughed into policy. That was a huge plus for the Australian community, and many other countries copied Australia when they saw how beneficial that was. I think we have to repeat that lesson again when it comes to cannabis. 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.

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 CHAIR: Yes. Thank you, Alex. That was really illuminating. I very much appreciate you giving your time to us today, particularly given the decades which you have spent thinking about this specific issue. As I mentioned at the beginning, you will receive a transcript of this. Please do have a look at it and just make sure—

Dr WODAK: I will.

The CHAIR: we have not misunderstood you in any way. Again, on behalf of the committee, thank you so much for your time and for your submission.

Witness withdrew.