Inquiry into the use of Cannabis in Victoria

Professor Nicole Lee

Organisation Name:360Edge
Your position or role: Director

SURVEY QUESTIONS

Drag the statements below to reorder them. In order of priority, please rank the themes you believe are most important for this Inquiry into the use of Cannabis in Victoria to consider::
Public health,Social impacts,Young people and children,Mental health,Education,Criminal activity,Public safety,Accessing and using cannabis

What best describes your interest in our Inquiry? (select all that apply) :
Working in the alcohol and drug services sector

Are there any additional themes we should consider?

Select all that apply. Do you think there should be restrictions on the use of cannabis? :
Personal use of cannabis should be decriminalised.
(Decriminalised: there are no criminal or civil penalties instead a person is referred to a drug diversion program or other health/ treatment service),Personal use of cannabis should be legal. ,Sale of cannabis should be legal and regulated. ,Cultivation of cannabis for personal use should be legal.

YOUR SUBMISSION

Submission:

Do you have any additional comments or suggestions?:

FILE ATTACHMENTS

File1: 5f4c2a44f3ce4-Submission Inquiry into the use of cannabis in Victoria.pdf
File2:
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Signature:
Nicole Lee

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Parliament of Victoria

Legislative Council, Legal and Social Issues Committee

Parliament House, Spring Street

EAST MELBOURNE VIC 3002

Professor Nicole Lee

Director at 360Edge

[redacted]

31 August 2020

Submission to inquiry into the use of cannabis in Victoria

Thank you for the opportunity to make a submission to the Inquiry into the Use of Cannabis in Victoria.

It is 360Edge's position that:

- The current criminalisation of cannabis possession and use exacerbates drug-related harms
- Cannabis-related harms would be better managed via a government regulated system of cannabis use, possession and supply, through decriminalisation or legalisation
- Reducing cannabis consumption by young people should remain a government priority and regulation is a means to achieve this

Cannabis use in Australia

Cannabis is the most commonly used illicit drug in Australia.[1] About 36% of Australians have tried cannabis at some time in their life and 11.6% have used it in the last 12 months. The Victorian prevalence of 11.5% is about the same as the national average.

The vast majority of people who use it are adults. People 30-49 years old are most likely to have used in their lifetime (with 51% of people 30-39 years old and 53% of people 40-49 years old having ever used it). People 20-29 years old are most likely to have used in the last 12 months (around 28% of that age group). The average age of first use of cannabis in Australia is 18.9 years old, and the average age of people who have used at least once in the last year is 34.9 years old. Around 19.1% of teenagers have ever tried cannabis, with only 10% of minors 14-17 years old ever trying it.

[1] Australian Institute of Health and Welfare 2020. National Drug Strategy Household Survey 2019: detailed findings. Cat. no. PHE 214. Canberra: AIHW.

Harms associated with cannabis use

Cannabis harms are low compared to other drugs

No drugs are without risks and harms. Compared to other common drugs, including alcohol and tobacco, cannabis is relatively less harmful.

In 2010, a multicriteria analysis by the UK Independent Scientific Committee on Drugs was conducted to assess the harms of 20 drugs based on 16 criteria.[2] The analysis has been very influential on drug policy. It found that heroin, crack cocaine, and methamphetamine were the most harmful drugs to individuals and alcohol, heroin, and crack cocaine were the most harmful to others. Cannabis was considered to be moderate-to-low risk across all criteria. [3]

A more recent study from Australia found similar results. Cannabis ranked 13th out of 22 drugs assessed (Figure 1).

