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

Associate Professor Peter Higgs, Burnet Senior Fellow, and

Ms Ashleigh Stewart, Research Assistant, Burnet Institute.

The CHAIR: Welcome back, everyone. I would like to declare open the Standing Committee on Legal and Social Issues public hearing for our inquiry into the use of cannabis.

Here with me today we have Sheena Watt, Kaushaliya Vaghela, Georgie Crozier and David Limbrick. I am Fiona Patten, the Chair of the committee.

Welcome, Ashleigh Stewart and Associate Professor Peter Higgs from the Burnet Institute. If I can just pause to give you some information: all evidence taken at this hearing is protected by parliamentary privilege, and that is provided under our *Constitution Act* but also the standing orders of the Legislative Council. This means any information that you provide this afternoon will be protected by law. However, any comment repeated outside the hearing may not be protected. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

As you can see, this is being recorded, and there will be a transcript made available to you in the coming days. I would encourage you to have a look at that just to make sure we have not misrepresented you. Ultimately it will be up on our website.

Again, thank you so much to both of you for making the time to join us today, and we welcome some opening remarks. Then we will have some committee discussion.

Assoc. Prof. HIGGS: Fantastic. Thanks a lot, Fiona. I am Peter Higgs. Ashleigh and I have worked together at the Burnet for a few years inside of the behaviours and risk program. I have actually been at the Burnet since 1996. I have got a full-time appointment, though, at La Trobe University; I am an associate professor in the public health department.

Ash and I have been working together on a few studies that are kind of flagship programs for the Burnet, a number of cohort studies that we do with people who use drugs, including people who inject drugs: the SuperMIX study, which has about 1300 people and has been going since 2008, where we interview people annually. We have also got a study just looking at people who use methamphetamine here in Melbourne, Bendigo, Latrobe and also in Shepparton. So picking up some of the issues around regional drug use and cannabis use in regional Victoria that I heard talked about this morning, I think that is important for us, although we are looking at meth users in that cohort.

We are also working on a cohort of people who have just come out of prison and following them for two years. So we recruited them inside of prison—that is part of Ashleigh's PhD—450 men that were recruited and then followed for two years, so we are getting to the late stages of that for Ash's work.

As I said, I teach in the department of public health, and Ash and I have both taught into a subject called 'drug use and addictive behaviour'. That has had about 1000 students in the last four years. And I would like to thank the committee for giving us a real-life opportunity to have something that students were able to use last year when you were calling for submissions. We ran through in one of our tutorial sessions how you might make a submission. I saw there were over 1400 submissions to this inquiry, which is a phenomenal amount. I am sure a number of my students put in student submissions on their own.

The CHAIR: Well, please thank them for us.

Assoc. Prof. HIGGS: That is all right. I will hand over to Ash just to highlight some of the things that we want to note in our submission.

Visual presentation.

Ms STEWART: Absolutely. So if I can just ask for the next slide, please. Thank you.

So cannabis, as we know, is the most widely used illicit drug in Australia. The first statistics on the screen there are in relation to the 2019 *National Drug Strategy Household Survey*. They have been reported quite extensively, and I am sure you are all across that. So I will jump to the statistic on the end of the screen, on the right. The last figure represents an annual survey of young people aged 16 to 29 years that is run by the Burnet Institute and has been run since 2015. It is called the Sex, Drugs and Rock 'n' Roll survey. Approximately 50 per cent of the young people surveyed reported lifetime cannabis use in that group, and of them 20 per cent reported past-month cannabis use. So that is the main takeaway from that slide. Next slide, please. Excellent. Thank you.

Some of the harms associated with cannabis use—we know that smoking unregulated cannabis has inherent harms, with unknown potency and unknown growing conditions and the type of cannabis that people might be purchasing; organised crime associated with the production and distribution of cannabis, which may also link people seeking cannabis from these markets with other criminal activity and also access to other illicit drugs. Due to the stigma associated with cannabis use, we know that people are less likely to seek help for their cannabis use, which is a real issue. And in relation to societal costs this figure is developed by the National Drug Research Institute—and it was spoken to this morning by VADA, I believe, in their hearing—so we know that the costs of cannabis use between July 2015 and July 2016 have been estimated at about $4.5 billion, and over half of those costs are related to crime and criminal justice costs, so it is quite substantial.

In 2017–18 the Australian Criminal Intelligence Commission reported cannabis to account for the greatest number of drug-related arrests nationally, and 90 per cent of all arrests were related to cannabis consumers as opposed to cannabis providers, so it is quite a big number. But we do not know, Pete, whether that is offences just for cannabis or whether it is offences that also come with some other charges as well.

Assoc. Prof. HIGGS: I think our experience would suggest that it is add-on charges to people who have already been charged with other things. So it is very hard to separate those from each other.

The CHAIR: Yes. We have tried a number of times.

Assoc. Prof. HIGGS: I am sure you are across that.

The CHAIR: Yes. It is difficult.

Ms STEWART: So there are approximately 8000 to 9000 cannabis possession offences that are recorded each year here in Victoria, and of these, 27 per cent of offenders are sentenced to imprisonment for possession and 17 per cent of offenders are sentenced to imprisonment for cannabis use.

Assoc. Prof. HIGGS: But again, it is going to be because they have been charged with other offences and they have added those charges on, so it is kind of a net-widening process.

The CHAIR: Yes.

