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—Thursday, 25 March 2021

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WITNESSES

Mr Sam Biondo, Executive Officer, and

Mr David Taylor, Policy and Media Officer, Victorian Alcohol and Drug Association.

The CHAIR: Thank you, everyone. Welcome back to those who are watching from home. We are very pleased to have with us today Sam Biondo and David Taylor from VAADA, the Victorian Alcohol and Drug Association. Thank you so much for coming in. Thank you very much for your submission. For those at home, the submission is available on our website.

I just need to let you know, and I am sure you have you heard this before, that all evidence taken at this hearing is protected by parliamentary privilege, and that is provided by the *Constitution Act* but also under the standing orders of the Legislative Council. Therefore any information that you provide to us today is protected by law. However, any comment repeated outside this hearing may not be protected. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

This is being recorded by Hansard. Ultimately the transcript of today will go up onto our website, so you will receive a copy of the transcript in a few days, and I would encourage you to have a look at it.

We have all received your submission, so I very much appreciate that, but if you would like to make some opening comments and then we will open it up for a committee discussion.

Mr BIONDO: Thank you so much, and it was very interesting to hear the previous speaker because it actually puts before you the very complexity of this issue and the conundrum that actually exists. I think our presentation will talk to some of that conundrum and lay out some of the harm, as we see it, occurring in the Victorian community.

I do have four pages of big text. It will take about 10 minutes, and then I am happy to answer questions. Before I go on I would like to begin by acknowledging the traditional owners of land we are on and pay my respects to elders past and present, and I extend that respect to any Aboriginal and Torres Strait Islander people here today.

I would like to also express my thanks for the opportunity to present this committee today with the intention of highlighting a number of pragmatic, evidence-based policies and innovations to respond to cannabis-related harm. The Victorian Alcohol and Drug Association—VAADA—is a non-government peak organisation representing publicly funded Victorian alcohol and other drug services across Victoria. VAADA aims to support and promote strategies that prevent and reduce the harms associated with AOD use—alcohol and drug use—across the Victorian community.

While it is recognised that there are many views held about cannabis harms across the community, VAADA is particularly concerned at the harm generated through what we believe to be inappropriate, poorly targeted and excessive justice-related responses, and these justice responses direct people into ill-equipped and certainly not fit for purpose justice systems, prolonging various harms, and that is part of the conundrum we are talking about. These harms play out in the estimated cost of cannabis to the community, with a national cost of approximately $4.5 billion in 2015–16. Of this amount, over half the expenditure—$2.4 billion—relates to criminal justice system expenses, with smaller portions related to health care, traffic accidents, premature mortality and workplace expenses. The misalignment with the law and order focus on cannabis is evident, with 92 per cent of all cannabis-related arrests in 2017–18 targeting consumers and with only 8 per cent of arrests reflecting those trafficking cannabis.

Nationally in 2015–16 the cost of imprisonment related to cannabis was $1.1 billion. This was the largest sole expenditure and relates to 3400 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. An expansive, inefficient correctional system is not a luxury we can afford in this economic climate, and clearly it is nothing short of a failure in addressing many individuals' complexities and vulnerabilities.

While we have welcomed the new VicPol drug strategy, which on the surface seems to offer some hope of moving people with minor drug possession issues away from the criminal justice system through a sharper focus on diversion and towards practices aligned with therapeutic jurisprudence, in reality, and in isolation, it will take a long time to change the existing punitive culture around minor drug use.

Despite this prospective positive move, recent data from the Crime Statistics Agency notes that during COVID-19 there was a 20 per cent increase in drug-related offences, amounting to a five-year high. Four out of five of those offences were for possession, and 35 per cent of all offences related to cannabis. This is an increase of 27 per cent in the year leading to 2020. These are huge numbers.

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. 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.

There are a number of perverse outcomes occurring on the back of intense policing endeavours. The first is the emergence of synthetic cannabis, which has inadvertently been promoted through the criminalisation of natural cannabis. It is widely accepted that synthetic cannabis carries greater harms than natural cannabis, with the Victorian coroner finding that it contributed to 12 fatal overdoses between 2017 and 2019. In contrast, natural cannabis has never been viewed as directly causing fatal overdose. The coroner reflected on evidence which indicated as a harm-reduction strategy that it would be preferable for a person to consume natural cannabis rather than synthetic cannabis. Victorian treatment agencies have noted that those presenting with dependence on synthetic cannabis are more likely to experience co-occurring issues, such as mental illness, and will endure a harder withdrawal process. We await data on the impact of COVID-19 on the illicit drug market and whether there was greater use of the dark web and engagement with synthetic cannabis.

