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

Dr Erin Lalor, Chief Executive Officer *(via videoconference)*,

Ms Jill Karena, State Manager, Victoria and Tasmania, and

Ms Laura Bajurny, Information Officer, Alcohol and Drug Foundation.

The CHAIR: Thank you, everyone. Welcome back. We are very pleased to be joined by Laura Bajurny, Jill Karena and of course Erin Lalor from the Alcohol and Drug Foundation.

Before I begin with some of the formal words, I would just like to quickly introduce you to the committee. We have Sheena Watt, Kaushaliya Vaghela, Georgie Crozier and David Limbrick, and as you know, I am Fiona Patten, Chair of the committee.

Just to let you know, all evidence taken at this hearing is protected by parliamentary privilege. That is provided under our *Constitution Act* and also under the Legislative Council standing orders. Therefore any information that you provide today is protected by law; however, any comments repeated outside may not have the same protection. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

As you can see, we are broadcasting live from our hybrid Zoom hearing, and we are also recording this. You will receive a transcript in the coming days. I encourage you to look at that and check for any errors, because ultimately it will be on our website and form part of the committee's final report.

We would really like it if you could make some opening remarks, and then we will open it up for committee discussion.

Dr LALOR: Thanks, Fiona. I will start by making the opening remarks, if that is all right. I would like to start firstly by noting some of the facts about cannabis and its associated harms and to point out that the majority of young people do not and have not used cannabis. Eighty-four per cent of young Victorians, those aged 12 to 17 years of age, report that they have never tried cannabis. Cannabis use is highest amongst the 18- to 29-year-old age group, but use then starts to decline as people get older. We do see higher rates of cannabis use in some populations, including amongst Indigenous people.

It is important also to acknowledge that cannabis use is not without risk and that there can be health and social consequences associated particularly with heavy or consistent use. Regular or prolonged use can lead to dependence and withdrawal symptoms when ceasing use and is a risk factor for mental health impacts such as anxiety, depression and experience of psychosis. People who are dependent on cannabis may experience negative impacts on their work, family and other social relationships. Additionally, the stigma associated with cannabis use and particularly with cannabis dependence can prevent people from asking for support, and this can lead to internalised feelings of shame and worthlessness.

We know that adolescents are at greater risk of harm because the adolescent brain is undergoing significant development, and the use of any psychoactive drug, including cannabis, risks interfering with those processes. Some of the research suggests that cannabis use in adolescence is a risk factor for experiencing mental illness and that young people who have experienced trauma, have a family history of mental illness or possess other biological risk factors may be particularly susceptible to experiencing adverse effects from cannabis use.

Now, some people fear that cannabis use increases crime in our community, but it is important to understand that this is not the case. Most cannabis-related offences are for possession, and in relation to violence, nearly twice as many people report that they have experienced more alcohol-related incidents than illicit drug—and that is any drug—related incidents. But there are implications of cannabis use for road safety, and it is important that we reduce the prevalence of driving while impaired. A recent study showed that illicit drugs were present in 12.7 per cent of crashes in Victoria, although this does not necessarily mean that it caused them. And our current drug driving tests are structured so that they do not necessarily address impaired driving. The substance may be present, but it may not be impairing driving.

I think it is also important to note that despite half a century of concerted efforts—including the very best efforts of state and federal police—to disrupt and eliminate supply, cannabis remains the most commonly used

illegal drug in Australia. An unfortunate consequence of these efforts has been the criminalisation of people for their personal use and possession of drugs. Often their interaction with the criminal justice system and the resulting impact on employment, housing and travel are more harmful than the drug use itself.

The strategies to reduce cannabis-related harm are varied and complex, and today we have got an opportunity to talk about many of these. These include the prevention programs that the ADF runs, which are really about strengthening protective and risk factors and looking at community-led efforts like those of the local drug action teams and models like Planet Youth from Iceland and Communities that Care from the US, as well as programs like the Good Sports program. Evidence in schools, including the potential for harm if evidence-based approaches to education are not used, is something else that we can talk with you about, and also mass media campaigns, including those that employ shock tactics, which are not effective, and those that seek to reduce stigma. We have done a lot of work in looking at how best to communicate and send messages to that 18- to 29-year-old age group, the group that most frequently uses cannabis, and we run many programs that seek to reduce stigma.