Ms STEWART: And just to reiterate, we know that engagement with the justice system has really long-term, life-altering impacts on people, the community, and these also include the over-representation of marginalised communities, particularly Aboriginal and Torres Strait Islander people, within the justice system; the increased risk of future engagement with the justice system and increased risk of receiving a future custodial sentence; trauma caused by ongoing and repeat engagement with criminal justice systems; the poor social outcomes, such as housing instability and employment, which are exacerbated through having a criminal record; poor health outcomes; and things like disruptions to medical care, like opioid substitution treatment or mental health care, that are increased by entering and exiting prison. And all of these are faced alongside the challenges with reintegrating back into the community after secure custodial sentencing, so that is quite problematic. Next slide, please. Thank you.

Our situation here in Australia—I am sure you guys are pretty across this as well, but just to reiterate—de facto decriminalisation is provided in most states here in the form of police referral to education, assessment and treatment or referred to as drug diversion programs. We know that these 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.

So the de jure decriminalisation for cannabis is currently provided in South Australia and the Northern Territory here. I believe it was provided in Western Australia for a period of time but not anymore, and this is in the form of a civil penalty scheme. These schemes have eligibility restrictions, which increases program access and decreases some of the issues around social equity that are inherent in some of the de facto schemes that we are aware of, but it is really important to highlight that both these schemes may result in criminal penalties in the case of not meeting certain requirements. The ACT, we know, introduced sort of a limited cannabis legalisation scheme that came into effect in January last year, and the legislative change 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. But unlike other jurisdictions around the world, the sale or supply of cannabis—including, technically, passing a joint to a friend—does still remain a criminal offence and you still cannot consume cannabis in public, so there are some potential shortfalls which we might touch on in the next slide, please.

Assoc. Prof. HIGGS: It is also worth noting that you cannot buy seeds anywhere. Whilst it is legal to grow it, you cannot actually access seeds anywhere, so there are kind of contradictions I guess in a sense in terms of how you might manage that for the best of people. Also, growing using hydroponics is illegal in the ACT, presumably as a way of trying to reduce harm associated with potency, which is we think a good thing. But yes, not everything is perfect I guess.

The CHAIR: But if you do not have a backyard, yes.

Assoc. Prof. HIGGS: Exactly. And not everyone wants to grow their own.

Ms STEWART: Next slide, please. Thank you. So this figure here that you can see on the screen comes from a 2016 paper that was published in *Addiction* journal by Caulkins and Kilmer. I think it also came up in the NDRI submission that was submitted to you guys, and it speaks to 12 alternatives concerning cannabis supply, ranging from complete prohibition and criminal sanctions, on the left of the screen, right up until sort of removing cannabis from the law books into an unregulated market, on the right of the screen. Prohibition but with decreased criminal sanctions is largely enforced in Australia, as we saw, and does have some inherent issues with eligibility, social inequity and does exclude often those with the highest need. And the ACT model we spoke about just before: I guess any aims with this model to undercut the black market and separate people who use cannabis from criminal elements do need to have a mechanism to meet the cannabis supply needs of the bulk of the people who use cannabis, and as Pete said before, 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, as I have read.

Towards the other end, with the free market, a substantial amount of evidence about this does come from the US on the fully commercialised profit-driven models, and you did hear about that from two people this morning in the hearing as well. I guess our experience from alcohol and tobacco shows decades of challenges and efforts to revert the consequences of a profit-driven market, and that has been highlighted by many others as well. Next slide, please. Thank you.

There are a number of non-commercial or middle-ground options for cannabis legalisation, and such approaches are likely to potentially have less adverse impacts on public health. 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. You do have to be registered with a club as well. You can have one member who can cultivate on behalf of others, and clubs can provide a legal supply for people who lack the time, space or skill to grow themselves. Cannabis clubs are potentially one of the smaller scale operations that can undermine a substantial share of the black market.

Assoc. Prof. HIGGS: There is quite a bit of detail on that in one of the other submissions we saw from the drug policy monitoring program at UNSW. I cannot remember the name of the academic there—

The CHAIR: Yes. Is it Alison?

Assoc. Prof. HIGGS: Alison is the chair, but the woman who wrote the application—Vendula. Anyway, there is quite a lot of detail on that.

The CHAIR: When you look at the legislation on face value, it is sort of a 'We just won't look there' kind of model in Spain.

Ms STEWART: Some of the larger scale productions do provide a greater ability to regulate and collect taxes, but as you heard from one of the people who spoke this morning, there actually are a lot of costs and effort that go into regulating that market as well.

Our last slide, please. Thank you. Just a couple of main points, I suppose. Regulated markets do already exist for the production, trade supply, marketing and advertising of prescription drugs, alcohol and tobacco, and we can take some lessons from what we have learned in this approach. A conservative regulatory approach that limits and monitors the impact of market changes and restricts the power of those private enterprises is really important, and we must avoid adverse consequences of that rampant commercialisation that we have seen previously with tobacco and alcohol.

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. A public health approach to minimise harms is obviously really crucial here, and any reform needs to be subject to some strict monitoring and evaluation, and these frameworks do need to be established prior to any legislative change.

Assoc. Prof. HIGGS: Excellent.

The CHAIR: Great, thank you. That was excellent, really succinct. I will open it up for questions. Kaushaliya, can I start with you?

Ms VAGHELA: Thanks, Chair. Thanks, Ashleigh, and thanks, Professor Higgs, for your submission and for your time today. In one of the slides we saw the regulatory models, and in your submission there is mention of different jurisdictions. Out of all those jurisdictions—I have heard briefly about the ACT, the way it has been legalised over there and overseas as well—out of all those existing models, which is the one which is the most successful that can be replicated over here and why?