So what do we do? 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.

We do not need to look far to view examples of reform which hold promise. The ACT government has progressed a reform resulting in decriminalisation of small quantities of cannabis and permitted the cultivation of a small number of plants. As yet the sky has not fallen in. Elsewhere you can look to Canada, the Netherlands, Portugal and even various jurisdictions in the United States. The United States is an interesting place because it has a very unique approach to the commercialisation of anything that is brought out there, and so I think that is part of the thing that needs to be taken into account in your considerations. Among these reforms, where various versions of decriminalisation have occurred the general consensus formed from the data—and as noted by the Scottish government's recent report *International Approaches to Drug Law Reform*—illustrates that there has been largely no impact on consumption levels. Young people, who remain at greater risk from cannabis use, have not increased their consumption. There are indications of reduced binge drinking amongst young people, with accompanying reductions in violence, hospitalisations, correctional service engagement and motor vehicle accidents. These findings are accompanied by obvious reductions in engagement with correctional services, freeing up police to engage in more pressing and relevant police matters. You will be happy to hear this is the last page.

The CHAIR: No, take your time, Sam. It is fine.

Mr BIONDO: The economic circumstances ushered in by COVID-19 do not allow the luxury of unfettered and harmful growth in corrections, with pragmatic, evidence-based reform being of great necessity. Beyond these reforms there is a need to note and respond to the health impacts of cannabis use in the community. We know that cannabis can cause harm for some, whether it is heavily policed or decriminalised. Our formal

submission to this inquiry notes that 19 196 clients presented with cannabis as a drug of concern in 2018–19 in Victoria—that is to our treatment services—and in 2018–19, 1902 young people aged between 15 and 24 years old were hospitalised for cannabis in Victoria.

We note, also of concern, that 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 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. We know that currently there are over 2500 Victorians—today—waiting for AOD treatment, and every day up to 500 000 people nationally who are in need of AOD treatment are not engaging support. Investment in treatment provides a sevenfold return on investment, which manifests in reduced offending; improved social circumstances, including with employment and health; and, international evidence indicates, a 4.6 to 8.4 return on investment for each $1 spent on youth AOD treatment. System capacity remains a live issue.

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 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. Thanks for your time.

The CHAIR: Thank you. That was very succinct. Thank you very much, Sam. We will open it up for questions. David, I know that you have been doing a lot of the policy and research in this, so feel free to jump in at any time. Deputy Chair, Tien Kieu, will start the questions.

Dr KIEU: Thank you, Chair. Thank you for your presence here today and your submission. You have gone to the heart of the matter—of the education and also some increased funding, as proposed by you. Do you support decriminalisation as a means to regulate the matter, because those two issues are quite separate?

Mr BIONDO: The war on drugs has not worked, and as my presentation provided you, it has criminalised a lot of otherwise normal individuals. Our view is that creates considerably much greater harm for those individuals and the community. We are not saying that there needs to be an absolutely laissez-faire approach to this issue, like there is in some countries. I think that is wrong, and I think that is creating other problems. But there needs to be some balanced approach to dealing with the issue in Victoria and Australia. We have seen successful outcomes in countries like Portugal and the Netherlands, and if you have not done it already, I think you should consider the way in which the Dutch have approached this issue. The results of that are, as I understand much of the research that I have been looking at, a reduced consumption for young people—slightly reduced. It actually puts pressure on the hidden economy because if you are starting to regulate something, you actually bring it into the open and you create disincentives for people to engage with that hidden economy, with all the added things that they do with the profits that are gained from that underground economy.

Dr KIEU: It has not been the case for the tobacco industry, for example, because perhaps the tax is too high on the legal tobacco cigarette you can buy over the counter versus the one out the back of the shop there.

Mr BIONDO: Yes, it is an issue, and we recognised that when they were talking about it. Even though taxation is a very successful way in which you can reduce consumption, there is probably a point where the elasticity stops and people look for alternatives, which may be even more dangerous. So there is a need to take that factor into account and follow the evidence and follow the research that gets done with this.

Dr KIEU: Thank you.

The CHAIR: Thank you. Kaushaliya.