Then we would happily talk with you about drug law reform and the opportunity to reduce harm by reforming policy around drug possession, drawing on experiences internationally, particularly in Canada and in other jurisdictions, especially the ACT where we have seen cannabis possession laws changed with no resulting increase in ED presentations or cannabis use. We have undertaken research into effective prevention programs and how best to deliver information to people and reduce stigma, and we have undertaken a number of surveys with family and friends of people who use drugs.

We can also talk about the work we have done in developing resources for health professionals and others to start to address stigma and about our prevention programs and our drug information programs. So I am going to pause there and just hand back to the committee for any questions that people might have or need from me or Laura or Jill.

The CHAIR: Great. Thank you very much, Erin. We appreciate you all taking the time to join us today. I will let Kaushaliya Vaghela start the committee's questions.

Ms VAGHELA: Thanks, Chair. Thanks, Dr Lalor, and Jill and Laura, for your submission and your presentation. Today we have heard from presenters supporting the legalisation of cannabis use and opposing the legalisation of cannabis. What you are suggesting in your submission is more of the preventative approach, which we have also heard with previous speakers as well, but at the same time you have used the words 'evidence-based' investigation before we go and do research on whether it is the Portugal model or Planet Youth. Does that mean that we do not have enough data or statistics which show or say what are the actual impacts of the use of cannabis on young people? Is that why you are suggesting that—because there is not enough data to suggest which way we should go? I know you have also mentioned that youth should not be punished if they use because it is counterproductive. I just want to know, is this the reason why you are saying it has to be evidence based?

Dr LALOR: I can start the response to that and then perhaps hand to you, Laura. There are two components to the evidence basis we talk about. The first component is the evidence for prevention programs amongst young people in particular. There is some really good evidence from international programs, like the Planet Youth program in Iceland and the Community Care program in the US, that shows that when we use data-informed approaches that seek to strengthen protected factors amongst young people, we do see reduced alcohol and drug use. Those programs are well proven, but it is not understood necessarily how we can expand their reach in Australia.

When we talk about wanting more evidence, it is really around the impacts of policy change on possession of cannabis. We know from the international experience that there are a whole lot of different models that can be used when we talk about regulating or legalising cannabis. We have seen some models that were considered in the referendum in New Zealand, we have seen models in Canada that are not commercial models and models in the US that are commercial models. The data around those is all very, very different, and it can be used to argue either side of the coin, depending on the position that someone wants to put forward. I think we are learning a lot more, and Laura can talk more around what we have been learning around the Canadian model. In the last 12 months we have started to see more evidence around the nature of the impacts of change that might legalise cannabis versus simply removing criminal sanctions for people who are in possession of cannabis, so a decriminalisation model. Laura, did you want to talk a little bit about the Canadian experience?

Ms BAJURNY: Yes. I would also like to point out that they do not have to be mutually exclusive. I think that investing in prevention is critical no matter what model of reform we are looking at. Whether it is a decriminalisation model à la Portugal, whether it is legalisation à la Canada, we should be investing in prevention in any regard.

In terms of the Canadian statistics, what we found in the 2019 Canadian student tobacco, alcohol and drug survey is that post legalisation the use rates of cannabis between 12 and 18 years have remained quite stable, and incrementally the first instance of use is starting to go up. People are understandably concerned that if something is decriminalised or legalised, are we going to see more young people using it? And what we are seeing out of Canada is that that is not the case.

The CHAIR: Great. Thank you. Georgie.

Ms CROZIER: Thank you very much. And thank you. It was really interesting to get your perspective on that. I would like to ask about Planet Youth and the experience and what your understanding about that program is. I am very concerned with or my interest is about the mental health and wellbeing issues for people who do take cannabis, but I am very keen on understanding from your perspective that program, if you would not mind explaining it to the committee.

Dr LALOR: I can talk to Planet Youth as well. Planet Youth is a program that has been running in Iceland for more than 20 years. They started it when they were recognising that the youth in Iceland were amongst the highest users of cannabis, alcohol and tobacco in Europe. They had attempted an approach of 'Just say no' and it was not working. It was not shifting use amongst young people. They looked closely at the research that they were doing that considered what were the characteristics of the young people in Iceland who were more likely or less likely to use alcohol, cannabis and tobacco. What they found is that those who were less likely to use substances had very strong relationships with parents, they were connected into a positive school environment, they had peers that were unlikely to be using alcohol and drugs and they were protected through the larger regulatory environment in which they lived—the community environment in which they lived.