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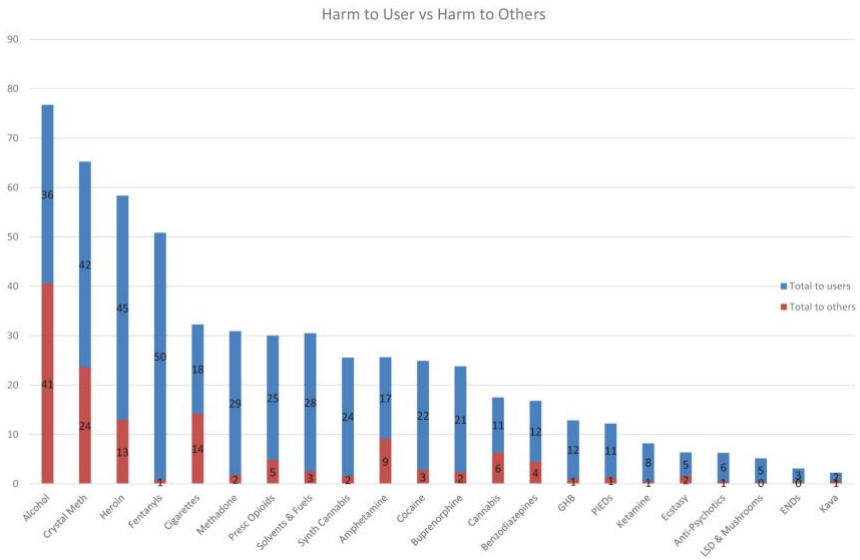
[2] David J Nutt, Leslie A King, Lawrence D Phillips. Drug harms in the UK: a multicriteria decision analysis. The Lancet, 2010; DOI: 10.1016/S0140-6736(10)61462-6
[3] David J Nutt, Leslie A King, Lawrence D Phillips. Drug harms in the UK: a multicriteria decision analysis. The Lancet, 2010; DOI: 10.1016/S0140-6736(10)61462-6

Figure 1: Harm to self and others of selected drugs (from Bonomo et al., 2019)



The causal direction of harms has not been established

Acute health harms as a result of cannabis use, such as overdose, are very rare. Harms commonly associated with recreational use of cannabis are generally mid to long term, including dependence, cognitive deficits, mental health problems, and, among younger people, poor school outcomes.[4]

The causal direction of these harms is not well established and the evidence of association is mixed. It may be, for example, that people with existing cognitive deficits or other risks factors for developing cognitive deficits are more likely to use cannabis, rather than cannabis causing those cognitive deficits.

There is no doubt that cannabis can produce short-term changes to thinking, working memory, executive function, and psychomotor function – that's one of the reasons why people use it.

A large longitudinal cohort study[5] found that, among people who were heavy users of cannabis, cognitive functioning declined more than people who used occasionally, but more recent longitudinal twin studies[6][7] concluded that there is no reliable relationship between cannabis use and cognitive functioning. The studies showed that adolescents who used cannabis had lower cognitive functioning before they started using cannabis.

Regular cannabis use has been found to double the risk of schizophrenia, but risk of psychosis due to cannabis consumption appears to be limited

[4] Hall, W. (2015), Cannabis health effects. Addiction, 110: 19-35. doi:10.1111/add.12703
[5] Meier MH, Caspi A, Ambler A, et al. Persistent cannabis users show neuropsychological decline from childhood to midlife. Proc Natl Acad Sci U S A. 2012;109(40):E2657-E2664. doi:10.1073/pnas.1206820109
[6] Jackson NJ, Isen JD, Khoddam R, et al. Impact of adolescent marijuana use on intelligence: Results from two longitudinal twin studies. Proc Natl Acad Sci U S A. 2016;113(5):E500-E508.
[7] Meier MH, Caspi A, Danese A, et al. Associations between adolescent cannabis use and neuropsychological decline: a longitudinal co-twin control study. Addiction. 2018;113(2):257-265.

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to certain vulnerable populations, who may have gone on to develop schizophrenia without cannabis use.

Young people, individuals with previous experience of psychosis and those with a high genetic risk of schizophrenia appear most at risk of psychosis due to cannabis consumption.[8] However, there are no indications that higher rates of cannabis consumption in the population increases the rate of schizophrenia.[9]

In addition, to put the risk in context, the rate of schizophrenia in the general community is approximately 1%. Therefore, the rate of schizophrenia among people who use cannabis is potentially 2% of the less than 12% that use regularly.

Teen cannabis use is associated with poorer school outcomes but, again, causation has not been established. It is likely that social determinants of health outcomes including family poverty, education, and employment are drivers of both early cannabis use and poorer school outcomes.