Ms VAGHELA: Thanks, Chair. Thanks, Sam and David, for your time today. We have heard both sides of the story. We have heard, 'Yes, it should be legalised—the use' and the other people saying, 'It should not be legalised'. But some of the components are common—whether it is early intervention where we educate the young people right from early on and so on and so forth, research-based implementation and what the data is. At times we hear that the data is put along with other drug use or along with alcohol and so on and so forth. So

do we have over here data which clearly shows the use of cannabis in youth only and the impacts? You already mentioned that we do not have a big number in terms of fatal outcomes. But what I do want to know is: if we say, 'Do not criminalise and allow a low amount of use', do you think that is going to solve the problem?

Mr TAYLOR: Look, I do not think there is any silver bullet to alcohol and drug problems. We often spend a lot of time and there is an awful lot of hope that there will be one policy, one solution, which will solve all the dilemmas. Incremental reforms which are evidence based and pragmatic can progress small changes which then need to be reviewed, and that is probably where we would be looking at. We would not be looking to sweep the table and make sweeping reforms on things off the bat. We look to what is occurring in other jurisdictions. We look toward their evidence. We consider the particular Victorian environment, which I note is significantly different to the US. So if you look toward, for instance, the rate of opioid-related harms there, it is very different with regard to the US. So making attributions here with regard to any policy impacting opioid-related harms in the US is, I think, a complex thing. So a shift toward minimising justice-related interventions for low-level use would certainly be a positive step forward in the short term.

Mr BIONDO: And, if I may, Chair—

The CHAIR: Yes.

Mr BIONDO: you mentioned education. I think the focus has to be on harm reduction. 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.

Ms VAGHELA: Yes, because you mentioned about a high expense in enforcing criminalisation, so can that money, instead of that, be used for education purposes or harm reduction purposes?

Mr BIONDO: Yes. Look, I am a dreamer and I have said it to anyone that listens: the money that goes into the prison system to deal with people with mental illness and alcohol and drug issues is badly spent. It is the wrong place to put it. What you need to do is—call it 'justice reinvestment'—put it back; reintegrate people who have had that negative experience in the prison; support them with their mental health needs in the community, their housing needs, their alcohol and drug needs; and create some opportunities for them to be gainfully engaged in employment or activity. They will not go back into the prison system. The current measures are: you pluck them out because they have done something wrong; you process them in a bureaucracy, the court system; you stick them in jail, you create greater harm, you get them hooked on something else; you send them without adequate discharge back into the community; and then you get that recidivism cycle that is outrageous.

Now, if you look at a place like Norway, there is a 26 per cent recidivism rate because they understand reintegration. Netherlands is the same. Singapore is doing it. We are hopeless at it here. It has to be part of what Parliament looks at.

The CHAIR: Thank you.

Dr KIEU: That will be another inquiry.

The CHAIR: Look, I certainly think that social disadvantage and brushes with the criminal system are just as relevant to this inquiry as they have been to just about every single inquiry we have done, whether it is homelessness, spent convictions et cetera. David Limbrick.

Mr LIMBRICK: Thank you, Chair. And thank you, Mr Biondo and Mr Taylor, for your submission and appearing today. We have spoken about the harms and reducing harms from drugs, from cannabis in particular. What sort of harms surface in the treatment area—like, cannabis-related harms—and how does the current criminalisation regime affect treatment and reduction of those harms?

Mr BIONDO: Numbers—huge numbers of people are being driven to us. When you know that particular substances are out there, yet you cannot inform the public of what they are because we do not have testing regimes, we do not have a public system of notifying people of harmful substances out there and you watch

people be sitting ducks to those substances, that is bad for everybody. It is certainly bad when they die—bad for their families, bad for the community.

We have seen examples of mass incidents where some of the evidence was actually in police forensics. The forensic unit of Victoria Police knew that there were bad substances around. It was not communicated to the community, and a number of people died out of that. So that is one thing.

Mr LIMBRICK: That is not cannabis-related harm.

Mr BIONDO: No. 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. Maybe the messaging on harm reduction and prevention would be better. Maybe you could bring things to light that you cannot talk about at the moment in an open way because there is so much pressure to keep things hidden.

Mr TAYLOR: Further to Sam's comments, we are supportive of what the government has done with regard to ensuring there is a commitment to put a psychologist in every school. I mean, I can look at a map here with regard to regions which have increased cannabis-related treatment demand. Now, that is within the adult space, and I am looking particularly at growth corridors and probably some not surprising regional areas. You know, scope to go and look at having AOD clinicians who could work with young people, perhaps even considering peer work and so forth, within some of those areas which have already been deemed high-risk could be seen as significant early intervention and harm-reduction activity, which could reduce the likelihood of future engagement with the adult treatment system, the adult justice system and a range of other health issues.