So what Iceland started to do was to introduce activities that really strengthened those protective factors. So they worked with parents to get them to understand the importance of positive role modelling, of understanding where the kids were late at night, of knowing the parents of their children's friends. They worked with peer groups and they worked with schools, and they took a whole-of-community approach to prevention. They found enormous differences. Over the last 20 years they have shifted from the highest users of substances in Europe to amongst the lowest, and they have now started trialling that program in other parts of the world; they have introduced it to into South American countries, into parts of the US, and into many other European countries, and they are seeing similar declines over time.

Ms CROZIER: Sorry to interrupt. Would you have that data on where that program has gone into those additional countries?

Dr LALOR: We can certainly share with you some of the information that we have got from them on effects in other countries. Absolutely, we can send that after the presentation

Ms CROZIER: Thank you.

Dr LALOR: The Australian trial: we, through our local drug action team program, are now piloting it in sites in New South Wales and in South Australia. The surveys were done there in October 2019, and this year we will do the second lot of surveys. The South Australian government has committed to extending the pilot in South Australia for five years. The pilot in Australia, or the process, requires opt-out consent. So it means that all young people in a school complete the survey, and if they do not want to do it or their parent does not want them to, they opt out. Most requirements for education departments in Australia require opt-in, where parents are required to say, yes, their children can participate in that particular survey, and that means that we can sometimes miss out on information from kids who are most in need.

Ms CROZIER: So you would recommend that opt-out system—consent system? Is that what you are saying?

Dr LALOR: It is a requirement of the Planet Youth approach. We were not able to do the pilot in Victoria because we were not able to get approval for an opt-out approach to consent. It has been run in South Australia and New South Wales only at this point in time.

Ms CROZIER: Thank you. That is very interesting.

The CHAIR: David.

Mr LIMBRICK: Thank you for appearing and for your briefing earlier this week. It is interesting—one of the things that we have heard a number of times is ways to raise the age when adolescents first access or initiate their use of drugs. What you mentioned with the Canada model, the success that that has had in somewhat raising that: what do you think is the root cause of that? What has actually caused that to go up? Is it just coincidence or are there reasons there that we can draw on?

Ms BAJURNY: It is so incremental. I would not say that there is directly a cause. I mean, certainly in Canada, especially since legalisation, there have been broad awareness programs, especially running in schools, to make sure that people understand that cannabis use is not without risks and especially for adolescents. There is a growing consensus that cannabis use can be very harmful to adolescents. That might be part of it, but again it is such an incremental increase I would be hesitant to say that the awareness campaigns have made that massive of a difference. But I do believe that evidence-based drug education in schools can have a significant impact, and the research in Australia has borne that out, in the use not only of cannabis but also of alcohol in hopefully preventing and delaying the uptake of alcohol and other drugs by young people.

Mr LIMBRICK: Thank you. You probably saw this question coming, but I was going to ask about what are the benefits of the prohibition regime that we have in Australia at the moment. Are there any benefits that would be removed if that regime was to be taken away?

Dr LALOR: I think it is fair to say that it is well recognised internationally that prohibition is not having the impact that everyone thought it might have. We have not seen drug use stop when prohibition has been in place. Even if you think about the time when prohibition was introduced for alcohol, it did not stop people from using alcohol either. We know that prohibition actually increases the stigma that people who use drugs experience and that stigma is a major barrier to help-seeking behaviour; it actually increases harms and does not reduce harms. The position of the Alcohol and Drug Foundation is that we need to look at drug use as a health issue, not a criminal issue. We want to respond to people who use drugs with compassion, and we know that where we have removed criminal penalties for possession of illicit substances we have not seen an increase in use; we have not seen an increase in harms. You only need to look at the ACT to see an example of that in Australia, where laws were changed in the ACT to allow people to grow cannabis within their own home: there was, in that 12 months following the introduction of that legislation, no increase in emergency department presentations; police said it was not any more difficult to enforce; and we certainly did not see an increase in use.

Ms BAJURNY: And just to add to that as well, recognising that oftentimes the interaction with the criminal justice system that occurs because of the criminalisation of personal use and possession is far more detrimental to the individual than the drug use itself.