Assoc. Prof. HIGGS: I guess it depends on what you are trying to achieve with your model. The ACT is the closest example, but it is also a very recent example. We have now just gone into 12 months of implementation there. I think, as we noted, there are some real problems with the ACT model though in terms of contradictions that just do not seem to kind of make sense, so having some process of understanding how many people are actually growing their own, where are people buying their cannabis from—those sorts of things are going to be important in terms of helping to monitor. We are not experts in the impact of the different ways in which models might work. Ash and I both talk to people who use drugs where cannabis is almost as common as cigarettes are amongst them. We know obviously that having an illegal market does not disenfranchise them from using it, but they do not have any control over the quality of or what is in their drugs. We think that putting some kind of regulations in place whereby we can actually control the amount of THC, especially the impact that that has on people, and where people know what they are actually consuming is going to have a better outcome for people.

Ms VAGHELA: And if it is legalised, because we heard from one of the speakers today that the way the use of cannabis or the way it is promoted or used, whether it is in proper advertising or on social media—it is hard to regulate that. In your submission you have also recommended that we make sure that we regulate the advertising and packaging and so on and so forth. Is it easier the way that we were able to do it for, say, cigarettes?

Assoc. Prof. HIGGS: Well, we could use cigarettes as the model. You could have plain packaging. You could just have cannabis available in little baggies that people kind of buy on the street anyway with the THC content they want, whatever the name of it is. There are ways in which you could do that. You could offer it up for sale through tobacconists where you can get tobacco now. It is not illegal to have tobacconists—they can show the branding, whereas in supermarkets you are not allowed to see brands. So there are ways in which I think tobacco is a good example. We know exactly how many milligrams per cigarette we are getting because of that. I think it is a good example in terms of how people are going to access it. The price and taxation arrangements obviously are a massive burden on people who have got fixed incomes.

We know that most people who smoke—it is down to about 13–15 per cent of the population now. But the proportion of people who are low income, using drugs, mental health conditions, those sorts of populations, are using tobacco a lot more than Ash and I are, for example, or many other people that we work with.

Ms VAGHELA: I will come back in a second.

The CHAIR: Okay. Thank you. Georgie.

Ms CROZIER: Thank you, Chair.

The CHAIR: Georgie, David, then Sheena then me.

Ms CROZIER: I was not expecting that.

The CHAIR: Sorry.

Ms CROZIER: Thank you very much for your very interesting presentation and the evidence that you have provided to the committee and making the time. I am interested in the health impacts—both physical and mental health impacts. I think there is significant evidence out there to suggest that there are linkages and real concerns around a range of issues, and I have spoken about those this morning. Some of the evidence we heard from America I think is really interesting because they are so much more advanced than we are. But one of the things that did concern me was the complexity in nature of this drug. It comes in different forms. It is not just the THC component. I think it is Oregon where it is legal but only 15 to 30 per cent is sold legally. There is still that illegal element, that black market element, so it is not being totally captured and regulated and they are having these issues. So I am wondering if you have looked at that international evidence to that degree and could provide some comment to the committee.

Assoc. Prof. HIGGS: I do not think we have. 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.

Ms CROZIER: I made the point because you quite rightly point out that it is often the most disadvantaged and vulnerable in our communities that have high rates of smoking. A packet of cigarettes costs $50.

Assoc. Prof. HIGGS: I know. It is crazy.

Ms CROZIER: There is a black market in this country for cigarettes. But my point is also: with alcohol there are price points, but even the cheaper prices for alcohol have not stopped the consumption, and they have detrimental health impacts. So my concerns are about: what potentially we are doing is not addressing the real problem about how dangerous these drugs are.

Assoc. Prof. HIGGS: Yes. I guess it is: who gets impacted and then how do we design our interventions for those populations, because we know most people who use alcohol actually do not have a problem with it. So why is that the case? You and I could both have drinks before work if we wanted, but we know that we would not function as well if we did, so we choose for a whole range of reasons to not consume drugs that are available to us at a level where they cause us harm. The same can be said for cannabis. If you are looking at young people, we know that 20 per cent of people are using it monthly but not all of them are turning up at hospital emergency departments. The sorts of harms that you are going to see are coming to a particular population. I heard Sam's presentation this morning before we got here: very focused on those treatment providers and where we need to be really focusing that. But that is just for a small kind of hard edge of the population, I guess. Most people who are consuming the drug now are not actually having a problem with it.

Ms CROZIER: Could I ask, because I am interested in your research, about the use of this for kids as a gateway.

Because I certainly know people who started off smoking dope back in the 80s and then got onto heroin. This drug is more complex than what it was then. We have got ice. We have got amphetamine. We have got a whole range of drugs out there that are being abused by especially young people, which is I think really concerning. I am just wondering how this fits into that.

Assoc. Prof. HIGGS: I think for all people who use those other drugs that you talk about, heroin and methamphetamine, they are a small proportion of the population—5 per cent perhaps have tried those drugs at any one time, according to the national household survey. I mean, it is hard to know. People do not necessarily want to put their hand up and say that they are kind of doing those drugs, but almost all those people will have used alcohol, cigarettes and cannabis before. So it is not like those drugs are necessarily a gateway to heroin use, because we have got 50 per cent of the population reporting ever using cannabis in our young people survey but the use of illicit drugs in that population is about 1 or 2 per cent.