So we would say it is worthwhile considering that, and that also speaks to something which the royal commission into mental health found. When it reflected on how demand is determined with regard to mental health services, it said, 'How we have done it for years is historical—we look at what happened last year, and we assume that is going to happen next year'. And what that speaks to is those people who are currently engaging the system. It does not speak to the 500 000-plus people who could benefit from clinical AOD treatment but do not access the system. It does not speak to the over 1 million, I think, which the royal commission found in Victoria are not engaging the mental health system at the moment who would benefit from that.

So again it is also looking at how we determine demand for services and looking at the models and how that determines the allocation of resourcing, and that then comes back to looking at those regions where there is higher demand and looking at the various social aspects which could speak to, for instance, increased numbers of people being released from prison into those regions or a range of other health and social factors which could be contributing to harmful substance use and other indicators of disadvantage.

Mr LIMBRICK: Thank you.

The CHAIR: Thank you. Georgie.

Ms CROZIER: Thank you very much, Chair. Thank you, both, for being with us this morning and your submission and evidence that you have provided to the committee. You mentioned, I think, and please correct me if I have got this figure wrong, 625 000 people in Victoria in the last 12 months have used cannabis and they are 14 years and over. My first question is: how many of the 625 000 are children, meaning under the age of 18? Have you got that data?

Mr BIONDO: No, I do not have the data. In fact I do not even have the data of what comes through our alcohol and drug system because it is so appallingly collected.

Ms CROZIER: Why is that? It is being poorly collected from where?

Mr BIONDO: Because we do not have an adequate data system in our sector. We have got a data system. It was introduced three years ago. It does not work. We have great difficulty in collecting throughput data. Much of the publicly available data is collated and presented by the Australian Institute of Health and Welfare.

Ms CROZIER: Is that the data you are referring to then?

Mr BIONDO: Yes.

Ms CROZIER: Thank you. I just would like to go to another question about this early intervention. My issue is around the health impacts of cannabis use, both physical and mental health impacts, and we have heard from various witnesses this morning. In this state the government is putting into place education programs on respect and gender-based diversity issues in early education settings, some in primary school. What is your view in relation to the lack of education in this very important area in schools at those very early ages? Do you have a view on that?

Mr BIONDO: Yes, I do have a view, and I recently presented evidence at a federal inquiry. My issue is if it is done, it has to be done very well. You cannot have amateurs talking about drug issues in schools. The United States had a program called the DARE program—very large, went for many years. What it actually ended up doing for a significant cohort of drug-naive people is it piqued their desire to actually go and try drugs.

Ms CROZIER: But that is the whole point, isn't it? We do not want them trying these drugs at such a young age.

Mr BIONDO: It did the opposite of what was intended.

Ms CROZIER: I am interested in the forms, the complexity of cannabis that we have been presented with this morning. I do not think the general public understand what forms cannabis comes in, and certainly children do not understand those impacts. The inconsistency in the message that we are sending to children—I think it needs to be done better. As you say, you cannot have amateurs going in and doing this stuff. But we have to do something, because at 14 and above, with the mental health impacts, the depression, the psychosis, the emergency department presentations because people are having these drugs, it is not doing certainly themselves any good or our society as a whole.

Mr BIONDO: I agree; it is very important. If it is done appropriately and properly and with harm reduction messaging, the results will be very positive for the community. If it is done as a 'just say no', it will not work. If it is done driving stigma, it will not work. There are good ways and bad ways to do it. It is about structuring up the right sort of education, the right sort of people to deliver the education and then carefully targeting the audience.

Mr TAYLOR: If I might add to that also, when I came to the sector 10 years ago I have to say 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. I guess I would raise that as a first thing.

The other thing is that there are various initiatives. There was a federal initiative around a decade back called First Response; I think it is mentioned in our submission. The early reviews of that program, which provided a little bit of initial support and referral to people who were showing risk indicators, were positive.