The lifetime risk of developing cannabis dependence is much lower than for other illicit drugs at 9% compared to 23% for heroin, 17% for cocaine, 15% for alcohol and 11% for stimulants.[10]

Daily use increases risk of dependence with around a third of daily users thought to be dependent.[11] Around 37% of people who use cannabis are daily users. So one third of 37% of all users are at risk of dependence.

Claims that cannabis is a 'gateway drug' which leads to consumption of more harmful drugs, has been thoroughly debunked.[12] While it is true that people who use other drugs later most often use cannabis first, the converse is not true - most people who use cannabis do not go on to use other drugs. [13] In addition, alcohol and tobacco usually precede cannabis use, which if the theory were correct, would make those drugs the 'gateway' to cannabis and other drug use.

Harms associated with cannabis prohibition

Australia's official policy on alcohol and other drugs, the National Drug Strategy, is based on harm minimisation. There are three pillars to this policy, including supply reduction (law enforcement), demand reduction (prevention and treatment) and harm reduction.[14]

In a harm minimisation framework, policies should focus on keeping harms to a minimum, resulting in a net reduction in harm. However,

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[8] Semple, David & Mcintosh, Andrew & Lawrie, Stephen. (2005). Cannabis as a risk factor for psychosis: systematic review. Journal of psychopharmacology (Oxford, England). 19. 187-94.
[9] Semple, David & Mcintosh, Andrew & Lawrie, Stephen. (2005). Cannabis as a risk factor for psychosis: systematic review. Journal of psychopharmacology (Oxford, England). 19. 187-94.
[10] Hall, W. (2015), Cannabis health effects. Addiction, 110: 19-35.
[11] www1.health.gov.au/internet/main/publishing.nsf/Content/health-pubs-drug-cannab2-ch73.htm
[12] A summary can be found at Dave Levitan, 'Is Marijuana Really a 'Gateway Drug'?' FactCheck <https://www.factcheck.org/2015/04/is-marijuana-really-a-gateway-drug/>
[13] Fergusson, D.M., Boden, J.M. and Horwood, L.J. (2006), Cannabis use and other illicit drug use: testing the cannabis gateway hypothesis. Addiction, 101: 556-569. x
[14]Australian Government, National Drug Strategy nationaldrugstrategy.gov.au

some of the most significant harms from using illicit drugs, including cannabis, are precisely because they are illegal.

Despite the platform of harm minimisation, the focus on prohibition to achieve this has resulted in:

- A flourishing unregulated black market, with no quality control or limits on purchase of cannabis by minors.[15]
- The stigmatisation and life-altering impacts of criminalisation, including labelling effects, employment and visa limitations as a result of a criminal record and the criminogenic effects of imprisonment. [16]
- Significant burdens on the justice system (police, courts and prisons) to prosecute drug-related offences and/or to divert offenders to programs.[17] [18]
- Default normalisation of alcohol as the most widely consumed, psychoactive substance in Australia despite significant harms.[19]
- Criminalisation acting as a barrier to harm reduction interventions.[20]

Recognising the failures of prohibitionist approaches to drug policy, many countries are now exploring other strategies to reduce cannabis related harms, including decriminalisation and legalisation.

Cannabis decriminalisation

The decriminalisation of cannabis refers to the removal of criminal penalties for the use and possession of cannabis within a jurisdiction.[21]

Decriminalisation of small quantities of cannabis exists in the ACT, South Australia and the Northern Territory.[22] Despite nearly 30 years of decriminalisation, ACT and South Australia have the lowest rates of cannabis use in Australia (10.5% and 10.6% respectively, compared to the Australian average of 11.6%).

Decriminalisation models do not involve the legalised sale or cultivation of cannabis, merely the removal of criminal penalties for use and possession.