Ms CROZIER: Sorry, we will move on, but I am interested in this line of questioning because it is really important. Fifty per cent of your young people's survey—

Assoc. Prof. HIGGS: Yes. So that was through our 'Sex, Drugs and Rock 'n' Roll'; we used to go to the Big Day Out from 2005—

Ms CROZIER: Okay, so that is quite a—

Assoc. Prof. HIGGS: Particular cohort.

Ms CROZIER: Yes.

Ms STEWART: Fifty per cent of lifetime use, though, so it is hard to differentiate between someone who has had one joint, so it is probably the recent use or the use in the past month that is the more interesting stat, which is 20 per cent of those—

Assoc. Prof. HIGGS: Twenty per cent of people who reported using.

Ms STEWART: who said that they had used it. So it was about 160 people out of—

The CHAIR: I think that mirrors the drug household survey as well.

Assoc. Prof. HIGGS: Probably, yes.

Ms STEWART: Yes.

The CHAIR: If you look at those 18- to 29-year-olds, you are looking at about 25 per cent who had used it in the last 12 months.

Assoc. Prof. HIGGS: Yes, and that is the data that is kind of as good as it gets. I guess we are in a position where we are looking at sentinel populations of people who use drugs every day pretty much—that is part of and parcel of the work that we do. And I guess the harms associated with cannabis use really come from the crime associated with getting caught up in that stuff. But cannabis is kind of an add-on to the other things that they are involved in. And most people in our studies would say cannabis is like smoking. It is just a normal part of what we do. It is not a problem for us, whether that is a self-recognition thing or not. Whether or not we can get treatment that offers that—and obviously we heard about the lack of places for treatment—maybe more people would be encouraged into treatment, but not everyone wants it either, and you cannot kind of force people into treatment if they do not want it.

Ms CROZIER: Sure, but I think we have had such a big push in this country on tobacco and the harms of tobacco and we do not seem to have that same push in relation to the harms of cannabis. And I think there is a mismatch there in terms of—

The CHAIR: But also, if you look at the continuum of harm, cannabis is nowhere near tobacco.

Ms CROZIER: Well, is it? I do not know. I want to hear from them.

Assoc. Prof. HIGGS: Well, I mean, again, Shalini I think talked this morning about Yvonne Bonomo's work on the ranking of harms associated. And you know, alcohol and tobacco, our legal drugs, cause the most harm because more people use those, and they are better, I guess, documented in terms of that. Whenever you have got an illegal drug being used, it is much harder to find the people who are going to do the surveys in those populations of people, who are going to put their hands up and say they do it. There is certainly a lot of work going on in the alcohol and drug field about how hard it is to admit to using drugs if you have got a prominent position. Ash and I are not necessarily going to tell you everything about what we are doing with our drug consumption in the same way that you are able to do with alcohol, where we can talk about how much alcohol we had on the weekend and those sorts of things. So there is a lot of that stigma that makes it really hard to admit that you need help with it and to have treatment places offered up.

Ms CROZIER: Thank you.

The CHAIR: Great. If there is time, we can come back. David.

Mr LIMBRICK: Thank you, Chair. And thank you, Professor Higgs and Ms Stewart. I have got two questions, one each. Firstly, Professor Higgs, you said that you had done a lot of work with cannabis consumers, and we often hear from politicians about their grand ideas about plans for markets and this sort of thing. What do you think the cannabis consumers actually want? What sort of model do they want?

Assoc. Prof. HIGGS: Well, again, I mean, this is something I saw Harm Reduction Victoria had put in quite a comprehensive—that is a group that represents people who consume drugs. I do not know that we ask. In some of the work that I do I see people on the streets who income-generate by selling cannabis on the street. That is kind of just part and parcel of what they do. I have talked to them about how they would feel about us going down that track and doing them out of an income. They have talked about having opportunities to be able to work in shops like that.

We heard a lot about peer experts. In the cannabis social clubs there is a real model where you can have people who are consuming able to provide advice to other people, so you can get real life experience, I guess, about what drugs, which streams of cannabis are good at the moment and what you need it for—we know people self-medicate, using it to help with depression or with cancer pain. There is a whole range of ways in which it is used, so having that advice, I think, is important. But the main thing is to have experts in the same way that we have baristas these days to talk to people about the different kinds of coffee you can consume: 'Have you tried this?' We've got the new dripolator', those sorts of things. To have experts—people who consume cannabis—giving us that advice I think is a really good way to go. We have not really asked them about that, but I think it is an important part of anywhere we go with this.

Mr LIMBRICK: Thank you. Ms Stewart, on one of the slides that you presented before about the harms from cannabis I could not help but notice that almost all of the harms there seemed to be caused by prohibition itself rather than cannabis. Is it your view that most of the harm around cannabis is actually around prohibition? I think you mentioned something like 50 per cent of that $4 billion was just around the justice system.

Ms STEWART: Yes, I guess that is in relation to societal harms and harms to the economy and then harms to people that are caused by that prohibition and what happens for people who get involved in the criminal justice system. Pete said before as well that most of the people who use cannabis can use it in a way that does not create a huge amount of harm to them, and the population of people that do have a lot of harms is quite small. 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. I think they are probably a lot of the harms that may be—

Ms CROZIER: Have you got data on those things? I would be really keen to have that.

Ms STEWART: I mean, it would definitely exist, and we could provide something after the hearing, I am sure; we could put something together. But the harms in relation to use, as we said, are quite small. I think there are a lot of harms that surround that that do come with a subpopulation of people who use cannabis, and I guess that subpopulation is quite affected by criminal justice harms.