Mr LIMBRICK: Thank you. I have one other question I would like to ask. We have been looking at lots of different models around the world, in countries and various states—within the US, for example—and they have all tried different approaches. If Victoria was going to go down this path of decriminalisation or legalisation, what sorts of mistakes or missteps have other countries or states made that we could learn from and not make? I realise there are probably a lot, but, yes.

Ms BAJURNY: You would almost have to approach it model by model, because I could easily point out to you all of the missteps that happened in Canada, especially in Canada trying to find that balance between meeting the demands of buyers, right, in a commercial sense but also having the public health lens and trying to find that balance between enough tax but not too much tax and regulating things like THC content while still meeting the needs and demands of consumers. It is a really tricky and delicate balance, and they are still hammering out the details. There is a really great paper that was written by Transform Drug Policy Foundation that I would love to send you that looks at it in detail.

Mr LIMBRICK: Okay.

Ms BAJURNY: I would say that the primary issue with decriminalisation over legalisation is that the issue of drug trafficking remains in terms of cannabis offences.

When we talk about decriminalisation, we are not advocating for the removal of criminal penalties for drug trafficking. That should absolutely still be a criminal matter. So that is an issue that does remain under a decriminalisation model, whereas under legalisation that obviously ceases—well, it becomes less of a problem. As Canada has shown, it can still be a bit of a battle to push people into the legal market, but they are finding improvements now.

Mr LIMBRICK: So this balance that you are talking about is about: if you have a very high tax and high regulation model, then for those products that are banned or whatever that demand will still be met but by the black market still. This morning we heard that if you had a totally free market you would not have that organised crime element but you might have other problems.

Ms BAJURNY: Yes, and it comes back to how you find that balance, because then with a totally free market you are looking at probably the sale of more harmful products. If you were talking to some American representatives, they might have spoken about things like the harms from concentrated cannabis products and how they are associated with significantly more health impacts. So it is a delicate balance. I am not an economist. I would absolutely bring one in to help me out with that though.

Mr LIMBRICK: Yes. Thank you very much.

Dr LALOR: I think the other thing I would add is that we can look to other countries around the models that they have used to legalise cannabis to look for lessons learned, but we have actually also got a legal drug here in Australia that we have lessons to learn from as well, and I am referring to alcohol. So when there are commercial drivers, the more of the product that you sell, the more money is made, and that can result in increased harms and targeting marketing to people who may be most at risk of harm. Certainly consideration for how we seek to ensure that children are not able to get access through a legalised model is important to consider, and also consideration of what you might be able to do to support people who are using it in a harmful way and to make sure that people understand the early signs of potential dependence with illicit substances. So even in the alcohol space I think we have got lessons to learn in Australia.

Mr LIMBRICK: Thank you very much.

The CHAIR: Thank you. Sheena.

Ms WATT: Thank you, Dr Lalor and colleagues, Jill and Laura. I have a couple of questions, but I am going to start with the first one, which is around primary prevention programs. We have not talked about that today, and I would really kind of appreciate an opportunity to hear from you on what you see as the effectiveness, what are the programs that you deliver and what has your evidence shown after what I think is many years and many clubs' engagement with these programs, because having previously worked in sport I know that they really are an important lever of community attitudes and whatnot—and behaviours. So, anyone? I am not sure who to send that to, but I would not mind hearing from you about your primary prevention programs.

Dr LALOR: I will start, and then I will hand to Jill, who can provide a little bit of detail. We do run a number of primary prevention programs. One of them is the Good Sports program, and one of them is the Local Drug Action Team program. The Local Drug Action Team program really brings communities together to identify the issue that they want to address, and then they develop a plan of action that starts to strengthen protective factors. The model is not dissimilar to the Planet Youth or Communities that Care models, but it is in Victoria not informed by data. So we have got a number of communities that are coming together in collective action to develop and deliver initiatives within their local communities to prevent alcohol and drug abuse, particularly amongst young people.