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[17] Ritter, A., McLeod, R., & Shanahan, M. (2013). Monograph No. 24: Government drug policy expenditure in Australia – 2009/10. DPMP Monograph Series. Sydney: National Drug and Alcohol Research Centre.
[18] Shanahan, Marian; Hughes, Caitlin and McSweeney, Tim. Police diversion for cannabis offences: Assessing outcomes and cost-effectiveness [online]. Trends and Issues in Crime and Criminal Justice, No. 532, Jun 2017: 1-13
[19] Reiman, A. Cannabis as a substitute for alcohol and other drugs. Harm Reduct J 6, 35 (2009).
[20] O'Keefe D; Ritter A; Stoove M; Hughes C; Dietze P, 2020, 'Harm reduction programs and policy in Australia: Barriers and enablers to effective implementation', Sucht, vol. 66, pp. 33 - 43
[21] Hughes, C., Ritter, A., Chalmers, J., Lancaster, K., Barratt, M. & Moxham-Hall, V. (2016). Decriminalisation of drug use and possession in Australia – A briefing note. Sydney: Drug Policy Modelling Program, NDARC, UNSW Australia.
[22] Hughes, C., Ritter, A., Chalmers, J., Lancaster, K., Barratt, M. & Moxham-Hall, V. (2016). Decriminalisation of drug use and possession in Australia – A briefing note. Sydney: Drug Policy Modelling Program, NDARC, UNSW Australia.

Cannabis has been decriminalised (to varying degrees) in many countries across the world.[23]

Research has found the following benefits to the decriminalisation of cannabis:[24]

- Lower costs to society, especially the criminal justice system.
- Lower costs to individuals, including improving employment prospects.
- No change to drug use or drug-related crime as a result of decriminalisation.

However, a key disadvantage of the decriminalisation model is that it has no impact on cannabis supply, allowing black market operators to continue to operate.

Cannabis legalisation

Cannabis legalisation involves implementing a model for regulated cannabis supply to the population.

Sale, supply, possession and use of cannabis has been legalised in Uruguay, Catalonia, Canada and a number of jurisdictions in the United States.[25]

There have been some promising findings from these countries including:

- No evidence of increased cannabis use by young people following legalisation.[26]
- Decreased illicit drug markets in legalised jurisdictions (although some indication of cross-border illicit activity).[27]
- No increase in crash fatality rates in legalised jurisdictions.[28]

If cannabis is legally supplied, the number of people who come in contact with the criminal justice system will almost certainly be reduced, but little is known about the size of reduction. Likewise, the impact on drug treatment outcomes is unclear,[29] although presumably, as stigma is reduced access to treatment is improved.

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[23] Including Portugal, Argentina, Austria, Belgium, Belize, Bermuda, Bolivia, Chile, Columbia, Costa Rica, Croatia, Czech Republic, Ecuador, Estonia, Georgia, Israel, Italy, Jamaica, Luxembourg, Malta, Mexico, Moldova, Netherlands, Paraguay, Peru, Slovenia, South Africa, Spain, Switzerland, and 16 states and 1 territory in the United States.

[24] Hughes, C., Ritter, A., Chalmers, J., Lancaster, K., Barratt, M. & Moxham-Hall, V. (2016). Decriminalisation of drug use and possession in Australia – A briefing note. Sydney: Drug Policy Modelling Program, NDARC, UNSW Australia.

[25] EMCDDA, 'Models for the legal supply of cannabis: recent developments' emcdda.europa.eu/topics/pods/legal-supply-of-cannabis

[26] JA Dilley, SM Richardson, B Kilmer, RL Pacula, MB Segawa, M Cerda Prevalence of cannabis use in youths after legalization in Washington State JAMA Pediatr, 173 (2019), pp. 192-193

[27] Hall, Wayne, Stjepanović, Daniel, Caulkins, Jonathan, Lynskey, Michael, Leung, Janni, Campbell, Gabrielle and Degenhardt, Louisa (2019). Public health implications of legalising the production and sale of cannabis for medicinal and recreational use. The Lancet 394 (10208) 1580-1590.