Assoc. Prof. HIGGS: It is definitely a dose-related response; so the more consumed, the more harmful it is going to be. Most people who consume it—the same way with alcohol—do not consume it at problematic rates. For those who do, then that is where the problems come. So the more you use, the more harms will be associated with that.

So what is it that we can do to reduce the amount of harms that come from individual use? You have probably been looking at the alcohol literature that shows that the amount of alcohol being consumed seems to have gone down over the years. There is a lot of work coming out of the La Trobe University Centre for Alcohol Policy Research that shows young people are not drinking like they did when we were all younger—not you, Ash, but the rest of us here—

Ms CROZIER: So that generation.

Assoc. Prof. HIGGS: Yes, exactly. And we are looking at what is happening in Canberra at the moment. The amount of alcohol harms that have been caused through that stuff has not been measured. It has been known about but has not really been measured. So I think there is something to be done around that. And self-education, the peer stuff—most people do not want to get trashed when they go out and have a few drinks, but we do see that in the city and at different nightclubs. What is it that we can do that limits that is what is important to think about.

Mr LIMBRICK: Thank you.

Ms WATT: Thank you, Ms Stewart and Associate Professor Higgs. I just had a question about the different models that you presented earlier and I just wonder if you could comment on some of the consumer assessments for participation in those different groups. What I mean is that we have got the social club models and then you have got the full open consumer market, so I just wonder, in terms of consumers engaging with those different models, are there assessments? Are there police checks? Is there a measure of different barriers to entry for participation in those different market models? I am interested in that if you have anything on that.

Assoc. Prof. HIGGS: Yes. My understanding—Ash has probably got a bit more detail—is that it really varies and we can design the models as we want to best fit. The local junior soccer club has 400 members but how many are active in that group? We know, for those of us who do voluntary work around committees and stuff, most of the social groups or the small NGOs that we are involved in are driven by a small number of people, so it is my expectation that that would be the same in the way in which cannabis social clubs work. You know, some of the work that I have read—you can have a monthly meeting where you invite guest speakers along and can consume cannabis, but you can also hear about the harms associated with those sorts of things. But not every member is going to go to those sorts of things. Some members are going to have different reasons for why they get involved.

There are obviously some issues around the cannabis, making them viable. Do you have to consume every month? Do you have to buy every month? We can set them up the same way in which we have wine clubs: you can put your membership on pause for a while or those sorts of things. I think there are a lot of existing things we already have whereby people can think about the kinds of models. We are being marketed to by those wine clubs. I do not know how many there are now, but Qantas Club comes with one now, and all of the different things that you can get. But thinking about how they work, talking to those people about how many members they have and how you look at those things I think are going to be worth looking at as well.

Ms STEWART: I think some of the models as well—with particularly the cannabis social clubs there are restrictions on memberships and how many people can be in a club. There are restrictions on the amount of plants per person within a club, so it is not just free reign. There is licensing. They have to be registered. In Uruguay I think every person who is part of a club has to actually officially be registered.

Ms WATT: Yes, it was in that point that I was interested.

Ms STEWART: So I think it would depend on the path that we went down, if that was something that was of interest. There are a lot of models for how different cannabis clubs work. I think also to your point, Uruguay actually does not use just cannabis clubs; they have cannabis clubs, they also have a pharmacy model, they have a model where you can use your own—it is kind of a bunch of those models that we saw on the screen that are in play there.

Ms WATT: I just wonder if there are any sort of groupings around medical needs, so it could be sort of a cancer grouping club.

Assoc. Prof. HIGGS: There are those for sure—social clubs that just exist for people who need it for cancer pain or for HIV, those sorts of things. It is really important to kind of look at. I guess our biggest take-home message is that we have got to get it out of the illegal market, whatever way you can do that, to try and make it more regulated. You are not going to stop people—I think it would be difficult to stop it being used in the illegal market anyway. But if we can regulate it in some way and people know what they are actually smoking or eating or whatever it is, then those are the sorts of things that are going to help with reducing the sorts of harms. The crime costs alone are going to be phenomenal. The expunction of sentences: I am assuming cannabis offences are going to be one of those ones that can be gone. Do we have to wait 10 years to get a cannabis offence off? That would be one thing that we would really need to consider if we go down that model: thinking about then backtracking for people who have been charged with cannabis offences.

The CHAIR: Yes, that is right, as we have seen with other crimes, such as homosexuality, where we did expunge those crimes from records. Thank you. Please say no, but in looking at the New Zealand legislation—and obviously when you wrote this submission it was prior to the referendum—that was quite a different piece of legislation to anything we have seen in the US, Canada, Uruguay or the Netherlands, and in your opinion was that kind of heading towards the sort of mark?

Assoc. Prof. HIGGS: Again, it was one thing we used in our case study for uni for the students to kind of think about: what are the different sorts of models? It was at a prime time in second semester where people could use that. They had not had the vote either. My feeling was, without knowing it in huge detail, that it seemed like a sensible way. I was surprised it did not get over the line, but I was not in-country to hear all of the back and forth.

The CHAIR: I think it put limits on THC content, limits on advertising, obviously licensing, testing and things.

Assoc. Prof. HIGGS: All of those things seem sensible, yes.

The CHAIR: I was really interested in what you need for a comprehensive evaluation of cannabis policy, and I think that is something that should be really important in anything that we go with. Do you know if the ACT has any form of framework?

Assoc. Prof. HIGGS: I actually do not off the top of my head.

Ms STEWART: I actually do not know either, no.