The Good Sports program has been around for 20 years. It had a focus on alcohol and tobacco in the early years, and in recent years we have introduced components that are looking at helping clubs support people who may be using illicit drugs and direct people to appropriate support and information. But the other thing about the Good Sports program is we know that participation in community sport is a really strong protective factor, and the more we can engage kids in positive club culture, the less likely they are to use illicit drugs. And Good Sports clubs have greater participation than non-Good Sports clubs, particularly amongst young people and

amongst women. So Good Sports not only changes club culture around alcohol and drugs but it also encourages people in community to participate in sports, which is a great outcome.

For an example of some of the local drug action team activities, I will hand over to Jill, who can describe a bit more to make the program a bit more real than I have just described it.

Ms KARENA: Thanks for that, Erin. I will just start by saying—just to give you a sense of the scope of what we are talking about—we have got about 55 local drug action teams in Victoria and that is spread through metro and rural areas, and we have got almost 3000 Good Sports clubs, and again that is right across Victoria. So those programs basically focus on, as Erin mentioned, increasing protective factors and reducing risk factors, delaying the onset of AOD use and experimentation, harm minimisation and also facilitating local partnerships to create and sustain change for the long term. And we do that through the adoption of evidence-based approaches and trialling and building new evidence. Evidence on new approaches that will work is a really important part of these programs, and co-designing action plans and developing partnerships to maximise impact is also a really big part of these programs.

As Erin mentioned, the evidence shows that there is a range of factors that prevent AOD harms in young people. So these are the things that we focus on in these programs. I will just quickly run through them again: positive relationships with parents and other family members are really important; enjoying and completing school or moving through to an employment pathway is also really important; connection with positive adult role models outside the home is a critical one; developing future-oriented recreational pursuits, so finding something positive for them to do when they are not at school or at home; and living in communities with lower levels of drug use. So when you think about those principles, they basically form the core of the local drug action teams and the good sports programs.

So I was just going to give you a bit of an idea of the kinds of activities that some of our local drug action teams do: some of them focus on encouraging young people to stay engaged in education, and that could be working with employment or areas of employment in their local communities to give them training or pathways; developing leadership skills and positive role models, and that can be peer based or adult based; increasing employability, again looking at different models of training and skills development that will assist them in finding work; and deepening connections with culture, as we have a number of LDATs that are either First Nations based or in CALD communities, and deepening the connection to culture is a really important part of providing protective factors for those young people. Peer-support projects—there are lots of those across the LDAT teams. There is increasing family and community connectedness in a whole range of ways, that could be arts based—again it could be training or other kinds of projects. Reducing stigma is a really big one across a lot of the LDAT programs. Reducing social isolation and loneliness, particularly in some of those rural and regional areas, is a critical element of the success of some of our LDAT teams. Increasing parental involvement, as Erin mentioned, is a really critical one, and a lot of our LDATs focus on how to bring families together in a whole range of ways. Increasing positive leisure activities in some of those, particularly during COVID, has meant looking at how you move some of those leisure activities onto an online platform so that young people are not left behind. And there is building knowledge around AOD and its harms in lots of different ways, and some of that is games based. They can be education programs or actually activities that they run.

So there is a huge range of activities, and every community is a little bit different in the way they approach it. And I think a really critical part of how we do local drug action teams is actually working with the local communities to a design a program that is going to work in that community, for that community, and that is going to be sustainable in the longer term.

The CHAIR: Great.

Ms WATT: You started on it, but it was around the protective factors around culture for Aboriginal and Torres Strait Islander communities and also culturally and linguistically diverse communities. Have you done particular research into that as part of your programs with the LDATs or is that more anecdotal? I am interested to know the evidence base around these particular groups, which, as you said in your opening remarks, have higher use.

Ms KARENA: We do some of that in Victoria, but I know there is probably a lot more happening in other states as well. So I will hand back to Erin, who has probably got a better view of that.

Dr LALOR: It is a great question. A lot of the feedback that we have had from local drug action teams that have taken an approach to connection to culture and country for Aboriginal and Torres Strait Islander communities—a lot of the evidence has been anecdotal at this point. The first couple of years of the LDAT program was establishing the program, getting communities up and running, and a lot of that was focused on capacity building. It is not unusual for community development programs like the Local Drug Action Team program to require that sort of start-up phase.