[28] JD Aydelotte, LH Brown, KM Luftman, et al. Crash fatality rates after recreational marijuana legalization in Washington and Colorado Am J Public Health, 107 (2017), pp. 1329-1331

[29] Hall, Wayne, Stjepanović, Daniel, Caulkins, Jonathan, Lynskey, Michael, Leung, Janni, Campbell, Gabrielle and Degenhardt, Louisa (2019). Public health implications of legalising the production and sale of cannabis for medicinal and recreational use. The Lancet 394 (10208) 1580-1590.

Research has found some increases in use among middle- and older-aged groups in legalised jurisdictions, but not amongst young people.[30]

One study,[31] found small increases in cannabis disorder in legalised jurisdictions in the United States. The proportion of respondents aged 12 to 17 years reporting cannabis use disorder increased from 2.18% to 2.72% after legalisation. The proportion of respondents 26 years or older reporting frequent cannabis use increased from 2.13% to 2.62% and those with cannabis use disorder, from 0.90% to 1.23%.

This year, the ACT partially legalised cannabis, allowing adult residents of the ACT to grow up to 2 plants per person to a maximum of 4 per household, or to possess 50g or equivalent of dried cannabis.[32] The legislation has enabled the ACT Government to put in place numerous safeguards to protect the interests of children and young people. Under the legislation, use and possession is legal but sale and supply of cannabis is still a criminal offence.

No jurisdictions in Australia currently allow for the regulated commercial supply of cannabis.

Given the risks associated with the current black market in cannabis, 360Edge supports a cannabis legalisation model in Victoria that includes regulated supply.

Models for regulated cannabis supply range from very restricted approaches (such as Uruguay) to free market approaches (such as USA).

Best-practice controls are similar to controls over alcohol and tobacco, including:[33] [34]

- Strict regulation of product including limits on potency, labelling and packaging
- Age limits
- Bans on advertising
- Graduated taxation measures designed to disrupt black markets firstly, followed by ‘sin taxes’ to disincentive heavy use
- Continued prohibition on driving whilst impaired by cannabis
- Clear public health messaging to ensure that the public is well informed about potential harms and how to avoid associated health and social problems.[35]

It should be noted that although commercialised models have dominated global discussions, alternative ‘middle-ground’ legalisation

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[31] Cerdá M, Mauro C, Hamilton A et al. Association between recreational marijuana legalization in the United States and changes in marijuana use and cannabis use disorder from 2008 to 2016. JAMA Psychiat 2020;77:165–71
[32] Drugs of Dependence (Personal Cannabis Use) Amendment Bill 2018 (ACT)
[33] A Englund, TP Freeman, RM Murray, P McGuire Can we make cannabis safer? Lancet Psychiatry, 4 (2017), pp. 643-648
[34] Beau Kilmer (2019) How will cannabis legalization affect health, safety, and social equity outcomes? It largely depends on the 14 Ps, The American Journal of Drug and Alcohol Abuse, 45:6, 664-672.
[35] Hall W. Minimizing the adverse public health effects of cannabis legalization. CMAJ. 2018;190(35):E1031-E1032.

models exist. For example, Vermont and Washington, DC have limited legal cannabis supply to home grows and gifting.[36]

Other options for cannabis supply include government monopolies to allowing socially responsible businesses that do not exclusively focus on profit. [37]

Reducing cannabis use by young people

Regardless of which policy models are implemented, we support steps to limit the consumption of cannabis by young people under the age of 18.

When it comes to reducing cannabis consumption by young people, there is little evidence that mass media campaigns have an impact.[38]

There is a small but convincing evidence base that shows that brief interventions for young people can lead to behaviour change for alcohol and other drugs.[39] [40]

Tailored drug education programs can be effective. However, the evidence doesn't support all types of programs. School based programs that adopt a harm reduction goal rather than a narrow focus on decreasing demand have been shown to prevent and reduce alcohol and other drug use.[41] [42]

For school-based drug education programs, the best interventions:[43]

- use interactive methods
- are delivered by trained facilitators
- are delivered through a series of structured sessions with refreshers
- normalise the non-use of alcohol and other drugs
- impact perceptions of risk associated with substance use
- provide opportunities to practise and learn personal and social skills.