There were increases in the very early stages, remember we did not have much time and measuring alcohol- and drug-related improvements often takes time. There were mild increases in wellbeing, a reduction in their K10 scores with regard to determining mental health issues and so forth. So some of these things hold promise, and it was discontinued as far as I can understand. I think it had federal funding, so there was—

Ms CROZIER: What about the state funding? I mean, we have had the mental health royal commission here in Victoria. That would have addressed a lot of these issues or hopefully would have addressed a lot of these issues. I mean, we have got to stop passing the buck and really get to the nut of the issue here, because it is so devastating for so many people, and you are seeing that day in and day out. You talk about the lack of investment here in Victoria and beds around regional Victoria. What advice would you give to the committee in relation to that investment that is required?

Mr BIONDO: Sure, I will have a go at this to start off with. 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. We need to be brought into a modern-day era of how we treat people who have an alcohol and drug issue, including dealing with the stigma, dealing with the pragmatic legislation that is required, dealing with things that reduce harm and dealing with the justice system. So part of it is around the alcohol and drug system, but there are other components around it that interact with it and that create some of that harm as well. And certainly purely on the treatment side of it we need greater capacity in terms of withdrawal, its ability to work seamlessly with residential—

Ms CROZIER: Have you put a figure on that for government? I mean, do you know what that looks like?

Mr BIONDO: Look, frankly, we play around with figures every state budget submission, but it is at the achievable end of what we think we might be able to bite at every year. You need to go to some federal work that was done by the National Drug and Alcohol Research Centre at the University of New South Wales. They created a whole-of-population health look at what is required across the nation, looking at economic modelling of what is required in particular regions and locations and states.

Ms CROZIER: So what has been done here in Victoria?

Mr BIONDO: I do not think they use that model.

Ms CROZIER: The government does not? Have they done any work in this area?

Mr BIONDO: I don't know. I have never been engaged on it. Some of my colleagues interstate have, but not in Victoria.

Ms CROZIER: Would you suggest to the committee that that modelling needs to be done?

Mr BIONDO: Yes. It is called the DASP model, and I think it is worthwhile having a look at.

Ms CROZIER: Thank you.

Mr TAYLOR: I would add our budget submission has noted that from data which we have determined from other jurisdictions 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. And on top of that, drug treatment is a continuum, so people progress from one treatment type to another. It is a continuum of care. You will hear that term a lot when you talk to our folk, and so one of the aspects of this is that people, before they go into residential rehabilitation, will benefit greatly from going through a withdrawal process and often a residential withdrawal process.

We have not seen a commensurate uplift in residential withdrawal with regard to the same uplift which was afforded for residential rehabilitation. So it runs the risk—and we saw this during COVID; I think a lot of services saw these sorts of things during COVID in particular—of various backlogs occurring and bottlenecks occurring. That is the first point I would make on that. The second point I would make is that the youth AOD treatment sector is around 20 years old. It was built around the turn of the century. At that time, despite various indicators of harm and so forth and a greater sophistication as to how we understand some of the challenges young people face, we have seen an additional increase in capacity in Latrobe with regard to a residential facility and I think some years back a small parcel of additional resourcing on youth outreach.

I really think there needs to be significant examination of what the demand is for youth treatment, the impacts of youth treatment on preventing further issues as people progress and get older, how that can prevent those harms, and really having a good look at how we can make that system do so much better than it is already doing. We have got some fantastic people working in that space, but it has been struggling. I am aware of that.

The CHAIR: I think that, yes, you get much bigger bang for your buck the earlier you start in any form of treatment or early intervention. Just coming back to cannabis, in your submission—it is from the Australian Institute of Health and Welfare's national drug household survey—you mention that 2.9 per cent of cannabis users would be deemed at high risk of harm, including dependency. This seems quite different to the figures that we have heard this morning, where I think they were suggesting up to a third of cannabis users were dependent in the US. It does seem to be a small percentage. I am wondering if you could expand a little bit on that and also expand on what cannabis-related harm is. Is this criminalisation—receiving a criminal record; is it lung disease; is it mental health issues?

Mr BIONDO: Potentially it is all 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 than this. That deregulation in itself leads you to probably use more harmful cannabis than other places, so you do not have that smorgasbord to choose from, if I can crudely put it that way.

As to the need to intervene at that age, as David was trying to indicate, if we can get in young and intervene, of course the outcomes can be a lot better. If we are able to do harm reduction and education that is adequate and suitable and honest enough, then you get probably some good results. All these things can chip away at a point of a per cent, and you will drive that number down. There is no quick fix. Saying no does not work. You have cultures within families, within communities and within society itself. Australia has an addiction to substances: alcohol, methamphetamine, cannabis—

The CHAIR: Tobacco.