Over the next 12 months we are going to be undertaking an impact evaluation of the Local Drug Action Team program that will start to collect data that helps us understand the strengthening of those protective factors, and we are talking about the need for that evaluation to include both quantitative and qualitative mechanisms to be able to gather that data. Many of the Indigenous communities that we work with are undertaking activities that are much more appropriate for the geographical locations that they are in. Some of them are in far north Queensland or north-west WA, so they are quite different from the activities that we see in many of the metropolitan areas, and the evaluation approach that we would take to those is going to be very different as well.

The CHAIR: Thank you. Thank you again; this has just been fantastic. I want to just follow on a little bit from David's questioning around Canada. I am using Canada because I realise it is probably where you are most familiar with, Laura, and I know Erin has been in Canada as well. We heard this morning that legalisation or a regulated market does not necessarily get rid of the illegal market. We have heard varying information about what happens. I was just wondering if you have seen this with the illicit market in Canada and whether that is changing. Just following on from that, are there any other positive outcomes in the evaluations of the Canadian model that are starting to emerge?

Ms BAJURNY: I can speak to the findings of the *Canadian Cannabis Survey* that was released with the 2020 figures. That looks at—I brought my graphs this time—at the changes between 2019 and 2020 as to how many Canadians who participated in the survey are purchasing from a legal storefront and from a legal online source.

The CHAIR: Could you just tell us where—are these self-identifying or was this a random selection?

Ms BAJURNY: It is an online survey. People are informed that it is about cannabis. They believe that they have a higher proportion than the national average of people who do use cannabis responding to these surveys—which, when we are looking at prevalence data, is not ideal, but when we are looking at purchase data, is very helpful. There has been a really positive shift between 2019 and 2020, where 41 per cent of respondents in 2020 were saying that they purchased from a legal storefront and 13 per cent were saying they buy from an online source. They also asked how often people buy either legally or illegally. We are seeing that people reporting that they never make illegal purchases is sitting at 55 per cent of respondents. So it is not there yet, but they have seen big improvements. COVID might have had an impact on people's behaviour because cannabis stores were deemed an essential service, so people could still get cannabis—much like alcohol was in Australia.

The CHAIR: Yes.

Ms BAJURNY: People could still go to a legal cannabis storefront when maybe they would not have been able to pop around to their neighbourhood dealer's house anymore. Hopefully that shift is maintained over time. People are changing their habits. Also the market is starting to catch up. The way that it was rolled out between all the different provinces—because Canada, like Australia, is a lot bigger than people tend to think; there is a lot of regional variation and a lot of provincial control over things like licensing and density regulations—was done very differently in different places, and some places like British Columbia were very slow to open legal storefronts. They had all kinds of product supply issues. It seems as if that is starting to iron itself out, but definitely there are lessons to be taken away from how that has been managed.

The CHAIR: Yes. We saw the steady rate—the rate was not increasing—for young people using cannabis. From those figures, is there any way to extrapolate whether there has been an increase in cannabis use in Canada? Or are there are other jurisdictions that might have better data on that?

Ms BAJURNY: Overall, when we are talking about adults—and they frame adults as 16-plus in the Canadian cannabis survey—the critical thing is that we are seeing daily use remain stable because those are people who are more likely to be experiencing a dependence on cannabis. We have seen increases in past-

month use and past-year use, but because that is either monthly or yearly, not on a daily basis, those are people who are more likely to be using infrequently, possibly experimentally, less likely to be dependent. The other positive thing I would point to, although we are not seeing a huge jump forward in that 12 to 18 age of initiation, is that we are seeing increases in the 16-plus, where now the average age of initiation is 20 years old.

The other positive I would point to is about drug driving, which I know is a significant concern. So since legalisation, from 2018, they have seen the number of people reporting driving within 2 hours of smoking or vaporising cannabis, which is when someone is more likely to be intoxicated, come down. In 2018 it was 27 per cent and in 2020 it is 19 per cent—still far too many people, but clearly something is working there. There have been major changes to drug-driving laws and there have been big awareness programs, some of which were quite humorous, which can be a good way to cut through the noise and get your message across. But yes, they are seeing positive shifts in people driving after using cannabis.

The CHAIR: Just finally, you have spoken about it and we have heard it from other witnesses today that there needs to be ongoing education. I mean the protective factors and the resilience work will hopefully be intergenerational in that area. But if you are looking at a regulated market, and you may have some people who have never used cannabis before, was education factored into the legislation and was it part of the legislation or was it just a component that was seen as crucial to the rollout of legislation?