The CHAIR: That is fine.

Assoc. Prof. HIGGS: You would assume that they would have.

The CHAIR: Yes.

Assoc. Prof. HIGGS: You would hope that they would have, yes.

The CHAIR: You would hope.

Assoc. Prof. HIGGS: But, again, just exploring that with them would be pretty easy to do.

The CHAIR: That is right, and we will speak to them. I am wondering, could you expand on what you believe would be the kind of things that would need to be in that framework?

Ms STEWART: Yes. I mean, from the perspective of someone who analyses health administrative data I think really some massive improvements in the way that we collect data and the coding and things that we have around any harms in relation to cannabis or any health datasets, so people presenting to emergency departments for cannabis use or harms, ambulance call-outs, hospital admissions, primary healthcare. All of that stuff really needs to be improved so we can monitor that quite well. I think that is part of that evaluation and monitoring framework as well. Definitely anything in relation to driving under the influence of cannabis needs to be monitored quite well, and I think that was touched on this morning in one of the hearings.

I think some research on people who use cannabis is really required. I mean, I am kind of doing a bit of a plug I guess for us at the Burnet, but we do have these longstanding projects for community groups and prison-based recruiter groups of people who inject drugs. I think a longitudinal cohort study of people who use cannabis is really important, and it is something that would help us in our evaluation monitoring of such use and changes in legislation.

The CHAIR: Even just that question of in the ACT who is growing, who is still purchasing illegally. It would be interesting to see those patterns and see the use and things like that in a framework.

Ms STEWART: Yes.

The CHAIR: Are you aware of any kind of evaluation frameworks in any other jurisdictions?

Assoc. Prof. HIGGS: They must be doing stuff in the US. We see a lot of the published papers. There must be other work that is not published as well that is being collected. I guess part of the problem is thinking about just stuff that you see in peer-reviewed literature, which is obviously two, three, four or five years behind when the data was actually collected and those sorts of things. But I would suspect listening to the Americans this morning that they would have stuff in place. We could certainly provide some advice on things that you might want to think about in terms of getting that in place. I know that for the work of the injecting room in Richmond, the cohort that we did, we were fortunate enough to be able to have pre-injecting-room data and then post-injecting-room data. There are ways in which we could use the existing data, our Big Day Out data centrally collected from young people since 2005. It is a particular group of young people, those who attend music festivals, but they are probably the ones who are going to be more at risk of consuming than ordinary school groups. You do not want to just have a population sample necessarily. We can pick that up through the national drug strategy household survey.

The CHAIR: Yes, so more of those sort of sentinel groups where you can see trend changes.

Ms STEWART: The surveillance systems that we have in Australia as well, so our EDRS, or the ecstasy and related drugs reporting system, and the IDRS, or the illicit drug reporting system. I mean, obviously their sentinel samples each year of people who do use drugs, but even to monitor market changes would be really interesting if there was a change in legislation—to be able to look at that over time. Some of them have been going since the—

Assoc. Prof. HIGGS: 2000s.

Ms STEWART: 2000s. It has been a while, so that would probably help us monitor some of the changes that come in and whether or not people in those subsamples are accessing their cannabis by different means.

The CHAIR: Yes. Kaushaliya.

Ms VAGHELA: We also heard previously from the other presenter, and you mentioned in your slide the $4.5 billion it cost us. Currently that is what it costs us. So we are just looking at the impact in terms of dollar value. We also heard that legalising it could also increase the use. We are still not 100 per cent sure what the use of cannabis could be on mental health and physical health. We heard that it could lead to psychosis and so forth. That could lead to more hospitalisations. So while we are trying to save money from the justice system, we could be spending more money in the hospitalisation and health systems. How do we know that by correcting one we are not creating a problem in the other system?

Assoc. Prof. HIGGS: Well, we do not until we do it I guess, ultimately. If we have some control over being able to look at what is actually happening, then we have got a better chance of being able to control for that. I mean, knowing what you are consuming as opposed to not knowing at the moment is going to be helpful. So people will be able to say that they have had this. We know what the THC content is. We are not going to be able to stop people being curious about things. It will be new for us. The ACT will give us some guide. The American models where it has gone all open slather will give us some guide. In Canada now it is recreationally available—those sorts of things.

Ms STEWART: I guess it is also hard to measure at the moment because it is not a system that we have in play. But if the stigma was not there and people did have the chance and the opportunity to seek help before it

got to a point where maybe they ended up in hospital systems, that could have an impact on not ending up there in the first place. We cannot measure that. We do not know yet. It is possible.

Ms VAGHELA: Yes, we heard about destigmatising. That could also help.

Assoc. Prof. HIGGS: But also alcohol. It is like most people who have a problem with alcohol are not seeking treatment for it. Is that because of stigma, of not wanting to admit that you have got a problem? Is it because of the lack of places? We do not actually know that very well either. Is it because some people are just going to be at that really hard end? What can we do to help them as much as possible?

The CHAIR: Georgie.

Ms CROZIER: Thank you, Chair. Just to go back to some of the issues that I raised earlier in relation to the effects, I think we heard this morning that with CUD, cannabis use disorder, one in three will have experienced that and that it can lead to some very adverse health and mental health impacts. We are talking this afternoon around what can be done and a framework and there is not enough data and the ACT has not got the model right, and it just seems to me that we need to be looking very, very carefully at what is happening before we do any of this. Admittedly there are so many unknowns here. But what we do know is that in some of these areas that have had legalisation and decriminalisation for some time they are turning around and going backwards. They are not allowing their local communities to sell, to have cannabis shops open and things like that, as we heard this morning.