Mr BIONDO: pharmaceuticals, tobacco. You look at all of those and there are pretty concerning figures across the board of it. Cannabis is one element of it. From my professional opinion, harm reduction and prevention messages are really important and I think having a treatment system that is able to intervene and provide support when someone is in a critical situation or even before they are critical and then using the corrections system as a last resort.

The CHAIR: And, as you mentioned, the possibility of regulating so you can control what is out there in the market.

Ms CROZIER: Can I just follow up?

The CHAIR: Yes, go.

Ms CROZIER: On that very issue that you spoke about, I think you said in your evidence to us that 2500 Victorians were waiting for a rehab bed.

Mr BIONDO: Yes, waiting for treatment across a range of activities.

Ms CROZIER: Does that include detox?

Mr BIONDO: Yes.

Ms CROZIER: Okay. So that is not just a bed; that is detox services too.

Mr BIONDO: It is an amalgam figure.

Ms CROZIER: Is that each day, did you say?

Mr TAYLOR: We are conducting a survey, at this stage we are aiming to make it quarterly, where we ask agencies—not-for-profit agencies, funded agencies—about their waitlists across all their funded programs, the number of people waiting on those waitlists. So what that offers us is a breakdown of the number of people waiting on a given day across each treatment type for each agency, and then we can aggregate that to get a total number across various treatment types and the total number across the state. Now, some of those people might

be waiting for a residential service for a number of months. Others might be waiting for intake for a number of days. So what we have done is we have called it a sort of daily snapshot or one-day snapshot of sector—

Ms CROZIER: It's a lot.

Mr TAYLOR: Well, 2500 is quite a lot, but it is in its early stages. We have conducted the survey twice at this time, but we intend on continuing to do it.

Ms CROZIER: Thank you.

The CHAIR: Just finally from me: I noted that you talked about people seeking treatment for cannabis, and there seemed to be quite a significant decline in the numbers over the last decade. What do you put that to?

Mr TAYLOR: Look, it is a very good question, and what we see is a significant decline occur around the 2013–14 mark in people presenting where cannabis is a secondary drug of concern—

The CHAIR: Oh, okay.

Mr TAYLOR: Now, there are a couple of things at play there. The first thing is that that was when the sector was recommissioned. We saw in the ASPEX report at the time that indicated in the short term, post the recommissioning, there was around about a 20 per cent overall reduction in service access in that following year. So, I guess, when you are changing your system, you are going to have some teething issues with regard to people figuring out how things are done and the system realigning itself.

The other issue there, and again it is not something I can verify, so I want to put that very clearly, is that it is quite probable that the way we count people coming into the system with regard to secondary drugs of concern was modified. So it may have been that there was less capacity to count multiple drugs of concern, where beforehand that may not have been the case. Again, I cannot verify that, but that is an understanding I have been offered from conversations with people.

Dr KIEU: But there may be a reason why it is modified already—

The CHAIR: It might just be a number thing. Just finally, having listened to Dr Sabet, and I think you heard Tamar Todd as well, if there were maybe the top three things that we were to look at in a careful regulation of cannabis, do you have thoughts on what those three things would be?

Mr BIONDO: I think the laissez-faire market that is just thrown out with minimal regulation is quite concerning to me. I think that the messaging and the harm-reduction messaging, the education side of it, needs to work hand in glove with what gets done. I think we certainly need to address the criminal justice perspective of it, and some of the investment that goes in there should go into treatment, because you need to maintain that balance, and hopefully the balance goes to the positive rather than the negative. I think, based on Portugal and the way things transpired there and the Netherlands—

The CHAIR: Yes, Portugal is a model of decriminalisation, we would suggest, and the Netherlands would be more, in the Dutch way, a model of legalisation.

Mr BIONDO: And the police have just decided to turn a blind eye to certain behaviours. The substance is actually still illegal to supply, but yet you have coffee shops that are able to get their supplies illegally but sell it legally.

The CHAIR: David, did you have—

Mr TAYLOR: Look, nothing too much to add to that, no. I think Sam summed it up.

The CHAIR: Thank you both, and look, thanks for your continued advocacy in this area. I know I have got your budget submission. I am sure that most of the people around this table would probably—if you have not sent them a copy, please do.

Mr BIONDO: We have got a new one.

The CHAIR: Thank you. Thank you everyone.

Witnesses withdrew.