Programs are more likely to be ineffective if they:

- use didactic methods
- are information-only, particularly if they are based on fear
- are based on unstructured chat sessions

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[43] UNODC, 'International Standards on Drug Use Prevention' (2015) available online at: https://www.unodc.org/documents/prevention/UNODC_2013_2015_international_standards_on_drug_use_prevention_E.pdf

- focus only on building self-esteem and emotional education
- address only ethical or moral decision-making or values
- use ex-drug users as testimonials
- use police officers to deliver the program.

There is evidence to support both universal school-based programs (delivered to all students regardless of risk), [44] as well as more specialist programs to target young people at greater risk.[45] The latter seems to have greater impact, but needs to be implemented carefully to avoid stigmatising at-risk young people.

Conclusion

Addressing cannabis related harms requires re-thinking how we approach drug policy. The aim should be for a net reduction in harm, which is in line with Australia's official drug policy. Currently, the legal status of cannabis increases drug related harms.

There is compelling evidence for Victoria to decriminalise cannabis use and possession, as well as strong evidence for the legalisation of cannabis supply.

Legalisation or decriminalisation of cannabis use by adults, would allow resources to be prioritised on preventing cannabis use and harms by young people.

360Edge welcomes the opportunity to assist in implementing best-practice cannabis policy in Victoria and is available to provide further evidence if necessary.

Yours sincerely,

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[44] Teeson, M, Newton, N and Barrett, E 'Australian school-based prevention programs for alcohol and other drugs: A systematic review' (2012) 31(6) *Drug and Alcohol Review*
[45] Newton et al, 'The long-term effectiveness of a selective, personality-targeted prevention program in reducing alcohol use and related harms: a cluster randomized controlled trial' (2016) 57(9) *Journal of Child Psychology and Psychiatry*

About Dr Nicole Lee

Nicole is Director at 360Edge and Adjunct Professor at the National Drug Research Institute, Curtin University. She is a member of the Australian National Advisory Council on Alcohol and other Drugs (ANACAD) and board member, and chair of the Clinical Governance Committee, at Hello Sunday Morning. She is an International leader on alcohol and other drug practice and policy and has published widely on the topic. Nicole is a psychologist with 30 years' experience in the alcohol and other drug and mental health sector, and has provided key policy advice to state, commonwealth and international governments, as well as major international health organisations like the World Health Organization and the United Nations Office on Drugs and Crime. She is Deputy Editor of Drug and Alcohol Review and Fellow of the Australian Association for Cognitive and Behaviour Therapy.

About Jarryd Bartle

Jarryd is a Consultant at 360Edge and the owner of Jarryd Bartle Consulting, a specialist criminal justice consultancy. Jarryd is a specialist in the use of 'vice' laws to regulate anti-social behaviour and is an expert on criminal justice issues related to illicit drugs, sex work and 'deviant' subcultures. Jarryd has provided policy advice to state and federal governments, as well as not-for-profits and industry associations on his areas of expertise. Jarryd is also a sessional lecturer in criminal justice topics at RMIT University.

About 360Edge

We are a leading Australian health consultancy, specialising in the alcohol and other drug, and allied, sectors. We provide a full suite of advisory services to help health service organisations accelerate change. We work with leading international organisations, governments and not for profit agencies across Australia and internationally.

Our vision is for a thriving service system that provides the best policy and practice responses right across the spectrum of alcohol and other drug use. We see a sector that has continuous improvement at its core and is resilient and adaptable to change. Our mission is to ensure governments and services have the tools they need to respond effectively and efficiently to people who use alcohol and other drugs to reduce harms.

We are driven to make a positive impact in the world and strongly believe in social justice and human rights, and it drives all of our work. We believe that everyone has the right to the opportunities and privileges that society has to offer. Our values of excellence, transparency and integrity are at the core of everything we do. We live these values within the team and with our customers and collaborators.

Our team of experienced 'pracademics' take a 360 approach to viewing situations from multiple perspectives. We collaboratively and holistically work with our clients at every stage, wherever they are in the cycle of change, to achieve their goals. Our team of experienced 'pracademics' take a 360 approach to viewing situations from multiple perspectives.

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