My point is that because we do not have all of that data—and you have gone out there and got your data from those groups that you know are going to use, and they do use in those areas—should there not be a more strategic focus on getting that data and really focusing on the health impacts, getting the data off the EDs and knowing what is going on in our hospital departments? We know from lockdown and from the impacts of what is going on—the police will tell you that they are having to spend a lot of time in emergency departments with people with mental illness. Do you have a view on how we should be getting more data and looking at the health impacts of drug use across the board before we perhaps go down an ACT model or any other model that might be considered?

Assoc. Prof. HIGGS: Gosh, it is—I mean, my gut feeling is that the number of people who have problems with it is really at that end. So how do we actually monitor them? How do we get information from that population in particular?

Ms CROZIER: But you have said that they are in the prisons. You know where they are.

Assoc. Prof. HIGGS: But not all of those people have problems as well. Some of them do, for sure. I mean, we can ask them what is going on. I guess it is what do you want to know in terms of that stuff, because our hospital data will tell us how many presentations we get in the same way that it does for paracetamol. People who have too much paracetamol—

Ms CROZIER: That is right. We have that data. That is my point.

The CHAIR: We have got it.

Assoc. Prof. HIGGS: Yes.

Ms CROZIER: That is my point, and it is large. I mean, the impacts are large.

Assoc. Prof. HIGGS: It is, but it is for paracetamol. I mean, it is just—

Ms CROZIER: No, you cannot compare it with paracetamol.

Assoc. Prof. HIGGS: Well, I think in terms of—

The CHAIR: Well, I do not know. I mean, I think we have got—

Assoc. Prof. HIGGS: I think the admissions for paracetamol—

Ms CROZIER: I could compare it with coffee.

Assoc. Prof. HIGGS: Yes, I know, but people who overdose on paracetamol—I was surprised when I looked at the data. Hundreds of people a year are being admitted for those sorts of—and that is a drug that you can buy, you know, for—

Ms CROZIER: But they might have underlying issues as well.

Assoc. Prof. HIGGS: They might—

Ms STEWART: So might people who present for cannabis use as well.

Ms CROZIER: True. I am not disputing that.

Assoc. Prof. HIGGS: I guess what you are trying to get at is: how do we best serve the population who are most harmed, and how do we get information from that population?

Ms CROZIER: How do we help them?

Assoc. Prof. HIGGS: It brings up David's point about, 'Well, let's talk to those people who are using that drug, and let's think about creative ways in which we can get them to tell us what benefits they can have'. They have not had really that opportunity. It is hard to do when it is an illegal market, those sorts of things. Thinking creatively about how we might want to use the information that we can gather from that population itself is going to be useful. I mean, my gut feel would be that of the people that we speak to in our studies, most of them do not have a problem with cannabis. Even though they use cannabis, most of their problems are related to other drugs that are a lot more expensive than cannabis and have other kinds of harms associated, like heroin or methamphetamine.

But again, that is a population that are using those drugs regularly and we do not really know of people who are not using those drugs regularly but do use them and do not have problems. It is not kind of an easy thing to find out about.

The CHAIR: I was just thinking about that sex, drugs and rock'n'roll. That is actually young kids who are using drugs and are using cannabis?

Ms STEWART: I do not know. Do you have to be?

Assoc. Prof. HIGGS: No, you just have to be a young person who is attending a music festival.

The CHAIR: Yes, sorry. Out of the percentage who did report using cannabis, was there a percentage that reported that they felt that they had a problematic use?

Ms STEWART: I am really not sure that we asked, but we can check.

The CHAIR: Because I think that would be interesting.

Assoc. Prof. HIGGS: It is looking at health use, it is looking at pornography and those sorts of things. Yes, we could definitely. You could approach the Burnet and just say, 'We're interested in the sex, drugs and rock'n'roll cohort. What are the sorts of questions?'—because that is an annual survey for them—'We'd be interested in knowing about any harms associated with cannabis, can you add that as a question?'. That might be something that you would want to consider doing.

Ms STEWART: Which could also be the case for the ecstasy and related drugs system and the illicit drug reporting system. They are sentinel surveys and there are changes that happen each year, so it is something that we could add to the survey, to ask that population of people each year. There you go.

The CHAIR: Yes, great. Just today we have seen a huge variety in the statistics around problematic use. It has gone from 2.6 per cent to 30 per cent.

Assoc. Prof. HIGGS: It is how do you measure that as well. Is it an individual self-report problem, is there a scale that you kind of use that you tick that says, 'If I wake up in the morning and need it and tick that box, does that mean I've got a problem?'. I guess those sorts of scales, are they done consistently with populations. We do

not use those scales for cannabis in these surveys that we do generally, but they could be asked of people, and I assume they are being asked of people in treatment. Sam may have talked about—

Ms CROZIER: Medical journals are talking about this issue. They must be getting their data from a whole range of different avenues. So I suppose they are collating that and putting it together, too. So there is a lot out there. I think that is the point, isn't it?

Assoc. Prof. HIGGS: Yes. It is your research officer's job. They have got a lot of work to do. Good luck.

The CHAIR: They are madly drafting that letter to you. David, did you have any further questions? Very good. Sheena?

Ms WATT: No further questions from me.

The CHAIR: Kaushaliya?