Ms BAJURNY: My understanding was that it was embedded. I would want to fact check myself, but my understanding is that a component of changing the laws was saying, 'Okay, we need to have widescale health education campaigns so that people understand things like that cannabis impairs your driving', and now in 2020 we have 83 per cent of Canadians who participated in the survey who understand cannabis makes you impaired to drive. I do think that the protective factors element is the critical piece and that whether it is Canada or Australia we are seeing young people at least experiment with drugs like cannabis, with drugs like alcohol, which is still our number one concern, and the great thing about primary prevention is it addresses all of those harms. What I would really like to see is that while some people might experiment with cannabis, I want to see them not be harmed by that experimentation and to be able to do so in a setting where they are supported, they are connected with their community, they have positive relationships with their family members, they have great sport and recreation activities to be parts of their lives so that maybe they use drugs occasionally but they are not harmed by that use.

The CHAIR: Thank you. Does anyone have any final questions? Could I just ask one quick question in that case? It is looking at that drug-driving issue. It is more acute I would say in Australia because we do far more roadside and random testing, whereas in most other jurisdictions it is more the suspicion of impairment. Do you have any thoughts on how we might be able to move forward on that in Australia?

Dr LALOR: I think part of the challenge that we have around drug driving is that unlike drunk driving there is no good evidence of the level of concentration that results in impairment, and until we have better research that really informs that, it is very difficult for us to be clear about the correlation between the concentration versus the impairment. So there is more work to be done in that space. We have seen some changes in the Canadian response to drug driving as they have learned more as they have rolled out their program, which Laura could potentially speak to. But I think until we have got good research around that relationship between concentration and impairment we really are a bit stuck.

Ms BAJURNY: Yes, and I think that nails it, Erin. Although Canada has changed their laws, it is imperfect. It is still a bit arbitrary. One of the important things that I think they did do was they introduced that the amount of cannabis and the amount of alcohol that are legal to have in your system are both reduced when they are present together.

The CHAIR: Yes, I thought that was really interesting. David, I will let you go.

Mr LIMBRICK: Just on the same issue of drug driving, which is a concern of mine also, if there is no good science on those impairment levels, does that not imply that what we are doing now is unjust?

Dr LALOR: Yes, it does.

The CHAIR: Yes.

Dr LALOR: And I think there has been a lot of discussion around the need for us to be looking for impairment versus just the level of concentration, when we do not have good evidence. The laws that we have around drug driving are imperfect. The evidence is imperfect. So we need to be working in the best way possible to address mechanisms to reduce harm without unnecessarily penalising people.

The CHAIR: And I think what we are hearing from the education in Canada is that it is not necessarily a level, it is actually a time—it might be just the time between when it was consumed and when the person then felt sober enough to get behind the wheel. Certainly looking at the figures that you have got in your submission, we have 26 drivers with a BAC rate of over .05, and then going back to the drug drivers, it is just that they had a presence of the drug. I have never been able to find any evidence of a connection to impairment or a connection between the drug and the accident. I am assuming there is not any, Erin.

Dr LALOR: Well, we do not know. We know that drugs are present in I think around 13 per cent of serious crashes in Victoria. What we do not know is how many of those crashes were caused by the presence of drugs. We have to assume that it is a harm related to drug use, because we know that you do get impairment from drug use; we just do not know the level. So I think we are all interested in and committed to reducing drug-related harm. In this particular instance there is not enough evidence for us to know categorically how we should do that in the best possible way.

The CHAIR: That is right. And I think you know 13 per cent are found—we have got 11.6 per cent of Victorians saying that they do use cannabis, and that is much higher in the under-30 group, which is more susceptible to road fatalities. So it is not surprising that we are finding cannabis in a percentage of those drivers.

Thank you so much again. Thank you for all the work you are doing, and I am really looking forward to hearing about the evaluation of the programs because given the work that this committee has done over the years, everything we look at—whether it is homelessness, whether it is brushing up against the conviction system—comes back to those protective factors and comes back to that resilience. We know that that resilience is actually what is going to help us in a whole range of areas, whether it is violence, whether it is homelessness, whether it is justice systems. Thank you on behalf of Australia.

Dr LALOR: Thank you.

Ms BAJURNY: Thanks for having us.

Committee adjourned.