Ms VAGHELA: In the places where cannabis is legalised, we also heard there are still illicit shops selling cannabis because it is really hard to regulate and know sort of how they are operating and where the shops are. So even if it is legalised, you still have to have regulations on who is selling, what amount, how much. So that will take resources and some sort of regulation to see how that runs. Illicit shops are not going to go away anyway, because they will probably be selling at a cheaper price than what it is being sold at in a regulated place. So illicit shops are not going to go away. That is what we heard today.

Assoc. Prof. HIGGS: Yes. I mean, it may not, but there are not that many places you can buy alcohol illicitly, are there? There are some. You can buy tobacco illicitly and usually it is in the same shops that you buy it legally, but, you know, there are ways in which that happens. I mean, we need to think about how that sort of happens. It is very hard to get illegal prescription medication, but it does happen, you know—the internet. Of course we are going to be able to do that, but the tighter you try and make your kind of controls the less I guess scope there is to do that. It is your job, I guess, to think about different ways in which that model might work.

Ms STEWART: These things take time, as well. I think it was actually in the NDRI's submission. I think they have reported that in Uruguay like five years down the track after they had implemented what they implemented I think it was about 50 per cent of people who were buying their cannabis through legal means. It does take time as well to shift that market. It would not happen immediately if something was implemented.

The CHAIR: Yes, and I think we will hear this afternoon again from the ADF, who also have looked at that situation.

Assoc. Prof. HIGGS: Some of the education programs that ADF are really involved in—CLIMATE Schools is one that I think will be very interesting for the committee to kind of take note of. We are not across the education. We have not focused on that in our submission, but I think that is a really important kind of area of work, how do we do good drug education as well. I mean, we do it a bit at university, but it is one subject in an overall degree and it is not really focused on drugs as such.

The CHAIR: No, and I think they made the excellent point that people who are working in AOD could probably be some of the best people to be providing preventative education because they have the most knowledge around the substances. Sheena.

Ms WATT: I just have a question about the taxation models with legalisation, and I see here we have got a US model which is around the price of the product and then there are others that are weighted by THC content. Are there any other models for consideration in terms of taxation that are worth knowing about, frankly?

Ms STEWART: To be honest, I am not across taxation, but—

Ms WATT: Is there someone that you could recommend that would be?

Assoc. Prof. HIGGS: I mean, the US group—is it Caulkins—and those guys I think have done a lot of work—

Ms STEWART: Yes, Caulkins and Kilmer.

Assoc. Prof. HIGGS: Caulkins and Kilmer—I am sure they will be referred to in a number of submissions, but—

Ms STEWART: And they put that report together for Vermont. It is a massive report.

Assoc. Prof. HIGGS: But the different types of cannabis are also going to be important to look at—

Ms WATT: Yes, okay. That is what I thought.

Assoc. Prof. HIGGS: so whether or not you have edibles, whether you only have cannabis heads, leaf—how you kind of make that available. The harms associated with edibles are going to be obviously increased in comparison to people who choose just to smoke or vape their cannabis. Those sorts of things are important to kind of consider as well.

Ms WATT: I suppose that is another model then. By product type rather than by THC or price is actually a model that looked to that.

Assoc. Prof. HIGGS: Yes. I mean, again alcohol is going to tell you what is kind of best. There may be different ways. The higher the purity, the higher the taxation, but we had a lot of trouble with that with our UDLs and those sorts of things.

The CHAIR: That is right.

Assoc. Prof. HIGGS: We can learn from those experiences I guess, because they have been monitoring the harms associated with that price and how that was impacted. We don't do it for cigarettes, I don't think. It is a flat tax; it does not matter how much nicotine is in your cigarettes. We don't do it in that way, we just have a 'one overall' thing, so you kind of get a better bang for your buck if you are smoking 12 milligrams compared to light cigarettes or whatever. So those sorts of things need to be thought about for sure.

Ms STEWART: And I think a lot of this is covered more clearly in this report. It is by Caulkins and Kilmer and a group of others and it is called *Considering Marijuana Legalization: Insights for Vermont and Other Jurisdictions*. It is quite a big report, 200 pages. It would be worth having a look at.

Ms WATT: That is in your reference list, I assume.

Ms STEWART: Yes.

Ms WATT: Great. Thank you for that.

Assoc. Prof. HIGGS: Thank you.

The CHAIR: Thank you. That was terrific. That was a great session. Thank you so much for the work.

Assoc. Prof. HIGGS: I look forward to seeing the results. There are a number of months to come of hearings.

The CHAIR: Yes, yes.

Assoc. Prof. HIGGS: 1422 submissions to get through.

The CHAIR: That is right. And we will certainly be speaking to the ACT and just seeing what sort of framework they are using, because I did hear some reporting of roadside drug testing. I did hear results of a few of those just recently in the media.

Assoc. Prof. HIGGS: The medicinal cannabis cohort as well. I think there is one—the University of Sydney's Lambert institute—that is doing all that work. They have probably got some interesting work that is coming out of that because I think they are showing that people who are choosing to use their cannabis for medicinal purposes, most of them are still getting it through the illegal market.

The CHAIR: They just cannot afford it. That is right.

Assoc. Prof. HIGGS: So monitoring that now that we have got medicinal cannabis available in Victoria is worth doing as well.

The CHAIR: Yes, thank you. Now, we will give you a transcript in the coming days, so please have a look at it and make sure that we did not misrepresent you in any way. Thank you, and good luck with the rest of your PhD, Ashleigh.

Ms STEWART: Thanks.

Assoc. Prof. HIGGS: Thank you. Great to see you.

Witnesses withdrew.